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Delivering Psychological Services to Military Members

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Abstract

Since 2001, less than half of one percent of the American public have volunteered to serve in the United States Armed Forces. With high-tempo repeated deployments and unconventional warfare, the Post 9/11 military has been exposed to unique trauma and stressors during an unprecedented *two-decade long* conflict. In voluntarily taking on this role, members are immersed in the total institution of military culture and required to make countless personal sacrifices, often experiencing trauma or other stressors that most in a civilian population will never face. Prevalence rates of mental health problems in active duty as well as veteran populations suggest that approximately 15-30% have acquired mental health conditions (including PTSD, TBI, depression). Substance use and suicidality are often comorbid and may complicate the clinical profile considerably. Current treatment approaches include those well validated and common in general clinical populations (i.e., CBT, PE, CPT) although many have been modified for use with veterans. Nonetheless, despite billions of dollars in public support, many military members continue to not receive the mental health services they need. Challenges include system and access barriers, a lack of military cultural competency in providers, as well as societal and institutional stigma leading to veteran reluctance to seek mental health treatment. Best practice recommendations are offered to clinicians who seek to better serve clients who are military members (both active duty and veterans).

Delivering Psychological Services to Military Members

Currently, service members in the United States Armed Forces[1] comprise less than half of one percent (0.04%) of the nation's adult population (U.S. Department of Defense [DoD], 2017). In voluntarily taking on this role, military members are immersed in an all-encompassing culture and required to make countless personal sacrifices, often experiencing trauma or other stressors that most civilians will never face. Over the past two decades, a grateful nation has provided unprecedented levels of support for the many brave servicemen and women who choose this career path. It may therefore come as a surprise to some that, despite this support, many military members[2] remain underserved in the area of mental health. Challenges include system and access barriers, health providers' lack of familiarity with military injuries, needs, and culture, as well as military members' own stigma-related reluctance to seek treatment.

This chapter will provide mental health clinicians with suggestions for practice, grounded in a review of the literature, and integrated with the professional experience of the authors, both of whom have extensive experience working with this population. We will outline the challenges and detail the qualities necessary to work effectively with psychotherapy clients who are military members.

Scope of the Problem

In many ways, September 11, 2001 ushered in an era of unprecedented change for U.S. service members and those tasked with their care. Although veterans from all eras face unusual challenges, a number of factors aggregate to create a unique risk profile for veterans of post-9/11 conflicts. For combat troops, proliferation of devastating improvised explosive devices (IEDs)

[1] The U.S. Armed Forces comprise five branches: Army, Marines, Navy, Air Force, and Coast Guard (in war time). The National Guard and Reserve components are also included in total force demographics.
[2] The term *military member* will be used when referring to active duty service members and veterans as a group.

required a state of chronic hypervigilance for survival. Unlike any prior era, a significant portion of the military became battle weary as a result of multiple deployments. In fact, since 2001, a quarter of all service members have been deployed three or more times (prior eras saw a smaller percentage of servicemembers deployed to war zones, and typically only once). Health care providers adjusted rapidly to an evolving picture of complicated mental health conditions (MHCs)[3] including posttraumatic stress disorder (PTSD), traumatic brain injury (TBI) and related polytrauma. Although there is variability among the branches, one thing is clear: the prevalence of MHCs in the active duty military rose over the past decade, peaking in 2012-2013 when it reached an average of 24% for all branches combined. Fortunately, however, the same data also appear to reflect a modest downward trend since that time (cf. 20% in 2016) (Deployment Health Clinical Center [DHCC], 2017).

A Complicated Clinical Profile

As military medicine rapidly upskilled to cope with new and complicated injuries, survival rates improved. More seriously injured and blast-exposed service members were surviving than in previous eras, but they were surviving with polytraumatic injuries requiring lifelong care. Known as the "signature wounds" of Iraq and Afghanistan, PTSD and TBI estimates increased steadily. Survival in war zones, especially for those who are repeatedly deployed, requires a mental 'battle hardening;' this often means habituating to ever present trauma, violence, and death. While perhaps adaptive in combat, these changes can increase risk of MHCs and high-risk behaviors including substance abuse and suicidal ideation (Brenner et al., 2008).

[3] Authors have intentionally chosen to use the term *mental health condition* (MHC) when discussing clinical categories that may span psychological/emotional (e.g., depression) as well as neurophysiological (e.g., TBI) disorders. MHC is a more encompassing term, and our clinical experience has been that many military members respond more favorably to discussing their 'condition' rather than 'illness' or 'disorder.'

Mental Health Conditions (MHCs). In 2008, RAND released *The Invisible Wounds of War,* a seminal research report that found 31% of returning combat deployed service members met criteria for a primary MHC (PTSD or depression (11.2%); TBI (12.2%); and TBI comorbid with PTSD and/or depression (7.3%)). Importantly, only slightly more than half of those with PTSD or depression sought help, and only 43% of those with TBI engaged with care providers (Tanielian & Jaycox, 2008). By 2014, the Institute of Medicine (IOM) had updated estimates of MHCs that were two to three times higher than previously assumed. Specifically, they found 20-23% of military members met criteria for TBI, and up to 24% for PTSD. Additionally, the post-9/11 era saw an increasing awareness of issues disproportionately affecting women (now 10-15% of total forces). Research indicates that military sexual trauma (MST) is reported by up to 24% of military women compared to 1% of their male counterparts (Gundlapalli et al., 2017). Women who are victims of MST are at nine times the risk for developing PTSD compared to peers with no MST history, and suicide risk is also elevated (Murray-Swank, Dausch, & Ehrnstrom, 2018).

Military Suicide. Any gesture, attempt, or suicide is—clinically—a critical situation. Furthermore, it is the case that approximately one in five suicide victims in the United States is a veteran, and that veterans may be at slightly elevated risk for taking their own lives when compared to civilians (U.S. Department of Veterans Affairs [VA], 2016). However, it is not clear that military suicides have dramatically increased as is commonly reported. Often, suicide rates in the military are compared directly with civilian rates; however, given the demographics of the military, this is not an appropriate comparison (Ramchand, 2018). Recently, researchers undertook a comprehensive analysis adjusted for demographic and other differences and found that—contrary to popular belief—rates of military suicide, historically, were actually *lower* than that of the civilian population. Something did change in 2005—military suicide rates began to

increase *up to* that of the civilian population (Reimann & Mazuchowski, 2018). However, it does not appear the increase in suicide rates was due to combat exposure or the stress of deployments as was commonly assumed; in fact, rates for the never-deployed active duty, Reserve and Guard components also increased. In the large-scale longitudinal *Millennium Cohort Study*, factors most strongly associated with military suicide were sex (male), mental disorder (depression, 'manic depression') and substance abuse (alcohol). Combat and other deployment experience did *not* factor into any of the predictive models (LeardMann et al., 2013).

Poverty. Although many military members have a right to access services and assistance, a disturbing percentage of veterans face both food and housing insecurity (Fargo et al., 2012; *Feeding America*, 2017; U.S. Department of Housing and Urban Development [HUD], 2018). In 2017, for example, *Feeding America* (now partnering with the VA) reported that 20% of households receiving regular food aid contained at least one veteran or military member. Additionally, when compared to civilians, male veterans are at 1.3 times the risk of homelessness and women veterans are at 3.6 times the risk of homelessness. Fortunately, this problem has been addressed aggressively, and numbers are continuing to drop from a high of 200,000 homeless veterans in 2003 to 40,000 in 2017 (HUD, 2018).

Family Problems. On average, military members marry and have children earlier than their civilian counterparts; not only must military members adjust to a potentially high-risk career, they also bear the responsibility of engaging their family in this lifestyle (Clever & Segal, 2013). As might be expected given the unique stressors of military life, the families of military members evidence a slightly higher risk of behavioral and mental health problems when compared to the civilian population; military children sometimes manifest anxiety/mood problems as well as difficulties in school (Siegel & Davis, 2013). Military spouses often struggle

to cope with the responsibilities of both parental roles while the military member is away (Lewy, Oliver, & McFarland, 2014).

Considerations for the Clinician. Although anywhere from 15-30% of military members live with a MHC, given the demands of military life, it could be argued that most military members and their families evidence a remarkable degree of resilience. This reminder is offered as a caution against perceiving veterans as a "broken" or "disabled" population as they are often portrayed in media representations. Therapeutically, it is more helpful to adopt a strengths-based approach with military members; not only is it less stigmatizing, such an approach is similar to military culture and values familiar to the client.

Barriers to Service Delivery

Systems of Care

None of the major systems of care serving military members are designed to collaborate or share information, and eligibility criteria can vary. Demand routinely exceeds capacity, and there are longstanding calls for broad reforms and improved solutions. Not surprisingly, from the veteran's perspective, finding treatment can seem like a daunting task.

Private Sector. Although federal agencies provide care to a vast number of veterans, the need is greater. To address this gap, thousands of non-profit, faith-based, and community-based organizations sprung up post-9/11 to offer free services to veterans (Tanielian, Batka, & Meredith, 2017). Philanthropic contributions for these initiatives were strong in the early years of the conflicts; however, donor support has declined steadily over the past decade. Furthermore, many organizations provide excellent care; however, because most are free from federal oversight, there is no way to ensure quality or consistency of care. Additionally, the fact that

veteran information is not shared between private and federal entities can be problematic when attempting to coordinate care for the veteran (especially those in crisis).

Government. It may be surprising to learn that less than half of the nation's 22 million veterans are enrolled in federally-supported systems of care (Tanielian, Batka, & Meredith, 2017). The enrollment rate for post-9/11 veterans is higher (62%) than the average, with nearly six in ten of enrolled veterans carrying a mental health diagnosis (VA, 2017). Military members receive health care primarily from two federal systems: The Military Health System (MHS) within the DoD serves active duty and retired veterans; the Veterans Health Administration (VHA) within the VA primarily serves veterans. Eligibility requirements vary, and not all veterans qualify for VA care; however, the VHA provides health care to approximately 40% of all veterans and some active duty service members. With more than 1,200 health care facilities and programs, the VHA is the largest integrated health care system in the United States; currently, more than 9 million veterans are enrolled in VA programs (VA, 2018).

The MHS and the VHA provide a wide range of specialized and cutting-edge mental health care programs and clinics for military members; indeed, they are often on the forefront of state-of-the-art treatment approaches such as virtual reality exposure therapy for PTSD (Rizzo, Hartholt, Grimani, Leeds, & Liewer, 2014). Nonetheless—as might be expected within systems of care serving millions of military members—barriers remain.

Access to Care

Recently, attention has been paid to long wait lists and other issues for veterans receiving care at the VA (e.g., Government Accountability Office [GAO], 2016). In 2014, the V*eterans Access, Choice, and Accountability Act of 2014* (Veterans' Choice Program) was created by Congress, which authorized a 10-billion-dollar fund, in an effort to ensure speedy access to a

civilian doctor for veterans who (a) live 40 miles or more from a facility, or (b) cannot see a VA doctor within the mandated 30-day consultation window. The Veterans' Choice program was widely applauded but rapidly drew down funds and soon approached bankruptcy, forcing the government to face the spectre of another debilitating scandal and potential shutdown of services. In an effort to avoid this, *The VA Choice and Quality Employment Act of 2017* was signed into existence and an additional 2.1 billion dollars was authorized to provide for continued service provision, hiring and training of even more providers, and research and development initiatives.

Wait times. The VA has implemented improvements and wait times generally have decreased steadily according to data posted publicly (VA, 2018). Wait time is measured as the amount of time before a veteran is seen, relative to the preferred appointment date. For example, if a veteran is due to be seen by October 10, but the first available appointment is October 15 – the wait time would be five days. Fortunately, according to available data, the average wait time for a VA mental health appointment is currently only 5.74 days; however, veterans may wait longer depending on a number of variables (type of treatment required, specialized services available (e.g, polytrauma, PTSD clinics), and regional issues (such as ratio of providers to veterans)). In addition to other measures, the VA has responded to criticism by expanding capacity, hiring thousands of additional providers, and offering high quality training in evidence-based practice (EBP) to clinicians. The VA has also improved transparency by offering online access to view average wait times at local facilities as well as quality ratings of the care provided. These efforts appear to be slowly paying off; some recent studies have found strong support for and satisfaction with VA-based care (Brunner, 2018; Kimerling, 2015).

Priority Ranking System. In the VA health care system, veterans are enrolled based on

an eight-tier scheme which gives preference to those with low income and service-connected disability ratings (for example, conditions rated 50% or more disabling are given first priority; Purple Heart recipients and prisoners of war (POWs) are ranked in the third tier). This system was intended to ensure that the most in-need veterans receive attention first; however, especially if other barriers are present (e.g., distance), this type of priority scheduling may deter those veterans with MHCs who have not yet been evaluated for service-connection and/or are not considered to be significantly disabled (both of which would fall into priority tier 5).

Distance. Although most VA facilities are located in urban settings, approximately one in four veterans live in rural communities. A specialized office was created in 2007 to address health issues present in the 2.8 million veterans in rural communities across America (VHA Office of Rural Health [ORH], 2016). For rural veterans, the long distances from urban centers limit timely and routine access to many kinds of services, including mental health care. The majority of rural residens are men, but the isolation also negatively impacts women veterans' access to care (up to one third of women veterans reside in rural locales), especially for those who have a history of MST (Brunner et al., 2018; Murray-Swank et al., 2018). Of gravest concern, rural veterans appear to be at higher risk of suicide than their urban counterparts (ORH, 2016), and nearly twice as likely (60%) as urban veterans (35%) to own personal firearms (Cleveland, Azrael, Simonetti, & Miller, 2017), a factor that greatly increases risk of suicide completion.

Considerations for the Clinician. Clinicians are encouraged to appreciate the significant barriers that many veterans must overcome to access mental health care. Not only may they have waited a long time to qualify for service, the veteran may have traveled a great distance or at great inconvenience to keep an appointment. Respect for their time is shown by adhering to an

established schedule and booking appointment times well in advance and at the veteran's convenience if possible. If telehealth treatment options are available and appropriate, this approach may be advantageous for some.

Reluctance to Seek Treatment

Surveys of military members show that concern about the impact of seeking and receiving mental health care is intimately tied to stigma (Bovin et al., 2018; Brown & Bruce, 2016; DeViva et al., 2016; Hoge et al., 2004). Over the past two decades, service members appear to be *slightly* more likely to seek mental health care; however, more than half of those with problems still do *not* seek help suggesting that de-stigmatizing efforts must continue (Quartana et al., 2014).

Negative career impact. Willingness to seek treatment has been linked to concerns about public shaming and self-stigma, but even more importantly, to concern about the impact on career trajectory. In fact, worry about negative career impact is consistently rated as the first (Brown & Bruce, 2016) or second (Tanielian & Jaycox, 2008) most important reason for refusing to seek help for mental health problems. These results suggest that while stigmatization in general is problematic, the culture within military institutions may be even more so. Service members with a MHC may struggle with valid concerns about the potential for a denied promotion, or retracted security clearance, should they request help for MHCs. Acknowledging the cultural stigma as well as concern about military suicide, military leaders have begun to speak openly about MHCs and the need to seek help early (Acosta et al., 2014).

Self-stigma. Even discussing a condition such as PTSD can be difficult for veterans. For example, the word "disorder" in *posttraumatic stress disorder* is so objectionable to many military members that they have either dropped the word entirely (referring instead to 'PTS') or

advocated for changing it to ‘injury’ (or *PTSI*). This latter proposition was considered so important that the cause was taken up by (now retired) Army General Chiarelli, who brought his request to the American Psychiatric Association (APA) as it planned the fifth revision of its Diagnostic and Statistical Manual for Mental Disorders (DSM) in 2012. Ultimately, the status quo prevailed; however, this brief foray into the highly charged and political realm of disorder-naming revealed that there are sensitivities on all sides. To effectively address stigma means acknowledging its existence at the public, institutional, and individual levels.

Considerations for the Clinician. As authors have noted previously—words matter. Simply choosing language that allows veterans to engage in discussion about psychological injuries without feeling ‘broken’ or ‘weak’ may serve to increase their engagement. Use of the more general term ‘mental health condition’ in conversation is both accurate and less stigmatizing than mental ‘illness’ or ‘disorder.’ If the client prefers ‘PTS’ to ‘PTSD,’ there is no harm in referring to the condition as ‘PTS.’ By mirroring their use of language, you not only make the veteran feel ‘heard,’ you are also protecting their dignity and demonstrating sensitivity around their psychological wounds.

Developing Military Cultural Competence

Although it has gained more currency recently, efforts to promote military cultural competence is not a new endeavor (Carrola & Corbin-Burdick, 2015; Luby, 2012; Meyer, Writer, & Brim, 2016; Strom et al., 2012). One of the more thoughtful, relevant, and comprehensive reviews of the subject is offered by Reger and colleagues (2008). Highlighting the fact that the military is indeed its own unique and distinct culture, they note “to the extent that a culture includes a language, a code of manners, norms of behavior, belief systems, dress, and rituals, it is clear that the Army represents a unique cultural group” (p. 22). In fact, these aspects of culture

apply equally well to each of the five branches comprising the United States Armed Forces. As clinicians, the importance of cultural competence is reinforced by the American Psychological Association's Ethics Code (2017):

> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their branches or research, psychologists have, or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their branches, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies. (pp. 4-5)

To be successful working with military members, clinicians must have an overall appreciation for military culture as well as the impact of that culture on the formation of its members' identity. For many Americans, the terms *mission, teamwork*, and *service* are words that are used loosely in the workplace and peppered throughout human resource presentations. For military members, these words have a significance far beyond the way in which they are used in civilian settings. Veterans may have comrades who gave their lives in support of *the mission*, and being part of a *team* meant being willing to literally place the life and welfare of your soldiers above your own. It is critical therefore that clinicians first learn to listen carefully and respectfully to the language used by military members; common terms can have different meaning and valence.

There are many differences between the five branches of service (and even within each branch, subcultures exist); however, a common military culture is woven throughout. Values like

honor, duty, obedience, and sacrifice are forged into a core ethos that helps to create a cohesive and strong fighting unit. Understanding military values and principles is essential to forming effective therapeutic relationships with military members. Following is a brief discussion of a few core themes.

Collectivism: The Importance of the Group Over Self

Perhaps the most significant difference between civilian and military cultures is how the military places great emphasis on the importance of the group over the individual; this style is termed *collectivism*. Collectivism is the expression of a cultural value system that emphasizes group cohesiveness, interdependence, common values, and subjugation of self-interest in favor of group benefit (Christian, Stivers, & Sammons, 2009). On the other hand, in American society, *individualism* is both promoted and valued. As a result, it can be difficult for civilians to understand and respect the mindset that is required in a truly collectivistic organization such as the military. Specifically, collectivism demands (a) acceptance that one's value is only as part of the larger group, (b) an engagement with and commitment to the group on an emotional level, and (c) a singular focus on the goals of the group over one's own agenda (McGurk, Cotting, Britt, & Adler, 2006). This ethos is inculcated in military members from the first day of basic training. Eventually, such values permeate all aspects of a service member's worldview and lifestyle.

Collectivism is the model for militaries worldwide primarily for the purpose of getting things done. In order to accomplish group goals (referred to as the *mission*), service members must work together as a cohesive team with a single vision. In the military, few goals can be accomplished by a solitary individual. The complex and high stakes nature of military assignments is not conducive to solitary viewpoints, perspectives, or efforts. The mission often

requires many highly trained and educated professionals working together towards a common goal. In the civilian world, although teamwork is considered important, a premium is placed on individual accomplishments and self-promotion. In the military, it is just the opposite: only when the team succeeds, does the individual succeed.

As discussed by Moore (in press), collectivism is also important for maintaining unit morale. In my (B.A.M.) experience as an Army psychologist consulting on behavioral health issues with commanders and other senior military leaders in Iraq, lack of unit cohesion and low morale were almost always at the center of a poorly functioning unit. Invariably, these poor functioning units had senior leaders who put their own needs before the needs of their soldiers, in sharp contrast to core military values. Although this style is often a byproduct of poor training or deficient leadership abilities and not intentional, the lack of a collectivistic unit culture created tension, strife, and hostility between team members. In turn, this led to poor decision making, reduced compassion and empathy, and loss of purpose and meaning.

Considerations for the Clinician. To work effectively with military members, the clinician must understand the central and overarching importance of collectivism. Even after separating from the military, many veterans continue to be influenced by and live their lives in accordance with the values and principles inculcated during military service. If a clinician promotes and urges autonomy and independence within the therapeutic relationship too early, it is possible that a breakdown in communication and trust may occur. Moreover, clinicians should be careful not to view some values—such as a need for strong structure and order—as inherently dysfunctional. Clinicians should become intimately aware of their own value system; as with any client, the psychotherapist's own value system can have a significant impact on treatment outcomes.

Solution Focused: Adapt and Overcome

The phrase "adapt and overcome" is commonly used in the military. It is used to convey the high value placed on personal characteristics of determination, grit, and problem-solving. This philosophy is taught to service members from the first day of basic training and emphasized throughout their careers. Service members are taught that problems are merely obstacles that must be overcome in order to achieve a goal; resilience and dogged refusal to give up on a problem are highly praised. This philosophy also reminds the service member that flexibility and adaptability are critical characteristics that must be practiced and applied.

Considerations for the Clinician. The focus of psychotherapy over the past few decades has shifted from passivity and exploration to one of activity and awareness. Cognitive-behavioral therapy, the most commonly employed and highly-researched approach, has broad applicability here. Although every client is unique, the clinician who is comfortable with a more directive and prescriptive approach to treatment will likely find a receptive client in many veterans. As noted, service members are taught early to be solution-focused (as opposed to problem-oriented). This action-orientation can pay dividends for the clinician who is able to capitalize on a veteran's training and skill set. In our experience, veterans are more likely than civilian clients to reliably complete homework assignments and follow guidance given. They are generally comfortable with identifying negative cognitions and behaviors and willing to implement strategies to correct them. However, those clinicians who take a more passive and explorative approach to psychotherapy may find that some military clients become impatient, frustrated, or resistant. As a result, difficulty establishing and maintaining rapport, or early termination may occur. Clinicians are encouraged to reflect upon their own style and to engage in a discussion with

the client about therapeutic orientation and ‘fit’ early in the process.

Show No Weakness

The prototypical military member reflects strength, resolve, and stoicism (Sherman, 2005). These are highly adaptive traits while in service, especially during combat deployment. Display of emotion is seen as weakness, and reserved for times with loved ones, if at all. Unfortunately, for the clinician, attempts to avoid being seen as ‘weak’ by displaying emotion will spill over into the therapeutic process (assuming the veteran even gets to that point). Clinicians are reminded that stoicism is closely linked to stigma, which prevents many veterans from seeking care (Hoge et al., 2004); as such, this topic itself may bear discussion early in the therapeutic process.

Considerations for the Clinician. Clinicians must appreciate the fact that stoicism is an adaptive and reinforced trait in the military. The clinician unfamiliar with military culture and values may mistakenly interpret the veteran's stoicism as resistance or disinterest. This may lead to feelings of frustration and inadequacy on the part of the psychotherapist. In our experience, dealing with issues of stigma and stoicism early in treatment is important. Not only does it reduce the chance of misinterpreting the veteran's presentation and the therapeutic relationship, it also demonstrates interest in the client and savvy about military culture. This, in turn, can strengthen the working alliance.

A Military Tradition: Families

Unlike most jobs in the civilian sector, when a person signs a contract with a branch of the armed forces, they are also “signing” on behalf of their family who instantly become part of the larger ‘military family.’ Military family members (or ‘Dependents’) are provided services and benefits, receive training and support, and soon learn how the needs of the *mission* and the

team supersede personal priorities. Families are such an integral part of military culture, that family data is included in the annual demographic report on military members (DoD, 2017).

Children often follow in the footsteps of their parents with regard to career choices. This is true in both civilian and military families (Bachman, Segal, Freedman-Doan, & O'Malley, 2000; Dietrich & Kracke, 2009). However, the pattern appears to be even stronger for those with military ties (Gegax & Thomas, 2005). In our work with veterans, we have come to appreciate that the military is more than just an organization; it is also a lifestyle. Growing up as a *military brat*[4] can be a source of strength. This role is connected to a unique subculture of people who possess a remarkable amount of pride, connectedness, and grit. Repeatedly adjusting to new cities, neighborhoods, schools, and friends can produce children who are more tolerant, culturally savvy, resourceful, adaptable, and willing to befriend others who are 'different' (Park, 2011). However, it can also cause disrupted schooling and behavioral problems in a minority of military children. Although the psychosocial effects of this cultural affiliation are mostly positive, there is a heightened risk of some stress-related problems in military family members (Siegel & Davis, 2013).

Despite the many challenges of military life, there is a strong tradition of service in military families. Those who have grown up in a military family are much more likely than civilians to enter the service themselves; in fact, approximately 60-80% of new recruits have a military member in the family, and up to half of new recruits are children of a career military parent. For example, researchers have found that children of Navy veterans are eight to ten times more likely than civilians to volunteer for military service (Stander & Merrill, 2000). This commitment is remarkable given how disruptive a military lifestyle can be. However, there may

[4] *military brat:* a non-pejorative term used to describe children of service members

be other reasons children follow in their parent's footsteps. Growing up in the insular culture of the military may cause a child to develop a fear or even distrust of the 'civilian world.' Worldview, values, customs, and rules for living can differ widely between these two realms, which can lead to uncertainty and anxiety. Continuing to work within the 'family business' may be the most comfortable and logical choice for some military children (Hall, 2016).

Considerations for the Clinician. Individuals enter the military for many reasons. For many veterans and their families, military service is a source of great pride; they often think of and describe this time as the best years of their lives. Clinicians should avoid assuming that military service was the veteran's only career option, or that they were unequipped for other endeavors. In our experience, there is a prevalent and inaccurate notion that military service is a lesser alternative, chosen only because there were no other career or educational opportunities. To assume such can be deeply insulting to a veteran. Instead, clinicians are encouraged to invite clients to share their own stories and reasons for joining the military. Such a narrative can be very illuminating and contribute to the development of the therapeutic alliance.

Developing Cultural Competency

Increasing awareness and familiarity with any foreign culture is never a 'one-and-done' effort. The best way to gain military cultural competence is to serve within the military; however, we assume that most reading this chapter have not had that opportunity. As such, there are a number of high-quality training resources offered online and in face to face workshops. The *Center for Deployment Psychology* (www.deploymentpsych.org) offers a variety of cultural competency as well as evidence-based intervention courses for clinicians who work with military members. Another valuable resource is the *Tragedy Assistance Program for Survivors* (www.taps.org); this material is particularly helpful for clinicians working with family members

who have lost a military family member. Lastly, the *National Center for PTSD* (https://www.ptsd.va.gov/) is a VA program that provides a comprehensive database on information related to PTSD.

Effective Strategies and Empirically-Supported Treatments

The recent wars in Iraq and Afghanistan have led to a tremendous amount of research on the psychological consequences of what is now more than 17 years of sustained operations. Fortunately, a wide range of evidence-based treatments are available for clinicians to learn and implement.

Posttraumatic Stress Disorder

A number of treatments are available that are effective for treating PTSD in veterans (see Moore & Penk, in press). Two of the most popular and widely-researched approaches are *prolonged exposure* (PE) and *cognitive processing therapy* (CPT). PE is a manualized, trauma-focused intervention based on cognitive behavioral principles, and comprises four primary components: (1) imaginal exposure, (2) *in vivo* exposure, (3) psychoeducation about trauma, and (4) relaxation training (Foa & Kozak, 1986). The typical treatment protocol consists of 60- and 90-minute sessions over the course of 12 weeks (Foa, Hembree, & Rothbaum, 2007). Research supports the use of PE with veterans and it has been shown to achieve remission rates of more than 50% in some groups (see Peterson, Foa, & Riggs, in press, for a comprehensive review).

A comparable treatment, in regard to efficacy and relative ease of learning and application, is CPT; it has been shown to be effective in both civilian and military populations (Resick, Monson, & Chard, 2008, 2017; Resick & Schnicke, 1992). Based on the premise that faulty cognitive schemas impair the client's ability to function, CPT helps the client challenge maladaptive beliefs, particularly as they relate to safety, trust, power, esteem, and intimacy. The

client is given regular homework assignments that promote awareness of faulty cognitions and those cognitions are challenged and modified in psychotherapy sessions. Similar to PE, CPT is an intervention lasting 12 to 16 weeks and can be used effectively with the veteran population (see Williams, Galovski, & Resick, in press, for a comprehensive review).

Based on the authors' experiences, both PE and CPT can be very effective. However, early termination may be a problem for some military clients who are not ready or prepared to confront traumatic memories or complete challenging homework assignments between sessions. Since both approaches are trauma-focused interventions, some level of engagement with the trauma is required. Early termination may be more of an issue with PE as its active ingredients are imaginal and *in vivo* exposure. On the other hand, CPT requires a significant amount of homework between sessions; for the less motivated client, this may present a problem.

Other Disorders

Depression, generalized anxiety disorder, and panic disorder are highly comorbid with PTSD in the veteran population. Our clinical work has shown that unless addressed specifically, other untreated disorders lead to poorer rates of PTSD remission and overall reduced quality of life. To our knowledge, there are no specific treatments tailored to address these comorbidities. Therefore, standard cognitive and behavioral treatments for panic disorder and generalized anxiety disorder are first line interventions. Depression is commonly comorbid with PTSD in veteran populations, and although treatments specific to PTSD like PE and CPT can alleviate depressive symptoms (as a side effect), they generally do not lead to remission of depression. Consequently, depression often requires separate psychological and pharmacological interventions. Regarding the former, interventions gaining popularity include *acceptance and commitment therapy* (ACT) (Hayes, 2004) and mindfulness based cognitive therapy (MBCT)

(Segal, Williams, & Teasdale, 2013). In our experience, like PE and CPT, the ACT and MBCT interventions are relatively easy to learn and apply, and have been found to be effective.

Finally, as noted earlier, suicidality remains one of the more critical and challenging mental health issues to manage. Recall that recent research has shown the top three risk factors for suicide in service members are being male, having depression, and alcohol abuse. Combat and other deployment experiences or trauma did not factor into any of the predictive models (LeardMann et al., 2013). Accordingly, clinicians are encouraged not to make assumptions about suicide risk, but rather to ask about it, sensitively and with respect, after building a degree of therapeutic trust. If suicidality is determined to be a factor, two suicide risk mitigation interventions that have shown some success are the *collaborative assessment and management of suicidality* (Jobes, 2016), and the *brief cognitive-behavioral therapy for suicide prevention* (Bryan & Rudd, 2018; Rudd et al., 2015). Both interventions are rooted in cognitive behavioral principles and incorporate practical strategies for minimizing and eliminating risk in treatment planning. Research on these treatments specific to the veteran population is limited; however, in our clinical experience, these interventions have been effective at reducing suicidal ideation in military members. Furthermore, they are well-tolerated and relatively easy to administer by clinicians with education and training in cognitive and behavioral therapy.

Future Steps

For the authors and many of those drawn to working with military members, the motivation can be summed up simply: *To serve well those who have served*. The most important first step to improving care for military members is to create greater awareness and opportunity for training in military cultural competence; such courses are becoming widely available and clinicians are strongly urged to utilize them. Next, clinicians must be aware of and actively

confront stigma surrounding mental health treatment; addressing these issues early can help to build a stronger and more effective working alliance. Also, because many veterans may not be willing or able to engage directly with the VA, other models for service delivery should be expanded. By embedding mental health in primary care or community-based outreach centers, veterans are more likely to utilize services as well as less likely to worry about issues related to stigma (Cigrang et al., 2017; Shiner et al., 2009).

Finally, advances in technology over the past two decades have allowed for a range of telehealth services. A recent study of PE therapy comparing in-person vs. telehealth delivered services found equal outcomes in terms of veteran improvement and satisfaction (Gros, Lancaster, López, & Acierno, 2018). Our experience is that Post 9/11 veterans (the millennial cohort) generally report satisfaction with telemental health services, especially as it can reduce wait times and improve accessibility. To this end, we believe expanded efforts to research and implement new and proven telemental health services is called for. This modern approach may be the most practical solution given the numbers of military members needing services (and the comfort level with technology of the millennial cohort).

Ultimately, telehealth delivery is also likely to reflect the best cost-to-benefit analysis; however, it is not without risk. The care of clients in active crisis, as well as knowledge of governing law are among the many issues that clinicians must carefully think through and prepare for. In addition to a host of clinical issues, consideration should be given to training in technology, cybersecurity, and related competencies, as well as potential liability risks. Interestingly, one veteran recently reported to the first author (KCK) that telemental health "works well, but *only* in a controlled setting." Consistent with VA policy, veterans must attend a VA clinic or Vet Center to connect with a telehealth provider; if the veteran is in crisis or

suicidal the clinician can immediately alert local staff or emergency responders. For this reason, it may be unwise for private practitioners to engage veterans in the same telehealth format as civilian clients (i.e., located in their homes) who may not have the same trauma or risk profiles as do veterans. Clinicians interested in telemental health service delivery should seek out training (often offered as continuing education courses) and ensure they clearly understand the practical, legal, ethical, and therapeutic implications of engaging in this promising new 21st century approach to the provision of mental health treatment.

Successfully reducing barriers to mental health treatment for military members in the future depends upon a combination of (a) increasing military cultural competency in providers, (b) decreasing stigmatizing beliefs in the military and its members, while (c) expanding non-traditional systems of service delivery. Only when all of these options have been fully exhausted can we truly say that we have fulfilled our nation's obligation to serve well those who have served us in our nation's armed forces.

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