REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

Special Issue: Therapeutic Relationships with Service Members, Veterans, and their Families

Cathleen A. Lewandowski, Guest Editor

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Volume 19 Spring 2013 Number 2

INTRODUCTION TO THE SPECIAL ISSUE ON THERAPEUTIC RELATIONSHIPS WITH SERVICE MEMBERS, VETERANS, AND THEIR FAMILIES

Cathleen A. Lewandowski, Editor

I am pleased to present to you this special issue, focusing on therapeutic relationships with military service members, veterans, and their families. Like many of the authors in this issue, I served as a clinical social worker with a combat stress unit in Iraq. And, like many of my fellow veterans, I have been involved in finding ways to help and support other veterans and their families. For me, it has meant advocacy, education, and training. Most readers of this issue, I am sure, are aware that there is no easy answer or quick fix for PTSD, TBI, and the other invisible wounds of war, including chronic depression, ensuing self-medication, over-reliance on pain and sleep medications, and military sexual trauma. After many years of clinical trials, we now have a handful of evidence-based interventions and promising practices to treat these conditions. But they are not easy, don't always work, and sadly, are not readily available to the thousands of service members, veterans, and family members who need them.

As a researcher, I know that when the randomized clinical trials are over, leaving us with some answers but just as many unknowns and questions, it is time to return to the more qualitative approaches; time to listen once more to what we can glean from our collective practice wisdom. And this was my motivation for deciding to organize this special issue. I also wanted to gather some of the stories from fellow veterans as well as from practitioners who, through their professional counseling, give the best that is in them to those who have served, and to the military families who also make tremendous sacrifices.

This issue has been organized into three broad groupings: narratives written by combat veterans (of which there is one stellar contribution), those about working with service members in combat arenas, and narratives which focus on working with military service populations and their families in the VA and statewide settings.

By reading these vivid and engaging narratives, readers can glean several insightful nuggets on establishing therapeutic helping relationships with service members, veterans, and their families. Overall, readers will have a good exposure to a range of experiences, thoughts, and honest emotions of the active-duty service member, veterans, and their families.

Most of the contributors to this special issue are veterans, who deployed overseas to combat, or hostile fire areas, including Iraq, Vietnam, Afghanistan, and Somalia. The issue includes seven accounts from veterans who served with combat stress units; Adams, DeCoster, Dixon, Lewandowski, Nedegaard, and Yarvis deployed as social workers, and Convoy served as a mental health psychiatric nurse. As ones who retired from active duty, both Nedegaard and Dixon take the long view, and share a bit of their retrospective on lessons learned from their careers as military social workers.

In working with military populations, especially during times of combat, social workers and other helping professionals are certainly at risk for secondary trauma. When deployed, helpers themselves are vulnerable to the same stressors and, like other soldiers and service members, must figure out a way to cope with them. At the same time, they must cope with what service members are telling them when they seek services from a combat stress service provider. By reading these narratives, especially the narratives of those who served with combat stress units, readers may gain an increased understanding of secondary trauma among those who work with military populations, and how it may be an inevitable occupational hazard if the job is done well.

Foci of the Issue

The narratives touch upon PTSD, TBI, and military sexual trauma (MST). Most reflect on the impact of

being deployed on veterans, service members, and their families. Adams and Convoy reflect on their brief interventions with service members who experienced MST. Lewandowski, Pitetti, and Yarvis reflect on how deployments affect marriages and intimate relationships, while Coccoma also reflects on how deployments and the military lifestyle affect military children. Both Lewandowski and Yarvis touch upon the subject of fidelity during deployment. Through these narratives, one can come to understand that there is no one-size-fits-all strategy. Like relationships, each couple must figure out for themselves what works best for them.

As a Vietnam veteran, Pitetti's narrative stands out, as he reflects on his war injuries, both physical and psychological, and his remarkable journey of healing and reconciliation. Through it all, it was the steadfast support of his wife, and the longing, perhaps unexpressed, to re-join his fellow vets that sustained him and made all the difference. This narrative, as well as those of Yarvis, Lewandowski, and Coccoma, shed light on the crucial role of spouses and significant others in sustaining service members in deployment and contributing to their re-integration and healing. However, Pitetti's narrative most aptly illustrates the power of the camaraderie of fellow vets in healing, even in successive decades after their tour of duty is complete.

Brockway and colleagues, Adams, Dixon, Lewandowski, and Nedegaard talk most pointedly about lessons learned on establishing therapeutic relationships with service members and veterans. Nedegaard and Yarvis openly share their personal journeys of coping with their own post-deployment concerns, role-modeling the principal of helpers helping themselves, by seeking professional help and/or self-reflection.

Barnett, Coccoma, Brockway, and colleagues describe their experiences as civilians working and interacting with service members, veterans, and their families. These narratives demonstrate that civilians who are not veterans can establish positive therapeutic relationships with veterans, using similar skills that would be effective in establishing rapport with other client populations. Barnett's narrative describes the challenges service members face as they seek to participate in a wellness program (weight loss), while keeping up with their duties as an active-duty service member. Coccoma shares her experiences, observing and interacting briefly with military families who were in transit, and what she learned about the stresses and resilience of military families. Brockway and colleagues provide several vignettes of veterans with TBI who received counseling services via tele-health through a VA special project.

Individual Contributors

Pitetti is a combat veteran who served as a platoon leader with the 101st Airborne Division in Vietnam. His story of trauma, reconciliation, and healing is most touching. It has been many years since the Vietnam conflict ended – yet veterans from this conflict, as well as from earlier conflicts, continue to struggle with PTSD and adjustment to the home front. Only now are some of them coming forward and seeking help, some because of the attention now given to the current crop of combat veterans who served in Iraq and Afghanistan. While professional counseling is almost always helpful, Pitetti's story illustrates the importance of family, the huge role a spouse can play in supporting the healing process of their veteran spouse, and the value of bonding with fellow veterans.

Dixon provides an excellent narrative on the nature of personal and professional growth over the scope of a career. Within this, he provides illustrations of working with service members, and reflects on what he learned about how to establish a therapeutic alliance. Dixon shares his thoughts on military culture, competence, and the process of developing a therapeutic relationship with an active-duty service member that are most excellent and spot on. Sometimes practitioners, especially neophytes, feel intimidated and a little unsure of themselves when seeking to establish that all-important therapeutic relationship. In his narrative, Dixon breaks it down in a way that is simple yet profound. In so doing, he stresses the importance of seeing the person before you as an individual – beyond the uniform. His description of professional growth that comes through the learning process can be applied to work with all clients.

Yarvis' narrative is a highly personal account of how a deployment and combat stressors impacted him and his relationships with family members. From a clinical perspective, Yarvis describes the concept of

sub-threshold PTSD, identifying it as an important condition to be recognized and addressed in practice. Regarding the impact of military service and deployments into combat zones on relationships, Yarvis writes frankly about sexuality and the dimension of intimate relationships between partners, and how military service and deployments can affect this most personal dimension of the self and a marriage.

Adams talks about his service as a Navy social worker, deployed with a combat stress unit in Afghanistan. The title of his narrative aptly describes how he and other members of his combat stress team established credibility by experiencing the same threats and discomforts of the soldiers they were supporting. Regarding MST, Adams' narrative touches upon some issues that arose in counseling a male soldier, who shared that he had been a victim of MST, highlighting that anyone can be victimized – MST is not solely a women's issue.

I happen to be the only female veteran deployed to a combat zone who contributed to this special issue. I drew upon mythology and music to reflect on my experiences and the experiences and stories of those soldiers I knew and counseled. Reading and listening to music were two important coping strategies for me during my deployment, so it seemed fitting that I wove mythology and music into my narrative. The lyrics I include relate to the situations I describe, and, in most cases, were songs that I, and likely other soldiers listened to as well. Love, conflict, and death seemed to be ever-present, if not right there, but always hovering around the edges of whatever was happening.

Nedegaard speaks most directly about his experiences and how he sought therapy for himself. More than any of the other narratives, he shares his own thoughts about how stigma, or the perception of stigma, affected his help-seeking and self-perception, as well as how it is perceived by other soldiers. Intellectually, he knew it was acceptable for a helper to seek help. Emotionally, he too was vulnerable to the struggle faced by any service member or veteran who feels they aren't doing what needs to be done. Otherwise, he would not have sought counseling. Lest readers be concerned, he found that counseling did help him to navigate the shoals of post-deployment reintegration. He is alive and well, and willing to share his story with us.

Convoy's narrative is brief, yet also quite powerful. And it is its brevity that in fact contributes to the impact his narrative may have on readers. He reflects on his brief contacts with a female soldier who told him about an incident with MST that occurred while she was deployed in Iraq. Those service members, who must cope with regular stressors of serving in a combat zone, must also cope with this trauma, and the devastation of perceived betrayal by a fellow service member in arms. Thanks to the courage of many service members and veterans who have come forward to tell their story, we are now more painfully aware of the issue of MST. Though he heard this story as an active-duty nurse, all helping professionals need to be aware that they can confront MST among any service member or veteran they serve, in any setting.

DeCoster, also a clinical social worker who deployed with a combat stress unit, describes his experiences as an academic, moved by patriotism, to sign up for the military. He was deployed soon after receiving a direct commission. He provides a good description of the pre-deployment training that occurs at the “mob” or mobilization site. He draws keen comparisons between the behavior, hopes, and dreams of traditional-aged college students of modest means, with those of the soldiers deployed at his camp who were served by his combat stress unit. To borrow from a most excellent documentary, this is who soldiers are, and where soldiers come from.

Brockway and colleagues describe some of their clinical work in a VA setting, through a special project on tele-health. While some may debate whether one can establish a viable therapeutic relationship over the telephone or the internet, Brockway and colleagues aptly illustrate that yes, tele-health can be just as therapeutic as face-to-face encounters. In fact, when reading this narrative, I couldn't help but speculate whether tele-health might have been even more effective for these veterans than an office visit. Perhaps it was difficult for them to get to the office; and perhaps they feared a face-to-face visit would be too intense. The telephone or internet, on the other hand, provides access and maybe something of a filter or safety net. I can imagine how a veteran might think, well, if I

don't like it, I can always hang up – a lot easier than walking out of an office. Through this narrative, readers will come to appreciate the strengths and limitations of tele-health, and how communication issues and challenges of establishing the therapeutic relationships can be the same, regardless of the mode of communication.

Coccoma describes her experiences observing and interacting with service members, spouses, and young children, as they were traveling on Space A military flights. While other narratives describe the importance of the spouses, this narrative is the only one touching upon the unique needs of the military child. The insights she gleans and shares with us from these brief encounters are touching and illuminating. Readers will get a good sense of what it's like to travel Space A, and gain a deeper appreciation and understanding of the strengths, needs, and vulnerabilities of military spouses and children. Coccoma does a great job of linking the theory of the deployment cycle with her interactions and observations of these soldiers and families during an emotional and vulnerable time.

Barnett's narrative describes another facet of military life: the mandate for all service members to maintain standards for fitness and weight. Service members who exceed weight standards are often referred to special programs such as the one where she did her internship. By reading this narrative, one wonders how service members can focus on losing weight while maintaining their rigorous and demanding schedule for training and fulfilling their military duties. Taking care of one's health, while also giving one's all to Uncle Sam can indeed be challenging. And let us not forget taking time for one's family! Finally, Barnett's narrative is also a good example of process recording. Journal readers may remember that there was a call from the journal's editor, for more process recordings.

In Closing

I want to thank those who reviewed manuscripts for this special issue, and the students and staff who labored behind the scenes in formatting and copyediting the manuscripts. I especially want to thank Steven “Leo” Leopold for his tireless work on making this issue happen. In addition to doing the majority of the copyediting and formatting, he provided me with helpful suggestions along the way on how to bring this issue together as a cohesive whole. By working with him, I also learned some of the finer points of publishing a journal. He is a veteran who returned to school for his MSW and was recently hired by the Louis Stokes Cleveland VA Medical Center, in Cleveland, Ohio, to work with veterans who are homeless or at-risk. This makes him especially qualified to work on this special issue.

I also want to express my appreciation to Robin Richesson, who created the original artwork for the cover. Most importantly, we should all express our deep appreciation and gratitude to the authors who opened their minds, hearts, and for some, even their souls, so that we might come to a deeper understanding of what it takes to establish therapeutic relationships with service members, veterans, and their families. After reading these contributions, I invite you to share your thoughts and reflections on these narratives with the journal by emailing them to: reflections@csuohio.edu. Reflections editors will include some of these letters in subsequent issues. Based on the importance of the topic and the level of response from both readers and potential contributors, the *Reflections* editorial staff members plan to include more narratives on working with military populations in future issues.

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Looking Back:
My Life as a Disabled Combat Vietnam Veteran

Ken Pitetti

Abstract: This is my personal account and perspective as a disabled Vietnam combat veteran. My intent is to provide insights into how I handled the unique challenges of (1) coming home to an intolerant welcome of antiwar protests and marches, (2) fighting in a war with no ideological basis and no final resolution of conflict, and (3) left with little to no support in coping with the symptoms of post-traumatic stress disorder including isolation, rage, survival guilt, sleep disturbances, nightmares, and "flashbacks."

Keywords: Vietnam; PTSD; survival guilt; self-medication; camaraderie; spousal support; resilience; memorial

Introduction

It was a dying request by Captain John Miller, played by Tom Hanks in the movie, *Saving Private Ryan*. "James…earn this. Earn it," he said to Private James Ryan (played by Matt Damon), a soldier in the 101st Airborne Division. In the movie, Captain Miller and his squad of men had fought halfway across France to find Private Ryan, the last surviving brother of four servicemen. In the movie, they accomplished their mission.

"James…earn this. Earn it."

*****

I served in Vietnam as the 3rd platoon leader, 1st Lieutenant, "C" Company, 2nd Battalion of the 506th Regiment (Currahees), 101st Airborne Division. In the summer and fall of 1970 my regiment continuously locked horns with the 324th B Division of the North Vietnamese Army (NVA). Elements of the 101st Division, including my regiment, had engaged the NVA 324th B Division that summer in the Battle of Fire Support Base Ripcord. Fire Base Ripcord was located about 30 kilometers northwest from the coastal city of Hue (Nolan, 2000). It was a disparate battle in the midst of a devastating war – with both sides taking heavy casualties. It was now late October, and the NVA had mended their wounds, and they were looking for payback.

Payback came in that last week of October when the monsoons arrived early and because of the bad weather we found ourselves in a compromised position. Like wolves after their prey, elements of the 324th NVA Division began to circle us – and NVA sapper units were busy planting land mines throughout our area. On October 31, we were attempting to secure an area, hoping the weather would break so we could be extracted by helicopters, and that is when I stepped on the landmine.

Unlike World War II (WWII) and the Korean War, the men I fought with were very young, 18-20 years. In fact, the Vietnam War has been labeled America's first teenage war (Williams, 1979). But like WWII and the Korean War, they all came from different backgrounds, cultures and points on the map. On that day, most of us were sick, running fevers because of the weather – and all of us were physically, mentally, and psychologically exhausted. As I lay retching and withering with pain from the traumatic amputation of my lower leg, the men of the 3rd platoon, led by Sergeant Chuck Reilly, stood firm and secured the area. Their heroic action allowed me to be medically evacuated (MEDEVAC) by helicopter – removed from Harm's Way – leaving my men. No, abandoning them. Thus began my "survival guilt" that I have carried with me until recently (Lifton, 1973).

My Dust Off (helicopter) took me to the 18th Surgical Hospital in Quang Tri, where they removed remnants of my right lower leg – which now ended 6 inches below my knee. But I was alive and in the postoperative haze of anesthesia, I thought about the last few days – the men I fought with, the men who stood with me, the men who gave me another chance in life. I owed them, I thought. I owe them.

"…earn this. Earn it."

Alcohol, Sleep, Pain, and Rage

I know the sleepless nights and I know the nightmares – it comes with war, any war (Schnurr, Lunney, Sengupta, & Waelde, 2003; Weiss et al., 1992). With sleep, my problem was falling asleep. Some of us turned to alcohol to "relax" and dull the senses in order to enter that wonderful state of unconsciousness in which all sensory activity is suspended – sleep (Kormos, 1978). My "overuse" of alcohol in the evenings coincided not only with its ability to dull the senses for sleep, but also to blunt the pain due to the immediate post-surgical healing of my stump (amputated leg) and initial prosthetic fitting. However, in time, I was to realize that stump pain and discomfort would be a daily, lifetime reality due to ill-fitting prosthetics and constant skin complications which included scar tissue abscesses and skin breakdowns.

The alcohol "habit" started five days following my surgery in the 18th Surgical Hospital in Vietnam when I was flown into Fitzsimmons Army Hospital in Denver. Whether it was the Vietnam "stigma" of veterans having drug habits (which the majority of us did not) I do not know, but pain medications for us were extremely restricted. I was told "no more morphine and any such stuff" by the head nurse as I was wheeled on a gurney to my bed, situated in a ward with about 40 other beds, each filled with wounded soldiers. "And another thing, Lieutenant, there is no rank in my ward. You are all just patients, MY Patients."

Liquor of any kind, of course, was prohibited in the hospital. But my ward had already established the means and methods of circumventing this obstacle with an intricate scheme involving the family and friends who visited. It suffices to say that when the lights went out in the ward at 2200 hours (10 pm), the bottles came out.

"In vino veritas," which is Latin for "in wine there is truth." The alcohol uncorked the rage in us, and we shared this rage in our whispered and hushed conversations in the darkened hospital ward. We fought in a hostile war, where the Vietnamese people hated us and wanted us to leave. We came home to a hostile country, where Americans were either suspicious of us or scorned us for killing to survive. For the latter, for killing to survive, we were called "psychopathic killers" (DeFazio, 1978).

The map I carried in Vietnam was a collage of blues, greens, and browns that colored the topography we patrolled. It was a vague map with no real landmarks, just brown contour lines signifying hills, valleys, and ridgelines. Wide and narrow blue lines represented rivers and streams. And green, lots of green for thick, double to triple canopy jungle with vines that reached and grabbed and tore at our equipment, clothing, and skin. The map accentuated the vagueness of the war. There was no real objective, no hill to take and hold, no road to secure. There was nothing "secure" in Vietnam. One day we would be flown (air-mobile combat assault) into a hill marked #650 on the map, then work our way down into a valley and then scale a ridgeline that led to another hill, marked with another number. On that hill we might set up a night defensive position, and if there were trails nearby, trails that showed signs of enemy use, we would move into an ambush position. The next day we would patrol another ridgeline then cautiously descend into another valley only to climb another hill marked #541 or #496. The military word for this was "search and destroy." The mission, the purpose of this war? Body count. This was the first and only American war where the mission was not defeating a country, but killing as many "Vietnamese combatants" as possible (DeFazio, 1978).

Towards midnight, in the darkened ward at Fitzsimmons Hospital, the alcohol-induced stupor would allow me to sleep and escape the pain and rage. And so it went for years. During the day, sober, I was able to focus on my work, engaging its challenges and "gutting out" the pain until evening – when sunset issued in the first drink. But the booze was taking its toll, on my marriage, on my family, on my professional endeavors. I looked into the mirror one day and didn't like what I saw. I was not living up to my promise. So I just stopped drinking, cold turkey – never to touch it again. I owed the men of the 3rd platoon, my wife, and my family. I owed them.

"…earn this. Earn it."

Bringing the War Home

The enemy soldier was charging me, his bayonet thrusting toward my chest. I had just expended all

the rounds in the magazine of my M16 rifle and had no time to reload. A swift upward thrust with the butt of my rifle deflected the bayonet and I used the enemy soldier's forward momentum to spin him to the back of my foxhole. I had to crush his throat now with my hands because I knew behind him more enemy soldiers were advancing. I wrapped my fingers around his throat and pressed my thumbs hard against his trachea to crush it.

Screams from a familiar voice and the sensation of someone pounding on my chest woke me from the nightmare. "Babe, stop it, stop it, you are choking me," my wife, Carol Sue, yelled as she fought to break the grip that I had around her neck.

Our families, especially our wives, bore the brunt of our psychological scars. Carol Sue and I had married a few months before my leaving for Vietnam. In coming home to her I experienced what most of my Vietnam veterans did not – gratitude and relief of me returning, patience with my odd behaviors and most importantly, love and all the wonderful attributes that go with that word.

Because of me, Carol Sue is also a Vietnam veteran. She knows our broken, restless sleep – she has shaken me many times out of nightmares as I yelled out in agitation. She has held me as I wept when on a few occasions, very few, I opened up and told her of the unbelievable acts of bravery I repeatedly witnessed members of my platoon display – yet they were for naught, for nothing. She knows of our bouts of cold and seemingly uncaring attitudes when empathy towards friends and family was needed but not given because we learned in Vietnam not to care – we couldn't care and survive. She and our son experience my sudden, frightening outbursts of anger when a seemingly innocent, innocuous event triggered flashbacks to a moment in time where the ugliness of warfare ruled the day.

If I could, I would turn back time and have waiting for each one of my veterans a spouse like Carol Sue. A companion that would have helped them vanquish the ghosts that haunted their minds – and they would have fared better in their life's journey (Figley & Leventman, 1990).

"…earn this. Earn it."

Closure

It was May of 2013. I was scanning my groceries in the self-service check out area at McConnell Air Force Base commissary and a man about my age approached me.

"I heard you were with the One Hundred and First Division in Nam," he said with a smile. The man motioned with his head toward John, one of the clerks, and said, "John just told me." John was a Vietnam Veteran with whom I had spoken to on occasion. John smiled and yelled over to me, "I told you I knew someone you should meet."

"I'm Tom Muskus, I served with the Hundred and First." He continued to smile, and stuck out his hand.

I took his hand and firmly shook it. "Ken Pitetti…..So who were you with?" There were a lot of Vietnam Veterans I have met that "talked the talk" but when pressed, served as an "attached" support element (i.e., not infantry) and never saw a bullet fired in anger.

"First platoon, Bravo Company, Second of the Five-O-Sixth. And who were you with?" Tom released my hand, and waited for my response.

The 2nd Battalion of the 506th Regiment, the Currahee "Stand Alone" Regiment, has a storied and proud history beginning from its creation during World War II prior to the European invasion in 1944. It earned its honorable reputation in the bloody battles of D-Day, Operation Market Garden, and The Battle of the Bulge. In Vietnam it was recognized for its combat distinction in the Tet Offensive, Battle of Hamburger Hill, and Battle of Fire Base Ripcord. And it continued to serve, as the 2nd Battalion, 506th Regiment, with the same Esprit De Corps in the Iraq and Afghanistan wars.

"I was the 3rd Platoon leader, Charlie Company, Second of the Five-O-Sixth," I answered.

"Well, LT, when were you there?"

"LT" was short for lieutenant, a common way enlisted men and non-commissioned officers addressed us. "Summer and Fall of 1970," I

answered. I was still hesitant about getting too friendly.

“Pitetti, that was your last name, right?”

I nodded.

“Yeah, I think I remember some talk about losing another LT from Charlie Company when I was on Fire Base Rakkasan. I don't remember the name exactly, but I remember it was Italian. That could have been you.”

In Vietnam there were three platoons with each company, with about 25-30 per platoon. The platoons, however, performed constant combat patrols independent of the other platoons. Platoons came together for two reasons, one good, one bad: when providing perimeter defense for a fire base or organizing for an assault on a fortified enemy position. On a fire base there was one hot meal a day, a “rigged up” 50 gallon barrel for a shower, quiet time to write letters back home, and relatively secure nights in a bunker. If it was for an assault, and if the NVA were waiting, an assault meant casualties – on both sides. Because of the usual platoon size patrols, it was not uncommon for members of the same company, but serving in different platoons, not to know one another. The fact that he knew about Fire Base Rakkasan, one of the many temporary military encampments used throughout the Vietnam War to provide artillery fire support for infantry platoons and companies in the field, was a positive sign to continue the conversation.

I had just finished working out at the Base gymnasium so I was wearing shorts and my prosthetic leg was obvious. Tom looked at it, “is that where you got that?”

“Yes, landmine.”

Tom nodded his head in an understanding manner. “They were nasty buggers, we lost a lot of guys to those.”

I stood silent, not knowing what next to say. Here we were, two combat veterans who shared the same war, patrolled and fought on the same ground, for the same unit, standing silent. If we were from another era, from another war, we would have gleefully hugged one another, bonded as kin by the same baptismal waters of being part of a war that was fought for a clear purpose, and won. But the Vietnam War was different, and I had left behind members of that company on the battlefield that day in October. Except for a few letters I had exchanged with my medic, Specialist Joe O'Donnell, I had not made any contact with any of the men in my platoon or company since returning. This was a common reality with Vietnam veterans, for we were “often too frightened to attempt to find out what happened to those left behind” (Howard, 1976).

Tom pulled out his wallet and handed me his card. “I am a representative of our Regiment, Ken. We have a web address on the internet specifically for those of us who served in the Charlie Company during that time. If you are interested you can join us. My e-mail is on the card.”

I took it, and without looking at it, slipped it in my pocket. He noticed the quick, almost dismissing manner I handled his card. His eyes locked into mine.

“At our reunions, some of the platoons are without their Lieutenants because a lot of them were killed over there. I know you are well aware of the casualty rates of platoon leaders,” Tom said pointedly. “Your platoon might be without a platoon leader and it would be important for those men to have one again.”

That struck an emotional chord. I broke off from his stare and looked at the floor.

“Let me know if you are interested, Ken,” he said as he began walking toward the exit door. “It was good meeting you,” and continued walking toward the exit doors of the commissary, but stopped and turned back to me. “Currahee, brother,” he called out, then disappeared through the doors.

Currahee, Cherokee for “stand alone,” was a nickname given to the 506th Regiment in its early beginnings in WWII at Camp Toccoa, Georgia. It was our regimental motto, and we officers called out “Currahee” when we returned a salute from our men – a tradition that continues today. I had not had that word spoken to me for 43 years.

That night, as I was finishing up final preparations for a lecture I was giving the next day, I took out Tom's card and stared at it. Carol Sue happened to walk into my office and looking over my shoulder, pointed at Tom's card, which had the 101st Airborne Screaming Eagle insignia on it, and asked, "What is that about?"

I told her. She thought for a moment, then quietly, but sternly said, "You have no choice – it is time….it is time."

I e-mailed Tom, found out the contact numbers, and "re-joined" Charlie Company/2nd Bn/506th Inf/101st Airborne Division that night. It was an amazing web site that they had developed, and most important, they had a listing by platoon of many of the members of Charlie Company with their contact number. It had been over 43 years, but I looked through the list of the 3rd platoon hoping a name might be familiar. I stopped at Dave Simonds, and there was his e-mail. Carol Sue was right, I had no choice, I had to find out…it was time.

My first contact with Dave was introductory – who I was, and did he serve at the same time I did.

His response came that night. Yes, he was in the 3rd platoon at that time.

It was time. I clicked "Reply."

"Dave:

I was there from August to Nov 1 (stepped on a landmine) – were you with the 3rd platoon on that day? Background. I get up every day thinking about that day – thinking that I somehow led the 3rd platoon into a mess, then got wounded, extracted, and left you guys there to deal with it. I have returned and been successful in my life – but I still think of that day – every day."

He is probably at work, busy, I thought. Probably won't get back to me until, well, maybe tomorrow. But the reply came back within minutes.

"Lt:

A lot happened that day, but it was the day I remember you made us men. After that day I knew I was going to make it, I went on to get my SGT. stripes and led by example which I learned that day from you. I have also talked (which I do very seldom) with my friends and family about that day and how it made me survive. But don't think you let us down or left us in a mess. You have carried that around for 40 years and I hope this will help you."

Epilogue: Lt. Pitetti Returned to Charlie Company

There was a reunion of my company at Ft. Campbell, Kentucky, in March of 2014. I have stayed away from all types of "Vietnam Veterans Reunions" for reasons discussed above. But in our e-mail that day, Dave Simonds gave me no choice. He said that Charlie Company needed to get LT Pitetti back with them again.

For three days I was with them. We hugged one another and yes, shed tears, and kept saying, "Welcome home, brother." I told them that I returned home and complemented my Bachelor's Degree in Biology with a Masters in Biology and followed that with a Doctorate in Human Physiology. I told them that I am now a professor at Wichita State University in the College of Health Sciences and that I teach and contribute to the professional development of physical therapists, physician assistants, nurses, medical laboratory technicians, and speech therapists. I told them how my research has contributed to improving the physical work capacities of persons with physical and mental disabilities. I introduced them and their wives to Carol Sue and told them of our son who went to the United States Air Force Academy. I told them all this because I wanted them to know that I didn't waste it. And everything I have accomplished since Vietnam was because on that day in October, 1970, they stood and they fought – and allowed me to live.

Last Mission

The Vietnam Veterans Memorial in Washington, D.C., The Wall, is hallowed, haunted ground – an emotional walk. When discussing the location and theme of our next C Co reunion, The Wall was brought up. There was a moment of hesitating silence, then one member stood and told his story. He had driven 6 ½ hours from his home, alone. Walked to the entrance, stopped, turned around and drove 6 ½ hours back home. Others in the room

said they had similar experiences. Alone, they could not get to those panels that held the names of our fallen brothers. In April of 2015, the men of Charlie Company will go to The Wall – together.

References

DeFazio, V. J. (1978). Dynamic perspectives on the nature and effect of combat stress. In C. R. Figley (Ed.), *Stress disorders among Vietnam veterans: Theory, research and treatment* (pp. 23-42). New York, NY: Brunner/Mazel.

Howard, S. (1976). The Vietnam warrior: His experience and implications for psychotherapy. *American Journal of Psychotherapy, 30*, 121-135.

Kormos, H. R. (1978). The nature of combat stress. In C. R. Figley (Ed.), *Stress disorders among Vietnam veterans: Theory, research and treatment* (pp. 3-22). New York, NY: Brunner/Mazel.

Lifton, R. J. (1973). *Home from war.* New York, NY: Simon and Schuster.

Nolan, K. W. (2000). *Ripcord: Screaming eagles under siege, Vietnam 1970.* Novato: Presidio Press.

Schnurr, P. P., Lunney, C. A., Sengupta, A., & Waelde, L. C. (2003). A descriptive analysis of PTSD chronicity in Vietnam veterans. *Journal of Traumatic Stress, 16*, 545-553.

Weiss, D. S., Marmar, C. R., Schlenger, W. E., Fairbank, J. A., Jordan, B. K., Hough, R. L., et al. (1992). The prevalence of lifetime and partial post-traumatic stress disorder in Vietnam theater veterans. *Journal of Traumatic Stress, 5*, 365-376.

Williams, T. (1979). *Vietnam veterans.* Unpublished manuscript, School of Professional Psychology, University of Denver, Denver, CO.

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A Social Worker in the Making: The Questions I Had to Learn

Mark A. Dixon

Abstract: This paper reflects the progression of the author's clinical perspective in working with military members in an active-duty setting. An applied pattern of establishing therapeutic rapport is described and clarified through numerous examples, commentaries, and personal reflections.

Keywords: therapeutic alliance; military treatment; rapport; healing; social work intervention

Introduction

As an active-duty social worker in the U.S. Air Force since the summer of 2007, I've had the opportunity to serve a community of service members that is both diverse and unique. An Air Force Mental Health Clinic mirrors this complexity and comprises a variety of helping professionals; consequently there is a wide array of knowledge and skills available to effectively engage military members in the helping relationship. This range of skills should be encouraged for at least two reasons. First, though varying degrees of conformity are a necessary part of military life, there is no “one size fits all” answer to social and therapeutic needs. The military is too complex an organization and is filled with such a diverse set of individuals and personalities for such a mindset to be useful in a treatment environment. Second, as part of a multidisciplinary team, we (social workers) have the opportunity to work with others, who have different methods and perspectives of therapeutic engagement, thus enlarging our available skillset. This creates immense, collective insight and I have drawn strength from the knowledge that many others have shared with me during my progression. This article serves as a reflection on the progression of my clinical perspective from a newly licensed, idealistic, civilian social worker to one with an array of experience in military settings establishing therapeutic relationships. With this in mind, I hope to be able to share a few of the lessons learned from my experiences.

I found there are six fundamental questions which guide me in establishing therapeutic rapport with military members. They are as follows: What brought you here? What is it you actually do? Who is in front of me? How does your military experience affect you? How do you think of yourself now? What have you gained or given up? These questions are not asked in serial fashion per se. Rather, they represent a framework to develop a progressive understanding about the military member's history, environment, behavioral strategies, and cognitive patterns. With this understanding comes an increased ability to more accurately identify their needs and to more effectively engage them in a manner conducive to establishing the helping relationship. This framework did not come to me immediately or in an organized fashion. It resulted from numerous encounters that have left me at times exhilarated and hopeful and at other times baffled, frustrated, or embarrassed. This framework represents my attempt to make sense of these experiences in a fashion that is non-chronological, yet organized and applicable across treatment settings.

What Brought You Here?

This question addresses both what brought an individual into the military and into my office. Learning how to more effectively ascertain this information has proved critical, for it fundamentally addresses motive, both intrinsic and extrinsic. What motivates service members remains a subjective matter and one that needs to be accounted for in the therapeutic relationship. I have found that not addressing this can present a significant stumbling block to therapeutic alignment.

When I began working in the Air Force, I made the mistake of assuming that I knew why everyone joined and that they were all for similar reasons. I have since found in working with military members that this is a much more complex issue. Some

individuals join because it is a part of them; their mothers could tell you about their son or daughter who was always bound for the military. Some see the military as an opportunity to gain skills, focus, direction, or educational benefits. For others, it is a practical solution to under or unemployment. Others may fulfill a family tradition of military service. I have worked with some who were on a self-destructive trajectory and wanted to alter their environment in order to help make personal changes. Others are drawn to the excitement and challenge of military service. There are numerous other reasons and combinations of reasons that motivate people to join the military; the important thing is to account for it. Without that context, it can become difficult to accurately understand a military member's reaction to a given situation or their presenting problem. Thus, understanding why someone joined becomes an important tool for me in understanding how they experience the experience of military service.

In a similar fashion, I first thought that everyone who came to see me was there for the same reason: to get help. Yet this is not always the case. For example, on one occasion a patient presented to me and his doctors with significant physical impairments and limitations. I was thus shocked to see this same individual two days later at the Base Exchange walking and jumping around, laughing with friends, and in apparently good physical health. During our next session, I had a frank discussion about the discrepancies of what I had witnessed. His reactions were predictably quite defensive. Though initially uncomfortable, the act of addressing the topic directly, revisiting some of the regulations about medical care, and allowing him an opportunity to explain the situation, made the therapeutic relationship much more honest and productive. Through this discussion I learned what really brought him into the clinic−he hated his work and was trying to get out of his unit. He did not see the value in his job and did not get along with his supervisor. A successful resolution was eventually developed once his true motivation was understood. I have learned that military members need to be challenged directly when appropriate. This allows a more transparent therapeutic relationship to be developed and maintained.

In another situation, a Soldier with many years of service and significant responsibilities came to see me due to the extent of personal distress he was experiencing. Within minutes of our discussion, he told me that “my guts feel like they are about to f$*%^& crawl out of my mouth…that's how I feel right now.” This struck me as a poignantly descriptive statement for a first session. His description represented an intense emotional state expressed in his own way. As we considered what brought him into the clinic, we came to an initial understanding that he didn't know how to relax. Though a consummate professional with tremendous talents, abilities, responsibilities, experiences, and energy, he didn't know how to unwind. He was a workaholic with an underdeveloped ability to relax and disengage from his work. Through further exploration, we learned that he valued his work to the extent that it became the sole provider of his ego-strength, his social support, and his sense of value in the world. As retirement began to loom in the near future, his ability to manage that loss in his life was intolerable. The more he buried himself in work and the mission, the worse his emotional reactivity became, and the more he felt trapped in an unending cycle of ineffective coping. He felt a sense of helplessness, which he had never experienced before, while his life seemed to slowly spiral out of control. He began to make real progress as we worked together to strip away the veneer of his professional status, to find the root of his personal motivations, and to learn how to balance the varying aspects of his life. It was a unique situation that helped me appreciate the level of imbalance and the attending consequences that can come to one's life while engaging in apparently positive activities. In addition, it gave me a valuable opportunity to see how obscured the mind-body connection can be with some military members; they remain in tune with their physical being but not their emotional state.

What Is It You Actually Do?

All members of the military are associated with an identifier, a label if you will. In the Air Force it is the Air Force Specialty Code (AFSC) and in other services it is the Military Occupational Specialty (MOS). Essentially, these codes identify what career field we are in to other people. That job can be anything from infantry to social work or aviation to communications. Everyone in the military is

assigned one of these identifiers. My experience has been that it is easy to place too much emphasis on these identifiers. It is easy to lose opportunities to develop a therapeutic alliance with the patient by only considering the generalities of a career field rather than accounting for the full scope of what the individual actually does. I also try to account for the efforts that most units employ to establish an Esprit de Corps or comradery that will help support them through difficult trials, such as deployment, combat, casualty care, etc. This unity becomes an incredibly powerful experience for many members. However, it can also lead to distrust of others who are not in their career field or that somehow don't fit the mold. Thus, being able to accurately identify what service members do and some of the struggles they experience will go a long way in establishing a therapeutic alliance.

The initial assessment is critical to developing helping relationships with military members. Among other things, it has become a great opportunity for me to ask questions about the military member's career field. This proves to be an important clinical tool in educating and orienting me in the therapeutic relationship by contextualizing some of the military member's attitudes and perspectives. My perspective of the military is much broader and my ability to accurately empathize increased by learning about what military members do. One particular patient struggled with the regimented style of his military career field in the Air Force. He told me about his unit and some of the things that he struggled with. I learned that he joined the military, after two years in college studying art, to gain computer skills so he could move into graphic design afterwards. That is when the extent of his struggle to adjust became evident. He was used to a much more relaxed, free-flowing, non-regimented lifestyle which was the exact opposite of what he was doing. His expectations were crushed and he didn't have a sufficient frame of reference from his past experiences to effectively cope with and resolve the situation. He also informed me that I was the only person in the military who had asked him about his interest in art. Knowing how his past interacted with his current military status provided a crucial link that he needed in our relationship. He subsequently made some significant changes in his attitude using cognitive approaches that eased some of the burden; but ultimately there was too much dissonance in personality style for a lasting fit in the military. This military member underscored for me the criticality of assessing and validating his motivating factors and employment context.

Since I can't actually observe firsthand what most veterans may do or have done, I have to rely on patient report. This can be quite unsettling at times. I have listened to reports of experiences that sounded fictitious, but later read documentation supporting the story. I've also had military members share stories that seemed plausible and realistic, but turned out to be a total fabrication. It is an uncomfortable process for me, as a therapist, to determine to what degree I'm willing to believe reports at face value. I recall one particular patient who was a truly decorated war hero and had some issues he wanted to address regarding his multiple deployments. I knew somewhat about him beforehand and had learned about some of his experiences. Treating an individual of this caliber made me somewhat nervous and I wanted to appear as knowledgeable and experienced as possible. However, this began to get in the way of his healing. I was too eager to identify with where he had been to let him tell me in his own words and in his own way. I was so eager to accept his report that I didn't even let him tell it. I wasn't guiding him in the process at that point; I was directing. I had to change strategies quickly. Early in our third session, I began focusing on what brought him into the career field, how he gained his expertise, his many responsibilities, and his numerous deployments. Once I allowed him to tell me in his own words what he actually did for his work, the relationship quickly became one of collaboration. I tried to understand what he brought to the table from his experiences and he evaluated what I had to offer in his healing process. In a telling sign of his confidence in the healing process and in me, he later referred a close friend to come talk with me specifically. I pondered the significance of this gesture. What would have made him comfortable enough with the therapeutic process to disclose to an associate his own struggles while partially staking his reputation on my ability to connect with his friend? It wasn't until that point that I recognized the degree to which trust had been developed. Most military members I've worked with want to know two things about me as a social worker: 1) Can I do

what I say I can do? 2) Can I understand them? In other words, can I do my job and can I understand theirs? When I have successfully established that with patients, they are more apt to share what is really on their mind. This is when the therapeutic relationship truly becomes productive because I am no longer being assessed if I can help, I am being asked to actually help.

Who Is in Front of Me?

I experienced two significant challenges upon joining the military and working with military personnel. First, I had to learn to understand the individual in front of me despite the uniform, rank, position, formalities, regulations, and unit reputation. I have come to truly appreciate the extent to which the military thrives on conformity and standardization. Military members all wear service specific uniforms and abide by regulations that dictate hair length, cell phone cover color, number and location of body piercings, tattoo placement, backpack style, color of socks when working out, and the manner of prescribed greetings. We are to abide by customs and courtesies which are alive and well in the military. We have all gone to some level of Basic Military Training. We all use jargon and terms that those outside of the military tend to struggle with. In other words, we even talk the same on some level that is unique and unified. Second, military members, as a group, are trained to comply with lawful orders from those in authority. Serious consequences can result from disobeying an order, challenging authority, and becoming non-compliant with expectations. When an authorized and lawful order comes down through the chain of command it becomes the duty of military members to follow and uphold it. This becomes critically important to understand in my work so that I actively avoid the appearance of giving an order when working with patients. In a military setting, compromising patient self-determination and creating an exaggerated imbalance of power arises when we come across as telling members what they have to do. Thus, the challenge is to see the individual that lies beneath the imposed conformity and always foster self-determination.

As a newly licensed and commissioned 29-year-old, I was fairly confident in my therapeutic acumen and felt that I had mastered the ability to develop rapport and provide good clinical interventions. Unfortunately, because of that overconfidence I became overly directive in some of my recommendations. I didn't give orders, but as most patients agreed with my suggestions for treatment I tended to give more. It took me awhile to learn that a service member will likely respond “Yes, sir”, “Yes, ma'am” to a treatment plan, even when imposed, because that is protocol and a trained response. However, if they aren't required to come back for further treatment they frequently won't under those circumstances. Consequently, I had poor patient compliance and retention in those cases when I became directive. That helped nobody and proved to be an ineffective approach to building therapeutic rapport. I had to learn that on some levels I am an authority figure for many who seek treatment and had to redouble my efforts to ensure that self-determination was preserved. That being said, there are occasions in which the chain of command may need to order a patient to treatment. This is known as a Command Directed Evaluation (CDE); however, those situations are not the norm and have clearly delineated policies and established protocol to protect patient's rights.

I have found that, during the initial phase of a therapeutic relationship with a military member, they are frequently hesitant or uncomfortable with the idea of coming in for help. They tend to present in one of two ways upfront. First, they are stoic and speak in measured tone and language, conscious of customs and courtesies within the relationship − just what I would stereotypically expect from a service member. Often, this is the first time a junior enlisted member may have had a personal conversation with an Officer. They may be quite uncertain about how to act and what to say. For instance, one military member appeared extremely uncomfortable in the session and later said something I found to be humorous. I laughed for a moment which brought a look of surprise to his face. When prompted to explain his reaction he said, “I didn't know Officers were allowed to laugh.” This provided the perfect opportunity to discuss with him the nature of the professional and therapeutic relationship, which put him greatly at ease. Second, a military member may appear using language that can be abrupt, rough (i.e., lots of swearing), or both. When I see this I generally consider it a sign of some level of distress, as they

have dropped the formalities and opted for a manner of speech reflecting their day-to-day speech and emotional state. When I acknowledge these patterns and look past both types of presentations, I am able to reach these particular patients. In some sense they seem to be testing my reactions as they are internally asking the same question I am, “Who is in front of me?” If I appear either judgmental or naïve in my understanding and reactions, both credibility and trust are compromised. However, when the first group begins to swear I know they are becoming more comfortable with me and the relationship. When the second group slows down with the obscenities they tend to feel more at ease with having been given “permission” to be themselves in the relationship. This change in language usage seems to indicate their comfort level in the therapeutic setting. It is rewarding to see changes in the military member that are reflective of a supportive relationship, at this increases the potential to make progress with their presenting concern.

How Does Your Military Experience Shape You?

The military provides numerous opportunities for experiences that can shape and change people in a positive or negative manner. I think a critical therapeutic task in developing a successful helping relationship is to understand how military experiences have shaped the people who come in for treatment. In particular, as I began treating individuals who had experienced traumatic events during combat, I initially became engrossed in these emotionally charged accounts and the richness of details. The nature of their stories were at times troubling to me, yet they sent a powerful message about the extremes of human experience. My therapeutic tools in treating trauma were limited to evidence-based treatments for PTSD such as Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). However, these never seemed to fully capture what has always intrigued me about social work − the strengths perspective and our view of the individual in the environment. I began to see disconnects between my perspective and some of my therapeutic training. I became more interested in the increasing discussion about resiliency, psychological first aid, pre-exposure training, and posttraumatic growth. I still don't think that these constructs have been given sufficient attention. The more I learned about these topics and worked with those who have been involved with trauma (combat, child abuse, sexual assault, accidents, etc.) the more impressed I've become by the resourcefulness of these survivors. It became evident to me that trauma doesn't have to be a one way disorder but can have multiple and complex effects on an individual, some of which can be growth promoting. It was an idea that seemed to resonate with my conception of the human experience. This change in thinking altered the way I treat members who struggle with their experiences. I needed to look for the whole spectrum of change and experiential effects, good, bad, and indifferent. Of course, when PTSD is present an evidence-based treatment is necessary, but I don't ever want to overlook the shaping potential that can occur due to a service member's ability to overcome adversity. In doing so, I gain the advantages of the strengths perspective and an opportunity to change their outlook on difficult situations. Thus, for some I have seen their military experience become a transformative one.

One patient that I worked with had lost someone very close to him in a truly traumatic fashion. He was making slow improvements in reducing suicidal ideations and his level of self-imposed isolation. During one session I asked how he had grown as a result of his loss. He initially struggled for words but with further explanation he identified his use of art to help manage the depression that followed his experiences. When he showed me pictures of his artwork, I became mesmerized by the skill and talent required to say so much without saying a word. He later identified that part of the outcome of this traumatic event was an ability to reach others in a powerful way through his talent in the medium of art. He had never related the two and may not have made this connection had we focused solely upon deficit reducing and standardized treatments without exploring the full range of how his military experiences have shaped him. I truly gained a great appreciation of the capacity within the medium of art to vet emotional distress and promote healing.

While in Afghanistan I worked with a Non-Commissioned Officer (NCO) who had deployed multiple times, regularly engaged in combat, and enjoyed confidence in his abilities and talents as a warrior. However, one day he had a near-death experience in which he was lucky to survive, let

alone walk away with relatively minor injuries. Our initial work together didn't yield much progress until we explored his thought process in the moment of the event. He had the instantaneous and quite realistic thought that he was going to die and there was nothing he could do about it. For the first time ever, he was directly confronted with his own mortality in a manner that he had not considered before. It left him shaken and uncertain. Prior to that event, he had never really addressed the fact that he could actually die in Afghanistan, or anywhere else for that matter. Of course, in the back of his mind he knew it was a possibility but he had never had the experience of facing his imminent death. After several hours of therapy during his physical recovery he made several tremendous realizations about the importance of his family, religious views, and how he was treating others around him. He built upon his already well developed ego strength and returned to his unit to continue serving as an effective combat-ready Soldier. Yet, his experiences left him with a much deeper appreciation for life. As he considered that experience a turning point, he came to the core of what was important to him, which left him more steady and confident than before. Gratitude was the ultimate result, which I have found to be a common trait among many combat veterans. As a developing social worker I am constantly improving my ability to develop a relationship with military members whose experiences are so profound in shaping their perspective. This is done in part by exploring and uncovering to what extent their military experiences truly shape them.

How Do You Think of Yourself Now?

There are a variety of concerns that bring service members to a military mental health clinic (MHC) − child abuse, domestic violence, relationship problems, isolation, depression, anxiety, eating disorders, personality disorders, trauma, or alcohol and drug problems. One issue that may be somewhat unique to the military is the duty, for some, to exert violence upon others in times of war or conflict. Some struggle with these experiences, in particular about how they view themselves and how they think others will view them. I have worked with service members who base their entire personal perception on reactions or circumstances that take place in mere seconds. They may become self-conscious while holding a mistaken belief that they have failed or not measured up to a standard of performance that may not have been realistic in the first place.

In one such instance, a Soldier presented with severe symptoms of depression and was struggling to perform effectively at work. We began working together for several weeks and I truly struggled with how to help this individual alleviate some of his symptoms. I followed standard protocol by thoroughly reviewing his medical record, addressing depression, completing an evidence-based treatment protocol, and coordinating with his prescribing physician, but nothing seemed to work. While discussing his combat experiences, it became quite evident that he had developed a profound and enduring sense of shame about his first firefight. The part of the incident in question was a natural, momentary, physical pause during a situation in which he was temporarily isolated and left without clear instructions or method of communication. In short, he was shrouded in the fog-of-war.

However, it wasn't until I specifically asked him what he thought of himself as a result of that event that he verbalized the negative perceptions that now pervaded his worldview. Prior to this event he viewed himself as a capable warrior with no fear, but afterwards he internalized that he was a coward. This service member interpreted that pause to indicate personal weakness rather than part of a natural physical reaction to an unfamiliar and overwhelming situation. Even though he was decorated for his ensuing actions in the same firefight, he minimized all of those events to focus on these brief seconds. Over the course of subsequent treatment, he successfully put that brief period of time into a more balanced perspective. He improved his attitude, mood, and motivation. There was already some damage to his family life and career but he made cognitive connections and improvements that he hadn't previously made with several other therapists. I learned a valuable lesson that sometimes the central issue to be addressed is not the result of physical trauma but the short, overlooked disruptions to a service member's worldview and self-perception. It was an exciting process of transformation to witness as he made these changes; it reminded me why I wanted to come into this field in the first place.

I have found that the military experiences can change someone in a variety of ways, but in each case there is a unique element of how it changed their outlook that must be addressed. One service member came to see me, who had limited his social interactions, except for family, to active-duty members or veterans. This was proving to be a challenge for him in several ways. He cut off old friends; he didn't engage in hobbies if he thought too many civilians would be present; and he slowly became more and more isolated. Actually, he was quick to cut off any relationship which challenged him, including several other clinicians whom he abruptly stopped seeing. I sensed that I had to tread lightly until he was ready to be challenged by me; it didn't matter when I was ready for it. This service member was not depressed, rather he was frustrated with his apparent lack of desire to engage with the broader world. Over the course of treatment, our therapeutic relationship had become fairly strong as I tried to account for the scope of experiences from his numerous deployments and military activities. However, there was something missing in all of our conversations.

One session I asked him if he had killed anyone. His response to me was sharp and immediate, “I hate that question.” As it turned out, he had killed multiple people. These were events that he neither celebrated nor regretted but they had changed the way he looked at the world and thought of himself. He began avoiding civilians. Some would ask if he had killed people, even if they didn't know him personally, when they found out what he did for his job. He began to think that he had done something wrong and didn't like his perceived loss of control over his environment, so he chose to avoid the potential for the question by not engaging with civilians. He was not questioned by other military members or veterans, except for me. Overall, his personality was direct and humorous so a strategy of direct questioning actually fit him well at that point. Together we devised a plan for this uncomfortable situation. The next person who asked that question was to be informed of the personal nature of the question, but that he would answer it if they would similarly answer a personal question in return. He was then to ask these strangers and new acquaintances how many people they had ever slept with. The mere thought of turning the awkward and personal nature of other's questions back on them seemed to give him a new sense of control. It was a simple strategy that changed his cognitive processes enough to allow him to begin to more fully engage in social situations. Instead of avoiding others, he was almost hoping to be asked if he had killed someone so he could try out the technique. Our work together ended shortly thereafter due to his rapid progress with just that one tool. This experience taught me the importance of checking the strength of the relationship before asking some of the hard questions. I'm not sure if our early therapeutic rapport was strong enough to manage the level of personal sensitivity required to help him learn what he needed.

What Have You Gained and Given Up?

While working towards licensure I worked in a community mental health center in a mid-sized city in Indiana from 2005 to 2007. There were no military installations in the local area but I started seeing veterans return from Iraq or Afghanistan. They sought counseling in relation to some of their military experiences. These were Guardsmen and Reservists who served overseas for a year or more. I tried to understand their experiences but I never felt that I made the level of rapport they needed. At the time, I had little awareness of the difficulties that many Reservists and Guardsmen experience when returning home to their families and work. This is in addition to the absence of frequent association with their unit like many active-duty members have. For many, it presented an unexpected level of isolation − nobody with whom they regularly associated could actively or accurately identify with their experiences.

It was from these early experiences with those Guardsmen and Reservists that I began actively seeking to better understand the experiences of military members. I began speaking with veterans in other settings. I was surprised at the number of WWII, Korean War, Vietnam War, and Persian Gulf War veterans surrounding me. When I began asking, I learned that people I regularly associated with had spent time in the military. It became apparent to me that each person, regardless of branch of service or era in which they served, was shaped by their military experiences. It was that shaping process that I was so desperately trying to understand and which, surprising or not, I'm still trying to fully comprehend. It occurred to me that

part of what I was missing in my relationship with those Reservists and Guardsmen was an understanding of their level of sacrifice and the level of growth that sacrifice represented. In other words I did not know or understand what they had truly given up and what they gained in return.

Since then I have come to understand and witness many members of our military sacrificing years of their lives deployed and/or physically away from family and friends. There are also those veterans who are physically present, but mentally separated from those around them, including loved ones. They present a unique challenge. I had one such patient who will forever endure in my mind. He had been through several truly gruesome and well-known events that left him feeling isolated from others, including his family, and edgy all the time. He spent little time developing relationships and actively avoided as many reminders of those events as possible. After nearly 20 years of this isolation and ensuing depression, he decided to talk to someone about it. During our first session we spoke about the current state of his relationships, which were not good, his distance from his children, and the manner that he had isolated himself over the years. Both he and I could easily identify what he had given up−closeness and proximity with others. However, by exploring what he had gained from his service he said that it had helped him as a supervisor. He explained that he came to truly understand the struggles that many of his Airmen experienced and was motivated to ensure they had more support than he had received. Following that realization for him, along with the treatment for PTSD, he was able to utilize his many talents to improve the relationships in his own family. I saw him in passing almost a year after our treatment. He had a large smile on his face and said that his family was doing much better. They celebrated Christmas together as a family for the first time in nearly two decades. That was a wonderful moment for me to see the influence of mobilizing strengths by acknowledging the positive changes, not just negative ones, from military service. This Airman had given up years of enjoying family relationships but ultimately gained insight and compassion.

Another patient of mine came from a rural area with limited opportunities for employment or education. He joined the military and gained access to both. He had earned an Associate's Degree and was working on his Bachelor's Degree. He had gained awards and respect in his unit. He deployed twice and had awards and medals that made me envious. He was a great Airman. However, when I saw him he only accounted for his losses − being away from family and not being able to help on the farm. There was a sense of guilt associated with what he had left behind that seemed to obscure the value of the many things he had gained. We discussed this in therapy. His plan was to ask his family what they thought about him leaving home to join the military. The next time I saw him, he had a much different comportment. He learned firsthand from his family that they had gained a sense of pride in his service and were grateful for his opportunities to grow and learn. He developed a renewed sense of motivation and determination to succeed. Helping patients recognize and evaluate both the losses and the gains from military service proves critical to shaping the individual and developing the therapeutic alliance. I believe this to be one of the most critical lessons I have learned from working with military members.

Conclusion

My development as a therapist is a history of incremental growth and learning from the many successes and mistakes made over the years. The questions that I have proposed as important to establishing a strong therapeutic alliance took work to elicit from these experiences. I felt the impact before I recognized the meaning. In fact, I think that I had to learn them over time or I would not have learned them at all. Sometimes the important meaning of an experience only comes after a period of personal reflection. My ability to understand the unique dynamics and relevant contexts of military members in need has been an exciting journey. I had to have the embarrassment of a patient telling me about their lack of confidence in my ability to help them and then asking to be transferred to another therapist. I had to have the thrill of watching someone make a positive, dramatic change and learning from how that process unfolded. In short, I had to experience therapy as a therapist over and over again in order to translate what worked for me into a pattern of personalized engagement that yields meaningful results for my clients. I believe that the therapeutic alliance is the crucial factor to better outcomes; it generates a more creative,

helpful experience for the military member and the military social work professional.

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The Intimacy of Trauma

Jeffrey S. Yarvis

Abstract: Posttraumatic stress disorder (PTSD) is a serious problem for the military and for social workers involved with such clients. Clinical impressions have made it increasingly clear that soldiers serving in combat may experience harmful personal consequences for mental health and well-being. The research in this field focuses primarily on the presence of posttraumatic stress disorder and traumatic brain injury and their respective taxonomies. What is often lost is the stories of these men and women and the intimacy issues that each of us faces on the journey from deployment to reintegration. The following article represents an open discussion from the author's perspective on war and some tales from psychotherapy that illustrate the challenges to warriors, warrior families and practitioners alike.

Keywords: trauma; PTSD; TBI; combat trauma; reintegration; subthreshold PTSD

Imagine this scene. You are a soldier who has been successful for many years. You have been able to negotiate your way through life-threatening situations. You have exhibited restraint when feeling threatened. You followed rules, despite the fact that rules of engagement (ROE) are often different than what your training and your instincts tell you. You must exhibit restraint and at times remain unresponsive in the midst of violence and chaos. You have shown maturity and been rewarded with commendations for your competence and leadership on the battlefield.

Now imagine you come home. All you want to do is rejoin the real world and participate in the most mundane tasks. For example, I returned from Iraq after 364 days and wanted to help. My family of four had become a “threesome” and my wife did a spectacular job mitigating the impact of my absence. Being sensitive to the new rules my wife imposed on the household, I did not want to get in the way. Yet coming home made me feel like a third wheel and useless. I felt incompetent. So I asked to rejoin the family in subtle ways, such as running errands. On one occasion my wife asked me to go to the bank where we lived in Germany. She asked me to convert some US dollars to Euros so we could celebrate my return and our reunion. I sprang into action as if this task was really important and went to the bank on post. This benign event would normally be unremarkable. There I stood in a long line in the bank because it was “payday activities” day waiting for my turn with the teller. My wife met me at the bank and was surprised I was still waiting to make my transaction. As we stood in line, she began to tug at my sleeve, telling me I needed to calm down and relax. I was perplexed by her suggestion because I thought I was simply standing in line waiting for my turn. Truth be told, I felt like the people in line were like mindless robots going about their business like worker ants, while our men and women were on the battlefield risking their lives. I shrugged off her comment and whispered, “I'm just waiting for the teller.” She reiterated her request and added, “You really need to calm down! You are making people nervous!” I quietly stated again with my teeth clenched together that I was just waiting my turn. Next thing I knew, two military police officers (MPs) had me by each arm and escorted me out of the bank. Confused, embarrassed, and angry, I managed to get to my car without making the scene worse. When I got in the car, I sped out the gate of the base and my mood became very intense. My wife tried to calm me down and reached over to soothe me. When she touched me, it was as if battery acid had been poured on my arm. I threw her hand off of me, swore expletives at my family, and nearly put the car off the road. I braked the car hard and pulled off into the shoulder. I threatened to leave them all not only on the side of the road, but for good. It was not a father-of-the-year moment. I now knew I had a problem and I needed help. Perhaps this restraint I mentioned comes at a cost, perhaps regarding locus of control. To this day, I do not know exactly what I did in that bank to cause the interaction with the MPs. My wife observed that I did not do anything inappropriate or say anything. She also noted I was present and not somewhere else as if I were dissociative. She simply observed that I had an

intensity about me that made people nervous.

When reconsidering this situation, many things come to mind. Do all soldiers who return have PTSD or are there subthreshold or subtle issues that we all come back with (Yarvis, 2008)? All I know is I was 42, I had been in the US Army over 20 years, I have a PhD, and had researched, spoken about and written about PTSD and it did not mean a damn thing. I was in trouble and so was my marriage potentially. I think about the soldier who is 26 years old and deployed four times and is married to another soldier who has deployed two times. I'm a social worker who thinks about this stuff every day and it did not matter. So what about that soldier who kicks in doors during four deployments and never thinks about this stuff? How do providers help them and help them see what's going on?

I will say this carefully. Perhaps it is easier if you lose a limb. Do not misunderstand me. I would not trade places with someone who has sacrificed a part of their body. However, if you lose a leg it is obvious. You lose a leg and your appearance automatically solicits support to you. You lose a leg and providers assume you are not happy about it and assume there are co-morbid psychiatric issues. You lose a leg and you are treated like a rock star, rightfully so! However, when you lose your marbles and the grey cells in your head get mushed together, it is very hard to describe, very hard to solicit support. You may not know it is happening to you. I am reminded of that officer I was in the bank that fateful day that drove me into therapy. However, if it were not for the therapy I might not be married today, have a career or even be alive today.

To place this in another context, I used to teach special education. I worked with adults that had intellectual and mental health challenges. Some of these adults appeared normal, while others physically appeared to have these challenges because of Down Syndrome or some other physical difference. One of my duties as a special educator was to integrate my clients into their communities. So, I would take clients to buy their sundries at a local pharmacy. When I brought the individual with Down Syndrome into the pharmacy and the staff saw them struggling to locate the deodorant, for example, they were often asked if they needed help or shown what aisle the deodorant was in. However, when the normal looking individual, with equally profound intellectual challenges as their Down Syndrome counterpart, became confused or even asked for help, the pharmacy staff would treat them as if they were stupid or a bother. The fear and sense of incompetence that individual felt was palpable at moments like that. Sometimes our normal looking soldiers are made to feel stupid or no longer of value by their units that once embraced them. These are the same feelings our psychologically wounded warriors feel amidst the mundane tasks of reintegration when their issues begin to surface after they redeploy from combat.

Social workers and other providers can be critical interventionists for our psychologically wounded warriors. However, these care providers can only take patients as far as they can go intellectually, emotionally and spiritually. Even when we are not struggling personally, we often rely most on our training and the diagnostic yardsticks or taxonomies that come with the DSM-5 or ICD-10. We miss the subtleties of reintegration and focus on the pathology. If you remember nothing else from reading this article, remember to step out of the pathology and look at the process or “see the forest through the trees.”

The following are two tales or cases that illustrate this point. One is personal and the other is right out of my case files. First, most of us are familiar with PTSD. We understand that the major clusters are exposure to a life-threatening event or perceived exposure, avoidance, numbing and re-experiencing. We know through meta-analyses of research across populations with different types of trauma that re-experiencing, if observed, is most predictive of developing the full disorder if left untreated (Yarvis, 2008). What are not often discussed in the scholarly literature are the subtle symptoms associated with PTSD, such as guilt, sleeplessness, anger, and loss of sense of one's competence and confidence. When soldiers experience these symptoms, they may not think there is a problem and others will not necessarily associate them with a disorder (Yarvis, 2013). For example, I felt guilty about not being present for my family for 364 days of the most recent military-induced family separation. These 364 days were in addition to the some 1400 other

days I had spent away over the years. I did not know I felt guilty at first. I just knew I had not been there for my family and that I wanted to make up for lost time. One way this manifested itself was quite benign and I would have not brought this example into therapy, claiming it was a sign there was something wrong with me. We lived in Germany when I deployed to Iraq. My children lived among and went to school with German children. In Germany, German children learn to ride their bicycles at a very young age. It seems as if they are issued a bicycle at birth. At three years old, my daughter was cognizant of the fact that all her classmates knew how to ride their bikes and was embarrassed that she had not learned to ride her bike yet. I was close to taking the training wheels off when I left for Iraq and this task was one of the few things my wife did not get done while I was deployed. Like many fathers, that was ok with me because I fantasized about letting go of the bike and watching my child ride off into the sunset for the first time. So as if I was on a mission from G-d himself, I was determined to teach my children to ride their bikes upon my return. I was like a drill instructor barking, “G-d dammit pedal faster!” while my daughter cried and refused to ride under the pressure. Indeed I scared her. Meanwhile my antics were in full view of the women in my neighborhood whose husbands were all still deployed. I heard one lady exclaim, “Well looky here, the little social worker's family isn't so perfect now.” But it was as if, if I could just teach my kid to ride her bike, one year's worth of guilt could be swept away. The case only deepened the reintegration gap between my family and me and cut more deeply into my fragile and weakening sense of competence.

One's sense of competence is also impacted by the effects of traumatic brain injury (TBI), one of the signature injuries of the Global War on Terror (GWOT). Most mild cases abate and people return to their baseline functioning levels. With help, many moderate cases successfully achieve a high level of functioning and severe cases make significant improvements restoring neurocognitive pathways. However, experiencing a TBI can erode at one's confidence and self-image as a warrior. Most soldiers do not understand the etiology of TBI. And for clinicians, deciphering the nosological boundary between PTSD and TBI remains challenging because the disorders share many symptoms. The key for warriors with these co-morbid conditions is to address the warriors' perceived support rather than relying solely on the fact that they received support. There is good research that perceived support matters more in psychological recovery than received support (Norris & Kaniasty, 1996). The key with TBI is two-fold: (1) remembering that deciphering the nosological boundary between PTSD and TBI is difficult, and (2) that combating perceptions or TBI-myths held by soldiers about their TBI can erode at their confidence in themselves and the treatment systems around them (Brainline, 2014).

I mentioned the 26-year-old dual-military couple. The wife of the couple and young Army Specialist (E-4) came to see me. She had recently re-deployed from her second deployment and felt she might have PTSD, based on her husband's behavior and PTSD and TBI diagnoses after his four deployments. The two had barely seen each other over that eight years of marriage and had two babies along the way, both conceived during brief R & R visits during two of their deployments. They were struggling to be a couple and family and had much to readjust to.

When I asked her why she presented for therapy, she began to yell (which she continued to do in my direction for most of the session) loudly and cry. She opened with “My marriage is fucked.” Like most therapists I asked what “F'd” means (to her) because the range of meanings could go from rape to standing in a long line at a bank. She screamed, “We are getting a divorce because he's cheating on me.” All attempts to slow her down and calm/soothe her failed, adding to my own sense of incompetence. Finally when I got her to describe what happened, she told me that he has PTSD and she thinks she does too. She was worried about his recent heavy drinking and asked him to stop. It is important to pause for a moment. Many returning soldiers turn to alcohol to sleep and soothe themselves after the appearance of these very confusing subtle psychological symptoms. I was not a drinker at all and found that within three months nearly all the alcohol in my home, that was nearly all given to me as gifts, was gone and I was replacing it for the first time. So her husband was doing something similar. She begged him to stop drinking immediately and he complied. However, her husband now lacked his primary coping

mechanism and began to pace the home anxiously all night for days on end. Without sleep, he became more and more irritable. The mood culminated in a fight and the couple went to bed angry. This fight added to the fog of reintegration. They were in love but showed no love, did not laugh, did not have sex, and did not touch. Feeling remorse, my patient went to reach over to her husband and apologize but he was not there in bed. She grew worried and got up to search the house for him and caught him masturbating to pornography. As soon as she said the "M" word, she became bright red and said "Can we talk about this?" I nodded and she proceeded to tell me that she turned the corner and caught him masturbating to porn. She yelled at him and embarrassed her husband, who responded like a 15-year-old caught with his father's Penthouse Magazine, and stated words no spouse ever wants to hear, "I want a divorce!" She yelled at me stating, "This is why my marriage is f'd, you dumbass!"

Each subsequent question I asked was met with more hostility. Finally, I tried to get at whether masturbation and use of pornography was normal for them. I am not in the judgment business as a social worker, rather the risk management business. So, while I believe using porn reduces women or men to objects or their genitals and that using it behind their partner's back is a form of infidelity, I had to determine what is normal for them. Therefore, masturbation was normal for them. They did it together as part of their normal sexual activity. They also bought pornography together and used it privately and openly as an adjunct to their intimacy. She exclaimed, "But he did it without me and wants a divorce and must be cheating!" Her conclusion, although reasonable, represented cognitive distortions on her part brought about by her anxiety and depressive symptoms.

I asked her why her husband might masturbate? She remained heated and yelled, "Because he is cheating, you asshole!" My discomfort was exceptionally high. I persisted. I asked her about their history. They dated throughout high school, were honest and open, and truly in love. They enlisted together and despite their separations had never been unfaithful. So when infidelity was ruled out as a likely possibility I asked her the question again, "Why might he masturbate?" She grew frustrated with me. I changed tactics. I asked her about her two- and four-year-old children. I asked her if she ever noticed her children touching themselves. She angrily said, "They are NOT sexual!" I replied that I knew that and asked then why they might do it. She concluded because it simply feels good. And what happens when it feels good, I asked? She replied, "Oh, I guess it soothes them." I told her she was correct and then proceeded back to questions about her husband. I posed to her why might her husband who has just come home, cannot sleep, cannot drink, cannot communicate with or have sex with his wife, masturbate? She said, "Ok, I see your point…it soothes him." I instructed her to approach perhaps with an apology and talk to him about what happened. Two weeks later, she presented that they were doing "great" and joked, "If you can talk about masturbation, then you can talk about anything!"

The moral of the story is step out of the pathology and look at the process. If I did not allow the foul language or the discussion, I would have lost her or alienated her. Had I been overtly uncomfortable, I could have easily hid in the PTSD discussion and missed the real concern. Most soldiers have concerns about intimacy and feeling competent. They think how could I exist in combat and not be able to negotiate my role as a father, mother, lover, parent, etc. (Yarvis and Beder, 2011).

I remember rounding at the U.S. Naval Hospital in Bethesda with medical students. We visited with a 19-year-old Marine with bilateral amputation who lost his legs in Afghanistan, only a few weeks into his nine-month deployment. He was surrounded by his parents and his young bride. He was remarkably open to the medical questions and upbeat, still displaying the machismo of a combat infantryman. We left the room and I asked the young medical students what they missed, after a detailed medical examination. The medical students shrugged and stood silent. I asked the group why none of them asked about the marine's sexual activity or concerns. One of the medical students quipped, as if social workers just did not get it, "He's not thinking about that…he just lost his legs!" I countered with he is 19 and his newly minted bride is sitting at his side. Not only are they thinking about sex, but it is likely the elephant in his small hospital room. So I directed us back into the room and asked the marine and his family if we could ask

a few more questions. The marine graciously allowed us and sat up as straight as he could to face the officers in his room once again. I asked him did he have any concerns about sex. Before the marine could answer, his parents joked, those two love birds are likely sneaking into the bathroom to come up with new ways “to do it.” The couple blushed and the marine politely asked for some privacy with us and dismissed his wife and parents for a moment. He then began to express that he was not worried about the loss of his legs. He said he would fight until he could walk again someday, but that his biggest fear was that his wife would leave him if he could not find a way to have intimacy with her again. And he thanked us because in his weeks of hospitalization no one had asked him about this concern and it was his number one fear. We must learn to overcome our own discomfort to be effective clinicians in the process of helping warriors return home to functional lives.

The coming home process is a winding river, but it is often the clinician who is on the banks of the river, preventing it from flooding over for the warrior. Many warriors and family members have bi-polar feelings around the coming home process. We want to hold our families at a distance (perhaps to protect them) and pull them close because we have longed for intimacy. Another personal experience illustrates this notion of polarity. I was evacuated from theater (MEDEVAC’d) for nothing as impressive as injury sustained in combat, but because I may have suffered a heart attack. Apart from the fear of what was going on with my body, I felt guilt about being on a plane full of heroes. After I was cleared by the cardiologist in Germany, my wife, not unlike the marine previously, inquired about the possibility of being intimate since we had been apart for over 8 months. The doctor said, “Don't kill him.” The doctor offered to “help” us and stated I can spread out your follow-up appointments so the two of you can have some time together. However, all I was thinking about (and feeling guilty about) was returning to duty. And then before I could ask the doctor about returning immediately to duty in Iraq, my wife cut the doctor off mid-sentence and said, “You need to get him the f@#$ out of here!” I was relieved and horrified by her comments at the same time. I wanted desperately to be with my family. If asked while I was downrange, I would have given back all of my combat pay for a hug on each of my kids and wife. However, I also felt a strong sense of duty and there was a pull to complete my mission and return home properly with my unit. My wife felt the same. She wanted to hold me close and be intimate, but did not want to shed the thick skin she put on during our separation, only to have me taken from her again. These bi-polar feelings are very confusing. And one could also argue that there are negative psychological consequences to not completing one's duty in addition to these confusing bi-polar feelings. Of course we want to be with our families and our families want us to be with them, but we all want to serve (Yarvis and Landers, 2012).

When I came home for good I was asked to lead most of my unit's reintegration briefings and I also counseled many of my colleagues on and off the record about their family concerns. Like many, my homecoming was celebrated. But when the parades and celebrations ceased, reality set in. We had been apart for a very long time. I am fiercely proud of my marriage and the openness my wife and I have achieved, but deployments highlight the slightest fissure or insecurity in a marriage. Although there were no issues of infidelity, those questions came from my wife and from me to her. In addition to the difficult ideas circling in my head, I was not sleeping and was edgy and angry, although I was not mad at anyone or anything. I think the notion of being “keyed-up” is very real. Even without trauma, if a soldier works 20 hour days for a year, he or she cannot simply turn that physical vigilance off. My wife and children were scared and scared of me. All of these things led to some long nights, where we all sat with the loudness of the silence on some very long nights worrying, ruminating, and perseverating on a thought or distortion of a thought.

Therapists have to be able to discuss the most intimate of things. I pride myself on being able to do this personally and professionally as does my wife. One day after the fog of celebrations was long over, she said some powerful words, “I've thought about leaving you.” Pause for a moment and imagine the first thing that comes to mind when you hear words like that. My reaction was did she cheat? Of course I felt terrible that my best friend felt this way and that I had something to do with it. I also was angry with the U.S. Army for doing this

to us. Of course it was our choice to serve, but that did not matter at the time. The conversation evolved to “Am I a terrible wife for having those feelings?” Relief took over my body and I shared that I had similar thoughts, because who would want to put their life partner through such a thing. We complimented each other and our marriage for having the ability to remain so open. It was then that the journey of my real homecoming began, moving from trauma to intimacy.

At the end of that critical and intimate moment, I knew I still had a lot of work to do (it would be over three years to do the heavy lifting). I told her at the end of the conversation that I loved her and I believed her. I rationally knew my wife was this amazing and loving person whose loyalty was as ironclad as my own. But I told her that I cannot sleep and I will likely sit up all night with those painful words etched in my forehead and become paranoid with the words “I thought about leaving you” playing like a broken record, over and over again in my head. To my wife's credit she said, “You bring it on and I will reassure you as often as you need to ask me.” So I took her up on this and it lasted three months. Of course this behavior of mine was wearing her down and hurtful too because it suggested I did not really trust her. So one night she grew tired and reached her limit to pain with all of this and dragged me by the arm to her night table drawer. She angrily pointed to her drawer and showed me 21 batteries. Those batteries were the monument to her fidelity. While this falls in the realm of “too much information," it is a superb reminder that the journey home is not just about what we saw in combat or what we did. The journey is also about very VERY intimate things. Latex ‘boyfriends’ were new to us and we had to talk about it, but being able to talk about these things requires great maturity, safety and the ability to communicate without shaming your lover. It is intimacy that trumps all. I will reiterate, what about that 26-year-old couple who never thinks about these things nor could talk about these things even before combat? As a therapist it never ceases to amaze me how couples can engage in very intimate acts but not talk about the acts themselves or what they want from their partner. In combat we say complacency kills and we demand a kind of intimacy that leads to trust and cohesion in ways that are hard to describe to an outsider. But we do not demand that avoidance of complacency from our partners and family members.

Combat is also intimate. But what is functionally adaptive for combat may not work functionally in one's living room. These adaptations also contribute to the bi-polar emotions we feel. My wife and I demand openness. Nothing is taboo and no topic is off limits. However, do we want to share the evils we have been a witness to? “Why would I burden the people I love most with these things?” is likely what most soldiers ask themselves when withholding their war-induced trauma spectrum experiences from their loved ones. The soldier must consider that if they deploy again, they must consider these withholdings as means of not causing further or deeper worry for their families. However, withholding goes against the openness rule and fuels the cognitive distortions that something must be wrong or we would be open. Yes of course soldiers want to unburden themselves and be intimate with those they love, but they also want to protect those most dear to them. And there are some things that many soldiers feel only another soldier could understand. However, those relationships with other soldiers do create space between lovers. Do I really want to tell my children that I saw dead children when they ask me innocently was Iraq fun? Do I really want to tell my wife I thought I was never going to see her again on a number of occasions? The answer is both yes and no (Coll, Weiss, & Yarvis, 2011).

What is adaptive for combat is not always adaptive for home. In combat we know that “loose lips sink ships” and that maintaining operational security (OPSEC) is critical to mission and protecting American lives. At home this behavior might be seen as being secretive and dishonest. In combat we keep our weapons with us at all times to always be ready. At home we feel naked without them and unsafe, and with them we are potentially an accidental danger to others. In combat we target aggression and at home we must be passive, not aggressive. In combat we drive quickly and avoid obstacles and debris that could be hiding an IED, at home one can endanger other drivers and one's own passengers by driving “recklessly” or too aggressively. These are some examples where it is difficult to go from being tactical to practical. And there is that loudness of the silence. No one is

saying anything and many trauma victims call this a "conspiracy of silence" which victims feel re-traumatizes them (Danieli, 1998). How does one live with the sights, and the sounds, and the smells and the pain?" Who could possibly understand what I've seen, what I've done, what I could not effect? These are painful questions and they are not often captured in active thoughts. They may be unconscious and subtle concerns gnawing away at ones confidence, sense of purpose and self.

To many warriors, the most frightening and humiliating reactions to combat and operational stress often affects processes associated with memory, which impacts sense of competency and self. The experience of trauma can leave the soldier with absent or incomplete conscious memory of important events and/or lead to re-experiencing symptoms known often as "flashbacks." Sights, smells, and sounds can unexpectedly and abruptly cause the warrior to re-live sensory experiences associated with traumatic events and emotions, or intrusive memories. They can cause fear and confusion in the warrior and their family. A soldier can begin to become numb or avoid the stimuli or triggers associated with the previously benign stimuli that triggered the responses they experience. Without an understanding of the way the brain stores memory in trauma and within the strangling hold of silence, warriors conclude that if they "block out" these feelings and memories, perhaps with alcohol or other substances or simply avoiding stimuli, that they must be making up these experiences and that they have lost control of themselves. The gaps in memory, re-experiencing, dissociation, and nightmares for the soldier are proof that they are incompetent or crazy, when in reality they are normal responses, chemically, physically, and emotionally to trauma. These responses are designed to protect us.

To reiterate, it is harder to describe and solicit support for oneself when your marbles get rolled around than if you sustain physical injury. And if months later you do not even know what is happening to you. Automatic reactions, physical reactions, and response generalization can increase over time without intervention. Viktor Frankl (1961, p. 122) states, "Between stimulus and response there is a space. In that space is our freedom and the power to choose our response. In our response lies our growth and our freedom." Therein is the soldier's opportunity for restoration of control.

All of us in the helping professions who work with warriors and their families have a passion for helping them find solutions that are causing them concern, restore harmony among them and return the warrior to duty. Understanding military culture and the warrior's reality are key. Soldiers in therapy, like many of us, confront death and their mortality, locus of control issues, aloneness, and the restoration of meaning of life. However grim or intimate these topics might seem, they contain the answers to restoration of safety and control, wisdom and redemption, and healing and forgiveness. What we need to relate to the warriors in our care is that it is possible to heal soul wounds. It is possible to feel safe. It is possible to confront the truths of their lives and harness the power they have in their existence in the service of change and posttraumatic growth.

To the warrior the most obvious concerns relate to life and death. To adapt to the reality of death, we devise ways to bargain with it and escape it. Soldiers must do what most elderly people do later in life. They must put death out of their minds and turn it into something positive. They do not become complacent, but they distract themselves with something meaningful in the present. As therapists, by slowing down their combat experiences we can find the meaning we all seek. For example, a corporal tells me in session that he was in Sadr City, Iraq. He tells me "There I was, wearing the flag of the United States on my right shoulder, all the best thinking went into the creation of our great nation and America is a force for freedom, and it didn't mean a damn thing." He was describing observing Al Qaeda-supported militia kill children within his line of sight and there was nothing he could do. But when we slowed it down and he observed that perhaps the children in those beladiyahs or neighborhoods, where he patrolled, had perhaps even a few more months or years of life because he and his platoon mates were there, he felt the shame lifted. He was ashamed to have been given a bronze star medal because he believed he could have done more for all of the children he encountered, but now the medal had turned into a symbol of pride because he realized he had done the something he could do.

Now the corporal understood his nightmares about observing death simply as failed dreams rather than his failures. His nightmares were symptoms of his anxiety and guilt, not reflections of him as a man, as a husband, as a father or as a warrior. In his dissociative moments he split off from his family and his reality and most of all from the terror associated with his own mortality and death. This process is invisible and confusing, but in Sadr City his normal psychological machinery that protected him failed as he reached his limit to pain and his death anxiety or posttraumatic anxiety broke through. But he needed to see that the world was no safer before Sadr City and that he had the capacity before and after to restore that machinery, improve its functioning and focus on living his life again in a meaningful way. This is his journey and in some ways it is my journey because it is every warrior's journey. Each of us must negotiate these experiences in our own way. For the sick, dying, or soldier in combat we get a closer gaze at death, but often those who gaze at death and survive have a stronger pull to life.

I owe a great deal of debt to my wife, children, extended family, fellow soldiers, and valued colleagues for teaching me and allowing me to teach and counsel others on how to avoid existential isolation, loneliness and for helping me to break the conspiracy of silence.

References

Coll, J. E., Weiss, E. L., and Yarvis, J. S. (2011). No one leaves unchanged–Insights for civilian mental health care: Professionals into the military experience and culture. In J. Beder (Ed.), *Advances in social work practice with the military* (pp. 18-34). New York: Routledge.

Danieli, Y. (Ed.). (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.

Frankl, V. E. (1961). *The Harvard lectures*. Vienna. Viktor Frankl Archives.

Norris, F. H. & Kaniasty, K. (1996). Received and perceived social support in times of stress: A test of the social support deterioration deterrence model. *Journal of Personality and Social Psychology, 7*, 498-511.

Yarvis, J. S. (2008). *Subthreshold PTSD in veterans with different levels of traumatic stress: Implications for prevention and treatment with populations with PTSD*. Saarbrucken, Germany: VDM Verlag Dr. Muller Publishers, ISBN- 978-3-639-08332-3.

Yarvis, J. (2013). Posttraumatic stress disorder in veterans. In A. Rubin, E. Weiss, & J. Coll (Eds.), *Handbook of military social work* (pp. 81-98). Hoboken, NJ: Wiley.

Yarvis, J. (2014). *Military TBI topics: Ask the Experts*. Retrieved June 23, 2014, from Brainline Military website: http://www.brainlinemilitary.org/experts/profile.php?name=Jeffrey,Yarvis

Yarvis, J. S., & Beder, J. (2011). Civilian social worker's guide to the treatment of war-induced PTSD. In J. Beder (Ed.), *Advances in social work practice with the military* (pp. 37-54). New York: Routledge.

Yarvis, J. S., & Landers, G. (2012). PTSD in primary care: A physician's guide to dealing with war-induced PTSD. In V. Olisah (Ed.), *Mental Health*. In-tech Publishers.

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Just Show Up: Building Therapeutic Relationships in Combat Zones: OEF Afghanistan 2010-2013

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Abstract: Establishing, maintaining, and developing therapeutic relationships with Navy personnel in non-traditional settings during Operation Enduring Freedom (OEF), Afghanistan, required flexible professional strategies while maintaining professional boundaries and mission-oriented interventions. The Navy Mobile Care Team Five (MCT-5) consisted of five Navy personnel including two Licensed Clinical Social Workers (LCSWs), one of which additionally served as the team's Officer-in-Charge (OIC), a Navy Research Psychologist, and two Navy Hospital Corpsmen Psychiatric Technicians. MCT-5's official mission was to target all Navy Individual Augmentees (IAs) in Afghanistan from December 2011 to July 2012 (approximately 2,200 IAs) to provide preventive mental health care, surveillance, and command consultation, including care for the caregiver, at static medical commands, by engaging in routine site visits outside the traditional medical settings in an effort to reduce mental health stigma and remove barriers to care. The team motto, "Just Show Up," reflected a strategic shift from a more traditional client/provider relationship in which traditional office structures and engagement are more carefully constructed and regimented, to a process of engaging any and all units and individuals across Afghanistan in a more collegial camaraderie in which embeddedness with each unit was central and behavioral health activities were strategically structured and conducted with full anonymity and confidentiality. This narrative addresses challenges, insights, and implications to include nebulous professional boundaries among the various disciplines, official processes and protocols for addressing clinical problems, and "care for the caregiver" strategies employed by MCT-5 to provide its own mental health hygiene and support. While the narrative is factual and accurate, no names were used and details of all situations were altered to preserve security and sensitivity for all persons and situations described.

Keywords: Navy medicine; operational social work; Navy mobile care team; Afghanistan; strengths perspective; Operation Enduring Freedom

"Just show up" became the mantra for our Navy Mobile Care Team Five (MCT-5) mission to Operation Enduring Freedom (OEF) in Afghanistan from December 2011 to July 2012. Our five-person team consisted of two licensed clinical social workers (LCSWs), a Navy research psychologist (RP), and two Navy Hospital Corpsmen trained as Psychiatric Technicians. Our official mission called for the team to "emphasize preventive mental health care, surveillance, and command consultation, including care for the caregiver, at static medical commands, by engaging in routine site visits outside the traditional medical settings in an effort to reduce mental health stigma and remove barriers to care." The author served a dual role as Officer-in-Charge (OIC) of the team and as a licensed clinical social worker (LCSW), commanding and performing a preventive mission.

Our target population included every Navy Individual Augmentee (IA) we could possibly locate and contact in Afghanistan, approximately 2,200 at the time. As the name implies, a Navy IA is an active-duty or reserve sailor deployed as an individual to an assignment with a Navy or Army unit without the benefit of belonging to a designated unit prior to deployment. Some IAs meet other deploying unit members during pre-deployment training, but most are assigned alone, or with one or two other IAs, to units consisting of strangers who are often members of another service.

This IA population had been identified through prior surveillance as being at high risk for mental health issues because of the lack of pre-established unit support, frequent assignments to duties outside their areas of expertise, ambiguity of joint service protocols and systems. They often experience and frequent marginalization, ostracism, and relative isolation among teams consisting of strangers – characteristics that arguably constitute the "perfect (mental health) storm."

This selective narrative describes MCT-5's efforts to

create an integrated mental health outreach strategy (requiring seamless collaboration with established mental health services for referral of issues requiring formal mental health clinical assessment or treatment) and specifically our strategies, models, and processes, often developed in real time, to develop and enhance therapeutic relationships with military men and women across Afghanistan in very different jobs and circumstances with a wide array of needs and interests.

The primary mission was focused on formal surveillance that consisted of written anonymous questionnaires augmented by individual interviews and focus group sessions in addition to real-time unit, individual, and command feedback briefs. All our therapeutic outreach efforts were grounded in the structured surveillance/consultation process but, as expected, the limitless range and array of personal issues and circumstances quickly became the order of each day.

Of necessity, we conceptualized our broad mission strategy according to all three of the Institute of Medicine (IOM) levels of prevention interventions to target potentially everyone in our IA population (Universal Prevention), target subgroups of IAs at increased risk (Selective Prevention), and target specific individuals actually suffering subclinical distress or impairment (Indicated Prevention). We recognized the limitations of attempting to address each level of prevention but commonly reviewed the three levels to frame our population outreach and establish specific mission goals given the dynamics of a particular target group or area.

A pivotal factor, often overlooked by us as team members, was that each of us, in addition to being a team member tasked with providing constant and professional support to other IAs, was also an IA among all of our colleagues, many of which were actually in far more supportive routine circumstances than we. Some of our more humorous (and therapeutically bonding) moments came while interviewing a group of geographically-isolated sailors after we had travelled for hours with little sleep, arrived disheveled and mentally foggy, and had our "clients" look at us sympathetically, laugh, and ask if there was something they could do to help us, as we were obviously more in need of support than they at the moment.

This poignant reality – that we the "supporters" and they the "clients" were all in this together, constellated into our "Just Show Up" motto and modus operandi. Though we initially chuckled at the cliché, considering it a desperate form of gallows humor, we came to understand the conceptual power and strategic relevance of a very cognizant shift from a paradigm of seeing ourselves (and presenting ourselves) as "helpers" seeking "clients" to "treat," to a model of "total situational embedding" within a group of peers and colleagues without preconceived expectations or assumptions of dysfunction or pathological needs.

Certainly, we found individuals and groups with significant issues and needs, but focusing on commonalities and circumstantial strengths within a group or unit proved a pivotal watershed point for empathic and therapeutic engagement that would have been impossible had we presented as rigid mental health assets seeking to assess and treat dysfunctional people.

Word traveled astonishingly fast in theater and being perceived as intrusive, invasive, or psychologically or mentally superior shut doors tight and could have derailed our entire outreach mission; trust was *essential*. The "strengths perspective" (Saleebey, 1992, 2001), commonly recognized and promoted by social workers, was not simply a "perspective," it was a reality and requirement for theater-wide buy-in for a complex and diverse population of men and women living and working in a war zone.

Our first conscious recognition of the "Just Show Up" strategy occurred completely by accident. It happened when we set out on a mission to a painfully inaccessible forward operating base (FOB) along a hostile national border. Because of grueling winter weather, active hostilities, and limited means of transportation, we were delighted to finally catch a flight headed to the remote location – only to find ourselves landing unexpectedly in a completely different location than intended. According to our records, there were no Navy IAs assigned to the post in which we unexpectedly landed. Furthermore, we were told it would be two to three days before we could expect a chance to continue our trip to the target location.

We shouldered our backpacks and equipment and

began the half-mile walk to where we expected to find shelter and food. By sheer accident we passed a post office and stuck our heads in to get directions. To our astonishment, we found ourselves face-to-face with a unit of Navy IAs assigned to run the post office. We didn't expect them, they didn't expect us – but there we all were, face-to-face.

The first stage of our "Just Show Up" strategy, evolving unexpectedly from this encounter, consisted of – drum roll – shaking hands, piling into a vehicle, and heading out to find food and sleeping quarters. Introductions, a description of what we did (our mission), descriptions of what our host colleagues did (their mission) and substantial trust-building and therapeutic alliance were naturally grounded in light conversation, sight-seeing, ribald joking, and common commiseration about our mutual plight of facing yet another night in a combat war zone far from family and loved ones. A meal and a sleeping tent arranged with complete reliance on those we theoretically should "treat" (Exchange Theory) created a solid and appropriate therapeutic alliance that would dramatically set the stage for events that would follow in a very few days.

During our introductory meals and information sharing, we scheduled appointments with the unit and with various individuals (always anonymously and voluntarily) and the next day we set to work conducting our normal surveillance, focus group work, and training modules to all that were interested. We all worked together to establish a working environment with appropriate boundaries fixed both mentally and by the structure of the meeting rooms, private session spaces, etc.

I emphasize that we were becoming extremely aware that the success of this therapeutic bonding scenario with a group and its individuals seemed to be uniquely created by the *informal* and *collegial* strengths-based circumstances in which we all met as colleagues. We proceeded to clearly spell out our respective professional roles and boundaries and then agreed to proceed into the more formal helping encounter framed in our mutually established and respected professional roles.

After this serendipitous initial bonding and round of formal surveys and interviews that occurred over a three-day period, we finally were able to book a flight out and flew back to our home base. We were never able to reach the base we had originally set out to visit – making our impromptu connections at this accidental stop even more serendipitous.

Fast forward approximately eight weeks, and we got the disturbing news that this FOB had been attacked by insurgents, massive explosives were detonated in the common area, live small arms fire had been exchanged, and there was a U.S. fatality, in addition to the fatality of all involved insurgents. We learned that several of our colleagues from our initial visit had been personally impacted during the attack, including potential injuries.

From our home base, we immediately arranged a visit back to the FOB and, based entirely on relationships and contacts gained in our earlier impromptu visit, were able to quickly schedule both group discussions and individual sessions as needed; we are convinced this would not have been as effective had we not formed the initial camaraderie earlier. The unit commander told us we had been specifically invited back based on our prior visit with them. Bearing in mind that our mission was preventive, not directly clinical, we quickly arranged visits and briefs with all available clinical assets, including assets from other service branches, and learned what resources, personnel, protocols, triaging systems, and routine services were available. We learned from our involved Sailors what services they had needed, whether they received needed assessment and follow-up, and got updates on their progress; however, the most poignant, and time-intensive work was the narratives – the stories.

Two had been eating inside the chow hall when the building exploded and they suffered from various injuries. Both described the chaos and surreal experience as the chaos ensued and everyone inside struggled to exit the building and find their units. Another described in harrowing detail watching the direct exchange of gunfire barely 50 feet away while trying to calm the small group with him that had clustered behind a concrete barrier. All fully expected the insurgents to rush the barrier and many expressed being concerned about who should be in charge and issue orders to engage, given the group

included members from different service branches and included no direct combat specialists. The Sailor described his feelings, first of alarm and fear, then of the calm emergence of his combat training. He took charge, gave orders to prepare weapons, and established positions around the concrete block to return fire if the insurgents attacked. The insurgents ran a different direction and were either eliminated as threats or committed suicide using strapped-on explosive devices. Still, the immediate and close danger triggered an astonishing array of reactions among the small group and the group bonded in that instant to the degree they continued to be close friends in the following weeks.

We spent many hours over the next week listening to the individual experiences, the moral and values impact, i.e., the "moment-of-truth" moments several individuals described in detail. It was at moments like these when they had to decide whether to fire their weapons, where to take cover, who to answer to or who to give orders to, and how to guage the extent to which their traumatic response and fear impacted them or jived with how they had imagined they would respond in such a situation.

The narratives, the stories, were rich, intense, and extremely varied. The stories ranged from accounts of intensely emotional phone and video-camera conversations with spouses and family members to the choice of some to not tell their loved ones at all, in which cases some expressed guilt over the secrecy, but opted to spare their families increased fear or uncertainty for the future. In all cases, the sessions revealed dramatic "coming of age" insights in which we relived with them what it felt like to face death and possibly killing others – an experience that to them marked a passage from a state of innocence to the ultimate maturity of facing mortality and standing firm in the face of death. Most described a quiet certainty and satisfaction that they had stood up to real combat, survived, performed well, and attained states we defined as early stages of post-traumatic growth capability within themselves.

Not ironically, my own experiences, and those of our team, mirrored those of our colleagues in type and intensity. We didn't bond with these colleagues simply because we wanted to manipulate into their confidence – we bonded out of necessity based on identical experiences and needs. My traveling companion on this trip had a birthday the day prior to our departure. We spent his birthday night sleeping on the wooden boardwalk at the air strip, waiting for our flight. Early the next morning, I awoke and found my partner nearby in a light sleep on a wooden bench, fully clothed and weapons at hand. Even in sleep, he appeared peaceful and accepting – even happy – perhaps more in sleep than awake. I found a power bar, inserted a toothpick in it for a candle, and when he woke, we quietly celebrated his birthday amidst the uncertainty and danger. We took time to take birthday photos and post on our Facebook accounts – a birthday neither of us will ever forget.

Camaraderie formed in a war environment is based not only on trauma bonding, but largely on shared routine experience and mutual purpose – usually simple survival and dealing with the austerity and absence of family and quality of life. I recalled what the skipper of a ship told me years before during my welcome and in-brief: "Life aboard ship is about sharing everything. It's not just that everyone knows everyone aboard ship, it's that everyone knows *everything* about everyone!" That wisdom applied here. My greatest discomfort, I found over time, was the lack of privacy and the constant interaction with friends and strangers in the most intimate settings. Bathing and toilet facilities were public and usually required a substantial walk from wherever we slept. Both women and men walked openly to toilets and bathing facilities and joined others in that walk.

During a sub-zero degree night in a tent city in Kabul, I awoke after midnight when a group of French soldiers arrived. Apparently by design and practice, men and women in this group all stayed together. The group found a block of bunks that allowed them to space the women together among the men. No one in this environment completely disrobed, and all clothing changes occurred discreetly behind sheets or towels strung from the bunks to provide screens. The respect and group cohesion based equally among members of these multinational groups, were generally the safety net against isolation and crime. While sexual assaults in theater are well documented, I found much consolation observing the underreported and underappreciated protective environments and

habits that allowed the most privacy and respect possible among members of numerous different countries, and between women and men.

Observing how mutual inclusion, respect, and equality between women and men, and among diverse groups of all types, was generally practiced in all the allied forces I experienced, I came to appreciate that modeling this diversity and equality was most likely our primary mission in Afghanistan.

The highlight of this tour for me came during a mission to Shindand province accompanied by my female Assistant Officer-in-Charge. We spent two days conducting interviews and surveys with multiple individuals and groups and spent an entire night with security forces visiting Afghani families that had been blacklisted and dislocated. I took my first (and hopefully only) puff on a Hookah pipe offered in a post-midnight multi-family gathering around a campfire discussing the recent capture and beheading of some of their employees scarcely a week earlier and only a few hundred yards from where we sat. Thankfully, one puff of Hookah was enough to show my respect and engage the trust of the group as they went on to pass the pipe and more openly describe their losses and non-deterred aspirations.

All eyes, female and male, remained constantly on my uniformed female comrade. The equality between us, the professional demeanor, and the open discussion between us did more to establish the purpose of our mission than anything we could have said. The children, shy at first, soon approached her and began touching her uniform and staring in awe at her weapon. We moved naturally into a discussion of equality and professional interdependence as perhaps our primary political platform. We showed it by Just Showing Up – not by pontificating on human rights, or problems. The nasty taste of Hookah from my one puff was forever transformed into a memory of that night of deepest camaraderie with a family from a very different culture grieving murdered friends.

The following day we were awakened early by the Commanding Officer who loaded us into a truck and took us to a ceremony being held to present awards to local farmers who had undertaken agricultural and business courses and who were establishing themselves as pillars of the community. Attended by several multinational military leaders and the Governor of the province, the event began with high-level speeches about cooperation and peaceful collaboration on local economy and self-sufficiency; however, my female colleague and myself, standing at the back of the room, noticed a disturbance and side conversations among the dignitaries at the podium, who began smiling and pointing toward her – the uniformed female in the room.

A translator was quickly dispatched to us and began interpreting the discussion for us. The Governor of the province was saying that having a female officer in the meeting was a pivotal symbol of this collaborative ceremony and requested that she be allowed to join the group of dignitaries in presenting awards to the farmers.

She was ushered to the front and thrust into the line of dignitaries and assisted in greeting and handing out certificates to the graduating farmers, while the dignitaries spoke of the power of gender equality and participation, using her as an example. Afterward, the delegation moved outside where we mingled with the group and the female officer became the star subject of photos with both men and women and with the flag level officers of the multinational assembly.

Once again, more was accomplished by Just Showing Up and modeling our values than could ever have been accomplished by lectures or potentially condescending teaching about gender equality and participation. While the impact of such chance encounters was random and anecdotal, we were firmly convinced that the strategy of Just Showing Up and building a collegial bond extended beyond just our military population to direct pivotal relationships with our host citizens at the local levels.

Overcoming my discomfort with constant scrutiny and lack of privacy – opting to simply Show Up with my personality (introverted though it may be) as fully intact as possible, helped me engage others and form personal and therapeutic bonds among both military and civilian individuals and groups that no degree of professional bearing could accomplish.

Upon leaving Afghanistan, I found what I valued most was a simple private shower and room – a degree of distance, artificial as it was, from other people for moments of respite. The constant, polite (usually) interactions with strangers in casual encounters in laundry and dining lines, in transportation ports, and in late night gatherings around campfires and cigar nights created a common bond, but constantly left me feeling low-level anxiety and hypervigilance. There was simply no place to find personal space. For the extraverted, the environment was stimulating and exciting; for me, a strong introvert, the constant interaction was draining and stressful. It was my emotional discipline and team orientation that made me maintain friendly and supportive demeanor throughout each day – it was not my personal inclination. This was especially important for me to bear in mind when encountering our clients. I realized that for many, the additional burden of outsiders intruding into their fixed daily routines was a primary inherent burden – even without the extra burden of fearing my role as a potential mental health provider. Establishing thoughtful and respectful personal boundaries was essential from the outset – being a good *neighbor* was essential before any hope of being a mental health professional could be established.

We came to appreciate the impact of our therapeutic bonds formed through these encounters, only several weeks later, when our team and several of the many individuals we had encountered in similar situations throughout the mission prepared to leave Afghanistan. As we made farewell email and phone contacts with IAs we had encountered throughout Afghanistan, we found that many would be departing when we did from our base, and that most would be staying in extremely uncomfortable living quarters for the days leading up to our departure. We quickly saw the opportunity and made arrangements to have all who wanted or needed our living quarters to Just Show Up and "join our Mobile Care Team" - we determined to leave together as a group if at all possible.

In the end, our team of five had increased to approximately 15 and we all spent the final days sharing living spaces, often make-shift sleeping pads on the ground, taking our meals together, and spending evenings processing our deployment over campfires and late-night discussions.
We had met many of our "clients" in the stateside combat training programs. Many of us had bonded in our journey into Kuwait, then into Afghanistan, and now that it was time to leave we had reattached to as many as possible to depart together as a team. And at no point did we detect lowered "professional boundaries" or feel compromised professional boundaries.

Not surprisingly, many of our "client colleagues," over campfires or meals, openly discussed their relationships with us, overwhelmingly agreeing that what made the most impact was our willingness to "Just Show Up," and to ground even our most clinically sensitive issues in the broader context of shared therapeutic alliance. Specifically, we heard numerous times that while most had expected us to approach them with strict rigor and stultifying "professional distance," the time spent bonding as colleagues over meals and routine events helped establish a solid, trusting environment, one in which they felt very comfortable when they needed "the next level" of help – the formal referral for mental health assessment or treatment.

One typical formal referral resulted when I was approached by a Sailor in a busy hallway. The Sailor began a conversation by saying, "This tour has been challenging, but I've learned a lot," but before I could direct him to a more private area, he began naming some specific issues that I felt were far more suited to a private discussion. I immediately asked if there was a place we could speak more privately and the Sailor escorted me outside the facility to the fire pit area where no one was around. "I have gotten into some issues since something happened a couple of months ago. They are trying to send me home now, but I'm not ready to go home. I don't want to be around my family. I'm checking to see if I can start divorce proceedings from here." I learned quickly that this Sailor had been sexually molested. He had also since then had a significant affair. He was having serious financial problems, was not sleeping or eating adequately, was experiencing nightmares related to a recent missile attack on the FOB, and was facing disciplinary action. While the command had taken steps to address the legal issues and was preparing to try to send the Sailor back to the United States, no one had arranged for mental health care. Even

though the member was reluctant at first to consider mental health help, after discussing the combination of events and problems with eating, sleeping, and nightmares, the Sailor agreed for me to discuss mental health care with the commanding officer, who immediately arranged for the Sailor to be transported to the nearest mental health facility for an evaluation. The flow from collegial to professional intervention was smooth and grounded in a more trusting relationship.

Despite the periodic shift from collegial support to formal referral, to our knowledge, we heard of no complaints or reports that members felt uncomfortable with our more collegial interactions. Au contraire, we found that in many cases, the less formal interactions and forced close proximity (given the base security needs), resulted in individuals approaching us openly, in front of others, asking us for formal sessions and/or beginning to speak (what we considered to be) too openly in front of others. In such cases, we simply quickly set individual private meetings and did not engage the more sensitive issues openly. Such seems to be the nature of wartime camaraderie and collegiality. The isolation from broader society and the forced proximity can as easily promote open exchanges and trust as they can generate feelings of invasion or stigma. While stigma proved to be very alive and well, "just showing up" and being part of the overall team proved to show promise of a positive receptivity to "all things mental health."

As always, not everything was perfect and certainly we had to move quickly on occasion to move individuals into formal clinical care. This was substantially less prevalent than we expected (less than 1% of our encounters outside of formal medical settings resulted in formal referrals for mental health conditions that required clinical assessment or treatment). Our interpretation of this finding was two-fold: (1) the formal mental health clinical providers were doing a remarkable job of maintaining overall mental health hygiene for a potentially enormous pool of individuals who could easily succumb to more serious mental health needs, but alternatively, (2) individuals in a war zone, even under the most daunting biopsychosocial circumstances, prove to be incredibly resilient.

A third interpretation, which we have no real way to measure or prove at this point, is that fielding a high-visibility, leader-sanctioned, and approachable preventive mental health outreach program may actually help offset isolated instances where the stressors and conditions could lead to more serious stress injuries, and stress illnesses. Directed by the Vice Chief of Naval Operations, the Deputy Surgeon General of the Navy, and the war zone command structures, the Mobile Care Teams were seen as an inherent part of the combat zone environment and simply one more group of IA colleagues with which to commiserate and bond.

Insights, Issues, and Lessons Learned

While certainly a cliché, the phrase "Just Show Up" is firmly grounded in four valuable contemporary concepts practiced by social workers and mental health practitioners. First, it clearly implies *expanded access to care*. The official Mobile Care Team Mission specifically addressed the identified goal of extending preventive mental health care beyond the normal formal auspices – actually implementing "house calls" where licensed service providers were scarce.

Second, a process of "just showing up" implied, and actually delivered, a robust multi-disciplinary *continuum of care* model involving a multidisciplinary, and multi-level team that included surveillance, group information gathering, and when required and possible, a first-level clinical pre-assessment component. Given that the team's primary mission was non-clinical, the mixture of surveillance and mental health expertise provided a self-contained assessment team that was able to address a wide array of needs or issues, and immediately invoke either team-internal, or external resources needed to provide the service or expertise needed by a particular unit.

Third, the team saw the term "Just Show Up" *psychodynamically* in terms of Von Franz's (1993) notion that psychotherapy requires providers to present with each client with their *full personality intact*. Von Franz saw that only in fully engaged holistic therapeutic encounters could genuine positive growth or change occur. Hidden or unconscious motives on the provider's part (as well as the client's part) could result, at best, only in partial healing, commensurate with the degree that both provider and client allow their full personalities

to engage in the therapeutic encounter. Combat zone dynamics (isolation, group cohesiveness, long periods of time together as a group, etc.) lend themselves to more natural openness and reduce the artificiality of "staged" therapeutic encounters.

Fourth, "Just Show Up" is grounded in the strengths perspective (Saleebey, 1992, 2001). Rather than approaching each target individual or group as a potential "problem situation," having the entire target population as the focus of the engagement can help reduce stigma and foster a more holistic preventive mental health atmosphere. Formal non-invasive surveillance and focus groups, that focus first (and last) on strengths and coping mechanisms, serve both to bolster therapeutic alliance and to provide a discreet opportunity for evaluation of personal or group challenges and identification of more serious issues and needs.

Issues

Major challenges for multidisciplinary Mobile Care Teams include: (1) credentialing, privileging, and licensure auspices, (2) consistency of approach (given different disciplinary scopes of practice, and limited team members to address particular high-level situations that may be encountered), and (3) care for the caregivers (the team taking care of the team).

Licensure and Privileging in Theater

The team consisted of two Licensed Clinical Social Workers, a Research Psychologist, and two Navy Corpsman Psychiatric Technicians. The mission was limited to "preventive mental health" services, discipline-specific licensure, credentialing, and privileging. Oversight of team members was contained within the team and supervision was provided by the team Officer-In-Charge (OIC), and a Licensed Clinical Social Worker. While fully licensed and credentialed through each member's home station, the MCT-5 was "owned" and sanctioned by the non-medical operational command. As such, the team was not authorized, during this mission, to provide direct clinical services. The team protocol called for us to refer those needing clinical services to the nearest, or best-fitting, formal clinical services at established mental health departments across Afghanistan.

The team's protocol consisted of a stringent process whereby all indicated clinical issues were to be staffed from the non-clinical team members to one of the two team LCSWs, and ultimate referral decisions were made by the OIC as an LCSW. The process entailed extensive training and preparation of all team members to identify any pressing or outlying issues from individuals self-reporting, or by command referrals made by unit commanders informing the team of potential clinical needs by a unit member. When an individual was identified as potentially needing clinical assessment or treatment, the individual was consulted in private and, when indicated, was engaged by a team member in determining the most appropriate clinical provider or mental health department as near the unit's position as possible.

In all cases, even in cases of command referral, the commander was notified only of the need for clinical services and was engaged in the formal process of transferring the member to the appropriate clinic or provider. In all cases, the team consulted extensively with the commander to ensure mental health issues (especially those that were self-reported and already known between a troubled individual and the commander) were "normalized" and the negative impacts of stigma and labeling were addressed. It bears repeating that of all IA individuals contacted by MCT-5 during the mission, less than 1% required formal referral to a formal mental health provider.

In all cases requiring referral, a team member was instrumental in contacting the identified clinical provider or mental health department to insure smooth transportation and assistance (using "warm handoffs," which required any referred individual to be accompanied to a treatment facility by a mature and trained unit member). A referral process was considered complete only when the referral and transfer of an individual was completed and notice of successful transfer was received from the clinical team.

As such, the Mobile Care Team addressed gaps in privileging levels through the hierarchy of licensed providers on the team and documented completion of warm handoffs to providers actually privileged by in-theater medical auspices.

Varying scopes of practice for each team member

created logistical challenges at times. Given the massive MCT-5 to target-population ratio (five team members, two of whom were LCSWs, to a target population of about 2,200) required frequent splitting of the team to conduct simultaneous missions in different areas of Afghanistan with two groups of two team members each. In some cases, it was not possible to send one of the two LCSWs on a particular mission.

The team protocol in such cases was to establish and maintain dependable communications (via email or phone when possible) and to clearly delineate each member's scope of practice. In all cases, the formal preventive mission was primary, i.e., the preventive mission involved providing anonymous and confidential surveys, conducting factual focus groups, and identifying potential morale and/or cohesiveness issues. When an LCSW was not a member on a particular mission, any and all potential clinical mental health issues were immediately deferred by phone to an LCSW, who would either arrange a separate visit or negotiate a warm handoff referral to a formal mental health provider.

Consistency of care was assured by stringent delineation of each member's scope of practice, communication requirements for all issues, and ultimate approval and action taken by a licensed clinical provider on the team (and ultimately the OIC) in conjunction with clinical providers privileged in-theater.

Care for the Caregivers

Mobile Care Teams are especially vulnerable to burnout, vicarious trauma, and both acute and cumulative stress injuries. Teams and team members are especially vulnerable, because not only are they required to model positive and adaptive mental hygiene to all individuals they encounter, but are simultaneously exposed to the very same risks, potential dangers, and daily cumulative stressors faced by their target clientele.

In addition, MCT-5 traveled over 9,000 cumulative team miles across Afghanistan in order to reach the most outlying units possible. This travel aspect of the mission added a burden beyond what many individuals in fixed locations had to face as a regular part of daily routine. Travel in extreme cold (and heat, depending on the month), coupled with travel security concerns, intensified the acute and cumulative stressors on both the team and each of its members.

The dual-role (IA Sailors and preventive mental health team member) components of the mission were addressed by our team, beginning in pre-deployment training and team discussions prior to deployment. Daily schedules were clearly established to allow adequate personal time for each member to “escape” the daily grind and develop support relationships outside the team.

The team discussed its “game face” – our requirement to maintain superb military bearing and protocol in all official contacts – as well as how to provide opportunities for self-regulation and self-restoration. Since, as is normal in combat environments, all five team members worked out of the same small office, schedules were staggered flexibly throughout the 24-hour day to overlap, so each member could have “quiet” office time to use computers, make phone calls, and complete routine personal as well as mission paperwork. Generous gym and workout time was encouraged throughout work days when the mission allowed. Naps at various times of day were heartily encouraged as were regular substantive meals. Holidays (official or simply made up by the team), birthdays, and any other special occasions were enthusiastically celebrated and generated a rich collection of personal and team photos, videos, and email exchanges. Whenever possible, the team ate meals together, while each member was also encouraged to develop outside friendships or eat alone when feeling the need for personal time.

Perhaps the most important aspect of team self-care consisted of insistence on healthy team dynamics, including commitment to minimize triangulation of team members (forming exclusive cliques among team members). We insisted on emphatic total-team adherence to maintaining a positive, non-toxic office and work environment. Days began and ended with attention to the location and mental state of each member. The work was demanding enough without fostering intra-team conflict or a toxic work environment.

It is important to note that our team, like every other

team, had its crisis moments and conflicts. However, anticipating team challenges and dynamics, addressing them early and openly, and demanding positive team engagement were instrumental in establishing a very cohesive, growing, and emotionally stable team which, to this day, regularly communicates and shares memories and unique experiences.

Implications

Preventive non-medical and medical mental health outreach and deployment of embedded provider teams consisting of multi-disciplinary teams of professionals with hierarchically-diverse educational and skill levels is increasing dramatically in current war time strategy. Inherent in deployment of such teams are strategic consideration of both the engagement and therapeutic relationship-building paradigm and the varying discipline-specific scopes of practice and professional limitations and boundaries of all team members.

Formal institutional preventive outreach is increasingly important, both to help offset the development of more serious mental health issues and to expand the mental health footprint in circumstances such as war and major disasters, when clinical treatment services cannot logistically hope to adequately address all emerging clinical needs. Evolution of multidisciplinary and multi-tiered teams is an appropriate focus for all mental health professions.

Boundaries between the preventive and clinical functions can be expected to blur and it will be up to each discipline to work internally and with other disciplines to establish flexible and eclectic protocols and processes and educate, train, and prepare new practitioners to establish and practice in diverse and unexpected circumstances within ethical and effective protocols. In many cases, such as in the war zone scenario presented in this narrative, providers will be required to practice ethically and effectively with limited supervision and direction, and frequently with very limited resources.

Seeking out and providing supervision and peer guidance both from within one's discipline and from sister disciplines will become increasingly essential and licensed clinical providers will be required to establish intervention protocols and processes for non-clinical team members. As much emphasis must be placed on the team's own members and mental health hygiene as on the targeted client population.

Finally, “client” engagement can be expected to evolve beyond the 50-minute session model (very useful and appropriate in established settings), to a more embedded and holistic mental health intervention model. The massive emerging need for mental health services to address a large population of returning and wounded warriors and the continued call to proactively take services to the population, rather than waiting for the population to come to the services, will benefit from dedicated teams of exceptionally-prepared providers being ready and willing to…

Just Show Up.

References

Saleebey, D. (2001). *Human behavior in social environments: A biopsychosocial approach.* New York, NY: Columbia University Press.

Saleebey, D. (1992). *The strengths perspective in social work practice.* New York, NY: Longman.

Von Franz, M. L. (1993). *Psychotherapy.* Boston, MA: Shambhala.

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Eros, Thanatos, and Ares: Counseling Soldiers about Love and Death in a Combat or Hostile Fire Environment

Cathleen A. Lewandowski

Abstract: This narrative describes the experiences of a social worker counseling soldiers about love and death while deployed with a combat stress unit in Iraq during the early phase of operations. The author describes the basic purposes of combat stress units, some interactions with soldiers around love, loss, and grief, and draws some conclusions about these experiences. The narrative concludes with some suggestions on how to engage veterans in treatment upon redeployment, encouraging helping professionals to consider combat stress services as part of the continuum of care.

Keywords: Iraq, combat stress unit, mental health, client engagement, stigma, grieving, Greek mythology

I was assigned to a combat stress unit for my deployment to Iraq. The mission of the combat stress unit, like other medical units, is to preserve the fighting force. This mission totally affects how we approach our work with soldiers. Operating in a combat stress unit gives a whole new meaning to "brief therapy." It was rare that I saw a soldier more than once. Knowing this, I worked to keep our conversation as focused as possible. Back home, the goals of therapy may be to improve relationships, decrease depression, come to terms with one's past, or improve self-esteem. In a combat stress unit, operating within a combat, or hostile fire arena, these are secondary, or inconsequential goals. In a combat zone or hostile fire environment, it's all about keeping the mind, heart, and body in the game. Focus.

Introduction

The two themes I will explore in this narrative are counseling soldiers on their relationships back home, or love, represented by Eros, and their experiences with death, represented by Thanatos. I place these themes in a world influenced by Ares, the Greek God of war. Being associated with Ares makes places dangerous or militarized. Seen as a dangerous force, he often represents the physical, violent and untamed aspects of armed conflict, needed for successful outcomes in war. His approach stood in contrast to Athena who represented military strategy. In early mythology, Eros represented the creativity principle of attraction who brought humans together to form permanent relationships. In later sources, Eros embodied lust and erotic attraction (Weigel, 1973). Thanatos was a minor Greek God and brother to Hypnos, or sleep. Euripedes described Thanatos as the lord of the dead (Grene & Lattimore, 1956). Thanatos has been associated with doom, deception, suffering, and separation.

Eros, the first theme, explores counseling situations with soldiers about their wives and girlfriends. I say wives and girlfriends, as that was the scope of cases presented to me. The few female soldiers who were at our camp and who came to combat stress tended to focus on relationships at camp rather than at home. Rather than considering this as a gender difference, it may be that my experience reflects the soldiers I saw and should not be used to draw conclusions about how male and female soldiers used combat stress services differentially. It should also be noted that I was deployed before the "Don't Ask Don't Tell" policy was lifted when P.L. 110-331 was enacted in 2010. Knowing that anything shared with me was confidential but could, if needed, be shared with their command, I would have been surprised if a soldier had talked with me about homosexuality or homosexual relationships. With the new policy in place, soldiers may now feel more comfortable talking with combat stress social workers about sexual orientation. But in 2004, it was all hush-hush. The final caveat is that this narrative describes the perspective of the deployed soldier, and of my experiences deployed in a combat stress unit. While family members are mentioned, their experience and perspective are not explored.

The second theme of Thanatos describes situations where our combat stress team talked with soldiers

about death. Death, in contrast to Eros, does not discriminate. In this section, I discuss the conversations we had with soldiers about their feelings of grief related to the loss of a soldier as well as the loss of loved ones back home. All of these interactions, regarding love, loss, death and grief, took place in Iraq, a world which for us was a world influenced by Ares, god of war. Following the discussions of Eros and Thanatos I will briefly describe some of the hostilities near or at our camp, reminding us that Ares was ever-present. I will then draw some conclusions and discuss implications for establishing therapeutic relationships with service members and veterans who have been deployed to a combat or hostile fire arena.

EROS

In my experience, there were four main types of deployment-relationship concerns: ones stemming from confusing, or emotional phone calls or emails; learning of a confession of the wife being involved, or having an affair with someone else; or a "Dear John" communication. Headings for each of these sections are a song title or reference to a documentary or comic that seems to reflect the sentiment of that relationship situation. Listening to music was part of the overall coping strategy for a lot of deployed soldiers, myself included. Thus, it seemed fitting to use popular music and culture to illustrate these scenarios.

"I couldn't call you because I was on a mission"

The first type, confusing or emotional phone calls or emails, was in my experience the most common. As others have pointed out, this is the first time soldiers have been deployed where the telephone and email were fairly accessible. This fact of life was illustrated by the experience of a "Doonesbury" character, Ray Hightower, who tele-links with his wife (Wikipedia, 2014). In one scenario, Ray's wife is upset with him because he didn't call her when he said he would, and he was trying to explain how he couldn't because he was in a firefight. Just after the firefight, Ray was fretting to his buddy how his wife was going to be upset. He already knew how the conversation would go.

This Doonesbury scenario was pretty accurate. Sometimes soldiers would stop by to talk right after they got off the phone or had left the internet-café and were either confused or upset. The main question I would be asked went something like this: "Ma'am, what do you think she's thinking?" This question would come up after at least one, if not several emails and phone calls with their significant other. The soldier would find himself flummoxed on what to say, or how to respond following an argument or a heated discussion via the telephone and/or email. The times this really got to the soldier had to do with their wives' feelings of frustration or unhappiness with the relationship. When presented with these situations, I wanted to say, "I am here in Iraq, same as you, and have no clue what your wife/girlfriend is feeling or thinking about your relationship." But I put that aside, and decided that my main objective, in keeping with preserving the fighting force, was to provide whatever assurance I could that things would work out, that he should listen and be supportive as much as he was able from half-way across the world. The outcome of the relationship mattered less to me than the emotional well being of that soldier in the here and now. Since there was little either of us could actually do, best that the soldier think positively; better that he offer assurance and support, rather than confrontation. Besides, staying positive had a greater chance of helping the relationship than confrontation from afar.

It's the "End of the Road," But I Can't Let Go

In the Boyz II Men lyrics (1992), the singer declares that he knew his girlfriend was cheating on him but he didn't care, that he still loved her and wanted them to be together. Similar types of conversations occurred with soldiers and their significant others, via the telephone or email, where she would confess that she had been with somebody else. On occasion, a soldier would stop by Combat Stress to talk about it. What should he do? How should he respond? In these situations, I assumed that because he was asking me, he did not want to end the relationship. I would try to work with the soldier on how best to respond to preserve and even strengthen the relationship. We would talk about how the deployment was hard on both ends; how she was experiencing her own stress and difficulties; how she was missing him and was maybe feeling a bit vulnerable. I suggested that her confession was an indication she still wanted to be with him. I questioned her timing, but kept these thoughts to myself. I offered that he could tell her that he still wanted to be with her; that they could work it out. I

would try to create a space where he could share his hurt, and serve as something of a safety valve for the relationship – letting the steam out. Most times this seemed to work out, as during a deployment, soldiers would generally prefer a less than perfect relationship to no relationship.

"Cry Me a River"

In the song "Cry Me a River," Justin Timberlake (2002) sings that after all the heartbreak, he no longer cared; she could cry him a river, and he wouldn't change his mind – the relationship was over. Similarly, soldiers on occasion would be insistent that the confessed transgression was a deal breaker. The soldiers did not want to listen to what I would suggest, point out, or ask – it was over as far as they were concerned. In these instances, I wondered why the soldier came by the Combat Stress office if their mind was already made up. Perhaps they wanted someone to hear their side, someone who would just listen to what was really on their mind, without a lecture or ribbing that they would likely receive from NCOs and soldiers in their unit. Once, a soldier came in and said that this affair was the worst kind of betrayal. By his expression, and the way he said the words, I could tell he was experiencing this in a very deep way, like a soul-wound that would take a long time to heal.

Looking at him, he was the last person you'd suspect of being openly emotional, but on that day, he sat in my office and cried for quite a while. Still, for his sake, I tried to stay positive. "You love her; she means a lot to you. You feel this way now, but maybe in time you can find a way to work it out." But he just said no, and, after collecting himself, departed. From the perspective of his ability to stay mission-focused and for his own survival I was left wondering if it were preferable to just close that door and wall off his emotions. Confronting the difficulties and complexities that come with a rocky relationship could be distracting, and maybe he'd wind up thinking about his love troubles at the wrong time. That could be costly – even deadly.

"Seeing my sweetheart again is all that matters"

From what I observed, most soldiers, like this one, could endure just about anything except the loss of affection of that special person. This is true now, and probably has always been the case when soldiers went off to war. For example, in the documentary (Huston & U.S. Army, 1946), "Let There Be Light," a veteran, just returned from fighting in Europe in World War II, breaks down uncontrollably in tears when trying to explain to the Army psychiatrist what his relationship with his sweetheart meant to him during his long sojourn in combat. She was what kept him going; the thought of seeing her again was what he lived for throughout the entire war.

"I'll Find Someone Like You"

In her song "I'll Find Someone Like You," Adele (2011) speaks of her own heartache, now that the one she loves has ended the relationship. Crooning that she'd look for someone just like the one who left her only speaks to her deep affection. For those in relationships with soldiers, news of a pending deployment in itself can be a relationship ender. While some relationships end during the deployment, others end before the deployment begins. Even with this, soldiers might question what led the person to break up with them just as they were leaving. To myself, I wondered if the significant other already had doubts about the relationship. News of the pending deployment provided the impetus she needed for ending it. From the perspective of the significant other, this probably makes sense, but from the soldier's perspective, this can be pretty devastating. Not only is there the loss of this relationship, but there is no time to develop another relationship before departure. One soldier who talked with me about his pre-deployment break-up wanted me to tell him why she did it. More importantly, he wanted to know what he could do better so his next relationship would not end in the same way. Soldiers tend to be goal-focused, and this soldier exemplified this trait in his approach to relationships. Not only was he focusing on self-improvement, he was also beginning to think about his next deployment, which very likely would occur.

"Time of our Lives"

In "Time of our Lives," Tyrone Wells (2010) sings of a relationship whose time is up; "…a chapter has ended," and "…it's time to walk away." Listening to the song, I wondered about military couples who cope with the deployment by using their own version of the "don't ask, don't tell" approach. For these couples, separated for at least a year, there was

an implicit understanding to just not talk about any extra-curricular involvement or affairs that may have taken place during their time apart. In these situations, there was no need to declare that "I was faithful" in your absence, as such a declaration would also be problematic. What if the other partner had not been faithful? Either that person would feel compelled to lie, say nothing, or divulge that in fact they had been less than faithful to their spouse or significant other. Unless the couple was very comfortable with their partners' involvement with others, such situations could be awkward. Thus for most couples who adopt this strategy, "don't ask don't tell" means just that.

"Dear John"

> "I was overseas in battle when the postman came to me
>
> He handed me a letter and I was just as happy as I could be
>
> Cause the fighting was all over and the battles have all been won
>
> But then I opened up the letter and it started.....dear John."
>
> (Barton, Owen, & Talley, 1953)

The phrase "Dear John" is thought to have originated during World War II, when many wives and girlfriends decided to give up waiting for the soldier's return and started a new relationship. Skeeter Davis and Bobby Bare reflect this sentiment when they sang "Dear John," written about the Korean War. Though the phrase may have been coined in World War II and used during the Korean War, it's been said that the Vietnam War saw more "Dear John" letters than any other conflict to date. In contrast, there were probably fewer "Dear John" letters in Iraq and Afghanistan. It was probably more of a "Dear John" email. Or worse, the soldier would hear about it from another soldier in the unit who had heard about it from their wife or girlfriend. Sometimes I'd learn about a soldier receiving such communication from other soldiers, and, as in other circumstances when soldiers were concerned about a buddy, would encourage them to tell their buddy to stop by. No one ever did. Perhaps this was one of those situations where it was best to pack the feelings away and drive on.

Talking about "My Girl"

Smokey Robinson's inspiration for writing the song "My Girl" was his wife (Robinson & White, 1964). In the lyrics, the singer proclaims that he doesn't "...need money, fortune, or fame," because he has "...all the riches baby one man can claim." Even in stable relationships, many soldiers would talk with me about their wife or their girlfriend. What she liked, what she was doing back home, the gifts she had sent him, the vacations and special things they planned to do when he got home. These were happy conversations.

THANATOS

Beyond grief when a relationship ends, soldiers came to Combat Stress when a loved one back home died. A grandfather died; a mother died; and one soldier lost his adult son. Talking with these soldiers about their personal losses generally caused me to reflect on my own father, who was living in a nursing home. My father had suffered several strokes, could not walk or talk much, and got all his nutrition from a feeding tube. Because I was only given four days before I had to report to my unit and because my dad lived in another state, I was not able to see him before I deployed. I called the nursing home, and the aides wheeled him to the phone. I told him I'd see him as soon as I got back. Okay, he said, which, with the effects of his stroke, was all he could muster. I prayed that would be true, and I like to think my father had a will to live, not just for his own sake but for me and my brothers and sisters as well. My father did live, and I saw him when I returned, but others were not as fortunate. For starters, my oldest son, deployed shortly after me to Baghdad, lost his grandfather unexpectedly, when he was hit by a car. My son was very close to his grandfather. I was able to call him and we talked briefly about the accident and how he was doing. But more importantly, we talked about how it was hard to explain to the family, especially to his grandmother, that he could not come home for the funeral. Army policy is that soldiers can go home for the funeral when parents or children die, and they can only go home for grandparents if that grandparent had had primary responsibility for raising them. Though I agree that this is a good

policy, it can be hard for family members to understand it, especially if they have little exposure to the military. I told him I'd call the family as well, to reinforce what he had already said. I like to think that this was helpful all the way around, to assure his grandmother and others that he really could not come home for the funeral. This was one way I was able to support my son during our overlapping deployments, all the while recognizing that few soldiers had family members deployed at the same time who could perform similar roles.

Unit Tour Extension

The first time I consoled a grieving soldier over the loss of a friend happened shortly after we arrived at our camp and it wasn't in the office. This turned out to be a unit-tour extension related event. Some may think that a six- or twelve-month tour of duty is just that, but this is not always the case. On occasion, the Department of Defense may extend units' tours to "…maintain the force structure that commanders determine are needed" (DoD, 2007). Service members and their families know that this policy has everything to do with the mission, and little, or nothing to do with service member or family well-being. And for the most part, they are okay with that. But sometimes it gets to you, especially when emotions are running high. Here is what happened.

One afternoon I was walking to the dining facility and came across a soldier, down on his knees, crying and shouting, obviously in unabashed and abject grief for the death of his friend, a fellow soldier. Everyone was walking by, not looking at him, and acting as if they weren't hearing or seeing him. Maybe that's the way I should have behaved as well, but I didn't. Instinctually, I got on my knees beside him and threw my arm around him. He was so overcome with grief that I started crying too. But he was also angry. Extremely angry and just then, he didn't care who knew it. "He wasn't even supposed to be here! None of us are supposed to be here! We finished our tour. But because we were extended they made us get off the plane and do convoys again. We didn't even f-------- have our own equipment because it had been shipped home. He had just come back from visiting his father who is dying. They gave him special permission to see him, and he told his dad he'd be back home in a couple weeks. We were extended for two weeks! Only two more weeks and we would be going home. He should have stayed home and now he's dead! We shouldn't even be here! I hate the f-------- Army!"

I kept my arm around him, all the while he was shouting, crying as well, and watching, as he did, everyone who was walking past us. Soon, he was spent, and stood up. I did too, and we left, both of us heading in different directions. The next day a senior officer told me, "I SAW you with that soldier yesterday." I wondered what this officer thought about it – me being there all the while the grieved soldier was cursing the Army in such a public way. I like to think he thought it was a good thing. I didn't care though. There was no way that I was going to leave that soldier alone in his grief. Besides, what were they going to do? Send me to Iraq?

Several years have gone by since my redeployment. Looking back, I can honestly say I doubt I'd be able to recognize most of the soldiers I counseled face to face. But I remember this soldier's face, and feel I could pick him out in a crowd. Such is the power of raw emotion.

Death and Grieving during Deployment

My camp was essentially a fueling point, and a rest stop for convoys. Most convoys came through our camp, and when they did, our combat stress team supported them as well as the soldiers permanently assigned to our camp. At night I would often stop off at movement control, or the TOC to see how things were going, if the roads were quiet, or if there was activity. Mostly things were quiet, and it was easier to hit the sack after getting this news. But of course this was never a sure thing. On more than one occasion I was awakened with news that an IED had hit a convoy – that there were injuries and they would arrive at our camp soon.

In one such instance, a company commander learned that one of his soldiers who had been medically evacuated had died en route. It was his unit's first (and I hoped last) casualty. Before their convoy arrived, I was introduced to him. The news was hitting him pretty hard. I asked him to come to my office where we could talk privately. All the time I was talking with him, my team was touching base with the First Sergeant, Chaplain, and anyone else who knew about the incident. Once the office

door was closed, the tears started to flow. I'd already been through this with at least one other unit so I had a good sense of what I needed to tell him. Understandably, the first thing he wanted to do was call his unit's headquarters back in the states so that he could personally deliver the news. I told him that wasn't possible. Whenever there is an incident, they shut down the camp's phones and Internet. This assures that the family is notified through official channels rather than hearing second hand from someone in the unit. It also decreases the possibility for the spread of rumor and speculation among other unit members and family networks. I assured the Captain that he could call home as soon as official notification was made, and that the army was pretty efficient in doing so. "Your focus has to be on your unit here. I suggest you and your First Sergeant call them all together in our chapel so they can all hear it at the same time. The chaplain and our combat stress team can be there in case anyone wants to talk." We talked a bit about what he would say so that he'd be ready. I hoped this would be the only time he'd have to make such a speech but also knew that if he ever needed to do it again that he likely wouldn't need my assistance. His brief moment of private grieving over, he collected his composure and his gear. I gave him directions to the chapel and told him I'd meet him there. When I arrived, I stood in the back of the chapel – my team, a combat stress NCO and mental health specialist, already present. The Captain entered, and went to the front. Standing with the chaplain and his First Sergeant by his side, he delivered the sad news. He asked if anyone had any questions or wanted to say anything and that the chaplain and combat stress were here. As I anticipated, no one commented, though several heads were bowed. Silently, they emptied the chapel and headed for their tents.

The Hazard of Being a Gunner (and a Gun Truck Driver)

We were fortunate in that none of our combat stress unit members were killed during this deployment, though several of us traveled in convoys and visited Forward Operating Bases (FOBs) and Radio Relay Points (RRPs) as part of our work, myself included. However there was at least one death that affected me personally, as well as many of the soldiers on our small camp. It was when SGT B died. In a place where everyone blends in, SGT B stood out – he stood out because he had a genuine concern for the soldiers that he expressed every single day. He went out of his way to make life a little better for everyone. He knew I had a husband and two sons and never failed to ask me, the camp's combat stress social work officer, how I was doing, and how my family was doing. He was a gunner and was killed in an accident on the road. This is how I was told it happened. In the black of night, after going through a checkpoint, their driver sped up before totally clearing the barriers, which he probably could hardly see, and when he ran into one of them, SGT B went flying out the truck like a projectile. He died instantly. It was an accident. Traffic accidents happened there just like they do in the states. I understand gunners are encouraged to strap themselves to the truck, just for such circumstances but I knew of none who did. Too cumbersome, and they wanted to be able to get out of the truck quick – like if it caught fire. No one, including me, blamed the driver and we all told him so. Drivers have their own stressors and challenges, driving in the most unimaginable conditions. Today, I hope he is okay and does not carry guilt. We made a point to check in on him and talk with him about staying focused. I also encouraged him to seek counseling when he got home. It was not the time to examine any feelings of misplaced guilt in a deep way while still having to drive missions. There would be time when he got home, to process it. I hope he did.

Retrieval of Soldiers' Remains

Soldiers, all of us, have "other duties as assigned." There are general expectations of things we are required to do, regardless of our position or rank. One of these is the recovery of remains and body parts. It's a part of the military creed of leaving no one behind. The army issued a laminated training card on the subject, among other topics, and it was one of the trainings we, as a combat stress unit, could provide. Soldiers who officially had this responsibility were the ambulance units. We had one such unit at our camp, and as they were assigned, faithfully drove out on the roads when there was an accident, or an IED explosion – seemingly with little concern for their own safety. Some of the soldiers assigned to the ambulance unit were Emergency Medical Technicians (EMTs) back home and several reported that they had seen plenty. They were accustomed to retrieving body parts, they informed me, but they were concerned about the uninitiated unit members – the younger ones who

had never been called to the scene of an accident. These were the ones they asked us to speak with. When I did it, I dutifully reviewed the points listed on the laminated card, feeling confident all along that these soldiers would perform admirably if called upon. All of us would, if we had to. Most soldiers who talked about it said it wouldn't be a hard duty as the body parts were no longer a person – the person was gone – that the retrieved flesh was not a person or the soldier they knew – it was just flesh. This is essentially what is taught in training, that the body is not the person. I wondered if I would feel that way if I ever had to do it. It's one thing to talk about it and train for it – quite another thing to actually do it. Fortunately I never had to find out, but I did counsel a soldier who did.

He came to the office to talk with me about it, after having recently retrieved the body parts of a female truck driver who was killed after her truck was hit by an IED. He wasn't part of that unit, but had been given the requisite body bag and was called upon for casualty collection duty. She was a total stranger to him. I feel that I will never forget how he described it. His description was touching and I could tell he wanted to do the best for her, even in death, even when her body was now a collection of parts. The worst part he said was when he picked up her face. The way he described it, it sounded as if the face was no longer attached to the skull but that the face itself was intact so that he could see all her features.

Sitting in a chair across from me, he lifted his arm, holding his hand up as if he were holding her face before he placed it in the bag. It was a small gesture and a brief moment, but as he held his hand out, I envisioned a young female soldier's face – him holding on to a piece of her hair or scalp – her face looking at me. Then he set his hand down, as if once more he was placing her face into the bag. I wanted to ask him how it could be that her face was intact like that, or if it were even true that he picked up an intact face, but didn't dare. Besides it didn't matter. What mattered for us in that moment was that he had connected with her because he saw her face. And this was his question to me. He felt a desire to look up her parents and tell them what he had done. He asked me if he should. What to say? I tried to imagine that this was my daughter, or even if this had happened to my son – would I as a parent want to hear from the soldier who had picked up my child's body parts and who had held her disembodied face in his hands? Even in the moment I was thinking about it, I realized I was experiencing counter-transference and I used this information to respond to the soldier. Gently, I responded that if this were my daughter, I would want to hear from those who knew her when she was alive, what she was like, stories about her before she died; how she laughed; how she trained; who her friends were in the unit. I would not want to talk with someone who performed this last rite. Maybe other parents would feel differently but this is how I felt and I told him so. You have a need to do this, I said, but it is your need, and would not help her parents. We can talk about it, honor her in our conversation and wonder what she was like. He didn't argue with me, and soon left after he asked me this question. I like to think that in a way he was relieved, knowing that he had fulfilled his duty as a soldier, and that he had done all that he could and should, now that she was gone. But like the others I counseled, I will not know the end to this story.

Several years after I returned, I met a veteran who had been assigned to mortuary affairs. Theirs is noble, silent work. It could also be isolating, as mortuary affairs is often to the side of a base, on its own. We talked briefly about the difficulties in this work, and how, over time, soldiers assigned to this duty could be vulnerable to emotional trauma – all those body bags – all those bodies, and all those body parts. The veteran talked about getting counseling for the unit, and that it helped tremendously. I heard about how one soldier who, after being in the unit for some time, had related that one of the bodies in the bag was talking to him. For a moment, I recalled my conversation with the soldier who told me he had retrieved the face of the young female soldier and how she had seemed “alive” to him. For a moment I thought, “oh – they made a mistake,” and this soldier who they thought was dead was only sleeping and was actually alive. Like Lazarus. But no, they were all quite dead. It was apparent that mortuary affairs had finally gotten under this soldier's skin.

Relating this story, this veteran was happy to report that the counseling he received had made a big difference. What I did, what we do in combat stress units and what others do who counsel soldiers in the

VA, Vet Centers, and other settings, matters.

ARES

Though there was hardly any hint of hostilities at our camp, it was all around us. Further, soldiers assigned to our camps came back, after experiencing conflict, bombs, and ambushes in surrounding areas. Of note were the first and second battles of Fallujah, a period of excessive bombings and ambushes on a nearby supply route, a unit's clash with militants outside Baghdad, and a friendly fire incident that resulted in the death of a coalition soldier at a nearby radio relay point we supported. Finally, I myself experienced one friendly-fire incident – a drive-by shooting with another coalition unit that resulted in no casualties, and a mortar attack on our camp, also casualty-free.

April 2004, the month before we arrived, was also the month when the first Battle of Fallujah occurred. This was the deadliest month of the conflict to date, spiking from 52 coalition casualties in March to 140 in April, as well as 1,215 wounded. Similar figures would be seen again, when the second Battle of Fallujah took place in November and December 2004. The second Battle of Fallujah was the bloodiest battle to involve U.S. troops since the Vietnam War. Some soldiers from our camp participated. Overall, there were 217 casualties in November and December, and 1,972 total wounded. These are the highest totals when compared to all other monthly casualties and wounded, from 2003 to 2012.

During the period of the second Battle of Fallujah, the nearby supply routes were experiencing a great deal of bombings and ambushes as well. We supported several transportation and quartermaster units, those who drove the trucks carrying essential water and fuel as they came to our camp for more fuel. Many of these vehicles were in poor condition, and were not sufficiently armored for adequate protection. In November 2004, one Reserve unit we supported made the news when they refused to go out on any more convoys where much of the bombings and ambushes was occurring (Jensen, 2004). Soldiers driving fuel trucks refused to go out on the roads again as not all their trucks were armored. We had several interactions with members of this unit. Though keeping my own opinion in check, it was easy to be empathetic, as a poorly armored fuel truck is a great target for a roadside bomb or ambush. They received a great deal of support from family members in the States and from some soldiers stationed in Iraq. Though they could have faced court-martial for disobeying orders, these soldiers received the lesser non-judicial punishment of Article 15s (Jensen, 2004).

On March 2nd, a U.S. soldier stationed at a radio relay point south of our camp, killed a Bulgarian soldier in a friendly-fire incident. According to news reports the incident occurred in the evening when a civilian Iraqi car approached a Bulgarian patrol. When the vehicle did not stop after the patrol gave the signal, the Bulgarian soldier fired warning shots into the air. The U.S. radio relay point (RRP) was about 150 yards away, and soldiers, hearing the shots, began firing, resulting in a Bulgarian soldier's death (Toshkov, 2005). After the incident, our combat stress team visited these soldiers at the RRP, accompanied by members of their headquarters. We were there to assess the climate, and to provide stress and anger management classes, if needed. Though that was our purpose, soldiers stationed at the RRP were more than willing to show us a bullet hole in their trailer, which they said had been fired at them by the Bulgarians before they fired back. Since the Bulgarians had not identified themselves, they thought they were under attack. We listened empathetically, nodding our heads, without comment. Our role was to assist in de-stressing, not to investigate. In the meantime, our combat stress specialist dutifully provided the soldiers with anger and stress management classes, and, once finished, we headed back to our camp.

My own friendly fire incident was in the spring. A few times during my tour, I accompanied soldiers on their security tours in the area surrounding our camp, to get a sense of what they were experiencing. On one of these occasions, the soldiers had gotten out of the vehicle, to take a look around. I also got out. A few moments later, we were being fired on, but from a great distance away. The soldiers instantly told me to get back in the vehicle, and they quickly followed suit. They told me that the shots were coming from the main road, a drive-by shooting from a coalition unit. They also told me they had fired on this unit earlier, and now they were firing back at them. Tit for tat, I hoped

that would be the end of that. If it wasn't, at least it didn't end in another friendly-fire casualty.

Mortars are another story. A mortar is a weapon that fires explosive projectiles, or mortars, at low velocities and short ranges. The security forces at our camp would, about once a week, fire outgoing mortars, they said to let everyone know we were here, and were ready to defend ourselves. When they did fire one off, it could be heard across the camp. But I did wonder how I would be able to distinguish between outgoing (ours) and incoming (theirs). When I asked them, they said, “don't worry, you'll be able to tell the difference.” Mortars make kind of a thump sound when fired, which you generally will not hear from incoming. If you hear the incoming mortar, you'll soon hear the explosion, and then it's time to take cover.” One night I was on the phone talking with my husband, from our combat stress trailer. During the conversation, I heard the mortar followed by the explosion. It stopped our conversation, and, I immediately knew it was an incoming mortar from its sound. I knew I needed to head to a bunker, but didn't want to startle my husband. Of all times to be on the phone! “Did you hear that?” I asked. “Yes,” he said. Then, “I gotta go” was all I said, and hung up the phone. Grabbing my helmet and my protective vest I headed for the bunker. My 9-mil was already strapped to my thigh as I only removed it to sleep and shower. We stayed in the bunker for about 45 minutes, before we heard the all clear. It was another 24 hours before telephone communication was restored and I could let my husband know I was okay.

Gratitude

A few months before I left Iraq, a unit was heading home and getting ready to leave our camp. Redeployments were staggered so that an entire camp would not redeploy at the same time. This makes perfect operational sense, but it was hard to see people go to whom you had become attached, and to be left behind. They flew out in helicopters under cover of darkness. I was thankful they were able to fly out, rather than convoy. In the morning, I got up at my usual time and got ready to start my day. When I checked out the door to the trailer where our combat stress unit was located, I found a card taped to the door addressed to me. It was a thank you card. Beyond the pre-printed note of thanks, this soldier had written that during his deployment, he always counted on my smile and seeing it made him feel good. Even though we never talked, he knew that he had a friend in me, and knowing that got him through. And once again I cried. I knew several soldiers in this unit but this soldier was a stranger to me. During my deployment I would ask myself if what I did mattered. And I would, on occasion, be overwhelmed with an inexplicable sense of abject failure – something I had never felt before in my entire life. Reading this card, in spite of my uncertainties, my fumbles, I told myself yes, what we did – what I did – mattered, and thanked him in my heart for telling me so.

Conclusions

Transference and counter-transference theory may be relevant in understanding these brief interactions. Regarding transference I wonder whether the gender of the combat stress social worker affects how soldiers respond to the counseling situation. Though the military is to be gender-neutral in that we are all soldiers first, male leaders can be looked upon as father-type figures. It follows that women in leadership positions could also be viewed in the parental role. In regards to my own service with a combat stress unit, I wonder if my gender mattered or impacted interactions in any way. When I got home, I shared these thoughts with another combat veteran, who served with an infantry unit, and his response was that most definitely – you were something of a mom-figure for them. Regarding counter-transference, I certainly viewed many of the soldiers as sons, brothers, daughters, and sisters, and I was aware of how my own thoughts and feelings toward my loved ones influenced how I interacted with soldiers who sought out counseling from combat stress. During my deployment my thoughts were often with my sons, who both were active duty, my husband, who was pretty much on his own, and my father, in a nursing home and who got his news about me from my brother.

Looking back, I think soldiers valued my opinion as a woman at least as much, if not more, than my professional point of view. This was especially true when the subject was Eros, or relationships with their wives and girlfriends. Had we all been stateside, I think it's unlikely that these soldiers would have consulted a social worker about

relationship concerns. It was that we were all there together, and we received filtered views of what was actually happening back home. At the same time, our families back home got filtered views of our lives in Iraq. Both sides were, in their own ways, trying to protect the other, and in some cases, shielding themselves as well.

In talking with soldiers about their grief, their encounters with Thanatos, or death, I found that our combat stress office became for some, a place where they could grieve, a private place where they could cry. And of course, the world created by Ares was inescapable, coloring all of these interactions.

I don't believe I was more or less effective than my male counterparts. I do wonder how our respective genders impacted how we functioned and were perceived while serving in combat stress units. Perhaps this narrative will further our dialogue and research for enhancing combat stress operations in combat or hostile fire arenas.

Implications for Practice

In working with service members and veterans from the recent conflicts, it would be helpful to understand the basics of combat stress units, as this is how today's soldiers may have first experienced the helping relationship. In this regard, combat stress units may be considered an integral part of the continuum of care. In my experience of combat stress operations, the helping relationship is brief, generally one or two encounters, and scheduling is flexible, more focused on the soldiers' or unit's priorities than a fixed calendar. While deployed, combat stress social workers teach soldiers to "normalize the abnormal," and in so doing, teach coping mechanisms for normal functioning in an abnormal setting. As illustrated in these case examples, I encouraged soldiers to "pack-up" or put aside conflicted or confusing, and deep-seated emotions now, suggesting that they "unpack" these feelings in a more long term counseling relationship when they got home. While not expressed in these scenarios, it was not unusual for soldiers to share stories of past hurts and loss while they described what was happening in the present. There were stories of childhood abuse and neglect, chaotic upbringings, prior relationships gone wrong, loss of other loved ones, and previous deployment and combat experiences. Listening to these stories, I would quickly realize that the current incident had triggered these past events many of which were unresolved, with the soldiers experiencing a range of conflicted thoughts and feelings. I also realized that any attempt on my part to provide psychotherapy in this environment could only make things worse. Psychotherapy requires time, and a context where a stable, ongoing therapeutic relationship can be established. In this environment, sticking with the combat stress model of brief interactions, developing coping skills, and assisting soldiers to stay focused on the present, was the best strategy. And of course, a suggestion to seek additional help when they got home.

Social workers could enhance their success in developing a therapeutic relationship by being able to bridge the gap between traditional approaches to therapy and the combat stress model. They should also be able to explain the difference to their client, and the rationale for the different approaches. They will consider options for increasing flexibility in their approach, and will be able to educate service members on the value of unpacking feelings they had previously put aside. However, when grief and trauma are cumulative, such as when soldiers experience multiple traumas and/or deployments, unpacking one's feelings, or even acknowledging one has feelings, can become harder and harder. For example, soldiers' indifference toward their feelings and perhaps anything beyond the world of Ares is reflected in this phrase, which became the mantra for many Vietnam veterans: "don't mean nothin" (Shay, 1994, p. 38).

The emerging models for integrated behavioral health practice may be a useful approach for engaging veterans in a therapeutic relationship (Curtis & Christian, 2012). The integrated behavior health model is focused, time-limited, and incorporates constructive feedback and advice into the helping process. Similarly, social workers working with veterans and service members could judiciously incorporate guidance and advice into their practice, and avoid strategies that are completely open-ended. Once service members and veterans are engaged in treatment, and a trusting relationship is established, they may be willing to commit to a structured, manualized approach to treatment, for long-term concerns.

Finally, social workers and other helping professionals should be knowledgeable about resources available for veterans, family members, and active duty service members. One such important resource is the Vet Center, whose mission is to provide readjustment counseling to veterans. They can assist veterans in navigating the big VA and in linking them with needed services and clinicians. Vet Centers are now gearing up to provide services to active duty service members, as well as to those who served with mortuary affairs in the United States. I understand that they may also be able to provide services to drone pilots. Call 1-877-WAR-VETS, or email Vetcenteroutreach@va.gov.

References

Adele (2011). *Someone like you*. In *21* [CD]. London: XL Recordings.

Barton, B., Owen, F., and Talley, L. (1953) "*A Dear John Letter*" http://www.youtube.com/watch?v=UaPAenBgU7E, accessed February 1, 2014.

Boys II Men, (1992). "*End of the Road*", on album, Boomerang, released June 30, 1992, original soundtrack, written by Antonio Reid, Daryl Simmons, and Kenneth Edmonds, http://www.metrolyrics.com/end-of-the-road-lyrics-boyz-ii-men.html, accessed Feb 1, 2014.

Bumiller, E. (2011). "Obama ends Don't Ask Don't Tell" Policy, *New York Times*, July 20, 2011, http://www.nytimes.com/2011/07/23/us/23military.html, accessed February 1, 2014.

Cannistra, K., Downs, K., & Cristina Rivero, C. (2010). "A history of "Don't Ask Don't Tell, *The Washington Post*, Nov. 30, 2010. http://www.washingtonpost.com/wp-srv/special/politics/dont-ask-dont-tell-timeline/, accessed Feb 1, 2014.

Curtis, R., & Christian, E. (Eds.). (2012). *Integrated Care: Applying Theory to Practice*. New York: Routledge.

Grene, D. & Lattimore, R. (Editors and Translators) (1956). *Euripedes I: Alcestis, The Medea, The Heracleidae, Hippolytus, (The Complete Greek Tragedies)* (Vol. 3)., Chicago, University of Chicago Press.

Harris, E. (2005). U.S. troops kill 26 militants outside Baghdad, *The Stars and Stripes, Mideast Edition*, March 22, 2005, p. 3.

Huston, J. & U.S. Army. (1946). *Let there by light* [Motion Picture Documentary]. United States: U.S. Army.

Icasualties.org (2012) Iraq Coalition Casualty Count, http://icasualties.org/Iraq/Index.aspx, accessed April 28, 2014

Jensen, R. (2004). GIs who refused mission offered Article 15s. *The Stars and Stripes, Mideast Edition*, December 7, 2004, p 3.

Robinson, S., & White, W. (1964) "*My Gir*l", sung by the Temptations http://www.youtube.com/watch?v=4P1x7Yy9CXI, accessed February 1, 2014

Shay, J. (1994). *Achilles in Vietnam: Combat trauma and the undoing of character.* New York: Touchstone Press.

Timberlake, J. (2002). Cry me a river. In *Justified* [CD]. New York: Jive Records.

Toshkov, V. (2005). Bulgaria blames U.S. for soldier's death. *Seattle Times*, http://seattletimes.com/html/nationworld/2002200201_bulgariashot08.html, accessed April 28, 2014

USACHPPM, (2004). "*OIF Tip – How to face the injured and dead*," TC#7, March 2004.

Weigel, J. (1973). *Mythology Notes: Introduction to mythology, Egyptian, Babylonian, Indian, Greek, Roman, and Norse mythology.* In Cliffs Notes, London.

Wells, Tyrone (2010). "*Time of our lives,*" released on Album, Metal and Wood, March 2, 2010, http://www.lyricsmansion.com/result/time-of-our-lives-lyrics-tyrone-wells.html, accessed February 1, 2014.

Wikipedia, (2014). *List of Doonesbury characters*, http://en.wikipedia.org/wiki/List_of_Doonesbury_characters, accessed February 1, 2014.

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Establishing Rapport and Overcoming Stigma with Military Clients: Insights from the Field and Beyond

Randall Nedegaard

Abstract: Mental health issues in the military are becoming more prevalent, increasing by 65% over the past decade (Blakeley & Jansen, 2013). Adjustment to military stresses, including deployment and reintegration, take their toll on everyone involved, to include the mental health provider. This article focuses on the lessons learned by one former military mental health provider regarding the importance of establishing meaningful therapeutic bonds with clients. Several case examples from the deployed environment are used, as well as lessons learned from the author's personal experience with becoming a client. These help illustrate how difficult vulnerability can be within a military population. The importance of engaging in competent military cultural practice and the means by which one can gain additional military cultural competence are discussed.

Keywords: deployment; military cultural competence; stigma; mental health; rapport

The prevalence of mental health issues among our service members and veterans is on the rise. In a 10-year period between 2001 and 2011, the number of active-duty service members receiving a mental health diagnosis increased by 65% (Blakeley & Jansen, 2013). Prevalence rates were highest for Post Traumatic Stress Disorder (PTSD) and depression upon return from deployment, ranging from 9% to 31% depending on the level of functional impairment reported (Thomas et al., 2010).

Unfortunately, a large number of these military members encounter barriers to receiving care largely due to concerns about the labeling and stigma associated with mental health treatment-seeking (Kim, Thomas, Wilk, Castro, & Hoge, 2010; Vogt, 2011). Additionally, service members might agree that civilian providers are competent professionally, but many of these providers lack an understanding of service members' military experiences, challenges and language. This knowledge deficit is often a significant reason why military patients discontinue treatment with community-based providers after a single visit (Cogan, 2011).

This is a phenomenon that I have been very familiar with as I devoted 20 years of my life to treating military service members as a social work/psychology officer in the U.S. Air Force. The stigma and barriers associated with help-seeking among military members was something I have been well aware of since the early 1990s, but it was never more significantly reinforced than in my deployment to Afghanistan from 2009-2010. I led a Combat Operational Stress Control (COSC) detachment, with mental health teams spread out among eight Forward Operating Bases (FOB), all designed to enhance adaptive stress reactions, prevent maladaptive stress reactions, and assist soldiers with controlling combat operational stress responses and behavioral disorders (U.S. Army Medical Department, 2013).

While deployed, I heard about, or personally encountered, dozens of deployed service members who were struggling with significant stressors originating in the deployed environment or on the home front. Post deployment, I found myself struggling with some of the same issues as my former clients. I retired 10 months later and eventually sought professional help myself. Those experiences, and the experiences I encountered commanding behavioral health units stateside have taught me many lessons about the power and importance of the therapeutic relationship and the necessity of cultural competence in developing those relationships. What I have learned can be broken into the following categories:

- Opening up and/or admitting one's faults is very hard and can leave one feeling vulnerable, weak or judged
- Being able to listen and relate can be transformative
- Rapport and connection can come from reasonable pushing
- Many tools and methods of building rapport exist

- There are many ways to gain military cultural competence

Opening Up, Admitting Faults, and Feeling Vulnerable, Weak and/or Judged

It is well documented just how many barriers our military members and veterans face in order to be vulnerable enough to seek care and open up (Bein, 2011; Jones, Twardzicki, Fertout, Jackson & Greenberg, 2013). Between the fear of occupational and social repercussions, the stigmatization of mental health concerns, and the relative shortage of professionals who can relate to the trauma of war, it is no surprise that military members and veterans are reluctant to open up. One situation I encountered downrange provided me with an excellent reminder of how courageous it is to talk. The driver of an armored vehicle had an accident involving a pedestrian. He and his team had to stop the vehicle, dismount, view the carnage, and manage the situation with the local residents. If this weren't traumatic enough, the most challenging aspect of this situation was the reaction from his team. They were very angry with him for putting them in the middle of this terrible situation, accusing him of being too careless with his driving. He felt as though he let his team down, and his biggest fear was losing the trust of his battle buddies and being alienated from the unit. He was rapidly decompensating from the stress and anxiety. When I first arrived at the FOB, he had absolutely no interest in talking to me. In fact, I don't believe I could have gotten him to open up to me on my own. This military member was ultimately convinced to talk by pointing out how people around him were concerned, and that withdrawing into himself would only exacerbate that concern and potentially alienate him from the unit. It wasn't my skill at rapport building that got him to start talking, rather it was the trust he had in his unit leader.

After redeploying home, I could tell I was struggling but thought I needed to handle it myself. It seems that the stigma associated with help seeking even reaches helping professionals like myself, despite the countless hours I've spent over the past two decades trying to minimize that stigma with others. Rarely do people like being pushed, but I, like so many others, significantly benefited from consistent encouragement to seek help.

Most of the soldiers I served in Afghanistan had two factors working against them when it came to admitting fault. First, they were soldiers, warriors. The Warriors code suggests that one withstands the hardship of war for the greater good (French, 2001). This also suggests they are to suffer without complaint. Second, they were mostly men, and both the military culture and the mainstream culture tend to discourage men from being emotionally vulnerable with anyone (Brown, 2012).

The military is based on an “up or out” model in which you have to attain a certain rank in order to continue your military service. If one is not promoted fast enough, they will face what the military calls “high year tenure” and are forced to leave. For enlisted members, this means that one needs to attain the rank of E-5 (enlisted ranks range from E-1 to E-9) by your tenth year of military service. Officers generally need to be promoted to O-4 (officer ranks range from O-1 to O-10) or risk likely release from service. Those are minimum guidelines, and many career accomplishments are prominently displayed on the uniform in the form of medals, ribbons, and patches. It is a competitive system that creates opportunities for judgment, good or bad. In Afghanistan, I was most reminded of this while talking with a young soldier who had been in country for four months and hadn't yet been engaged by the enemy. Once soldiers have engaged the enemy, they receive a CAB or combat action badge (USAHRC, 2013). Because he was yet to be authorized for the CAB, he was the only infantryman on his small FOB who hadn't earned one. And because it is worn on the uniform, he felt everyone could see that he was not yet battle tested and was concerned that others in his unit would think that he was trying to avoid combat. He was experiencing such stress over this that he was simply desperate to engage the enemy, regardless of the consequences. Rapport building with this soldier was challenging because he was so fixated on earning his CAB, it bordered on obsession. That said, it was easy to relate to some of his core fears about inadequacy that we all struggle with to one degree or another. Spending time allowing him to vent and connect with his anxiety helped him overcome his hesitation to seek help. I also validated his courage to talk about this concern with me, framing it as a way to suggest that, if he exhibited bravery in a situation like this, he would

be likely to exhibit bravery when his life and the lives of his battle buddies were in danger.

Even though I was out of the military when I sought professional help of my own, I found myself fighting against those messages that said I "just needed to be stronger," "suck it up," and "drive on with the mission." I felt that people looked up to me and that I was expected to provide an example of strength for them. Help seeking felt like an acknowledgement that I was weak and hypocritical – somehow I didn't do a good enough job of taking care of myself. If I can't even take care of myself, how can I be trusted to help my clients take better care of themselves? As a result, I was very sensitive to any nonverbal cues that suggested others might think I was just complaining or wasn't being completely reasonable. Clients make decisions early and often about whether we really care about them. Judgment in any form damages that perception, yet so many aspects of military culture can promote judgment of others. Rank on one's sleeve, collar, or shoulder can equate to a price tag on a piece of furniture. We are acculturated to believe we get what we pay for.

Being Able to Listen and Relate Can Be Transformative

Wearing the same uniform and being deployed in the same general location broke through obstacles and created an ability to relate to the stresses soldiers were experiencing downrange. It earns one near instant credibility and can give you that essential foot-in-the-door with clients who would be otherwise reluctant to open up. In my many conversations with military members and veterans over the years, one of the biggest complaints I hear is how hard it is to open up to a civilian practitioner who can't relate to what they experienced as a military member.

When military members or veterans have finally fought through the obstacles to seeking care, they are often eager to open up. I display my military coins in my office, and this has led to several conversations from veteran students who want to share their story with someone who will understand and appreciate their struggle. For them, this is a sign of solidarity, providing credibility.

Therefore, it is no surprise that the vast majority of veterans I have encountered feel that civilian mental health providers should receive specialized, military culture training. Mostly, these veterans seem to be looking for someone who has basic knowledge of the military organizational system and who seems to them to really understand things like deployment, family separation, reintegration and military family dynamics impact their lives.

Most would be less reluctant to seek care from a mental health provider who had some military familiarity and training and would be more confident in that provider's ability to treat them effectively. This is consistent with the findings of Zinzow and colleagues (2012) who found that veterans benefit from professionals who have an adequate knowledge and appreciation of military culture and practice in military settings. Interestingly, my conversations with veterans indicate this would only slightly increase the likelihood they would actually seek help from said provider. This suggests that getting veterans and military members into the door requires more than just providing effective services and that, once we get them through the door, we have to take full advantage of the opportunity.

Rapport and Connection Can Come from Reasonable Pushing

As previously mentioned, many of us can benefit from strong encouragement by those who love us and want the best for us. As care providers, helpers, and family members, it is important to note that pushing is necessary at times. This is largely due to the fact that what military members and veterans are dealing with might be easier for them to avoid, or rather to address with a bottle of alcohol. This may be seen as a more culturally appropriate way to address these feelings rather than openly talking about them. For example, one client was reluctant to engage in cognitive behavioral therapy (CBT) for her PTSD but eventually engaged her treatment fully and completely. When asked what made the difference, she indicated that she initially gained confidence by the provider's ability to articulate what the treatment was about and why the treatment involved such an aversive emotional experience like exposure. That was enough to get her to try it. One of the primary factors she attributed to her decision to continue with treatment was feeling like someone cared enough to push her while also being sensitive

enough to give her breaks if therapy became too intense.

Many Useful Tools and Methods of Building Rapport Exist

Care and compassion have been great tools with which to build rapport, but it can be a challenge to demonstrate care if one can't relate to the situation the client is experiencing. In my conversations with veterans, a common theme regarding their civilian provider's military cultural knowledge is that they want them to be aware, but they don't want special treatment. From a culture that values endurance, strength, and tenacity, anything that might resemble pity or sympathy would likely be interpreted as something very offensive. Ironically, pity and sympathy are similar to concepts such as compassion or empathy, but the fine line that separates them makes a significant difference. Empathy involves an understanding of what someone is feeling by attempting to see it from their perspective, while sympathy suggests we feel sorry for the person for what they have experienced. Warriors don't want sympathy, as they knew the risks they signed up for. However, they can appreciate attempts of others to feel and understand a situation from their perspective.

Deployment changes everyone to some degree. When military members redeploy and need to reintegrate with their families and communities, they feel changed and often feel they don't fit in anymore. Many also feel as though people in their lives are uncomfortable and don't want to associate with them. This is not unlike experiencing a significant loss. Well-meaning civilian individuals may feel helpless because they can't relate to what this military member has just experienced, and thus they don't know how to help. In scenarios like this, it is easy to pick up on their discomfort and interpret that as rejection on some level. When social workers and other helping professionals are comfortable simply being with the person and not feeling it is their responsibility to fix the situation (and thus feel stuck and uncomfortable), more substantial connections can be made.

In the deployed environment, mental health professionals are encouraged to try to reduce stigma via walk-arounds. Walk-arounds involve approaching soldiers and beginning a conversation. COSC teams engage in hundreds of walk-around contacts each month. Having little experience with this sort of activity, I learned a great deal about how to successfully have a conversation with a fellow military member whom I'd never met before. I rediscovered how important the use of self is in these situations. For instance, football is a very popular sport in the U.S., and many military members are National Football League (NFL) fans. As a confirmation of this fact, we even had a team of popular football analysts come and air their weekly television show while I was in Afghanistan. Being an NFL fan, I engaged hundreds of soldiers by striking up conversations about football. I used my knowledge of the game to get them talking and help make them more comfortable around us mental health types.

There Are Many Ways to Gain Military Cultural Competence

I believe we must start by understanding the horrors of war and how people naturally deal with trauma. For instance, I had the opportunity to communicate with a new soldier via email in Afghanistan. I saved those emails and received his permission to quote them. They serve as a superb exemplar of the kind of situation many young soldiers face as they first engage in combat. He reached out to me after he experienced a traumatic incident that he was not comfortable sharing with anyone else: “I just don't like the whole idea of seeing these kids shooting at us and I have to put them down. How do I deal with that? Like, I know that it's either them or me. But I don't know.”

This was a level of candor he had not previously shared. It gave me the opportunity to normalize his inner conflict and questioning. It also allowed me to let him know that I was very encouraged he felt the way he did, because it meant he wasn't disengaging from his emotions, as is so common. It also allowed me to probe and ask about his trauma to help him process it in writing.

By doing this, it created a safe place for him to explore his feelings more. He later responded: “I view it [as] it's either they die or I die. And I know it's just a war of morals now, so they fight for what they believe, but I just can't comprehend why some little kid thinks he stands a chance against 10 MRAPs [armored vehicles]. We've taken fire every

convoy, and I've been on 12 [convoys] since I've been here. Working here can be really rough; it's the wild west in half of these cities. As for shooting back at kids, I'd say it's probably happened 4 or 5 times. All the same village..."

Clearly, this is some very vulnerable disclosure, and it must be handled with great care. It gave me an opportunity to acknowledge and empathize with the incredible challenge he was facing, support him by praising his willingness to be vulnerable, and offer some psychoeducation about how children tend to be easier to manipulate. This seemed to help as he responded, "thanks for laying it out like that."

This provided an opportunity to probe a little more, so I asked about the most traumatic occurrence he had experienced thus far. He responded: "The worst situation I had was while I was the TC (vehicle commander) because I had been gunner for about 30 hours straight. We took a piss break and got back in. I forgot to combat lock the door. When one of our guys threw a water to a kid, we got bumrushed by the whole village for water. I had a...kid come and open my door. I yelled at him and told him to get down, and our translator said it too. He refused. So I tried kicking the kid. He still held on. It came to me getting so mad that I butt stroked (struck him with the butt of his rifle) him in the chest. The kid was knocked out cold, and fell on his head...It's that kind of stuff that makes me question why we do what we do, but I care for all of our security." Once he opened up with this, we were able to process it.

Everyone has their limits with how much trauma they can tolerate and two months later, this young soldier had predictably started to shut down. "I feel indifferent about the whole [killing] thing. I've kind of gone numb with it. Not really caring. Not to the point that I don't care who I shoot, but that I just don't mind doing that stuff anymore. It just seems that in the Army, if you care, you're out. You're non-mission capable. And I've just grown with it...I don't hide any feelings. I don't know. They [feelings] just go away I guess. I'm just afraid that when I go home, I'll keep not caring about this stuff, and I don't want that."

Later emails tended to focus on the frustrations of deployment and how he felt more disconnected with his support system back home. "It seems like everyone is cutting me off...But it's alright, people are busy. And maybe that's just their way of dealing with me being gone. I don't know."

Toward the end of his tour, he had developed coping strategies, good or bad, to adjust to this chronic trauma: "I like the simplicity of just life and death, waking up every day, not worrying about what to wear, not worrying about keeping a girlfriend happy, just the only thing on my mind being a mission. Knowing I'll either complete it or not be alive if I don't. I don't know. Maybe I'm crazy...it really is SSDD [same shit, different day], except we get IDF [indirect fire] a lot more often, but that's whatever. I'm so used to it now, since I spent a ton of time on foot patrols and fire bases, so it's become almost a game of dodgeball for me. Gotta find fun in something I suppose."

At this point in the deployment, he had emotionally shut down for the most part. Any attempts of mine to encourage him to continue processing his feelings were essentially ignored. Once this skill is developed, a significant difficulty comes when reintegration is required and these feelings start to be addressed.

Clearly, opportunities like this are rare, and civilian providers need other ways to gain military cultural competence. There are several tools available to help educate the public on the military culture. For instance, the Center for Deployment Psychology (CDP) offers workshops, online training, and even a certificate program (CDP, n.d.) for civilian mental health professionals (with a graduate degree) who are actively treating, or plan to treat, military members or veterans. Another excellent resource can be found through the VA National Center for PTSD. This program offers clinicians guides, practice standards and a PTSD 101 training site, providing continuing education services for researchers, professionals working with trauma, and helpers (U.S. Department for Veterans Affairs, n.d.).

Finally, if you provide military-friendly services and/or have training in or experience with military culture, it is important to advertise it. Just like my military challenge coin collection advertises the fact that I'm former military, signs, certificates, or other

such indicators can be a valuable tool in getting the word out to veterans, military members, and their families that you care enough to be culturally competent and are a safe place to talk.

References

Bein, L. (2011). *Military mental health: Problem recognition, treatment-seeking, and barriers*. Dissertations (2009 -). Paper 147. Retrieved from http://epublications.marquette.edu/cgi/viewcontent.cgi?article=1146&context=dissertations_mu

Blakeley, K., & Jansen, D. J. (2013). *Post-traumatic stress disorder and other mental health problems in the military: Oversight issues for Congress Congressional Research Service*. Retrieved from https://www.fas.org/sgp/crs/natsec/R43175.pdf

Brown, B. (2012). *Men, women, and worthiness: The experience of shame and the power of being enough*. Louisville, CO: Sounds True, Inc.

Center for Deployment Psychology. (n.d.). *Certificate program*. Retrieved from http://www.deploymentpsych.org/training/certificate-program

Cogan, S. D. (2011). What military patients want civilian providers to know. *Substance Abuse and Mental Health Services Administration News, 19*(3), 4-6.

French, S. E. (2001). *The warrior's code*. Retrieved from http://www.au.af.mil/au/awc/awcgate/jscope/french.htm

Jones, N., Twardzicki, M., Fertout, M., Jackson, T., & Greenberg, N. (2013). Mental health, stigmatising beliefs, barriers to care and help-seeking in a non-deployed sample of UK Army personnel. *Journal of Psychology and Psychotherapy, 3*, 129.

Huston, J. (Director) & U.S. Army (Producer). (1946). *Let there be light* [Documentary Motion Picture]. United States: U.S. Army.

Kim, P. Y., Thomas, J. L., Wilk, J. E., Castro, C. A., & Hoge, C. W. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. *Psychiatric Services, 61*, 582-588.

Thomas, J. L., Wilk, J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010). Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry, 67*(6), 614.

Timberlake, J., & Storch, S. (2002). Cry me a river. On *Justified* [CD]. New York: Jive Records.

U.S. Army Medical Department. (2013). *Combat Operational Stress General Information*. Retrieved from http://www.behavioralhealth.army.mil/provider/general.html

U.S. Army Human Resources Command. (2013). *Combat Action Badge*. Retrieved from https://www.hrc.army.mil/TAGD/Combat%20Action%20Badge%20CAB

U.S. Department of Veterans Affairs. (n.d.). *PTSD: National Center for PTSD*. Retrieved from http://www.ptsd.va.gov/professional/index.asp

Vogt, D. (2011). Mental health related beliefs as a barrier to service use for military personnel and veterans: A review. *Psychiatric Services, 62*, 135-142.

Zinzow, H. M., Britt, T. W., McFadden, A. C., Burnette, C. M., & Gillispie, S. (2012). Connecting active duty and returning veterans to mental health treatment: Interventions and treatment adaptations that may reduce barriers to care. *Clinical Psychology Review, 32*(8), 741-753.

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The King of Nineveh

Sean Patrick Convoy

Abstract: This is a nursing narrative that captures the experience of a Navy Psychiatric Mental Health Nurse Practitioner with a therapy dog and military sexual assault victim while deployed to Mosul, Iraq, in 2009.

Keywords: Combat stress control team; Iraq; MST; therapeutic animals

I arrived in Mosul, Iraq, in January 2009. The C-130 landed on Forward Operating Base (FOB) Diamondback's tarmac awkwardly much in the same way an under inflated basketball comes to be still when dropped. As I stepped out of the back of the plane, a silt-laced Mosul genuflected to the north. As the ancient capital of Mesopotamia (Nineveh), it had an air of past importance but today it just looked tired.

As my vision began to accommodate to the light and dirt, I broke sight of the city's landscape and noticed three people waiving furiously at me. With them was a perfectly ordinary black Labrador Retriever wearing boots and goggles. His nose was outstretched into the acrid wind. The back half of his body wagged effortlessly in time. I instinctually moved toward that which was most familiar. I motioned to the dog (heretofore called Sergeant First Class Budge) before acknowledging his human entourage. Budge broke the distance between us in equal time until we were en guarde. He gave me one small lick. While I hoped for more, I didn't take it personally inferring he didn't want any more dirt on his tongue than I.

Budge's human entourage represented the Combat Stress Control (CSC) Team that I was scheduled to replace. My presence signified their ticket home. Consequently, I was met with wide smiles and exuberant energy. They took my bags, handed me a large bottle of water and drove me away to an adjoining base that I would soon call home, FOB Marez. I was a Navy Psychiatric Mental Health Nurse Practitioner augmenting an Army role during the Bush heralded troop “surge” period in 2009.

The CSC clinic was perilously situated in a one-story plywood building in the center of Marez amidst rows of Hesco barriers designed to fortify the building against mortar attack. Outside the front door stood CHUs (Containerized Housing Units) for the 20th Engineer Battalion. Across the street was a dining facility (DFAC). In fact, it was the same DFAC attacked by a suicide bomber in December of 2004 that killed 22 and wounded 50 coalition members. To the building's immediate right stood a makeshift thrift store that sold 10-year-old technology, bootleg DVDs and anything else the local entrepreneur could get his hands on. The name of the store was written in Arabic but the sign resembled that of a stateside 7-11. I completed a makeshift CSC Team of two Army Psychiatric Technicians and Budge, destined to provide prevention and primary mental health services to the 6,000 soldiers that constituted the 3rd Armored Calvary Regiment. The team I replaced was gone one week after I arrived.

Routines are your friend during deployment. I developed mine quickly: organizing and reorganizing my CHU, establishing a communication plan with home, stabilizing my sleep, venturing out to the DFAC and gym, setting up a panel of patients, and travelling off the FOB to Command Outposts (COPs) to see those that couldn't necessarily come to me. Even the irregularly regular mortar attack and car bomber became a routine. It really is amazing what one can adapt to absent better options.

On a day where my technicians were on a walk-a-bout, the CSC clinic was manned by just me and Budge. My desk was positioned in a manner where I could see out the front door into the open space shared by the Combat Engineer Battalion and CHUs. In my view, Budge sat lazily on the front porch, one part eager ambassador − one part reluctant watchdog. I didn't see her at first but heard Budge's tail feverishly beating the wood deck in time. I heard the faint voice of an English-speaking woman. Budge calmed to her touch. From my

view, I only noted a set of small hands with uniform sleeves coming down to the wrist. I chose to not interrupt. The interaction lasted a few moments. I never saw her face, nor she mine.

Later that same week, my technician team was again on walk-a-bout. I had just returned from the DFAC. The sun was hot, my belly was full and I was catching up on my clinical notes. I was startled by Budge's tail alarm again. A familiar English-speaking voice followed. Budge again calmed. Her hands came into view, followed by a brief view of her face. She was an enlisted member, dark hair under her cover, roughly late twenties. She offered me a reluctant smile and quickly directed her energy back to Budge. Given my ceremonious arrival to Mosul, I could not begrudge her admiration of Budge over a mere human. I walked to the doorway and said hello. She formally replied with a, “Good afternoon, sir” quickly redirecting her attention back to Budge. I said, “Budge is here most every day. Feel free to come by whenever you wish. He loves the attention.” With that I went back to my work. She stayed longer this time. Minutes later, I heard the tell-tale sound of gravel under her feet dissipating in volume as she walked away. I reflected on her affect and lack of eye contact. She had a look of old pain, the kind of pain that one futilely hopes to conceal.

Over the next couple of weeks, the young service member came back more regularly. Episodically, either she or I would attempt to resuscitate a superficial conversation. Each time Budge would provide the necessary social lubrication to keep it alive.

She returned on a day when the technician team left with Budge to do yet another walk-a-bout. Absent Budge's tail alarm, I was startled by her arrival to my door. Like an adolescent child, she asked for Budge. I informed her that he was touring the base with the technician team. There was a long pause. Noticing, I said, “I'm almost as good a listener as Budge... Wanna talk?” Tears streamed. She sat in the chair opposite me, arms tightly crossed in a futile attempt to hold herself together. She distantly spoke of her assault as her body rocked back and forth in time. Despite best efforts, my trained neutral affect broke. After bearing witness to her story, I praised her bravery and efforts to get help.

We developed a plan. She, Budge and I worked that plan over the next four months. While not symptom free, she was well on her way to seeing that sexual assault did not solely define her.

The day before she was scheduled to leave theater we had our last appointment. That appointment found her talking about her continued “stuck points” and future plans. She and I ended things with an awkward handshake and well wishes. The last image I had of her was out on the wood deck in an en guarde position with Budge. He offered her that tell-tale single lick. She smiled at me, again at him and then left. The sound of gravel beneath feet dissipating to a silence.

It is now several years later. I never again returned to Iraq, nor do I hope to. I heard through a friend that Budge died in 2012. I don't know what happened to her. Every once in a while when a hot breeze hits me or I see a Labrador Retriever I'm reminded of my time in Mesopotamia and I wonder what would have happened to her (and me) if Budge, the king of Nineveh, hadn't been there.

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A Social Work Academic in Iraq?

Vaughn DeCoster

Abstract: This essay describes a social work professor's experience of serving in the United States Army Reserve as a clinical social worker during the height of the surge in Baghdad. He reviews his ethical discernment to serve, mobilization before deployment, and his roles as social work clinician, teacher, and researcher.

Keywords: social work roles; Operation Iraqi Freedom; life trajectory; subjective diversity

Prologue

A brief explanation is needed before my story of going to war as a social work scholar-clinician. I wrote much of this shortly after returning from a 16-month deployment, 12 months of which were "boots on the ground" in southeast Baghdad during the surge in Iraq. This period from September 2006 to August 2007 was one of the most volatile periods of Operation Iraqi Freedom (OIF), with 1,167 military personnel killed, 24% of all deaths from the entire war (Fischer, 2014). Countless veterans I had known or worked with at the Veterans Administration (VA) told me that "Going to war is easy; it's the coming home that's hard." They were right; I struggled to get my bearings after returning. I was a tenured professor, surrounded by social workers but had scant conversations about the deployment. Hindsight tells me that I needed to interactively and repeatedly go through this narrative with others to try and make sense of it and, more importantly, accept it for what it was. I believe my need to "process" was the dominant drive to be around other combat veterans and my leaving academics to run a VA Readjustment Counseling Center for Combat Veterans (Vet Center). I suspect this post-combat struggle to find meaning then acceptance is something facing many veterans. Interestingly, Stur (2012) explored a similar disconnect between the warrior myth and post-war realities in Bruce Springsteen's songs addressing the readjustment struggles of Vietnam veterans. I think understanding this struggle is critical for joining clients where they are and establishing a meaningful therapeutic relationship.

One the most significant and difficult moments for me occurred on a Friday in the spring of 2008. I had been doing clinical drills as part of my Army Reserve obligation in the outpatient mental health clinic of a VA Medical Center and knew the staff quite well. That morning I was at the end of my rope and called the Chief of Psychiatry's nurse. "I'm not doing well and really need to see someone to talk, but no meds," I told her. She said, "I'll call you right back." She called and had me scheduled to see a psychiatrist who would listen, not prescribe. This started a deeper process for me that truly took a village: my wife, parents, two therapists, VA colleagues, and, most importantly, fellow vets. I truly believe that we process traumatic experiences through shared narratives. In the six years since returning from Iraq, I am 95% back to normal, still married, and returned to academics. This narrative was part of that process of accepting the experience and may prove useful to other clinicians assisting combat veterans.

A Social Work Academic in Iraq?

It was after 9/11 and the United States invasion into Iraq that the thought of joining the military crossed my mind. This wasn't the first time – in high school I had considered the military academies and then again after graduating from Tulane University with my Master of Social Work. The incongruence between my political beliefs and the military created a barrier to signing-up, yet the desire to serve remained. Furthermore, the social work profession's national organization strongly opposed Operation Iraqi Freedom (OIF). Nonetheless, I convinced myself this time that volunteering was right for several reasons.

History tells us that wars are fought by people from lower socioeconomic positions, many with GEDs, little technical training and few options to earn a livable wage. Many are "at-risk" even before going off to war. Kriner and Shen (2010) offer sobering

evidence supporting a "casualty gap" for wars fought by the United States over the past 75 years and the government's efforts to hide and exploit this gap. As a social worker/sociologist I was convinced I could help. Serving as a mental health provider, in my mind, would allow me to operate on a different set of principles and ethics, a Hawkeye Pierce paradigm I told myself. I also was irritated by the assumption that only conservatives act on principles of "selfless sacrifice," patriotism. I would prove this erroneous myth wrong and show that someone from the "other side" of the political aisle, an academic moreover, could answer the call to serve.

In March 2004, I received a direct commission in the United States Army Reserve Medical Service Corp as a social worker. In June 2006, my unit, a combat stress control (CSC) company, received orders for activation and began training (mobilization) for deployment to Iraq. The group was mostly social workers, occupational therapists, psychologists, two nurses and 20 or so mental health technicians. Many of us were new to the military; officers came from jobs in the VA, mental health facilities or social service agencies. The enlisted came from colleges, culinary school, used car sales or dance studios. Few had experience in the jobs they were about to do for the next year.

Mobilization training or "mobbing" tested our resilience: sleeping in World War II-era barracks, eating awful food, attending dozens of PowerPoint "enhanced" briefings, getting up at all hours to stand around and wait. We were told to be like "Gumby," the clay animation figure from the 1950s, i.e., to be extremely flexible. We learned basic soldier skills, things like throwing grenades, hand-to-hand combat, tactically clearing rooms, guarding bases, frisking insurgents and conducting convoy operations, things most of us never actually would do in Iraq. Whereas this skillset transition from reserve component to active duty was in many ways entertaining, the mental transition was more difficult, almost surreal at times. Courage (2013) describes this transition, its challenges and stressors for when a part-time job in the reserve or guard becomes a "full-time life" (p. 63). "This is not my full-time job – I have a real life and I am going back to it as soon as I finish…" (p. 65), stated a mobbing senior army reserve officer, showing how this mental transition is perceived as a temporary one for most of us but has permanent consequences to our post-war realities and narratives. Towards the end of mobbing, my thoughts bounced around from "I'm never leaving Ft. McCoy, when will this monotonous training end, if I watch one more Army PowerPoint show I'll vomit…" to "Let's get the show on the road so I can get my life back!" Mentally, mobbing is a numbing experience, creating a desire for combat just to leave a purgatory-like waiting state. Unfortunately, where the religious conceptualization of purgatory is a cleansing period before entering heaven, mobilization purgatory is the opposite. In less than 90 days, my narrative, as with many part-time soldiers, involved acquiring a temporary identity of active-duty Army officer and major life changes, dramatically different from my known reality as a scholar-clinician.

The Ivory Tower versus FOBs

As the commander of a combat stress team, I was responsible for providing combat stress and mental health services to soldiers in our area of operation across seven forward operating bases (FOBs). In some ways, FOBs were similar to life on a college campus – thousands of young adults away from home, stressed, abusing caffeine and sometimes alcohol, chasing the opposite sex through social media and trying to figure what they're going to do in the "real world" when they get out. Like students, soldiers also spent too much time playing online role-player games like the fantasy based *World of Warcraft* or the interactive combat game *Halo*, tried to function on perpetual sleep deficits and habitually texting, although the content of these messages likely varied tremendously. With the college-age mental health specialists on my team, two being female, we received timely texts on significant events in our combat area of operation, often knowing ahead of official channels. Many soldiers spoke highly of higher education, a justification for their entry into the military to qualify for the Post-9/11 G.I. Bill. When soldiers learned my civilian occupation, the response I got was, "What are you doing here?" but there was also a significant degree of respect, trust and confidence.

Soldiers and students under 25 years of age also share underdeveloped frontal lobes, resulting in poor or risky decisions easily influenced by peers and questionable impulse control (Steinberg, 2005).

Considering my experience teaching college students from modest upbringings, soldiers and students alike viewed their present paths as opportunities to improve their life situations. By all accounts, enlisted soldiers reminded me of my undergrads: young, idealistic and impressionable. This was a safe, albeit deceptive, association within my personal narrative; the reality was starkly different. Doors do not necessarily open for combat vets like the recruiting propaganda suggests. War veterans are more likely to suffer from depression, anxiety, alcohol abuse (Thomas, Wilk, Riviere, McGurk, Castro, & Hoge, 2010), posttraumatic stress disorder (Smith et al., 2008) and have higher rates of unemployment (Kleykamp, 2013), domestic violence, divorce (Karney, Loughran, & Pollard, 2012), and suicide (Hargarten, Burnson, Campo, & Cook, 2014) than non-combat vets or the civilian population.

These and other factors create a life trajectory dissimilar from civilian college grads and vastly different than the life courses soldiers imagined for themselves. This dissonance between their believed narratives and experienced post-war realities creates significant anxiety, anger, sadness, and perhaps existential angst. It became apparent that soldiers employ rationalization as much as students but this coping mechanism only takes you so far. Attempts to answer the unanswerable question, "Why did this happen to me, him, us, them…" usually leads to a series of "Because I am…" answers or simply, as Kushner (2007) suggests, "Because I am a bad person." As I learned in the post-war readjustment experiences, there is rarely a satisfying answer and acceptance is critical to accommodating this experience into life after war (Wolfe, Keane, Kaloupek, Mora, & Wine, 1993). Nevertheless, we must travel our narrative's sometimes-crooked pathway in a delusional culture, at our own pace, requiring a patient spouse, friend, or therapist.

Social Work Clinician

With over 16 years of experience, I was comfortable in the role of clinician: assessing, diagnosing, counseling. Soldiers weren't just dealing with combat but also things like cheating spouses, bankruptcy, U.S. immigration problems, military legal actions, child protection cases, or conflicts with non-commissioned officers (NCOs, sergeants). To the credit of the "Big Green Machine," *General Order Number One* (GO #1) prohibited the consumption of alcohol in theater, a smart move that reduced the drinking and drug issues. It also prohibited private firearms, entering a mosque, possessing any form of pornography, photographing or filming detainees or casualties, gambling, proselytizing, or cohabitating with the opposite sex.

As we now know, the first six months of 2007 were the deadliest in Iraq. This was our biggest challenge, dealing with the volume of death, horrific experiences and the resulting emotional trauma facing these soldiers. The loss of a friend or two to an explosively formed penetrator (EFP, a deadlier copper version of a IED), the inability to remove the driver of a Bradley fighting vehicle engulfed in flames, the instantaneous sniping death of a fatherly sergeant. After such "significant emotional events" I always led critical event debriefings, synonymous with a Mitchell's Critical Incident Stress Debriefing (CISD, Mitchell, 1983, 1988), used for years with emergency workers in the United States. I'd travel by helicopter or unarmored Humvee to coax the stories of unbelievable tragedy and incite emotional catharsis from the survivors. The years of professional training, supervision, reading the literature and, for me, teaching graduate clinical courses gave a false sense of confidence, challenged by the reality of war. To psychologically patch them up for a quick return to duty, soldiers needed a companion that was non-judgmental, accepting, supportive, open to their experience, and not driven to make things better. Soldiers are keen observers of people, trained to quickly determine friend or foe, safe or dangerous situations. The problem with recent wars is the enemy is indistinct from civilians. The battlefield is non-linear, and lacks a definitive front line. This inability to determine friend from insurgent, a safe route from one laden with IEDs, or predict a mortar cutting through a tin living quarters generates a level of uncertainty regarding basic security, a fundamental psychological need (Maslow, 1943). As one officer, being seen for combat stress, asked, "If I was wrong here (combat) at such an important time, how can I trust myself making easy decisions back home?" Again, a focused presence and listening to the individual was a powerful tool (Baer & Krietemeyer, 2006). Increased mindfulness also helped me become open to my own experience. But it is daunting to accept a 12-month experience filled with horrific events such

as those that occurred during the surge in Iraq, acceptance that seemed nearly impossible the first few years after deployment. These losses took their toll on everyone, myself included. Other than eliminating wars entirely, building psychosocial resilience seemed the key to helping soldiers cope, something academic skills proved invaluable at doing.

Teacher

Psychosocial education is a major tool in preventing normal combat stress from progressing into more serious mental health conditions. My combat stress control team and I routinely taught classes on stress management, anger management and tobacco cessation, the latter being our most popular class. Interesting how soldiers living in a deadly war zone wanted to prevent early deaths by quitting smoking or dipping.

Combat environments are dynamic and the military mission always takes priority, leaving little time for substantial psychosocial education. Going back to the mobbing advice of being like Gumby, we found flexible, brief, bottom-line upfront, referred to in Army-speak as the BLUFF approach, highly effective ways of teaching. I designed mini-lessons that were taught in minutes by enlisted mental health specialists, medics, chaplains or their assistants. These were one-page handouts or mini-pamphlets on topics like suicide, bereavement, combat operational stress reaction, sleep hygiene, depression, and positive coping. We wanted our messages to get out to everyone, not just the soldiers who came to see us. We'd wander around bases talking/teaching soldiers anywhere we could find them (e.g., chow halls, maintenance areas, flight lines, command posts), a CSC practice referred to as "walk-abouts," but we were doing "teach-abouts."

We also took these lessons to leaders at battle up-date briefs (BUBs), the Army's version of faculty meetings. After gaining rapport, I was allowed to give a 60-second report on combat stress, anonymous aggregate stats on soldiers seen and observed trends. Soon the officers and senior NCOs asked, "So what f*&# can we do about it!" The hook was set; they wanted solutions. I kept these mental health lessons short, personally useful and humorous, a lesson I learned from students when teaching unpopular subjects like research and statistics. It worked, maybe too well, because soon I was enduring five or six of these BUBs a week! I enjoy teaching and found comfort doing something that reminded me of what was becoming a past life. There reached a point, though, that it felt as if I would not see that life again. Caregiver stress, combat operational fatigue, burnout, PTSD – whatever you want to call it – is an awful state of numbness that happens in combat and follows many soldiers home, taking years and a dedicated effort to disentangle from one's narrative (Hoge, 2010).

The secret to this teaching role was the ability to quickly and meaningfully foster an educational version of therapeutic regard, making the interaction personal, building a sense of trust. Academics understand the benefits of student rapport in education (Jaasma & Koper, 1999). Mine was challenged by rank, education, age and professional role-induced status differences. I combated this through the use of humor, using similar language as soldiers and encouraging them to speak in their "native tongues," i.e., not judging them from their use of curse words, sometime crude slang, or politically incorrect expressions. I heard accounts of other officers voicing disapproval of such language with disastrous effects on their rapport with soldiers. In one occasion, the commander of a combat battalion denied a social worker from working with his soldiers and requested my team because, according to the Lieutenant Colonel, "I heard you get along with combat soldiers... don't judge us for how we talk." One of the most valuable compliments I'd receive was "You're not like those other docs." If you cannot tolerate the word "fuck," it is probably best to not work with soldiers or veterans. Yes, it's a vulgar word but it doesn't even come close to the vulgarity of war itself. I don't normally use crude language, don't tolerate it from my sons, but in permitting this less censored communication, soldiers were more open to the information being taught, placed greater value on my perspective, and perhaps engaged in a more genuine discourse within and among themselves.

Researcher

My skills as a sociologist also proved quite handy, from literature reviews showing the detrimental effects of sleep deprivation to statistical analyses showing the significant increase in combat stress during the big troop surge. Crunching numbers and

writing in that dull-scientific prose felt like a comfortable set of worn Levi's.

The Army loves numbers and encouraged CSC teams to perform battalion behavior health needs assessments using a representative sample of soldiers, a standardized questionnaire, and focus groups. The hardest part of these assessments was coming up with solutions. Multiple deployments affect people and there just aren't any magical solutions to reduce the psychological strain of a prolonged war. It gave commanders a snapshot of how well the soldiers and their families were doing with the deployment. Unfortunately, it wasn't a good picture. Towards the end of my deployment I began to feel limited in "making things better." My jaded advice was to send everyone home; there's only so much separation and stress a person and his family can take. I was myself reaching a state of burnout, something I had seen for months among other soldiers and health providers. In some ways I blamed myself for the burnout: "I should've taken better care of myself, paced things better, limited exposure to trauma, not gone out so much." This type of discourse is common among soldiers and vets too, questioning their own decisions and actions in impossible situations and owning too much of the experience. "I should've gone right instead left on that road… I could've been better at starting an IV… Why did I assign her to go on mission that day?" These were common statements I heard from combat soldiers. Soldiers, their leaders and combat social workers do the best they can in atypical situations. A few years later, my statistical skills helped validate this feeling state towards the end of the deployment. At the time of my burnout, we were experiencing the three most volatile and deadliest months of the war in Iraq (April, May, June in 2007), resulting in a 27% increase in referrals for combat stress, mental health, and critical event debriefings (DeCoster, 2014).

Conclusion

My background as a sociologist/social worker suited me well for deployment to Iraq, giving me an advantage and an unexpected degree of respect among soldiers and commanders. CSC teams are embedded with forward-deployed combat soldiers, living in the same environment and sharing similar risks. The Army has never done this before and the attitudes about mental health will change for thousands and thousands of soldiers. Social work is now on the top ten lists of medical professionals for Army recruiters. It's interesting that they are seeking a profession based on a feminist paradigm, following principles of empowerment, egalitarianism and advocacy. Social workers see themselves not only as clinicians but also as organizational change agents. It'll be interesting to see just what change this will have on the Army and its collective narrative as well as the tens of thousands of individual ones.

The above was my initial summation for this paper, a rather neutral ending inconsistent with my skepticism and genuine feelings that were not readily apparent. Many vets may experience similar contradictory feelings regarding service, hating and loving it at the same time. We yearn to return home when deployed but then wish to return to the simplified mission-focused existence of war. Nonetheless, I don't miss the "hurry up and wait" bureaucracy, mortar attacks, persistent deployment angst that was common during my time in service, and the senseless "mission above all else regardless of the cost" mindset. I do miss the people, the incredibly diverse, supportive, and selfless group of individuals in military service. Life is full of incongruences but combat military service demands the entire self, a total commitment, with tremendous physical and emotional consequences, possibly paid long after the actual deployment. As discussed earlier, the post-war realities of veterans (e.g., higher rates of unemployment, divorce, depression, suicide, homelessness) don't coincide with the "hero" status afforded them by the media and general public. I had contradictory thoughts and feelings about service from the beginning but now oppose war as a nation-state problem solving method, supporting the *Veterans for Peace* organization and movement.

Those that have firsthand experience of the costs of war often are most vocally opposed to it (Palaima, 2011). Double *Medal of Honor* recipient, Marine Corps Major General Smedley Butler's book, *War Is a Racket* (1935) is one of the most poignant and controversial criticisms of the United States Military and our foreign policy love of warfare. Commenting on the price of war he stated, "This bill renders a horrible accounting. Newly placed gravestones. Mangled bodies. Shattered minds.

Broken hearts and homes. Economic instability. Depression and all its attendant miseries. Back-breaking taxation for generations and generations" (p. 2). This was post-WWI but seems applicable to our current state of affairs in the U.S. after the Iraq and Afghanistan wars. War is a very subjective experience, framed by the uniqueness of each participant. Understanding this subjective diversity will greatly aid the therapist working with veterans, helping them discern post-war realities and the incongruences entrenched in this experience and their lives that follow.

References

Baer, R. A., & Krietemeyer, J. (2006). Overview of mindfulness- and acceptance-based treatment approaches. In R. A. Baer (Ed.), *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications* (pp. 3-27). San Diego, CA: Academic Press.

Butler, S. (2013). *War is a racket*. New York, NY: Skyhorse Publishing.

Courage, K. (2013). Army National Guard warriors: A part-time job becomes a full-time life. In R. Scurfield & K. Platoni (Eds.), *War trauma and its wake: Expanding the circle of healing* (pp. 53-68). New York, NY: Routledge.

DeCoster, V. (2014). Combat social work during the surge in Iraq. *Social Work in Mental Health, 12*(457-481).

Fischer, H. (2014). *A guide to U.S. military casualty statistics: Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom*. Washington, DC: Congressional Research Office.

Hargarten, J., Burnson, F., Campo, B., & Cook, C. (2014). *Suicide rate for veterans far exceeds that of civilian population*. Retrieved May 8, 2014, from The Center for Public Integrity website: http://www.publicintegrity.org/2013/08/30/13292/suicide-rate-veterans-far-exceeds-civilian-population

Hoge, C. W. (2010). *Once a warrior always a warrior: Navigating the transition from combat to home – including combat stress, PTSD, and MTBI*. Guilford, CT: Globe Pequot.

Jaasma, M. A., & Koper, R. J. (1999). The relationship of student/faculty out-of-class communication to instructor immediacy and trust and to student motivation. *Communication Education, 48*(1), 41-47.

Karney, B., Loughran, D., & Pollard, M. (2012). Comparing marital status and divorce status in civilian and military populations. *Journal of Family Issues, 33*(12), 1572-1594.

Kleykamp, M. (2013). Unemployment, earnings and enrollment among post 9/11 veterans. *Social Science Research, 42*(3), 836-851.

Kriner, D. L., & Shen, F. X. (2010). *The casualty gap: The causes and consequences of American wartime inequalities*. New York: Oxford University Press.

Kushner, H. S. (2007). *When bad things happen to good people*. Random House LLC.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370.

Mitchell, J. T. (1983). When disaster strikes...the critical incident stress debriefing process. *Journal of Emergency Medical Services, 8*, 36-39.

Mitchell, J. T. (1988). Stress: Development and functions of a critical incident stress debriefing team. *Journal of Emergency Medical Services, 13*, 42-46.

Palaima, T. G. (2011, March 31). [Review of the book *The causality gap: The causes and consequences of American wartime inequalities*, by D. L. Kriner & F. X. Shen]. *Michigan War Studies Review, 009*, 1-4.

Smith, T., Ryan, M., Wingard, D., Slymen, D., Sallis, J., Kritz-Silverstein, D. (2008). New onset and persistent symptoms of posttraumatic stress disorder self-reported after deployment and combat exposures: Prospective population-based US military cohort study. *British Medical Journal, 336*, 366-371.

Steinberg, L. (2005). Cognitive and affective development in adolescence. *Trends in Cognitive Sciences, 9*, 69-74.

Stur, H. (2012). Finding meaning in manhood after the war: Gender and the warrior myth in Springsteen's Vietnam War songs. In K. Womack, J. Zolten, & M. Bernhard (Eds.), *Bruce Springsteen, cultural studies, and the runaway American dream* (pp. 111-124). Burlington, VT: Ashgate Publishing Co.

Thomas, J., Wilk, J., Riviere, L., McGurk, D., Castro, C., & Hoge, C. (2010). Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry, 67*(6), 614-623.

Wanzer, M., & Frymier, A. (1999). The relationship

between student perceptions of instructor humor and students' reports of learning. *Communication Education, 48*, 48-62.

Wolfe, J., Keane, T., Kaloupek, D., Mora, C., & Wine, P. (1993). Patterns of positive readjustment in Vietnam combat veterans. *Journal of Traumatic Stress, 6*(2), 179-193.

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Do You Hear Me? Three Perspectives on Telehealth Counseling with Service Members

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Abstract: Mild traumatic brain injury (MTBI) has been called the signature injury of the Iraq and Afghanistan conflicts. Many service members suffer lingering effects of MTBI as well as co-occurring post-traumatic stress. In a randomized controlled trial, service members sustaining a probable concussion or complex MTBI during deployment received telephone-based problem solving training. Three therapists providing the intervention share their experience engaging and learning from their interactions with service members.

Keywords: brain injury; telephone counseling; military; combat trauma; labeling; problem-solving treatment; stigma; engagement; trust

Mild Traumatic Brain Injury (MTBI) has been called the "signature injury" of the wars in Iraq and Afghanistan, with over 240,000 service members sustaining a documented TBI since 2002, the great majority of them mild (Fischer, 2013). Thanks to advancements in medicine and personal protection, more service members survive than in previous conflicts, resulting in more individuals experiencing the lingering effects of concussive brain injury, including cognitive problems, pain, insomnia, anxiety, depression, and fatigue. Depending on the severity of injury, residual symptoms can interfere with the person's resumption of activities of everyday life (Bombardier et al., 2006; Bombardier et al., 2010; Gil, Caspi, Ben-Ari, Koren, & Klein, 2005; Glaesser, Neuner, Lütgehetmann, Schmidt, & Elbert, 2004; Masson et al., 1996; van der Naalt, van Zomeren, Sluiter, & Minderhoud, 2000). Factors that can contribute to the long-term effects of symptoms associated with MTBI include the direct neurobiological effects of the injury, the person's emotional response to changes in function, co-occurring problems such as post-traumatic stress disorder (PTSD), and the capabilities of the person prior to injury.

For persons with MTBI and/or PTSD, especially when diagnosis and treatment have been delayed, these symptoms may become chronic (Vasterling, Bryant, & Keane, 2012). Unfortunately, service members perceive numerous barriers to treatment, including concerns about being seen as weak, negative impact on careers, or having others lose confidence in them (Hsu, 2010). Even attending treatment on a regular basis can be problematic as service members can be called into work at any time, may be sent out for field training for weeks at a time, or be transferred to other units and/or bases. In addition, providing adequate treatment to the many affected active duty personnel and veterans who live distant from centers with expertise in MTBI and PTSD is a challenge.

Telehealth methods expand the outreach of experts and have shown some success in achieving symptom reduction in civilians with TBI (Bell et al., 2008; Bell et al., 2005; Bombardier, 2009). Moreover, telehealth strategies have shown efficacy for PTSD and depression (Osenbach, O'Brien, Mishkind, & Smolenski, 2013; Sloan, Gallagher, Feinstein, Lee, & Pruneau, 2011). Our group developed a telephone-based problem-solving intervention (CONTACT: Concussion Treatment after Combat Trauma) for a randomized controlled trial with active duty military, National Guard and reserve service members recently returned from deployment to Iraq or Afghanistan, who had sustained a concussion or complex MTBI (i.e., MTBI and PTSD or other chronic mood disorders combined), and compared it to usual care.

In this article three civilian therapists with diverse backgrounds, including diversity of experience in/with the military, share what they learned about engaging the approximately 170 service members who participated in the active intervention and how their prior experiences and interactions with service members impacted each of them and their therapeutic relationships. All soldiers' names below are pseudonyms.

"Falling Out" and Moving Forward

I struggled to reconcile the shambling, unsteady man, leaning on his petite wife as he moved towards me, with the confident, muscular soldier who had stood, proudly attired in full dress blues, in my wedding party a short 18 months prior. This was my first time seeing my older brother since a high-caliber sniper's rifle had exploded, leaving scarred ridges and valleys in what had been a muscular runner's leg, during his deployment to Afghanistan. Months had passed since his injury, yet he was still appalled by his body's limitations. I watched and listened to my brother that day and many days after, an often-silent witness to his pain, not knowing what words might ease the loss of his strength, both physical and emotional and, eventually, his marriage. I wondered how he would rise above the injury and find new purpose beyond that of an "Army Ranger," in a life that was so different than what he had imagined. At first, my suggestions that he pursue counseling were met with protestations: "I can't do that; I would never be able to do my job again." When his military career ended and angry outbursts threatened every social interaction, his excuses took on a new slant: "I can't tell someone what I think about doing to people when they make me mad – they would think I was crazy." Even now, years later, his mood continues to change almost as regularly as the tide and my suggestions are met with predictable resistance: "I know I should go, but too much time has passed; they might think I was faking." The labels – unqualified for duty, crazy, malingering - scared him and elicited a sense of powerlessness, shame, and fear, threatening his reputation as a soldier, former soldier, civilian and person. My brother wanted to be viewed independently of, not judged by, his injuries.

I brought this personal interaction with the military with me when I accepted the research interventionist position with the CONTACT study; I was determined to help soldiers move beyond the stigma attached to seeking help. Interaction with my brother, as well as my past work with children, families, and individuals who had experienced traumatic events, loss, and the emotional sequelae of various mental health conditions, coupled with my training as a Marriage & Family Therapist, gave me confidence that my perspective of working with the person in his/her family system would help me to understand wounded soldiers in the context of the military "family system."

Carlos was assigned to my caseload early on. As I read through his enrollment information I pictured a very distressed and unhappy young soldier. He confided during our first call that, despite his efforts to be a model soldier, "Leadership doesn't seem to care about the welfare of anyone." It seemed that his condemnation of "leadership" represented a need for someone to care about his welfare. I was confident I could help him.

In our third call, Carlos confided that inability to achieve restorative prolonged sleep at night left him feeling exhausted, resulting in his "falling out of line," i.e., not being able to stay in formation during early morning physical training (PT). "I never used to fall out of line before, but with my sleep issues, I get tired very easy. My First Sergeant doesn't like it when people fall out of line…I don't like it that he basically talks sh-- about me in front of other NCOs." Carlos' voice, flat yet angry, concerned me. I suggested he consider on-base mental health counseling, eliciting a long, pregnant pause on his end of the phone. I said, "I'm guessing you didn't like that suggestion?" Carlos explained, "I went to counselors when I was growing up and I never had a good experience."

Carlos' situation worsened. By our fifth call, he was removed as section leader and his soldiers were dispersed and reassigned because he couldn't keep up with morning PT. Carlos stated, "It sets up my image that I can't handle things – that I can't do something as simple as staying in a line."

"So it feels like it damaged your reputation?" I wondered.

"Yes. And the thing that bothers me the most was that I was the only E-5 in charge of a section, and I did everything just fine. It's just that I couldn't stay in line during PT," he repeated.

Carlos seemed to trust me. When he shared his personal disappointment with me I concluded that we had moved beyond simple engagement. Optimistically, I pushed forward with the research objective of our call, evaluating his problem-solving plan, which was to combat his depressed mood with

increased activity, including regular gym attendance. Confident of our mutual trust, I anticipated hearing about the successful follow-through with his plan's steps:

“Let's do the ‘E for Evaluate’ part of our plan. Tell me how your plan worked for you the last two weeks,” I prompted. I was taken aback by his report, “To tell you the truth, I didn't really do any of them, now that I look at it.”

“Talk to me,” I pressed, “what got in the way?”

“Well, I just didn't feel like doing them,” he admitted.

How could this be, I wondered. This was the second plan that Carlos had chosen, developed, but not completed. At first, his lack of follow-through seemed tied to unfamiliarity with the problem-solving process, but now it felt purposeful. I knew he needed help; I even sensed that he wanted help. Although difficult for him due to his lack of trust in counselors, he demonstrated his trust in me by disclosing and discussing the past weeks' frustrations and disappointments in each call. Why wasn't he following through?

I intensified employment of my therapeutic tools: compassion, active listening, space to talk, and coaching through development of his plans. Yet despite our rapport, I felt I was failing Carlos. I started to mentally label Carlos as “resistant.”

At our sixth call, I didn't entertain much hope that Carlos would report follow-through on his plan – in fact, I braced myself for the words, “I didn't really do much,” followed by my now routine, reactive efforts to convince and encourage his follow-through. Instead, Carlos began the call by announcing that he had seen a social worker on base the past Friday. I was surprised but encouraged, and prompted him to tell me more. To my dismay, however, he revealed that the appointment was discouraging and that his specific take-away from the initial meeting was that she labeled him “depressed.”

“When she told me about the whole depression thing that day, I felt really terrible and I couldn't even sleep,” he explained.

I wanted him to elaborate and examine his own thinking, “Why do you think you felt that way?” I asked.

“Since she told me that I was depressed, I was looking at every situation and analyzing it, like maybe she's right,” he explained.

This call challenged my beliefs about my recommendations. I realized that despite my own personal experiences with my brother's aversion to being defined by his injuries, I had missed this fear with Carlos. Carlos did not want to be labeled – by the military, by his family, by his peers, by the new social worker, or by me! I was guilty, though inadvertently, of mentally labeling this soldier “resistant,” and burdening us both with the related assumption that he was, in fact, “a failure” – repeatedly “falling out of line.”

As he struggled to articulate why he felt “terrible,” I made an effort to avoid any labels, instead externalizing the concept of depression as a set of feelings and behaviors that he was learning to manage, rather than something that defined him. He was a person managing his depressed feelings versus a “depressed” person. Using this approach, I aimed to offer hope about his ability to challenge the depressed feelings by using behavioral activation. As part of our problem solving intervention, I proposed that he was learning to embrace the idea that by choosing to “follow my plan, and not my mood,” he would be choosing to reject the depressed label, or any label for that matter.

“If someone tells you that you're depressed, do you think it's likely that you might act depressed?” I followed-up.

“I think that's exactly what happened…I was acting depressed. I felt worse than before I had come in,” he admitted.

I continued to shift the focus, describing his choosing to see the social worker as a success, hoping to reframe his thoughts and feelings by emphasizing the positive decision to follow-through with seeking out mental health services rather than focusing on the perceived “failure” of the appointment. “I want to celebrate the fact that you

went to an appointment with a social worker and were open and honest about how you feel, because I know how nervous you were about it, and how unsure about whether you really wanted to. But you did. You really overcame a fear you had."

Carlos' situation reminded me of how critical it was to appreciate the despair, shame, and hopelessness that he had experienced since the injury, which were reinforced every time he "failed" to follow-through with a plan or was labeled a failure at work or depressed by providers. Labels represented inherent negative assumptions to Carlos. He needed to experience success. I highlighted positive decisions, no matter how small. Experiencing even a partial success or follow-through would increase his motivation and buy-in and he would accept that it was okay to "fall out of line" at times, as long as he kept moving forward.

During that same call, we started the "E for evaluate" process of his latest problem solving steps. He reported that while he attempted breathing exercises for relaxation: "I didn't really feel anything and I stopped – it was kind of a waste of time."

I highlighted his action, emphasizing the success of experimenting with the steps of his plan. "Here's that thing again, where we need to applaud the fact that you tried it. You know there have been several times when you and I were on the phone and you told me, 'I forgot,' or 'I didn't do it,' so the fact that you actually did it and tried it is awesome…You followed the plan and not your mood."

As we continued to evaluate his plan, he recounted how he had followed through, albeit partially, on the steps of his previous plan to workout at the gym, "It went alright – I didn't really go for the first week, but I've been going twice a week now."

"Here's the cool part about this – you went from not going at all, to two times a week," I pointed out. I questioned, "On the days that you went to the gym, how did you rate your mood?"

"About a five (out of ten, where ten represents more depressive feelings)," he stated.

"What about the days you didn't go to the gym?" I inquired, in an effort to help him draw comparisons.

"About an eight," he admitted.

"What does that tell you? Is there a benefit to going to the gym, as far as how you feel?" I asked.

"Well, even if I'm feeling a little down at first, once I get there and start, it takes my mind off things," he admitted.

By reserving judgment about his not meeting his identified goal of exercise four days a week, we were able to celebrate what he *did* do; in so doing, he could not be labeled a "failure." Carlos learned that he did not need to be "perfect," yet another problematic label. Through active listening for hints of resiliency in the face of unfortunate or trying circumstances, we highlighted efforts on his part to try rather than respond impotently to upsetting situations. By my choosing not to give up on Carlos or label him, we avoided reinforcing his powerlessness, shame, and fear. Carlos learned to acknowledge success in the face of imperfection. I learned that service members are less concerned with their ranks and titles, and more concerned with being seen as individuals without labels. Moving beyond a "fall out of line" but rather forward, gives soldiers permission to discard their restrictive labels.

Battle Buddy

I am a doctoral candidate in clinical psychology with an emphasis in neuropsychology. My clinical training includes working with patients in acute inpatient medical rehabilitation, clients with clinical and forensic issues in a neuropsychological practice, cognitively impaired refugees seeking citizenship, attendees in brain injury support groups, and callers to a crisis line.

I am also a military veteran. It was my deployment to Somalia in the early 1990s that drew me into the study of psychology. I was alarmed to see children armed with weapons and ammunitions, and outraged at the public slaughter of a fellow soldier. I remember wondering then, "How can beliefs, values, and attitudes be so different from culture to culture?" I became interested in multiculturalism and what it means to be culturally competent regarding human experience and emotional reactions. I learned that there are distinct between-

and within-cultural differences as well as subcultural differences, and that the military is a unique subculture (e.g., Reger, Etherage, Reger, & Gahm, 2008). As a military veteran and aspiring clinical neuropsychologist, I was drawn to the CONTACT study to apply my knowledge and skills to fostering the recovery of service members returning home with concussions and complex MTBI.

Among the many things I learned from my clients in the CONTACT study was an awareness that I still act, think, and feel like a soldier – even after 17 years of being a civilian. My experience with Richard, whose story follows, illustrates the unique brotherhood and camaraderie that follows the crucible of training and combat, the counselor as a "battle buddy."

Richard was in his late twenties, married, without children. He spent nearly a decade on active duty and had experienced three combat tours between Iraq and Afghanistan. He worked in a non-infantry occupation and had a strong desire to further the mechanical skills he had acquired upon separation from the Army. He eventually received a Medical Discharge, began college, and maintained a good relationship with his wife.

Although Richard completed 11 out of 12 telephone sessions, it took over two weeks to get him scheduled for our first call. We corresponded by voicemail, email, and text message to find a workable date and time. Military duty can be all consuming; finding flexibility for appointments proved an arduous task. When we finally connected our conversation was somewhat guarded, not surprising since the military rule of thumb is to never volunteer information. I knew from his baseline information that Richard was not feeling well. He perceived his overall health to be at about 70% and reported difficulty adapting to change and being unable to see the humorous side of things.

Richard was driving to a medical appointment during our first call, a scenario that occurred from time to time with some service members. In fact, it was rare to find a service member totally "at ease" to talk. Initially he provided brief, vague responses. But once I described my background, including my military service, his voice and responses changed. Communication by telephone often necessitates detecting changes in affect and mood through changes in rate and/or tone of speech. I felt in that moment that Richard had connected with me because I was someone who had been there, done that, and understood the experience; he could trust me like a close, watchful friend in theater, a "battle buddy." Richard's voice became animated and his conversation became less guarded. We talked and shared a laugh or two, particularly about his relationship with his wife, who was also in the Army and outranked him.

Richard's laughter faded and his voice became serious as he began to talk about his darkest memories, a combat experience that left him with significant mood problems and distress as well as a back injury that would require surgery. He seemed to trust me; he began to recount the experience.

It was getting dark and his 12-hour shift had just ended. Early dinner, shower, and then sleep were in order. He had finished eating and was walking to his sleeping quarters when a bright flash of light robbed him of night vision and knocked him to the ground. When he came to, he was being dragged into the shower facility by two fellow soldiers. He tried to get to his feet. He remembered the light, but did not hear or feel the percussion.

The soldiers who dragged Richard out of harm's way checked him for injuries. He stood up and asked, "What happened?" unaware that he was slurring his words. His vision was blurry. He realized they had been hit by mortar rounds and shoulder-fired missiles. Richard shook off the dazed and confused feeling, commandeered the nearest soldiers, and ordered them to move with him to engage the enemy. They moved toward the gunfire, checking and clearing a couple of buildings, then came upon two soldiers in the distance dressed in camouflage but unrecognizable. Richard verbally challenged them. When they did not respond, reality sank in – they were not friendlies. He instructed one soldier to move to the side of the road and get down. After the next verbal challenge, the enemy fired on Richard and his men, hitting one soldier in the leg. Richard returned fire, screaming, "kill 'em, kill 'em, kill 'em! Drop those mother f-----s!"

As the evening darkened, bright red phosphorous traces from the shots fired illuminated the sky. Richard's descriptions reminded me of the first time I saw red traces fly overhead in Somalia; I had felt vulnerable. Richard felt vulnerable then and now. As his story unfolded, his rate of speech slowed and his tone dropped.

Richard remembered thinking to himself, “I am not a combat soldier. I am a mechanic!”

Adrenaline surged throughout his body as they advanced toward the gunfire. He reloaded his weapon. He spotted an enemy vehicle and shot at the driver twice, wounding him. He fired two more shots into the driver who simultaneously pulled the pin on a grenade, sending a ball of flames and a blast wave toward Richard and his men.

Richard paused in his story. I was clenching my fists and sitting upright. He acknowledged that it still haunts him that, perhaps because of the adrenaline rush or the fog-of-war or fear, he continued to fire at the driver who was now clearly dead and dismembered, unloading round after round into the driver's severed leg.

The firefight intensified. Richard's friend was shot in the face. He watched another soldier get shot in his good knee, the other being in a physical therapy brace; Richard found himself laughing at the irony. Then anger set in. Richard turned toward the enemy and unloaded his magazine into the face of the man who had taken the life of one and wounded another.

The phone conversation fell silent. I sat back in my office chair, headset on, staring up at the ceiling, and sighed. I had no words, just my own reflections. I was taken back to my own military experience, where survival, accomplishment of the mission, and *esprit de corps* necessitate acts of aggression, hypervigilance, and loyalty beyond measure.

Richard wanted to start living his life again but did not know how. I wanted to help him reduce extreme numbness and break the vicious cycle of depression. We talked about the importance of our military relationships – camaraderie and trust – and how the unique aspects of the military subculture molded who we had become. We talked about the activities that used to bring him joy and pleasure, how much he valued them, and what was getting in the way of his enjoying them again.

The blast wave that left Richard briefly unconscious also left him with a painful and debilitating lower back injury. He was to be discharged from the Army just after our second call. He just wanted out of the Army. I thought discharge could be the mechanism of change for him, a fresh start. However, his injury necessitated back surgery, which was rescheduled several times, extending his stay in the Army for months and exacerbating his depression, anger, and sleep difficulties.

Between our fourth and fifth calls Richard had surgery and returned home to recover. He felt the surgery went well. He was ready to move on with his life. He described waking and feeling ready to go outside. Standing on the strong right leg, he grabbed his support cane for stability but, on his first step, he collapsed to the ground in severe pain. He admitted crying hysterically as he attempted to pick himself up and try again. He remembered thinking over and over that he was in his twenties and was “broken,” and let down by the Army.

I could feel Richard's pain on our calls and I struggled. My empathy for Richard grew over our calls as I was also injured while serving in the military. I wanted more than anything to provide him the tools he needed to help his emotional recovery.

During our last few calls, Richard was in transition between Army medical care and Veteran Affairs medical care, thus not receiving predictable or reliable care from either. Appointments were too far out; his records were being transferred, a several week process. In the absence of other mental health care, I encouraged him to break down his difficulties into smaller pieces. Richard was by then ready to acknowledge his post-traumatic stress and depression symptoms, but was not ready to be labeled as depressed or suffering from PTSD. We worked indirectly on the symptoms of anxiety and depression that were preventing him from enjoying life, emphasizing pleasurable activity scheduling, self-monitoring, and mood rating to clarify situations in which his emotional numbness was bad, and less bad, flipping it around to less good,

and good. We discussed the things that brought him pleasure. I was not surprised to hear that leaving work to drive home brought the most pleasure – he rated that activity a 5 on a scale from 0-10. We compared other experiences, such as fishing, which he rated slightly less enjoyable at a 3. Richard was feeling again, feeling less numb. And I was feeling good about the progress, little by little. And more importantly, he was working outside of being labeled depressed or distressed.

I remember Richard thanking me. He planned to engage in an outside therapy to address his post-traumatic stress. He said, "I wouldn't have been ready for this before these calls, but I am now…and since the Army won't help me I guess I have to take what I can." He was able to reduce his post-traumatic stress symptoms.

I asked, "We began our sessions looking at stress reactions and we talked about reactions that worked well in theater, but not so much here at home. What changes have you noticed in these reactions since we first talked about them?"

He responded that he could now walk through a mall with his wife and not change lanes to avoid roadside debris (many improvised explosive devices were hid in such debris in theater). He said, "My reactions just aren't as intense." I pointed out that the use of exposure both in-person and over the phone can help to reduce his stress and increase his ability to feel again. He agreed yet acknowledged that there was still a lot of work to do.

I felt confident that Richard would succeed. He had successfully left the Army and attained VA medical care, and was planning to continue his therapies after our final call. And although he was still recovering from back surgery and experiencing numbness and depression, he was more resilient than when we started. He could better see his ability to adapt to change as well as see the humorous side of things.

I felt a sense of loss after our calls were completed; we had shared many experiences over the phone. I knew we had to close the door on our therapeutic relationship rather than leave it open in case he needed to come back. In a sense, we both ended our six-month tour over the phone, and were much better for it.

I Will Meet You Where You Are

I am a Licensed Clinical Social Worker who had worked primarily with trauma survivors, mostly women who had been sexual assaulted. I was hesitant to join the CONTACT study due to my inexperience working with service members. Not only had I no military experience or background, I had never even known anyone with a military background. I wondered what I had to offer soldiers, how I would relate to them, and how they would relate to me. I felt conflicted about our presence in Afghanistan and Iraq. However, given media reports that military mental health services for soldiers were limited and my confidence that the CONTACT study could provide soldiers excellent evidence-based care, I felt compelled to get involved and offer what I could to service members. Although working with a military population was entirely new to me, I trusted that I could offer quality intervention with caring and compassion.

Shortly after beginning the study, I began to doubt myself and question my decision to participate. These were soldiers, after all, accustomed to a strict formal code with dozens of military acronyms and experiences that I would never understand. Therefore, I followed the lead of our on-base trainers: I attempted to be more formal and use military language – unsuccessfully. My first telephone calls with service members felt uncomfortable and strained. My usual therapeutic style was stifled. Some service members did not show up for their next call; I worried that I was not successfully engaging them.

After careful reflection about what wasn't working, I let go of what I *imagined* a clinician working with service members was supposed to act like and was just myself, genuine and compassionate. I knew that engaging service members early on in the telephone calls was key to their continuing the intervention. To engage them, I decided to put down my formal approach and listen. As I used more reflective listening, asked more open-ended questions, and let the soldier take the lead, something happened: service members began showing up for their scheduled telephone appointments and our telephone sessions became

more meaningful.

George was assigned to me about a year into the study, by which time I felt more at ease working with a military population. However, George's baseline assessment, with some of the highest scores that I had seen in some time for distress, depression, and anxiety, gave me pause.

George had served in both Iraq and Afghanistan, receiving numerous concussions throughout his deployments and training over the course of his active duty. George also suffered from chronic back pain and had a history of alcohol abuse. Over time, he shared that he drank alcohol to relieve stress, to fall asleep, and to reduce pain from his combat-related injuries. George also had symptoms associated with depression and post-traumatic stress.

George had a tumultuous history with health care providers, particularly mental health providers. He had sought mental health treatment nearly 10 years ago but felt the therapist was judgmental and refused to return. Meanwhile over time, George's symptoms of post-traumatic stress worsened. He reported marked restlessness, anxiety around people, nightmares, and hypervigilance. He referred to these symptoms as “anxiety” and “worrying about nothing there.” His symptoms were troubling to his wife, who pleaded with him to seek help at the base behavioral health center. George reported that his drinking increased as a result of the anxiety. He recounted a more recent negative experience with his nurse case manager on base about the prescription of pain medication. After a verbal altercation with this provider, he stormed out of her office.

During the first telephone call with George, I had considerable difficulty engaging him. He was guarded, providing monosyllabic responses and speaking sharply to me in portions of the phone call. When I went through the parameters of confidentiality, he promptly told me that he would not be sharing anything personal with me so I did not need to be concerned with this. He told me that if he had thoughts of harming himself or someone else, he would not be telling me about it. He also taunted me during one portion of the call, asking me to address him using a phrase I felt to be unprofessional, even silly. I had to think on my feet. On one hand, I wanted to tell him, “No way am I calling you that.” Another option was to accede to his request so as not to make it a point of contention. I hoped that by not arguing or refusing to refer to him by this name that we could move on. I took a deep breath and went with the latter choice. I referred to him as he requested (which he put on speaker phone so that his wife could hear). Both he and his wife roared with laughter. I felt humiliated and wanted to crawl underneath my desk as I felt that my reputation as a competent clinician was called into question, but I swallowed my pride and just went with it. I met George where he was at that moment rather than getting into a power struggle. I believe that this decision helped to pave the groundwork to establish good therapeutic rapport.

Given how difficult the first call was, I was surprised when George answered for the second call. He never again asked me to refer to him with that phrase nor did he come close to taunting me again. I was pleasantly surprised that he completed all of his 12 telephone calls with me. I often got teary after completing a phone call with him because I could see that he was gradually opening up and trusting me.

Over the course of the 12 calls, George experienced numerous life stressors. We utilized Problem-Solving Training (PST) for decreasing his stress. He developed plans to take breaks outside when he became too stimulated around people and to turn to his wife for comfort, and these strategies were helpful for him. George attended his telephone appointments consistently having completed or partially completed his plan from the session prior. He revealed his thoughts and feelings about self-doubt and anxiety. However, I was concerned because his depression and anxiety scores continued to be high. I questioned whether we were making enough progress and wondered what I could be doing differently as a clinician. I had hoped to begin the protocol for Behavioral Activation with George to reduce his symptoms for anxiety and depressed mood but the tumultuous events in his life necessitated plans related to resolving his current problem at hand. I often brought up his case in clinical supervision and the clinical team listened to some of the more challenging phone calls.

As I began to understand George's low opinion of helping professionals and low self-confidence, I got the sense that he often heard what he was doing wrong and it was rare that he received encouragement or praise. I felt that he really needed to hear what he was doing well. There was a lot in his life that was not going well for him, but he was surviving the best way that he knew how and taking care of his family.

Giving too many praises would likely seem inauthentic and would likely not be received well by someone unaccustomed to receiving commendations in the first place. Therefore, I practiced strategic reinforcement: pointing out or complimenting each time he took any step to better his situation. I highlighted his showing up for our telephone calls despite the stressors that he was dealing with; I acknowledged that he valued his relationship with his wife; I let him know that he mattered to me, that I cared about him and his family. George responded by sharing, discussing more steps that he was taking to improve his situation. He readily shared with me his completion of a step of a PST plan, when he turned in paperwork at work, showed up to an appointment, etc. He was now highlighting his accomplishments himself. His voice became more animated as, I think, he was taking pride in completing tasks. I continued to reinforce George's progress.

Near the end of the study, George unexpectedly received orders to move to a new base across the country, and experienced a significant increase in his distress. He and his family had little time to pack and arrange for a new place to live. He forgot to turn in paperwork, resulting in the move being hurried. His wife had to leave her steady job and his child had to begin a new school. George and his family already struggled financially and barely paid their bills on time; it was very difficult for them to come up with the money needed for the move. The focus of George's PST plans now shifted to preparation for the move and the transition for him and his family to a new base and home. He created checklists with timelines, met with his wife regularly to plan, and practiced coping skills to deal with the stressful transition. I continued to point out how George was sticking to his plans.

To my surprise, after moving to the new base George advocated for a medical workup – including an assessment with a psychiatrist and social worker. As we discussed this plan, and I affirmed that he had shown courage to return to mental health treatment and to be open to the possibility of his symptoms improving, George said, “If it wasn't for you, I never would have done this,” that it was the telephone conversations with me that finally moved him to take this step. My jaw dropped and tears came to my eyes. We had come a long way from that first telephone call. I want to believe that by reinforcing George's steps toward change (as small as the steps were at times) he gradually began to build confidence in himself that he could improve his situation. I also believe that as he built trust with me (a helping professional who listened and cared for him) he realized that perhaps he could trust another helping professional.

After George's psychiatric assessment appointment, he was diagnosed with depression and post-traumatic stress. For George, receiving these diagnoses was comforting because he finally had a name for what he was experiencing. He shared his fears about entering treatment, including the potential for taking medication because he was afraid of what life would be like without these symptoms. His symptoms had simply become a part of his identity.

George and I problem-solved what specifically would help him to get the most out of his mental health appointments as well as what would help him to feel more at ease with his new providers. He brainstormed solutions including bringing his wife with him to the first appointments as both a calming source for him and a good historian regarding his symptoms. We discussed what would help him to have an “open mind” (his phrase) in order to have a good start to the appointments. This included a discussion about triggers for getting angry and how to calm down.

As I reflect on my work with George, I feel honored that he let me into his life and that in part because of our connection and work together he has renewed faith in working with mental health providers. I hope that he is adjusting well to a life with fewer symptoms. I am so grateful that we got beyond that trying initial call. As I step back and reflect on the larger experience of working with service members,

I appreciate that this work has changed me. When I began this study, the military population was foreign to me both professionally and personally. I truly did not know if I could identify with soldiers, whether I could hear how the atrocities of war impacted service members themselves, the people that they fight, and the innocent, and how soldiers would be changed after returning from war. I felt intimidated and under-prepared. I tried to cope with this by being overly formal pretending to be someone that I am not. I worried that the telephone would create an additional barrier to connecting with soldiers. But I knew that I needed to trust my skill-set and myself. I learned that the telephone requires careful listening and adept engagement skills but that many service members appreciate the anonymity and convenience. For the most part, I have made very genuine and close connections with the soldiers I have worked with. Service members told me that the phone calls became important outlets for them and that they looked forward to them. On my end, I felt connected to their lives and moved by their experiences. I also understand now that I don't need to comprehend the war itself. Instead, I just need to understand and connect with the person on the other end of the phone, this human being who has likely suffered and wants so much to be heard. My lack of experience working with soldiers has not mattered. What has mattered is relating to each soldier as a human being.

Reflections

Military life is an all-encompassing universe with its own rhythms, demands, language, and priorities, with armed conflict as an unfortunate necessity at times. In this universe many thousands of individuals must cope with the aftereffects of combat. Sometimes they “fall out of line” and must work to overcome those aftereffects as well as the historical and personal barriers to asking for help in order to move forward. We found that focusing on differences between the military vs. civilian approach to helping was less meaningful than listening to the service members' stories and learning from them. We were reminded to avoid labels and judgments, even mentally, which can be challenging due to the strong feelings that the topic of war can elicit. We learned that a previous connection with the military could help us engage with service members, but also that previous experience was not required. We found that the important components in engaging service members were generally the same as with civilians: being present, authenticity, empathy, compassion, meeting the service member where he/she was, really listening and hearing what they were saying, providing a safe place to be open, acknowledging and celebrating positive small steps. And, importantly, each of the therapists learned something unexpected about themselves that they will carry forward in their work with future clients, whether military or civilian.

References

Bell, K. R., Hoffman, J. M., Temkin, N. R., Powell, J. M., Fraser, R. T., Esselman, P. C., & Dikmen, S. S. (2008). The effect of telephone counseling on reducing post-traumatic symptoms after mild traumatic brain injury: A randomized trial. *Journal of Neurology, Neurosurgery, & Psychiatry, 79*, 1275-1281.

Bell, K. R., Temkin, N. R., Esselman, P. C., Doctor, J. N., Bombardier, C. H., Fraser, R. T., … Dikmen, S. (2005). The effect of scheduled telephone counseling on outcome after moderate to severe traumatic brain injury: A randomized trial. *Archives of Physical Medicine and Rehabilitation, 86*, 851-856.

Bombardier, C. H., Bell, K. R., Temkin, N. R., Fann, J. R., Hoffman, J., & Dikmen, S. (2009). The efficacy of a scheduled telephone intervention for ameliorating depressive symptoms during the first year after traumatic brain injury. *Journal of Head Trauma Rehabilitation, 24*(4), 233-241.

Bombardier, C. H., Fann, J. R., Temkin, N. R., Esselman, P. C., Barber, J., & Dikmen, S. S. (2010). Rates of major depressive disorder and clinical outcomes following traumatic brain injury. *The Journal of American Medical Association, 303*(19), 1938-1945.

Bombardier, C. H., Fann, J. R., Temkin, N., Esselman, P. C., Pelzer, E., Keough, M., & Dikmen, S. (2006). Posttraumatic stress disorder symptoms during the first six months after traumatic brain injury. *Journal of Neuropsychiatry and Clinical Neuroscience, 18*(4), 501-508.

Fischer, H. (2013). *U.S. military casualty statistics: Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom* (Congressional Research Service 7-5700). Retrieved from http://www.fas.org/sgp/crs/natsec/RS22452.pdf

Gil, S., Caspi, Y., Ben-Ari, I. Z., Koren, D., & Klein, E. (2005). Does memory of a traumatic event increase the risk for posttraumatic stress disorder in patients with traumatic brain injury? A prospective study. *American Journal of Psychiatry, 162*(5), 963-969.

Glaesser, J., Neuner, F., Lütgehetmann, R., Schmidt, R., & Elbert, T. (2004). Posttraumatic stress disorder in patients with traumatic brain injury. *BMC Psychiatry, 9*(4). doi:10.1186/1471-244X-4-5

Hsu, J. (2010, September). *Military culture 101: Overview of military culture* [Online training]. American Psychological Association.

Masson, F., Maurette, P., Salmi, L. R., Dartigues, J. F., Vecsey, J., Destaillats, J. M., & Erny, P. (1996). Prevalence of impairments 5 years after a head injury, and their relationship with disabilities and outcome. *Brain Injury, 10*(7), 487-497.

Osenbach, J. E., O'Brien, K. M., Mishkind, M., & Smolenski, D. J. (2013). Synchronous telehealth technologies in psychotherapy for depression: A meta-analysis. *Depression and Anxiety, 30*(11), 1058-1067.

Reger, M. A., Etherage, J. R., Reger, G. M., & Gahm, G. A. (2008). Civilian psychologists in an army culture: The ethical challenge of cultural competence. *Military Psychology, 20*, 21-35.

Sloan, D. M., Gallagher, M. W., Feinstein, B. A., Lee, D. J., & Pruneau, G. M. (2011). Efficacy of telehealth treatments for posttraumatic stress-related symptoms: A meta-analysis. *Cognitive Behaviour Therapy, 40*(2), 111-125.

van der Naalt, J., van Zomeren, A. H., Sluiter, W. J., & Minderhoud, J. M. (2000). Acute behavioural disturbances related to imaging studies and outcome in mild-to-moderate head injury. *Brain Injury, 14*(9), 781-788.

Vasterling, J. J., Bryant, R. A., & Keane, T. M. (2012). *PTSD and mild traumatic brain injury.* New York, NY: The Guilford Press.

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Transitions and Tradeoffs: A Social Worker's Snapshot of the American Military Family

Patricia Coccoma

Abstract: With men and women of the U.S. military abroad at war, the risks and challenges they face performing those duties, while also remaining in contact with their families, can be significant. This article traces the personally and professionally rewarding experience of a social worker observing military service members' abilities to cope with stress and the determination of troops stationed overseas and their families to overcome those challenges and remain connected during a period of separation.

Keywords: military families; stress; trauma; physical separations; deployment

Introduction

Are social workers prepared to understand the myriad of transitions and tradeoffs our military men and women endure when deployed away from home and their families? The profession focuses upon returning combat troops and their acclimation to home, family, and familiar surroundings. But do we know firsthand some of the experiences they encounter while deployed, including how they maintain connections to their families? Such first-hand information for a social worker may be the exception, but certainly would add value to our work with this special group of individuals.

Recently, I took advantage of Space-A travel, a benefit available to military personnel and their families (active or retired). It provides direct travel to the air terminals located at active United States military bases in Europe. This experience allowed me to openly observe the daily operations of our military transportation and base operations in addition to interactions between military personnel and their visiting family members. While I did not directly connect with any military service members and their families, I quietly observed interrelationships and both the personal and service related situations they encountered. These opportunities inspired me to consider more their ability to cope during challenging times, such as times of transition, and reflect upon the usefulness of this experience in providing differentiated social work practice skills to them as clients upon my return from this trip.

The stand-by status experience with Space-A travel occurs at the passenger air terminals on active military bases. I had to wait to either catch a flight or hop to another military base to eventually reach my final destination: Germany. One's military status (highest to lowest) is ranked accordingly: active, family of active member, and retired. That status determines one's place in line at the ticket counter and who boards the next available flight. My spouse is retired military, so our stand-by status was behind active military and their families.

While navigating this process, we flew from Charleston Air Force Base in South Carolina to our final destination of Ramstein Air Force Base in Ramstein, Germany. The aircrafts are typically C-7s or C-17s, which are generally used to transport needed supplies to military and/or civilian personnel in many parts of the world, including areas of conflict.

It took several days to leave Charleston because of flight cancellations and flights that could not accept passengers while transporting hazardous (combustible) materials. This time afforded me the opportunity to observe several family situations of enlisted members of our armed forces who were motivated to remain together during their time with each other. This also included a variety of situations such as when military family members travel from the U.S., simultaneous to their military spouses leaving the war in Iraq and meeting at a friendly destination for a brief visit. This paper is a reflection of those occasions, snapshots of personal exchanges, tradeoffs, and transitions between family and military personnel. This resulted in a greater awareness and appreciation for not only the

determination, coping strategies, and hardiness of these families, but also my own professional knowledge from lessons learned.

The active-duty American service member makes major personal and physical commitments and sacrifices for the protection of our country, especially during periods of deployment to foreign lands, be they times of war or peace. Much has been said of the motivation and focus of such brave men and women, yet little is directly known of the motivation, challenges, and desires of deployed service members and their families to physically visit, relocate, or both, to the deployment location. Stress and coping with physical separation can take an emotional toll on service members and their families.

Carver, Scheier, and Weintraub (1989) stated that individuals cope with stress in two different ways: problem focused coping, which occurs when problem resolution reduces one's stress, and emotional focused coping, which aims to reduce the emotions experienced rather than addressing the source of those emotions.

While Di Nola (2008) supports these two methods of coping, the author refers to three types of stressors experienced by families of deployed troops where the coping methods were utilized:

> emotional (missing the soldier, safety concern for the soldier), deployment-related (managing budget, Powers of Attorney, and increase in childcare costs), and general life events (non-English speakers, new to installation, etc.). The list of stressors noted at that time were loneliness, financial insecurities, children's discipline, and an overall feeling that the military was not concerned for their well-being. Some spouses did not use programs available to them for fear of being classified as unable to handle their problems. Others were not able to seek family support because they were not stationed near them. Family roles had to be changed and required adjustment by both parents and children. (p. v)

The Internet has provided an array of opportunities for all members and their families to stay connected. Receiving current information on family and friends back home or Internet phone calls to hear one's voice, for example, promotes family connections. While being electronically connected may have its disadvantages, such as interruptions in troop member's concentration to their duties, its benefits include reduced stress as a result of familial separation. The use of email, cell phones, social networking sites like Facebook or Twitter, and texting can provide instantaneous news. However, even with the stress reduction benefits of these electronic methods, the desire to personally connect is often of great importance to both deployed troops and their families.

Social workers assisting this population knowingly promote available resources and advocate for military members and their families using available resources to benefit family connections during times of deployment. Yet, firsthand experiences of a social worker witnessing an enlisted military member and his/her family devote their energies to being together when deployed, and sharing that experience to further the social work profession may be infrequent.

While traveling, this civilian social worker witnessed and reflected upon snapshots of military personnel and their families attempting to visit together with limited time. During these occasions, opportunities for me to converse with some families occurred. What I have learned in reflection of these snapshots and interactions with the families has provided help to me with my practice skills. These snapshots included moments rich with information affirming the resiliency of the family systems during times of transitions and tradeoffs as well as lessons learned for the social work profession. Several of these snapshots are shared below.

Snapshot One

In Charleston, South Carolina, while waiting for the next scheduled departure to Ramstein, Germany, an Air Force Major and his family were awaiting the same flight. He and his family are stationed in Germany. They had been in the U.S. to attend a family wedding. Now, they were returning to his base in Germany and their temporary home, as his leave orders were soon ending.

During our wait, this family shared their fun-filled and memorable experiences of the recent family wedding. Throughout their stories of the wedding itself, some talked not only of their pleasure being back in their home town visiting with family and friends, but also of the strain of being away from all those familiarities for so long. Despite the festivities of the wedding, their moods were melancholic at best.

The wait for this flight was long. Later that evening, the family was observed sleeping in the waiting room on the floor and in several oversized chairs. The Major was awake, making several telephone calls advising his commanding officer of the likelihood that he was unable to meet his leave orders, specifically the return date deadline. His facial expression was strained yet pensive. One could not help but wonder if the sense of pleasure from being with family in the United States had given way to worry and urgency to return to base, a sense of personal crisis. As a social worker, seeing the event unravel in real time provided a different and more personal perspective rather than from hearing about it in an office setting at a later date.

After several hours, everyone on “stand by” was able to board a flight being readied to leave for Germany. Seating in a C-17 is not comparable to the seating on a commercial 757 aircraft. Passengers sit in uncomfortable troop jump seats which fold down from the wall of the plane and are made of a mesh material. Because there were fewer passengers on this flight, most people occupied three seats for comfort. Some had inflated air mattresses placed upon the floor and stretched out to sleep while others inserted ear buds and listened to music on their iPods. My husband and I made efforts to become comfortable although we did not prepare for comfort like others. Our seating was in close proximity to the Major and his family. Once airborne, the mood of the Major's family seemed to change from one of tension and worry to relief. But not the Major, who was now trying to sleep on an air mattress on the floor between cargo containers. The flight across the Atlantic Ocean was eight hours.

I was filled with the excitement of flying in a C-17, thus I was far from sleep. There was an instant when the Major's wife and I glanced at one another and we smiled. This gave way to a brief conversation between us. She shared that her husband had to go directly to his office the moment he stepped off the plane, adding that she would be responsible for deplaning with her children, carrying their luggage, and finding transportation from the terminal. My interest in her story was apparent, and she told me how they enjoyed their visit home, especially with their older children, who have established their own lifestyles and families. She was already missing them. The conversation was friendly and supportive. Listening to her details of their trip seemed releasing for her and beneficial for me. I learned firsthand about some of the difficulties military families endure during deployment.

The remainder of the overnight flight to Germany was uneventful; most passengers slept and awoke to an early morning sky in Ramstein. The moment we were able to deplane, the Major leapt into a waiting car and left his family to tug, pull, carry, and drag luggage and bags of their belongings down the ramp of the aircraft, onto the tarmac, and over to the bus waiting to take passengers to the terminal. The family's irritability, physical exertion, and exhaustion, while obvious to me, were carefully controlled. Once in the terminal, the Major's wife and two adolescent children again struggled to convey their belongings through the terminal to a taxi outside; they then drove away. They seemed familiar with the routine. Knox and Price (1995) acknowledged the importance of the military spouse and his/her contributions to the performance, readiness, and retention of active duty and reserve military members. This snapshot affirmed the importance of family support for the deployed service member. My experience viewing the Major's ability to instantly transition from being with his family to being with his service family affirmed that it could only successfully occur with the support and understanding of his family. I gained insight into the demands and stress of military life. Maintaining family connections is an important consideration as I practice and I assist a military family.

Snapshot Two

Inside the large bustling terminal at Ramstein Air Base, it was amazing to see the number of men and women from our military either coming or going on

flights. A look at the travel board reflected flights to Kuwait, Mindenhall, Spangdaheim, Okinawa, and other air bases in the United States and Europe. All of the flights formed connections to other parts of the world, especially the Middle East, such as Iraq and Afghanistan. We maneuvered through customs and answered questions to assure our true intent in visiting Germany. As we did, we found ourselves looking up at a large banner simply stating "USO." In that designated area, dozens of men and women were using the Internet and calling home from available phones as well as their cell phones. Some were laughing, some appeared anxious, and others were asleep. At this location, I realized that these troops were awaiting their next flight to take them to their new assignment or were returning to their assigned location in Iraq, Afghanistan, Kuwait, or elsewhere. Here they were enjoying a short respite from the war in the terminal USO.

The Iraq and Afghanistan wars did not have to be explained, they had a presence in the terminal and the USO area. Men and women chatted about their war related experiences. Some had sustained non-life threatening injuries and were using crutches or wheelchairs. Nearby was a dining area with fast food restaurants. Tables were occupied by United States military as well as Iraqi military. Seated near our military personnel, one could easily hear these men and women share their exploits. It felt surreal; I did not have any prior direct exposure to war. Ten hours earlier, I was in the United States, yet now I was observing a scene that I was not prepared to see: active-duty U.S. and ally soldiers either returning to or arriving from combat. Having spent a moment to acquaint myself to the surroundings, I realized what I heard firsthand today, a world away from home, will be read in the U.S. news tomorrow. How is it that these men and women, here to protect us from harm, were able to converse outside of the war theater so casually? Were they debriefed prior to landing in Ramstein? Were they so exposed to war situations that they had become callous or immune? What services were available to assist these people with the transition from war zone to safe zone? This heightened awareness lingered within me.

As the time on base passed, answers to my questions became apparent. I discovered that military personnel are provided orientation and information surrounding what Waldrep, Cozza, and Chun (2004) refer to as the emotional cycle of deployment. The authors describe five phases of deployment. The first phase being pre-deployment, this occurs when the military personnel is aware that they have been assigned to the war zone but may experience a sense of denial even though the clock to leaving has started. At this phase, the military member and his/her family begin to receive training, information, and preparation for this event: the deployment. They are supported by the military, taught how to prepare for and create a "normal" life with their spouse abroad at war, and also introduced to other military spouses in the same or similar situation. This can result in the natural evolution of informal and formal support groups, where the process of normalizing what they will see, hear, and do is allowed to occur.

Up to one month from their departure date is considered the deployment phase, where many emotions arise, some expected, others not. Yet, the camaraderie witnessed highlighted that this group of military men and women strongly supported each other. They stay abreast of their normal lifestyle at home despite their direct involvement in the war. For example, they can be heard talking about sports scores back home and the latest entertainment news. Doing so provided them the relief and the balance they needed from their work in the war.

During the sustainment phase, the service person is in the midst of deployment while their family develops a new routine to accommodate to their lifestyle. During this phase, families experience their greatest challenges. The children's experiences of the absence of their parent may affect academics and behaviors in general. The parent at home may find difficulty adjusting to the responsibilities that both parents once shared. During this phase, resources to support the families' success are optimal.

The re-deployment phase occurs when the service person prepares to return home while their family prepares for their return. Excitement and anticipation is shared by all members as is the awareness that the return will affect the adaption of the family routine during the sustainment period.

The Departments of Defense and Veterans Affairs

offer much in the way of debriefing post war / post deployment. This includes face to face training, emotional support with trained clinicians, and other needed activities prior to returning home. Established resources such as the Army's Family Readiness Group, the National Military Family Association, the Air Force Key Spouse Program, Marine Corps Key Volunteer Network, and the Navy's Ombudsman's Program provides assistance, information, and support to family members of military personnel throughout the enlistment period, including times of deployment. These services are essential to reducing the stress military personnel and their families face when they are deployed overseas.

Personal hardiness is a dimension of control when a commitment to respond to a challenging and stressful event(s) occurs. Hardiness encompasses various coping styles in real-time (Crowley, Hayslip Jr., & Hobdy, 2003; Kobasa, 1979). Listening to those men and women's normal conversations allowed me to become aware of their individual hardiness and use of available resources in their efforts to reduce their stress. As a social worker, this was enlightening. Their behaviors while being with each other, conversing about normal daily activities at home, etc., were able to occur as a result of the support from within their command and from family and friends, as well as their personal resolve, focus, commitment, and hardiness to transition home, post combat. It is likely that those men and women were not appearing callous or immune; they most likely employed coping skills to preserve a sense of normalcy for themselves and their fellow personnel. This was important knowledge for this professional.

However, when military personnel return to a life, post deployment, the ability to cope with their former home routine and lifestyle is strongly challenged. It is this challenge where a social worker can provide continued support and interventions of new coping strategies to empower them during their process of change. Ford, Shaw, Sennhanser, Thacker, Chandler, et al. (1993) stated timely preventive interventions during the acute phase of the readjustment process appeared to assist veterans and their spouses in the readjustment process.

Snapshot Three

During different moments of my travels in Germany and France, I realized that, for some, life traveling abroad is not leisurely or without incident. As I observed U.S. military families separated due to deployment, their efforts to remain connected became more apparent. On one occasion, while taking base transportation, a young woman and her three children boarded our bus. This woman carried her youngest child on her back in an infant backpack. Her two other children, boys about three- and four-years-old, were holding hands as they climbed up the stairs and onto the bus. As they cautiously walked the aisle, the overall silence broke when their mother proclaimed, “Sit in the next seat.” They quickly did. As she watched her boys seat themselves, she returned to the curb and began to pick up her suitcases. She clearly was struggling to walk up the stairs of the bus with an infant on her back. Spontaneously, several people leaped from their seats, assisted her, and brought her bags on the bus for her. She appeared relieved and exuberant as she displayed her appreciation.

Once comfortably seated with her children and her large bags of luggage in view, we began to converse; I was the nearest seated passenger. She shared that this was their fourth day of trying to board a flight back to the U.S. and, for many reasons out of her control, she had not been able. She and her children had spent long days at the terminal without the relief of day care or a place for the children to nap. Their meals consisted of sandwiches from Subway for lunch and cereal for dinner.

She was physically exhausted. Her face was drawn and her voice was tired. Yet, when she spoke of her visit with her husband who had already departed back to Iraq, she visually brightened. She smiled, and the drawn look on her face disappeared. She talked about how her older children laughed and played with their dad nonstop. She described how it was for them, as a couple, when he saw their infant child for the first time. Clearly, this was an emotional moment for her. Remembering those events in addition to her retelling of the experience served as an example of emotional focused coping (Carver, Scheier, and Weintraub, 1989). As I listened, I considered all the effort, struggle, and

perseverance this young mother undertook with her young children to travel from the West Coast of the United States to Germany to see her spouse and father of her children, if only for a brief visit. She never sounded disappointed about her marital separation due to her spouse's military deployment. Her observed love and dedication to her family appears to support her during these periods of transitions and tradeoffs. From our discussion, I found her to be independent, resilient, and well versed in the resources available to her, which allowed her to travel a long distance to be with her spouse and allowed him to be with his family. While she may have been weary, she was determined to remain strong in her commitment to her spouse and her family.

Snapshot Four

The most personally and professionally rewarding experience during this trip was the return flight to the United States from Germany. Having spent two long days and several closed flights to Space A travelers, I boarded as one of the last passengers on the Freedom Shuttle. The Freedom Shuttle is an independently operated commercial 737 jetliner contracted by the United States military to fly U.S. military men and women home from their duties in the war theaters of Iraq and Afghanistan. While many troops return via military transports, this airliner runs round trips three times per week from Baltimore-Washington International Airport to Ramstein, Germany and Aviano, Italy. Available seats for Space A travelers are few and infrequent.

We traveled back to the U.S. seated among men and women returning home from the front lines of the Iraqi war, either permanently or for a leave. Many looked tired yet glad to be going home. Many had carry-on duffels with white sand in the crevices and creases. Their boots, also covered in sand, were white where they were once either khaki green or tan. Some had minor wounds to their faces or limbs; one person used crutches to walk. Fortunately, all boarded the aircraft independently.

Imagine the excitement as well as anxiousness these service men and women were experiencing as they returned home. I was proud; I was humbled. I wanted to speak to one or two of them to ask about their experiences, not just about being in war, but also about returning home. Who was waiting for them? What did they want to do first when they walked into their home? But, I did not intrude, as I realized this was their time to unwind and ready themselves for home. It would not be appropriate for me to inquire about their combat experiences, but if approached, I decided I would engage in conversation. This was a rare event to be among men and women returning home directly from a war.

Most of the flight was quiet. It was 10 hours of air time, non-stop to Baltimore. Many people slept, many people read, and some sat silently while others were engaged in soft conversations. I wondered what their thoughts might be. Maybe those first hugs, a favorite meal, a cool drink, a local newspaper, or a glance from a parent's or a child's eyes. All so intense, and yet so comforting at the same time.

As the plane approached Baltimore and prepared for landing, the lieutenant seated next to me put down his book and met my glance. Without considering anything but enthusiasm for him and the others, I said, “Welcome Home,” to which the lieutenant replied, “Thanks, it's good to be on friendly soil.”

Upon leaving the plane, collecting bags from the carousel, and going through U.S. Customs, the enthusiasm of the military personnel was palpable. Not only did the custom agents welcome them home with excitement, but off in the distance, in the direction of the main terminal, band music could be heard.

As the young men and women gathered up their duffels and walked towards the main terminal, they were curious, as if to ask, “What is the music all about?” They promptly found out. As they exited through the arrival gate to the main terminal, the USO was celebrating their return. The gate area was decorated with red, white, and blue balloons and banners. Marching band music from a stereo was loudly playing while military veterans from several past wars had formed a line to shake their hands as they entered the main terminal. It was a proud moment to experience, for all.

We sat and watched nearby for a long while pondering the commitment these men and women have toward all American citizens. Their certainties

and confidence in their undertakings reflect their and their family's knowledge that the tradeoffs and transitions are very important and part of their commitment to ensure our freedoms.

Conclusion

A social worker seldom has a direct opportunity to gain an awareness and knowledge of the challenges enlisted men and women encounter, including remaining connected to their loved ones when deployed away from home. With the Internet and other technological advancements, information is exchanged routinely over miles between these men and women and their families. Yet, observing and listening to their attempts to meet and spend time together in foreign lands provided me with a first-hand appreciation for the determination of a family to remain connected. They travel for days, sleep in terminals with small children while awaiting the next flight, and advance through multiple transitions in the process, trading off conveniences with the goal of spending time with their spouse, father, or mother worlds away.

There are valuable lessons gained from this adventure for the social work profession. It is essential for social workers to know that, while our freedom at home is significant, it is even greater for the men and women of our armed forces and their families. Realizing this heightened my understanding of the motivation that drives those in combat and the family members who support them. Freedom empowers them to survive on the front lines, but may also be a barrier in their transition to a different lifestyle once home. From a clinical perspective, a social worker must be knowledgeable about a person's motivation, hardiness, and drive between situations of combat and returning home, which can be either a benefit or deterrent to this transition for the service member and their family.

Another significant lesson is the ability of military families to create and maintain an emotional bond that not only promotes their lives together, but also fills the void created by the deployment separation. Specifically, the more established their respect, trust, and communication, the greater the likelihood that the deployment separation will be less costly to them and their family upon reunification.

Children are impressionable and also fragile. From observing these young family members, this writer saw that support for them during this time needs to be rather specific and yet different from that for the spouse. Being mindful of how separation affects children in school, with their peers, with sleep habits, and with behaviors in general is important. Separation may be viewed as a trauma, a loss, even if it is situational; more so if it is permanent. As a social worker, we should not expect that their parent will be able to meet all their emotional needs while also attending to their own. They are a special population deserving special attention.

Lastly, I acquired knowledge, whether informally observed or communicated, of cultures diverse from my own. To observe service members of the Iraqi military seated with U.S. service members, exchanging conversations of humor or of focused intent, reflected their support for and respect toward the mutual goal of freedom. To converse with a service member's family regarding their efforts to spend time together during deployment affirmed their strength and ability to remain connected during periods of separation worlds away. These snapshots of military families not only provided opportunity for knowledge gained and lessons learned, but also left a lasting personal appreciation for the strength and resiliency of the family.

References

Carver, C., Scheier, M., & Weintraub, W. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56*(2), 267-283. Retrieved from http://ft.csa.com/ids70/resolver.php?sessid=lfmv1tqsk1pnt7ho7diu1l1de7&server=csawe b116v.csa.com&check=c7a992c0737533b70ecb7fe88fd1850c&db=psycarticles-set-c&key=PSP%2F56%2Fpsp_56_2_267&mode=pdf

Cozza, S., Chun, R., & Polo, J. (2005). Military families and children during Operation Iraqi Freedom. *Psychiatric Quarterly, 76*(4), 371-378.

Crawford, W., Crawford, A., & Crawford, R. (2008). *SPACE-A QUESTIONS & ANSWERS*. Retrieved September 19, 2008, from Military Living website: http://www.spacea.info/faq.html

Crowley, B. J., Hayslip Jr., B., & Hobdy, J. (2003). Psychological hardiness and adjustment to life events in adulthood. *Journal of Adult Development, 10*(4), 237-248. doi: 10.1023/A:1026007510134

Di Nola, G. (2008). Stressors afflicting families during military deployment. *Military Medicine, 173*(5), pp. v-vii.

Ford, J., Shaw, D., Sennhanser, S., Greaves, D., Thacker, B., Chandler, P., Schwartz, L., & McClain, V. (1993). *Psychosocial debriefing after Operation Desert Storm: Marital and family assessment and intervention*. Retrieved from http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=20&hid=110&sid=36f873e3-591e-4c56-8e83-9d7e1fb97e84%40sessionmgr114

Hoshmand, L., & Hoshmand, A. (2007). Support for military families and communities. *Journal of Community Psychology, 35*(2), 171-180.

Kobasa, S. C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37*, 1-11. Retrieved from http://ft.csa.com/ids70/resolver.php?sessid=949r4bshpph1m9l3kg9ta9nk00&server=csaweb116v.csa.com&check=f6d805dd8ef3218a5f3cab45dbd6282e&db=psycarticles-set-c&key=PSP%2F37%2Fpsp_37_1_1&mode=pdf

Knox, J., & Price, D. (1995). The changing American military family: Opportunities for social work. *Social Service Review, 69*(3), 479-497.

Waldrep, D. A., Cozza, S. J., & Chun, R. S. (2004). The impact of deployment on the military family. In *U.S. Department of Veteran Affairs, National Center for PTSD, Iraq War clinician guide* (2nd ed.). Retrieved from http://www.ptsd.va.gov/professional/manuals/manual-pdf/iwcg/iraq_clinician_guide_ch_13.pdf

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Reflections on a Therapeutic Healthy Lifestyles Intervention for Three U.S. Service Members and One Civilian

Tracey Marie Barnett

Abstract: In this narrative, I describe the experiences of three male military service members: 44-year-old African American, 36-year-old Hispanic American, 30-year-old European American and one 28-year-old civilian African American male and my interactions with them. All four men joined a 12-week health, wellness, and financial literacy program operating under the umbrella of a social work clinical research setting in the Dallas-Fort Worth, Texas metropolis. They all had the same goal of losing weight, but for different reasons. Although two accomplished their weight loss goals, and one of those two lowered his blood and glucose levels, the other two learned healthy lifestyle changes that I hope will be forever implanted in their hearts as they continue their journeys to ideal cardiovascular health.

Keywords: wellness program; process recording; healthy lifestyle intervention; obesity; motivation

This narrative describes my experience as a novice civilian military social worker who, due to a class requirement, implemented a healthy lifestyle intervention created for mother and child dyads, but was later tailored for a select group of service members and one civilian. This program operates under a social work clinical research setting in the Dallas-Fort Worth, Texas metropolis. Obesity is a serious public health issue in the state of Texas, as rates are expected to double in less than 20 years in more than half of residents. It is well documented in the literature that overweight and obese individuals encounter employment, education, and healthcare discrimination. Regarding job applicants in the civilian world who have the same qualifications, overweight and obese individuals are rated more negatively and are less likely to be hired. However if an applicant is seeking military employment, his/her chances of employment move from “less likely to be hired” to possibly “not being hired at all.”

According to Mission: Readiness (2012) childhood obesity is a national security issue, as one in four young adults are ineligible for military recruitment because they are either too overweight, poorly educated or have a serious criminal record to join the military. In addition, the military has spent well over $1 billion a year on treating weight-related diseases (Department of Defense, 2012). The rising prevalence of obesity in civilians presents a challenge for military recruitment (Yamane, 2007). As of 2007-08, those who were between the ages of 17-42, were over the body fat and weight enlistment standards for the Army. This means that, due to weight and body composition, 5.7 million men and 16.5 million women were ineligible for military enlistment (Cawley & Maclean, 2012).

All four men in this healthy lifestyles intervention had an overall goal to improve their cardiovascular health. One in particular needed to lose weight as he was preparing for an upcoming military fitness test. Due to military budget cuts, he was well aware that if he did not meet the required fitness standards, he could possibly be dismissed. Because service members have to work under serious and challenging conditions, being healthy and fit is essential to national security. To hear a civilian discuss a dilemma such as this, in terms of job security, is highly unlikely. In the civilian workforce, it is more common to hear that one has faced weight-based discrimination in career advancement.

As an African American female social work Ph.D. student, my research area is obesity prevention and cardiovascular health improvement. My family history is painted with members who have various types of cardiovascular disease and some who even lost their lives from various health disparities. After completing a research project to assess the needs of returning student veterans at The University of Alabama and finishing a graduate internship at

Walter Reed National Military Medical Center, I thought that I knew a lot about United States service members. However, I quickly learned that the old adage is quite true, "When you meet one veteran, you have met one veteran. All veterans are different." After working with these service men and the civilian for 12 weeks, I fully grasped the overarching implications of that statement.

The overall purpose for this project was to help social workers identify the needed knowledge, attitudes, and skills necessary, while working with veterans and their families who may be at risk or affected by cardiovascular disease risk factors such as obesity, diabetes, hypertension, high cholesterol, etc. The health, wellness, and financial literacy program implemented here is just one of many that operate under this clinical research setting. Participation in this study consisted of the following: a single two-hour face-to-face session (pretest), follow-up half-hour telephone sessions, weekly health tips which lasted 12 weeks, and a post face-to-face health counseling wrap-up session (posttest). With the exception of pretest and posttest sessions, this program was not initially designed for 12 weekly health counseling face-to-face sessions, but rather weekly phone sessions. However, in this narrative I will explain the occurrence of one exception. To track the progress of all participants, they were asked to complete questionnaires and wellness journals. Also, participants engaged in health, wellness, and financial literacy counseling interviews by phone each week for 12 weeks.

Three service members and one civilian, all male, enrolled for this intervention: one African American/Veteran, one Hispanic American/Active Duty Reserve, one Caucasian/Active Duty Reserve, and one African American civilian. For this narrative, I will refer to the African American male veteran as Detroit, the Hispanic American as El Paso, the Caucasian male as Denver, and the civilian as Memphis.

Needless to say, I was ecstatic to work with these men and help them obtain their weight loss and overall health goals. However, as a 26-year-old black female working with four men individually, I did begin to wonder if I could truly help them. I also wondered if my ethnicity or gender would help or hinder my relationship with these four men. We'll see at the end of 12 weeks!

Participant Profiles

As previously stated, due to a class assignment for an outside elective, I had to work with an individual(s) and help them obtain their weight loss and overall health goals. I recruited participants by placing flyers all over campus, sending mass emails, and asking people by word of mouth. However I did not want just anyone to join. I specifically wanted an equal sample of veterans or active duty service members and civilians, but unfortunately that did not occur.

Detroit

Detroit is an African American male, 5 feet 9 inches tall, body mass index (BMI) = 35.4, and 44 years old. He is a grandfather, lives with his wife and all four of his children are grown. Detroit was a part-time worker at the host clinical setting, but under a different program. Suffice it to say, I saw him at least once a week which was unavoidable. After hearing my frustration with not being able to recruit enough people for my class project, Detroit expressed that he needed to lose weight and lower his cholesterol and blood pressure. Unbeknownst to me, Detroit had served in the military. He said he wanted to join my study because he was seeking overall self-improvement and wanted to adopt healthier eating habits. "I just want to be healthy, ya know, because a lot of my family members had health problems."

As a matter of fact, Detroit was diagnosed with hypertension and was told by his doctor that he needed to monitor his daily food intake. His father died from abdominal cancer, while his older brother died from prostate cancer. Furthermore, his mother was diagnosed with high blood pressure. Detroit's doctor recommended that he eat more fruits and vegetables. He was highly motivated and had superior support from his friends and family.

Because Detroit and I worked in the same setting (yet under different programs), instead of providing him with 12 weekly telephone health counseling sessions, we met face-to-face instead. I had a gut feeling from the very beginning that Detroit would probably fare better than any other participant at the end of the program, as he was the only one of the four that saw me on a weekly basis. No one else

would benefit from these face-to-face sessions.

El Paso

El Paso is a Hispanic American male, 5 feet 9 inches tall, body mass index (BMI) = 35.0, and 36 years old. He was referred to me by another social worker who stated that she had a client that needs to retake his military physical activity test. El Paso did not want to risk the possibility of failing his activity exam, as he was receiving numerous Veteran Affairs (VA) benefits. Failing such a test could put him at risk for loss of benefits. The reserves would have allowed El Paso to retake his physical until he passed, but he wanted to pass on the first go around. After hearing about my program, El Paso felt that he should join because it could possibly serve as a support system. The first time I met with El Paso was at McDonald's (a favorite restaurant of his) and he shared with me that he wanted to lose 20 pounds, however, according to him, the hardest thing about managing his weight was his dietary intake. In the past he tried the Subway diet for breakfast, lunch, and dinner. He lost 10 pounds and gained it all back. El Paso also eats at a local mom and pop Mexican restaurant each day. "It's hard to turn down those burritos and tacos. That place reminds me of home." After hearing this, I began to think of how I could help him select healthier meals at this local restaurant.

Now, some readers may wonder why I met with El Paso at McDonald's instead of the clinical site. One of the objectives at the clinical research center is to provide assertive community outreach, meaning we will go to our participants if needed; they do not have to come to us. Our center is a strong advocate for not placing additional barriers on our clients. Therefore certain programs allow for us to meet clients in a setting that is conducive for them.

Denver

Denver is a European male, 6 feet 5 inches tall, body mass index (BMI) = 33.9, and 30 years old. He joined the project by way of a flyer that he noticed on campus. When we met face-to-face, he revealed that he thought I was offering academic/life counseling services. I told him that counseling was not the main focus in the program, but that would not preclude me from implementing such services at his request. He mused over this for a few seconds and said, "OK." Denver's father had a heart attack two years ago and his mother was diagnosed with coronary artery disease. He lives with his wife and six-year-old daughter. In 2005, he joined Weight Watchers and lost 40 pounds in four months, but he gained all of his weight back. He began Weight Watchers again in December 2012 and lost six pounds. Weight Watchers taught him that his current weight was very unhealthy and one thing he disliked the most about Weight Watchers was counting points. "Man, counting points is hard; they expect me to write down every little thing that I eat. I keep forgetting, and I just usually give up." He usually has problems "falling off the wagon." He feels that when he waivers from his diet, it's a lost cause and he might as well eat whatever he wants. Most importantly, he does not want to be a victim of heart issues like his parents. His goal is to reach a healthy weight.

Denver says the hardest part about managing his diet is where he works, Starbucks. At Starbucks, Denver can get free items whenever the store is open. Even if he is not working, he can drive-by, or stop in, and get free food. Denver stated, "Who wouldn't want to eat free food?" Also, Denver began the program one week prior to the Super Bowl. He told me that he already knew that on Super Bowl Sunday he would eat tons of foods that were not healthy. Denver and I discussed a few healthy choices that he could substitute for unhealthy foods on Super Bowl Sunday. He said that he would give this a try, but I never heard how this went for him. Later you will know the reason why.

Memphis

Memphis is an African American male, 6 feet tall, 35.4 body mass index (BMI), and 28 years old. He heard about the program from a friend who lived in Texas. Memphis' friend provided me with his contact information as he granted permission for me to contact him. I spoke with Memphis and explained the purpose of the program/project. Although Memphis lived in the Northeastern part of the United States, his location did not exclude him from being a participant. Although I met with all other participants for the pretest and posttest face-to-face, Memphis and I met via Skype. After hearing all details of the program, Memphis expressed strong interest in joining because he stated that he needed a strong support system.

"Tracey, mane, I just don't got no one around me that can help me stay motivated. They think I'm crazy cuz I try to watch what I eat. My homeboy said that he watch what he eat too... Yeah, he watch it go straight in his mouth!" Memphis was interested in losing weight because he wanted to try out for a professional football team. He is a welder, lives with his younger brother, and has a bachelor's degree. "Mane, I ain't never wanted to give up on my dream of playing ball, but I'm starting to realize that it might not come true. If I don't make it, I guess I'll just go to school to cut hair." In fact, I could easily sense his frustration and despair as he described this intervention program as his last resort.

He was very interested in losing weight because he feels like this is his last chance at professional football. Since he was a small boy, born and raised in the South, he has always dreamed of playing football. He played in college but was hurt on two occasions. He feels that it is his duty to help his family out of poverty. Memphis was well aware that the odds were against him. He knows that his current age, 28, is typically when most professional athletes begin to see a decline in performance. Memphis knew that he would be competing against individuals who were in their early 20s, but playing for a professional team, and trying out for one was always a dream of his. At one point Memphis stated, "Yeh, but God will make a way. If it's for me, it's for me." Memphis often said that if he did not make the team, at least he knows that he gave it his best. Memphis also shared with me that his mom is obese, but his father is not. Also, his maternal grandmother died from cancer, but he could not recall the type. Memphis does not have much family support in his attempts to lose weight, so he wants to enroll as a way to have an accountability partner.

Let the 12-Week Counseling Sessions Begin

Weeks 1 and 2

As previously stated, the intervention required me to implement 12 weekly telephone sessions regarding nutritious meals, physical activity, and financial literacy. Detroit was the only participant that did not receive weekly health counseling sessions by phone, instead we met in person at the research clinic. During this time, Detroit lost four pounds. In the second week, he told me that he wanted to bring a slice of cake to work for his lunch dessert, but was afraid that I would catch him. I told Detroit that it was ok if he had cake once in a while, but he should learn to consume everything in moderation. Detroit had numerous questions outside of the weekly content provided in the curriculum. I had to do a lot of extra research for him. It was frustrating at times, but I'm glad that he was so eager to improve his health. He also shared with me how he increased his running speed. Detroit stated that his wife said to him "Oh, so you can't get healthy when I want you to, but when someone else helps you, you do what they say." Detroit said he replied, "Yep!" Overall, Detroit said that his wife told him that no matter whom or what inspired him to get serious about his health, she was happy that he was making positive lifestyle changes.

Within these two weeks, El Paso had lost two pounds. I knew El Paso would not stop eating from his favorite Mexican restaurant, so I made attempts to help him make healthier choices from the menu. As previously eluded, El Paso ate at a mom and pop restaurant. Therefore they didn't have a website. So, one Saturday evening I drove to the restaurant to locate a menu. To my surprise while standing in the back of the line, El Paso was at the very front placing his order. I was so embarrassed! I did not want him to think that I was stalking him. I assume that he thought nothing of it because after seeing me, he invited me to sit down and eat with him, but already feeling uncomfortable, I made up an excuse, grabbed the to-go menu and left. After getting home and going through the menu, I realized that based off the menu, El Paso had no healthy options from which to choose. I called the restaurant and asked what vegetables they served. I was told only lettuce and guacamole. "That's it!" I replied. "Nothing else?" That's all, I was told. I asked "Well can you bake anything instead of frying it?" The receptionist replied, "We fry everything here; we don't bake. I'm sorry ma'am, but I have to go now." After hearing this I felt so defeated. How can I help El Paso eat nutritiously from his favorite restaurant when they don't provide healthy options? I mused over this for a few days. Needless to say, I had my work cut out for me.

During this time, Memphis lost five pounds. The key to his success was that he stopped drinking a

large majority of his calories. Memphis said that after reading the article I emailed him regarding sugary, flavored beverages, he saw a huge need to drink only water. However it was not easy for him to do this as his brother loves to drink sodas and juice, and these items still remained in his home. After realizing that we had numerous similar childhood upbringings, Memphis would oftentimes ask me to pray for him. This is something that none of the other men ever requested from me. I began to wonder, "Will his faith impact his outcomes?" Only time will tell…

By the end of week two I was very proud of these men. Three of them adhered to their appointment times and were very engaged during the health counseling sessions and even requested additional material. However, I could not say the same about Denver. I made several attempts (called, texted, and emailed) to contact Denver, but he did not return my messages. When we met for the first time, he appeared to be highly motivated to lose weight, so it was difficult for me to understand his lack of treatment adherence.

Weeks 3 and 4

Detroit

Detroit appeared to be meeting all of his goals. According to him, he was exercising longer and with greater intensity. He downloaded a free weight loss application online and provided me with his login and password. Detroit said that it would help him if he could email me his daily food logs each night. No one else did this. So, just like clockwork, at the end of every day around 11 p.m., Detroit would email me his daily food log via the online weight loss program. By doing this, I was able see what he ate each day. Because Detroit was so methodical in everything he did, he would also preplan every meal the night before. This gave me the opportunity to see what Detroit ate that day, and what he planned to eat the following day. This was very instrumental as it helped me to structure the advice I gave to him. Since Detroit requested extra help, I could predict that he would probably lose more weight than the others. There were times when Detroit had slight problems with particular "situational" triggers. Meaning, he could have satisfied his hunger, but when he passed the snack machine, he would purchase an item or two. I suggested that he no longer walk by the one snack machine that is located in the entrance of the building where he works. Detroit enjoyed eating food late at night in the bed because he had issues with insomnia. He said this stems back to a few traumatic experiences from his deployments. Detroit also loves Snickers, and I suggested that he replace Snickers with high fiber chocolate bars (110 calories each).

El Paso

By this time, I had gathered two additional Mexican restaurants of El Paso's choice and in turn, I had no luck with them as well. Therefore I found a few healthy Mexican recipe dishes online and shared them with El Paso. He said that he would give it try, but I wasn't too confident that he would. During these weeks, he shared that he went grocery shopping and attempted to select healthy foods. He was now preparing a brown bag for lunch and only eating at a restaurant every three days. This was a big adjustment, as El Paso used to eat out daily, maybe twice a day, before beginning the program. El Paso stated, "I still snack at night, but I try to remember what you said and make healthier choices." I praised El Paso for doing such a great job. I inquired about his level of physical activity, and he stated that he had no time to exercise.

El Paso worked six days a week at a job that required him to sit for nine hours or longer. Two nights a week after getting off from work, his college night class would begin within two hours and on Wednesdays he went to church. On most weekends, if he didn't attend drill, he was helping his parents or some family member with yard work. El Paso felt that the exercise he got on Saturdays and Sundays were enough. However I explained to him how important it is that he tries his best to reduce sedentary time as much as possible throughout the week. I gave him the following tips: use the stairs instead of the elevator or escalator, when going places locate a parking spot far from the door, and get up from your desk at least every 30 minutes to one hour to stand up or walk. I also suggested that he try and exercise 30 minutes on a few days before work.

Denver

This week was no different than the weeks before. Denver would not return my calls, texts, or emails.

I remembered during his intake that he mentioned going to the gym every morning on certain days of the week. For the next two weeks, I went to the gym when he was supposed to be present, but he never showed up. By this time I began to wonder… Is it me? Did I offend him? Why isn't he returning my calls, texts, or emails? Why is Denver not at the gym? (He had told me this was when he worked out.) Due to the phone that Denver had, I was able to see on my end the exact time he received and read my text messages. This really hurt my feelings. There were times when Denver would receive and read my messages immediately, but he never responded. I felt terrible.

Memphis

In weeks three and four, Memphis slowly began to lose motivation to obtain his goal because his car broke down and he was dissatisfied with his current job. I tried to help Memphis locate jobs in his area, but he would never follow through. I even helped him with his resume, cover letter, and drafted emails to potential employers, yet still, he would never follow through. He would talk to me for hours about his football career dreams, but his actions did not always line up with what he should have been doing. Memphis would often blame his limitations on his lack of transportation to a gym. I suggested that instead of driving to the gym that he should try walking. Memphis replied, “Mane, Tracey, do you know how far I live from the gym? Plus it's cold as a mutha outside. I'm gone freeze off my black tail.” It appeared that Memphis was slowly sinking into a deep bout of depression. Therefore, I began implementing problem solving therapy with him.

At first Memphis thought I was crazy to suggest that he may need some type of therapy. It is well documented in the research literature that most African Americans do not seek mental health treatment due to the attached stigma. However, since he did not have to go to a physical location and “therapy” took place by phone, he began to accept my help in this area. Also, Memphis and I discussed the possibility of asking someone to take him to the gym after work, but he stated this was not an option. Within a few days, Memphis created his own gym-like obstacle course in his home, yard and basement. He realized that everything he needed to work out was located at his fingertips, in his home. He said that this realization came after utilizing problem solving therapy.

Weeks 5 and 6

Detroit

This week Detroit reported “I went to the doctor today, and my cholesterol was down. My doctor says if it stays this way when I come back in 3 months, then he will take me off of my medications!” This week, Detroit's plan was to increase his weight lifting. However this did not happen because he injured his shoulder. I suggested that he go to a doctor, but he didn't think it was that serious. I began to wonder if he was overdoing it. Maybe Detroit was trying to lose too much weight in a short period of time. Also, during week 5, Detroit did not pass a major state licensure exam. Four of five days this week he went over his daily caloric budget. Detroit did not understand why he was not losing weight as fast as he had been in the beginning. He did admit to indulging in a lot of junk food to calm his nerves due to failing his exam. He discussed with me how defeated he felt after failing his exam. Plus, everyone at his current job knew that he was scheduled to take the exam on a particular day, so he had to come to work with numerous people asking if he passed or hearing congratulations when indeed he did not pass. I could understand how he felt as I did not pass a similar exam the first time a few years back. I was hoping this would not set him back in terms of his weight loss goals. I'll never forget something Detroit shared with me… “I've been through a lot. It sucks that I didn't pass, but I'll get over it eventually and retake it. When I was deployed, I should have died at least three times, but I didn't. If I can survive that, I can surely pass this test.” After hearing this, I was sure that Detroit would get back on his feet. He just needed some time.

El Paso

For the past two weeks, I made several attempts to contact El Paso. My first assumption was that school, work, family, and church must be getting pretty hectic. The one time that El Paso returned my call was during a moment when I was not available. I called him back several times, but he didn't answer. I began to wonder why I was not being successful at reaching him. Did I say anything the previous weeks to offend him? Could possibly life in general just be too overwhelming at

the moment? Even though El Paso did not reach back out to me, I still made several attempts to touch base with him. I sent him healthy Mexican dish recipes, but still to no avail.

Denver

This week Denver emailed me stating that he was deeply sorry for the lack of communication. Within the past few weeks he had lost a dear friend, was struggling with his four classes, and he was having smoking issues with his Post Traumatic Stress Disorder (PTSD). Furthermore, he just found out that his wife was pregnant. He sincerely apologized and stated he would start logging everything in his free online web application starting that day. Although Denver stated that he would begin logging everything daily, he did not follow suit. I appreciate Denver providing me with an update; however, he still did not complete what he said he would do in the email that was sent. I realized that he currently had numerous life altering circumstances, and health, physical activity, and weight loss no longer appeared to be a top priority. In my reply email, I offered to counsel Denver if he needed someone to talk to, but he never took me up on my offer. I located resources to assist him in dealing with issues of PTSD and smoking and shared these with him, but he never replied to my email. I also shared with him the numerous resources and counselors that were available in the area that worked with veterans specifically. I wanted to give him an opportunity to work with or see another counselor besides me just in case he wasn't comfortable with me, or sharing this very fact, but he never followed through.

Memphis

I recognized that Memphis was not keeping up with his daily logs as he once had. A few days later, he told me that his grandfather passed away. Memphis has been under a lot of stress lately and this is why he had not logged food or exercise this week. However he did report that he rode a bike for 20 minutes, walked a mile, and completed a 15-minute run one evening after work. The funeral was scheduled to take place down south. Already struggling to make ends meet, Memphis had to borrow money from a few friends just to get home for the funeral. Also, because he could not afford to fly, he had to drive, which caused him to miss a day of work, which set him back even more financially. Before he traveled home down south, he told me that he knew it would not be easy to remain physically active and make healthy food choices. So for these weeks my plan was to let Memphis grieve the loss of his grandfather. I told him not to worry about his logs. However I did explain to him that exercise may indeed help his overall mental health. My plan was to not “hound” him about eating healthy and logging his food. I gave him about two weeks to recuperate.

Weeks 7-8

Detroit

Over these few weeks, it appeared that Detroit was doing well. He removed the candy jar (situational trigger) from his home that sat in the living room and replaced it with a fruit bowl. Also, Detroit told me that at one point he saw me on campus and he thought I saw him too. He was on his way to the snack machine. He said this was a quick reminder to him that he should make a U-turn and go back to his desk. At this time it seemed that he had overcome not passing the licensure exam. He was back to his regular self. When Detroit didn't pass his exam, he began to do a lot of reflecting on his time spent overseas. He told me that he could not get over his experiences from serving in Iraq. He would often ruminate over the several times he should have died and he realized how much devastation this would have brought his wife and children. Detroit realized that he endured three “near-death” experiences, so with this perspective, not passing a test could not compare. He continued to lose weight and at this time was five pounds away from his weight loss target. When comparing his logs from the past week to the current week, it was apparent that he took my advice and made high fat reductions.

El Paso

For these two weeks, I called, emailed, and texted El Paso, but he never responded. By this time I was really hoping that he was ok because it was not like him to ignore my calls and emails and never return them.

Denver

For one week during this two-week time period, Denver emailed me his food logs, but he would not answer the phone when I called. He later informed me via text that he had not been feeling well and stopped going to the gym. Based on his class

schedule, I could see that he was very busy and was enrolled in many classes that had a lab. I was concerned that he was not eating enough due to the overwhelming stressors of school and daily life. I voiced these concerns, but told Denver that I was proud of the healthy food choices he was currently making. I also offered to counsel him and suggested other counseling places, but he did not acknowledge my suggestions as we were communicating via text.

Memphis

Due to Memphis' grandfather's passing, his schedule was greatly affected. He did not track his food for almost two and a half weeks. However, he did tell me that he lost a total of 11 pounds. To help him get back on schedule, he started taking weight loss supplements and muscle enhancements. He took only one pill per day in the morning before breakfast, along with one orange, and drank water. In addition to these pills, he also took an OMEGA 3 pill before going to bed and usually ate a small sandwich at night for dinner. I was very concerned about the weight loss supplement that he was taking, so I decided to do some extra research on the side. I found that these pills had numerous life threatening side effects and I shared these articles with Memphis. He was not fazed by the facts at all. He stated, “Mane, my uncle sell this stuff. He wouldn't give me nothing bad.” In fact, his uncle was a distributor of the product and Memphis felt that he could trust anything provided by his uncle. He also stated that he would be fine, since it was just a 30-day weight loss program. Needless to say, I did not want Memphis taking these pills, and I still fear the long-term health consequences that could result years from now.

Weeks 9-10

Detroit

During these weeks, Detroit was very happy and he continued to make behavior modifications and it appears that he seriously applied the weekly health counseling lessons to his daily life. He had lost a total of 18.4 pounds, and he was excited about reaching his overall goal of 20 pounds within the next two weeks. I was so proud of Detroit. He received numerous compliments and this was a tremendous boost to his self-esteem. Detroit also asked if he could continue to send me his food logs after the program ended. I thought to myself, “If he does this I'll have to continue doing research on his behalf… I wasn't too fond of still having to work on this project although I was very happy that he had truly been successful.” I told him that he could send them to me if it helped him, but I could not provide any tips or do extra research as the program will have ended. Detroit stated that he understood.

El Paso

During these weeks, I finally spoke with El Paso. He shared that he had a lot going on in his life and he would not be able to participate in the program any longer. He apologized for “wasting” my time. I explained to him that he did not waste my time and I hope that he learned a little for the time that he was enrolled. Consequently, he felt that he had taken on a class load that semester which was not ideal. He explained that his grades were beginning to drop and he did not need to be involved in anything “extra.” I offered to connect him with a local tutor that helps veterans for free, but he stated he did not have time. I asked him what he was going to do about his military physical exam. He explained that since he could keep taking the test until he passed, he would rather go with this option. Also, El Paso got another job, so he now had to work on weekends, which took away more time from his studies.

Denver

Unfortunately, I did not hear from Denver during these weeks. I tried my usual methods of contact, but he never responded. In my heart, I felt as if Denver had dropped out of the program weeks ago, but did not make this declaration as I had with El Paso. I was left with so many unanswered questions.

Memphis

This week, Memphis appeared to be on track and he didn't mention any problems. Tryouts were quickly approaching. Memphis had experienced a lot in the past few weeks and his spirit was not the same as before. He was excited about tryouts, but he no longer carried victory in his heart. For the past couple of weeks, we had only texted and not spoken to each other.

He stated that he just did not feel like talking. He self-reported via cell texting that he lost an additional four pounds. During this time, he was

trying to maintain this weight because he had now reached his weight loss goal of 15 pounds.

Weeks 11-12

Detroit

At this time, Detroit appeared to be very happy with the weight he lost. He was also proud that he lowered his cholesterol, and if he continued these lifestyle changes, he could cease taking his cholesterol medication. Detroit felt like he had done so well because he "knew" that I looked at every meal that he ate daily. According to him, "I won't have problems continuing the lifestyle changes once I'm out of this program." Furthermore, he planned to send me 3-, 6-, 9-, and12-month updates. Incidentally, Detroit successfully reached his weight loss goal of 20 pounds!

El Paso

I did not speak with El Paso during the final two weeks as he stated that he did not want to participate any more.

Denver

At this time, I still had not heard from Denver and he had not emailed, texted, or responded to any of my attempts to contact him. I assumed that final exams were having a huge impact on him and he probably was feeling more pressure than ever to finish the semester successfully, by passing all of his classes. Also, due to previous email conversations, I assumed that his additional life stressors had probably added to his lack of communication. However, knowing all of this did not stop me from feeling as if I failed Denver in some way. I reached out to him numerous times and I knew that he was purposefully ignoring me. I could see when he would read my text messages. Still today, I'm not sure what I could have done to help him. Or maybe he was not ready to change. Maybe he was still in the pre-contemplation and contemplation stages of change. I guess I'll never know for sure.

Memphis

After tryouts, Memphis felt a little defeated as his stated "This was a little more than I bargained for." He self-reported that he felt like he was as prepared as he possibly could be for the tryouts. Although he did not make the team, he lost weight, has a new job, and feels good about himself. I was very proud of Memphis.

Conclusions

Although I began this project with the goal of helping four men learn more about healthier eating habits and lifestyle choices, I possibly ended up learning much more than they did. Albeit research is present which identifies "ideal" lifestyle choices and healthy weight management techniques, I have yet to find an all-encompassing guide that helps one to deal with daily life stressors while seeking to lose weight. Weight loss management is often viewed as a "beast" itself. Invariably, when one is presented with additional, often magnified challenges, the issues associated with weight loss are usually tossed to the wayside.

Under the new Affordable Care Act, it is required that most insurance plans help obese patients lose weight. Also, the VA has a 12-week program, called MOVE!, that is designed to help veterans lose weight. I would argue that losing weight, in addition to dealing with stressors of daily life, would be more arduous for veterans when compared to civilians. The veterans that I encounter are still dealing with trauma-related issues such as PTSD from military service. The Substance Abuse and Mental Health Services Administration (SAMHSA) stated that "trauma exposure has been linked to later substance abuse, mental illness, increased risk of suicide, obesity, heart disease, and early death" (SAMHSA, 2011, p. 8). Issues such as traumatic brain injuries, PTSD, musculoskeletal issues, and many more can impede progress towards goals that one may have set for themselves, such as weight loss.

Throughout the 12 weeks, I learned that life doesn't just "wait" to happen to us when it's convenient. Although one can have the best-laid plans, a wrench can be thrown in the midst which completely throws all well-meaning efforts off track. During these times of difficulty, it's inherently important to keep "first things first." In essence, an individual can desperately long with all of his heart, mind, and soul to lose weight, but without the proper support and guidance, all efforts can become null and void.
I often wonder if I provided enough support to these men, as they struggled with major life events. Should I have halted the food education efforts and focused more on "soul searching" to identify deeper

issues that were present which ultimately hindered some of their progress? Could I have experienced better results if I had simply provided more empathy to El Paso, as he expressed his frustration with the additional stressors that entered his life? Would things have been different if Memphis had not lost his grandfather? Could the stress associated with this major loss been more important than focusing on weight loss at the time?

If I haven't learned anything else, I now realize that life is all about balance. Although we often possess certain goals which are critically important for overall health and well-being, issues will often arise that are beyond our control that should take precedence at the time. There are numerous life events which are simply beyond our control. However, the key lies in how we choose to respond to these challenges when they arise. In the future, as a social worker, I will seek to not only help my clients improve their overall physical health, but I will also become more proactive in helping them to increase their mental well-being. This type of approach is referred to as integrated behavioral health. I now realize that the two are not separate components, but they are actually dual entities which cannot be viewed in isolation.

In closing, I must realize that clients are people first, and ***all*** aspects of their lives must be viewed with the same level of importance. Life is like a game; you never know when a curve ball is going to come your way. Therefore, I must continually remind myself that all individuals are not created the same, and certain adjustments must be embraced along the way to meet the individual needs of each client. In education, it's critically important to tailor instruction to meet the needs of each learner. Social work is no different. There is no “one size fits all” solution. I must continually strive to meet the client where he/she is at that time. If this means stopping or halting a study to effectively deal with a major life event, then bring me a whistle because I'm about to call a “time-out.”

References

Cawley, J., & Maclean, J. C. (2012). Unfit for service: The implications of rising obesity for US military recruitment. *Health Economics, 21*(11), 1348-66.

Mission: Readiness. (2012). *Still too fat to fight.* Retrieved October 8, 2012, from http://missionreadiness.s3.amazonaws.com/wp-content/uploads/Still-Too-Fat-To-Fight-Report.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). Retrieved February 19, 2012, from http://www.samhsa.gov/

U.S. Department of Defense. (2012). *DOD to improve nutrition standards across the Armed Services for the first time in 20 years.* Retrieved February 24, 2012, from http://www.bostonglobe.com/news/nation/2012/02/10/military-fight-fat-food-upgrade/9Aw1M6HOruUVXJFzAA6BAP/story.html

Yamane, G. K. (2007). Obesity in civilian adults: Potential impact on eligibility for U.S. military enlistment. *Military Medicine, 172*(11), 1160-1165.

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Letter from the Editors

Michael A. Dover, Editor, and Steven Leopold, Issue Production Manager

Readers of this journal know that many narratives published here contain the voices of two writers. The same is the case for the present Letter from the Editors. This Letter from the Editors reflects the voices of two members of the *Reflections* editorial team: Michael Dover, editor of *Reflections*, and Steven "Leo" Leopold, 2013-2014 Graduate Assistant. Since working together during the last academic year, both of us have re-enlisted, and we will tell you how.

Michael's Voice:

With his M.S.W. in hand, Leo agreed to serve as the *Reflections* Issue Production Manager. In that capacity he has mastered the use of our open source Scribus desktop publishing software, a robust and free alternative to the proprietary products of Adobe and other firms. In addition, Leo signed on as a Social Worker for the Veterans Administration hospital here in Cleveland.

To that role he brings life experience and experience in the military, about which he shares in his very *Reflectionsy* contribution at the core of this Letter. *Reflectionsy* is not a typo! A *Reflectionsy* piece is one in which we bare much of ourselves, as we seek to write articles that are true to the narrative method described by Josh Kanary in his piece "Show and Tell in *Reflections* Narratives," the inaugural entry in our Many Ways of Narrative series (Volume 18, Number 4).

I think that *Reflectionsy* describes much of what we publish. But if you disagree and object to this journal using such an outlandish word, please let Johanna Slivinske, our Associate Editor for Issue Quality, know! Johanna has been quietly working to improve the quality of our issues since Fall 2013. She also contributed a narrative of her own to the Special Issue on Mentoring in the Helping Professions, Volume 18, Number 3. Johanna is empowered to stop the presses if she feels there is an issue that is not yet ready to be published. If you have any concerns about issue quality or suggestions for how to improve the quality of this journal overall, please feel free to write Johanna at jddetwiler@ysu.edu.

Please also feel free to contact our most important recent source of reinforcements: Cathleen A. Lewandowski, who since July 1 serves as Director and Professor of the Cleveland State University School of Social Work, publisher of this journal. She can be reached at c.lewandowski@csuohio.edu.

I am very pleased that the special issue which Cathleen originally proposed to former editor Eileen Pasztor at California State University Long Beach has now been published. This issue includes a wonderful narrative which Cathleen wrote. I would encourage you to read it carefully. I think you will agree that the person directing our School and overseeing the publication of this journal truly gets it about *Reflections*.

My own version of re-enlistment has been to volunteer to extend my term as editor beyond the initial three-year term to which I was appointed in May 2012. Cathleen has appointed me to serve as editor for two additional years, through May 2017. Further reinforcements have recently arrived in the person of our new editorial assistant Kailie A. Johnson, B.S.W. Candidate, and our 2014-2015 Graduate Assistant, M.S.W. Candidate Alison Murphy, L.S.W. I am fully confident in the future of this wonderful journal.

Leo's Voice:

I hope the knowledge, practice experiences, and personal accounts in this issue will contribute to helping veterans embrace their proud service and release any ghosts that may linger. Having been privileged to be privy to these accounts, I suppose I should provide one of my own.

My existence of late has been the most challenging, albeit rewarding, experience I've faced since my young, closeted, and terribly anxious self joined the U.S. Air Force to get the "H" out of Ohio, 25 years ago. Eight years growing up in the Air Force was

followed by five years of soul-searching, and soon I found myself back home in Cleveland circa November 2001. I was right where I was supposed to be. And now, here I sit at this computer, working with a wonderful batch of articles for this special issue.

Lately, I've been listening to my Thomas Newman station on Pandora quite a bit. It's been soothing and relaxing, during a period of angst and transition. I've been working these past few years on learning to trust the process. As I started writing this, I'll be damned if a song from the U.S. Army Band and Chorus didn't start playing, with a score from *Saving Private Ryan*. Ahh, sweet serendipity!

I recently graduated from Cleveland State University with my MSW. After getting into the accelerated 11-month MSW program, I received a graduate assistantship. This gave me the opportunity to be involved with this journal. I feel fortunate to have been able to stay on past graduation, and also to see this special issue to fruition. I've always been proud of my veteran status, but I was reinvigorated with the unique culture of the military and veterans a few years back, when I attempted to rejoin after "Don't Ask, Don't Tell."

I walked into the recruiter's office, observed him talking and interacting with his co-workers, and was flooded with an environment, culture, and camaraderie that I had largely forgotten about, and sorely missed. I learned they had a program to earn your MSW through the U.S. Army, receive a direct commission, and then go forward as an active-duty social worker. After previously serving eight years, I could finish what I had started 20 years prior. I had just barely made the cut-off for the age limit. I completed the paperwork, and I was on track. My medical records were being reviewed and the next step would be to go to Texas to check out the program, as if I needed selling. And then… roadblock: The fact that I've taken an anti-depressant for the last 10 years disqualified me for a commission.

Old resentments against "the system" rushed towards the surface. Luckily I've since learned tools from sobriety, age, and wisdom that helped me quickly release those to the wind. You see… I believe resentments are like personal poison; they only hurt the person holding onto them. After my army plans came to an abrupt end, I soon realized that the next best thing would be to work with veterans. So I got into CSU and scored an internship at the VA (U.S. Department of Veteran Affairs).

I had the perfect field instructor and environment. She blended professionalism, example, and empathy, while holding me accountable, and making sure I was learning from it all. After graduation, I got a temporary position with the VA, which led to a permanent one. I'm now working with homeless and at-risk vets at the VA, along with community partners. Working with veterans has been a great way for me to reconcile my military past with my new civilian career and existence. It's these two worlds that are so wonderfully woven together in these articles. Several perspectives are given, with explanations on how they can benefit practice.

The military provides experiences that can be hard to comprehend for civilians (with due respect to civilians). But with all of the greatness comes a price for some. I spent six months in Saudi Arabia during the mid-1990s, but lucky for me, it was between major conflicts. I have no idea the depth of what many veterans have been through, but I have a small, respectful taste of it. I know the outfit and can picture the setting. If I can, in the slightest way, help veterans struggling with the price they paid, and release their resentments to the wind, I will have been successful.

As I wrap this up, what is playing on my Pandora? The score from *Band of Brothers*. May all the brothers (and sisters), who gave a piece of themselves, whether peacetime, wartime, years ago, or at present, take the good, leave the rest, and push forward, so their experiences can benefit their comrades. You are not alone.

Michael's Voice:

Reading Leo's narrative style helped me to realize how lucky those of us who are associated with this journal really are. Each of us who is now involved in the *Reflections* team is engaged in a great deal of emotional labor, although that may not always be obvious.

From the editorial staff to the dozens of active reviewers, we agree not just to edit and review articles, but to open up our hearts and minds to the voices of not only the authors but of the people and communities to whom the authors give voice.

The same is true of you, dear reader. Each time you open up this journal, whether to read the present issue or to peruse the complete and precious collection of articles on our website (now going back to Volume One, Number One), you expose yourself to the possibility of being deeply affected by what you read. Nearly every issue has articles which move readers to laughter or to tears, as well as articles which make us ponder our practice and our profession or to re-think how we work for social justice.

Certainly this was the case for the issues edited by Sonia Leib Abels, and those later edited by Jillian Jimenez and Eileen Pasztor, when this journal was published at California State University Long Beach until Winter 2012.

And certainly this is the case with the present issue, which is one of the most *Reflectionsy* issues I've ever read. It has been a privilege to have worked with Cathleen as she spearheaded this excellent issue, and with Leo as he worked doggedly to get the issue ready for the C.S.W.E. Annual Program Meeting and for publication by this Fall's Veteran's Day, on Tuesday, November 11, 2014.

In Tampa at the conference, I was pleased to once again be offered the opportunity to stand at *Reflections* corner within the the University of Michigan booth in the display area. On one of the days I was there, I counted five times in one day that someone took one look at the art work by Robin Richesson on the cover of this special issue, saw the name of the journal in its familiar block letters, and exclaimed: “Reflections! I love that journal!”

It isn't often that you hear that about an academic journal. The fact that this fine issue was edited by the person, Cathleen A. Lewandowski, who now directs our School of Social Work and oversees the publication of this journal, bodes well for the long-term future of this beloved journal.