

# 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.

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