Volume 37/Number 1/November 2015/Pages 1–14

PRACTICE

Counseling Military Veterans: Advocating for Culturally Competent and Holistic Interventions

Paul Carrola
Marilyn F. Corbin-Burdick

The large number of military personnel returning from combat operations in Iraq and Afghanistan with symptoms of mental illness has led to increased focus on specialized veteran mental health treatment and posttraumatic stress disorder. While this focus is both beneficial and warranted, it may lead to a myopic view of the experiences and needs of veterans. This article examines the responsibility of mental health professionals to balance the unique nature of veterans' experiences with their individual diversity rather than viewing them or their experiences through a strictly pathological lens. Failing to take a holistic approach to counseling each veteran may inadvertently stigmatize veterans as a group. The value of wellness counseling and the risks of over-pathologizing symptoms underscore the need to take a more diverse approach to counseling veterans and assist them with reintegration into their communities.

Over 1,400,000 military service members have taken part in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF; Baiocchi, 2013), which together have lasted over 10 years (OIF: 2003–2011; OEF: 2001–present; Torreon, 2012). These men and women have had a variety of military rankings, enlistments, deployments, and durations in the field. Some are full-time military; others may be National Guard or reserve members deployed only once or several times. The unique stresses of deployment and combat operations can have both medical and mental health consequences for them and their families. Reintegration difficulties, family issues, financial problems, substance abuse, posttraumatic stress disorder (PTSD), and medical disability are just some of the difficulties service members and veterans may have to deal with when they return (Beder, Coe, & Sommer, 2011; Elbogen, Johnson, Wagner, Newton, & Beckham, 2012; Golub & Bennett, 2014; LeardMann et al., 2013; Lemaire & Graham, 2011; Lester et al., 2010; Lundberg, Bennett, & Smith, 2011; Sayer et al., 2010; Sporner et al., 2009). While medical and mental health agencies

Paul Carrola and Marilyn F. Corbin-Burdick are affiliated with the University of Texas at El Paso. Correspondence about this article should be addressed to Paul Carrola, Department of Educational Psychology and Special Services, University of Texas at El Paso, 500 W. University Ave, Ed 703, El Paso TX 7996-0633. Email: pacarrola@utep.edu.

are doing a great deal to respond to the psychological needs of service members and their families, some interventions run the risk of unjustly pathologizing them and their war experience. We set out to evaluate current problems faced by veterans and the trends of mental health treatment for clients with veteran or military backgrounds in order to identify more culturally competent and holistic interventions to assist them.

CURRENT CONCERNS

Although many issues can make reintegration after deployment difficult, certain factors can contribute substantially more to the difficulties. Because length of deployment has been found to have a negative impact on how military personnel reintegrate with their families, Beder et al. (2011) recommended that to smooth reentry clinicians promptly initiate family counseling. Families left at home often reorganize in order to cope with the absence of a deployed parent. Returning service members then find that familial routines and behavior patterns have changed and find it difficult to integrate themselves back into the family system. Service members may also not have access to the same relationship camaraderie and support they had while deployed (Beder et al., 2011; Lester et al., 2010).

Children of returning veterans often have problems with behavior and mental health (Beder et al., 2011; Lester et al., 2010). Lester et al. (2010) found that in general children of deployed parents did not present higher levels of depression, internalizing or externalizing symptoms above community norms, but clinically significant symptoms of anxiety in children were correlated with higher rates of anxiety and parental distress from an at-home civilian parent or a parent recently returned from deployment. This suggests that emotional problems may extend beyond the service member to affect the children. Chartrand, Frank, White, and Shope (2008) found that children of deployed parents experience more stress than children of parents who are not deployed. Several studies have suggested the extent to which spouses demonstrate similar experiences. Eaton et al. (2008) reported spouses screening positive for major depression at rates similar to the returning military personnel. These examples are consistent with the general systems theory concept of circular causality, which postulates that individuals function within a system as subunits, each influenced by and influencing the other subunits (Seligman & Reichenberg, 2014). Thus, in treating a client with PTSD, it is probably necessary to also treat the symptoms and effects that the family, particularly the children, may be experiencing.

In addition to reconnecting with families, returning soldiers may find it difficult to reconnect to their nonmilitary communities. Sayer et al. (2010) found that regardless of PTSD status Iraq and Afghanistan combat veterans post-deployment had challenges in multiple domains of functioning and community involvement. Disabled veterans are at greater risk of such reintegration problems as impaired economic self-sufficiency, disruptions in social relationships and social networks, mobility and architectural barriers, and various social, institutional, and attitudinal limitations (Lundberg et al., 2011; Sporner et al., 2009). Furthermore,

veterans with disabilities often have to not only reconnect with their families and home communities but also develop new connections and relationships with others with disabilities in the community (Lundberg et al., 2011; Sporner et al., 2009). The fact that veterans have shown an interest in services related to reintegration into the civilian community (Sayer et al., 2010) is evidence that interactions involving both veterans and civilians may benefit their adjustment.

Suicide and PTSD are among common problems associated with military service that media outlets cover. Risk factors associated with suicidal ideation in OIF/OEF soldiers include events before deployment, previous exposure, post-deployment issues, financial problems, and a clinical diagnosis of psychosis, depression, or PTSD (Elbogen et al., 2012; Lemaire & Graham, 2011; Maguen et al., 2011). Heightened post-deployment social support has been found to be negatively correlated with suicidal ideation and with the severity of traumatic stress (Lemaire & Graham, 2011; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). While it is crucial to validate and not minimize war experience when providing mental health services, the risk factors suggest areas of a client's experience beyond military service that also need attention. It is also likely that a client's symptoms may improve by resolving such risk factors, which may have promoted the development of symptoms. Further, increasing family and community connections may also be beneficial in diminishing the risk of suicide and PTSD.

Medical Bias

The American Counseling Association (ACA) Code of Ethics states, "The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients" (ACA, 2014, p. 4). The preamble states as one of the core professional values of the counseling profession "Honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural context" (p. 3). Given these ethical obligations, counselors have a duty to consider the implications that current diagnostic practices and utilization of medically based interventions may have with regard to labeling clients who have served in the military. To ensure social justice for and to improve the welfare of veterans, counselors should be fully aware of the potential for bias in their treatment—including the bias inherent in strict application of a medical model.

For the past four decades use of the medical model by the helping professions has been both praised and criticized (Beecher, 2009). Mental health professionals use the medical model to help identify and meet a client's needs through diagnosis and treatment (Beecher, 2009). Beecher (2009) states that the medical model has had a major impact on mental health systems and notes the argument that it has made significant contributions in creating the policies and definitions of mental health practice. Lovell and Ehrlich (2000) found that the authority of *managed health care* (a medical model system) within mental health is clearly having a negative effect on psychotherapists in terms of, e.g., narrowing treatment options, loss of autonomy for psychotherapists, and lowered morale. Those authors also cited lower treatment quality, pressure to make quick diagnoses, and

premature terminations as having been associated with mental health treatment under managed care. Beecher (2009) cites the criticism that the overemphasis of the medical model (as represented by managed health care) often leaves clients and their families feeling that clinicians regard them less as individuals and more as disorders. As clinicians address the mental health needs of veterans, it is important to acknowledge the effects of the medical model in treating them, because they may be especially vulnerable to a pathology-based bias.

Another aspect of the medical model that has the potential for pathological bias can be seen in psychiatric treatment. Seal et al. (2012) noted that more emphasis on treating pain has led to a near-doubling of opioid analgesic prescriptions nationwide since 1994. Consequently, many treatments for clients with PTSD and traumatic brain injuries (TBI) include prescription medications (Seal et al., 2012). Although these can often be effective, some studies have found a high rate of inappropriate medication, which may be having damaging effects on OIF/OEF veterans (Abrams, Lund, Bernardy, & Friedman, 2013; Seal et al., 2012). Abrams et al. (2013) found that veterans with PTSD were often prescribed medications whose use was not supported by Department of Defense (DoD) guidelines. OIF/OEF veterans diagnosed with mental health disorders, with or without pain symptoms, were found more likely to be prescribed medications to address pain than those without a mental health diagnosis (Seal et al., 2012).

Seal et al. (2012) also found that veterans who were prescribed opioids had a higher prevalence of adverse clinical outcomes, such as emergency or inpatient admissions resulting from opioid-related injuries and accidents, substance overdoses, self-inflicted injuries, and violence-related injuries.

In a study to identify the preferences of OIF/OEF veterans for co-occurring PTSD and substance use treatment, Back et al. (2014) found that 47.1% of such clients preferred both psychotherapy and pharmacotherapy, 44.1% preferred psychotherapy only, and only 8.8% preferred pharmacotherapy alone. We suggest that using medications inappropriately to treat veterans who have a mental health diagnosis may also be doing harm by pathologizing their military identities. Because over-pathologizing may add to already perceived stigmas related to mental health care, it may deter such clients from seeking and maintaining needed treatment and may constrain their personal growth. In contrast to the pathology or medical model of seeking symptoms to treat and reduce, using wellness-based interventions as primary treatment or a routine supplement to medical treatment may be more appropriate and effective for OIF/OEF veterans.

CURRENT TREATMENT APPROACHES

The U.S. Department of Veterans Affairs has numerous hospitals, centers, and facilities throughout the United States that offer veterans a variety of services, ranging from medical and mental health treatment to financial assistance. Mental health services include outpatient treatment, awareness/information sessions, call centers, peer support services, parenting support and classes, and residential/inpatient treatment (U.S. Dept. of Veterans Affairs, 2014, August 7). Treatments within these services may be evidence-based psychotherapies, such as

cognitive behavioral therapy, acceptance and commitment therapy, illness management and recovery, psychotropic medications, psychosocial interventions, and social skills training. Substance use disorders, military sexual trauma, depression, PTSD, anxiety disorders, bipolar disorder, schizophrenia, and family-related issues are the main concerns that such services are directed to address (U.S. Dept. of Veteran Affairs, 2014, January 9).

Professionals who may be involved in mental health diagnosis and treatment include licensed professional counselors, social workers, peer specialists/counselors, psychiatric nurses, family physicians, internists, physician's assistants, nurse practitioners, obstetricians, gynecologists, psychiatrists, and psychologists (U.S. Dept. of Veterans Affairs, 2014, January 9). The wide array of services and the variety of professionals administering them give clients who are veterans treatment options that they and their families should benefit from. However, in offering such services, mental health professionals have an obligation to constantly evaluate their effectiveness and the ethical limitations on various practices and to maintain counselor competence in working with certain populations (ACA, 2014).

There has been discussion about the potential harm of linking reactions to war experiences with mental illness or requiring mental health treatment (Caplan, 2011). Although the benefits of self-help groups and other informal support systems such as friendships have been cited as instrumental in veteran reintegration (Hinojosa & Hinojosa, 2011), as well as being financially and regionally accessible for most clients (Miller, 2010), many veterans are currently subject to multiple treatment interventions and providers must consider multiple treatment options (U.S. Dept. of Veteran Affairs, 2014, January 9). The Iraq and Afghanistan Veterans of America (2014) report that 73% of OEF/OIF veterans with mental health injuries are currently seeking treatment in military, V.A., and non-V.A. treatment centers. Given this large percentage of veterans actively receiving treatment, it is imperative to determine the most effective interventions that professional counselors can use. The effectiveness of interventions depends not only on culturally informed counseling but also on the ability of counselors to implement both medically and holistically based approaches as appropriate.

VETERAN WELLNESS COUNSELING

Unlike the medical model approach, the wellness model does not focus on pathology-based assessments and treatments. It is defined as

> a way of life oriented toward optimal health and well-being in which body, mind and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally it is the optimum state of health and wellbeing that each individual is capable of achieving. (Myers, Sweeney, & Witmer, 2000, p. 252)

These authors have described the wellness model as encouraging wellness and positive well-being with preventive and developmental interventions. Myers and Sweeney (2008) also noted that in 1989 the American Association of Counseling and Development (now known as the ACA) passed a resolution,

"The Counseling Profession as Advocates for Optimum Health and Wellness," that reaffirmed the profession's commitment to its foundations in a developmental guidance approach. The wellness model has been substantiated as demonstrating a promising presence, rather than simply a subject of interest, for future counselors (Ginter, 2005).

The wellness model has been found to promote understanding of cultural groups and may benefit other minority groups, including those with disabilities or certain faith traditions, who continue to secure less service from professional counselors (Myers & Sweeney, 2008). Outcome studies have demonstrated that wellness interventions are effective and that they were useful for people who had job-related stress that put them at risk for decreased wellness (Myers & Sweeney, 2008). The wellness model can also be used to help clients to consolidate their military experiences as part of their identity rather than being the sole defining aspect of who they are.

Specific aspects of the wellness model that can be directly related to veteran treatment can be seen in posttraumatic growth (PTG) models. PTG proponents posit that positive changes in relationships, views of self, life philosophy, and spirituality can be gained in the aftermath of trauma (Tedeschi & Calhoun, 1996). These changes go beyond basic coping or even thriving; they take the client beyond what was present before the trauma (Tedeschi & Calhoun, 2004). Joseph, Murphy, and Regel (2012) have proposed an affective-cognitive processing model that allows counselors to facilitate growth after trauma by providing a supportive environment that allows clients to enter a cycle of processing stress and to gain positive growth through that processing. Utilization of such strength-based approaches could provide alternative and supplemental treatment for veterans diagnosed with PTSD.

Culturally Integrated Counseling

As culture and diversity have become accepted as necessary components of counselor competence (Sue, Arredondo, & McDavis, 1992), it seems appropriate to advocate multicultural functioning with clients. Veteran populations seem uniquely positioned to benefit from such advocacy since their need to connect or reconnect with family and community members has become apparent. The Helms Racial Identity Model provides a framework for counselors to understand how variances in cultural identity status can be a source of either dissonance or empowerment (Helms, 1995). That status can be connected to how clients function in a multicultural setting. Veterans returning from combat experiences are moving through an identity formation process analogous to the Helms model. The military culture itself creates the foundation for initiating a new identity formation process unique to veterans because their military identity can be seen to contribute as much to their worldview as such other cultural factors as gender, ethnicity, or social class.

Viewing treatment of military service-related PTSD through an identity formation process can help counselors address such PTSD-specific symptoms as feelings of alienation and persistent negative beliefs about oneself and the world

(American Psychiatric Association, 2013). It is the primary author's experience that many clients with PTSD exhibit dysfunction in their lives due primarily to feeling isolated from others and suffering severe discomfort with social interaction. The value of military social connections has also been discussed in research with military veterans with PTSD (Hinojosa & Hinojosa, 2011). While the value of these social connections should not be minimized, practitioners should realize that the strength of those connections may make it more difficult to establish nonmilitary connections (Weiss, Coll, & Metal, 2011).

How both veteran-clients and mental health professionals view veteran identity will likely have major implications not only for client functioning but also for how treatment is given and received (Weiss et al., 2011). The Helms model (1995), using the ego statuses of people of color in terms of racial identity, can be used to understand how people identifying as veterans may be responding to reintegrating into civilian lives and relating with those who have different experiences. The statuses consist of conformity (pre-encounter), dissonance (encounter), immersion/emersion, internalization, and integrative (Helms, 1995). When working therapeutically with clients on concerns about reintegrating from military to civilian life, counselors can help them to feel comfortable by using a strength-based approach that encourages them to draw from their various identities while engaging in diverse settings.

Counselors should be familiar with the ways their clients view themselves and with the beliefs that motivate their situations. For example, clients with a military background who have moved from the conformity (pre-encounter) identity status into an integrative status would indicate recognition that the military is just one identity they can call upon in responding to life experiences. This might be expressed with the following statement, "Yes, I'm a soldier, but I'm also a husband, a father, and now I hope to be a student. I know I have a lot of strengths to pull from and a lot of different people I can rely on to support me." Clients who are well-grounded in an integrative understanding of their identities will likely be better equipped to face reintegration challenges and better able to adopt a healthy and functioning lifestyle.

Cultural and social development may also be important in reducing or preventing mental illness in veterans. In some instances, lower levels of psychosocial and moral development have been associated with veterans diagnosed with PTSD than those who did not have the diagnosis (Taylor & Baker, 2007). While admittedly it is difficult to determine whether the lower developmental level should be attributed to PTSD or combat exposure or whether it contributed to the PTSD, this relationship suggests that both preventive measures before deployment and treatment after might benefit from psychoeducational approaches that enhance skills to confront and resolve psychosocial and moral dilemmas.

The ability to function in a culturally diverse environment seems necessary for many reasons and can likely be connected to overall wellness for both military and nonmilitary persons. While the benefits of military relationships and connections can be crucial to veterans reintegrating with their families and communities (Hinojosa & Hinojosa, 2011), new nonmilitary relationships can be equally beneficial. Challenging veterans to confront the emotional risks that accompany

establishing new social relationships outside of the military culture may help them to overcome feelings of isolation and mistrust. It also has the potential to heighten their coping skills and reduce PTSD symptoms (e.g., lack of ability to experience positive emotions and detachment from others) by increasing feelings of general security and stability within the civilian community.

Reducing Clinical Bias

While identifying pathology may be an important part of getting clients the treatment they need, clients may benefit from counselors taking steps to prevent over-pathologization of their identity and experiences. Over-pathologization can lead to clients being stereotyped and may stigmatize them as sick or damaged. Stigmatization in turn may result in over-diagnosing and exclusive reliance on psychiatric services. It can also miss or ignore crucial factors in client stories, which can introduce social justice concerns (Boysen, Vogel, Madon, & Wester, 2006; Smith, Foley, & Chaney, 2008). Clients with a military background may pick up on counselors stereotyping them, intentionally or unintentionally. This may inhibit needed treatment by validating client reasons for isolating themselves from civilian communities.

PTG is a rational alternative approach to the pathological view of how to treat PTSD. Its proponents posit that positive psychological gain can result from trauma (Tedeschi & Calhoun, 2004). While the idea that traumatic events are opportunities for positive growth has been around for centuries, discussions about applying PTG models in counseling U.S. combat veterans is quite new (Tedeschi & McNally, 2011). The cognitive processing of traumatic events as they relate to the worldview individuals assume and their life narrative and personal goals is a central component of PTG, which can help the individual to become psychologically stronger and wiser about life than before the traumatic event (Tedeschi & Calhoun, 2004). Pietrzak and Cook (2013) provided evidence of significant resilience in older veterans who had experienced numerous traumas. Although resilience is not the equivalent of PTG, their evidence suggests that trauma or combat exposure has the potential to evoke positive as well as negative psychological outcomes. It also supports the argument that veterans—and people in general—process trauma differently.

Although the concept of PTG has been accepted within the mental health profession for some time (Tedeschi & Calhoun, 1996, 2004), the recent proliferation of combat-related PTSD diagnosis and treatment may have inadvertently led to overgeneralizations about the effects of combat experience. Generalizations are not only potentially harmful because they narrow treatment options; they are also fundamentally incorrect. Tedeschi and McNally (2011) have succinctly conveyed the message that the effects of combat experience are more complex than many are aware of: "PTSD is not the inevitable outcome of combat, and even if it is present, there are other aspects of posttrauma living that are of great value" (p. 23). Their recommendations on facilitating PTG with U.S. combat veterans highlight an appropriate alternative to pathology-based treatment of PTSD and offer counselors opportunities to use holistic interventions to treat such clients.

An example of how stereotyping clients can lead to such concerns can be seen in unchecked counselor perceptions of LGBT clients. Boysen et al. (2006) found that the stereotypes of LGBT clients as being more likely to be depressed, having addiction-related issues, and having body-image-related issues influenced the quality of how they are treated in psychotherapy. Smith et al. (2008) noted other biases that counselors may have in regard to social class, ability, and sexual orientation, and their potential consequences, such as (a) negatively influencing the quality of the therapy given; (b) low perception of counselor competence; and (c) possible unintended harm to clients. They recommended that counselors in training should become aware of client experiences and have the opportunity to confront their own biases or assumptions. Unchecked assumptions not only do a disservice to clients but may add to client reluctance to seek treatment.

The implications of the multidimensional etiology of mental illness can be seen in current studies of suicide risk factors (Elbogen et al., 2012; LeardMann et al., 2013; Lemaire & Graham, 2011; Maguen et al. 2011). LeardMann et al. (2013) examined risk factors associated with suicide by current and former U.S. military personnel. They found that, rather than military-specific variables, such mental health outcomes as manic-depressive disorder, depression, and alcohol abuse were independently associated with suicide risk. They asserted that the results of their study were consistent with previous findings that mental health problems rather than deployment or combat were correlated with suicide risk. Lemaire and Graham (2010) also found that prior exposure to abuse, prior history of suicide attempts, and being diagnosed with a mental health disorder were closely associated with suicidal ideation among OIF/OEF veterans; they also found that strong social support was a protective factor. LeardMann et al. (2013) further suggested that the increased suicide rate may be an effect of an increased presence of mental disorders within the military. Their results imply that counselors should consider the client's history before military service equally with their military experience when determining treatment. For example, an individual who has a history of both unresolved trauma and social isolation may be more likely to develop PTSD after certain war experiences than someone who does not have such a history and who has strong social support.

RECOMMENDATIONS FOR COMMUNITY AND MENTAL HEALTH PRACTICE

Considering the implications of the current concerns of mental health counselors as they work with clients who are veterans, we suggest the following practical recommendations for counselors who serve veterans:

- Do not limit case conceptualization to combat exposure or military experience; consider all possible causes of distress or concern.
- Encourage the involvement of family members in counseling and client work on family relationships and dynamics.

- Become knowledgeable about the concept of PTG and incorporate growth enhancement strategies into the counseling process *if* trauma is part of a client's history (see Tedeschi & McNally, 2011).
- Challenge yourself to connect with the client even if you do not have military experience or knowledge of the military. Establishing a close therapeutic relationship with someone outside the military can facilitate the ability of clients who are veterans to develop other integral relationships within the community.
- Advocate, encourage, and challenge clients to see themselves as having an important role in the civilian community.
- Consider cultural identity models to help conceptualize client growth and development toward multicultural integration.
- Use evidence-based treatment approaches—those that have proven effective with veterans have generally been those that are accepted as effective with nonveteran populations: cognitive interventions, brief exposure therapies, and motivational interviewing (Jakupcak et al., 2013; Kip el al., 2013; Lande et al., 2011).
- Be familiar with the VA/DoD clinical practice guideline for management of post-traumatic stress (U.S. Dept. of Veterans Affairs and Dept. of Defense, 2010) and other current government guidelines for practice, but do not rely on them exclusively in making treatment and other clinical decisions.

Although many practitioners may accept these generally accepted recommendations at face value as appropriate and even necessary, we contend that a broad, pathology-focused treatment approach has limited their impact. Consequently, we believe that the recommendations should be *intentional* throughout the counseling process.

CONCLUSION

Service members, military veterans, and their families have experiences that many who have not been associated with the military will not experience. Stresses of deployment, exposure to combat, and other military-related activities present unique concerns for counselors and other mental health professionals. While it is important to directly address client military experiences, it is also important for counselors to be wary of stereotyping veterans and to be cautious about entering a therapeutic relationship without checking their own biases and assumptions. Also, while military service may be a key and rewarding aspect of a client's identity, it is only one part of the client's total identity. As with the cultural background of all clients, one trait they identify is only a single aspect of their whole identity and does not define them absolutely. A client who has served in the military may be a parent, a student, a spouse, or any of an endless number of

other identities that all interact to define who a client may be and how the client approaches problems.

Counselors working with veterans could benefit from familiarizing themselves with integrated treatment approaches and re-emphasizing the wellness model and strength-based theories. Reinforcing the sense of military identity and experiences as positive assets in addition to recognizing the strengths of other facets of client identities may heighten both individual wellness and a client's comfort and autonomy within the civilian community. Using wellness and multicultural approaches would help clients understand that their differing identities are not just parts of them that are sick. They will be better able to view their various identities not only as unique but also as being aspects of a whole. Consolidating incongruences within individuals by acknowledging and addressing the many contexts in which they interact can benefit the mental health of veteran clients. Counselors should also consider the interest veterans have shown in reintegration services when they draft their treatment plans (Sayer et al., 2010). Including veterans in civilian treatment contexts may help them reconnect with their families and communities.

Finally, increasing research into the effectiveness of strength-based treatment models and interventions (e.g., models that facilitate PTG rather than treating posttraumatic stress) would increase the acceptance and availability of wellness-based interventions for veterans. We believe that refocusing on the wellness model will not only help counselors to build on their therapeutic strengths but also provide needed supplemental interventions and enable clients to benefit from multidisciplinary treatment.

REFERENCES

Abrams, T. E., Lund, B. C., Bernardy, N. C., & Friedman, M. J. (2013). Aligning clinical practice to PTSD treatment guidelines: Medication prescribing by provider type. *Psychiatric Services, 64*, 142–148. doi:10.1176/appi.ps.201200217

American Counseling Association. (2014). *ACA code of ethics*. American Counseling Association. Alexandria, VA: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Back, S. E., Killeen, T. K., Teer, A. P., Hartwell, E. E., Federline, A., Beylotte, F., & Cox, E. (2014). Substance use disorders and PTSD: An exploratory study of treatment preferences among military veterans. *Addictive behaviors*, 39, 369–373. doi:10.1016/j.addbeh.2013.09.017

Baiocchi, D. (2013). *Measuring Army deployments to Iraq and Afghanistan*. Retrieved from http://www.rand.org/pubs/research_reports/RR145

Beder, J., Coe, R., & Sommer, D. (2011). Women and men who have served in Afghanistan/Iraq: Coming home. *Social Work in Health Care*, 50, 515–526. doi:10.1080/00981389.2011.554279

Beecher, B. (2009). The medical model, mental health practitioners, and individuals with schizophrenia and their families. *Journal of Social Work Practice*, 23, 9–20. doi: 10.1080/02650530902723282

Boysen, G. A., Vogel, D. L., Madon, S., & Wester, S. R. (2006). Mental health stereotypes about gay men. *Sex Roles*, 54, 69–82. doi:10.1007/s11199-006-8870-0

Caplan, P. J. (2011). *When Johnny and Jane come marching home: How all of us can help veterans*. Cambridge, MA: The MIT Press.

Chartrand, M. M., Frank, D. A., White, L. F., & Shope, T. R. (2008). Effect of parents' wartime deployment on the behavior of young children in military families. *Archives of Pediatric and Adolescent Medicine, 162*, 1009–1014. doi:10.100/archpedi.162.11.1009

Eaton, K. A., Hodge, C. W., Messer, S. C., Whitt, A. A., Cabrera, O. A., McGurk, D.,…Castro, C. A. (2008). Prevalence of mental health problems, treatment need, and barriers to care among primary care-seeking spouses of military service members involved in Iraq and Afghanistan deployments. *Military Medicine, 173*, 1051–1056. Retrieved from http://0-web.a.ebscohost.com.lib.utep.edu/ehost/detail/detail?vid=7&sid=a2f2f2ac-6388-438e-af36-c638df4da4f2%40sessionmgr4002&hid=4212&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#db=a9h&AN=35522589

Elbogen, E. B., Johnson, S. C., Wagner, H. R., Newton, V. M., & Beckham, J. C. (2012). Financial well-being and postdeployment adjustment among Iraq and Afghanistan war veterans. *Military Medicine, 177*, 669–675. Retrieved from http://0-web.a.ebscohost.com.lib.utep.edu/ehost/detail/detail?vid=11&sid=a2f2f2ac-6388-438e-af36-c638df4da4f2%40sessionmgr4002&hid=4212&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#db=a9h&AN=76561647

Ginter, E. J. (2005). Wellness research: An agenda for the future. In J. E. Myers & T. J. Sweeney (Eds.), *Counseling for wellnesss: Theory, research, and practice* (pp. 151–165). Alexandria, VA: American Counseling Association.

Golub, A., & Bennett, A. S. (2014). Substance use over the military–veteran life course: An analysis of a sample of OEF/OIF veterans returning to low-income predominately minority communities. *Addictive Behaviors, 39*, 449–454. doi: 10.1016/j.addbeh.2013.06.020

Helms, Janet E.; update edited by Ponterotto, Joseph G., Casas, J. Manuel, Suzuki, Lisa A. & Alexander, Charlene M. (1995). *Handbook of multicultural counseling* (pp. 181–198). Thousand Oaks, CA: Sage Publications, Inc.

Hinojosa, R., & Hinojosa, M. S. (2011). Using military friendships to optimize postdeployment reintegration for male Operation Iraqi Freedom/Operation Enduring Freedom veterans. *Journal of Rehabilitation Research & Development, 48*, 1145–1158. doi:10.1682/JRRD.2010.08.0151

Iraq and Afghanistan Veterans of America. (2014). *2014 IAVA member survey: Perceptions and views from Iraq and Afghanistan combat veterans on the challenges and successes of the new greatest generation of veterans.* Retrieved from http://iava.org/survey/

Jakupcak, M., Hoerster, K. D., Blais, R. K., Malte, C. A., Hunt, S., & Seal, K. (2013). Readiness for change predicts VA mental healthcare utilization among Iraq and Afghanistan war veterans. *Journal of Traumatic Stress, 26*, 165–168. doi:10.1002/jts.21768

Joseph, S., Murphy, D., & Regel, S. (2012). An affective-cognitive processing model of post-traumatic growth. *Clinical Psychology and Psychotherapy, 19*, 316–325. doi:10.1002/cpp.1798

Kip, K. E., Rosenzweig, L., Hernandez, D. F., Shuman, A., Sullivan, K. L., Long, C. J.,…Diamond, D. M. (2013). Randomized controlled trial of accelerated resolution therapy (ART) for symptoms of combat-related post-traumatic stress disorder (PTSD). *Military Medicine, 178*, 1298–1309. doi:10.7205.MILMED-D-13-00298

Lande, G. R., Williams, L. B., Francis, J. L., Gragnani, C., & Morin, M. L. (2011). Characteristics and effectiveness of an intensive military outpatient treatment program for PTSD. *Journal of Aggression, Maltreatment & Trauma, 20*, 530–538. doi:10.1080/10926771.2011.588149

LeardMann, C. A., Powell, T. M., Smith, T. C., Bell, M. R., Smith, B., Boyko, E. J.,...Hoge, C. W. (2013). Risk factors associated with suicide in current and former US military personnel. *JAMA*, 496–506. doi:10.1001/jama.2013.65164

Lemaire, C. M., & Graham, D. P. (2011). Factors associated with suicidal ideation in OEF/OIF veterans. *Journal of Affective Disorders, 130*, 231–238. doi:10.1016/j.jad.2010.10.021

Lester, P., Peterson, K., Reeves, J., Knauss, L., Glover, D., Mogil, C.,...Beardslee, W. (2010). The long war and parental combat deployment: Effects on military children and at-home spouses. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*, 310–320. doi:10.1097/00004583-201004000-00006

Lovell, J., & Ehrlich, A. (2000). Effects of managed mental health care on attitudes of psychotherapists about their work, their clients, and the future of psychotherapy. *Critical Strategies: Psychotherapy in Managed Care, 1*, 135–157. Retrieved from http://0-web.a.ebscohost.com.lib.utep.edu/ehost/detail/detail?vid=15&sid=a2f2f2ac-6388-438e-af36-c638df4da4f2%40sessionmgr4002&hid=4212&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#db=a9h&AN=28018993

Lundberg, N., Bennett, J., & Smith, S. (2011). Outcomes of adaptive sports and recreation participation among veterans returning from combat with acquired disability. *Therapeutic Recreation Journal, 45*, 105–120. Retrieved from http://www.va.gov/adaptivesports/docs/lundberg_final.pdf

Maguen, S., Luxton, D. D., Skopp, N. A., Gahm, G. A., Reger, M. A., Metzler, T. J., & Marmar, C. R. (2011). Killing in combat, mental health symptoms, and suicidal ideation in Iraq war veterans. *Journal of Anxiety Disorders, 25*, 563–567. doi:10.1016/j.janxdis.2011.01.003

Miller, G. (2010). *Learning the language of addiction counseling* (3rd ed.). Hoboken, NJ: John Wiley and Sons.

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The Wheel of Wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78*, 251–266. doi:10.1002/j.1556-6676.2000.tb01906.x

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling and Development, 86*, 482–493. doi:10.1002/j.1556-6678.2008.tb00536.x

Pietrzak, R. H., & Cook, J. M. (2013). Psychological resilience in older U.S. veterans: Results from the National Health and Resilience in Veterans Study. *Depression and Anxiety, 30*, 432–443. doi:10.1002/da.22083.

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Psychological resilience and postdeployment social support protect against traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. *Depression and Anxiety, 26*, 745–751. doi:10.1002/da.20558

Sayer, N., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services, 61*, 589–597. doi:10.1176/appi.ps.61.6.589

Seal, K. H., Shi, Y., Cohen, G., Cohen, B. E., Maguen, S., Krebs, E. E., & Neylan, T. C. (2012). Association of mental health disorders with prescription opioids and high-risk opioid use in US veterans of Iraq and Afghanistan. *JAMA. 307*, 940–947. doi:10.1001/jama.2012.234

Seligman, L., & Reichenberg L.W. (2014). *Theories of counseling and psychotherapy: Systems, strategies, and skills*. Upper Saddle River, NJ: Pearson Education Inc.

Smith, L., Foley, P. F., & Chaney, M. P. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling and Development, 86*, 303–309. doi:10.1002/j.1556-6678.2008.tb00513.x

Sporner, M. L., Fitzgerald, S. G., Dicianno, B. E., Collins, D., Teodorski, E., Pasquina, P. F., & Cooper, R. A. (2009). Psychosocial impact of participation in the National Veteran's Wheelchair Games and Winter Sports Clinic. *Disability and Rehabilitation, 31*, 410–418. doi:10.1080/09638280802030923

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477–486. Retrieved from http://0-web.a.ebscohost.com.lib.utep.edu/ehost/detail/detail?vid=25&sid=a2f2f2ac-6388-438e-af36-c638df4da4f2%40sessionmgr4002&hid=4212&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#db=a9h&AN=9206290424

Taylor, J. G., & Baker, S. B. (2007). Psychosocial and moral development of PTSD-diagnosed combat veterans. *Journal of Counseling and Development, 85*, 364–369. Retrieved from http://0-web.a.ebscohost.com.lib.utep.edu/ehost/detail/detail?vid=32&sid=a2f2f2ac-6388-438e-af36-c638df4da4f2%40sessionmgr4002&hid=4212&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#db=a9h&AN=25930256

Tedeschi, R. G., & Calhoun, L. T. (1996). The post-traumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455–471. doi:10.1002/jts.2490090305

Tedeschi, R. G., & Calhoun, L. T. (2004). Post-traumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1–18. doi:10.1207/s15327965pli1501_01

Tedeschi, R. G., & McNally, R. J. (2011). Can we facilitate posttraumatic growth in combat veterans? *American Psychologist, 66*, 19–24. doi:10.1037/a0021896

Torreon, B. S. (2012). U.S. periods of war and dates of current conflicts. Congressional Research Service, Library of Congress. URL: http://fas.org/sgp/crs/natsec/RS21405.pdf

United States Department of Veterans Affairs and the Department of Defense. (2010). *VA/DoD clinical practice guidelines for management of post-traumatic stress.* Retrieved from http://www.healthquality.va.gov/guidelines/MH/ptsd/

United States Department of Veterans Affairs and the Department of Defense. (2014). *Mental Health.* Retrieved from http://www.mentalhealth.va.gov/

Weiss, E., Coll, J. E., & Metal, M. (2011). The influence of military culture and veteran worldviews on mental health treatment: Practice implications for combat veteran help-seeking and wellness. *The International Journal of Health, Wellness and Society, 1,* 75–86. Retrieved from http://0-web.a.ebscohost.com.lib.utep.edu/ehost/detail/detail?vid=37&sid=a2f2f2ac-6388-438e-af36-c638df4da4f2%40sessionmgr4002&hid=4212&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#db=a9h&AN=92985660