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A Phenomenological Examination Of The Civilian Mental Health Clinicians' Perceptions About Serving Military Members And Their Families

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A PHENOMENOLOGICAL EXAMINATION OF THE CIVILIAN
MENTAL HEALTH CLINICIANS' PERCEPTIONS ABOUT SERVING
MILITARY MEMBERS AND THEIR FAMILIES

by

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DEDICATION

Giving honor to the Guiding Light in my life, Lord Jesus Christ, I dedicate this work to our military service members of the United States and their families.

ACKNOWLEDGEMENTS

I am fortunate to have the love of my life, my husband Chuck Gordon, who provided total and unwavering support for this latest academic adventure. To my children, Cynthia and Eddie who kept me on my toes in more ways I can say, I thank you. To my parents, Eddie and Albertha, a very appreciative thanks for instilling the importance of education from the very beginning. I know Eddie Smalls is looking down as he nods and smiles, from his heavenly home. I am most grateful to my sister, Ramona Chisolm, who patiently placed a roving eye on this manuscript. To my most, best friend, Syndia Moultrie who endured hearing about the current chapter and cheered the coming of the next one, I thank you.

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ABSTRACT

This study utilizes qualitative inquiry to examine the perceptions of nine civilian mental health clinicians. The goal of this study is to answer the primary question: How do civilian mental health clinicians perceive working with the military population? The three sub questions that further direct this study are: (a) how do the clinicians describe their perceptions of their knowledge base to work with the military, (b) how do the clinicians describe their attitudes and beliefs about this special population, and (c) how do the clinicians describe their understanding about the world view of the military population? To answer these research questions, semi-structured interviews were conducted and analyzed using phenomenological methodology. The results are presented along with implications for counselor educators, supervisors, and clinicians.

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CHAPTER 1

Background of the Problem

According to Wilson (2008), culture is defined as the values, norms, and assumptions that influence human action and military culture is defined as a specific institutional culture with norms that service members adhere to (Wilson, 2008); there is a tradition of its combat, masculine-warrior framework (Dunivin, 1994). For example, the Army has its own language, manners, norms and belief systems (Reger, Etherage, Reger and Gahm, 2008).

Service members and their families experience an everyday lifestyle that is different from civilian life, such as the effect of deployment on the service member and the family (Lincoln, Swith & Shorteno-Fraser, 2008; Hall, 2011). Military service is considered to be more than an occupation, but the development of skills and values that differ from that of civilian life; it creates a force that is mission ready by incorporating structure, discipline and constant training (Redmond, Wilcox, Campbell, Kim, Finney, Barr and Hassan, 2015).

The importance of culture is recognized in the multicultural competencies which was developed by Sue, Arredondo and McDavis (1992) and later approved by the Association of Multicultural Counseling and Development (Sue, Arredondo and McDavis, 1992, Sue, 2008). The multicultural competencies provide guidance for working with different cultures by covering three dimensions; (a) attitudes and beliefs,

(b) knowledge, and (c) skills (Sue, Bernier, Durran, Feinberg, Pederson, Smith and Vasquez- Nuttall, 1982; Sue, Arredondo and McDavis, 1992).

While cultural competence has historically been applied to racial and ethnic minorities, it has its importance within the ethical treatment of military members (Reger, et. al, 2008). The experiences of the service members and their families need to be understood in the context of the military culture (Fennel 2008, Lincoln, Swift & Shorteno-Fraser, 2008, Demers 2011). There are a number of cultural factors that need to be considered in the psychological assessment and treatment of military personnel such as, use of acronyms, the rank system, behavioral expectations and belief systems (Reger et. al, 2008; Hall, 2008). Mental health clinicians would need to be educated on the military culture so that assessment and treatment measures are layered with cultural understanding and sensitivity (Coll, Weiss & Yarvis, 2011; Holmstrom, 2013), which would enable understanding their worldview, attitude and the traditions of the military (Hall, 2008), while recognizing the unique skills and strengths of this population (Wilson 2008, Redmond, et. al, 2015). The importance of recognizing the culture of a group has become increasingly important. The most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (2013) highlights the need to give emphasis to one's culture in assessing diagnostic criteria.

As veterans return from the Middle East conflict in their efforts for Operation Enduring Freedom and Operation Iraqi Freedom, they often present not only physical symptoms, but also psychological concerns (Batten & Pollack, 2008). They are likely to need mental health treatment from community-based mental health clinicians (Burman,

Meredith, Tanielian and Jaycox, 2009; Luby 2012), additionally, working in conflict zones may result in posttraumatic stress disorder (PTSD) (Black & Collier, 2014).

An Interagency Task Force on Military and Veterans Health (2013) identified several goals to ensure active and veteran military members, along with their families, received any needed mental health services and supports. Among the goals were efforts focused on enhancing access to mental health not only with the Veterans Affairs system, but also among community providers. It is realized that no one organization can entirely meet all of the needs of the military population and so it is critical that community-based services are considered and available (Savitsky, Illingworth, and DuLaney, 2009; Burnam, Meredith, Tanielan and Jaycox, 2009). With consideration for the multicultural competencies (Sue, Arredondo and McDavis, 1992) and the American Counseling Association Code of Ethics (2014), mental health clinicians and other healthcare providers have a responsibility to serve military members and their families in a competent manner (Davis, Blaschke, and Strafford, 2010; Savitsky, Illingworth and DuLaney, 2009).

Statement of the Problem

There has been continuing efforts by organizations and governmental agencies to focus on access to mental health care for service members and their families (Eaton, Hoge, Messer, Whitt, Cabrera, McGurk, Cox and Castro, 2008; Bowling & Sherman, 2008; Kudler & Porter, 2013), in particular service members and their families who suffer from the negative consequences of war (Burman, Meredith, Tanielian and Jaycox, 2009; Bowling & Sherman, 2008; Spera, 2009; Gorman, Blow, Ames, & Reed, 2011; Padden, Connors & Agazio, 2011; Lara-Cinisomo; Knobloch, & Theiss, 2012; Chandra,

Burns & Lau, 2013). Focus has also been given to identifying community mental health clinicians and their availability to provide counseling to service members and their families (Savitsky, Illingworth and DuLaney, 2009; Dickstein, Vogt, Handa and Litz, 2010; Koblinsky, Leslie, & Cook, 2014; 2014; Miller, Finn, and Newman, Smith, 2014), especially as the realignments of military bases and base closures have increased the need for civilian-based services (Luby, 2012) and the need to improve community-based care (Burman et al, 2009). According to Meyer (2015), the importance of understanding the culture of the military is often overlooked, thus, it would impact the clinician's ability to work effectively with the military population (Hall, 2011; Black & Collier, 2014).

There are nuanced factors in understanding the culture of the military.

Manderscheid (2007) compared the conflict in the Middle East to past wars and noted the differences and how this may result in needs that vary for veterans from other wars. Mental health clinicians who realize this cultural awareness may find that they are in a crucial role for the readjustment process as they establish a therapeutic alliance and provide support (Koenig, et. al, 2014).

While there are efforts to note that mental health clinicians will need to receive training to work with the military, there has not been a focus on the clinicians' perceptions about working with service members and their families. Increasing the knowledge base about any existing barriers from the standpoint of the clinician is important and will provide information that will be helpful as training programs are developed and clinicians prepare to work with the military population.

The focus of this phenomenological study is to explore the perceptions of mental health clinicians about serving the military population. Utilizing the framework of the

multicultural competencies, this study will focus on the mental health clinician's cultural competence about working with the military population.

Purpose of the Study

The purpose of this study is to investigate the mental health clinicians' perceptions about working with the military population.

Research Questions

The primary research question is "How do mental health clinicians perceive working with the military population?" There are other sub questions that further direct this study, (a) how do the clinicians perceive their knowledge base to work with the military, (b) how do the clinicians perceive their attitudes and beliefs about this special population, and (c) how do the mental health clinicians perceive their understanding about the world view of the military population?

These questions guide the research to gain an understanding of how the clinicians evaluate their capacity to serve the military population. Several studies (Kilpatrick, Best, Smith, Kudler, & Cornelison-Grant, 2011; Gonzalez, 2014; Hickerson, 2014; Koblinsky, Leslie, & Cook, 2014; Miller, Finn & Newman, 2014; Smith-Osborne, 2015) have elucidated the need for mental health clinicians in the community to have an awareness about working with the military population. It is recognized that the clinician needs to understand the military culture so that assessment and treatment measures are applied with consideration for the military context (Coll, Weiss, & Yarvis, 2011; Holmstrom, 2013). The need for clinicians to be informed by the military culture is further advanced by the emphasis on training. Study after study (Eaton, et al, 2008; Demers, 2011; Kilpatrick et al, 2011; Stewart, 2012; Koblinsky, Leslie, & Cook, 2014) reports the need

for training with some specifically addressing challenges that reflect the military population. Research that addresses the clinicians' needs may prove especially helpful to train the mental health clinicians and includes the counselor –in-training in their preparation to work with the military population. A more detailed discussion will be provided in chapter three regarding the further investigation of these research questions.

Conceptual Framework

The purpose of this phenomenological study is to explore the civilian mental health clinicians' perceptions about serving military members and their families in hopes that themes, meanings, and essences are determined from their experiences (Moustakas, 1994). According to Moustakas (1994), the goal of a phenomenological approach is to determine the meaning of an experience from the persons having the experience, thus allowing for the gathering of individual descriptions from which general or universal meanings are gleaned leading to a path of understanding that is reflected in the essences or structures of the experience. Moustakas (1994) characterizes phenomenological research as, "The understanding of meaningful concrete relations implicit in the original description of experience in the context of a particular situation is the primary target of phenomenological knowledge" (Moustakas, 1994, p. 14).

The methodology employed in the phenomenological approach utilizes interviews with the participants as a source of data collection; it is through the informal, but interactive process of the interview, which incorporates open-ended comments and questions that information is sought (Moustakas, 1994). With the phenomenological method, information can be gathered about how human beings make sense of experiences and process it through their consciousness; thus to capture this data requires a

meticulously fashioned method through in-depth interviews with people who have experienced the phenomenon (Patton, 2001). The phenomenological inquiry focuses on the lived experiences of human beings and makes use of their subjective experiences (Patton, 2001).

Assumptions, Scope, Limitations, and Delimitations

Assumptions

Grinnell and Unrau (2011) assert that nothing is absolute and knowledge is attained by making observations and by deriving assumptions from what is observed. There are two assumptions that I acknowledge with this study. The first assumption is that the civilian mental health clinicians have either the experience of working with the military population or have some notion about the military population. The second assumption is that, within the in-depth interview, they would be able to provide information from their experiences or ideas about working with the military population.

Scope

This study focuses on civilian mental health clinicians in the Upstate region of South Carolina who are in private practice.

Limitations

There are several limitations recognized in this study. The research relies on the skills of the researcher and is subject to biases and idiosyncrasies present (Grinnell & Unrau, 2011). This will be discussed further in chapter three when the role of the researcher is presented. While the semi-interviews produce a rich data, volumes of data will result which can cause data analysis and interpretation to be time consuming (Grinnell & Unrau, 2011). The researcher's presence during the data collection can also

be a factor and affect the responses of the participants and due to this qualitative research design; it would be unavoidable (Maxwell, 2013). Finally, although measures are taken to maintain confidentiality and anonymity, this may also be challenged when findings are presented (Grinnell & Unrau, 2011).

Delimitations

There are two main delimitations within this study. First, this study is delimited to civilian mental health clinicians currently working in private practice within the community setting. Secondly, this study is delimited to mental health clinicians who are licensed as professional counselors, marriage and family therapists or independent social workers. These delimitations provide a focus to meet the goals of this research.

Significance of the Study

Knowledge Generated

As efforts continue to identify and prepare community mental health clinicians to work with the military population, the clinicians' perceptions will be another layer of information to consider. This research is needed to gain additional information regarding the clinician's perception about working with the military. The significance is realized in that the clinician may have concerns about their preparation to serve the military population despite being identified as a community resource for the service members and their families. As the community mental health clinicians acknowledge their lack of preparation to work with the military population, more concentrated efforts can be targeted to meet the needs of the clinicians.

On another level, the knowledge generated from this study may have significance for counselors-in-training, specifically students in counseling programs. This could have

new meaning for multicultural courses as the military population becomes a focal point of interest with the goals of preparing students to later work with service members and their families.

Professional Application

Beyond training, to present mental health clinicians with a readiness to serve the military population, expertise in the subject matter of the military culture can be another level of attainment. This would translate into training others to prepare to work within the military population.

To further the academic emphasis, beyond inclusion of the military as a unique culture in multicultural classes or family studies, another level would be the designation of ‘understanding the military culture’ as a course. This would also lend itself to continued research about the military lifestyle.

Social Change

Perhaps foremost in the order of the social change is the consideration of the military as a social group instead of a military organization. The former lends itself to more humanistic qualities than the latter, with needs and considerations as any other group. In recent years, the military has been a source of social change with its repeal of the “don’t ask, don’t tell” policy. The military could be a fertile ground for other courses of social change.

Operational Definition of Terms

Service member includes all of the branches of the military as it would be inappropriate, for example, to refer to a member of the US Navy as a soldier and a soldier

as a sailor. Use of the term ‘service’ denoting military service member is a more inclusive term.

Mental health clinicians in this study refers to licensed professional counselors and licensed marriage and family therapists, thus the licensed practitioners who are licensed by the regulating agency in South Carolina which is the South Carolina Labor, Licensing and Regulation Board.

Pre-deployment refers to the time period before the service member is deployed to another country in support of national conflict or the overall mission of the military.

Post deployment refers to the time period following the service member’s return from overseas duty.

Re-integration refers to a period of time following a service member’s return from deployment status which is considered a phase of the deployment cycle with identifiable emotional characteristics (Hall, 2011).

TRICARE refers to the health care program designated for the United States Department of Defense Military System (Blaisure, Saathoff-Wells, Pereira, Wadsworth & Dombro, 2012).

Summary

Key Points

The research about mental health clinicians in the community has given much focus to meeting the training needs of clinicians to work with the military population. The literature, however, has not addressed the clinicians’ perceptions about working with the military. An investigation about the concerns of the clinician will add to the training considerations for clinicians and allow an opportunity to meet their perceived needs.

This study proposes that input from the clinician should be included to adequately develop training programs for the clinician.

CHAPTER 2

Review of the Literature

Introduction

This review of the literature and related research presents findings about mental health clinicians and their hypothetical or actual involvement working with the military culture. The literature review includes both theoretical and research articles as well as recently published books that have comprehensively covered the topics of mental health and the military.

The organization of the review begins with recognizing the cultural competencies that was first introduced by Sue, et al. (1992) and later adopted by the American Counseling Association. A presentation of literature follows that outlines how the military is a unique culture.

Counselor competence is then discussed especially as it relates to cultural awareness, then moving toward the notion of cultural competence along with highlighting cultural sensitivity and cultural humility.

Cultural competence, specifically for the military culture is emphasized. Literature is presented that focuses on the particular challenges of military service members and their families. Consideration is also given to the veterans as they reintegrate into the civilian setting. Studies will be presented that give particular focus to the cultural competence of community healthcare professionals; mental health clinicians

are a particular focus. Overall, cultural and ethical considerations are presented about working with military personnel and veterans.

The strategy used in gathering the literature for this study was largely the use of search engines such as google scholar, online journals, Springerlink and Pubmed, utilizing the key words: military culture, military families, military mental health, mental health clinician and cultural competence. The use of search engines also included cross-disciplinary searches, key authors in the field and literature reviews of dissertations. Government sources were also identified through the use of search engines for example, the Department of Defense and the Rand Corporation. Books covering the military culture were located through google scholar and by reviewing the references of articles. The sources most used were google scholar and reviewing references from the literature. The year parameters for research and theoretical articles and books were 1992 to 2016.

Themes and Perceptions Explored

The review of the literature addresses the military as a cultural group recognizing through the various sources that they function differently than the civilian world. The military is established, through the literature (Dunivin, 1994; Burrell et al, 2006; Fennell, 2008; Wilson, 2008; Coll et al, 2010; Hall, 2011; Blaisure et al, 2012; Cole, 2014; Forgery & Young, 2014; Redmond, 2015) as a cultural group and the multicultural competence standards are implied. Of the three broad categories from the standards, emphasis in the research is given towards knowledge and often depicted as training for the community mental health clinicians.

The notion of counselor competence is explored as differing theoretical and research articles assert the notion of cultural competence. This importance is stated

repeatedly in that assessment and treatment measures in mental health would need to be layered with cultural considerations to be effective with the military population. The literature is not clear as to what is actually meant by competence. Is it merely the function of completing a training session? Does the counselor provide feedback regarding cultural competence or identify barriers to attaining cultural competence? The questions aforementioned are important, considering that the need for community clinicians is well established in the literature, especially as veterans and family members may not be proximal to a military base and will rely on community resources.

Cultural Competency

Perhaps a changing direction in the counseling field was a 1982 position paper wherein the notion of the need for cross cultural counseling was highlighted identifying three broad characteristics of the culturally skilled counseling psychologist (Sue, Bernier, Durran, Feinberg, Pedersen, Smith and Vasquez-Nuttall, 1982). The three characteristics included beliefs and attitudes, knowledge, and skills which extended consideration not only for the client in the three identified areas, but also for the counselor as well. For example, the position paper identified that the culturally skilled counseling psychologist has knowledge about the particular group they are working with to the extent that there is an awareness of the counselor's own cultural values and biases, knowledge of the client's worldviews and intervention and strategies to incorporate the cultural knowledge. Sue et al. (1982) primarily focused on four groups in our society; African Americans, American Indians, Asian Americans and Hispanics and Latinos. They also gave relevance to other oppressed groups such as women, gays and lesbians and other special populations.

Ten years later, Sue, Arredondo and McDavis (1992) had dual publications in the *Journal of Multicultural Counseling and Development* and the *Journal of Counseling and Development* encouraging the adoption of 31 multicultural counseling competencies which defined and outlined the importance of a culturally competent counselor. Notably, the authors emphasized the importance of multiculturalism inclusive of all persons and groups for which lack of consideration would be a denial of social reality. Additionally, Sue (2008) asserted that to truly value and support cultural diversity, aim must be taken to remove barriers within organizations. Sue (2008) also emphasizes the point that to know oneself as a racial and cultural being aids in understanding barriers that may be present for change to occur, therein lies an awareness of cultural values, biases and assumptions that shapes one's worldview.

The adoption of the multicultural counseling competencies is demonstrative of an ethical practice and cultural responsiveness (Arrendo & Toporek, 2004) as there is a need in a pluralistic society to implement best practices to effectively work with clients (Coleman, 2004). The case for cultural competency in psychotherapy is clear, as the cultural competency practices are adopted in the mental health field; it affords the opportunity for positive benefits in intervention outcomes (Sue, Zane, Hall, & Berger, 2009).

Cultural Sensitivity

Fowers and Davidov (2006) extrapolated from the multicultural competencies a major principle. Overall the competencies reflect having an openness to another which is beyond knowledge about another's culture, but challenges one's own self-awareness and

culture biases, thereby leading to actions that have an essence of cultural sensitivity towards others.

Cultural sensitivity is regarded as a distinct perceptual process, the ability of the counselors to extend the notion of multicultural counseling by acquiring, developing and putting into use an accurate cultural perceptual schema (Ridley, Mendoza, Kanitz, Angermeier & Zenk, 1994). Three steps are proposed by the aforementioned authors to achieve the cultural perceptual schema: counselors are attuned to cultural stimuli that reflect the perceptual schema; information is organized so that cultural variables are understood, and the information is then organized in a schema that has a cultural relevance for treatment goals and interventions.

Cultural Humility

Tervalon and Murray-Garcia (1998) further expounded on the notion of cultural competence by introducing cultural humility, a continuing process where one makes a life-long commitment towards self-evaluation and self-critique. The goal of cultural humility, as addressed by the aforementioned authors, began in the medical field which allowed for reforming of the power imbalances between the doctor and patient. Tervalon and Murray-Garcia (1998) noted, from the literature, that when cultural competence is lacking, the reason is not due to lack of knowledge, but instead a recognized need for change from the practitioners in regard to their own self-awareness thereby changing their attitudes to effectively work with diverse patients. The suggestion is clear from these authors, cultural humility differs from cultural competence; there is an emphasis on self-humility that fosters mutual respect in the client-professional relationships.

Hook, Owen, Davis, Owen, Worthington, and Utsey (2013), furthered the point of openness relating it to the concept of culture humility. The study examined the importance of cultural humility and whether cultural humility was rated more important than other multicultural competencies, such as knowledge and skills, when one is seeking a prospective therapist. They first conducted a pilot study reasoning that it allowed for collecting evidence as to whether the students would perceive any importance to the notion of cultural humility. The participants for this study included 117 college students ranging in age from 18 to 52 years old. They consisted of 31 males, 84 females and 2 identified as other. The participants were asked to identify the aspect of their cultural background that is most dominant for them and rate its importance. They were then asked to imagine being in a session with a therapist and given four different scenarios which paired low or high humility with low or high knowledge. The participants rated the confidence level they would anticipate in the scenarios and whether they would continue with the therapist.

The results indicated that the participants varied in identifying a dominant cultural aspect of themselves such as race, nationality, gender, sexual orientation, religion, socioeconomic status, language, family and other. The greatest designation was found for race, language and other. The hypothesis stated by the researchers was supported in the results which indicated participants attributed an importance to cultural humility and it was more important than other therapist characteristics reflected in the multicultural counseling competencies such as knowledge, skills, experience and similarity.

Guided by an ethical force, multiculturalism has been a movement within the field of psychology with a theme of inclusion, social justice and mutual respect (Fowers &

Davidov, 2006). Foremost, it allows for effective counseling as strategies are developed with consideration for the cultural background of the client (Marbley, Steele, & McAuliffe, 2011). As cultural diversity increases in the United States, the importance of achieving appropriate levels of competence to work with culturally diverse populations remains increasingly important (Constantine, Hage, Kindaichi & Bryant, 2007).

The relevance of viewing an individual or group through the lens of their culture has become increasingly important. To this end, the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (2013) recognizes the importance of culture in the assessment and treatment of disorders in that one's culture should be considered as diagnoses are assigned and treatment plans are developed. The realization of this importance is, however, often overlooked in the military (Meyer, 2015), which inhibits the ability to work effectively with military service members and their families to provide effective services (Tanielian, Faris, Batka, Farmer, Robinson, Engel, Robbins, & Jaycox, 2014a; Hall, 2011).

The Military as a Culture

The various branches of the military, which consists of the Air Force, Army, Marines, Navy, their respective reserve components, the National Guard and Coast Guard, is composed of various ethnic and racial groups, but all subscribe to defend the Constitution of the United States, adhere to the Military Code of Conduct and the Uniform Code of Military Justice (Fennell 2008). This diverse group of people in our society function under the military system that is uniquely different from the civilian world (Hall, 2011); the military is a specific institutional culture with norms that the

military members subscribe to (Fennell, 2008), thus governed by rules and regulations (Eaton et al, 2008).

The military environment subscribes to a unique way of life and fits the definition of culture; the traditions and values are shared by its members; they adapt to changing trends and utilize symbolism and language within a military context (Dunivin, 1994; Demers, 2011). Within this culture are deeply set values of strength and psychological resilience which are viewed as necessary for the survival of the forces (Reynolds & Osterlund, 2011). If service members are seen from this perspective, a level of understanding can be gained about how they interact with society (Wilson, 2008).

The Military Lifestyle

The military culture is regarded as an influential one in that their indoctrination creates both a belief system and values that differs from the civilian world (Coll, Weiss, & Yarvis, 2011). Military families withstand many challenges as they cope with the demands and stressors of the military culture (Allen, Rhoades, Stanley, & Markman, 2010), and endure unique stressors that directly affects each family member in differing ways (Hall 2008; Blaisure et al, 2012; Gleeson & Hemmer, 2014). For example, service members work and live in conditions where they may be isolated on a military base and, if serving overseas, in a foreign residence (Burrell, Adams, Durand & Castro 2006; Hoshman & Hoshman, 2007). Adding to the complex military lifestyle is the priority of the mission along with a constant regard for secrecy and commitment to sustain the mission (Hall, 2008). There is the additional pervasive concern involving risk of injury and death, especially during wartime (Drummet, et. al., 2003; Hall, 2008; Blaisure et. al., 2012).

The military spouse also is challenged with frequent relocations (Burrell et al, 2006; Blaissure, et al, 2012) as it poses barriers to completing post-secondary education goals and establishing a career (Hall, 2008). Relocations are a cyclical process as there is the anticipation of the move, which ends months after the actual move, and is re-experienced with the next expected permanent change of station (MacDermid, Weiss, Green, & Schwarz, 2007). The spouse must also endure separation from the service member and may live a great distance from their hometown (Hall, 2008). Additionally, the spouse also endures the pervasive concern about the service member's risk of injury or death (Allen et al, 2010, Burrell et al, 2006).

Children of military personnel are impacted by the military lifestyle. A report compiled by the Office of the Deputy Under Secretary of Defense [DUSD] (2011) indicated that almost 2 million children in the United States have at least one parent in the active or reserve military. Deployment of the service member is particularly stressful on children, especially young children who depend on their parents as a central figure which becomes increasingly difficult when both parents are members of the military (Osofsky & Chartrand, 2013).

The Needs of the Military Population

It has become increasingly important for communities to be prepared for the eventuality of service members and veterans to receive services. According to Luby (2012), the realignments of military bases and base closures have resulted in an increased need for civilian-based services, thus creating the need for culturally competent providers in communities as well as on military bases. Luby (2012) highlights the need for

communities to intensify behavioral health and social support services and provides a framework that addresses military culture awareness and building community services.

An Interagency Task Force on Military and Veterans Mental Health 2013 Annual Report, which consist of the Department of Defense, Department of Veterans Affairs and Department of Health and Human Services, identified initiatives to ensure that the military service members and their families receive the needed mental health services and support. It also encouraged partnering with communities to provide services to the military population. Cole (2014) included the school counselor as part of the community as the school counselors are likely to interact with the military population, specifically the children of military personnel and thus, must have the cultural competence to effectively work with military children.

Counselors who deem themselves as multicultural competent are characterizing their readiness and ability to work with clients who are from various cultural and ethnic backgrounds (Fennell, 2008; Hall, 2008;); it is a counseling approach that takes into account the context of the person's culture while adhering to the guidance as stipulated in the cultural competencies (Sue, et. al, 1982; Sue, et. al, 1992; Sue, 2008)

Research Studies on Cultural Competence Applied to the Mental Health Clinicians

Researchers (Frey, Collins, Pastoor & Linde, 2014) sought to understand if the needs of the military are recognized. They selected a random sample of 1,000 social workers from five states (Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia) for a total sample of 5,000. A 21.9% response rate was yielded which resulted in the completion of 1022 surveys from social workers working in various settings ranging from non-profit to private practice. Of note, was that 1.7 (17) worked for

the military or a military contractor. Their scope of practice included working with individuals, families, groups, organizations and neighborhoods or communities. Thirty-one percent of the sample indicated they accepted TRICARE, the health insurance administered by the military. The researchers noted that 12 months prior to the survey, 26.6% (272) of the participants indicated they had worked with service members or their families; 33.7% (344) reported working with retired service members and their families while 21.7% reported working with National Guard members or reservists and their family members.

The survey utilized in this study was developed by the researchers along with input from the University of Maryland (Baltimore), School of Social Work Supporting Returning Soldier's Initiative. It consisted of three major sections for which respondents were given a detailed list of specific needs and asked to rate the needs on a five point rating scale from 1 (not a problem) to 5 (an extreme problem). The list of needs was compiled from previous research on social work with the military, which also included collaboration from members involved with the Returning Soldiers Initiative. The survey included an open-ended question at the end of the survey for which the participants provided brief examples of how their work contributed to serving the military community.

The data from the survey items was analyzed using PASW 19 while the open-ended questions were analyzed using an open coding process to identify categories and themes from the social workers' responses. The results indicated that there were five domains identified from which the military community may experience need: mental and emotional health, physical health and wellness, social and environmental, interpersonal

and military specific. Additionally, they identified major mental illness, posttraumatic stress disorder, depression, anxiety and substance abuse as the primary problems found among service members and their families. They also noted the post deployment stage as the most critical time for these needs to be addressed.

While this study indicated some level of cultural awareness among the social workers in that they were able to recognize the needs of the military population, it only focused on being able to identify the needs and does not indicate whether the social workers perceived a sense of preparedness to work with the service members. It does, however, present a piece of the puzzle when considering the multicultural competencies, which supports the present study in that the cultural competencies are explored. Further, the present study would provide yet another piece of the puzzle as the qualitative inquiry would allow input from the civilian clinicians about their perceptions to work with the military.

Smith-Osborne (2015), focused on an intensive continuing education initiative which trained social workers for military social work practice. Specifically, she reviewed a continuing education course housed in the social work department to examine the outcomes with the participants. The participants for the study included a cohort of those who completed the first certificate in the program (N = 23) and others completing at least one certificate course from July 2011 to March 2013 for a total sample size of 268. The participants worked in various practice settings to include, private practice, agencies, public school and college settings, correctional facilities, medical centers and military settings. The data collection for this quasi-experimental, post-test-only design study involved an administrative record review to include a review of the department's standard

evaluation form that was completed at the end of each seminar. These reviews enabled an investigation of the use of the program along with learning outcomes.

The results indicated that community practitioners believe there is a need for the military and veteran certificate program. Participants involved in the military social work program indicated, via comments on the evaluation forms, that the courses aided their depth of understanding in a range of areas relevant to working with the military population. It was noted, however, that only 23% of the participants within the civilian agencies selected the military culture elective.

The author of this study suggests implementing a survey with civilian agency participants who did not select the course to gain an understanding for the reasons. There is a stated concern that the participants may not have realized the importance or relevance of the course especially as it relates to cultural competence. Further, the author questions whether the participants view the military as just another occupation and an assessment of their cultural competence may further aid in understanding their positions.

This research points to the importance of cultural competence from the perspective of the clinicians to the extent that it questions why some participants did not choose the military course elective. The questioning is further extended with consideration for plausible explanations as to why the course was not chosen, which shines a light on cultural competence. Seemingly, if there is not a regard to increase training in the area of military culture, the importance of cultural implications is not realized. As the present study utilizes a phenomenological approach, an opportunity is provided for a deeper understanding of how the mental clinician perceives working with the military.

Gonzalez's (2014) dissertation provided an analysis of the cultural competence of military healthcare professionals within a team setting, thus seeking to understand the extent to which military mental health care professionals demonstrate cultural competence given the cultural diversity that may exist within the military population. The target group for this comparative, quasi-experimental study consisted of 225 military and civilian members attending a leadership course. The instrument used to gather data was the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC-R). The results indicated that the participants involved in cultural competency training on average scored higher than those who were not involved in the training. Additionally, 40.9% of the participants were found to be operating at a cultural aware (cultural sensitivity) level while 63% of the participants were determined to be in the cultural desire category. The cultural desire category (motivated for cultural competence) was indicative of the need for more cultural training opportunities.

The author of this study (Gonzalez, 2014) determined that the implications point to the need for organizations to anticipate which cultural communities will need to be served and efforts then directed at developing the competence to serve them effectively.

This study was limited to a military setting and utilized quantitative measures to distinguish between those who were determined to be culturally aware versus cultural desire. Gonzalez (2014) brings forth the notion that cultural implications are of consideration within the military. While this study focused on the military setting and the cultural implications, the present study places emphasis on the civilian setting and the cultural implications with regard to the military. Further, as a qualitative inquiry there is

an opportunity to understand in greater depth the factors that may surround one's cultural awareness versus cultural desire.

Hickerson's (2014) dissertation took a dual approach collecting data from two categories of people so as to identify some of the mental health needs of military families along with determining the readiness of the civilian clinicians. Hickerson based research on the assumption that community providers for the military population may be unaware of their specific and unique needs. This qualitative action research approach with phenomenological and appreciative inquiry, involved ten military family members and five community clinicians. A focus group served as the method of data collection for the military family members and interviews for the clinicians. The research question for this study focused on discovering the needs of military families and whether the local clinicians were fully aware of the needs. A data matrix was utilized to group data into categories which facilitated identifying emerging themes.

The data from the study, clinical interviews and the focus group, was presented in themes and categories. From the clinical interviews, several trends were noted: clinicians were exposed to working with military families at various levels, those with the greatest exposure to military families presented lack of knowledge about the military culture as a major concern, and a reoccurring trend was the need for the community to understand the military culture. The focus group results indicated that some military family members noted the need for counseling to address a range of problems from marital issues to adjusting to civilian life post military service.

Hickerson (2014) notes two common themes emerging from this study were expressed by the military family members and the clinicians: the need for family

members to receive education about coping with mental health issues and general knowledge about the problems they encounter.

Although this research may provide interventions that are important for future research and action planning, a limitation in this study is that it focused on increasing knowledge without an emphasis on the cultural competency of the clinicians. The present study will allow for greater information to be sought utilizing the methodology of in-depth interviews to gather rich data.

Yet another dissertation (Stewart, 2012), addressed the development of military cultural competence with civilian clinicians as it relates to military personnel returning from conflicts with combat-related posttraumatic stress disorder (PTSD). The research question involved investigating the significance of military cultural competence among therapists treating combat veterans diagnosed with PTSD. The assumption posited by this researcher is that the military functions socially as a distinct cultural group and cultural competence with minority groups is the professional standard as derived from the work of Sue et al, (1992) in the development of the cultural competencies.

The research design employed a quantitative approach with a target population of 26 military veterans who either had experiences or beliefs related to homecoming, combat trauma and mental health treatment with civilian providers. Additionally, all of the veterans involved in the study self-reported as having experienced PTSD symptoms or was diagnosed with PTSD. The participants completed an online survey, The Combat Veterans Survey which included 59 items related to consent or referrals, demographics, themes about homecoming, military culture and treatment expectations. The items allowed for responses on a common rating scale and in a binary format. Two additional

instruments were utilized: a four item posttraumatic stress disorder survey to screen for PTSD and a four item survey to assess significant risks for suicidality.

The results indicated that the null hypothesis for this study should be rejected given this is a larger sampler number to substantiate such a finding. Specifically, the findings were that, 44% of the participants indicated a comfort about receiving services from a civilian provider; however, 72% preferred working with a military provider. Overwhelmingly, 88% indicated that civilian clinicians should have a familiarity with the military culture; 37% had a concern that civilian clinicians would not be able to understand their experiences as it relates to being in the military. Overall the findings indicated that military cultural competence has significance in relation to delivering effective mental health care to returning military personnel diagnosed with combat-related PTSD.

Stewart (2012) states that although the sample size was very small, it satisfied the goal of this research to expound on existing data as it relates to combat veterans' attitudes about mental illness and seeking treatment. Noting that this area of research has not given attention to the role of the clinician's cultural competence with the military population, the implication from Stewart (2012) is that a study such as this should consider gathering additional data regarding beliefs about illnesses and seeking treatment while contemplating the clinician's military orientation (identifying as military or non-military) and the level of military cultural competence.

Although this study gives attention to cultural competence, the target population were the military members. The notion of cultural competence for civilian clinicians is limited to what the military personnel perceive, especially given that 74% of the military

personnel prefer a military provider. There may be elements of cultural competence for the civilian providers that are better explained by the civilian providers. This study, however, points to the importance that military members have about the civilian providers possessing some knowledge about the military. It appears, however, that gaining information about cultural competence from the civilian counselors could prove crucial in developing curriculum and training material to further prepare civilian providers to work effectively with the military population. The present study facilitates an opportunity to gain information about cultural competence from the civilian mental health clinicians' perspective with in-depth interviews.

A 2011 report (Kilpatrick, Best, Smith, Kudler & Cornelison-Grant) based on a web survey of mental health and primary care professionals provided significant findings about the educational needs of health care providers who work with military members, veterans and their families. The project methodology was purposed to gather information from a large and diverse group of primary care and mental health care providers largely from the private sector. The primary methodology involved obtaining several lists of the mental and health care professionals and inviting them to participate in an online survey. Using a web-based survey, the professionals were invited to participate in a brief survey (approximately 10 minutes) that addressed the following topics: type of speciality/practice, acceptance of TRICARE insurance, prior or current service in the military, prior or current training at Veterans Affairs Medical Center, opinions about the quality of care provided by the Department of Defense and Veterans Affairs (VA) to include knowledge about the eligibility requirements, knowledge and confidence about best practice treatments for relevant conditions and the professionals' interest in training

topics and modalities. Additionally, the professionals had an opportunity to give open ended responses to questions regarding how they would determine the use of educational material and the types of training resources which may be helpful.

The survey findings were based on 319 (response rate = 97.6%) providers, who agreed to participate, from a total of 327 who accessed the survey. They consisted of mental health professionals (approximately two-thirds) with the remaining sample self-identified as primary care providers or other professionals. The most prevalent group among the mental health professionals were psychologists followed by psychiatrists, social workers and other mental health professionals. Of the primary care speciality, the most prevalent type was family medicine followed by pediatrics and internal medicine. More than half of the providers (59%) indicated that their practice accepted TRICARE insurance while 28% said they did not; 13% was unaware of their status regarding the acceptance or non-acceptance of TRICARE.

Very few (16%) professionals indicated having ever served in the Armed Forces, Reserves of National Guard, however, about one third (33%) related completing some of their training at a VA hospital; only 12% reported ever being employed as a health professional within the VA system. These results suggest that most of the providers did not have any direct experience with the military and further, they lacked training in working with the VA which could have paved a path to understanding about the military culture. Additionally, more than half (56%) of the community providers did not ask their patients about prior or present military service.

Key findings also included community professionals having less knowledge and confidence to treat PTSD, traumatic brain injury, substance abuse or dependence, but

greater ability in treating depression, suicide or issues related to family stress. Twenty-nine percent of the professionals indicated they were knowledgeable about referring a veteran for services at the VA; more than half indicated a desire to learn more about the eligibility requirements for the VA. Forty-eight percent of the professionals indicated they would readily refer a patient to the VA, 34% provided neutral responses regarding a tendency to refer to the VA. Overall, the professionals indicated a desire to learn more about becoming a TRICARE provider and ways to maximize and expedite services.

Implications and recommendations arising from this report indicated the need for a training focus that would include understanding the military culture and VA programs to include promoting efficient and sensitive ways to screen patients not only about their military service, but also available resources for the military members and their families.

While this study provided an informative glimpse of the community healthcare professionals and the gaps that are present in their knowledge about the military culture and resources, it did not provide a plausible rationale regarding the health professionals' lack of knowledge or confidence. It did not identify any barriers that would interfere with the clinicians acquiring knowledge about working with the military population. Gathering more in-depth information from the healthcare professionals with a qualitative approach, as the present study provides, may possibly have a greater impact on the design for curriculum and training material that will facilitate their military cultural competence.

A recent study published by the Rand Corporation (Tanielian, Farris, Epley, Farmer, Robinson, Engel, Robbins and Jaycox, 2014b) focused on community-based mental health civilian providers to determine their readiness to provide services to the military members and their families in a culturally competent manner. The research

questions for this study were, identifying key factors that reflect providing high quality mental health services to veterans and how successful is the need being met in the civilian sector. The sample for the study was obtained from existing panels of health care providers. Emails were sent inviting their participation in the study. A total of 522 mental health care professionals were recruited for the study which included 128 psychiatrists, 127 psychologists, 132 social workers, and 135 licensed counselors. For this quantitative research, the RAND researchers (Tanielian et al, 2014b) designed a web-based survey to obtain information regarding the providers' readiness, knowledge, attitudes and behaviors as it relates to knowledge and awareness, comfort and skills to work with the military and veteran population. The survey domains included: the provider characteristics, practice and caseload characteristics, assessment behaviors, military cultural competency, training to deliver evidence-based care, comfort with treatment approaches for the military population, addressing PTSD and major depressive disorder, attitudes toward practice guidelines and prescribing practices. The data was analyzed utilizing descriptive statistics, bivariate analyses, and logistic and linear regression.

The results showed that six percent of the participants had prior military experience or previously worked in a Veterans Affairs (VA) setting with psychiatrists. More than half of the participants worked within 10 miles of a Veterans Affairs or Department of Defense facility. Findings from the military competency domain indicated that 19% of the participants were characterized as having "high military cultural competency"; 70% of those working within a military or VA setting had a high military cultural competency. Twenty-four percent of the participants within the TRICARE

network had a high military cultural competency, while only eight percent of those not affiliated with the military setting or TRICARE met that criteria. It was noted that neither the type of profession (i.e., psychiatrist or licensed clinician) nor the number of years in practice were related to military cultural competency. The bivariate analysis indicated and the logistic regression model confirmed that the professionals who worked in military or VA settings and those affiliated with the TRICARE network were more likely to meet the threshold of culture competency compared to those who were not working in the military or VA setting and had no involvement with TRICARE.

The findings regarding the use of evidence-based approaches among the psychotherapists, which includes social workers, licensed professional counselors, and clinical psychologists, showed that thirty-five percent indicated they are capable of delivering evidence-based approaches such as cognitive behavioral therapy and prolonged exposure therapy for PTSD and major depressive disorders. They reported receiving training and supervision to deliver at least one evidence-based practice approach for PTSD and depression.

Only 13 percent of the participants met the researchers' readiness criteria. Utilizing a multivariate model to examine associations between years in practice, practice affiliation, proximity to military or veteran treatment facilities and insurance status, it was determined that the providers' practice affiliation was significantly linked with readiness. Specifically, it was found that professionals who worked mostly in a military or VA setting were more likely to meet the criteria for being culturally competent and delivering evidence-based treatment approaches for PTSD and depression than those who worked outside the military and veteran settings. Additionally, the professionals within the

TRICARE network were more likely to meet the criteria of readiness than those working outside the TRICARE network.

The results are revealing in that 65% of the psychotherapists indicated they did not have the training and supervision to deliver at least one evidence-based treatment approach for individuals diagnosed with PTSD and major depressive disorder. This would be concerning as the inference is clear; the selected professionals from the community are unlikely to have the skills needed to deliver optimal mental health care to military service members and veterans. The researchers additionally noted that among the psychotherapists that have training, 41% indicated they delivered evidence-based treatment approaches for a majority of their patients; the suggestion is, training alone is not a guarantee for the delivery of optimal mental health care. This echoes previous studies in that knowledge does not ensure cultural competence (Stewart, 2012; Gonzalez, 2014; Hickerson, 2014; Koblinsky, et al, 2014; Miller, et al, 2014; Tanielian, Farris, Batka, Farmer, Robinson, Engel, Robbins, & Jaycox, 2014b).

When both cultural competency and the use of evidence-based treatment approaches were combined, the researchers noted that the overall readiness of the professionals to deliver culturally competent, evidence-based treatment was 13 percent. The professionals who met this criterion also tended to be connected with the Department of Defense, Veterans Affairs facility, or connected with the TRICARE network. The researchers note that these findings especially indicate that if military or veteran members seek services outside the Department of Defense or Veterans Affairs, they may be met with “providers who are not as well prepared to deliver culturally sensitive care” (Tanielian, et al, 2014b, p. 21). The researchers further note that although the providers

met one threshold such as culturally sensitivity or competence, they may not necessarily meet another threshold such as training in or using evidence-based approaches. While cultural competency aids in engaging the military population, resulting in increased access to mental health services, there may be a need for emphasis in other areas which leads the professionals in the use of effective treatment approaches.

This study pointedly highlights the need for the training of civilian mental health professionals not only to gain familiarity with the military population, but also for the importance of having a comfort level to work with this special population. The results of the study indicated the degree to which the professionals felt “comfortable” working with the military population, but did not explore further their reasons for feeling comfortable or not having the comfort level. The researchers indicate, however, that gaining this additional information would be significantly helpful in designing training programs. Perhaps a further exploration of the professionals’ perceptions and experiences for working with the military population will lend further clarity to the characterization of “comfort” level, which is the intent of the present study utilizing a phenomenological approach.

Referencing the returning service members from Iraq and Afghanistan, another study (Koblinsky, et al, 2014) focused on the civilian mental health clinicians’ capacity to serve the military population, knowledge and confidence in treating 14 identified veteran conditions along with their interest in receiving training to work with this population. This study also examined the clinicians’ referral and screening practices.

The sample population for this study were licensed behavioral health providers which included social workers, psychologists, professional counselors, marriage and

family therapists and psychiatrists. They were recruited via an email invitation which was sent to 22,000 licensed clinicians through their respective professional boards. An estimated response rate of 9% percent was obtained with 1,725 participants completing the online survey. Due to the exclusion of some participants because they were working on a military installation or serving for the military, the final sample size consisted of 1,665 civilian behavioral health providers. A more precise response rate was not available due to the researchers not having access to the professional board databases and further complicated by not knowing the numbers of undelivered email invitations and surveys.

The researchers utilized a needs assessment survey which was adapted from a web survey in a study by Kilpatrick, et al, 2011. Along with collecting demographic information, the survey also gathered information about: (a) screenings and referrals, (b) knowledge of effective treatment approaches, (c) confidence in treating conditions found among the military members and their families, and (d) interest in training to work with the military population.

In addition to descriptive statistics, data was also analyzed using a multivariate logistic regression. Specifically, it was used to assess the participant's self-rated knowledge in treating the conditions found among the military members and their families and if it could be predicted based on the demographic characteristics or military experience of the participant. Knowledge regarding the 14 conditions was regressed on various factors for the provider such as, age, sex, veteran status, membership in a military family, training or employment in a Department of Defense or VA facility, recent

provision of treatment within the military population and whether the practice was in a rural or urban setting.

Analysis of the demographics indicated that the largest group were social workers comprising 60% of the sample; 34% of the participants were in a private practice setting, and almost half (48%) were 55 or older and more than half (81%) women. Six percent of the participants served in the military while 38% had familiarity with the military due to treating members in the active or reserve forces. Additionally, 31% of the participants were affiliated with TRICARE; almost half (49%) were not affiliated while 20% were unsure of their agency's involvement with TRICARE.

The researchers noted that almost half (49%) of the participants regularly screened their clients for military background; while 16% reported occasionally screening and 34% indicated never screening for military involvement. Beyond the screening, half of the participants indicated regularly questioning veterans about stressors related to the military lifestyle; only 43% however, included similar questions for family members.

Thirteen percent of the participants indicated that they regularly referred clients to VA health facilities; 38% reported that they periodically make VA referrals and 44% indicated that never make VA referrals. Various responses were obtained from the participants when questioned about their tendencies to not make VA referrals. The responses ranged from lack of knowledge about the VA, to include the process of making referrals, and concerns about the services such as wait time and the quality of care.

The research participants indicated they had extensive knowledge regarding the best practices to treat veteran conditions. The highest percentage was found for family stress and relationship problems (34%), depression (35%), anxiety (33%), PTSD (32%),

suicide/suicide ideation (31%) and substance abuse and dependence (30%). With regard to treatment, it was noted that the participants were confident about treating conditions in which they had the most knowledge such as, depression (37%), anxiety (35%) and suicide/suicide ideation (30%). Additionally, 28% of the participants felt a level of confidence about treating PTSD in veterans. The participants indicated some interest for receiving training about treating the 14 conditions found among the military population. The conditions most indicated were traumatic brain injury (52%), depression (52%), anxiety (52%), grief and bereavement (52%), caregiver stress (51%), and anger (51%). Eighty-nine percent of the participants reported they were interested in face-to-face training in their local area, while 52% had interest for webinars.

Yet another factor in predicting the participants self-rated knowledge was the age of the participant; those 55 years or older were 1.3 to 1.9 times more likely to have knowledge about treating anger, anxiety, depression, PTSD, suicide/suicide ideation, and family violence. The male participants demonstrated a greater knowledge about treatment approaches (1.4 to 2.1 times) more than female participants to treat anger, anxiety, depression, substance abuse, PTSD, suicide/suicide ideation and family violence. Participants with family members in the military also had a tendency to have greater knowledge in treating some of the 14 conditions such as anger, caregiver stress, family stress, family violence, military sexual trauma, sleep disorders, substance abuse disorders, and suicide/suicide ideation. The strongest indication (1.8 to 4.8 times) of the participants' knowledge for effective treatment approaches were those having worked in the Department of Defense or Veterans Affairs settings, especially those who worked with the military population in the past year. The researchers noted that this study highlights

the need to provide culturally competent behavioral health care for the military population.

This study focused on the capacity of civilian providers, thus their ability to address 14 veteran conditions, which presents as a different approach from an emphasis on cultural competence. They also sought to gauge the clinicians' interest for training. Of note, this study included several occupations found within behavioral health such as, psychiatrist, psychologist and clinicians. Further, they sought to determine the relationship between military knowledge and other factors. The authors also included gaining knowledge about the practices of the clinicians, whether the clinicians inquired about military service and stressors related to the military lifestyle. While there is a pertinence to understand the capacity of the providers to treat the military population and have a regard for asking about the military involvement, the present study will provide a clearer picture of the interactive behaviors of the clinicians as their perceptions about working with the military is understood on a deeper level with the in-depth interviews.

A study by Miller, Finn and Newman (2014) continued to answer the pervasive concern about community healthcare professionals with the question, “[a]re communities ready?” Miller, et al, (2014), sought to assess providers' practices, attitudes and knowledge about working with the military population. The researchers in this study sought to evaluate the clinical practices of clinicians that are not associated with the Department of Defense or VA. The overarching question was whether the needs of the military population are adequately being met.

The target group for this study were psychiatrists, psychologists, mental health counselors, psychiatric nurses, social workers, marriage and family therapists, alcohol

and drug abuse counselors from two large cities in Oklahoma, Tulsa and Oklahoma City. The professionals' contact information was obtained via their respective professional licensing boards and was invited via email to participate in the study; some were notified by mail as those licensing boards only released mail addresses. The survey was available online from May until November of 2010. Of the 2,654 mental health professionals contacted, 128 (4.82%) completed the survey. The professionals participating in the study worked in various settings; 34% in private practice, 24% in outpatient clinics and 12% in community health centers. Of note was one participant who self-identified as an active military service member, 11 participants indicated they had previously served in the military and 75% of the participants reported they had a family member either currently serving in the military or is a veteran of the military.

The participants completed a 30 minute, 50 item online survey answering questions about their professional characteristics, methods related to assessment and treatment, areas self-identified as competent, training needs and their perceptions about working with service members. Information was gathered about their clinical practices with questions relating to procedures surrounding intake and diagnostic screening to include therapeutic approaches and referral processes. The participants' competence to work with the military culture and the assessment and treatment of various conditions such as, PTSD, traumatic brain injury, substance use disorders, depression and suicide was obtained with the use of a 10-point response scale in which higher scores indicated a greater perceived competence. The participants also rated their areas of interest for training in these areas also using a 10-point scale. Their perceptions about treating service members were obtained using case vignettes for which the participants selected

the top three diagnoses they considered for the case vignette based on the symptoms. A 10-point scale was utilized to answer questions as to whether the individual depicted in the case vignette would return for another session and the anticipated time for treatment based on a 7-point response ranging from one to two months to greater than one year. Follow-up questions allowed for assessing the participants' feelings related to emotional strain, personal satisfaction and whether professional consultation was needed for the case. Responses on a 10-point scale indicated, with higher scores, whether there was increased strain, satisfaction and consultation.

The data was analyzed utilizing descriptive statistics and the Wilcoxon Signed Rank Test. Although the findings indicate more than half (57%) of the participants reported they have provided services to military service members, 96% revealed they spent 30% or less of their time serving this population. Thirty-three percent of the participants expressed they asked clients about their military status. Fifty-seven percent indicated working with military family members, but spending 30% or less of their time working with them. Queries regarding the screening of clients for conditions such as PTSD, traumatic brain injury, sexual assault, partner violence and child abuse revealed traumatic brain injury was included less in the screening process than other conditions.

Findings about the use of treatment approaches demonstrated that the top three choices were cognitive-behavioral therapy (70%), relaxation training (65%), and psychopharmacology (46%). Of note, is that 18% of the participants expressed feeling incompetent about working with clients diagnosed with PTSD and would refer them to another professional. Additionally, 65% of the participants reported incompetence to

work with clients diagnosed with traumatic brain injuries and would refer them to another professional.

Utilizing the 10-point scale, participants indicated their level of knowledge about the military culture as average. There was no significant difference found among the various professions. Compared to knowledge level, interest in receiving training about the military culture was higher. Case vignettes were utilized to direct participants to consider a maximum of three diagnoses based on the symptoms presented in the vignettes. The top three diagnoses given were; PTSD (95%), anxiety disorder (38%) and panic disorder (34%). The participants were asked whether the client in the case vignette would return for the next session, the anticipated length of treatment, amount of consultation needed, and if the participant would find the case burdensome or satisfying. The results suggested that the participants were unsure of the client's return for the next session. The length of treatment varied with responses ranging from five to six months to more than one year. Findings suggested that the participants acknowledged the need for additional professional consultation. Participants also indicated that the case would be difficult, but there would also be a high level of personal satisfaction in working with this case.

The researchers found that “training on ways to accurately and culturally appropriately screen about military status appears to be a community need” (Miller, et al, 2014, p. 402). They also noted that future studies should utilize qualitative interviews which incorporate a small, stratified random sample of the various community mental health professions.

This study paired perceived cultural competence with the ability to work with various conditions commonly found among the military population. The methodology included a means to test the providers' ability to diagnose. The authors noted that future studies may possibly benefit from a small, stratified random sample of community mental health professionals. The present study with its qualitative inquiry incorporates the author's suggestion with a focus on a small sample of licensed clinicians in the community.

Summary

Several studies presented here point to nuanced factors in working with the military population such as mental health conditions more commonly found among the military population, which is most likely to be addressed in a training program. While the case for training is made repeatedly to include knowledge and awareness about the military culture, there is a gap in the research about the perceptions of mental health clinicians. One study presented here focused on the social workers' observations about the status of military mental health, but there was not a focus on the social workers' perceptions of their readiness to serve the military population. Miller et al, (2014) comes close to acknowledging the perceptions of counselors as they sought to evaluate the clinicians' self-identified competence and their perceptions about working with the service members. It is clear from their position, the training of clinicians to work with the military population should also include ways to not only appropriately screen for military status, but also specifically addresses the common conditions found among the military population such as, PTSD and traumatic brain injuries.

This study will fill the gap in the research as there is a focus on the mental health clinicians and their perceptions about their readiness to serve the military population. The remaining chapters will further explore the perceptions of mental health clinicians about working with the military population. In chapter three the methodology for this research will be presented. Chapter four will include the results along with the findings. Chapter five will provide a discussion based on the research questions and results. Implications for further research will also be addressed.

CHAPTER 3

Methodology

In this chapter, the methodology for this study is introduced. The research question investigated is how do the mental health clinicians describe their perceptions about serving military members and their families; how would their perception influence working with the military population? A qualitative, phenomenological approach is employed to investigate this inquiry utilizing a semi-structured interview. This approach allows for initial questioning, but yet gives enough latitude that additional inquiry surrounding the question is allowed (Moustakas, 1994; Grinnell & Unrau, 2011). The significance of having this latitude is that the perceptions of the mental health clinicians are explored in such a way that there is a focus on their individual experience, which would not be facilitated in a quantitative approach (Grinnell & Unrau, 2011), thus from a socially constructed knowledge paradigm, qualitative inquiry with a phenomenological approach allows for understanding individual meanings and perspectives (Moustakas, 1994; Creswell, 2012). Finally, this study would inform further inquiry for the preparation of mental health clinicians to work with the military population.

Upon review and granting of permission by the University of South Carolina Institutional Review Board (IRB), the participants targeted for this study were licensed mental health clinicians who are in private practice in a community setting. Since this was a limited group having particular characteristics for examination, a purposive sampling method was utilized (Grinnell & Unrau, 2011).

Research Design

The goal of this research study was to explore the civilian mental health clinicians' perceptions about serving the military population. A qualitative approach afforded the greatest opportunity in this investigation as it allows for studying a social phenomenon in a natural context (Grinnell & Unrau, 2011). Additionally, phenomenological inquiry was employed in this qualitative study as it allows for understanding the in-depth experiences of the participants (Creswell, 2012). A qualitative design was chosen over a quantitative approach which allowed for gathering in-depth information from the participants through a semi-structured interview. Interviewing the mental health clinicians through this qualitative approach allowed for the collection of rich data. (Creswell, 2012). A quantitative approach for this study would be directed at testing a theory with a narrowed hypothesis (Creswell, 2012), thus it would not lend itself to focusing on qualitative interviewing for the purpose of exploration of essential themes and meanings (Grinnell & Unrau, 2011).

As this research involved the perspectives of licensed mental health clinicians about their cultural competence to work with the military, my investigation of a suitable research design led to qualitative inquiry with a phenomenological approach (Koblinsky et al, 2014; Miller et al, 2014; Tanelian et al, 2014b). My epistemological positioning was that the data are contained within the perspectives of the licensed mental health clinicians who provide services within their communities and to collect the data, I would need to engage with the clinicians. The phenomenological approach provided a method of inquiry that allowed for the study of subjective experiences, thus the lived experiences

of the licensed mental health clinicians as it relates to working with the military population.

This study sought to gain an understanding of the mental health clinicians' perceptions of their readiness to work with the military. Do they believe they are culturally competent by having knowledge about the best practice treatments for military members? How do they describe their attitudes and skills about working with the military?

Role of the Researcher

The role of the researcher in a qualitative approach differs greatly from that of the researcher in the quantitative approach. In the quantitative approach, the goal is for the researcher to be non-existent in that the participants act independently of the researcher (Grinnell & Unrau, 2011), however, in the qualitative approach the researcher is in essence an instrument in the data collection (Creswell, 2012). In this study, the researcher conducted the semi-structured interviews with the participants and analyzed the data.

A field journal was maintained during the data collection for the purpose of gathering additional information (Grinnell & Unrau, 2011). A sample field note is included in Appendix C. Additionally, although the researcher for this study is also a mental health clinician in private practice and operates from a cognitive behavioral theoretical orientation, the role assumed for this research was that of an outsider with the purpose of gathering information about the participants' individual perceptions of working with the military population.

The roles that involve this researcher included: a veteran of the US Naval Reserves, a former Military Family Life Consultant and Licensed Professional Counselor. These roles could seemingly present a source of respondent bias especially as it relates to data collection and analysis, in that the participant provided data that is honest and complete (Grinnell & Unrau, 2011). Maxwell (2013) identifies two broad types of threats to validity, researcher bias and reactivity; he notes that there are data that fits the researcher's existing theory or goals and data that "stand out". Additionally, as the researcher is a Licensed Professional Counselor with a theoretical orientation of cognitive behavioral theory, it may pose as an additional bias in that such linear thinking is counter to a phenomenological approach.

While it is impossible to eliminate the former roles of this researcher, effort was taken to reduce the validity threats; thereby increasing the credibility of conclusions drawn. A peer, who is a Licensed Marriage and Family Therapist, adjunct college professor and well versed in cognitive behavioral theory, reviewed the interview questions. The involvement of this peer was especially sought to aid in bracketing this therapist from leading questions during the interview. The peer brought to the researcher's attention any closed and leading questions found in the list of interview questions. The questions were then re-worded to form an open versus closed question. The peer also reviewed transcripts from the first two interviews to identify any tendencies for leading questions. Both the researcher and peer were able to identify instances of leading questions, for example a follow-up question was noted wherein the researcher asked the participant to give a number on a scale of 1 to 10 corresponding to their

comfort level to work with the military population. Corrective adjustments were made for the interviews that followed.

Another effort that addresses the threat of validity is the semi-structured interviews in this study which allows for the collection of rich data and relies on verbatim transcripts of the interviews (Maxwell, 2013). Additionally, validity threats are addressed with respondent validation which is a method for obtaining feedback about the collected data and conclusions drawn from the participants in the study (Maxwell, 2013). Discrepant and negative cases were identified in which there is not a specific interpretation or explanation and may indicate problems with that particular account given in the collection of data (Maxwell, 2013).

Context of the Study

Description of the Study. As this study focused on a limited group, a purposive sampling method was utilized from a Community Resource Directory which is maintained by the Carolina Center for Behavioral Health located in Greer, South Carolina. This directory lists Upstate South Carolina community mental health resources and includes an extensive list of licensed clinicians in the various counties of the upstate area of South Carolina. This directory provides a means to identify and survey mental health clinicians who are working in the community setting. Utilization of this list is similar to the sample recruitment method in Hickerson's (2014) dissertation wherein there was a focus on contacting local clinicians, Kilpatrick et al (2011) study wherein they obtained several lists of primary care and mental health professionals, and Tanielian et al (2014 b) wherein they obtained lists from a research organization and two of their vendors. Participants recruited from this listing met the criteria of licensed professional

counselor, licensed marriage and family therapist or licensed independent social worker (clinical practice).

Criteria for Selecting Participants. The criteria for selecting participants were (a) they are licensed as a clinician in South Carolina by the South Carolina Labor, Licensing and Regulation Board as a licensed professional counselor, licensed marriage family therapist or licensed independent social worker, (b) is presently in private practice and (c) does not specifically or exclusively serve the military population, but has worked with at least one military member or military family member. Due to consideration to balance time and resources, this study focused on clinicians in the upstate region of South Carolina. The rationale for the criteria of licensed mental health clinicians in private practice is due to the fact that research studies (Eaton et al, 2008; Lincoln et al, 2008, Burnam et al, 2009; Spera, 2009; Demers, 2011; Kilpatrick, 2011; Stewart, 2012; Koenig et al, 2014; Tanielian et al, 2014b, Gonzalez, 2014; Hickerson, 2014; Koblinsky et al, 2014; Miller et al, 2014; Smith-Osborne, 2015) referenced in chapter one and chapter two, overwhelmingly indicate the need for mental health clinicians in the community to be trained to work with the military population, so this study focused on a group of professionals who are practicing in a community setting.

The sample for this study was the result of purposive sampling which is a sampling method wherein selection is based on the unique position of the sample elements and thus may involve the entire population of a limited group (Grinnell & Unrau, 2011). The target group for this study are licensed mental health clinicians who are in private practice in the upstate region of South Carolina. According to Creswell (2012), the guideline for a sample size is five to twenty-five. Morse (2000) states a

sample size of at least six, Giorgi (2009) indicates one to ten. Moustakas (1994) discusses a research example which utilizes 12 to 15 participants. Patton (2001) highlights the ambiguous nature of sample size in qualitative inquiry further indicating that there are no rules for sample size in qualitative inquiry and provides examples of single to multiple case studies. Some researchers agree on sampling until saturation is reached (Lincoln & Guba, 1985; Morse, 1994). With these considerations in mind, and giving attention to the need to reach saturation, the sample size for this research was initially set at six. Due to not reaching saturation with six participants, interviews were scheduled and continued until a final sample size of nine indicated that saturation had occurred.

Data Collection. Interviews were scheduled during the initial or follow-up contact to meet at the participant's office for one hour with an allotted time of 45 minutes to one hour to conduct the interview. It was anticipated that 45 minutes would suffice to cover the interview. The participants were asked to read the informed consent (see Appendix A) and provided an opportunity to ask questions for clarity or concerns. Demographic information was collected from the participants to include, age, race/ethnicity, type of professional license, years in practice, location of practice, educational background, whether they have served in the military or was previously employed in a military setting. The interviews were audio recorded, with the participants' permission provided through the informed consent.

Moustakas (1994) describes the phenomenological interview process as informal and interactive relying on open-ended comments and questions with the goal of collecting data about the topic of the study and the research questions. The interviews for this study were conducted utilizing a semi-structured interview format. Moustakas (1994) makes

the point that although the researcher prepares questions in advance, these questions may be altered or not used at all, at the discretion of the researcher as the questions may evoke the full story of the participant's experience of the bracketed question.

The questions prepared for the interview were adapted from two studies presented in the review of the literature, Tanielian et al, (2014b) and Kilpatrick et al, (2011). Both of the aforementioned studies are closely in align with the present study as the researchers conducted a survey with civilian mental health providers to gain information about their ability to work competently with the military and veteran culture. The questions were modified to alter them from closed to open questions and to facilitate an interview which would gather rich data. Additionally, any wording that is leading or pre-suppositional was removed to remain true to the goal of investigating the participants' perceptions. Follow-up questions were utilized so as to further probe responses that are interesting or for further clarification (Creswell, 2012). The questions used in the interview are as follows.

Interview Questions

1. What would you say is your comfort level in working with military clients and/or their families?
2. Tell me about your experiences working with military personnel, veterans and/or their families.
3. What type of issues (diagnoses) have you encountered when serving this population?
4. Which treatment approaches have you found effective (not effective) in working with this population?

5. What kind of training have you had regarding your work with military members or their families?
6. What kind of training would you be interested in regarding military members and their families?
7. What are the resources you have found helpful (unhelpful)?
8. Are you familiar with working with military personnel, veterans and/or their families? How would you describe your level of familiarity?

Data Analysis.

The data analysis involved a four step process to analyze the transcriptions of the interviews from each participant as described by Moustakas (1994). The phenomenological analysis as described by Moustakas (1994) includes the process of: (a) horizontalization in which every expression of the experience is listed; (b) reduction and elimination to determine the invariant constituents; (c) the clustering of the constituents to derive the core themes of the experience; and (d) final identification of the invariant constituents and themes. Based on the invariant constituents and themes, an individual textural and structural description of the experience was constructed for each participant which included verbatim examples of the experience and the imaginative variation for each participant. From the individual textural-structural description, a composite description was developed that captures the meanings and essences of the experiences which represents the group of participants as a whole. This composite description is presented in the results in chapter four. Any discrepant data was recorded and reported as such and how it is an exception to the pattern (Grinnell & Unrau, 2011).

Finally, to validate the accuracy of the themes, the researcher employed four different methods to ensure the worthiness of the data. The following section describes the methods utilized.

Ensuring Trustworthiness

Lincoln and Guba (1985) assert that in qualitative inquiry the trustworthiness of the research is crucial to establishing its worth. Creswell (2013) references the term validation to describe the accuracy of a study and recommends using multiple methods to ensure validation `regardless of the type of qualitative approach that is employed.

Grinnell and Unra (2011) identify terms such as credibility, transferability, dependability, and confirmability to address trustworthiness. Utilizing the terms provided by Grinnell and Unrau (2011), there were four ways for which trustworthiness was addressed in this study.

Credibility. Grinnell and Unrau (2011) describe how credibility enhances internal validity by answering the question as to whether the findings of a study can be regarded as truthful. Negative case analysis enhances credibility as contradictory data is intentionally included thereby determining the limits of main themes (Grinnell & Unrau, 2011). In the present study, a discrepant case was discovered and documented in that Participant Three was an outlier for the criteria. It was not clear, until the interview, that Participant Three not only had a military background working in psychological services, but also worked in military mental health as a civilian for 20 years. This discrepant case was documented in the results and is discussed in chapter five.

Transferability. According to Lincoln and Guba (1985), qualitative researchers can extend the notion of transferability by providing thick descriptive data which will allow

comparison of one context to another context. In the present study, I have provided sufficient, detailed information regarding the setting and participant population.

Dependability. Miles, Huberman, and Saldana (1994) discuss the importance of using analytical memos to aid in establishing an audit trail as it captures the reflections and thinking processes of the researcher about the data. A memo book has been maintained throughout the gathering and analyzing of data for the purpose of capturing thoughts about the ongoing research process as it occurs during data collection, analyzing data and the final reporting. Aspects of the memo are further discussed in chapter five.

Yet another manner in which dependability was addressed, to ensure trustworthiness, is member checking. This entails returning to the research participants and asking them to confirm or refute the interpretations made (Lincoln & Guba, 1985). I have described in detail how the data and conclusions drawn were checked by the participants (Grinnell & Unrau, 2011).

Confirmability. Grinnell and Unrau (2011) explain that while qualitative studies do not aim to be objective, there is a need, however, to acknowledge and supplement the researcher's subjectivity and bias. Confirmability was met in two ways for the present study. First, triangulation was employed in this research by having a peer analyze the data from two interviews to determine if the same decisions are made with the data collection rules established. The peer was provided an explanation of the process by which the data was analyzed for this study. The peer has a Ph.D. in Counselor Education and Supervision, has taken qualitative courses and has conducted research analyzing data using phenomenological inquiry. A more detailed explanation of this process is provided in chapter four.

Second, including an inventory of detailed biases and preconceptions, based on personal reflections, when reporting findings aids in ensuring trustworthiness (Creswell & Miller, 2010). I have demonstrated reflexivity about my biases throughout the study by tracking these biases through the audit trail and showing transparency about how decisions were made. This has further aided in assessing for any influences that my background and perceptions has on the results of the present study. The inventory is further expounded on in chapter five.

Ethical Considerations

Prior to beginning this research, an application was submitted to the University of South Carolina Institutional Review Board (IRB) and research did not begin until it was approved by IRB. Participants were provided with information related to the informed consent that entailed confidentiality and privacy, and how data will be stored (see Appendix A). The participants were also advised in the informed consent that their participation is voluntary with no repercussions if they decide not to participate at any time during the research.

To maintain the participant's confidentiality, participants were identified by demographic information; however, the names of the participants have been omitted (Grinnell & Unrau, 2011). A numbering system was also used in the interview recording process labelling the recording and transcript by the participant's number. Additionally, data reported as findings has identifying information removed so as to preserve the confidentiality of the participant. This is especially important as participants' statements are included in the results in Chapter 4, as identifying statements reflecting themes from the data collection are presented.

Summary

The goal of this research is to add to the breadth of current knowledge about mental health clinicians in the community working with the military population. Specifically, this research seeks to answer the question about the clinicians' perceptions of serving the military population. This qualitative approach with a phenomenological inquiry seeks to capture data that provides information regarding the perceptions of the mental health clinicians about their cultural competence. A semi-structured interview is planned with the goal of collecting and analyzing data so as to determine the existence of patterns and themes.

The remaining chapters will address the implementation of this study. In chapter four, the results of this study will be presented. Additionally, quotes from the participants will also be included to further highlight the results obtained. In chapter five the results of the data analysis will be presented along with a discussion of the results, with consideration for the current literature, and followed by the conclusion. Implications for future studies will also be addressed.

CHAPTER 4

Results

The purpose of this chapter is to present the process by which the data was captured and analyzed to produce the findings. The process included data collection, data analysis, sample demographics, data tracking methodology and the discovery and validation of the themes. The data collection process describes the method in which the data were obtained by the researcher. Demographics of the sample are presented which describes the characteristics of the participants involved in this study. An explanation is provided to demonstrate how patterns were noted from the audio transcripts and themes derived. Finally, the researcher will present the procedures which facilitated the rigor for this study to ensure the accuracy of the data obtained.

Sample Demographics

The sample of participants in this study consisted of nine licensed civilian mental health clinicians located in the Upstate area of South Carolina in the following counties: West Union, Greenville, Greer, and Spartanburg. The group of clinicians consisted of two Licensed Independent Social Workers (Clinical Practice), three Licensed Professional Counselors, and four Licensed Marriage and Family Therapists working in the community setting either in a solo or group practice. Of note, was that three clinicians were also Licensed Professional Counselor Supervisors and one was a Licensed Marriage and Family Therapist Supervisor. Based on the South Carolina Department of Labor,

Licensing and Regulation website, all of the participants are listed as active for their respective licensing boards.

The ages of the participants ranged from 36 to 69 years. Of the nine participants, three were male and six were female. Eight of the participants were Caucasian and one was African American. The years in private practice ranged from 1.5 to 33 years. Four of the participants were in a group practice, while five were in a solo practice. One participant worked in a college setting full time, in addition to having a part-time solo practice. Only one participant (Participant Three) was prior military and one participant (Participant Four) was the spouse of a military veteran. Additionally, Participant Three was discovered, during the interview, to be a discrepant case; it was not detected during the initial contact by telephone of his past involvement with the military. He was an outlier for the criteria in that he was prior military having served as a commissioned officer in the Army for two years in the occupation of Personnel Psychologist. He also worked in mental health services, as a civilian, on a military base for 20 years. Given Participant Three's background, he has an extensive familiarity with the military culture to include military mental health. The researcher made the decision to continue with the interview and include him in the analysis of data to gain any insight his perceptions would offer. Findings from his interview are reported and discussed further in chapter 5. A summary of the sample demographics is presented in Table 4.1.

Table 4.1 – Sample Demographics

Participant	Age	Credential	*Years	Setting	Sex(Gender)	Race/Ethnicity
1	59	LISW-CP	26	Group	M	White
2	57	LPC	8	Group	M	White
3	69	LPC	5	Solo	M	White
4	49	LMFT	6	Group	F	White
5	36	LMFT	9	Solo/College	F	White
6	61	LPC	18	Solo	F	White
7	37	LMFT	1.5	Solo	F	Black
8	43	LMFT	10	Group	F	White
9	63	LISW-CP	33	Solo	F	White

** Years indicate the number of years in private practice.*

Data Gathering

Upon approval from the University of South Carolina Institutional Review Board, the researcher utilized a community directory, which is produced by a behavioral health hospital (Carolina Center for Behavioral Health), to identify prospective participants who were licensed mental health clinicians. Clinicians were randomly selected from the directory. Telephone calls were made to 34 prospective participants. Voice messages were left introducing the researcher as a Licensed Professional Counselor and a doctoral student conducting research for a dissertation. Included in the voice mail message was a brief summary about the study and a request for an opportunity to discuss it further. There were three calls in which contact was made during the initial effort. The study was explained and inquiry was made as to whether the participant worked within a military setting or specifically with the military.

Several prospective candidates returned the call to the researcher. Upon agreement to participate in the study, an interview was scheduled. It was also explained to the prospective participants that this researcher was seeking civilian mental health clinicians who has seen at least one client with a military background, but does not specifically serve the military population.

Information was given about an incentive package of information on military resources and opportunities for training to include universities offering a military social work certificate. Prospective participants who were interested in the study and agreeable to meeting with the researcher were scheduled for a face-to-face interview. Within 24 hours of IRB approval, seven participants were scheduled for interviews (six as initially planned and an additional participant in the event saturation was not met). Two additional participants were later added to the initial seven after transcript data was analyzed to achieve saturation. In the event additional participants were needed to meet saturation, two prospective participants indicated they were available.

The participants chose to meet in their respective offices. At the beginning of the interviews, the researcher explained the goals of the study, provided informed consent forms and collected the participants' demographics. The interviews were recorded on an audio recorder. A back-up device, an iPad, was also used to record the interviews utilizing the voice memo application. Of note, is that Participant Four requested the recording to be discontinued as she shared more in-depth information about a military veteran's case as it involved pending legal matters. At Participant Four's request, information from the off-record comments was not included in the findings. At the completion of the interviews the incentive package was given to the participants.

Data Tracking Methodology

The interviews were transferred from the audio recording device to a laptop and transcribed by Verbalink.com. A confidentiality agreement was obtained from Verbalink before any audio files were sent on their password protected online system. A sample transcript is located in Appendix B. The researcher read the transcripts along with the

audio to ensure accuracy and made minimal corrections to the transcripts. The transcripts were read again before analyzing the nine interviews employing the four-step process of analysis as outlined by Moustakas (1994). The four-step process included highlighting and listing the participants' expressions that was relevant to understanding their experience of the phenomenon, reduction and elimination of the expressions to derive the invariant constituents, clustering and thematizing the invariant constituents, and a final identification of the invariant constituents.

An individual textural-structural description of the meanings and essences of the experience was constructed for each participant, which also included the invariant constituents and themes. Each participant received the textural-structural description for their respective interviews and was asked to give feedback as to whether the analysis did or did not convey what they intended during the interview. Every participant indicated that the analysis was accurate and most of the participants offered laudable comments such as, "impressive summary" and "very good summary of our interview". Some of the participants also commented about their incomplete sentences and use of filler words such as, "ahs" and "uhs".

Transcript data were given to a peer who holds a Ph.D. in counselor education and has conducted research utilizing a qualitative approach with phenomenological inquiry. The peer was provided an explanation of the process by which the data was analyzed for this study and randomly given two transcripts (Participant Two and Participant Eight) to analyze. The peer identified four themes that were identical to four of the six themes identified by the researcher. After a discussion, a consensus was reached regarding the remaining two themes identified by the researcher.

Themes Discovered

The research question for this study was, “How do mental health clinicians perceive working with the military population?” The participants who agreed to be a part of this study shared their experiences as it relates to working with the military population. As the transcriptions were read for accuracy and then analyzed, six themes were revealed as depicted in Table 3.2.

Table 4.2 Themes

Six Themes	
1	Learning from the clients
2	Viewing the military as a speciality
3	Posttraumatic stress disorder as a common diagnosis
4	CBT and EMDR as common treatment approaches
5	Utilizing the internet as a resource
6	Interest in understanding reintegration

Learning from the Client

The first theme was revealed when the participants were asked about their familiarity with the military. Most of the participants indicated they have learned about the military from their clients. They indicated various ways in which information is received from their clients which aids them in understanding their worldview.

For example, Participant One indicated he has worked with former clients who were in the military and also gained familiarity from having family in the military. Participant Two adds that working with veteran military clients increases the comfort to work with them. He also recalls working with co-workers who were veterans of the military while working in law enforcement and explained how that adds to his knowledge. Participant Two stated that although he does not have a military background,

he believes his experiences in law enforcement allow his military veteran clients to relax and open up to him. Participant Two noted the importance of this:

A lot of folks – it doesn't matter who you are, what the problem – a lot of folks, they scare the counselors when they tell their story. Well, you know, having done what I've done for all these years, they know that there's no – and I understand what it means to see people who's been killed and, co-workers or, you know, who's lost their life. And that seemed to have a level of, "Wow, somebody does listen." And, it's just a lot of times with the folks I've seen, it's just kind of normalizing their feelings.

Participant Three, however, states his knowledge of the military is due to his prior service and working as a civilian in a military setting:

I was in the adjutant general corp. I was a personnel psychologist, they called it an examining entrance station in Pennsylvania where they, processed people who were being drafted or people who were enlisting. They have that now. I think they call it MEPS [Military Entrance Processing]. I spent 20 years working for the Army Behavioral Health Services at Fort McPhearson in Atlanta. That post is now closed. It wasn't closed when I retired, but it's closed now.

Participant Four believes she has mostly learned about the military during the 12 years she was the spouse of a military service member. In response to the question about her familiarity with the military, Participant Four responded in the following manner:

Pretty familiar. Actually, the last duty station that my husband had, I didn't take the position, but I was asked to be an ombudsman for the local

area. I just couldn't do it because I had really young kids. I'm familiar with that [the military].

Participant Five also indicated her familiarity with the military:

Um, through the, uh you know, through my years in practice I have on occasion worked with people, usually not – I'm trying to think. I don't think I've ever worked with anybody who was active duty. Usually, its people who have, you know, come out of the military. Mostly veterans, sometimes their families, their children and spouses.

Participant Seven shared how she learned about the military when she agreed to be a part of a start-up program for homeless veterans. She describes how being a part of the military seemed to be the best part of their lives:

I remember that being a part of the military was the best part of their lives in a sense. What they, how they spent their time, highly dedicated, that service was important to them that they spent a great deal of their time in the military.

Participant Eight describes how she learns from the client:

I learned from them. If I don't know, I don't understand, then we'll spend a session with them – if they say – if they start using military speak, I'll say, "Talk to me about it. Tell what that means", which becomes part of the therapy. For them to be able to tell me about it, and I can sort of gauge the emotional level as they're talking about it. And I learn that way. And then I become more comfortable.

Participant Nine believes that her willingness to learn from her clients, with a military background, makes her particularly effective. She relates how she learns from her clients about the military and asks questions because she has an interest in their version of the world.

Well, they need to know that you're not gonna be freaked out, that you can manage your anxiety about anything they may tell you. A Vietnam veteran who was a Navy Seal doing dark ops in Vietnam, the only person I ever had come in, sat down and said, "Have you ever killed anybody" – that was his first thing he said to me, and I said, "No, but I'm imagining you're going to tell me that you have". And we worked together.

I reacted calmly. I let him – he brought in maps of everything, showed me kinda where he was and things he did. And I let him tell me his stories. I wasn't freaked out. I was able to mirror. "That must have been awful for you".

Participant Nine also adds how a vicarious learning experience is a window to increase her knowledge about the military in that she provides clinical supervision for licensure to two LPC-interns who work in a military setting.

Viewing the Military as a Speciality

The second theme was revealed as participants spoke about working with clients having a military background. Most of participants either referenced the word “specializing” or “expertise” when talking about serving the military population. Some of the participants furthered the point characterizing the involvement of working with the military population as having a personal interest, genuineness, comfort level and

confidence. The second theme captures the clinicians' characterization of working with military as they view it as a speciality.

Participant One shared that he knows about military from family and former clients:

Well, you know, I have family in the military. I have, um, former clients who were in the military. I've worked with them and their families and what not, but probably not to the degree of somebody who specializes in that area or who works out of a VA clinic or that sort of thing.

He also adds that he does not want to claim a level of expertise he does not believe he has.

Participant Two describes the importance of having a genuineness to work with veterans:

I don't want to sound prima donna, but if your interest is not helping these guys recognize what is the junk that they've seen, then I don't think you have any business doing it. Maybe it's just selfish on my part. I just know there's a lot of good folks out there that's either been in the military, know someone who has, who kinda has a basic understanding of what they go through.

Participant Two stated how he connected with a military veteran:

I mean the last guy I had; he'd been to six different counselors. One he didn't trust'em and two he said, "They don't even got a clue what I've been through." That's what he told me. He asked me flat out, "Have you ever killed anybody?" I said, "No, but watched one of my deputies die

one morning.” He [client] said, “We’re gonna be okay.” That was his words, not mine. He said, “The most I’ve ever been to the other ones was twice.” And he said, “This has been going on for eight years.” And it had gotten to the point that his marriage was breaking up, just because of his anger, his depression.

Participant Three believes that in addition to his desire to serve the military population, his prior military experience in Vietnam forges a connection:

I mean, the guy that was a Gulf War vet, I mean right off the bat, that’s- you build some rapport instantly with somebody like that. ‘Cause they know kinda where you’re comin’ from. When you walk in the door - and that’s what this Star program, or whatever, I think was tryin’ to help with - and you sit down with a therapist - who doesn’t know the difference between a sergeant and sergeant major - particularly if they’re still active duty, that’s kind of a problem. ‘Cause they have - they - you’re basically conveying to them that you don’t have a clue about the world in which they live. And it’s a - it’s a different world. ‘Cause I think a lot of people don’t have any basic idea at all. I would rather do it, but that’s because of my experience.

Participant Four describes a fairly comfortable level of working with the military which is due to being a spouse of a military veteran as it affords “common footing”. She explains that having private clinicians become aware of the military population needs would be beneficial and that one needs to have a personal interest:

If you've never been in the military and you don't know how it's structured, it's not like civilian life at all, people don't understand. 'Cause I don't know how you would be able to work with them if you hadn't had some sort of background. That's not the area of population that they [therapists] want to see necessarily. I think you have to have a personal interest in the area that you are serving as a therapist.

Participant Five describes a seemingly cautionary approach about serving military veterans and their families:

I wouldn't say, "Hey, bring'em all to me. I got this." But I wouldn't say, "Oh no, not military. "I think I always have to meet the family in person to kinda see where they are and what issues they're really presenting with to determine my level of comfort. Like I said, I'll never put myself out there as an expert in doing it. I'm not gonna say I'm a specialty. It really depends on the family, and then I talk to them about what they're looking for before I can say how comfortable I am.

Participant Six echoed similar sentiments relating she is not as comfortable as she would like to be in working with the military client:

I haven't had a lot of experience. I have worked with and am currently working with some people who are veterans, but that's not a speciality area for me. I just think sometimes, depending on – and I wouldn't hesitate to refer out if I felt like I needed to – but I think sometimes, you really need somebody with a speciality in that area if it – if you really want the best results. Now again, I feel adequately prepared to deal with

these clients, but it's like addiction issues. If you're working with somebody and their addiction's manageable, a lot of therapists can do that. But if it gets to the point where it's really severe – so I don't – you know, I'm gauging that constantly, to make sure that it's not above my scope of practice.

Participant Seven offered to score herself and indicated a 6 on a 10-point scale in comfort level to work with the military population. Upon inquiry for clarification, she gave the following response:

Why would I be a six and not a seven? Cause I don't have that clientele to build that confidence, that skill to truly grow in it. I mean they're not walking through my door. You don't have opportunity to build confidence and grow from working with them.

Participant Eight also offered to score herself and gave a 7 or 8 on a scale of 10 stating she is “pretty comfortable” working with the military population. She added, however, that she does not “seek out” this population further stating it is not a speciality for her:

I think what I've heard both of my – guys say is that they feel when they're talking to somebody else, like, the fact that I was not in the military, and they almost feel like – or they've said, “Unless you've been there, unless you have felt like your life is very well threatened or unless you felt like you failed on the job in saving another life, there's no way you can really understand. You can just do the best you can as a professional trying to help, but there's no way you can really get to where I am.” And that's

absolutely true. I agreed. And I did think of the – the old adage where I was always told, you don't have to have gotten divorced to do good therapy with somebody who's divorced. Or you don't have to experience all of life to do it. On the other hand, I agreed that with this speciality, I could see how that would be helpful to have that experience.

Although Participant Nine is on the insurance [TRICARE] panel to serve the military population she is hesitant to claim it as a speciality:

I would not ever claim to say that I specialize in treating the military. I have TRICARE, I'm a TRICARE provider and have been for many, many years. So I've had – but it's not that they've been a primary percentage of the people that I serve, but they are a set of people that I have served.

Additionally, Participant Nine describes how working with all kinds of trauma has helped her to understand the military:

I deal with all kinds of trauma. Not just military trauma, but because of that training, I get military people.

Posttraumatic Stress Disorder (PTSD) as the Most Common Diagnosis

The third theme was revealed as every participant indicated serving a client, with a military background, diagnosed with PTSD. While the participants spoke of other diagnoses such as depression, substance use problems, relational issues and anxiety, posttraumatic stress disorder was the most common diagnosis found among all of the participants.

Participant One stated that in addition to PTSD he saw other diagnoses such as depression and substance use problems. He also indicated working with clients who

presented with relational issues and grief. Participant One related this insight about PTSD:

People who have PTSD often have sleep disorders because of their unconscious re-enactments and things like that. They have the nightmares and all those sorts of things there. In-country PTSD is a survival mechanism. Hair trigger, wakefulness, and all that kind of stuff are survival mechanism. They're the things that they're taught, in some respects, in order to survive in that environment. But when you leave that environment, they're not that helpful. I see people in the military as people who have been trained in a certain set of skills that are applicable in the environment that they work in, but may not necessarily be applicable in the environment they live in.

Participant Two recalls that his first encounter with a client having a military background was a Vietnam War veteran:

Uh, he told the story of being in a – and I'm not much on the numbers – I think it was a battalion, whatever size that is. And they got left out in the middle of the jungle for purely political purposes. Um, it was right toward the end of the war. Um, they were saying, "Okay, we're, we're de-escalating involvement." The whole time they were just getting eaten alive. And whatever the number of people that was in that group, four of 'em came home. And he really hadn't talked that much about it. Came home, got married, had kids. Life is good. And then one of the four contacted him. He, he went south real quick. You know, he went and they – the four

of 'em met up somewhere in Florida. And he just – night – you know, typical nightmares, flashbacks, the whole works.

Participant Three indicated that one of his current clients is a Gulf War Vet diagnosed with PTSD and military sexual trauma:

Came back from the Gulf War in the early '90s and he was pretty wiggled out. I mean, he had some other – some things happen to him besides being on the front line of the Gulf War, which was not a very long war. It was pretty short, but he had some rough experiences with that and he was a victim that he'd never talked about much before, with sexual assault. While he was asleep.

Participant Four relates that in addition to PTSD she has also seen clients who are veterans of the military with other diagnoses:

Well, the one younger, mid-20s guy, obviously substance, I would say abuse and dependence. Depression, PTSD, anxiety. I think those are the major headers that I've seen.

Participant Five explains that she saw both children and adults, as clients, from the military setting:

I think, you know, the ones I've worked with, the children especially, I think one client in particular, when they came back we were dealing with transition issues because they'd been abroad and deployed with their family member. We handled those transition issues and then it kind of morphed into dealing with ADHD [attention-deficit/hyperactivity disorder] and then dealing with, as the child got older, teenage

relationships, and that kind of stuff. So, the family's military experience was kind of much more in the forefront initially, less so now. I do work with a veteran who has traumatic brain injury [TBI] and PTSD now.

Participant Six reports she has been working with two veterans who are both diagnosed with PTSD, with one of them also the victim of military sexual trauma:

I can tell you about the most recent ones. I'm working currently with two. And when I say in the past I've worked with some, they've just identified as veterans, but we haven't really worked on veteran issue or military issues. But I am working with two particular clients currently. Both are, have been diagnosed with PTSD. So that's where our main focus is, is on working with their issues related to the PTSD. It's been very good. They've made good, both of these have made very good progress. And I'm not an expert in PTSD either, but I've had basic training, you know, in just as I have with most everything if you have that broad-based training in education and counseling. So, I think they're making very good progress.

Participant Seven presented a different view about working with military veterans diagnosed with PTSD in that she was working with a homeless population and recognized Maslow's hierarchy of needs in that their basic needs were not met:

I remember doing co-therapy and this one gentleman, he would be stuck in, you know his life as a soldier and so he would meet the diagnosis for PTSD. But I think about like when basic needs aren't met, shelter, meals, that the other stuff, the other illnesses, mental health issues can't be addressed in a sense. Plus, that whole Maslow. So the focus of therapy

was a lot of resources, getting them resources. So it felt somewhat case management like.

Participant Eight characterized her client's diagnosis of PTSD as "extreme" and shared this account of a client whose PTSD was triggered several decades later:

When he came back home, he had trouble finding work, but then he finally found work, it was with EMS. EMS just took that PTSD that he already had and made it a thousand times worse 'cause in so many situations you can't help somebody and he kept feeling, "I could do something better. I should do something better." And of course, all the images of the awfulness he saw. So he shoved it all down and just kept walking, just kept on getting it. And about two years ago he had what I guess you'd call a nervous breakdown. It's just like it all just came – he just got flooded. Everything he forgot about just flooded back and couldn't even function. He couldn't breathe. Couldn't – he had to be hospitalized. It was really bad. He had no treatment for decades. He didn't – wouldn't even have identified it as that [PTSD]. He didn't even know that he had it. He says that he worked himself half to death, which I think now we know was a coping mechanism. Work so much that you can't even think. And he never dwelled. He tried to – he wanted to forget the images, and so he did. He blocked'em very well, successfully. And I don't really know why it happened or how it happened, but it just broke open one day and he was just completely flooded with all of it and became incapacitated.

Participant Eight had another interesting perspective about PTSD:

And this is something that's always – I find interesting is that there have been – you'll probably laugh at this, but there have been several studies on the effectiveness of taking a certain amount of fish oil, omega 3s, if you're in a position that trauma could happen and you take it every day. It supposedly protects the brain from as-severe trauma if you have high levels of the omegas in your body. I've often said, "Why isn't our military not loading them down with it every single day?"

Participant Nine also relates serving military veteran clients who are coping with relational issues. She explains seeing clients with PTSD along with depression and anxiety, as those mood disorders tend to co-exist with PTSD. Participant Nine had the following perspective about PTSD:

I think the people – the thing that's hard with – people in the military, they're being traumatized as adults. And what we know from the research is that if someone has gotten traumatized in a military situation and they have a childhood history of trauma, that their risk factor for PTSD goes up quite a bit.

Cognitive Behavioral Theory and Eye Movement Desensitization Reprocessing

Cognitive Behavioral Theory (CBT) and Eye Movement Desensitization Reprocessing (EMDR) were found to be the most common treatment approaches among the participants. Some of the participants related using other treatment approaches, such as Neurolinguistic Programming (NLP), solution focused and narrative therapy, but most of them indicated incorporating CBT.

Participant One, who is also certified in EMDR, described the use of treatment approaches for clients with a military background in this manner:

Well, of course, I use a cognitive-behavioral model. But in working with people with PTSD, it really depends on how recent the experiences are. Some of the stuff, the current research out there is showing that, for example, in the acute circumstance, right when the traumatic event happens, EMDR works very, very well to keep them from anchoring or internalizing the experience. But long term, I find that NLP works much better than EMDR for the more distant experiences. And if I have a client who I feel really would benefit from that [EMDR], I tend to refer, because for me, it's an ethical thing. If somebody's better at something than I am, then I think that's in the client's best interest. I'm a little odd that way, I think.

Participant Two related that in his therapeutic approach he mostly utilizes CBT:

Well, it's more I guess just CBT. You know, kind of mixed in with a little bit of this and a little bit of that. You know, could I put a name to it? No, but I guess basics, you know, CBT.

Participant Two also adds that the stance of the therapist is important:

I think the biggest thing that wouldn't be helpful is if there's any air of judgment. Or anything that would feel like that what they have done is less than acceptable. You know, because a lot of times, especially these fellows that's been in combat had to kill someone and they beat themselves up for it.

Participant Three describes the utility of CBT in this manner:

Well, I've just kinda lean toward cognitive behavioral therapy, primarily. So I guess my forte is probably anxiety disorders, posttraumatic stress or phobia or whatever, all that kinda stuff [CBT] do better with mood disorders, depression, so forth.

Participant Four described how CBT and solution focused provides structure for the therapy, but also acknowledges consideration for EMDR:

Well, with those diagnoses [PTSD, anxiety, depression], a cognitive behavioral approach is more effective. I would say because it is very structured, but I'm more solution-focused. So I'm just thinking of that one younger guy that I saw. I would say, CBT and solution focused gives me goals that we were working towards. I don't do this, but there are people in the area that do possibly some EMDR if they get to that point. Because that's evidence based treatment and it's been hugely helpful with trauma.

Participant Five described her use of CBT, but also highlighted a perspective she takes when working with clients from the military population:

I think a collaborative approach works real well for me because I can't ever – I can't really take that expert position in a too hard of a way because I think it, would be met with too much resistance; I think it makes it uncomfortable. I think anything that would be a little more hard line, a little bit more of "I'm the expert. Here's your structure" – not that structure wouldn't work for people in the military, because obviously they're quite used to it, but I think it's a fine balance between letting them

know that I know what I'm talking about, but I'm not trying to boss them around in this area; I'm not trying to tell them about their experience. My impression would be, from the people that I've worked with, anything that would be, that would put me too much in that, like the expert, and I think the one-down position works real well for me in, in those situations with the veterans.

Participant Five added that she is trained in trauma focused CBT and will refer clients to another therapist if they are specifically seeking EMDR as she is not certified in that intervention.

Participant Six did not indicate a particular theoretical approach and commented that she determines her approach during the session and explained it in this manner:

Coping strategies of course, and then just gradual exposure to things that, of course, we can't recreate the actual experiences – but just gradual exposure to what happened to them and processing slowly the actual events. I kinda gauge that particular session and determine what works in that session, as opposed to saying, “Well I do Adlerian or I do cognitive behavioral.

Upon inquiry regarding a particular theoretical approach, Participant Six responded:

No, that's probably the wrong answer, but it's true, it's honest.

Participant Seven shared her perspective on a treatment approach when working with military veterans who are homeless:

Cognitive behavioral therapy and a lot of narrative therapy of just telling their story, without judgement. Having a stance of willing to learn from

the patients, the clients at the time, not knowing about, because I don't know your history. I don't know your story just listening, non-judging. You know, no judgments about how you became homeless. I stayed away from like the emotionally focused therapy because men tend to be more cognitive and following their approach in not pressuring or, I don't know if the word is pressuring, but I would ask like what are, what feelings come with, you know, finding yourself homeless after service, after you served your country. And just allowing them to express whether it's, I can't remember most of the feelings, but maybe there was some depression or, being cautious. But letting them return to that time where they were heroes in a sense where they were valued 'cause they didn't feel valued being homeless after all that they had done.

Participant Eight, who has certification in EMDR, related using EMDR exclusively when serving clients who have both a military background and a PTSD diagnosis.

Just the EMDR. The EMDRs all because once I learned about that, which is sort of tailored for PTSD, I just have gone with that. And I've done it for all kinds of different things with mixed results. It just really sort of depends. But like this – the severe guy [diagnosed with PTSD] I was telling you about was able to just sort of process through and remember and came out at the end being able to say, which for him was huge – being able to recognize that there was nothing he could have done in any of these cases. It wasn't his fault. It was just really awful, awful things that

happened. And he was never gonna forget it, but that the images didn't have to haunt him and it wasn't his fault.

Participant Nine is also trained in EMDR and while utilizing other therapeutic approaches has a different perspective from the other participants about CBT:

Well, I'm trained, I'm an advanced master practitioner of neuro-linguistic programming, and that has a lot of, sort of experiential processes that you can take people through and help them change things. My graduate school training was in psychodynamic and I'd say that's sort of the stew that I cook everything in. I do psychodynamically informed therapy which really with all of the people that training, where the whole thing is CBT, CBT. You don't get trained in that. And the research shows that CBT interventions work as long as you're in therapy. And after you're out of therapy, it drops. And there are other therapies that have more longer lasting things because you're really doing deeper work within people's psyche than just doing behavioral change and thinking how, changing how you think.

Participant Nine gave this example about using EMDR with military clients:

And because I'm trained in EMDR, so he [veteran client] came to me to do work with EMDR, but we ended up not working just on the military stuff, but going back to early childhood stuff.

Utilizing the Internet as a Resource

The participants indicated that they had little to no formal training about working with the military population and identified various workshops they attended which

included a session about working with the military or a one-day workshop on the topic of military culture. Since most of the participants indicated resorting to various online information to gain an understanding about the military culture, the fifth theme identified is utilizing the internet as a resource. They related searching various websites, to include the Veterans Affairs website, to gather information about the military as well as taking advantage of online opportunities to gain continuing education credit. Participant One described gaining information in this manner:

It's more like generalizing from experience what works, what doesn't work, what does the literature hold, that shows what is most effective in working with them. I subscribe to a number of online medical journals, but when it comes to the other stuff, some of that is coming from just Google searches and finding things like that.

Participant Two provided this response about working with his first client who was a Vietnam Veteran:

And I looked it [Vietnam War] up and, whew, it must have been a mess over there.

Participant Two also shared how he has prepared himself to work with clients who have a military background:

I've done a lot of reading, study, just read on PTSD because, yeah, it's what I know. Reading, I guess continuing ed on DVDs, since nobody does much around here. A lot on grief, a lot on depression, anxiety disorders. Believe it or not, the VA's a good resource. They do a lot of research. All their stuff is a website away. They do a little quarterly publication that

goes into the latest and greatest. And yeah, I think like anything else, you have to have an interest.

Participant Three held a different perspective about seeking training opportunities and utilizing the internet as a resource since he has a military background which also includes working in military setting as a civilian:

I remember one time I saw something here a year or two ago that there was some kinda registry they were trying to create in the state and it was for people that were working some with military families and I for some reason, I thought, "I can't even get through the mud to get on the thing" and basically it was, there was something offered to try to help people who were working with military understand the system, about rank and all. And how the hierarchy works, the chain of command and all that kinda stuff. I know all that. It'd be like for somebody that'd never worked in it at all.

Participant Four did not indicate utilizing the internet as a resource. She described a collaborative relationship with personnel from a local Veterans Affairs clinic:

Actually, we have a close working relationship with a psychiatrist that worked with the VA. And then I also have a personal friend who is a LISW [licensed independent social worker] that works over at the VA now. From time to time, if we have a situation they may, the friend of mine that works over at the VA, she may call me and say, I have somebody that I'd like to send you, I think you'd be a good fit. Or just the collaborative

relationship that I have with the psychiatrist and her experience I could call her and just run a case by her if I needed to.

Participant Five, who is a provider for TRICARE, related how she used online resources about the military culture for continuing education purposes:

I wouldn't say that I've had any specific training. I know that I've probably attended some conferences or I have some books or I've done some reading, it's not that I've ever had a class or I've specifically taken any certification to work with the military. I know they [TRICARE] have offered some things and I think I have done, now that we're talking about; I did an online training with them. It was probably a couple years back now. So, I have done probably some online trainings and I think it was offered through TRICARE, and then now through AAMFT [American Association of Marriage and Family Therapists] our professional organization. They do have online trainings that you can now take and I've not done one, but I know that they have those, so I haven't done those.

Participant Five also indicated completing PTSD 101 training through the Veterans Affairs website.

Participant Six reported attending workshops about the military, but did not seek online resources for information:

Yeah, I've had periodic trainings, like you know, going to a conference or I may have two or three hour trainings at a workshop or I may have a one-day training through the region that the DAODAS [SC Department of Alcohol and Other Drug Abuse Services] group does. So that's the extent

of my training for military issues. I know that I've had the two or three hours at a couple of different conferences.

Participant Seven related she attended a workshop in addition to completing online trainings about the military culture:

I've attended some training. I physically attended this one, Military Child Education Coalition. I've attended one of their trainings. [Completed] online trainings through Vets MFLC [Military Family Life Consultant], all of them.

Participant Eight shares how she has searched online about a specific war and that she has not received any formal training:

Zero [trainings], I've done. Now when this guy [military veteran with PTSD] came in, I got very quickly online and started looking for books and articles. And I went back to my EMDR books and read specifically because that was tailor made for PTSD, but I had not done those studies for so long that it's like, "Let me go back and look and see exactly the details on this for veterans or for people who were injured in the war". And so I did sort of like that background stuff just because I was a little nervous when I found out that somebody who was this injured was coming in and other therapist had said, "No". I thought, "I don't want to be the third one to tell him no". But besides that, nothing formal.

Participant Nine responded to the question about helpful resources in this manner:

Probably on the internet. There aren't that many, there are more now than there used to be, but there really aren't that many continuing

education things, at least not around here, specifically focused on working with veterans. I see now, more of them now than I used to. But see, mainly like I said, I meet the person where they're at, and find out from them in their world kinda, I just follow my head as about what's important and ask questions.

Interest in Understanding Reintegration

Most of the participants indicated in some way an interest for learning more about the military culture especially as it related to returning from their deployments and returning to civilian life; thus, the final theme reflected the participants' desire to learn more about the military life as it relates to the varying aspects of reintegration.

Participant One shared this perspective about workshops related to the military:

And you look at, for example, a lot of – there are a number of military people who retire to the Upstate [South Carolina], after their service is over. And so you look at, okay, what is the family systems effect of the chronic separations? Would be kind of an interesting thing to look at. And, of course, you know, further issues regarding PTSD and, and sleep disorders. What occurs to me just now is something I've never heard of anybody doing, which would be more of a reintegration process of how do military people reintegrate into the community. And what skills do they need to develop and what skills do they need to let go of.

Participant Two provided this response about his interest for additional training on topics related to military personnel:

Probably the biggest thing is just understanding the culture. You know, I think that would be the biggest thing. So I think you have to understand the culture. I think you have to try to understand the conditions that they live in when they're deployed. Since the military has gone so dependent on reservist and National Guard, that something else I think that needs to be addressed. The full-time folks, that's their job.

Participant Three indicated less of an interest for additional training about the military culture, he responded in this manner:

Depends on what it was. I mean, I'm kinda winding down. Probably another year, I'm still plannin' to retire.

Participant Four indicated a desire to know more about military personnel re-acclimating to civilian life and also the diagnoses found among the military population as they return home from deployments:

To know more about some of the diagnoses they are coming home with then if I were going to work primarily with military families I'd need to know more, you know, wherever they've been on active duty. Because I know that, there has been such a huge influx of PTSD. Um, I do have a client right now whose husband was in the Gulf War and he's come home with PTSD. He's got fibromyalgia and he was exposed to a lot of chemicals that were over there when they set the oil fields on fire. And so, according to her, he struggles with symptoms associated with that. So I'd want to know more about what they're coming home with to help identify that. And I think that would help in their treatment so that they don't think

that it's just all in their head, that they're imagining that. Maybe, you know re-acclimation into civilian life if that's something that they choose. And you know, I think too, even when they do come home and if they're still in the military just being here and not where they were trained to be and how they're acclimating to all that. You know, I'm sure that there are a lot of resources out there that I'm not aware of. There's probably a lot more at the VA that I don't know about.

Participant Five indicated a desire to understand the military personnel returning from their engagements:

Anything [training] that, I guess being, sensitive to their experiences and how it differs from even those vets who came from, you know, previous military engagements.

Participant Five also shared other topics of interest as it relates to serving the military population:

I think, you know, kind of general, just general training about culture. I think it's always helpful to know, even amongst the different branches, just like a little, general, like how do they approach things, because, you know, having not had anybody in my family in the military or anything, it's very easy – "Oh, they're –" – you know, the big mistake to call everybody in the Army. They're all; they're all not in the Army. There's the Marines. There's the Navy, and they've got their specific things that are, specific cultures, I guess. But, also, anything having to do with trauma, because I think there's so much that especially those in the military, you know, are seeing

– or anybody who's ever been – but especially because we're in such an ongoing – we have such – you know, militarily, there's so much continuing to go on.

Participant Six stated an interest to add to knowledge gained from a workshop session:

From what I remember in the short training that I have had is that there's almost like a different mindset for people when they've been away, they've been deployed and then they come back and it's a different mindset when they come back and they've experienced lots of horrible things. And then they have to readjust to the real world again. So I think more training helping people like me to understand those kinds of issues. I think if I had better insight to how it affected them when they're actually at war or in those kinds of really risky situations, or the readjustment.

Participant Seven related an interest for the type of training she would find helpful in serving military veterans:

Trainings that focus on coming home, transitioning into, I guess is the words, no longer being a soldier, or are you always a soldier"? Just transitioning. Permanently, not going back, and you're not going to be deployed again.

Participant Seven also included the military families in her training interests:

Trainings with the families that are here while their family members are away and deployed.

Participant Eight expressed an interest in knowing what to do for service members as they returned home and separate from the military:

I would love to know what to do for them once they get back out. I would love to know how to help them be functional once they get out. Job placement. As far as that goes.

Participant Eight also related concerns about the family members of active and veteran service members and shared this perspective as to why she believes training should be targeted to assist them as well:

Certainly the impact of all of this on the family members. Living with somebody with PTSD. And because they're victims too in their own way from all – they're having to do. Often having to be barked at and yelled at.

Participant Nine recognized a changing military culture and stated she would like to receive more information about the military culture. She shared this perspective in response to training topics she would be interested in:

To learn more about military culture. Because I think the military culture's changing, as well as I can tell, so kind of just staying up with kinda what's going on, what kinds of things, hearing about other people that are working with the military, and yeah, just learning from them about what things that they got faced with, how they handled it, their reflections on it or whatever. Those kinds of trainings would be useful. Yeah.

The findings derived from the data collection were significant in exploring the research question: How do mental health clinicians perceive working with the military population? While efforts have been focused on the preparation of civilian mental health

clinicians to work with the military population, a review of the literature shows a gap in focusing on the civilian mental health clinicians' perceptions. The data collected for this study represents the thoughts and experiences of the participants as they considered serving the military population. According to the participants, their thoughts and experiences indicate they perceive they are able to provide mental health services for the military population. The themes revealed were based on their experiences of working with the military population and providing further information regarding how they characterize their provision of services. The association between the themes and the review of the literature are further discussed in chapter five

Summary

Chapter four presented the manner in which data was collected and analyzed for a sample population of nine civilian mental health clinicians. The research question investigated was how civilian mental health clinicians perceive serving the military population and their families. The findings resulted in the revelation of six themes which captured the mental health clinicians' perceptions about serving the military population. The six themes were: learning from the client, viewing the military as a speciality, posttraumatic stress disorder as a common diagnosis, cognitive behavioral theory and eye movement desensitization as common treatment approaches, utilizing the internet as a resource and interest in understanding reintegration.

In chapter five, the findings are discussed in greater depth especially as it relates to the review of the literature. Additionally, chapter five also includes the researcher's reflections, implications of research for counselor education programs, the limits of this research, and suggestions for future research.

CHAPTER 5

Discussion

The purpose of this chapter is to explain the findings from chapter four especially as it relates to the review of literature presented in chapter two and an iterative review as new insights emerged from the themes. The limitations will also be addressed referencing its implications from chapter one and finally, the significance of this study is included for counselor educators, licensed mental health clinicians and supervisors.

Overview

This study was conducted to investigate the mental health clinicians' perceptions about working with the military population. The primary research question that led the investigation was, "How do mental health clinicians perceive working with the military population?" There were sub questions that further directed the study: (a) how do the clinicians perceive their knowledge base to work with the military, (b) how do the clinicians perceive their attitudes and beliefs about this special population, and (c) how do the mental health clinicians perceive their understanding about the world view of the military population?

A qualitative design with phenomenological inquiry was employed for this research as it would facilitate exploring the civilian mental health clinicians' perceptions through in-depth interviews so as to determine themes, meanings, and essences of their experiences (Moustakas, 1994). A purposive sampling method was utilized and nine mental health clinicians were selected for this study, which was a limited group having

the particular characteristics for examination (Grinnell & Unrau, 2011). The participants were licensed by the state of South Carolina either as Licensed Professional Counselors, Licensed Marriage and Family Therapists or Licensed Independent Social Workers to provide mental health services within the community. A point of saturation was met (Lincoln & Guba, 1985; Morse, 1994) as the nine mental health clinicians were interviewed; transcriptions of the audio recording were prepared and then analyzed using the four step analysis process as described by Moustakas (1994).

The findings of the study revealed six themes about the clinicians' perceptions of serving the military population as the participants shared their actual experiences of working with clients, who have a military background and their family members. The six themes were: (a) learning from the client about the military, (b) viewing the military as a speciality, (c) posttraumatic stress disorder as a common diagnosis, (d) CBT and EMDR as common treatment approaches, (e) utilizing the internet as a resource, and (f) interest in understanding reintegration.

Interpretation of Findings

The review of the literature, as presented in chapter two, have indicated the importance of having civilian mental health clinicians' in the community available and prepared to serve the military population (Kilpatrick, et al, 2011; Gonzalez 2014; Hickerson, 2014; Koblinsky et al, 2014; Miller et al, 2014; and Smith-Osborne, 2015), and an understanding about the military culture (Hall, 2008; Coll, et al, 2011; Petrovich, 2012; Holmstrom, 2013). The goal of this study, however, was to investigate the perceptions of the civilian mental health clinicians regarding their thoughts and experiences about serving the military population. While the review of the literature

shows the importance of training the community mental health clinicians to serve the military population, there appears to be a gap in the literature regarding the civilian mental health clinicians' perceptions about serving the military population.

Perceptions about Serving the Military Population

In response to the primary research question, "How do mental health clinicians perceive working with the military population," the participants readily shared their experiences and beliefs about serving clients with a military background. In addition to the primary research question, there were sub questions that addressed their perceptions about the military population with regard to: knowledge base, attitudes and beliefs, and understanding the world view of the military population. These sub questions reflect the three broad categories of the multicultural competencies (Sue et al, 1992). In the following section, the six themes revealed in the present study are discussed to include comparisons with previous related studies and the review of the literature presented in chapter two.

Learning from the Client. This theme was revealed when the participants were asked about their familiarity with the military. Most of the participants indicated they had family members in the military or had worked with clients in the past with a military background. They shared how working with military veteran clients added to their knowledge and how they would ask their clients questions to gain an understanding about the military culture. While there was not a specific study found which highlighted learning about the military culture from the client, several studies (Gonzalez, 2014; Stewart, 2012; Smith-Osborne, 2015; Tanielian et al, 2014a; Koblinsky et al, 2014; Miller et al, 2014) indicated the importance of cultural competence to work effectively

with the military population, which includes the various branches of the military along with their active and reserve components (Hall, 2008).

A study conducted by Forgery and Young (2014) with a quasi-experimental pre-post-test design emphasized the importance of cultural competence by comparing learning outcomes of students who took a military social work course with those who did not. They found that there is a general lack of knowledge about the military culture which also extended to mental health professionals working in the field. Kilpatrick et al, (2011) found in their study of healthcare providers that there were a low percentage of providers having experiences working with the military population and training should be directed toward improving an understanding of the military culture.

Given the aforementioned studies, while the participants in this study utilized their clients to learn about the military culture, it seemingly questioned their cultural competence to work with the military population. A study conducted through the Rand Corporation (Tanielian et al, 2014b) furthers this point as they indicated that mental health providers in the community varied in being knowledgeable and comfortable to treat clients with a military background. They interpret that their findings suggest military service members, veterans and their family members who seek care in the community may encounter providers who do not possess cultural sensitivity about the military culture.

Viewing the Military as a Speciality. A review of the literature supports the characterization of the military as a speciality by emphasizing the importance of understanding the culture and the need for community mental health clinicians to receive training (Dunivin, 1994; Burrell et al, 2006; Fennell, 2008; Wilson, 2008; Coll et al,

2010; Hall, 2011; Blaisure et al, 2012; Cole, 2014; Forgery & Young, 2014; Redmond, 2015). For example, in a study conducted by Miller et al, (2014) an online survey sought to examine the knowledge, common practices and training needs of community mental health providers to determine their readiness to serve the military population. The online survey questions reflected the three broad categories of the multicultural competencies which are: knowledge base, attitudes and beliefs, and understanding the world view of the military population. The researchers echoed the theme of viewing the military as a speciality as they found that there is a need to train civilian mental health clinicians on ways to accurately screen clients about their military status. They noted that the screening would better enable the clinicians to work effectively with the military population. Additionally, the researchers found that a majority of the clinicians had minimal training as it relates to serving the veteran population, which included graduate training, thus, suggesting an inadequacy for knowing about the military culture.

Similarly, Smith-Osborne (2015) conducted a study, strongly suggesting the military as a speciality as it focused on an intensive continuing education course training social workers for military social work practice. The results demonstrated that the community practitioners believe there is a need for the military and veteran certification program and that the courses aided their depth of insight to better understand a range of pertinent areas to effectively work with the military population.

In the present study, most of the participants made some reference to the military as a speciality. For example, Participant One stated he has a familiarity with the military, but added:

I've worked with them and their families and what not, but probably not to the degree of somebody who specializes in that area or who works out of a VA clinic or that sort of thing.

Participant Five related a similar sentiment:

Like I said, I'll never put myself out there as an expert in doing it. I'm not gonna say I'm a speciality.

Participant Nine commented:

I would not ever claim to say that I specialize in treating the military . . . it's not that they've been a primary percentage of the people that I serve.

Participant Seven's comment was particularly revealing about viewing the military as a speciality as she referenced skill and confidence.

I don't have that clientele to build that confidence, that skill to truly grow in it. I mean they're not walking through my door. You don't have the opportunity to build confidence and grow from working with them.

The participants also recognized the uniqueness of the military culture and some participants asserted the need for clinicians to have at least a basic understanding about the military culture. The participants conveyed they were of capable of working with military veteran clients and some indicated they would make a referral if the client's case was beyond their scope, or if a specific intervention was requested for which they did not have experience or certification such as, EMDR.

Participant Three, who is an outlier for the criteria, remarked that his prior military status forges a connection with military members. He stated he has an identity with military veterans because of his time in Vietnam and is able to understand the

experiences of the veterans who have been in combat situations. Participant Three also echoed the views of other participants as he reflected on viewing the military as a speciality:

I mean the guy that was a Gulf War vet, I mean right off the bat, you build some rapport instantly with somebody like that. 'Cause they know kinda where you're comin' from. When you walk in the door - and that's what this Star program, or whatever, I think was tryin' to help with - and you sit down with a therapist - who doesn't know the difference between a sergeant and sergeant major - particularly if they're still active duty, that's kind of a problem. 'Cause they have - they - you're basically conveying to them that you don't have a clue about the world in which they live. And it's a - it's a different world. 'Cause I think a lot of people don't have any basic idea at all. I would rather do it, but that's because of my experience.

Posttraumatic Stress Disorder as a Common Diagnosis

When the participants of this study were asked to share their experiences about working with the military population, they spoke of several diagnoses such as, depression, anxiety, substance use disorders, relational issues, military sexual trauma, deployment and reintegration issues. All of the participants, however, related they had served a client in the past or present with PTSD and so this particular diagnosis was identified as a theme among the participants. This theme is supported in the literature and according to a comprehensive study conducted by the RAND Corporation (Tanielian & Jaycox, Eds, 2008); two major combat-related injuries are of concern, PTSD and TBI.

The researchers also identified in the study that the prevalence of PTSD among deployed service members is greater than depression and it is also recognized as the most common mental health condition affecting between 5 to 15 percent of the service members.

The participants appeared to have some insight about the PTSD diagnosis relating comorbid diagnoses such as, depression, sleep disorders, TBI and military sexual trauma. Additionally, although PTSD was a common diagnosis found among the participants, they had differing perspectives about PTSD resulting from their experiences and perceptions. For example, Participant Five stated:

I do work with a veteran who has traumatic brain injury and PTSD now.

Participant Three remarked about another dual diagnosis that included PTSD.

... he had some rough experiences with that [PTSD] and he was a victim that he'd never talked about much before, with sexual assault. While he was asleep.

Participant Six remarked that one of her two clients, diagnosed with PTSD, is also diagnosed with military sexual trauma (MST).

The participants' experiences of comorbid diagnoses with PTSD were found in the literature. For example, the association between sleep disorders and PTSD are supported in the literature as one study showed that military personnel suffering from insomnia are more likely to have PTSD (Mysliwiec, Pierce, Smith, Trapp & Roth, 2013). The comorbidity of military sexual trauma in the literature shows an association with high rates of posttraumatic stress disorder (Cloitre, Jackson & Schmidt, 2016; Hoyt, Rielage, & Williams, 2012). Yet another comorbid diagnosis with PTSD is TBI. An interesting finding in the literature is a study conducted by Depue et al. (2014) which

sought to understand the differences in brain structure with the occurrences of both PTSD and TBI. They found that the changes in brain circuitry contributed to symptoms related to PTSD and cognitive deficits. Yet a concerning comorbidity, found in the literature, is that of depression due to the risk of suicidal behaviors (Ramsawh et al., 2014). For the most part, the participants recognized the seemingly complex nature of PTSD.

Participant Seven, whose work with the military population was limited to homeless veterans, related another perspective:

I remember doing co-therapy and this one gentleman, he would be stuck in, you know his life as a soldier and so he would meet the diagnosis for PTSD. But I think about like when basic needs aren't met, shelter, meals that the other stuff, the other illnesses, mental health issues can't be addressed in a sense. Plus that whole Maslow. So the focus of therapy was a lot of resources, getting them resources. So it felt somewhat case management-like.

Veteran homelessness is well supported in the literature. One study which was conducted with over one thousand Iraq and Afghanistan veterans found that money mismanagement was a problem for a significant number of veterans and related to homelessness (Elbogen, Sullivan, Wolfe, Wagner & Beckham, 2013). Tsai and Rosenheck (2013) noted in their study that childhood family instability and childhood abuse were predictors of homelessness among the veteran population and to a lesser degree, conduct disorder was also a predictor. Yet another study focused on a cohort of veterans from the Iraq and Afghanistan conflicts. Metraux, Clegg, Daigh, Culhane & Kane (2013) utilized the administrative records of thousands of military veterans and noted that a combination of

service in Iraq or Afghanistan and PTSD were risk factors for homelessness. Other risk factors for veteran homelessness include substance use disorders and mental illness (Tsai & Rosenheck, 2013).

Participant Eight shared this perspective when considering the impact of PTSD on the family members:

Certainly the impact of all this on the family members. Living with somebody with PTSD. And because they're victims too in their own way from all – they're having to – they're often having to be balked at and yelled at.

Relationship concerns among military personnel were noted in a study by Khaylis, Polusny, Erbes, Gewirtz, & Roth (2011) in which 100 National Guard Soldiers completed an anonymous self-report questionnaire to assess PTSD symptoms. They found that in addition to endorsing PTSD symptoms, they also indicated concerns about their romantic relationships. Additionally, soldiers diagnosed with PTSD and who were also parents expressed concerns about their child-rearing practices.

Two participants from this study related an understanding of PTSD beyond the symptoms. For example, Participant One explained how he views PTSD as a survival mechanism:

PTSD is a survival mechanism. Hair trigger, wakefulness, and all that kind of stuff are survival mechanisms. They're the things that they're taught, in some respects, in order to survive in that environment. But when you leave that environment, they're not that helpful. I see people in the military as people who have been trained in a certain set of skills that

are applicable in the environment that they work in, but may not necessarily be applicable in the environment they live in.

Participant One adds that one of his clients, who recently returned from deployment, had another deployment pending. He stated they discussed working on his symptoms upon his return from the deployment as he recognized the symptoms were a part of his survival mechanism.

The notion of PTSD as a survival mechanism was not explicitly noted in the literature, but a review of the neuroscience of PTSD provides a different view. One study sought to investigate the patterns of spontaneous brain activity in combat-related PTSD; specifically, the researchers were interested in areas of the brain involving the amygdala and the various cortices (Yan et al., 2013). The investigators discovered that there is increased activity in spontaneous brain activity even in the absence of a provoking trauma; thus the finding asserts that the amygdala of PTSD patients has increased activity in instances of threatening stimuli and during a resting state which contributes to the symptoms of PTSD.

While there is some support for Participant One's account of the usefulness of PTSD symptoms, a review of the literature does not appear to support delaying treatment of PTSD. In fact, Wangelin and Tuerk (2014) symposium's article tackles the ethical issues surrounding the treatment of PTSD and using exposure therapy as treatment while the service members are currently in combat zones.

Participant Nine showed a greater understanding about PTSD symptoms by pointing to research:

And what we know from the research is that if someone has gotten traumatized in a military situation and they have a childhood history of trauma, that their risk factor for PTSD goes up quite a bit.

This is supported in the literature, for example one study investigated multiple childhood traumas in a sample of 582 adults and 152 children. The findings indicated that childhood versus adulthood traumas, were indicators of an increasing PTSD symptom complexity in adults (Cloitre, Stolbach, Herman, van der Kolk, Pynoos, Wang, and Petkova, 2009), thus exposure to cumulative childhood and adult traumas pose as major risk factors for the development of adult PTSD (Herringa, Phillips, Fournier, Kronhaus and Germain, 2013; Voorhees, Dedert, Calhoun, Brancu, Runnals, and Beckham, 2012).

Participant Eight shared an interesting perspective about PTSD from a preventive stance:

I find interesting is that, there have been – you'll probably laugh at this, but there have been several studies on the effectiveness of taking a certain amount of fish oil, omega 3s, if you're in a position that trauma could happen and you take it every day. It supposedly protects the brain from a severe trauma if you have high levels of the omegas in your body. I've often said, "Why isn't our military not loading them down with it every single day?"

Surprisingly, Participant Eight's perspective was supported in the literature. The Durham VA Medical Center is currently conducting a 10-year clinical trial, which began in 2008, investigating the use of Omega-3 Fatty Acids with veterans aged 18 to 65 and who have a current diagnosis of PTSD to determine if it can be utilized as a treatment strategy.

In addition to the aforementioned clinical trial, Lewis and Bailes (2011) promote the concept of dietary supplementation with Omega-3 Fatty Acids as “neuroprotection for the warrior” because it increases the brain’s resilience to counter the effects of TBIs. Similarly, Matsuoka (2011) proposes a conceptual model describing how the use of Omega-3 Fatty Acids can be used as a preventive measure for PTSD highlighting its effect on neurogenesis in the hippocampus area of the brain, which is responsible for fear memory and contributes to PTSD symptoms.

The participants shared how their clients incurred the PTSD diagnosis several years ago, but were triggered by some recent event into active symptoms when they presented for mental health services. It was noted from the participants’ accounts that the PTSD symptoms did not occur until years later after the exposure. For example, Participant Eight made the following comment about her client:

He had no treatment for decades. He didn't – wouldn't even have identified it as that [PTSD]. He didn't even know that he had it.

Participant Two had a similar account from his client who did not show symptoms of his PTSD from the Vietnam war until years later when he was contacted by one of four surviving soldiers from his unit.

And he really hadn't talked that much about it. Came home, got married, had kids. Life is good. And then one of the four contacted him. He went south real quick.

This later onset of PTSD symptoms is supported in a RAND corporation study (Tanielian & Jaycox, Eds, 2008) which noted that mental health treatment for the service member

needs to be considered beyond the time period after deployment, especially as the need may increase when PTSD symptoms occur months or years after the traumatic event.

CBT and EMDR as Common Treatment Approaches. When the participants were asked about the theoretical approach they utilized to serve clients who have a military background, they indicated several approaches such as narrative therapy, neurolinguistics programming and solution-focused. Most of the participants mentioned CBT as their primary approach and several referenced EMDR; therefore, these two approaches were noted as a theme among the participants. Additionally, some participants stated they were either certified in EMDR or noted the use of it as an option to the extent they would make the necessary referral to a therapist who specializes in EMDR.

According to a research study by Tanielian et al. (2014b) and as presented in chapter two, CBT was the primary theoretical orientation utilized by a majority of social workers, licensed counselors and psychologists. The clinicians also indicated that CBT was the most common therapeutic technique for which they had received the most training. When the participants in Miller et al.'s (2014) study were asked about the technique they use to work with military clients diagnosed with PTSD, more than half of them indicated cognitive behavioral therapy.

Additionally, the participants of the present study commented on the use of EMDR. For example, Participant Eight related how she exclusively utilizes EMDR with her military clients who have a PTSD diagnosis:

The EMDRs all because once I learned about that, which is sort of tailored for PTSD, I just have gone with that.

The use of EMDR was assessed in the study by Tanielian et al. (2014b) and was described as a validated PTSD psychotherapy. In Stewart's (2012) dissertation, focus is given to EMDR as a current evidence-based treatment for PTSD and describes how it has gained much attention because it is a modality that involves exposure techniques along with biofeedback. Miller et al. (2014) noted in their study that a very small percentage of clinicians utilized EMDR as a therapeutic technique to work with military clients diagnosed with PTSD. Tanielian et al.,'s (2014b) study also indicated that very few clinicians received training in EMDR. Perhaps the comprehensive nature of the EMDR approach and the specialized training that the clinician needs to receive is the reason for the low percentage (Shapiro & Laliotis, 2011).

Utilizing the Internet as a Resource. The participants in the present study were asked which resources they found helpful to inform them about the military population. Most of the participants indicated they had received minimal training, for example Participant Two stated:

I've done a lot of reading, studying, just read on PTSD. I guess continuing ed on DVDS since nobody does much around here.

Participant Nine echoed a similar sentiment:

There aren't that many, there are more now than there used to be, but there really aren't that many continuing education things, at least not around here, specifically focused on working with veterans. I see now, more of them now than I used to.

Some participants reported they had attended a three-hour session during a conference or a one-day workshop event which specifically focused on serving clients with a military

background. Most of the participants, however, indicated utilizing the internet in some way to gain information and so this was revealed as a theme. They either spoke of conducting an online search about a war or conflict that the client referenced or gaining insight about a specific topic for the military client they were serving such as, PTSD.

Kilpatrick et al.'s (2011) study surveyed providers about resources they identified as being helpful to increase their knowledge to work with current and former members of the Armed Forces. The results from the study indicated that the most popular resources were: web-based training courses, conferences or workshops and one-page informational hand-outs. It is noted from this study that the popularity for web-based training courses, conferences or workshops differed by one percent which suggests that participants are likely to participate in web-based trainings or attend a conference. Similarly, Koblinsky et al.'s (2014) study, which focuses on 14 veteran conditions, found that participants were mostly interested in face-to-face training in their respective geographic areas while more than half indicated interest for webinars.

For the most part, the participants of the present study were noted to take measures to prepare for their military clients and gain some understanding of the military culture, which they did not receive during their formal training. In the Tanielian et al. study (2014b), the participants were asked specifically about their ability to provide evidenced based approaches to serve military clients diagnosed with PTSD. The study's results indicated there was a need for training among the civilian mental health clinicians especially those who completed their formal training some time ago. In the present study, almost half of the participants completed their formal training ten years ago or more and also reflect a group who completed their training "some time ago".

Desire to Understand Reintegration. The participants were asked what kind of training they would be interested in regarding military members and their families. The responses included understanding the military culture; more about PTSD; reservists and National Guard; and common diagnoses found within the military population. Most of the participants related a desire to learn more about reintegration as it relates to service members returning to their families from deployment or returning to civilian life upon separating from the military. Participant One captured a sentiment that was repeatedly heard from other participants in the present study:

What occurs to me just now is something I've never heard of anybody doing, which would be more of a reintegration process of how do military people reintegrate into the community. And what skills do they need to develop and what skills do they need to let go.

Participant One relates many issues that military members and their families face. This is supported in the review of literature as it indicates that the military lifestyle poses challenges for both the service members and their families (Hall, 2008; Allen et al., 2010; Coll et al., 2011; Blaisure et al. 2012; & Hemmer, 2014). Additionally, Luby (2012) highlights that due to realignments of military bases and closures there are an increased need for civilian-based services in the community and therefore, clinicians who have a competence and readiness to serve the military population (Fennell, 2008; Hall, 2008).

The review of literature did not support this theme. Kilpatrick et al.,'s (2011) study identified topics that participants were interested in learning more about. It included topics of interest such as, roles that women fulfil in the military and the impact on their health; service members with legal issues; veterans and reservists with housing

problems, and medical and mental problems of active duty and veteran members. Gonzalez's dissertation (2014) did not explicitly support this theme, but showed that the clinicians viewed military cultural training opportunities as limited. Hickerson's dissertation (2014), found that the clinicians believed more training was needed in holistic therapies and family counseling therapies to effectively work with the military population.

Finally, although Stewart's dissertation (2014) focused on a sample of military veterans, an interesting finding was noted as the veterans indicated a difference between "appreciation" and "respect" in that civilians may respect the military service of the veterans, but yet not have an understanding of the military lifestyle which would foster "appreciation". Although Stewart (2012) focused on military veterans, the difference that is offered between "appreciation" and "respect" has implications for the cultural competence of clinicians, as appreciation would entail having empathy, an informed stance which is beyond respect for clients.

Cultural Competence

The participants' perceptions are explored in this study and the review of the literature includes cultural competence. Its implications as it relates to the themes are discussed, especially as they reflect the three broad categories of competencies which include, knowledge, attitudes and beliefs and skills (Sue et al., 1992).

Cultural Sensitivity

The review of the literature and the present study suggest there is more to training in order to become multicultural competent. Fowers and Davidov (2006) emphasize the notion of "openness," which is beyond knowledge about one's culture. The suggestion is

that “openness” allows for challenging one’s own self- awareness and cultural biases so that differences are recognized and appreciated. This is also echoed in Stewart’s (2012) dissertation when the distinction is made between “appreciation” and “respect”. Stewart (2012) seemingly draws a parallel to Fowers and Davidov’s (2006) notion of openness, leading to cultural sensitivity, in that appreciation fosters empathy and understanding thereby, affecting cultural competence. Participant Two’s comment appears to support this idea when he shares how he connected with military veterans:

I mean the last guy I had; he’d been to six different counselors. One he didn’t trust ’em and two he said, “They don’t even got a clue what I’ve been through.” That’s what he told me.

Participant Three added similar thoughts which indicated the importance of cultural sensitivity as he gave his perspective about the military:

‘Cause they have – they – you’re basically conveying to them that you don’t have a clue about the world in which they live. And it’s a – it’s a different world. ‘Cause I think a lot of people don’t have any basic idea at all.

Participant Eight shared an awareness that she captured from her clients which further promotes understanding towards cultural sensitivity:

I think what I’ve heard both of my – guys say is that they feel when they’re talking to somebody else, like, the fact that I was not in the military, and they almost feel like – or they’ve said, “Unless you’ve been there, unless you have felt like your life is very well threatened or unless you felt like you failed on the job in saving another life, there’s no way you can really understand.

Similar to the construct of cultural sensitivity, Smith (2014) offers a framework that counselors can utilize to effectively work with the “inherently complex military cultural amalgam” that is most likely to be encountered when providing therapy to veterans. Smith (2014) recognizes that a high degree of counselor reflexivity is needed in which the counselor is constantly in self-reflection as it fosters increased awareness thereby enabling an adjusted action to meet the needs of the client.

Perhaps a possible resolve for clinicians in Participant Eight’s position is cultural humility which is explained in the next section.

Cultural Humility

As stated in the review of the literature, Tervalon and Murray-Garcia (1998) introduced the idea of cultural humility which is recognized as a lifelong commitment one makes towards self-evaluation and self-critique. The authors note its importance in that it is not reflective of knowledge, but a self-awareness that allows for a difference in attitude to effectively work with diverse clients, thus an emphasis for self-humility that fosters a mutual respect towards others in the client-professional relationship. Perhaps that is the essence that Participant Five shared when she responded to the query about any theoretical approach she believed would not be helpful when working with the military population:

My impression would be, from the people that I’ve worked with, anything that would be, that would put me too much in that, like the expert, and I think the one-down position works real well for me in, in those situations with the veterans.

According to Tervalon and Murray-Garcia (1998) if the professional adheres to a lifelong commitment of self-evaluation and self-critique, it affords the opportunity to “redress” power imbalances between the professional and client so that there is less of an authoritative style, but one in which the professional values the client’s agenda and perspective. Luby (2012) includes a similar notion which has application to the military culture. Community civilian providers can increase their cultural competence by conducting a self-inventory and honestly evaluating their position regarding military and political issues so that personal values do not have an impact on the provision of care and services (Luby, 2012).

Social Change

The purpose of this study was to investigate the civilian mental health clinicians’ perceptions about serving military members and their families. As stated in chapter one, perhaps foremost in the order of social change is the consideration of the military as a social group instead of a military organization. A regard as a social group lends towards more humanistic qualities and thus recognizes it as a group that has needs and considerations as any other group.

While the findings of this study support the need of civilian community mental health clinicians to receive training, an overarching consideration that has reverberated from the review of the literature to the discussion in this study is the importance of multicultural competency. The distinction is made between knowing about the military culture to having culture sensitivity and culture humility fostering an understanding that leads a path to empathy. According to Tervalon and Murray-Garcia, a lack of cultural

competence is not suggestive of a lack of knowledge, but a need for self-awareness and a change in attitude about working with clients from diverse backgrounds.

The participants in this study shared their perceptions and thoughts about the military population. They indicated how they perceived the military as a speciality and that clinicians would need to understand the worldview of clients with a military background. Their interest to understand reintegration and how they can assist military clients was strongly suggestive of understanding the differences between military and civilian life. For the most part, the participants shared their experiences in serving the military population and identified ways in which they took extra measure to increase their self-awareness and provide therapeutic services.

The participants in the present study basically made a call to those that work with the military population to have an understanding about the military culture that fosters connection in some way. They identified ways in which they forged a connection as they shared about having family members in the military or some parallel experience from which they could draw from. They spoke not as former military, with the exception of Participant Three, but with a strong recognition that the military population holds a different world view than that of the civilians' world view and it requires professionals to also understand that difference. Finally, the findings from this study have important implications for the profession of counseling and they are presented in the next session.

Recommendations for Action

As stated in chapter one, the significance of this study was that the participants' perceptions are another layer of information to consider as training efforts continue to prepare mental health clinicians in the community to serve the military population. As

anticipated, this study revealed the perceptions of the participants and indicated their concerns about serving the military population. The following section discusses recommendations for counselor educators and clinical practice based on the findings in this study.

Counselor Educators

Given the participants' responses in the present study, it is apparent that serving the military population was not included in their formal training. It is also noted that for the past several years, there has been some kind of conflict or war in the United States and the needs of the military members and their families would have existed. As schools consider multicultural counseling courses for counseling students, there is a need to address the concerns and needs of the military population along with gaining an understanding about the military lifestyle. Inclusion of the military population in graduate courses may begin the process of mental health clinicians recognizing the military as a unique culture with different concerns and needs compared to the civilian population. Course content should consist of understanding the military rank, customs and traditions to include pertinent military jargon, common diagnoses and evidence-based treatment approaches.

Yet another consideration is that the counselor-in-training may aspire to work in a military setting and will need at least some basic preparation to be viable in such a setting; similar to the counseling student who aspires to work in an addiction setting and has an opportunity to complete elective courses in addiction for preparation.

A model military culture course. Given the findings of this study and the amplified importance of cultural competence, specifically cultural sensitivity and cultural

humility, a model course is recommended by the researcher for counselors-in-training about the military culture. This model course embraces the standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) by supporting one of the eight common core areas, social and cultural diversity. The military culture course for counselors-in-training can serve as a course or, at a minimal, inclusive in the course content for a multicultural course.

Overall the course objective is to prepare students to develop the cultural competence to effectively work with the military population and their families. Specifically, the course objectives reflect gaining an understanding about the military lifestyle, diagnosing common disorders found among military veterans, and use of evidence-based treatment approaches.

The following topics are recommended for the researcher's model course. Selected topics can also be considered for inclusion in a sub-section of a multicultural course.

1. Military personnel rank and system. Students gain an understanding of the various branches of the armed forces and their ranking system especially as it relates to enlisted personnel, non-commissioned officers, and commissioned officers. The students will be able to recognize the appropriate references for military personnel, for example a soldier in the Army versus an airman in the Air Force and a sailor in the Navy. This also includes appropriately addressing the various ranks in that distinction is made between lower and higher ranks.

2. Uniform Code of Military Justice (which describes military law) and the Military Code of Conduct. Students receive a brief introduction to the military governing system which requires adherence by all military personnel especially as it relates to rules of engagement in conflict situations and enables a further understanding of service members' duties in combat situations.
3. Military lifestyle. Students are able to identify the demands and stressors of the military lifestyle such as frequent moves, living in isolation, deployments and risk of injury and death for the service member. The students are able to recognize the unique challenges of the military lifestyle from the perspective of the service member and the family members, such as the challenges that the spouse and children face. Additionally, students become familiar with locating military resources to include the lingo and acronyms commonly used in the military setting.
4. Mental health issues of the military service member and the family members. Students are able to identify and diagnose common disorders found among the military population. Emphasis is also given to relationship problems and other challenges which do not meet the criteria for a diagnosis, but presents as a mental health concern.
5. Mental health treatment approaches. Students gain an understanding of evidence-based treatment approaches found to be effective with the military population to include the validated psychotherapies for treating

PTSD and substance use disorders as recommended by the Veterans Affairs program.

Towards a regard for cultural sensitivity and cultural humility, two course activities are recommended for the researcher's model course.

1. Panel discussion. A classroom session dedicated to a panel discussion of active duty or veteran military personnel along with family members provide for hearing the personal accounts of their experiences related to military life.
2. Experiential learning. To foster experiential learning and cultural immersion, students participate in some type of volunteer service related to serving military service members or their family members; or attend a military event, such as a military basic training graduation, which is open to the public. Examples of volunteer service include, but are not limited to, United Services Organization (USO), Yellow Ribbon Reintegration Program events, and the National Military Family Association. The learning activity includes a reflection activity such as writing a report or a presentation to the class.

Clinical Practice

While previous literature has supported the training needs for civilian mental health clinicians in the community, the present study indicates there have been minimal opportunities for the participants to receive training. Additionally, all of the participants described viewing the military as a speciality, however they related being able to serve their clients while readily stating that working with the military is not their area of

expertise and do not claim it as a speciality. The participants also reported the need to gain knowledge and familiarity to work with the military population.

Given the aforementioned factors, a recommendation for the civilian mental health clinicians in the community is an opportunity to receive training to work with the military population that consists both of face-to-face as well as web-based training. A greater consideration is the recommendation to offer certification to work with the military population, not unlike the certification that is offered to work with those who are diagnosed with addiction, to include working in the addiction setting. The certification process would require a specific number of training hours, client contact hours and supervision to meet the criteria. Once certification is attained, a registry can be maintained which acknowledged civilian mental health clinicians in the community with the military as a speciality.

Yet another recommendation would entail including continuing education units which specifically addressed working with the military population given that licensed clinicians are routinely required to complete a specified amount of training within a given period.

The inclusion of evidence- based approaches is also an important consideration as mental health community clinicians receive training to work with the military population. In the Tanielian et al., (2014b) study, three validated PTSD psychotherapies were noted in serving the military population which are prolonged exposure (PE), EMDR and cognitive processing therapy (CPT). The only psychotherapy noted from the three aforementioned among the participants of the present study is EMDR, yet all of the participants indicated they had treated a military client with PTSD in the present or past.

Additionally, only a few of the participants in the present study indicated having certification in EMDR. All of the participants, however, recognized EMDR as a specialized intervention. The recommendation is for the civilian mental health clinicians to receive training in the evidence-based approaches to work with the military to include the validated PTSD psychotherapies. Particular emphasis should also include training in diagnosing PTSD and determining the appropriate level of care for treatment.

The aforementioned recommendations for action are particularly significant in that, according to the National Board for Certified Counselors, the Department of Defense now allows licensed professional counselors to serve the TRICARE population. Previously, licensed professional counselors were required to meet an additional certification to serve the military population within the TRICARE system. With the change of this legislation, it is more crucial that mental health clinicians in the community are culturally competent and skilled to serve the military population.

A model for a speciality certification in military culture. As the American Counseling Association Code of Ethics (2014) emphasizes the need for counselors to demonstrate cultural sensitivity and cultural competence in their clinical practices, the researcher recommends a model for mental health clinicians to gain a speciality certification in the military culture. The overall goal of the certification is to enhance the skills of practicing clinicians in that they are prepared to provide services reflecting cultural sensitivity and cultural competence for the military population. Further, a registry of civilian mental health clinicians with the military culture speciality should be maintained through national and local registries, to include community

directories, which facilitate locating mental health clinicians in the community with this specialization.

The researcher's military culture certification speciality program consists of 12 credit hours from a post-secondary institution. The 12 credit hours consist of courses which will facilitate understanding the military culture and the provision of clinical counseling services. While three of the four courses are mainly didactic with experiential components, the fourth course is designed to focus on experiential learning through field work involvement. The specific objectives and course summary content for the four courses are as follows.

1. Military culture and military lifestyle. This introductory course provides the mental health clinician with an understanding of the military culture to include the tradition and customs of the military, personnel rank and system. The clinician will be able to appropriately recognize the references for military personnel, especially as it relates to the various branches and distinctions between lower and higher ranks. Military law (Uniform Code of Military Justice) and military code of conduct will be reviewed to introduce the clinician to the military governing system, further gaining an understanding of service members' rules of engagement in combat situations. The clinicians will be able to identify the demands and stressors of the military lifestyle such as deployments, frequent moves, living in isolation and the service member's risk of injury and death, especially in combat situations.

Emphasis will also be given to understanding the unique challenges of the military lifestyle encountered by the service member and the family members. As an experiential component, classroom sessions dedicated to panel discussions of active duty or veteran military personnel along with family members will provide for personal accounts of experiences related to military life.

2. Assessment and diagnosis of mental health disorders found among the military population. This course will assist the clinician in understanding common disorders found among the military population. Assessment measures will primarily focus on the *Diagnostic Manual of Statistical Disorders* (2013) and meeting the diagnostic criteria as presented. Additionally, focus will also be given to identifying mental health concerns which are not inclusive in the mental disorders, but also has clinical significance, such as the Z codes in the *Diagnostic Manual of Mental Disorders* (2013).
3. Evidence-based treatment approaches for the military population. In this course, the clinicians will gain a working knowledge of treatment approaches found to be effective with the military population to include the validated psychotherapies for treating PTSD and substance use disorders as recommended by the Veterans Affairs program. Additionally, clinicians, who are interested, will be provided information to begin the process of becoming certified in EMDR.

4. Experiential learning through fieldwork involvement. This final course in the certification process will facilitate field work involvement in which the clinician will participate in some type of volunteer experience to gain experience in working in a military setting. Possible sites include local National Guard units, veteran homeless organizations or programs, and other military organizations that support working with military service members or their families such as, United Services Organization (USO) and Yellow Ribbon Reintegration Program events. Additionally, clinicians who are currently licensed can consider volunteering with the non-profit organization, Give an Hour, which provides free mental health services to military service members and their families.

An additional consideration for counselors-in-training, who are completing their coursework at a university which utilizes students in training to provide free counseling services to the community, is to include working with the homeless military veteran population. Such a community clinic site can be expanded to include working with the homeless veteran population through grants sponsored by the National Coalition for Homeless Veterans, Veterans Affairs and Substance Abuse and Mental Health Services Administration (SAMHSA).

Recommendations for Further Study

The present study focused on community mental health clinicians who had some contact with the military population in that they had seen at least one military service

member. A recommendation for further study would be to capture the perceptions of community mental health clinicians who have never worked with a military service member or their families. Exploration of community mental health clinicians who have no specific experiences to draw from could possibly shed light on barriers perceived by the clinicians, especially as it may relate to myths and misunderstandings about serving the military population.

The participants in the present study related that all of their clients were veterans of the military; they did not have a client who was presently serving on active duty in the military or have a current status of National or Air Guard. Another recommendation is to explore the perceptions of community clinicians who are currently working with members of the active military, to include those who have current status with the National or Air Guard, to determine if experiences differ from serving the veterans.

Limitations

According to Grinnell and Unrau (2011) limitations are found in all studies and if the limitations are not cited, the author will unintentionally give the impression that limitations are not present in the study. With that in mind, the limitations noted in chapter one, along with other limitations found in this study will be discussed.

In chapter one, researcher bias and idiosyncrasies were identified as a limitation in this study. It was further explained in chapter three, the roles of the researcher included being a veteran of the US Naval Reserves, a former Military Family Life Consultant and Licensed Professional Counselor. As the researcher made self-introductions to the participants and explained the study, information was shared about being a Licensed Professional Counselor and a doctoral student conducting research to

fulfill the requirements of the dissertation. Information was not shared about the researcher's prior military status, however if the participants made such an inquiry, it was the intention of the researcher to share the prior military experience. This information was not otherwise offered in that it could possibly have an impact on the participants' responses.

Additionally, to address this researcher's bias and idiosyncrasies a peer was used for triangulation of the interview process, especially as the researcher was the sole data collector for this study. A peer reviewed the interview questions to ensure that the researcher utilized open-ended questions. The peer also reviewed the first few interview transcripts to note any tendencies that the researcher would have to lead the interviewee when seeking clarification or probing the initial interview question. The researcher utilized another peer to analyze two of the interview transcripts to determine if some of the same decisions were made in the analysis process.

Chapter one included a limitation about the semi-interviews producing rich data. Nine interviews were conducted which produced a significant amount of transcribed material. Meticulous care was taken by the researcher to read and re-read the transcripts, compare with the audio for accuracy and analyze the data.

The challenge of confidentiality was identified as a possible limitation with the present study. Meticulous care was taken to present the findings without any identifying information to compromise the confidentiality of the participants or their clients. For example, one participant shared additional comments about a particular client after the recording device was powered off, at her request, out of concern that the legal issues

involving the client would be easily identifiable. Those comments were not included in the findings.

A final limitation of this study is that a single-session interview was conducted with the participants. While the session allowed for the collection of rich data, a second interview session would have allowed for further probing of the participants' responses. The second interview would have been especially useful after analyzing the transcription data to gain further clarity about topics presented by the participants.

Conclusion and Researcher Reflections

This study presented the perceptions of community mental health clinicians to serve military members and their families. The participants readily shared thoughts and experiences about their work with military members and their families. I was somewhat surprised about how forthcoming they were in sharing their experiences and noted how they seemingly had a genuine interest for meeting the needs of their military clientele despite their limitations in training. For example, when one of the participants stated, "I did not want to be the third counselor who said no." Other behaviors that indicated their interest to help also included searching online for information to understand the client's military experience in a war or conflict, and taking time at the end of the session to inquire about any military jargon that was used during the session.

I was also fascinated about the service members' willingness to "teach" their therapists about the military lifestyle. I wondered, however, if the willingness to "teach" their therapist would be different if the members were on active duty status in the military. I was curious as to whether the service member enjoyed sharing memories, but

if they were currently in the midst of the military lifestyle would be more concerned about the therapist being able to relate to their lifestyle.

As I continued to reflect on this study, I was reminded of Participant's Eight comments as she shared the client's comments, ". . . there's no way you can really understand." My thoughts are the participants found ways to connect with the clients they were serving. Perhaps training curriculum needs to incorporate ways to reflect on one's own life experiences to find points of connection, not unlike what Tervalon and Murray-Garcia (1998) suggest. It appears that being able to serve the military population is more than acquiring knowledge, but an intentional self-evaluation about aspects of the culture that not only provides for self-awareness, but lends itself to ways to connect.

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Appendix A

CONSENT FORM FOR COUNSELOR STUDY ABOUT SERVING THE MILITARY POPULATION

Thank you for your willingness to participate in this study. I am a graduate student at the University of South Carolina pursuing a doctorate degree in Counselor Education and Supervision and this study is part of the degree requirements. The purpose of this study is to investigate the mental health clinicians' thoughts and experiences about working with the military population. The results of this study have potential implications for not only mental health clinicians currently practicing in the field, but also counselor education programs as well as other programs that prepare mental health clinicians.

If you agree to participate in this study, you will be asked to meet face to face for an interview for approximately 60 minutes at a location that is convenient for you. You will also be asked to provide feedback regarding the information collected at a later date for the purposes of accuracy.

Your participation is voluntary and at any time during the interview you can decide not to continue and you may refuse to answer any of the questions. There is no penalty for deciding not to participate or answer any questions. You will be provided a copy of this form for your records.

Due to the nature of this study, which relies on a transcript of the interview, we would like to audio record the interview. I will not share your responses with anyone except for those involved with this research. You will not be personally identified in any presentation of this data. I will not store the answers with your full name as a precaution to make sure your information remains confidential. The interviews will be transcribed into an electronic file and maintained on a password protected computer. Paper copies of the file will be kept in a locked filing cabinet.

If you have any questions after the interview is completed you can contact me at 864-921-5721. If at any time you have the need to contact my faculty advisor (Dr. Joshua Gold) you can reach him at 803-777-1936.

Appendix B
SAMPLE TRANSCRIPT

Interviewer: I think we're ready.

[Background conversation]

Interviewer: All, right, Ms. _____

Interviewee: Okay

Interviewer: Let's see. Your credentials are?

Interviewee: LMFT and Ed.S.

Interviewer: And what else as far as degrees?

Interviewee: Just the – well, the EDS is the degree, the graduate degree. And then the LMFT is the license. And then certification in the EMDR.

Interviewer: Oh, are you?

Interviewee: Mm-hmm. That's it.

Interviewer: And what is your bachelor's in?

Interviewee: Psychology. It's a BS in psychology.

Interviewer: BS. Where'd you go to school?

Interviewee: College of Charleston.

Interviewer: Oh, okay.

Interviewee: Yes.

Interviewer: And years in practice?

Interviewee: Years. Let me think about this for a minute. Ummm, counting internship would you say or –

Interviewer: No.

Interviewee: – actual license?

Interviewer: Yes.

Interviewee: I would say – let's see. Edmond is twelve, so ten years.

Interviewer: Ten. Okay.

Interviewee: Time starts flying, right?

Interviewer: I know. My goodness. Oh, and if you don't mind me asking your age.

Interviewee: Forty-three.

Interviewer: Really?

Interviewee: That should be more like 63, but 43.

Interviewer: All right. So are you familiar with work and with military personnel, veterans, and/or their families?

Interviewee: Not all the time, but I have had some, but that wouldn't be my primary demographic, but I've had some.

Interviewer: Ok, when you say some . . .

Interviewee: I would say just the two. I've had two individuals. I've had two men with that background. I may have had people who have had that background way in their past, but it didn't have anything to do with the reason they were seeking therapy. So it could be that that was – is part of their intake, but they might be seeing me for something completely different and there's no PTSD.

Interviewer: So that's something you screen for in your assessment?

Interviewee: Mm-hmm.

Interviewer: And just ask whether or not they've been in the military?

Interviewee: Right. And just generally – the general intake of why they're seeing me. And then we get that through their history. If the reason they're seeing me matches something that I think could be connected to PTSD, then I'll screen directly for that. Otherwise, I don't necessarily screen every single person for it.

Interviewer: You don't screen them for PTSD, you don't screen them for being in the military?

Interviewee: That would – no. It would just be part of their history I don't say, "Have you ever been in the military?" But I think it usually just comes up in the history if they have been.

Interviewer: But that's not a particular question, though, on the assessment?

Interviewee: No. Uh-uh.

Interviewer: And how would you describe your level of familiarity with the military personnel that you've seen?

Interviewee: With the ones I've seen?

Interviewer: Yes.

Interviewee: My level of...

Interviewer: Or just as the population to serve, how familiar would you say you are with them? How would you describe it?

Interviewee: Umm, moderately, I would say, just based on I've had some family members who were in – so just based on their stories and what you hear on TV. And just from laymen's terms-type familiarity. That's about as far as it goes.

Interviewer: And you said family members?

Interviewee: I had a brother who was in the marines, and my father was – did some clerical stuff, it wasn't like combat or whatnot, but with the army way back when.

Interviewer: And I forgot to ask you about that. Were you ever in the military?

Interviewee: No.

Interviewer: Employed in the military setting?

Interviewee: No.

Interviewer: But you – the extent of your military personal connection is your families that have been in.

Interviewee: Right.

Interviewer: Brother and father.

Interviewee: Right. And then just learning through clients, the few I've had. And typically, especially since they – you have PTSD, they talk a lot about it. So I learn a lot from them about...

Interviewer: So you would say a lot of your information comes from learning from the clients?

Interviewee: Mm-hmm. Yes.

Interviewer: And were you around when your dad was in?

Interviewee: No. Way before I was born. And there was no PTSD or anything from that. Actually, it was kind of a joke because he was a – did clerical stuff and he broke his ankle doing something completely unrelated to anything, a ladder or something, and then he was sent home and that was it. So there's zero PTSD or whatnot from that.

Interviewer: So he wasn't in very long is what I'm gathering.

Interviewee: No. Maybe a year.

Interviewer: Really?

Interviewee: Yeah.

Interviewer: And your brother?

Interviewee: My brother went when he was eighteen years old and served as much as he had to. Basically he discovered pretty quickly that he didn't love it, and he was finished in probably his early 20s.

Interviewer: So tell me about your experiences working with those who have been there or those who are veterans.

Interviewee: Well, one is a very extreme situation. Well, I don't have a huge pool to judge from, but the one I have is he actually was a guard in

Beirut. He was guarding a building. Am I supposed to actually be giving it to you like this? So I don't tell you what...

Interviewer: Just don't mention names or anything.

Interviewee: Yeah. Yeah. So one – I guess I'll say of the two I have, one is much more surface, the PTSD is about a lot of things, and then the other client is directly linked to very specific war situations. One, he was in charge of guarding a building that people drove bombs into it and 230-something men that he was responsible for died. The whole building collapsed. And the only reason he didn't die is because he was ordered to be at his post, which was far away from the building. He would have had zero way of preventing it. And even if he had, he would have never left his post because he was ordered to do that. And in the army, you don't go against the rules.

But we've had to work very hard for him – his feelings about, "I should have done something different. I could have done something different." And of course, just the visual flashbacks of him running and trying to save people, and there was nothing to save. They were just body parts to retrieve.

Interviewer: Wow.

Interviewee: And so his was a very extreme PTSD.

Interviewer: So he was over that many people? Him alone was over?

Interviewee: Those were his peers or his comrades. And they would all take turns having to be on the post. There were actually two posts. One in the front and one in the back of the building. So he and another guy, it was their turn to just be guarding. And they would switch off. And any other time he would have been in the building dead, but he just happened to be guarding when these tankers got driven into the building with all kinds of bombs. Suicide bombers drove them in. And everyone died. The whole building just collapsed. Except for he and his friend who were on the post.

And so everything – and when he came back – there was another incident there that was also very violent that still plagues him. But when he came back home, he had trouble finding work, but when he finally found work, it was with EMS. EMS just took that PTSD that he already had and made it a thousand time worse 'cause in so many situations you can't help somebody, and he kept feeling, "I could do something better. I should do something better." And of course, all the images of the awfulness he saw.

So he shoved it all down and just keep on walking, just keep on getting it. And about two years ago he had what I guess you'd call a nervous breakdown. It's just like it all just came – he just got flooded. Everything he forgot about just flooded back and he couldn't even function.

Interviewer: I see.

Interviewee: He couldn't breathe. Couldn't – he had to be hospitalized. It was really bad.

Interviewer: So from the time that he started working with EMS to the time that all this happened, how much time are we talking about?

Interviewee: From the –

Interviewer: How many years ago?

Interviewee: – breakdown – from the start of the EMS to the breakdown?

Interviewer: From his time in the military to the breakdown.

Interviewee: The military that would have been in the '80s with Beirut bombing.

Interviewer: Yeah, I thought it was...

Interviewee: Yeah, that was in the '80s. And then he came home and he started working. He was a police officer and EMS. He held two jobs. So both of those were not good for somebody with PTSD. And so what would that be? He did that, oh, I mean twenty-something years. He recently stopped doing that and he got on with Michelin. And so there was a space – it was when he was with Michelin that he had the breakdown. But it was many decades from the initial injury of PTSD to when he had the breakdown and started seeing me.

And the first few therapists he saw told him that he was not stable enough to do EMDR with. But I felt like he was. And so we did. And it was a good thing.

Interviewer: So it sounds like there was a period of time that he did not have any treatment for his PTSD.

Interviewee: He had no – treatment for decades. He didn't – he wouldn't have even identified it as that. He didn't even know that he had it. He

says that he worked himself half to death, which I think now we know was a coping mechanism. Work so much that you can't even think. And he never dwelled. He tried to – he wanted to forget the images, and so he did. He blocked 'em very well, successfully. And I don't really know why it happened or how it happened, but it just broke open one day and he was just completely flooded with all of it and became incapacitated.

Interviewer: Yeah. It's quite interesting that he would choose those two professions.

Interviewee: I'm just trying to fix what was broken on a very subconscious level. I couldn't help, but maybe I can help here. But putting yourself in an impossible situation.

Interviewer: Yeah. Yeah. So you don't think it was any accident or coincidence that he ended up being a police officer or EMS?

Interviewee: I don't. He doesn't say, "Well, yeah, that's why I did it." But even I know that we are driven in directions for different reasons. And I think probably he was trying to fix what he couldn't fix maybe.

Interviewer: Yeah. Yeah. And so it sounds like he was just constantly triggered until...

Interviewee: He wasn't constantly. I think that he was reinjured over and over. The thought in his mind of, "I should have done something better" continued to be there. And every time he couldn't save somebody or every time he came up to a scene where somebody had – was already dead, he wouldn't be able to say, "If I had just gotten here faster. If I had been psychic enough to have been here before it happened." Just that feeling was always there.

Interviewer: So he wasn't triggered, but he just kept – as you said, reinjured.

Interviewee: It was compounded, just compounded.

Interviewer: Yeah.

Interviewee: But the – I guess he doesn't even know what triggered him to actually have active PTSD. Before – I'm sure there's a name for it, but it's kind of like when you're blocking everything and you don't realize that you've been injured, but the damage is happening inside. He didn't know that that was going on until it just sort of opened up. And nothing particularly triggered it that he could identify.

He just went to work one day, he felt like he was gonna get the flu, he felt very sick, and then all of a sudden it was like his brain just opened up. So maybe a virus. I don't know.

Interviewer: Hmm. Ok, what about your other person?

Interviewee: He has spent some time – he is a marine, and he spent some time over in Iraq very recently. Actually, I'm sorry. He is not a marine. He is – what is it that you do here and then you sometimes get sent a reserve guard?

Interviewer: National Guard.

Interviewee: National Guard. He's a National Guard. But most of his PTSD is from being a police officer 'cause he's a police officer who did National Guard on the weekends.

Interviewer: I see.

Interviewee: And he has seen a lot. He's been to a lot of wrecks where there were body parts on the highways, and he's seen the awful stuff that happened to the body and with trauma. And then when he had to go over most recently to Iraq, just having to handle the bodies of soldiers that came in just is sort of – again, it just all sort of came together. The foundation was laid here with police work, and then that just sort of topped it right off.

Interviewer: I see. I see.

Interviewee: But for him, medication has helped tremendously, whereas the first guy I was telling you about medication has kept him from completely – has kept him functional, but it has still taken just a lot of intensive therapy to get him anywhere near okay.

Interviewer: Ummm, OK, any other issues that you – maybe even with these guys, other than PTSD?

Interviewee: Mm.

Interviewer: Or diagnosis?

Interviewee: Ummm, well, just the irritability that goes with it and how it affects relationships. Is that what you mean? Like how it affects...

Interviewer: Well, just any mood disorders or any other accompanying diagnosis.

Interviewee: No, not that I – no. Not – at least not currently. Umm, and the complaints are things that could go – could be anything, but we have to assume is the PTSD like the irritability and the very little patience for much of anything and quick to anger.

Interviewer: Ok, so which treatment approaches have you used? I heard you mention the EMDR.

Interviewee: Just the EMDR. The EMDRs all because once I learned about that, which is sort of tailored for PTSD, I just have gone with that. And I've done it for all kinds of different things with mixed results. It just really sort of depends. But like this – I was pointing here 'cause that's where he sits. The severe guy I was telling you about was able to just sort of process through and remember and came out the other end being able to say, which for him was huge – being able to recognize that there was nothing he could have done in any of these cases. It wasn't his fault. It was just really awful, awful things that happened. And he was never gonna forget it, but that the images didn't have to haunt him and it wasn't his fault.

Interviewer: Yeah. Ok, so EMDR is what you – is that what you start – you don't start off with that, do you?

Interviewee: Not in the first session. No. The first – if they come in and they say there's PTSD, like whether it's for abuse or – but you're talking just primarily military right now, right?

Interviewer: Right.

Interviewee: 'Cause I'll say I have for other things where people come in and say, "Look. There was a trauma that happened to me of some sort." And we'll take the first session and I'll get – and maybe even the second session. Just get background, just the basic family stuff. More about them. And pretty quickly – if that's what their thing is, I'll just go on to EMDR knowing that that's probably gonna offer the fastest relief.

Interviewer: Any other approaches that you use?

Interviewee: There may be things that kinda go with it, just like cognitive behavioral stuff. Simple things like this guy, the more severe guy, not doing a very good job with his eating and taking care of himself and sleep schedules and being very disorganized because

of everything. So maybe using cognitive behavioral just to help him – how do we get you on a schedule? How can you remind yourself? That sorta thing.

Interviewer: So you would say CBT provides what for you in working with a client?

Interviewee: Structure.

Interviewer: Is there anything that you have found that would not be helpful or just in thinking about some of the approaches, you don't think it would be as effective?

Interviewee: Hmm. Solution focused probably wouldn't be necessarily because what worked prior to being traumatized will have nothing to do with a traumatized brain necessarily. It's really hard to tell without knowing the clients about what wouldn't work. I don't know. I'd have to think about that one.

Interviewer: So how would you say – or what would you say is your comfort level in working with military clients or veterans?

Interviewee: Pretty comfortable. Is there a – if there's a scale, I can give you a number __

Interviewer: Great.

Interviewee: – comfortable. A scale of one to ten?

Interviewer: Yeah.

Interviewee: With ten being the most comfortable ever?

Interviewer: Uh-huh.

Interviewee: Eight. Seven or eight.

Interviewer: And you give yourself an eight because?

Interviewee: Because I learned from them. If I don't know, I don't understand, then we'll spend a session with them – if they say – if they start using military speak, I'll say, "Talk to me about it. Tell me what that means", which becomes part of the therapy. Them to be able to tell me about it, and I can sort of gauge the emotional level as they're talking about it. And I learn that way. And then I become more comfortable.

Interviewer: Well, that kinda leads me into my next question. I know you said you learn from your clients. That's one of the ways that you've gained some information. What kind of training, if any, have you had [*Inaudible due to crosstalk*]?

Interviewee: As far as military specifically?

Interviewer: Yes.

Interviewee: Zero. I've done – now, when this guy came in, I got very quickly online and started looking for books and articles. And I went back to my EMDR books and read specifically because that was tailor made for PTSD, but I had not done those studies for so long that it's like, "Let me go back and look and see exactly the details on this for veterans or for people who were injured in the war."

And so I did sort of like that background stuff just 'cause I was a little nervous when I found out that somebody who was this injured was coming in and other therapists had said, "No." I thought, "I don't want to be the third one to tell him no." But besides that, nothing formal.

Interviewer: And you said you didn't want to be the third one to tell him no. So he actually went – did he actually go or this was on the telephone call that they told him they couldn't help him?

Interviewee: One was actually in session, and he went specifically for EMDR because he had – his wife was reading about how do you treat this? And one was on the phone, I believe, and basically in describing him, she said, "Oh, get him more stabilized on medication, and then we'll talk about it. It sounds like he's very unstable." And then the second one they actually went and sat down and upon talking to him – because he does have a very physical – he'll tremor hard when he talks about it to the point where the couch will almost just shake.

Interviewer: Yeah.

Interviewee: And so it can be a little scary to see it. And she basically just said, "I don't – until you get a little more stabilized."

Interviewer: So the first one he was referred to medication. With the second one, did she refer him somewhere?

Interviewee: No. Not that I know of. Because I think that they just sort of quit looking for a little while, and then they decided to try this therapy thing again. And so I wanted to – if I felt like – that he would be safe and it would really truly would be okay – I saw – his wife comes every time, and she's a huge support. And I knew that he had in-house support, extended family members, siblings, people who were always there. So I knew he had that much. I knew he had a history of being a very stable person. And there were a lot of things in his corner that I felt like, "I think he can do this."

Interviewer: Yeah. So when you discovered that this client was coming, you kinda did some of your own exploring and research –

Interviewee: Right.

Interviewer: – to gather this information to bring yourself up.

Interviewee: Yeah. Up to snuff.

Interviewer: Yeah. That's what I was thinking [*Laughs*].

Interviewee: Up to snuff [*Laughs*]. Are we from the south or what [*Laughs*]?

Interviewer: So what kinda training would you be interested in regarding military members and their families? What topics would – do you think would be helpful if they were covered?

Interviewee: Certainly the impact of all this on the family members. Living with somebody with PTSD. And because they're victims too in their own way from all – they're having to – they're often having to be barked at and yelled at or, goodness with this guy having to go out in the middle of night 'cause he's wandered. Scary. I thought because the police had found him in heat stroke in the middle of the road because he wandered. And just stuff like that. So they're being traumatized too. So a way to incorporate into family therapy.

I think that what I've heard both of my – these guys say is that they feel when they're talking to somebody else, like, the fact that I was not in the military, and they almost feel like – or they've said, "Unless you've been there, unless you have felt like your life is very well threatened or unless you felt like you failed on the job in saving another life, there's no way you can really understand. You can just do the best you can as a professional trying to help, but there's no way you can really get to where I am." And that's absolutely true.

Interviewer: Yeah. Now, one of them said that to you?

Interviewee: Both.

Interviewer: They both said that to you.

Interviewee: In their own words, they both said it.

Interviewer: Yeah. And what was that like for you when you heard that?

Interviewee: I agreed. I agreed that you're right. And I did think of the – the old adage where I was always told , you don't have to have gotten divorced to do good therapy with somebody who's divorced. Or you don't have to experience all of life to do it. On the other hand, I agreed that with this specialty, I could see how that would be helpful to have that experience.

Interviewer: And when you say experience, are you talking about the trauma part or the military part?

Interviewee: The military part. Or training on what it's like. Even if you – for some reason you didn't serve, but that was just your passion, you really wanted to help in that area, I could see how it would always be more helpful to have specialized training or certification or whatever it may be.

Interviewer: Yeah.

Interviewee: And I would never seek it out. When you fill out on these forms what are your specialties, on there will be military. I don't put that 'cause I would never consider that my specialty. It's like if it's – that sorta ended up in my lap oddly. One of them I was doing marital therapy with him and his wife for years before he was like, "Could I see you on – I have some things –" once the marital therapy stopped, he was like, "I have some things." I had no clue he had this.

And so he started talking, and it's, "Wow. Well, you have PTSD." And I explained to him, "I do EDMR. I feel comfortable with it. If you want to get referred to somebody who does other specialties " he said, "No, I already know you. I'll stay with you." And then the other guy basically – the phone was call other therapists have said, "No. He wants you to interview him and see if you think you could try." "Okay, I'll try."

Interviewer: So when you say specialty, I want to just kinda pull up addictions for a moment 'cause that's not your specialty, is it?

Interviewee: No.

Interviewer: So on those forms would you check off addictions or not?

Interviewee: No.

Interviewer: So you don't check off addiction?

Interviewee: I do not. Uh-uh. Because if somebody truly has an addiction and they want help and they come see me, I know the stuff we learned in the addiction class 85 years ago and the little articles I read along the way, but because that's not my specialty, I don't. So no, I wouldn't feel right doing that.

Interviewer: So you don't seek 'em out, but if they end up in your lap, you're not – you're gonna try to help the best way you can?

Interviewee: If addictions end up in my lap – I'm referring them every time. You're talking about, I'm referring to the military __

Interviewer: The military – okay.

Interviewee: But military –

Interviewer: Military...

Interviewee: – yeah, I'll do it. Yeah, I'll try because I feel like a lot of issues that have – and PTSD looks a lot of like whether or it's not because you were raped or because you were beaten. For whatever the reason, it looks a lot alike. And so I have a comfort level in working with it. With EMDR specifically, there's nothing different that you do no matter what traumatized a person. And I'm comfortable with that. So I'm willing to – if I can – as long as I have the relationship with a client and they feel comfortable with me, I'll do EMDR on whoever.

Interviewer: Right. So you feel there's some parallels that can – that you can draw from?

Interviewee: Right.

Interviewer: For the basic things.

Interviewee: Trauma. To say trauma is trauma is not exactly right, but in some ways. The way the brain processes it and the way it affects people, their brain doesn't necessarily know why it's traumatized.

Interviewer: So if you had a client come in and he or she had some issues that were very specific, specifically related to the military, how would you go about that? How would you go about...

Interviewee: Questions and questions. I would say, "Tell me more about what's going on. Tell – describe to me exactly what it is when you – what do you mean when you say that?" And I ask a lot of questions. And even when we start the EMDR, I'll do the straight EMDR, which means I'm not asking any questions during the process. But when the processing is over, I'll say, "Okay, let's have fifteen or twenty minutes to talk." And during that time I'll say, "You mentioned this. What does that mean? What does that mean? How is that important?" And so I just – I let them teach me. And so far – I haven't had many, but so far they seem to enjoy it.

Interviewer: Really?

Interviewee: They seem to enjoy not reliving the bad stuff, but – like mess hall's not a good example 'cause I know what mess hall is, but if I want to be like, "You said the word mess hall, what is that?", they'd be like, "Oh, well, that's just where you go eat." They don't seem to mind that sort of basic stuff.

Interviewer: That's good.

Interviewee: Yeah.

Interviewer: So any other type of training that you would – but let me know if you need to go ...

Interviewee: You're fine.

Interviewer: What kind of – what other topics would you like to see covered?

Interviewee: Specifically for –

Interviewer: Military.

Interviewee: – military. Let me think. I would love to know what to do for them once they get back out. I would love to know how to help them be functional once they get out.

Interviewer: As far as...

Interviewee: Job placement. As far as that goes. And this is something that's always – I find interesting is that there have been – you'll probably laugh at this, but there have been several studies on the effectiveness of taking a certain amount of fish oil, omega 3s, if you're in a position that trauma could happen and you take it every day. It supposedly protects the brain from as-severe trauma if you have high levels of the omegas in your body. I've often said, "Why isn't your military not loading them down with it every single day?"

Interviewer: Yeah. Hmm. So it's a protective factor?

Interviewee: It is a protective factor that there have been – if you get online and you put in omega 3s preventing PTSD, you're gonna find research pop up everywhere.

Interviewer: Wow.

Interviewee: And that frustrates me because if something that simple and that easy and it's not expensive –

Interviewer: Yeah. Hmm.

Interviewee: – why would you not be giving that to our – I think policeman should be taking it, the people in EMS, and certainly our soldiers should all have it.

Interviewer: Yeah. Hmm.

Interviewee: So I'd like to see a little something on that [*Laughs*].

Interviewer: OK, new research. And specifically omega 3 fatty acids [*Laughs*].

Interviewee: That's right.

Interviewer: All right. So any resources that you have found helpful? I know you mentioned going online. Is there a particular site that you visit or...

Interviewee: I do not remember 'cause this guy started – I've been seeing him for years now, so I really can't remember exactly what it was. I know – so the details of the battles he told me about were big enough that it was – you could find it. So I went and typed in like

Beirut bombing, 1982, something like that, I think it was, and I was able to read the whole details of exactly what happened.

Interviewer: OK, so you were able to read about his incident.

Interviewee: Yes. And then he had another incident that was also – and I was able to just type in and read what the news was saying about what had happened way back when. And then, of course, looking up therapeutic-type stuff.

Interviewer: Hmm.

Interviewee: But I can't remember specific sites. Just a random –

Interviewer: Just Google.

Interviewee: – search and read.

Interviewer: Yeah. So you found that helpful?

Interviewee: Mm-hmm.

Interviewer: Yeah. Is there anything that you sought out that you didn't find all that helpful?

Interviewee: Not that I can think of 'cause I'm sure if I didn't find it helpful, I just scrolled on and I didn't commit to memory that you're not – you were not helpful.

Interviewer: That makes sense [*Laughs*].

Interviewee: Yeah.

Interviewer: Well, I have some information for you that I think might be helpful.

Interviewee: Oh.

Interviewer: This is just a folder I put together. So if you're working with someone in active duty –

Interviewee: Oh.

Interviewer: – or veterans.

Interviewee: Thank you.

Interviewer: There's some sites there that could look up as far as education opportunities.

Interviewee: That is perfection. Thank you. Now...

[End of Audio]

Appendix C

Sample Field Note

Date: 3-14-2016

Participant Number #2

Office was very difficult to find, located behind another building and not readily seen from the street.

Group practice with at least four other counseling offices noted.

Very nice building, a church makes up about a third of the building located on the first floor.

Participant Two's office was on the second floor.

Office furnished like a living room with a desk, large sofa and chair. Participant sat in a large rocking chair and indicated that was his chair as we entered the room.

Participant left the door open during the interview.

A large US flag in a shadow box was noted along the wall in the office.

Participant Two readily shared his experiences and was very forthcoming in answering questions.