Trauma Informed Care Delivery Working with Military Veterans in COD Treatment Settings

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Abstract

This paper is a review for delivering trauma informed care delivery when working with the military veterans, and their families in a co-occurring treatment setting. The author will attempt to emphasize the importance of trauma informed care with this special population along with current trends in the treatment strategies. There has been an increase in the need for co-occurring treatment for this population. Recent statistics in the number of military members returning home from war and integrating back into their home communities have been alarming high incidents of suicidal deaths, about 18 to 22 veterans per day, according to the Department of Veteran’s Affairs (VA’s) 2012 Suicide Data Report, they have a suicide rate 50% higher than those who did not serve in the military, also the rate was higher among veterans who never deployed. Minnesota having the second highest suicide rate in the nation among the members of the National Guard, Minnesota having the 10th largest state Guard by size. There is a need to bridge the gap in services to assist and support veteran’s integration back into families and communities. The veteran’s and the communities they return home to need to be responsible for bridging or filling in the gaps to readjustment to civilian life. The author is a United States Navy Veteran as well as a military spouse, as well as, a mother of an Air Force National Guard veteran. It is my passion and personal mission to make a difference in our communities in helping military veterans and their families reintegrate successfully and hopefully, therefore, reduce the incidents of suicide attempts and deaths. A portion of the project will be creating an in-services curriculum to inform civilian clinicians on how to engage the veteran and their family members in therapy along with the best practices in trauma informed care with co-occurring clients.
Table of Contents

Post-Traumatic Stress Disorder and Treating Military Veteran’s ................................................. 4
What is Post Traumatic Stress Disorder? ......................................................................................... 4
How This Disorder is Currently Treated in the Military and Communities ................................... 5
Risk Factors to Consider in Working with PTSD and Military Vets .............................................. 11
Developing Unique Individual Strategies ....................................................................................... 16
Creating Social Connectedness and Support ................................................................................ 20
Helping Military Veterans and their Families with Re-Entry to Home Communities .................. 21
Conclusion ........................................................................................................................................ 23
References ....................................................................................................................................... 25
APPENDICES .................................................................................................................................. 30
  Appendix A ................................................................................................................................... 31
    The Vets Center Model of Care .................................................................................................... 31
  Appendix B .................................................................................................................................... 41
    Resources and Advocacy: Helping to Address the Barriers ......................................................... 41
Trauma Informed Care Delivery Working with Military Veteran’s in COD Treatment Settings

**Post-Traumatic Stress Disorder and Treating Military Veteran’s**

This masters project, gives a brief review of changes in the DSM-5 manual criteria for Post-Traumatic Stress Disorder (PTSD) and the current treatments currently used to treat individuals with this disorder, particularly special populations such as the military or veterans of military service and those with co-occurring disorders. The author will also detail their findings in terms of empirical support for these specific treatments for PTSD and research findings relating to people in the military service arena. It is very important in providing psychotherapy services when working with military veterans and their families to be informed and aware of trauma, in order to, safely and properly treat individuals, as there is a high rate of PTSD among military veterans.

**What is Post Traumatic Stress Disorder?**

First of all, the definition of post-traumatic stress disorder according to DSM-5 has eight elements. The DSM-5 Diagnostic Criteria: criteria apply to adults, adolescents, and children older than 6 years. A key element to this diagnosis is there needs to be exposure to actual or threatened death, serious injury, or sexual violence in one (or more) ways: directly experience trauma, witnessing, in person, events that occurred to others, learning that the traumatic event occurred to close family or friend, and experiencing repeated or extreme exposure. There also needs to be negative alterations in cognitions and mood associated with the traumatic event(s) (American Psychiatric Association, 2013). The classification of the disorder has been re-classified from an anxiety disorder to a new category of trauma-related and stressor-related disorders. There has been some recent debate to identify a subset of anxiety disorders term “fear circuitry disorders” that appear after a traumatic or stressful event is experienced. Some of the
disorders in the fear circuitry disorders would include; PTSD, panic disorder, agoraphobia, social anxiety disorder and phobia’s. There is some evidence traumatic experiences precede the onset of panic disorder. (Castonguay & Oltmans, 2013).

**How This Disorder is Currently Treated in the Military and Communities**

McDevitt-Murphy, Monahan, and Williams (2014), stated since September 11, 2001, there has been over two million United States military personnel mobilized and deployed to combat zones as part of the global war on terror (GWOT). McDevitt-Murphy et al. (2014) reviewed research which has established that deployment stressors and combat exposures of these wars has increasingly caused outcomes of co-occurring PTSD, and Substance Misuse. In these GWOT combat zones there has been many veterans exposed to improvised explosive devices (IED’s) resulting in physical, psychological injury and many military members who have lost their lives. McDevitt-Murphy et al. (2014), stated that life in a war zone exposes many men and women to sexual assaults, treating gruesome injuries, torture, war crimes involving civilians, mutilation of corpses and other exposure of atrocities. Non-combat veterans can also be faced with traumatic events during training accidents or other routine duties. For many returning veterans, reintegration is both joyful and stressful. For some veterans, the symptoms of PTSD may make their readjustment more difficult and those challenges can make PTSD symptoms worse and increase substance use as a means to self-medicate (McDevitt-Murphy et al., 2014).

According to Bodrog and Wittenberg (2014), the treatments of choice for PTSD for most clinicians in the general population is trauma-focused psychotherapy. Comprehensive treatment based on systemic reviews of the evidence including guidelines from varies institutions. Most often Cognitive Behavioral Therapy (CBT) is used along with psycho-education, anxiety management, exposure therapy, and cognitive restructuring. Among the military there are some
similarities and a few differences in the treatment of individuals with PTSD. There is a preference in treating veterans at the smaller veteran’s centers. One reason is that having a smaller space it creates a less overwhelming atmosphere and easy parking accommodations, and minimal staff which allows the veteran to feel welcomed and safe. At the Vets Centers, Bodrog and Wittenberg (2014) stated there is typically a ‘walk on in’ no appointment needed policy as well as free services for eligible veterans. The Vets Center model has a Federal initiative to hire 80% veterans and the St Paul Vets Center has 100% Vets staffed there. Another fact is Vets are more inclined to talk about issues with other vets and feel that other vets will ‘get it’ and relate to them better. The mission statement of the Vets Centers is “We are the people in the Veterans Administration (VA) who welcome home war Veterans with honor by providing readjustment counseling in a caring manner. Vet Centers understand and appreciate Veteran’s war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community.” Additional wrap around services offered at the vets centers include: individual and group therapy, family pre and post deployment counseling, military sexual trauma (MST), benefits assistance, substance abuse counseling, employment, VA claims, crisis counseling and care, outreach services to vets homes. The Vets Centers promote collaborative partnerships with the medical facilities to better serve the Veteran and their families by using a Veteran-focused centered model (Bodrog & Wittenberg, 2014).

The Veterans Medical Centers have more barriers and constrictions in the treatment of veterans including; they are constricted to using evidenced based models of treatment, there are increased wait times and are more researched focused, and can be an overwhelming atmosphere for the veteran seeking help. The smaller Vets centers have the advantage in having more flexibility in using different treatment modalities, scheduling and services they can offer to
individuals in a seamless transition to civilian life in their home communities. Some common readjustment issues for veterans in returning to home communities are; jobs, anger, trauma experiences, family issues parent-child problems, relationship, drinking and drug use, depression, anxiety, isolation, sense of belonging, guilt and shame, grief and bereavement, dealing with civilians not understanding the military experiences (Bodrog & Wittenberg, 2014).

In treating trauma with veterans of war, Bodrog and Wittenberg (2014) stated the clinician needs to have an understanding of the different wars and the different approaches a clinician would use with the war issues; World War II, Korean War, Vietnam era, Gulf War, Iraq and Afghanistan Wars in treating trauma related to the veteran’s ‘war experience’. The Vets Center provides outreach services and direct readjustment counseling services and refer Veterans to local services too. The program is designed to provide easy access to services with minimal bureaucratic barriers to counter the effects of stigma and fears in accessing mental health services. In beginning to counsel a veteran, like with anyone, it is important to attune with the individual and use empathy, validation, and normalizing their situation to create a therapeutic alliance and build rapport with the client. Bodrog and Wittenberg (2014), stated that it is fine to use a stronger approach with a veteran as the person is used to direct approach in communication and no need to talk around an issue, there is a high meter for not being up-front and honest, so best practice is to get to the point right away. First, and foremost safety in working with veterans is key as there are statistics that 22 veterans commit suicide daily in the (Department of Veterans’ Affairs, 2012).

Trauma-informed care is grounded in a person-centered approach, recovery-oriented practices, empowerment strategies and attempts to avoid re-traumatization of the patient (Kelly, Boyd, Valente, & Czekanski, 2014). Kelly et al. (2014), recommended an emphasis on safety;
help the veteran build physical and emotional safety, with provider and patient being aware of potential triggers. The boundaries should be clearly established through collaborative decision-making with the veteran, along with setting privacy standards, confidentiality and mutual respect from the beginning and on-going (Kelly et al., 2014).

Boden et al. (2011), addressed the safety issues with male veterans with substance use disorders (SUD) and PTSD, suggesting if using Seeking Safety (SS), a present focused, manualized, cognitive-behavioral integrated treatment for PTSD was addressed early on simultaneously during the treatment intervention the veteran had better outcomes. The SS primary goal in treatment is to reduce symptoms of PTSD and SUD by focusing on safe coping skills, which includes case management services. One limitation to this study was it only included male veterans, so it is not certain this intervention would be as effective with female veterans, however, noted that past studies with females and non-veterans had positive outcomes (Boden et al., 2011).

It is important to increase a sense of purpose and belonging with veterans and adjusting back to civilian life. Connecting veterans with other veterans or opportunities that are presented with a mission solution focus has been found to be an effective readjustment strategy. In readjustment to communities veterans may start to isolate and not socialize, so in getting them to build social interest and connection, which is Adlerian, and found to be helpful (Rasmussen, 2016). Accessing for mental health conditions which may need medication will help in avoiding self-medication with substance abuse. There may be black or white thinking encourage the veteran to replace it with compromise and healthier positive thinking. Another approach to consider is good self-care and physical health encouraging the veteran to engage in exercise related activities (Bodrog & Wittenberg, 2014).
According to Dr. Paul Rasmussen, (2016), an Adlerian psychotherapist, author and professor, who works with veterans in South Carolina, it is important to help build psychological muscle. Traumatized individuals with psychological muscle (emotional resiliency) prior to the trauma, will generally respond well to exposure and cognitive reprocessing. He goes on to say that most people do not reach adulthood with sufficient psychological muscle. Traumatized individuals who did not have psychological muscle prior to the trauma are inclined to use the trauma as a safeguard. It seems that having this psychological muscle is a resiliency factor.

Rasmussen (2016) states in Adlerian based treatment, the focus is growth, rather than simply symptom reduction. Rasmussen (2016), currently uses Adaptive Reorientation (AR) methods which are Adlerian based therapy methods to treat veterans. The responsibilities of the therapist in this treatment includes understanding the law of movement with preference, psychology of use, the role of safeguards and the importance of psychological muscle. The AR therapist explores and conceptualizes the overall style of movement to assist the patient in better self-understanding and optimal movement. AR therapist also provides recommendation for reorientation coupled with support, encouragement, hope, and optimism. Rasmussen (2016), emphasizes patience and optimism are critical, but not more than reoriented movement, and be prepared with a variety of strategies for prompted effective movement.

Rasmussen (2016), outlines AR strategies including; hear the veterans’ story, identify the desired state at its core, use psycho-education, and find their stuck points. AR is a process of distinguishing immediate from the optimal, adapting basic social skills ground in social interest, optimal problem solving techniques, and promoting lifestyle reorientation. The responsibilities of the patient include; accept that everyone can grow and do better, accept the realities of social living, accept responsibility to change, identify and abandon outdated safeguards, accept the
inevitability of sacrifice (disappointment and periodic failure), and to learn effective ways to recognize and celebrate the joys that remain available in life (Rasmussen, 2016).

Rasmussen (2016), instructs the therapist in treating a veteran who has trauma to, as much possible, separate trauma-based treatment from Adaptive Reorientation therapy and to use separate therapist. He suggests that the therapist should avoid doing trauma work without attention to AR. The patient needs to develop psychological muscle or emotional resilience first and this should be started right from the beginning of the therapeutic process (Rasmussen, 2016).

Bodrog and Wittenberg (2014) stated veterans have been trained and conditioned for heightened responses, as well as, physiological response is conditioned and training and combat. The veterans that have anger management issues are more in tune with fight or flight responses as many have had to fight for their life in battle. So therefore, there is a detachment problem that many veterans experience as they had no time for emotions, they frequently had to turn off emotional response to be able to “carry out the mission” during combat service. There may be some issues of anxiety as the veteran had to be on alert and thinking ahead and have difficulty in turning off this hyper alert response. Some evidenced based practice modalities commonly used for treating PTSD with veterans is Eye Movement Desensitization and Reprocessing (EMDR) therapy, Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and Imagery Rehearsal Therapy (IRT) (Bodrog & Wittenberg, 2014).
Risk Factors to Consider in Working with PTSD and Military Vets

Castonguay and Oltmans (2013), list the risk factors to consider in treatment of PTSD which are variables that increase the risk in developing PTSD including; but not limited to; prior psychological disturbances, genetic/family history, abuse history, female gender, the nature of the trauma, and levels of low social supports and environmental factors. Research has been collected from military records that determined what factors predispose individuals at high risk to develop PTSD if exposed to trauma events. There has been twin studies which indicates a role that genetics contribute in the risk factors to develop PTSD if exposed to trauma too. There has been evidence people’s capacity for conditioning may be a risk factor for PTSD development. One study compared startle responses in Vietnam combat veterans and their non-combat-exposed monozygotic twins. This study found evidence of more slowly habituating skin conductance to startle responses in veterans with PTSD and their non-combat-exposed co-twins compared to veterans without PTSD and their non-combat-exposed co-twins. This finding suggests more slowly habituating skin conductance responses to startle stimuli may represent a pre-trauma vulnerability factor for PTSD. There is a high correlation of trauma and clients with co-occurring disorders. In working with clients with PTSD and co-occurring disorders it is important to use trauma informed care (Castonguay & Oltmans, 2013).

Among U.S. military personnel and combat veterans who have been deployed to recent wars in Afghanistan and Iraq, co-occurrence of PTSD and mild TBI (Traumatic Brain Injury) is 48% (DSM-5, 2013). Capehart and Bass (2012) stated the diagnosis and management of a veteran with PTSD and TBI is quite clinically challenging. Psychotherapies need to have adaptations for the veteran with PTSD and TBI in order to obtain optimal success (Capehart & Bass, 2012). It is important to recognize these clients’ need for stability in their primary
therapeutic relationship; therefore, this therapy work should not be administered in environments with high staff turnover and without supervision and extensive training (Center for Substance Abuse, SAMHSA, 2005). Clients with chronic PTSD and multiple traumatic events tend to abuse the most addictive substances (cocaine and opioids) and also commonly used prescription medications, marijuana, and alcohol. Also, PTSD symptoms are a common trigger of substance use. While under the influence of substances, a person may be more vulnerable to trauma. After abstinence of substance use the client may develop increased or heightened symptoms of PTSD at first and make the person at risk for relapse without adequate treatment of PTSD (Center for Substance Abuse, SAMHSA, 2005).

McDowell and Rodriguez (2013), findings further support the idea that the existence of comorbid substance use disorder and PTSD does not contraindicate trauma-focused treatment. In their study, McDowell and Rodriguez (2013), found evidence-based PTSD treatment produced outcomes for Veterans almost equivalent or slightly better than those without a substance misuse pattern. Trauma-focused treatment did not increase the risk for relapse, and overall decreased symptoms of PTSD. Another research study done by Coker, Stefanovics, and Rosenheck (2016) indicated that specialized intensive long term treatment for PTSD reduces substance use as well as violent behaviors. Coker et al. (2016) stated that it is very important to have proper discharge planning and follow-up protocols for individuals completing long-term intensive treatment in order to have the best outcomes. The treatments that play a role in providing the best care for Veterans with co-occurring disorders and PTSD include and not limited to; contingency management, cognitive-behavioral therapy, motivational interviewing, psychotherapies, medications, computerized therapies for substance use within specialized intensive PTSD programs (Coker et al., 2016).
There has been mixed results regarding the research of using cannabinoid treatment for PTSD with military veterans, (Betthauser, Pilz, & Vollmer, 2015). Betthauser et al. (2015) stated that individuals suffering from PTSD symptoms related to military trauma, often use cannabinoids as a means of coping, with some reporting benefits and relief in terms of reduced anxiety, insomnia, and improved coping ability. The research has been largely inconclusive, according to Betthauser et al. (2015), there is a growing need for research to compare the effects of cannabinoids with conventional pharmacotherapies for PTSD, in order to, demonstrate whether one treatment is superior to another in terms of safety and efficiency. Bujarski et al. (2016) stated that the treatment outcomes are poorer for veterans with cannabis use disorder (CUD) and PTSD, being the most common co-occurring disorder along with CUD. There are also concerns about negative consequences from the military associated with CUD diagnosis. Bujarski et al. (2016), suggested increased CUD education and training for clinicians to improve veterans care at the Veterans Affairs Health Care Systems (VA) to address these issues.

In research done by Lippa et al. (2015), researching deployment related psychiatric conditions and disabilities of military veterans of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), found there were many challenges in re-entering civilian life after military service. There are disabilities in occupational functioning, social functioning, and in their overall quality of life in relation to psychiatric symptoms. In this Lippa et al. (2015) study, it was found that the interacting effects of these conditions leads to additive and multiplicative, functional impairments in daily living, and increased incidents of disability. The most concerning combination of diagnosis were depression, PTSD, and a history of military traumatic brain injury. This represents a deployment trauma factor that increases the risk for other clinical issues such as; sleep disturbance, substance abuse, and substantial long
term disabilities. These veterans require highly integrative interventions or co-occurring trauma informed treatment interventions, appropriate for individual challenges and treatment needs of each person (Lippa et al., 2015).

Conard and Saul’s (2014) findings pointed out the increase in females National Guard and Reservists being deployed to the Gulf War II zones and PTSD issues that exist for them, as well as, their male counterparts. Conard and Saul (2014) also noted the stigma in that exists in the military associated with reporting mental health issues and it may be under-reported; and therefore, undertreated and more needs to be done to reduce this stigma and barriers to getting the appropriate care. They suggested that veterans with PTSD should have quarterly mental health assessments by mental health professionals for the first year and then yearly, providing the veteran is progressing well (Conard & Sauls, 2014).

Post-traumatic stress disorder is a serious problem facing multiple generations of veteran populations (James et al., 2012). There have been studies that have shown veterans diagnosed with PTSD have an increased risk for premature mortality many years after their military service is done (James et al., 2012). There is a high occurrence of risk-taking behaviors among veterans with PTSD symptoms, including; alcohol and substance abuse, driving after drinking, firearm possession, interpersonal aggression, thrill-seeking behaviors, sexual risk-taking, risk factor for HIV infection, aggressive driving practices, and suicidal ideations were among the most frequently occurring behaviors. James et al. (2012), indicate there is a high cost to veterans, their family and our society, and further research is needed to examine the impact of existing treatments on this risk-taking behaviors. They didn’t, therefore, have enough evidence that would show treatment for PTSD decreased these types of high-risk behavior.
Borsari, Conrad, Mastroleo, and Tolou-Shams (2014), pointed out a link between veterans with PTSD and SUD to criminal behavior. This prevalence of veterans with co-occurring disorders and involvement with legal problems has led to the development of diversion programs called “Veterans Treatment Courts VTC’s” (Borsari et al., 2014). These VTC’s are intended to help veterans with mental health problems received the proper treatment. This approach with VTC’s is hoped to provide access to needed care in a safer environment, instead of focusing on punishment, but there is improvement needed in these programs according to Barsari et al. (2014).

Elbongen, Beckham, Butterfield, Swartz, and Swanson (2008), examined the risk of violent behaviors among veterans with severe mental illnesses (SMI) and found PTSD did elevate the risk of both domestic and interpersonal aggression. SMI’s include; schizophrenia, bipolar disorder, depression with psychotic features, and other psychotic disorders. Elbongen et al. (2008) point out that is important to assure there is stable living situation to optimally reduce the chances of violent behavior in the community. PTSD combined with TBI doubles the risk factor of violence, as there can be increased irritability, agitation, hyperarousal and anger dysregulation. Their research indicated that it may be routine for clinicians to do a violence risk assessment when treating the newest generation of veterans (Elbongen et al., 2008). Elbongen et al., (2008) suggested interventions which would address PTSD symptoms along with cognitive rehabilitation techniques to reduce the risk of veterans’ violence for this SMI population.

Seal, Cohen, Shi, and Neylan (2013), outlined the risk observed in veterans with PTSD consistent across four main pain diagnostic categories, including; headaches, back pain, neck pain, arthritis and joint pain. Seal et al. (2013) also revealed data that veterans with PTSD compared to those with other or no mental health diagnosis were significantly more likely to
receive prescription opioids for chronic pain. Those with PTSD had higher-risk opioid behaviors including using higher doses of opioids for longer periods of time, receiving more than one opioid or benzodiazepine concurrently, and displaying aberrant opioid behaviors. Veterans with PTSD and chronic pain had worse clinical outcomes than veterans not prescribed opioids, including overdose, suicide attempts, and violent injuries (Seal et al., 2013).

Jeffreys, Capehart and Friedman (2012), review the importance of pharmacotherapy as a treatment option along with other trauma-focused treatment and psychotherapies for PTSD among veterans. Jeffreys et al. (2012) list first line pharmacotherapy agents include selective serotonin reuptake inhibitors and the selective serotonin-norepinephrine reuptake inhibitor venlafaxine, prazosin for nightmares. The second-line agents have less evidence for usefulness in PTSD treatment and carry a potentially greater side effect risk, including, nefazodone, mirtazapine, tricyclic antidepressants, and monoamine oxidase inhibitors. Jeffreys et al. (2012), stated benzodiazepines and antipsychotics are not recommended for treatment of PTSD. Jeffreys et al. (2012), indicated when providing this evidenced-based pharmacotherapy for PTSD symptoms can be encouraging engagement in treatment and can help to improve treatment outcomes.

**Developing Unique Individual Strategies**

Techniques to use in my own counseling sessions is first establishing a therapeutic and trusting relationship with client by using empathetic listening skills. Then creating a safe place for the client and utilize trauma screening tools in the assessment phase of treatment. Some clients who are prone to ruminating about their condition or have trouble managing anger may not be responsive to exposure type therapy and may benefit more cognitively oriented approaches first (Castonguay & Oltmans, 2013). Again, it is imperative for anyone working in
treatment settings or private clinics to be informed and aware of trauma, especially with client’s who are military veterans, in order to, safely and properly treat individuals effectively.

In working with clients with co-occurring disorders, one of the basic Adlerian concepts is to find the origin of the presenting problem, which Individual Psychology looks at the person’s mistaken beliefs. The origin of problems rooted in early recollections and private logic relates to how this influences choices we make in the present. In discovering a client’s lifestyle and guiding principles can uncover the individual’s original problem, therefore, helping them to gain insight. This in turn can allow the person to make different choices in the future. Helping to recognize what triggers a client with co-occurring disorders before the client resorts to old coping patterns. Hopefully, it will help them to avoid these pitfalls in the future, and avoid relapse (Ansbacher & Ansbacher, 1956).

In the Adlerian viewpoint of insomnia it is usually found at times in all psychological diseases, especially in co-occurring disorders and the severest psychological disorders. If you want to find out how insomnia fits in with the whole personality, ask the patient: “What would you do if you could sleep?” Then the client will tell of what he is afraid. The client is so afraid of the problem and tense; therefore he cannot relax and, thus, he or she cannot sleep. Everyone who does not sleep has a purpose, in which is supported by not sleeping. Insomnia occurs only in a situation in which a person is confronted with a problem for which the client is not prepared. Sometimes insomnia is a tool of ambition. This can be used as an excuse for not doing what is expected of the person, which is safeguarding. Every behavior has a purpose. Creating daily structure and usefulness is an Adlerian concept of working towards the useful side of life in relation to others and the greater community, of which one belongs. This is a necessary skill in creating wellness and a healthy recovery lifestyle (Ansbacher & Ansbacher, 1956).
Another Adlerian concept that will help inform my practice is the one which addresses the person’s tasks of life. There are five tasks of life; the work task, the social relations task, the love and sexual task, the self-task, and spiritual task. These are the main challenges that people, regardless of their lifestyle, must confront (Ansbacher & Ansbacher, 1956). It is important to work with the client to explore how their co-occurring illness has affected their life in these areas. It also helps create a dichotomy in which it creates a discrepancy, and may help in making some decisions about how the client wants to move into the future. This is also co-occurring because in chemical dependency treatment there is a spiritual component to recovery. Some people struggle with the twelve step concept of a higher power in recovery. The Adlerian concept of the spiritual task is one of the tasks of life. There are five subtasks with which individuals deal: relationship to God (or higher power), religion, the universe, immortality, and the meaning of life (Mosak & Maniaci, 1999). There are many individual interpretations of these subtasks and would be a valuable alternative to the client who has difficulties with the twelve step model, therefore, the clinician can address spirituality in a broader sense and allows more inclusion for every individual. In working with individual treatment plans, it is important to help the individual to identify with their higher power and either form a relationship with their higher power, rediscover their higher power, or redefine what spirituality means to them in their recovery journey. It is an important Adlerian task of life and important recovery skill too. People can either be encouraged or discouraged. If they are encouraged, they will risk doing things they are not sure of doing and possibly lead to growth. They will see the world as a safe place. If they are discouraged, they will not take risks; they will hold onto their convictions and not seek to change or grow. They will see the world as a hostile place. In doing these therapy exercises the person will work on creating a safe place for themselves in the world. When a
person feels safe and encouraged they will have more social interest and will be able to deal with the tasks of life in a non-harming healthy way (Mosak & Maniaci, 1999).

Clients may struggle with shame and guilt while in treatment. Early Recollections can be used to address the shame and guilt by having the person think about an early memory where the client felt shame and what they decided about themselves and others, which is very Adlerian, when we do early recollections. It is helpful with co-occurring disorders to explore defense mechanisms and this is a way that can keep clients stuck in patterns if not brought into their awareness. This is therapeutic and can be used in helping to formulate healthy behaviors and keeping the client safe using more functional coping methods. This in turn will help clients improve self-esteem and create higher quality relationships with others as they are developing a healthy recovery lifestyle (Ansbacher & Ansbacher, 1956).

The use of Adlerian concepts to address any ambivalence regarding values when working with the person with co-occurring disorders. A client might have ambivalence between their lifestyle of using, versus, symptom management for chemical dependency and mental health. If there is a discrepancy between the value and meaning and how they are actually behaving, there will be an opportunity to evaluate that and motivate thru stages of change. This is Adlerian as it relates to values and beliefs of the clients. The neurotic person has a private intelligence, but is not reasonable, in that the conclusions do not appear logical to other people as well. In this constellation the neurotic’s value judgments also become corrupted. The client will be found striving for superiority on the socially ‘useless side’, that is on the valueless side, valueless from the point of view of society. Ultimately such striving becomes valueless to the patient because all values are in the last analysis social values. Many times people entering treatment for co-occurring disorders have trouble knowing how to make changes and asking for help from others.
So this would be a helpful tool in building those skills (Ansbacher & Ansbacher, 1956). In Adlerian Individual Psychology, there is the concept of social connections and feelings of inferiority. The natural social interest of every human being reaches its limits when feelings of inferiority arise. The human race is conditioned to inferiority feelings. One specific type of inferiority feeling is the social inferiority feeling affecting the single individual. Instead of uniting the person with others, it sets the person up against others. If this were to happen the social interest development of the person would also become impaired. One cannot develop a feeling of belonging if one considers oneself looked down upon. In this case a person will overcompensate for their feelings of inferiority and of not feeling that they belong in the community. In overcompensating the person will choose either useless or useful means of doing this compensation behavior (Ansbacher & Ansbacher, 1956).

Another Adlerian concept of importance is related to the subject of movement. Individuals display characteristic movements in relationship to being faced with challenges. Behaviors are related to movement. Adler, (in Ansbacher & Ansbacher, 1956) stated that clinicians should trust only movement, because that tells what the person’s true intentions are in any given situation. So it’s not what the client says, but what they do that is most important. A very common slogan in treatment and recovery is to walk the walk, not just talk the talk, or according to Mosak and Maniacci, (1999), watch the person’s feet not their mouth.

Creating Social Connectedness and Support

People do not schedule enough time to take care of themselves especially when they are using substances, or in early recovery from co-occurring disorders. As a result, tasks and chores go uncompleted. The Adlerian concept of making oneself useful or moving towards the useful side of life, and social interest is an important goal in treatment of COD recovery. Human
behavior was seen by Adler as goal oriented and socially embedded. People strive to belong and fit into society and in their community. Healthy people are people who help others. They are people who look outside of themselves. This concept can be used to give client’s psycho educational materials regarding good self-care, as well as, offering homework exercises encouraging the person to think outside of the self and increase interacting with others, which is, social interest (or horizontal striving; Ansbacher & Ansbacher, 1956).

Laser and Stephens (2011) review supports of families of active military service members appear to have stronger support networks and more resources available to them: “The enlisted service member family may have greater knowledge of what to expect about deployment due to the family’s proximity to a military base and to other military families” (p. 28). “National Guard or Reservist families may be isolated from other military families or military support” (Laser & Stephens, 2011, p. 28). Esposito-Smythers, et al. (2011) list many programs, as well as, web sites that offer support, encouragement, mental health help with psychoeducation, outreach programs, and peer-based support groups. Reservists and National Guard members are typically paid less by the military verses active duty members, which can cause them greater financial hardships (Laser & Stephens, 2011).

Helping Military Veterans and their Families with Re-Entry to Home Communities

Naomi Nakashima (2015), in her masters project How the Stages of Deployment Impact Family Dynamics Based on the New Deployment Paradigm? outlines the way military deployment today differs from the past and how each stage of deployment effects different family members. Nakashima (2015), gives guidelines for civilian mental health practitioners to assist them in helping military family members in each stage of deployment thru reintegration. She goes on to say that the reactions of family members to the stress of deployment may further
be influenced by their ages, how other members of the family are reacting to the deployment, and their roles within the family prior to the deployment. Families who are well supported are often able to adjust through the stages of deployment faster and more easily then families who are not well prepared (Nakashima, 2015). “Nationwide parents, teachers, military leaders, and health care professionals are working to provide psychosocial support to minimize the stress of military child and family” (Flake, Davis, Johnson, & Middleton, 2009, p. 272).

Through these changes, the family unit itself changes. “Even among highly adaptive and resilient families, the end of the deployment marks the beginning of new realities for each family member and the family system as a whole” (DeVoe & Ross, 2012, p. 188). In the final stages of the military services member’s deployment is the stage of reintegration back into their family system and home community. They need to establish new routines and a new sense of normalcy, a “new normal”, which can be particularly challenging, and when support for the military member and families need the most support.

In research conducted by Ruscio, Weathers, King, and King (2002), indicated that emotional numbing is the only aspect of PTSD associated with veteran’s perceived relationships and their children. The Ruscio et al. (2002) findings suggested that war-zone veterans with severe emotional numbing, not necessarily with diagnosed PTSD, have risk factors for interpersonal problems. This is particularly important information for mental health clinicians to consider and assess for when working with a veteran and their families.

In the research findings of Miller, Reardon, Wolf, Prince, and Hein, (2013), there was a strong relationship for substance–related disorders between spouses and indicated that one partner’s substance abuse tended to encourage substance abuse in the other over time. The relationship issues between spouses or partners also was found to affect treatment outcomes and
created a greater relapse risk if the spouse drank alcohol too. Miller et al. therefore, (2013) recommended efforts to better integrate partners into veteran treatment programs and interventions that involved both members of the couple.

The author has created a curriculum to provide this knowledge to train civilian mental health professions to have a good understanding of how they can help military family members with deployments and reintegration, as well as, helping the military veteran with reintegration back to their home community (See Appendix A). Appendix B contains a list of resources that can assist counselors in working with clients who are veterans.

**Conclusion**

There is a high rate of suicide among our veterans returning home from serving our country in the United States. There is also a high rate of PTSD among military veterans that needs to be properly and effectively addressed. It is crucial within the first year of returning home to help service members, veterans and family members transition to a positive life after service or deployment. The challenges of adjustment and transition, post-traumatic stress (PTSD), traumatic brain injury (TBI), and physical disabilities, all need to be addressed. These issues can result in barriers to getting education, employment, health care, and overall individual well-being. Some of veterans’ needs are addressed by nonprofit programs, Veterans Administration (VA) support, but there are many gaps in care and resources available, especially for the veterans returning home to rural areas. In Minnesota, with a higher amount of reservists or national guard members leaving jobs to deploy and coming back home to rural areas, not to active duty military bases, veterans tend to lack supports and rely more on civilian professionals, community organizations, churches and the veteran members’ families. There is, therefore, a significant need to inform, educate, and assist with more civilian mental health and chemical
health providers (co-occurring services), more effective trauma informed treatment services, non-profit organizations to help to reduce barriers and bridge the gap for these families who gave so much to their country, to be able to have a successful experience in readjusting back home.
References


APPENDICES
Appendix A

The Vets Center Model of Care
Appendix A

Curriculum: “Helping Military Veterans and Their Families with Re-Entry and Readjustment”

There is a power point presentation and will include video recording of presentation.

Adapted from the work of B. Bodrog and E. Wittenberg, 2014 at The St Paul Vets Center, as presented at HealthPartners in Bloomington, MN on November 19, 2014.

The Vets Center Model of Care

- Majority of staff are Veterans-including combat vets
  - Vet center initiative is to hire vets (≥80%)
  - Vets are more inclined to talk about issues with other vets
  - Vets feel that we “get it”
- Vet centers are small for a reason
  - Smaller space, easy parking, less overwhelming atmosphere
  - Minimal staff allow vets to feel welcomed and safe
- “Walk on in”
  - No appointment needed
  - Eligibility, free services

Their Mission Statement

- We are the people in VA who welcome home war Veterans with honor by providing readjustment counseling in a caring manner. Vet Centers understand and appreciate Veterans’ war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community."
Types of Services the Vets Centers Offer

- Individual
- Group
- Family pre/post Deployment
- Military Sexual Trauma (MST)
- Benefits Assistance
- Substance Abuse Counseling
- Employment
- VA Claims
- Crisis
- Outreach

- Vet Centers promote collaborative partnerships with the medical facilities to better serve the Veteran and their families by a Veteran-focused and centered model, but…

- VAMC (Veteran’s Affairs Medical Center)
  - constricted to use evidence based models
  - increased wait times, research focused
  - overwhelming atmosphere

- Vet Centers have more flexibility in using different treatment modalities, scheduling and services
- Referrals
• Seamless Transition

Common Readjustment Issues

• Jobs
• Anger
• Trauma Experiences
• Family Issues
• Parenting
• Child
• Relationship issues
• Drinking/Drug Use
• Depression
• Anxiety
• Isolation
• Mental Health
• Sense of Belonging
• Grief/Bereavement
• Guilt/Shame
• Civilians

• It is important to provide outreach, direct readjustment counseling services, and refer Veterans to local services. The program is designed to provide easy access to services with minimal bureaucratic barriers to counter the effects of stigma in accessing mental health services.
Readjustment counseling

• Counseling 101
  ○ Attunement- To bring a relationship into harmony
  ○ Continue to use empathy, validation and normalizing
  ○ Create Therapeutic Alliance and build rapport (let them tell their story but don’t stay there)

• OK to use stronger approach
  ○ Vets are used to direct approach and have high BS meter
  ○ No need to talk around issue; get to the point

• Safety First
  ○ 22 Vets commit suicide each day

• Increase sense of purpose and belonging
  ○ Connect vet with other vets or vet opportunities
  ○ Give them a “mission”-solution focused

• Replace negatives with positives
  ○ Isolation vs socialization
  ○ Substance abuse vs medication
  ○ Black or white thinking vs compromise

• Self-Care and Physical Health
  ○ Exercise-Exercise-Exercise
Readjustment Counseling// Be Aware of:

- Vets have been trained and conditioned for heightened responses
- Physiological response is conditioned in training and combat
- Anger-Vets are more in tune with fight or flight response (many have had to fight for their life)
- Detachment (no time for emotions)-Vets frequently had to turn off emotional response to “carry out the mission”
- Anxiety-Always thinking ahead and improving
- Depression/Sadness

Trauma Focused Therapy and Techniques suggested to consider using:

- Cognitive Processing Therapy (CPT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Imagery Rehearsal Therapy (IRT)

Special Population considerations:

- African American
- Native American
- Asian American and Pacific Islander
- Hispanic/Latino
- LGBT
- MST (Military Sexual Trauma)

**Cycle of Deployment**


Stage of Deployment:

**Provider Assessment and Anticipatory Guidance** (Predicting Difficulties: with deployment) Assess previous history of family dysfunction, mental health issues in parents, special needs of children, recent family relocation, and previous problems during a deployment.

**Predeployment** (Training Up and Mobilization) Discuss responsibilities and expectations of each family member during upcoming deployment. Make plans and goals for family rather than “put lives on hold.” Decrease likelihood of misperception and distortion.

Prepare for communication strategies and expectations.

**Deployment** (Initiate plans made during predeployment). Continue family traditions and develop new ones. Facilitate children’s understanding of the finite nature of the deployment by developing timelines (as age appropriate) Sustainment Establish support systems (extended family, friends, religious group, family support groups, etc.). Communicate with deployed service member via email, phone, and letters. Avoid overspending. Spend some time without the children. Ask children how they are doing.

**Postdeployment** (Return Adjustment and Reintegration) Take time to communicate and get to know each other. Spend time talking to each other. Take time to make decisions and changes in
routine. Lower holiday expectations. Keep plans simple and flexible. Do not try to schedule too many things during the first few weeks. Let the deployed parent back into the family circle.  

Important considerations for children at different developmental stages (Siegel & Davis, 2013; Nakashima, 2015):

**Preschool** (ages 0-5):

They may have feelings of Confusion, Anger, and Guilt. They may exhibit behaviors such as: Clinging, Demands for attention, Problems separating from the remaining parent, Irritability and aggression, Regression (thumb sucking or bedwetting), Sleep disturbances, Feeding Issues (more picky), easily frustrated and more difficult to comfort.

**School Age** (ages 6 to 13):

They may have feelings of Confusion, Anger, Guilt, Increased sadness (loss), Worry, Fear. They may exhibit behaviors such as: New Behavior problems or intensification of already existing problems, Regression, Rapid Mood Swings, Changes in eating or sleeping, Somatic complaints, Need to be “normal”.

**Adolescent** (14 to 18):

They may have feelings of; Anger, Sadness, Depression, Anxiety, or Fear.

They may exhibit behaviors such as; Misdirected or action-out behavior, School problems, Apathy, loss of interest, Denial of feelings, Increased importance of friends, Trying to take charge of the family.

Wexler and McGrath (1991) performed a pilot study which they were able to determine that many common emotional and physical reactions to military-induced separation
were reported by their spouses. In the Wexler and McGrath (1991) study the spouses at home were asked to report their personal reactions, and of their children. Sheppard et al. (2010) stated that the risk and resiliency factors interact and influence parent-child relationships, as well as, interactions and this in turn affects the child’s outcome.

They also found spouses ages 25 to 30 had increased worry and negative emotional states over others. Families who are well supported are often able to adjust through the stages of deployment faster and more easily then families who are not well prepared (Nakashima, 2015). “Nationwide parents, teachers, military leaders, and health care professionals are working to provide psychosocial support to minimize the stress of military child and family” (Flake et al., 2009, p. 272).

Through these changes, the family unit itself changes. “Even among highly adaptive and resilient families, the end of the deployment marks the beginning of new realities for each family member and the family system as a whole” (DeVoe & Ross, 2012, p. 188).

The final stage of a military service member’s deployment is characterized by his or her reintegration back into the family system, establishing new routines and a new sense of normalcy that takes these changes and growths into consideration while incorporating this legacy into the family system’s future (Nakashima, 2015).

Adaptive Reorientation (Dr. Paul Rasmussen, 2016)
Responsibilities of the therapist in this treatment includes understanding the law of movement with preference, psychology of use, the role of safeguards and the importance of psychological muscle. The AR therapist explores and conceptualizes the overall style of movement to assist the patient in better self-understanding and optimal movement. AR therapist also provides recommendation for reorientation coupled with support, encouragement, hope, and optimism. Emphasizes patience and optimism are critical, but not more than reoriented movement, and be prepared with a variety of strategies for prompted effective movement.

AR strategies including; hear the veterans’ story, identify the desired state at its core, use psycho-education, and find their stuck points. Distinguish immediate from the optimal, adapting basic social skills ground in social interest, optimal problem solving techniques, and promoting lifestyle reorientation. The responsibilities of the patient include; accept that everyone can grow and do better, accept the realities of social living, accept responsibility to change, identify and abandon outdated safeguards, accept the inevitability of sacrifice (disappointment and periodic failure), and to learn effective ways to recognize and celebrate the joys that remain available in life (Rasmussen, 2016).
Appendix B

Resources and Advocacy: Helping to Address the Barriers
Appendix B

Resources and Advocacy: Helping to Address the Barriers

- Vet Centers/MN
  - St. Paul 651-644-4022
  - MPLS 763-503-2220
  - Duluth 218-722-8654
- VAMC- 612-467-2000
- VFW
- American Legion
- County Veteran Service Officers
- Veterans Crisis Line
  - 1-800-273-8255
- Military One Source
  - 1-800-342-9647
- Regional Benefit Office
  - 1-612-970-1000
- College Vet Services/Clubs
  - Almost all colleges have one
- Beyond the Yellow Ribbon and Active Heroes PTSD help
  - www.beyondtheyellowribbon.org
  - http://activeheroes.org/