HELPING VETERANS THROUGH OUTREACH

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ABSTRACT

The present Master's project seeks to develop a better understanding of Veterans and what they are going through. Research methods include extensive data on the high suicide rates of Veterans. Veteran and service members are in need of a service to them that will address the issue of suicide and what can be done to help and eliminate this problem. The programs that need to be designed to help needs should be in locations that have Veteran populations so as to serve them with their needs. Ultimately, Veterans Affairs (VA) officials have boosted their mental health personnel and suicide hotline staff in recent years, but at this time their data does not reflect it helping Veterans getting the help that they so desperately need.

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I. INTRODUCTION

Veteran's suicide is a topic that hits close to home, being a combat Veteran means that unfortunately many battle buddies have fallen victim to this tragedy. Published January 9th, 2014 by the Stars and Stripes, the number of young Veterans committing suicide jumped in the years 2009 to 2011, a trend that Veterans Affairs officials hope they can reverse with treatment and intervention. If the morning newspapers headline was "*Twenty-Two Local Residents Committed Suicide Yesterday*," people would be shocked and want to know what happened and how to stop it from happening again. This is the sad reality that all Veterans experience as twenty-two of their brothers and sisters in arms commit suicide every single day. Why are Veterans taking their lives and why is it happening in such staggering numbers? In 2015, over eight thousand soldiers who served their country and risked their lives ended up making the choice to kill themselves. Comparing that number to the general public means that 20% of Americans who chose to take their lives were Veterans. This is an epidemic that must be stopped.

Many Americas think the Veteran Administration (V.A.) is the catch all for anything related to military service. Although the design of the V.A. is meant to help past service members, there is disconnect with getting Veterans the help they need and the V.A. having the funding and capabilities to help the millions of military Veterans. According to Office, Policy and Planning (2010), there are approximately 22 million military Veterans who live in America alone between the six branches of service; Army, Navy, Air Force, Marines, Non-Defense and Reserves.

II. RESEARCH METHODS

This research began with the blaring issue this author deals with daily in how past battle buddies are killing themselves at an alarming rate. In one year alone, three personal friends that all served in Iraq together chose to commit suicide. The question is, "Why is more not being done to help Veterans returning from combat reenter into civilian life and learn to cope with what they saw and did?"

Through the University of Alaska On-Line Consortium Library, several databases were accessed that focused on Veteran research and PTSD. Searches were limited to peer-reviewed articles and most dealt with current research in these topics. Main search topics included *Veteran Suicide*, *Veteran Outreach*, *Counseling Veterans*, *Veteran Administration* and *PTSD*. Other research was found through online Google searches of current Veteran organizations trying to help and Post Traumatic Stress Disorder books.

III. LITERATURE REVIEW

Early studies in the late eighteen hundreds on suicide done by Emile Durkheim explain suicide as a social pathology and in direct relation to social relationships and not just internal reasons. Abrutyn & Mueller (2014) discuss how Durkheim broke down the reasoning for suicide into four categories; anomic suicide, altruistic suicide, egoistic suicide and fatalistic suicide. Anomic suicide occurs when a person experiences an anomie--a sense of disconnection from society and a feeling of not belonging that result from weakened social cohesion. Anomie occurs during period of serious social, economic, or political upheaval, which results in quick and extreme changes to society

and everyday life. Altruistic suicide happens when there is excessive regulation of individuals by social forces, such that a person will be moved to kill themselves for the benefit of a cause or for society at large. Egoistic suicide happens when people feel totally detached from society. Ordinarily, people are integrated into society by work roles, ties to family and community, and other social bonds. When these roles are weakened through retirement, loss of family, friends or brothers in war, the likelihood of egoistic suicide goes up. Finally, fatalistic suicide occurs under conditions of extreme social regulation that result in oppressive conditions and a denial of the self and of agency. In such a situation a person may elect to die rather than continue enduring the oppressive conditions, such as the case of suicide among prisoners. Of these four types of early research into suicide and the reasons behind it, Veterans can especially fall victim to the anomie and egoistic types (Abrutyn & Mueller, 2014).

Studying what Veterans and active duty service members are dealing with and how they can be reached is the vital point of this review and comparing current counseling practices is viewed as well. There must be a technique to reach those that feel the only way to deal with their pain is to end their life. The research being looked into is all about why Veterans commit suicide and addressing those issues. Although there is a Veterans Administration available to help Veterans, the V.A. is not doing enough because the Veterans are still committing suicide in record numbers and thus a new outreach program is needed that focuses on peer relationships, medical attention and alternative methods.

A major illness that affects many Veterans is Post Traumatic Stress Disorder (PTSD) which is the reactions from traumatic events that can intensify, become

debilitating, and lead to suicidal thoughts (Coll et al., 2011). Understanding this reaction is important to understanding what most Veterans are dealing with in their minds. Showing what other research has done and how it is or is not helping is also going to be addressed. Looking for the risk factors and psychiatric or peer aid is another area being researched by the VA and private organizations as are alternative methods of helping those who need it.

According to the V.A. website the statistics for 2014 show as follows:

- In 2014, an average of 20 Veterans died from suicide each day. 6 of the 20 were users of V.A. services.
- In 2014, Veterans accounted for 18% of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the US population. In 2010, Veterans accounted for 22% of all deaths from suicide and 9.7% of the population.
- Approximately 66% of all Veteran deaths from suicide were the result of firearm injuries.
- There is continued evidence of high burden of suicide among middle-aged and older adult Veterans. In 2014, approximately 65% of all Veterans who died from suicide were aged 50 years or older.
- After adjusting for differences in age and gender, risk for suicide was 21% higher among Veterans when compared to U.S. civilian adults.
- After adjusting for differences in age, risk for suicide was 18% higher among male Veterans when compared to U.S. civilian adult males.

- After adjusting for differences in age, risk for suicide was 2.4 times higher among female Veterans when compared to U.S. civilian adult females.
- In 2014, there were 41,425 suicides among U.S. adults. Among all U.S. adult deaths from suicide, 18% (7,403) were identified as Veterans of U.S. military service.
- In 2014, the rate of suicide among U.S. civilian adults was 15.2 per 100,000.
- Since 2001, the age-adjusted rate of suicide among U.S. civilian adults has increased by 23.0%.
- In 2014, the rate of suicide among all Veterans was 35.3 per 100,000.
- Since 2001, the age-adjusted rate of suicide among U.S. Veterans has increased by 32.2%.
- In 2014, the rate of suicide among U.S. civilian adult males was 26.2 per 100,000.
- Since 2001, the age-adjusted rate of suicide among U.S. civilian adult males has increased by 0.3%.
- In 2014, the rate of suicide among U.S. Veteran males was 37.0 per 100,000.
- Since 2001, the age-adjusted rate of suicide among U.S. Veteran males has increased by 30.5%.
- In 2014, the rate of suicide among U.S. civilian adult females was 7.2 per 100,000.
- Since 2001, the age-adjusted rate of suicide among U.S. civilian adult females has increased by 39.7%.

- In 2014, the rate of suicide among U.S. Veteran females was 18.9 per 100,000.
- Since 2001, the age-adjusted rate of suicide among U.S. Veteran females has increased by 85.2%.

Current methods of care for Veterans leaving their military service include their completing a counseling checklist in a minimum of 90 days prior to military separation. Service members accept or decline transitional services at this time. The military provides services involving various activities, such as financial planning, resume writing, interview skills, job counseling, and placement services. The military reports low participation in transition assistance functions (Military and Veterans' Benefits, 2002), raising concerns that these types of career services will not be used by Veterans reentering the workforce.

In 2009, the military instituted an additional resource for remote Veterans. The Mobile Vet Center (MVC) project involves a mobile trailer that travels to remote locations to provide counseling services to Veterans. Currently, there are 50 MVC trailers across the United States to provide rural area outreach. Other services provided by the military for Veterans include job fairs, community reintegration programs, vocational rehabilitation, employment services, and access to mental health staff on and off base (Danish & Antonides, 2009). One main concern with these services is access. The shortage of behavioral health assets creates burnout, because the number of staff members to support Veterans is inadequate. Military social workers lead the coordination of care among Veterans and number 8,000 across the country, a

seemingly small number when comparing military service providers to the number of Veterans reentering from service (Coll et al., 2011). Clearly there is an immense need for more service providers to step forward to assist this population.

A. Understanding the Veteran and Their Background

According to the Office, V.A. (2017), over two million U.S. service members have been deployed to Iraq or Afghanistan since 2001. As the war in Iraq has ended and combat operations have ended in Afghanistan, the military is reducing its size, and thousands of military service members are leaving the service and returning and reentering the civilian lifestyle. A large portion of all Veterans are white males but there are also females and minority populations. There was a study by Maguen et al. (2015) on Iraq and Afghanistan war Veterans who screened positive for posttraumatic stress disorder (PTSD) and/or depression. They received a suicide risk assessment, and endorsed hopelessness about the present or future after their last deployment and between January 1, 2010 and June 29, 2014. The study used bivariate and multivariate logistic regression analyses to examine variables associated with having endorsed suicidal thoughts and a plan. Multiple factors were associated with suicidality outcomes, including longer time from last deployment to screening, an alcohol use disorder diagnosis, further distance from V.A. (rurality), and being active duty during military service. Besides these studies showing factors for suicide there also needs to be discussion on what Veterans feel towards each other.

Military service members are a distinct subset of society, complete with a culture governed by rules, traditions, values, and laws. Strategies taught during deployment,

like denial and emotional detachment, assist soldiers in dealing with combat stressors (Langford, Litts & Pearson, 2013). These coping strategies, although initially effective, may negatively affect post deployment societal functioning. Individual autonomy does not play a part in military culture; rather, the military utilizes a collectivist approach. Transitioning from the military culture to civilian life may produce a culture shock similar to that experienced by immigrants first arriving to the United States. Accompanying this shock are feelings of disorientation, status change, and a personal quest for meaning and identity (Coll et al., 2011). Seeking mental health assistance while still in the military feels like "career suicide" and thus many choose to seek aid outside the military world or none at all. The Veteran's level of military acculturation may determine the strength and number of barriers to receiving help (Danish & Antonides, 2009). Based on the lengthy exposure to the military culture, embedded values, and associated stigma, a distinct array of counseling needs exist for Veterans.

Veterans are a close knit community that often feels most comfortable with other Veterans. They seem to understand each other best as they have been trained in similar fashion and seen and dealt with similar situations. Trying to help a Veteran while being someone with no prior service is going to be a difficult situation as the Veteran may never feel comfortable opening up with the outsider. This has been a continued problem coupled with the fact that the military teaches strength and courage. It is very hard for the Veteran to admit they need help. As Langford, Litts & Pearson (2013) discussed, Veterans also come from a work environment where it is essential to function as a team. Military service instills the need to look out for one another. After

leaving the military, many Veterans still feel a responsibility to look out for their fellow Veterans and this offers a great opportunity for peer relationship aid.

Veterans have unique needs and some Veterans, especially those who have returned recently from combat, may feel uncomfortable amongst the crowds and commotion of an everyday life. Some Veterans may have disabilities, including post-traumatic stress disorder or loss of limbs or body functions due to their service (Langford, Litts & Pearson, 2013). Although some Veterans do have specific needs and disabilities, it is important to recognize that Veterans are coming from an environment where they learned to function and even thrive in the face of adversity. They are accustomed to toughing out difficult circumstances, particularly so they do not let down the other members of their team (Hoge & Castro, 2012). The stigma Veterans feel about mental illness, negative perceptions of treatment, and other barriers (including confidentiality concerns in the military setting) result in the majority of service members and Veterans not accessing care when needed or dropping out too early (Langford, Litts & Pearson, 2013).

In terms of stigma there are three main forms that Langford, Litts & Pearson (2013) talk about. Public stigma refers to beliefs, attitudes, and behaviors in the broader population, whereas self-stigma is the internalization of negative beliefs by group members, resulting in a diminished self-perception and failure to pursue goals. Label avoidance occurs when individuals do not accept symptoms or seek services to avoid the negative consequences of being labeled with a diagnosis. Studies involving military and Veteran populations underscore the multi-sided nature of stigma. Some barriers

reflected attitudes, and others signaled fear of discrimination. Other major barriers included things like difficulty getting time off from work or scheduling an appointment.

According to Cerel et al (2015), military service members deployed to combat zones can experience trauma related to their service which frequently results in poor mental health outcomes, such as PTSD, depression, and anxiety. This exposure has been found in almost half of all Veterans. Exposure to combat has been associated with an increased risk of PTSD and the intensity of combat exposure has been closely related to PTSD symptom severity. Recent research by Hoge & Castro (2012) has pointed to an association between suicidal ideation with certain forms of combat exposure such as dead bodies, body parts, and other carnage. Multiple deployments and long deployments have also demonstrated a negative impact on mental health outcomes and have been predictive of suicide attempts among military service members. Stress on the entire military due to the length of these recent conflicts and the burden placed on all the forces, regardless of deployment status, has been linked to suicide risk among those who were never deployed (Hoge & Castro, 2012).

It must also be taken into consideration that long-term psychological consequences of war and traumatic stress, in general, can be seen across war Veterans' globally. Mental health among war Veterans is very similar across cultures, in spite of socioeconomic differences (LeardMann, et al., 2013). Suicide rates are usually not calculated and compared to the general population; however, some research has been performed on Russian Veterans, British Falkland conflict Veterans, and Croatian local war Veterans. Studies showed, "that mental health problems of ex-military are diverse, polymorphic and have psychosocial consequences like social exclusion,

homelessness, self-harm and substance abuse" (Rozanov & Carli, 2012). In these same longitudinal studies of male Veterans with a history of drug abuse, it was found that PTSD, drug-dependence, non-fatal attempted suicides and suicidal ideation had a strong continuity over time, with suicidal ideation some four times more frequent in PTSD-sufferers. Veterans diagnosed with PTSD have an increased risk of death, not only from suicide, but from other causes as well. Evidence shows that suicide rates are higher among older and younger depressed Veterans with PTSD compared to middle-aged Veterans. Moreover, younger males were shown to have the highest suicide risk (Hoge & Castro, 2012).

Among former military personnel, there are many publications that focus on the role of underlying disorders of suicidality, especially PTSD. Post Traumatic Stress Disorder is a disorder often coupled with other medical conditions and with a growing prevalence among war Veterans (Hoge & Castro, 2012). PTSD is commonly present in those Veterans with a previous history of suicide attempts, psychopathology and severe substance abuse characteristics. Aggressive and self-aggressive behavior in Veterans occurs more often in PTSD cases. This data provides an explanation for many Veteran suicides; however, suicide cannot be linked as the result of one particular mental disorder. Moreover, some studies do not confirm that war Veterans who suffer PTSD are more likely to commit suicide. Notwithstanding, depression is considered the leading underlying disorder for suicide and recent studies suggest that PTSD has a pronounced effect on risk mostly if coupled with depression. This issue was addressed in the article by Rozanov & Carli (2012), who indicated a significant combination between PTSD and major depressive disorder (MDD) leading to the majority of individuals diagnosed with

PTSD and MDD having a psychobiological condition that can be termed as "posttraumatic mood disorder" (PTMD). This article goes on to describe other studies suggesting that patients suffering from the combination of PTSD and MDD differ clinically and biologically from individuals with PTSD alone or MDD alone. Individuals with both PTSD and MDD are characterized by a greater severity of symptoms, increased suicidality, and a higher level of impairment in social and occupational functioning.

According to LeardMann, et al. (2013) no intervention or treatment can prevent all suicides; one-quarter of service members who die of suicide saw a mental health professional within the previous 30 days. Individuals who make serious attempts often report perceiving suicide as an option that represents relief from chronic suffering or the burden they feel they place on others (for combat Veterans, this may involve survivor's guilt). Although suicide seems to be within an individual's control, it is not a decision or choice a person reaches when other options appear to have been exhausted. Suicidal intent is no different than any other life-threatening condition.

B. What is being done to help the Veteran

Some of the V.A. is working on developing more outreach strategies to reach Veterans dealing with suicidal thoughts and actions effectively. By customizing outreach strategies to appeal to all Veterans differing situations and letting them know that there are people who care and are available to help. There have been increases in V.A. and Department of Defense (DOD) funding for research and surveillance in suicidality. The Veteran Suicide Act called for a study of suicide in Veterans since 1997 and a report to

Congress. According to York, Lamis, Pope & Egede (2013), the V.A. established a Center of Excellence (CoE) at Canandaigua, New York. This CoE was organized as a prevention and research center with the goal of reducing the morbidity and mortality in the Veteran population associated with suicide. The Center's mission is to serve as a national, regional, and local resource on suicide prevention and mental health. The CoE is addressing the problem of suicide in Veterans at various levels of risk through research program evaluation, dissemination of evidence based practice and partnership. The VISN19 Mental Illness Research, Education, and Clinical Center (MIRECC), was also funded and focuses on research and clinical approaches to decrease suicide risk.

The V.A. is specifically trying to help the Veterans through other services as well like their Veterans Crisis Line Expansion. The 24/7 Veterans Crisis Line (VCL) provides immediate access to mental health crisis intervention and support. VCL also includes a chat service and texting option. Each responder receives intensive training on a wide variety of topics in crisis intervention, substance use disorders, screening, brief intervention, and referral to treatment (Office, V.A., 2017).

Besides the V.A. and their services there are a number of nonprofit organizations trying to make a difference. Some of these organizations include:

- **The National Veterans Foundation** has helped over 400,000 Veterans and their families with crisis and information services through a vet-to-vet hotline for all U.S. Veterans and their families. There are also Veteran counselors providing Veterans and their families with information, counseling and service referrals for issues around V.A. benefits, mental health counseling, housing, medical services, education benefits, financial issues and more.

- **The Coalition to Salute America's Heroes** is dedicated to providing severely wounded Veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn with the financial assistance and support they need to rebuild their lives and restore their hopes for achieving their greatest potential.
- **Puppies Behind Bars** is a program in which prisoners train companion dogs for Veterans with PTSD. Donors can sponsor a dog and receive updates on the dog's training and life with its Veteran.
- **About Face** is a website dedicated to improving the lives of Veterans with post-traumatic stress disorder (PTSD). Here, Veterans can learn about PTSD, explore treatment options and, most importantly, hear real stories from other Veterans and get advice from clinicians who have treated thousands of cases of PTSD.
- **Hope for the Warriors** is an organization trying to enhance the quality of life for post-9/11 service members who have sustained physical and psychological wounds in the line of duty. Services include career transition and education programs, health and wellness counseling, and community building initiatives for military families as they transition into civilian life.
- **Iraq and Afghanistan Veterans of America (IAVA)** is an organization that serves the 2.4 million Veterans of Iraq and Afghanistan from their first day home through the rest of their lives. Founded by an Iraq Veteran, the group's mission is to provide new Veterans with health, education, and employment support. IAVA also encourages ways for them to connect with other Veterans in their area.
- **Wounded Warrior Project (WWP) -** Wounded Warrior Project is a charity and Veterans service organization that offers a variety of programs, services and events for wounded Veterans of the military actions following September 11, 2001. They provide free programs and services to address the needs of wounded warriors and fill gaps in government care.
- **Wounded Warriors Family Support** was started by retired U.S. Marine Corps Colonel John Folsom in 2003. They help the families of those men and women who have been wounded, injured or killed during combat operations. It provides, free of charge, family-friendly retreats where wounded Veterans, spouses, and children can reconnect with each other in a low-stress setting that they would

otherwise not be able to afford. The goal is to offer these families a way to bond again and help heal the emotional and psychological trauma inflicted by war.

- **Make the Connection** - Connecting Veterans and their friends and family members with information, resources, and solutions to issues affecting their health, well-being, and everyday lives.
- **Real Warriors** - The Real Warriors Campaign is an initiative launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to promote the processes of building resilience, facilitating recovery and supporting reintegration of returning service members, Veterans, and their families.
- **Veterans-For-Change** - The purpose of Veterans-For-Change is to make major changes in the treatment and rights for all Veterans. They conduct research, develop ideas, solutions, and programs and do our best to make sure they are put into action. They also provide guidance and assistance to Veterans, spouses, their children and widows with their claims and appeals and the support of all Veterans who seek assistance.
- **Homes for Our Troops** is helping severely injured Veterans returning home from Iraq and Afghanistan. This organization builds mortgage-free and specially adapted houses for multiple amputees and Veterans with traumatic brain injuries. It also adapts existing homes for handicap accessibility.
- **Disabled American Veterans (DAV) Charitable Service Trust** - This group supports physical and psychological rehabilitation programs that provide direct service to ill, injured, or wounded Veterans. The programs support everything from driver's rehabilitation services for Veterans with traumatic brain injuries, to treatment for post-service mental health services. The Trust also helps to fund programs that provide food, shelter, and other necessary items to homeless or at-risk Veterans and their families.

Beyond the current organizations trying to help Veterans there has been a 154% increase in the number of women Veterans accessing VHA mental health services in recent years. The V.A. has enhanced provision of care to women Veterans by focusing

on training and hiring Designated Women's Health Providers (DWHP) at every site where women access V.A., with 100% of V.A. Medical Centers and 90% of Community Based Outpatient Clinics having Designated Women's Health Providers.

Veterans Affairs has also deployed a mobile app to support Veterans and their families with tools to help them manage emotional and behavioral concerns. The app includes a PTSD Coach and it has a tool for self-management of PTSD as well as a self-assessment tool; educational materials about PTSD symptoms, treatment, related conditions, and forms of treatment; relaxation and focusing exercises designed to address symptoms; and immediate access to crisis resources, personal support contacts, or professional mental healthcare (Office, V.A., 2017). The V.A. also has over 300 Vet Centers which provide community-based counseling centers for a wide range of social and psychological services including professional readjustment counseling to Veterans and active duty service members. In addition, the V.A. is using the "Make the Connection Outreach" campaign, extensive suicide prevention outreach and other specific mental health programs and services as a part of their outreach (Office, V.A., 2017).

There are also drugs being offered by medical professionals trying to treat the suicidal thoughts, depression and anxiety seen in many Veterans. Two of the larger used drugs are lithium and commonly-used alternative treatment, valproate. A noteworthy study done on the use of these popular drugs revealed that the use of lithium was in fact helpful as long as the Veteran stayed on it. Once the Veteran stopped using the medicine lithium, the risk of suicide over dependency issues was increased substantially. Smith et al. (2014) did the study on these drugs and they also

recommend more studies being done into the tragic correlations they found. Valproate did not show a higher suicide risk with use or with stopping treatment. All prescription drug use seems to show a possible calming affect while being used but since PTSD has no known cure there needs to be more done than medication alone.

A study done by Britton et al. (2012), brought up a correlation found in Veterans who did seek mental health. Those who did seek help still experienced a 30% higher suicide rates than those who had no symptoms and asked for no help. This shows that even though some Veterans are actively seeking aid when they know they are in need and risk of suicide, one in three will still end up killing themselves and current outreach and intervention is not effective enough.

C. Current Best Practices

1. Medical Model Approach

Mental health services include outpatient treatment, awareness/information sessions, call centers, peer support services, parenting support and classes, and residential/inpatient treatment. Treatments within these services may be evidence-based psychotherapies, such as cognitive behavioral therapy, acceptance and commitment therapy, illness management and recovery, psychotropic medications, psychosocial interventions, and social skills training. Substance use disorders, military sexual trauma, depression, PTSD, anxiety disorders, bipolar disorder, schizophrenia, and family-related issues are the main concerns that such services are directed to address (Office, V.A., 2017).

2. Veteran Wellness Counseling

Different than the medical model approach, the wellness model does not focus on pathology-based assessments and treatments. It is defined as a way of life oriented toward optimal health and well-being in which body, mind and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally it is the optimum state of health and wellbeing that each individual is capable of achieving. (Myers, Sweeney, & Witrner, 2000). The wellness model has been found to promote understanding of cultural groups and may benefit other minority groups, including those with disabilities or certain faith traditions, who continue to secure less service from professional counselors (Myers & Sweeney, 2008). Outcome studies have demonstrated that wellness interventions are effective and that they were useful for people who had job-related stress that put them at risk for decreased wellness (Myers & Sweeney, 2008). The wellness model can also be used to help clients to consolidate their military experiences as part of their identity rather than being the sole defining aspect of who they are.

Specific aspects of the wellness model that can be directly related to Veteran treatment can be seen in posttraumatic growth (PTG) models. These changes go beyond basic coping or even thriving; they take the client beyond what was present before the trauma (Tedeschi & Calhoun, 2004).

3. Culturally Integrated Counseling

As culture and diversity have become accepted as necessary components of counselor competence, it seems appropriate to advocate multicultural functioning with

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

Viewing treatment of military service-related PTSD through an identity formation process can help counselors address such PTSD-specific symptoms as feelings of alienation and persistent negative beliefs about oneself and the world (American Psychiatric Association, 2013). Many Veterans with PTSD show signs of dysfunction in their lives due to feeling isolated from others and suffering severe uneasiness with social interaction. While the value of these social connections should not be minimized, practitioners should realize that the strength of those connections may make it more difficult to establish nonmilitary connections (Weiss, et al, 2011).

Cultural and social development may be important in reducing or preventing mental issues in Veterans. The ability to function in a culturally diverse environment seems necessary for many reasons and can likely be connected to overall wellness for both military and civilians. While the benefits of military relationships and connections

can be crucial to Veterans reintegrating with their families and communities (Hinojosa & Hinojosa, 2011), new civilian relationships can be equally valuable. Challenging Veterans to confront the emotional risks that accompany establishing new social relationships outside of the military culture may help them to overcome feelings of isolation and mistrust. It also has the potential to heighten their coping skills and reduce PTSD symptoms by increasing feelings of security and stability within the civilian community.

V. PROGRAM DESIGN

Veterans are expected to admit that they have Post Traumatic Stress Disorder, anxiety or other mental conditions and that they are hurting and to also say that they feel suicidal, weak and that they are feeling down. Many civilians are unable to control their emotions and admit they need help and they have never experienced combat yet alone their friends dying. The key is to have a program which cannot only utilize current best practices, but can also incorporate other strategies that would be supportive of the Veteran and incorporating them into one system which will lower the suicide rates. Lowering the suicide rate is paramount and there has to be more done, twenty-two Veterans killing themselves a day is inexcusable and sobering.

The plan is to develop a Peer-Counseling group that is safe and comfortable, where these individuals can meet. Counseling is being done by other organizations but often only with licensed psychiatrists that have never served and in cold and sterile offices. This program will have a licensed Psychiatrist on hand for legal and medication purposes but the facility will ultimately be run by past Veterans that have been through trauma and that can relate to these service member and Veteran's needs. The goal of

the Psychiatrist will not be to give out meds but there are occasions where some can be used with other therapies to help. Much of the research done and this author's personal experiences show that most depression medicines cause suicidal thoughts; and as such will only be used in limited cases.

There will also be a training course that will be implemented for the peer counselors. The peer counseling will include topics on empowerment, hope, functioning, inclusion of cultural and spiritual considerations, anger management, improving self-esteem, community re-integration, managing setbacks, utilizing strengths, barriers to recovery and resiliency, how to mentor others and how to share your own story with others. With this cornerstone there can be head way made with those in need. The peer counselors will act as mentors for new Veterans seeking aid. There needs to be successfully transitioned veterans that engage locally with new veterans with the same military background now going through transition and by motivating communities all over the nation to take responsibility for veterans returning; welcoming, connecting, and including. The new Veterans will be able to contact their mentors when not at scheduled meetings as suicidal thoughts strike at any moment. It is vitally important to be there for these Veterans and be waiting for their call for help when life gets to be too much and they feel like they cannot handle it anymore. Alongside, this group would be additional classes specializing in different techniques that help Veterans; these techniques would include music therapy and service animal therapy. Ideally, a set office location will be used for occasional meetings but the majority of meetings would be had at recreational locations that focus on different activities which Veterans enjoy doing together. This could include simple game playing of video games or card games as well as group

camping and fishing trips or skiing, gardening and hiking. Finding a place in nature to meet and be able to discuss real and difficult subjects can be very beneficial. Renting a campground or reunion hall a couple times a year makes the setting more enjoyable than an office.

This program will have a fellowship of men and women that can communicate freely and openly with each other. This program will also have a mentor system and with the mentoring comes a peer counseling buddy will be given to all participants.

There is also an outreach aspect to this program. This outreach will find ways to keep Veterans driven and motivated in their personal interests so they are kept in the right state of mind to continue on and have a purpose for living. Local hobby groups would make nice partnerships here and offer opportunities for Veterans to find a new community of people interested in similar interests and allow for more social interaction. A partnership also needs to be found with this outreach and local companies willing to hire Veterans. Although there are national organizations trying to find employment for Veterans, there really needs to be more local companies stepping up and hiring Vets. This will allow the Veteran to not have to struggle with one more aspect of transferring to civilian life. Besides companies offering to aid Veterans in their search for work this program will work with and encourage community service by the participants in the program. Having a way to help others can go a long ways to help a Veteran feel like their lives are important and worth living.

Above all, the program needs to be soldier and Veteran based and driven. Those that have been there, in the dark hole, those with understanding of what is happening and going on in the hearts and minds of these tormented souls. The goals and motives

of those running this program would be to listen, i.e. group therapy and Peer counseling, and to offer suggestions on what helped them through the hard times and what got them through their rough times. The music therapy and service animal training would be used here as well. Camaraderie and giving these Veterans a new mission in life found in new friendships and new hobbies or service projects enables the Veterans to not have to give up and feel their lives are not worth living. The military teaches mission is number one and suddenly having no mission in life is very detrimental to most Vets, they need to have that goal of accomplishing something and can find it through this program.

Besides working hands on with the Veterans in this community and other communities a national effort to address this problem needs to be handled through the hiring of a lobbyist to work to recognize these efforts in the law. The lobbyist will understand that this program needs to be recognized by the V.A. and offered as an option, the lobbyist will also work with the V.A. to make sure they cooperate with our program and help the courts and law enforcement recognize that peer-counselors have the same privileged communication as do the clergy and psychologists.

Project Implementation

The implementation plan for looking into and researching help to keep Veteran and soldier suicides from happening should describe activities and resource allocation in as much detail as possible that will keep this act from happening and getting these individuals the help they need. It is exceptionally important to provide a good overview of who is going to implement the project's activities, as well as when and where, such

as who is in charge and who and what agencies are connected to this to make it a success and legal. The implementation plan needs to be divided into two important areas which are the activity plan and the resource plan. The activity plan needs to include specific information and explanations of each of the planned project activities. The duration of the project should be clearly stated, with considerable detail on the beginning and the end of the project. There are two main formats that can be used to express the activity plan: a simple table (a simple table with columns for activities, sub-activities, tasks, timing and responsibility in a clear and readily understandable format) and the Gantt chart (a universal format for presenting activities in certain times frames, shows the dependence and sequence for each activity.) The resource plan should provide information on the means necessary to undertake the project. Cost categories are established at this stage in order to aggregate and summaries the cost information for budgeting.

VI. DISCUSSION

This program is designed to help Veterans in our current community and can hopefully be used throughout the US. More communities and organizations nationwide need to be made aware of the hurting Veterans and how PTSD affects so many. There is starting to be awareness in this area but more must be done and more funding needs to be available to aid in these organizations work. What is being done now is not helping or is not going far enough to help these men and women. The prescription drugs and meds do not seem to work, or at least the ones that are being prescribed have too many side effects.

There needs to a combined effort to try and understand these Veterans and here are some areas of interest:

1. Engage in the needed research to determine what these drugs really do to these men and women and find alternatives that work better without the side effects that prescription drugs have. It does not always have to be medicine we are pushing on these men and women, there are just as good of other avenues out there where drugs are not needed and medicine should not only be used for these distraught Veterans.

2. If we are going to continue to use counseling as a method for these Veterans then let us find qualified individuals that have been down this road and that truly understand Veterans and their needs and who have been through trauma so that there is a bond and understanding. Also, there is a stigma among Veterans that by getting help they are then a target and looked at differently and it may hinder them in getting those certain kind of jobs they want and in some cases hinders them from other things in life that they are use too. Let us remove that stigma for these guys.

3. Find a way to have more options for a group therapy style setting for these Veterans with other likeminded Veterans, somewhere that is a safe zone for them where they can relax and feel comfortable to share their experiences and feelings. Somewhere with others that have been through the same things and they can relate. Veterans feel they do not fit in once they return from a tour overseas, that no one understands them and civilian life is hard to fit into again after being where they have been and the things they have seen. The group therapy setting with likeminded Veterans will include the sharing of mutual experiences. Although all

Veterans experience different traumas, there is camaraderie in hearing what a fellow soldier saw and experienced and knowing that one is not alone in what they are feeling. These group sessions need to be based on meeting where the soldiers want to come and talk, this can include activities shared together like card games or video game or outdoor activities and get-togethers.

4. Veterans need an outlet, let us find ways that they have that outlet. Whether it be getting them involved in music, sports, hunting, fishing, camping, hunting or anything that will get their mind off what they are going through and onto the fact that life is great and worth living. Give them an option of being involved in things that interest them and stimulates their mind and gives them a fight to keep going. Music has proven to be a wonderful therapy for people of varying issue and can have a positive benefit in relieving PTSD symptoms as a result of the intervention. Music therapy is effective in reducing depression symptoms and improving health-related quality of life.

5. They need to be given the chance to learn how to mourn again. The hardest part for a lot of these Veterans is they have lost the ability to mourn. They have been through a lot and have seen a lot and not had the time or chance to mourn the losses they have encountered. They struggle with loss and guilt and have bottled it all up. They need that time and help in the mourning process. Discussing what their feelings are and how the trauma has impacted them is needed with the healing process.

6. There needs to needs to be multiple therapy options for individualization of each Veteran. Some Veterans will need a service animal to help them cope with

their PTSD. A service dog can draw out even the most isolated personality, and having to praise the animal helps traumatized veterans overcome emotional numbness. Teaching the dogs service commands develops a patient's ability to communicate, to be assertive but not aggressive, a distinction some struggle with. The dogs can also help with hyper vigilance common in vets with PTSD. The service dog is designed to always be alert and now the Veteran can finally relax and know someone is still watching. The relaxation can finally lead to a good night sleep; which is often very elusive to Veterans.

VII. CONCLUSION

According to the V.A., they say that the treatments they put out do work, but that there are challenges in expanding outreach programs. Also trying to persuade Veterans to seek help and care is problematic since there has long been a stigma associated with mental health problems and PTSD. V.A. officials have boosted their mental health personnel and suicide hotline staff in recent years, but at this time their data does not reflect it helping Veterans getting the help that they so desperately need. Clearly more must be done. There must be an expansion of services by fellow Veterans who have experienced the same traumatic events that those contemplating suicide, have also dealt with. There must be that emotional connection with anyone trying to help. A Veteran is not going to listen to a civilian who has no idea of what war and all its effects have done, to give them advice. There needs to be more studies into other medical attentions that are not just depression based drugs that have more side effects than benefits in many cases. Simply medicating the suffering Veteran will not fix their overall

struggles and may simply give them a short term Band-Aid instead of a real cure (Mittal et al., 2013).

Veteran and service members are in need of a service to them that will address the issue of suicide and what can be done to help and eliminate this problem. The programs that need to be designed to help needs should be in locations that have Veteran populations so as to serve them with their needs. They also need to be equipped with individuals that have a want and heart to be there and help these people. The staffing need to be efficient and paperwork kept to a minimum. There needs to be funds available to for these items and for more outreach programs. Ideally these Counseling and self-help outreach facilities could also have community job placement and training aid.

A Veteran carries a military identity that is rich with culture, values, and rules (Coll et al., 2011). It is not necessary for counselors to become military experts; however, increasing awareness of the military experience, resources, and impacts for returning service members assists counselors in growing as informed counselors. Viewing Veteran career counseling through a contextual theoretical lens allows counselor educators and future practitioners an opportunity to develop and research practical and effective interventions.

REFERENCES

Abrutyn, S., & Mueller, A. S. (2014). The socioemotional foundations of suicide: A microsociological view of Durkheim's suicide. *Sociological Theory*, 32(4), 327-351. doi:10.1177/0735275114558633

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

Britton, P. C., Ilgen, M. A., Valenstein, M., Knox, K., Claassen, C. A., & Conner, K. R. (2012). Differences between Veteran suicides with and without psychiatric symptoms. *American Journal Of Public Health*, 102(S1), S125-S130. doi:10.2105/AJPH.2011.300415

Cerel, J., van de Venne, J., Moore, M., Maple, M., Flaherty, C., & Brown, M. (2015). Veteran exposure to suicide: Prevalence and correlates. *Journal Of Affective Disorders*, 17982-87. doi:10.1016/j.jad.2015.03.017

Coll, J. E., Weiss, E. L., & Yarvis, J. S. (2011). **N**o one leaves unchanged: Insights for civilian mental health care professionals into the military experience and culture. *Social Work in Health Care*, 50, 487–500. doi:10.1080/00981389.2010.528727

Danish, S. J., & Antonides, B. J. (2009). What counseling psychologists can do to help returning Veterans. *The Counseling Psychologist*, 37, 1076–1089. doi:10.1177/0011000009338303

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

Hinojosa, R., & Hinojosa, M. S. (2011). Using military friendships to optimize postdeployment reintegration for male Operation Iraqi Freedom/Operation Enduring Freedom Veterans. *Journal of Rehabilitation Research & Development,* 48, 1145-1 158. doi: 10.1682/JRRD. 2010.08.0151

Hoge, C. W., & Castro, C. A. (2012). Preventing suicides in US service members and Veterans: Concerns after a decade of war. JAMA: *Journal Of The American Medical Association*, 308(7), 671-672. doi:10.1001/jama.2012.9955

Langford, L., Litts, D., & Pearson, J. L. (2013). Using science to improve communications about suicide among military and Veteran populations: Looking for a few good messages. *American Journal Of Public Health*, 103(1), 31-38. doi:10.2105/AJPH.2012.300905

LeardMann, C., Powell, T., Smith, T., Bell, M., Smith, B., Boyko, E., Hooper, T., Gackstetter, G., Ghamsary, M. & Hoge, C. (2013). Risk factors associated with suicide in current and former US military personnel. *JAMA*, 310(5):496-506. doi:10.1001/jama.2013.65164

Maguen, S., Madden, E., Cohen, B., Bertenthal, D., Neylan, T., & Seal, K. (2015). Suicide risk in Iraq and Afghanistan Veterans with mental health problems in VA care. *Journal Of Psychiatric Research*, 68120-124. doi:10.1016/j.jpsychires.2015.06.013

Military and Veterans' benefits: Observations on the transition assistance program: Hearings before the subcommittee on benefits of the house committee on Veterans' affairs, *106th Cong*. (2002; testimony of Cynthia Bascetta).

Mittal, D., Drummond, K. L., Blevins, D., Curran, G., Corrigan, P., & Sullivan, G. (2013). Stigma associated with PTSD: Perceptions of treatment seeking combat Veterans. *Psychiatric Rehabilitation Journal*, 36(2), 86-92. doi:10.1037/h0094976

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The Wheel of Wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling and Development*, 78, 251-266. doi: 10.1002/j.l 5 56-6676.2000

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

Office, V.A. (2016). *U.S. Department of Veterans Affairs*. Web. Retrieved November 20, 2016, from https://www.va.gov/opa/publications/factsheets/Suicide_Prevention_ Fact Sheet_New_VA_Stats_070616_1400.pdf

Office, V.A. (2017). *U.S. Department of Veterans Affairs*. Web. Retrieved March 1, 2017, from https://www.va.gov/.

Office, Policy and Planning. (2010) "National center for Veterans analysis and statistics." Veteran Population - National Center for Veterans Analysis and Statistics. *Veterans Administration*, Web. Retrieved March 10, 2017, from https://www.va.gov/vetdata/Veteran_population.asp.

Rozanov, V., & Carli, V. (2012). Suicide among war Veterans . *International Journal of Environmental Research and Public Health*, 9(7), 2504–2519. http://doi.org/10.3390/ijerph9072504

Smith, E. G., Austin, K. L., Hyungjin Myra, K., Miller, D. R., Eisen, S. V., Christiansen, C. L., & ... Valenstein, M. (2014). Suicide risk in Veterans health administration patients with mental health diagnoses initiating lithium or valproate: a cohort study. *BMC Psychiatry*, 14(1), 1-30. doi:10.1186/s12888-014-0357-x

Tedeschi, R. G., & Calhoun, L. T. (2004). Post-traumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15, 1—18. doi: 10.1207/sl 5327965pli 1501_01

York, J., Lamis, D., Pope, C., & Egede, L. (2013). Veteran-specific suicide prevention. *Psychiatric Quarterly*, 84(2), 219-238. doi:10.1007/s11126-012-9241-3

Weiss, E., Coll, J. E., & Metal, M. (2011). The influence of military culture and Veteran worldviews on mental health treatment: Practice implications for combat Veteran help-seeking and wellness. *The International Journal of Health, Wellness and Society*, I, 75-86.