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Nicole Marie Arcuri Sanders
Capella University

Kellie Forziat-Pytel
Pennsylvania State University

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Nicole Marie Arcuri Sanders
Capella University
Kellie Forziat-Pytel
The Pennsylvania State University

Abstract
Licensed counselors are underrepresented as mental health professionals (MHPs) servicing military-connected clients (service member/Veterans and their families). Mixed-methods research, conducted by the authors, highlights key viewpoints of MHPs (counselor, psychologist, and social worker) interested in working with the military and on their level of confidence in working with this population. MHPs' experiences, perspectives of their profession's responsibilities to military clients, and their role in comparison to other MHPs is explored. Findings aid in advocacy efforts for the military population to receive counseling from qualified providers and support counseling program development to increase counselor employability among this group.

Military service members are indoctrinated into a distinct culture that has core values, ideologies, and missions. The culture is structured through branches and ranks so that there is a clear hierarchy for service. Mental health professionals (MHPs) serving the military population have specialized knowledge of military service which includes these cultural components (Prosek et al., 2018). An understanding of the culture increases MHPs ability to build strong therapeutic alliances, identify common biopsychosocial issues, appreciate the context in which issues are occurring, and improve treatment planning (Moore, 2012). MHPs working with the military need superior training in psychopathology for diagnosing and superior training in evidence-based therapy modalities for treating. MHPs serve this population with the goal of promoting wellness for service members, Veterans, and all military-connected individuals (e.g., dependents; Tanielian et al., 2014). Thus, the military represents a unique clientele for MHPs to serve.

Research supports military as a unique organizational culture that counselors must be specially trained to work with;

Author Note. Nicole M. Arcuri Sanders, Department of Social Work and Clinical Mental Health Counseling, Lock Haven University, Lock Haven, PA. Nicole Arcuri Sanders is now at the School of Social and Behavioral Sciences Capella University, and Kellie Forziat-Pytel, Department of Educational Psychology, Counseling, and Special Education, The Pennsylvania State University, University Park, PA. Correspondence concerning this article should be addressed to Dr. Nicole M. Arcuri Sanders, School of Social and Behavioral Sciences, Capella University, 225 South 6th St, Minneapolis, MN 55402 (email: Nicole.ArcuriSanders@capella.edu).

however, it is difficult to determine how much this training occurs during the initial mental health training program for MHPs (e.g., Master's of Counseling programs). Previous researchers have noted barriers to the inclusion of this culture in mainstream curriculum (American Counseling Association [ACA], 2020; Forziat-Pytel & Arcuri Sanders, 2021; Stebnicki et al., 2017) and finds that it is primarily infused into training programs as a result of the instructors being military-connected themselves (Hayden et al., 2018). Others have noted barriers related to available trainings in the community intended for cultural competency (Tanielian et al., 2014). Unknown is where and when the cultural competency training is occurring and why social work and psychology graduates are more predominant when compared to counselors in military counseling settings. Assumptions can be made that perhaps some graduate school training programs are utilizing tools for cultural competency that may not be widely known or published. For example, documents such as Competencies for Counseling Military Populations (Prosek et al., 2018) and Standards for Social Work Practice with Service Members, Veterans, and Their Families (National Association of Social Workers [NASW], 2012) can be found related to practice and competency guides to work with this unique group, but training seems to vary drastically regarding this organizational culture across programs. To better understand the MHPs (psychologist, social worker [SW], counselor) employed to provide counseling services to the military-connected population, the understanding of treatment history and of the mental health provider occupational role training is needed. More importantly, exploration of how the military defines each mental health provider role is needed. In this article, the examination of mental health provider roles within the military and the training required by the military for employment will also examine discrepancies in hiring practices. This examination is expected to explain possible confidence of competence variances among MHPs. Additionally, mental health service history and barriers to working with the military population are shared since this article also has an intention to inform Counselor Educators and Supervisors about navigating career opportunities and meeting student needs despite level of prior knowledge with the population.

History of MHPs in Military Counseling

In the history of mental health treatment in the military, primarily, psychologists and SWs have been granted access to treating the military population for mental health service needs (Department of Defense [DoD] & Department of Veterans Affairs [VA], 2015). In fact, it was not until 2006, that licensed mental health counselors were granted access to providing services to the military population within the U.S. VA (Public Law 109-461). However, standards to hire these professionals were not established until September of 2010 (38 U.S.C. § 7401(3)). Furthermore, the DoD's primary insurance carrier, TriCare, did not allow for licensed mental health counselors to seek reimbursement for independently treating beneficiaries. However, even after

granting licensed mental health counselors' access to serving the military population, these providers marginally represent the provider pool. The National Defense Authorization Act for Fiscal Year 2014 reported hiring 93 *other* licensed mental health providers (e.g., licensed mental health counselors) in comparison to 2,048 psychologists and 2,445 SWs (DoD & VA, 2015).

Moreover, psychologists and SWs can work with the military-connected population as a civilian, contractor, or fellow service member while the licensed mental health provider can only serve in the role of civilian or contractor. No research was found regarding why the licensed MHP is not a military occupational specialty (MOS). Even with a license (e.g., LPC), there are no MOS positions available for an individual with a degree in clinical mental health counseling wishing to use their degree. There are contract positions available for LPCs, but these are civilian positions (e.g., Military Therapist, Magellan Health, 2020).

Training Professionals to Meet Mental Health Care Needs of the Military

MHPs share commonalities as well as differences when looking at professional identities that seek to improve the mental health of their clientele. Military-connected individuals may seek mental health care to address service and nonservice- related issues. The goal of treatment is consistent across professions; however, the treatment approach may differ drastically given the training for this profession. This section looks at what can be ascertained from the available literature regarding training of psychologists, SWs, and counselors to service the military.

Psychologists

The American Psychological Association (APA) asserts "psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society" (2017, preamble). Psychologists strive to access a client's mental health through clinical interviews while maintaining a heavy focus on psychological evaluations and testing). Furthermore, psychologists are directed to treat any issues found through therapeutic techniques (APA, 2019). When reviewing the Ethical Principles of Psychologists and Code of Conduct, no specific mention of evidence-based practices is mentioned as a guiding principle for the therapy provided with clients, however, ethically, psychologists' work is based on established scientific and professional knowledge of the discipline (APA, 2017).

Service Members as Psychologists

According to the United States Navy (2020a), the military branch currently employs approximately 200 clinical psychologists as officers between the ages of 18 and 41. A Navy clinical psychologist can be appointed in this MOS despite military experience but must have their doctoral

degree from an accredited American Psychological Association (APA) program and their license allowing for independent practice. The clinical psychologist can be appointed when currently serving, if they have served before, or if they have never served previously. A full-time clinical psychologist is responsible to provide clinical care to service members of the United States Navy and Marine Corps as well as their families (Navy.com, 2020a). Navy full-time clinical psychologists are expected to conduct positive mental health seminars, provide clinical care in deployed settings, participate in military training exercises, provide training and mentorship to novice psychologists, and serve in "leadership and policy positions aimed at sustaining mental health within the military" (Navy.com, 2020a, para. responsibilities). Full-time clinical psychologists are stationed state-side, across seas, aboard aircraft carriers, alongside seal teams, and at the Naval Academy. Part-time clinical psychologists serve as a reservist with the responsibilities resembling a civilian psychologist. However, expectations are for them to help patients deal with issues related to their call of duty. Part-time psychologists are responsible for helping on and off-duty service members and their families during scheduled drilling and training periods close to their home.

In the Army, an individual can serve as either a clinical psychologist or a clinical psychologist student. The Army's Clinical Psychology HPSP Student MOS is designated for individuals seeking military service as an Active Duty [AD] or National Guard officer (GoArmy, 2011). The service member can seek this MOS despite military experience (e.g., previous, current, or none) as long as they have a bachelor's degree in psychology or a related field, are enrolled or accepted to an accredited Doctor of Clinical Psychology program in the United States or Puerto Rico, a U.S. Citizen, and able to maintain full-time student status. Army Clinical Psychology HPSP Students can receive a full-tuition scholarship for one or two academic years and are expected to train and work alongside the U.S. Army Health Care Team during their academic breaks (GoArmy, 2011). Army clinical psychologists are expected to work with soldiers and their families as an AD, reservist, or National Guard commissioned officer despite previous and/or current military experience. Army AD and reservist clinical psychologists in the Army are required to have their doctoral degree in clinical psychology, counseling psychology or another subspecialty as well as a current license (GoArmy.com, 2014a). Army reservists also are required to successfully complete an APA approved one-year internship. Job duties of the Army clinical psychologist include:

- Apply[ing] psychological principles, theories, methods and techniques through direct patient services, consultation, education and research in problems of human effectiveness, adjustment, and emotional disturbance in medical and other settings.
- Focus on investigation, evaluation, and amelioration of mental and

behavioral disorders; prevention of mental illness; and promotion of effective mental health.
- Conduct and supervise direct patient care, and plan and execute disease prevention and health promotion programs.
- Exercise command of medical units as provided by law and regulation.
- Perform special staff functions in health support for commanders at all levels.
- Conduct medical research on diseases of military importance; and conduct, supervise and participate in graduate medical education and training of other medical personnel needed to sustain a robust and readily available medical system (GoArmy.com, 2014a, Job duties).

The Air Force [AF] also has similar requirements for their clinical psychologists. Just like the Navy and Army, a clinical psychologist is considered a commissioned officer and can serve in this MOS as either AD or as a reservist; they must have their doctoral degree in clinical psychology or counseling psychology and an unrestricted license to practice (Airforce.com, 2020). Additionally, the AF requires all clinical psychologists to complete a clinical internship as a minimal qualification. The age requirement is the same as the Navy (18-41). AF Clinical Psychologists' duty is to provide continued and comprehensive care to Airmen and their families with the intention to improve their psychological well-being (AF, 2020).

Clinical SWs

The NASW designates clinical SWs as a specialty practice area of social work. NASWs are licensed providers who focus on assessment, diagnosis, treatment, and prevention of mental illness, emotional and other behavioral disturbances (2020). Clinical SWs shall practice cultural competence (NASW, 2005, standard 10) specialized knowledge and skills for effective clinical interventions with individuals, families, couples, and groups (standard 2).

Service Members as SWs

Navy full-time and part-time SWs are commissioned officers with a master's degree in social work from a Council on Social Work Education (CSWE) accredited program between the ages of 18 and 41. Each SW, despite work commitment, must be independently licensed. All SWs in the Navy are required to counsel and to lead workshops for service members concerning deployment. Furthermore, SWs are expected to practice, mental health, therapy/psychology, and provide case management and family services (Navy.com, 2020b). Full-time Navy SWs are expected to provide mental health therapy and crisis intervention, and also coordinate resources for social, psychological, behavioral, medical, financial, substance abuse, educational, and transitional needs in medical treatment facilities, major military medical centers, and Fleet and Family Support Centers throughout the world. Part-time Navy SWs,

are expected to provide the same services but only during scheduled drill and training periods close to home and then anywhere in the world (e.g., across seas) during their annual training. Navy SWs can be appointed in this MOS despite military experience (e.g., previous, current, or none).

In the Army, individuals can seek a MOS as a SW as an AD, reserve, or National Guard officer. Similar to the Navy, no enlisted options are available but any level of military experience is acceptable (GoArmy.com, 2014b). Army SWs must meet the same educational requirements of the Navy SWs but are required to be between the ages of 21 and 42. Reservist Army SWs can also request a waiver for the age if older than 42. According to the Army, all SWs, despite level of commitment to the military, should provide the following services:

- Provide clinical counseling, crisis intervention, disaster relief, critical event debriefing, teaching and training, supervision, research, administration, consultation and policy development in various military settings.
- Enhance unit readiness and the emotional well-being of military members, their family members, and other eligible beneficiaries.
- Conduct and supervise direct patient care, and plan and execute disease prevention and health promotion programs.
- Perform special staff functions in health support for commanders at all levels.
- Conduct research on conditions of military importance, and supervise and participate in graduate medical education and training of other medical personnel needed to sustain a robust and readily available medical system (GoArmy.com, 2014b, Job Duties).

Clinical SWs in the AF have the same requirements of education and licensure for this role as the Army and Navy despite current military experience. However, a minimum preferred qualification in the AF is that the SW already has postgraduate clinical experience . The age requirement of AF clinical SWs is the same as for the Navy. AF SWs' duties include helping Airmen and their families improve the quality of their lives by diagnosing issues and offering guidance and counseling (Airforce.com, 2020b).

Counselors

As described by ACA, counselors have the mission to improve individual's overall well-being (i.e., mental health) (2014, A.1.a.) The process is described as a collaborative effort between the counselor and the client. Specifically addressing clinical mental health counselors, the American Mental Health Counseling Association (AMHCA) asserts, "Clinical mental health counseling is a profession of licensed specialists trained to work with individuals, couples, families, and

communities to resolve complex mental disorders while promoting greater mental health and vitality" (2020, p. 2). AMHCA identifies a distinctive characteristic of the profession is that counselors, when licensed, are qualified to diagnose and treat mental health disorders. Furthermore, the counselors employ evidence-based treatment approaches from a holistic health perspective which account for cultural diversity and include partnerships with client's stakeholders to include integrated treatment teams (e.g., primary care providers).

Service Members as Counselors

Service members can be assigned billets that reflect the name of counselor, but they have little to no training as a counselor. For instance, Headquarters Marine Corps ensures that Operational Stress Control and Readiness (OSCAR) team members are embedded in units. OSCAR Team member certification training only requires 6 hours. Advanced OSCAR qualification only requires training of 4 days per the Marine Corps Order 5351.1, Operational Stress Control and Readiness Teams and Training:

> 1.b.3. Commanders will appoint OSCAR Mentors/Team Members who are strong role models, willing to assist and mentor other Marines. Mentors/Team Members with combat deployment experience are preferable. All unit members have the potential to be trained as OSCAR Mentors/Team Members. OSCAR Mentors/Team Members promulgate command climate; identify, support, and advise fellow Marines and Sailors on combat and operational stress issues and intervene to prevent potential stress concerns from becoming more serious injuries or illnesses requiring medical intervention.

They provide leadership through example and refer Marines to OSCAR Extenders (e.g., medical staff, chaplains, corpsmen; 4.c.) and MHPs (specialized medical personnel such as psychiatrists, psychologists, mental health nurse practitioners, psychiatric and psychological technicians and licensed clinical SWs; 4.d.) when problems persist. The intention of these positions is to provide prevention as well as to direct Marines to more qualified services. According to this order, more qualified services are met by OSCAR Extenders. OSCAR Extenders "extend" the capabilities of OSCAR MHP by bridging the gap between Marine OSCAR Mentors/Team Members and OSCAR MHP. Extenders work with OSCAR Mentors/Team Members to provide prevention services, formal counseling and medical care. OSCAR Extenders examine and review Marines referred to them by Mentors/Team Members and assist within the scope of their practice and expertise. They make further referrals to OSCAR MHP when necessary (4.c.).

> 4.d. OSCAR MHP are specialized medical personnel such as psychiatrists, psychologists, mental health nurse practitioners, psychiatric

> and psychological technicians and licensed clinical SWs. They provide specialized prevention services and formal mental health care and make diagnoses such as Post Traumatic Stress Disorder (PTSD) (MCO 5351.1, 2.13, p. 2-2).

In analyzing the policy, there is no mention of a licensed professional counselor despite these professionals' training as a mental health counselor who can not only provide prevention services but also formal mental health care and can make diagnoses such as PTSD. The basis for this omission by the DoD is unknown.

The AF offers enlisted airmen the MOS Mental Health Service. The minimum education required for this position is a high school diploma or General Education Development (GED) and must be between the ages of 17 and 39. These Airmen are expected to attend 8.5 weeks of basic military training and then 66 days of technical training for this MOS which will earn them mental health services college credit (Airforce.com, 2020c). AF mental health service MOS service members are expected to: (a) Perform initial basic assessment and obtain a patient's clinical information; (b)administer and score psychological tests; (c) assist patients with nutritional, hygiene, and comfort measures; (d) explain and interpret mental health services to patients and others; (f) perform combat and disaster casualty care procedures (Airforce.com, 2020c, career tasks).

Mental health service MOS service members work with psychiatrists and psychologists to ensure every Airman is mentally fit for duty with the goal of having Airmen overcome mental obstacles to serve the mission (Airforce.com, 2020c). An alarming duty for AF Mental Health Service MOS service members concerns their responsibility to administer and score psychological tests.

> Test user qualifications require psychometric knowledge and skills as well as training regarding the responsible use of tests (e.g., ethics), in particular, psychometric and measurement knowledge (i.e., descriptive statistics, reliability and measurement error, validity and the meaning of test scores, normative interpretation of test scores, selection of appropriate tests, and test administration procedures) (Committee, O. P. T. I. V., & Institute, 2015, p. 102).

According to the standards of educational and psychological testing jointly published by the American Educational Research Association (AERA), American Psychological Association (APA), and the National Council on Measurement in Education (NCME), there are three levels of test user qualifications (A, B, and C) (2014). Ethically, measures should be met despite the assessment.

Known Barriers to Professionals Regarding Military Mental Health Care

Perceptions of access and barriers to treating the military population among MHPs (e.g., SWs and psychologists) is unknown. Arcuri Sanders and Forziat- Pytel (in press) recently conducted a study exploring counselors perceived barriers to gaining access to working with this population. Research found that counselors report a number of barriers when seeking positions to service the military. Common themes noted the following barriers: (a) counseling needs a stronger identity, (b) counselors are not as respected, (c) other MHPs, specifically SWs, are the preference, (d) not recognized or given a specific job description by the VA/ other government systems, and (e) counselors are discriminated against (Arcuri Sanders & Forziat-Pytel, in press). Research was not found concerning barriers nor ease of access considerations for other MHPs (psychologists and SWs). Therefore, it remains unknown what varying MHPs believe regarding why certain MHPs have more or less access to working with this population.

Based on the findings of this research, an interesting area to study for MHPs becomes "perceptions of confidence" regarding their competency treating this population. Furthermore, the question, "could access and barriers be derived from beliefs that certain MHPs are believed to be more qualified in working with military issues?" could yield important information about why some MHPs groups are working more with the military-connected population than others.

In social work, research found that the VA is the largest employer of masters-level SWs despite researchers concerns with current social work curriculum not meeting the needs of the military-connected clients (Wooten, 2015). Psychologists also commended the government, specifically the DoD for being its largest employer for the field (Greenbaum, 2019). In fact, psychologists career paths receive clear guidance for each branch of the military. Understanding this research disparity from the perceptions of mental health providers can provide insight for possible advocacy efforts counselors may need to emulate from SWs and psychologists to gain more access to this population. Furthermore, understanding perceptions of qualified treatment of mental health providers for military-connected clients can aid efforts of mental health provider training programs.

Current literature focuses on barriers to care for clients rather than barriers to provide care for providers. Research indicates providers can meet the needs of this population by being competent in the organizational culture and in military specific mental health issues (Forziat, Arcuri, & Erb, 2018). Some common issues noted by literature unique for this population are Post-traumatic Stress Disorder (PTSD; Ramsey et al., 2017; Judkins et al., 2020), combat related circumstances (Maguen et al., 2011), stressors related to deployments (Booth-Kewley et al., 2010), traumatic brain injury (TBI; Agimi et al., 2019), and

military sexual trauma (Wilson, 2018). Previous research offers guidance on best practices to work with this population considering their unique cultural considerations; for instance, reality therapy as it considers the organizational culture (Arcuri Sanders, 2019). Researchers stress the importance of resiliency work with this population (Lin et al., 2015; Scoglio et al., 2019; Arcuri, 2015). Despite an abundance of resources to understand the population, counselors are still being underrepresented in the field. Updated research is needed, to include the understanding of perceptions of barriers to access this unique population. For counselors, this knowledge can support strategies intended to increase counselor employability with the military-connected population.

Purpose

This article reviews MHP training programs for a better understanding of individuals interested in working with the military population, explores MHPs' cultural competence training and explores barriers faced trying to service this group. The institutional review board (IRB) approved this research aligned with ethical processes that included human subjects and allowed for data collection to begin near the later part of 2019 and into 2020. This research surrounded the central question of 'How do these unique professional groups when compared, perceive access and barriers to treating the military population?'. This question was considered in relation to participants' interest in working with the military population and their military cultural training'. The purpose was to reveal (a) which MHP groups (psychologist, SW, or counselor) are confident in working with the military-connected population and (b) how these MHP groups perceive access and barriers to treating the military population, given their training. Findings shed light on possible advocacy efforts to reduce barriers to treating military-connected individuals as well as to improve any divide among MHP groups related to differences.

Prior research has not compared MHP groups with respect to their interest, confidence, and training for counseling the military-connected population. In addition, the current literature focuses on barriers to care for military clients rather than barriers to provide care for counseling providers.

Methods

Participants were recruited by professional field listservs, social media groups of mental health providers indicating interest in working with the military, and university graduate and doctoral programs. Participants were eligible if they were (a) a credentialed or licensed mental health provider (e.g., counselor, SW, or psychologist) and (b) previously or currently interested in working with the active military, veteran, and/or their family members in the role of a mental health provider. These criteria were chosen to account for the varying employable mental health provider roles serving the military. A maximum variation purposeful sampling procedure was utilized to account for qualities the participants possessed and

addressing a broad spectrum (e.g., military experience, various licenses, and provider experiences) (Etikan et al., 2016). Participants were selected based on these criteria to answer the research question which requires personal perception as an MHP. Purposeful sampling expects each participant "will provide unique and rich information of value to the study" (Etikan et al., 2016, p. 4).

The study resulted in a total of 50 participants which included seven males (7) and 43 females (86% female participation). In 2019, the U.S. Bureau of Labor Statistics [BLS] reported 79.7 % of psychologists, 75.7% of counselors, and 81.9% of SWs were females. According to these numbers, the sample was statistically representative of the gender ratio in the mental health field. Eighty percent (80%) of participants self-identified as Caucasian, 6% as Black/African American, and 6% as Hispanic or Latino, and 2% as multiethnic. The U.S. BLS (2019) found 89.9% of psychologists are Caucasian, 5.8% are Black/African American, and 10.3% are Hispanic or Latino. For counselors, 72.7% are Caucasian, 21.2% are Black/African American, and 12.7% are Hispanic or Latino (U.S. BLS, 2019). SWs reported to the U.S. BLS (2019) that 69.9% are Caucasian, 23% are Black/African American, and 14.3% are Hispanic or Latino. These statistics further highlight that the sample of participants can be generalizable to the ethnic identities currently working in the mental health fields.

Personal Military Connection

Of these 50 participants, 19 (38%) participants had personal military experience as the service member (six currently and 13 previously). Years of experience spanned from 1-3 years to 19 or more years and served as AD, as Reservists, and National Guard. Branches represented were the Army, AF, and Navy.

Nineteen (38%) participants identified as spouses of a service member; nine currently and 10 previously. Years of experience spanned from 1-3 years to 19 or more years and served as AD, as Reservists, and National Guard. Branches represented were the Army, AF, Navy, and Marine Corps.

Military Connection as a Mental Health Provider

The participants spanned all three licensed mental health provider fields (psychologist, counselor, and SW), 12% Psychologists, 32% counselors, and 10% SWs. The remaining 46% indicated that they were licensed but did not disclose their type of license (noted as a limitation to this study). Participants varied in the capacity they worked with the military-connected population as a mental health provider. Some identified as civilian contractors working for the government (e.g., DoD, VA), were employed as a service member in the field, and others worked in the civilian sector that had military-connected clients.

Instrumentation

Participants completed a mixed methods survey. It included 13 demographic questions, 14 multiple choice questions, and 7 essay questions. Researchers collected quantitative and qualitative data using a concurrent mixed methods design (Fetters et al., 2013; Schoonenboom & Johnson, 2017) to gather participant perceptions of access and barriers for varied MHP credentials. Mixed methods are intended to provide data that offers "breadth and depth of understanding and corroboration" (Johnson et al., 2007, p. 123).

Survey questions asked MHPs about their knowledge, interest, preparation in working with the military culture, perceptions of access and barriers for various mental health providers, perceptions of reasoning for these perceived access and barriers, and perceptions of other MHP groups serving the military. Participants were also asked demographic questions which included their connection with the military (e.g., none, former/current service member, dependent) and duration of connections. These added identifiers were intended to help interpret data among clusters. No psychometrics are provided on this mixed methods instrument given that it was created by the researchers in an effort to answer the specific research questions, and intended to function for a univariate analysis. The survey questions were intended to be descriptive. In addition, the survey sample size was small.

Analysis

Fifty participant responses were analyzed for this study. This sample size was the result of low response rate. Researchers desired at least 100 or more participants to provide varied insights from multiple mental health professionals within each area of specialty (e.g., counseling, marriage and family therapy, psychology, and social work). Since the research design was mixed methods and exploratory, the researchers felt it was appropriate to proceed with this sample size (i.e., N=50) given that it met the minimums required for qualitative research to reach saturation and quantitative research to conduct statistical analysis (Castro et al., 2010). The number of invited participants is difficult to exactly indicate due to fluctuating memberships among the listervs, and social media groups. Furthermore, the inclusion criteria would limit those who would qualify which cannot be accounted for due to this membership information not being made public. However, for context, the targeted population included individuals who were active or utilized the CESNET-L Listserv. The CESNET-L Listserv serves as a forum for counselors, counselor educators, and clinical supervisors, yet subscriptions are anonymous and therefore no demographics or other information are collected (CESNET-L, n.d.). Furthermore, this Listserv is private so subscribers cannot view other member's emails. Another listerv utilized was the Military and Government Counseling Virtual Newsletter. This

newsletter is sent out to members of the Military and Government Counseling Association. Membership is open to counselors-in-training, active counselors, and retired counselors.

Three levels of analysis occurred with the final data. The first level included frequency exploration among participant surveys, the unidimensional description. The second level was multidimensional, a cluster analysis for among and across homogenous groups (Jansen, 2010). The last level of analysis was the interpretation stage for explanation of varied derived clusters and generalizations across varying credentialed participants (Creswell, 2014).

The quantitative data was primarily analyzed for descriptive statistics and Likert scale agree-disagree questions related to interest and barriers faced as counselors trying to counsel military-connected individuals. The qualitative data were analyzed using thematic analysis. Two researchers conducted this study and both researchers coded raw data for initial codes and themes. It was not until review through investigator triangulation that final emergent themes were decided upon (Nowell et al., 2017). The researchers have been involved in the mental treatment of the military-connected population; therefore, extra steps were taken to safeguard the qualitative data from researcher bias. This included: (a) the utilization of participants' personally written verbatim responses (Moustakas, 1994), (b) triangulation which allowed for a space to check bias in interpretation (Nowell et al., 2017). A mixed method approach was necessary to improve the understanding of the phenomena and to generate new theories about barriers various MHPs face relative to counseling the military population (Castro et al., 2010; Fetters et al., 2013).

Results

The findings of this study suggest there is a high interest to serve the military-connected population (AD, veterans, and their families) among all mental health provider professions. On a five-point Likert scale, 91.7% of participants indicated they were either very much or quite a bit interested in working with the AD population (i.e., service members). Participants were not as interested in working with the AD Dependents (i.e., spouse and children), 58.3% in comparison. Similar to this statistic, 58.3% of participants in working with Veterans and 55.6% with families of Veterans.

Barriers

The findings from this study indicate that professional identity does not favor a field's perception of ease of access to providing counseling services to the AD population. More than half of participants (66.7%) strongly agreed or agreed that they have faced a lot of barriers seeking work with this population. Of these participants, 50% were counselors, 16.7% SWs, 8.3% psychologists, and the other 25% did not report their license. Similarly, 47% of participants noted facing barriers when seeking to work with AD Families (47.1% counselors, 17.6% SWs, and 35.3% did not

report their license). When seeking to work with Veterans, 36% indicated difficulty. Of these participants, 61.5% were counselors, 15.4% were SWs, and 23.1% did not report their license. Similarly, 33.3% of participants noted facing barriers when seeking to work with Veteran Families (58.3% counselors, 16.7% SWs, and 25% did not report their license). From these results, it can be suggested that counselors report experiencing more barriers in working with the military-connected population. However, since some participants did not indicate their role, this interpretation cannot be made.

Common qualitative feedback (*N*=24) was received from participants explaining the barriers they faced which highlighted lack of hiring of counselors for clinical positions. Most participants (76.5%), despite their licensure, indicated they believe counselors experience barriers in reference to working with the military-connected population in comparison to other helping professionals. Participants believed this barrier of counselors having a more difficult time than other professionals gaining access to work with this group was due to licensed counselors being considered: (a) undereducated, (b) lacking of professional standards in comparison to other fields, and (c) discriminated against by the DoD and the VA. Table 1 (see appendix A) shows qualitative themes for barriers experienced by all MHPs when asked on the survey to "Please explain the barriers you have faced in trying to work with the military-connected population as a mental health provider (e.g., LCSW, LPC, Psychologist)" and about direct opinions regarding whether or not they felt "licensed counselors (e.g., LPCs) experience barriers in reference to working with the military-connected population in comparison to other helping professionals".

These qualitative barrier findings were similar to (Arcuri Sanders & Forziat-Pytel, in press), which is interesting given that this previous study only included individuals from the discipline of counseling.

Mental Health Training Program Feedback

When comparing participant's perceptions concerning whether their mental health training program did a good job with preparing students for work with the military-connected population, results indicated that despite the profession, 52.94% of participants strongly disagreed or disagreed. Of these participants, and looking at those who indicated a profession, 80% of SWs, 36% of counselors, and 75% of psychologists strongly disagreed or disagreed with their training programs doing a good job of preparing students for work with the military-connected population. Only 14.7% indicated being in a specialty track for working with the military-connected population as a mental health provider and 26.5% took a specialty or elective course concerning this population.

Confidence

Of the participants who indicated their profession and answered the question concerning their level of confidence in working with each of the AD/Veteran military sub-groups in a mental health setting, 80% of the participants indicated they are either extremely confident or very confident. Of these respondents, 100% of the psychologists and SWs indicated they were either extremely confident or very confident while only 55.6% of the counselors did. However, when considering all participants who answered the question, despite denoting their profession, 70.6% indicated they are either extremely confident or very confident. Without knowing the other participants' profession, no direct conclusions can be made concerning this statistic.

Qualified to Treat

A profound finding, despite differentiating profession, is that the majority of the participants indicated that all professionals are equally qualified to work with numerous common military-connected mental health issues. Please see Table 2 (see appendix B). For most of the issues, approximately more than half of participants indicated a psychologist, SW, or counselor would be qualified to assist the client with their presenting concern. However, a significant number of participants did not feel all were equally qualified to help military-connected clients regarding housing concerns, criminal justice issues, or traumatic brain injury. Participants perceived SWs as the most qualified professional to assist military-connected clients with housing concerns (70.9%). When asked to choose the professional best able to assist clients with criminal justice matters, 38.7% indicated all would be qualified while others believed a SW (38.7%), counselor (12.9%), and psychologist (6.4%) would be better suited while 3.2% believed none of these providers would be the qualified choice. For the client presenting issue of traumatic brain injury, 61.3% of the participants indicated a psychologist would be the best qualified provider to seek treatment from. Conclusions from Table 2 suggest that mental health providers believe all mental health professionals are qualified to meet many of the common mental health needs of service members, veterans, and their families.

Discussion

There were several limitations in this study. First, the sample size is small for what is often preferred when analyzing quantitative data (Castro et al., 2010; Creswell, 2016). In addition, a requirement for participants was that they indicate their type of mental health provider license (e.g., LPC). However, the question designating their license was not required. This negatively impacted the results concerning the statistics connected to provider perceptions since some perceptions cannot be categorized to a mental health profession. For example, other participants (70.6%) indicated they are either extremely confident or very confident. Without knowing the

other participants' profession, no direct conclusions can be made concerning this statistic. This sample included individuals who are interested in working with the military and did not differentiate results by level of experience. The dissimilarity in experience could lead to differences in responses about providing services (e.g., feelings about confidence) to this population. Finally, this article explored MHP training programs through the Professional Organizations (e.g., ACA), military career guides, and participants, rather than from the training programs themselves.

Despite the limitations, surprisingly SWs, psychologists, and counselors report each profession as being equally qualified to address many of the common mental health concerns of the military-connected population despite variance in access to this population. Data compiled in this study that reports of the barriers licensed counselors face in obtaining work with this position supports the statistics concerning mental health provider representation despite the belief of being deemed qualified. A finding which may offer counseling training programs aid in advocating against this disparity is by revamping their training programs to address the needs of the military-connected population more specifically. Licensed counselors reported a significant decrease in confidence to work with this population compared to psychologists and SWs. There is a strong need for more military mental health providers. The DoD is said to be facing severe shortages of qualified providers (Kline, 2019). Counseling programs are encouraged to take these findings and implement curriculum addressing counselor cultural competence for serving the military population to meet the current employment needs within the field. Furthermore, increasing counselor competence in counseling the military population may result in decreasing the employment disparity between counselors and other mental health providers.

Currently, there are no other known studies to highlight the preparation of mental health providers, their confidence levels, or understanding of barriers to access in providing treatment to the military population. Future research is still needed to better understand training for competency in working with military connected clients and how to eliminate barriers for mental health providers to help increase the number of available providers for military-connected clients who need care.

Future Research

While this study added to our understanding of where individuals were learning of the military culture in their programs (i.e., electives versus specialties), numbers of individuals who had this specialized training does not match up with or make sense of the data where individuals noted confidence and competence to work with military connected clients. Future studies should seek to better cognize where all the training and practice occurred to become competent in working with this group. Perhaps individuals are receiving

most of this extra knowledge outside of training programs. If so, where? Work sites, or workshops? This information could help future educators identify where to send MHPs to improve their knowledge about working with military connected clients. Other studies should examine professional programs themselves to see what tools and classes they may be utilizing to provide this information. For example, ten programs from each MHP group could be selected for an initial analysis of "teaching for military cultural competency". For programs that do focus on this group, as follow-up, program evaluation studies should occur to see the effectiveness of training regarding this unique group. This would lead future researchers and educators to particular tools and/or teaching modalities that are more effective in training for this culture that is difficult to access in person.

This article shared information about mental health providers' perspectives on their profession's responsibilities to military clients, however, it would be helpful in a future study to examine their professional responsibilities relative to other mental health providers. Many of the participants who provided qualitative responses in this study provided inaccurate information about the identity of the counselor. One provider stated "LPCs are often not hired as they lack evidenced based training most of the time" and another stated "…hire LCSW, LMFTs, and psychiatrist over LPCs I believe because they are more highly organized with more stringent standards". These statements seem to indicate that better education and more advocacy is needed regarding the knowledge, skills, and abilities of counselors, particularly those coming from accredited programs by the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015), and holding National Board for Certified Counselors (NBCC) credentials and/or professional state licenses. All of these are sources to ensure competency in professional practice and key knowledge and skill areas in which other professions may view this profession to be lacking. In military programming, many individuals in charge (given the current make-up of MHPs in the military) will come from non-counseling backgrounds and be key components in the hiring process. Perhaps they feel individuals coming from backgrounds of their own (i.e., social work) are more suited to do the work and this perception is causing a barrier to counselors getting into these settings. Additionally, our questions were intended to be descriptive; we did not create a scale that could be tested. Future research can add additional context to this study by creating a scale that measures these constructs regarding this unique group.

The DoD trends show a strong need for more military MHPs (Kline, 2019). This article has identified possible reasons for this scarcity related to training and accessibility to the group based on barriers current MHPs are facing. Future research can and should continue to provide insight regarding these areas to reduce the likelihood of a true shortage of competent military MHPs.

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Table 1

Barrier Themes (Listed by Frequency) to Highlight Two Qualitative Survey Responses

Barriers for Whole Group Responses to Survey Question#11, "Please explain the barriers you have faced in trying to work with the Military-connected Population as a mental health provider (e.g., LCSW, LPC, Psychologist)"	Barriers for Counselors Responses to Survey Question #12, for those who believed "licensed counselors (e.g., LPCs) experience barriers in reference to working with the Military-connected Population in comparison to other helping professionals" and why
1. professional discrimination[a]	1. professional preference[b]
2. difficulty getting credentialed	2. professional discrimination
3. licensure required	3. difficulty getting credentialed
4. must have personal connections to access group	
5. reserved group which provides challenges to care	

[a] *Professional discrimination:* theme to capture information stated surrounding feeling seen as inferior or misunderstood by others. Responses were all from individuals discussing LPCs/counselors in barriers for the whole group.

[b] *Professional preference:* theme to capture information that about how settings prefer certain mental health groups over the other. Responses were all in direct response to discussing barriers for LPCs/counselors.

"" indicates a quoted question from the research survey participants completed

Table 2

Qualified Professional Needed for Mental Health Issues

Common Mental Health Issue with the Military-connected Population	Participant Percentage for the Response, "All are equally qualified" (e.g., licensed psychologist, social worker, and counselor)
Military sexual trauma	54.8%
Traumatic brain injury	32.3%
Trauma	51.6%
Suicidal ideation/behavior	54.8%
Guilt/moral injury	51.6%
Substance abuse issues	58.1%
Criminal justice issues	38.7%
Relationship issues with family	67.7%
Intimate partner violence	54.8%
Identity Crisis	54.8%
Physical Disability	60.0%
Career Concerns	45.2%
Religious Concerns	58.1%
Social Concerns	70.9%
Housing Concerns	19.4%
Deployment/family separation	67.7%
Adjustment (moving)	67.7%