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Wellness-Focused Supervision for Counselors Working with Military Service Members and Veterans

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Providing counseling to military service members and veterans presents a unique constellation of considerations for providers. The context of the military, exposure to traumatic events, and other service-related experiences can impact counselors working with this population. To ensure the wellness of providers, utilizing Wellness-focused supervision as a mechanism of support can prevent and remediate deleterious outcomes associated with clinical contact with this population. Utilizing Wellness principles informed by an understanding of the unique experiences of counselors assisting military service members and veterans creates a responsive supervisory environment fostering positive counselor growth and development. This article discusses the mental health landscape of service members and veterans, the context of the military, and the implementation of Wellness-focused supervision for counselors serving this population. A case study is discussed to further illustrate the application of this model.

Keywords: counseling military, clinical supervision, Wellness-focused supervision

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Military service members and veterans often experience unique circumstances associated with their service. Members of this population encounter specific experiences differentiated from a civilian existence such as engagement in combat; transitioning from military to civilian life; and career development considerations. There are indications that military service members and veterans of recent military conflicts are at an elevated risk of mental health challenges related to their service (Hom, Stanley, Schneider, & Joiner, 2017). Counselors who work with this population are exposed to clinical content that can unearth personal and professional concerns for those providing services. Clinical supervision provides a modality of support that can assist counselors struggling with issues associated with counseling military service members and veterans.

Given the nature of the combat-related service, mental health concerns such as Posttraumatic Stress Disorder (PTSD, American Psychiatric Association, 2013), depression, suicide, and transitional stress exist within military populations. There are indications of a high prevalence of Major Depressive Episodes and Generalized Anxiety among service members (Kessler et al., 2014; Rosellini et al., 2015; Stein et al., 2015). In addition, those who serve are at an increased risk of suicide (LeardMann et al. 2013; Shen, Cunha, & Williams, 2016) and suicidal behaviors (Nock et al., 2014) associated with major depression. Military service members experience unique stressors specific to pre-deployment, deployment, and post-deployment phases of deployment (Esposito-Smythers et al., 2011). In terms of PTSD, there are differences in the estimated rates of this condition across eras of combat such as Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) (11-20%), the Gulf War (Desert Storm) (12%), and the Vietnam War (30%). Regardless of the era of combat, rates of PTSD are higher than the estimated 7-8% in the general population (National Center for PTSD, n.d.).

By extension, counselors working with military service members and veterans will likely encounter clients experiencing PTSD and other mental health concerns. Continual exposure to trauma in clinical work increases the likelihood of negative well-being on the part of providers (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman, 1995; Cunningham,

1999; Kassin-Adams, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Counselors can be significantly impacted to the point of developing vicarious traumatization (VT) described as disruptions to a therapist's imagery system of memory, yielding painful experiences of images and emotions associated with clients' traumatic memories (Pearlman & Saakvitne, 1995). Though one experience with a client's traumatic issue can negatively affect the counselor, VT often manifests after repeated exposure to clients' traumatic narratives (Moulden & Firestone, 2007; Pearlman & Mac Ian, 1995). There is also the potential for first and second-hand exposure to traumatic events for counselors embedded in areas of conflict (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015).

Given these considerations, it is essential to develop modalities of support to augment this effect. Clinical supervision provides a context of support in which to address deleterious concerns on the part of counselors assisting military service members and veterans. Counseling supervision is a mechanism in which to prepare, teach, and monitor the quality of counseling provided by supervisees (Evans, Wright, Murphy, & Maki, 2016). In summarizing empirical findings of several studies, Watkins, Budge, and Callahan (2015) found supervision contributed to favorable supervisee outcomes such as enhanced self-awareness, increased sense of practitioner self-efficacy, enhanced skill acquisition, enhanced treatment knowledge, and utilization, and strengthening of the supervisee-client relationship. Johnson, Johnson, and Landsinger (2018) discussed the use of trauma-informed supervision as a means to support counselors in deployed military settings to ensure well-being on the part of those who provide services in this context. We propose the use of a Wellness-focused model of supervision to assist counselors who provide services to military service members and veterans regardless of the context in which counseling occurs. To better understand the experience of counselors providing services to this population, it is important to know the mental health landscape of those who serve.

Mental Health Concerns of Military Service Members and Veterans

Service members often experience little to no substantial ill effects related to their service, however there are those who are negatively impacted by their experiences in the military. When struggles arise, counselors may come in contact with these problematic issues via the therapeutic engagement. By extension, those providing supervision to these counselors are exposed to the traumatic experiences of clients. The following is a brief description of various concerns experienced by this population.

PTSD

PTSD can be experienced by anyone who suffers a particularly traumatic event. Military service members may develop PTSD in ways that are distinct from civilian populations. For example, soldiers in combat may experience trauma as a sustained event or series of events as opposed to a one-time occurrence, such as a severe car accident or sexual assault, which would be more typical in the civilian population. In response to combat conditions, hyper-arousal over time can further exacerbate the development of PTSD symptoms. Prolonged arousal of the sympathetic nervous system can lead to physical problems that further hinder emotional healing (Fragedakis & Toriello, 2014).

It is difficult to pinpoint the prevalence of PTSD among veterans due to issues of under-reporting and cultural stigma. Huang and Kashubeck-West (2015) found that, across all branches, military veterans' exposure to combat was positively correlated ($r = .67$) with developing PTSD. Fragedakis and Toriello (2014) report that between 12-30% of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans reported combat-related PTSD. Diagnosis of PTSD may be further complicated as some service members and veterans do not meet the full criteria for diagnosis, yet bear the burden of debilitating symptoms. In addition, there exists a high rate of co-morbidity between PTSD and other adjustment difficulties (Huang & Kashubeck-West). Of particular concern for counselors, elevated risks of developing major depressive disorder co-

exist with PTSD, increasing the risk of suicidal intention (Fragedakis & Toriello). PTSD can be complicated by the severity and duration of the initiating traumatic event, the resulting course of development (e.g., sustained vs. distinct), and barriers to treatment following the event. Counselors must assess for these various factors in order to make the most effective treatment decisions (Fragedakis & Toriello). In sum, approximately 77.3% of active-duty service members hospitalized with PTSD had co-morbid diagnoses, including mental health and substance abuse issues (APA, 2015).

MTBI

Mild traumatic brain injury (MTBI) occurs when there is a form of impact to the head. These injuries frequently occur during violent, life-threatening experiences, and may be referred to as “shell shock” or “getting your bell rung” by soldiers in the field. Around 20% of soldiers who served in Afghanistan and Iraq experienced MTBI (APA, 2015; Jones, Young, & Leppma, 2010). Because a traumatic event within the context of combat such as an explosion causes MTBI, PTSD is a frequent co-occurrence, with co-morbidity rates ranging from 13%-84% (Jones et al.). MTBI does not cause the same degree of behavioral or cognitive dysfunction as more severe TBI. Because these injuries often go undetected during deployment, soldiers may seek treatment for symptoms weeks or months after the injury (Jones et al.).

Suicide

The rate of suicide among service members and veterans has been a particular focus of public concern over the past decade. Nock et al. (2014) indicated that in the past, military service members and veterans demonstrated lower rates of suicide than the civilian populations. However, in recent years, the Army suicide rate has risen dramatically while the civilian rate remains stable. For example, suicide rates among active-duty military personnel began rising in 2005 from 10 to 11 persons per 100,000 to 18 per 100,000. These rates leveled off in 2009. The highest rates of

suicide were among Army and Marine Corps service members (LeardMann et al., 2013). US Military suicides account for 20% of military deaths. Self-inflicted wounds accounted for 23% (2nd highest) of U.S. Active Duty Military deaths from 2006 - 2018 (Congressional Research Service, 2018)

There are many factors counselors and supervisors must be aware of when assessing for and treating suicidal ideation in service members or veterans. The strongest predictors for suicide are the appearance of mental health disorders including self-injurious behavior, major depression, and substance use disorders (Shen et al., 2016). PTSD is of particular concern, as veterans with this diagnosis are four times more likely to report suicidal ideation than those without a PTSD diagnosis (APA, 2015).

Time since deployment or separation from the military also seems to play an important role in the development of suicidal ideation. Shen et al. (2016) reported that suicide rates rose post-deployment and within one year of separation from the military. The risk of suicide nearly tripled in the first year after separation from military service and remained elevated six years after separation. The risk of suicide for those who served only a short time (six months or less) may be as much as 12 times higher than for those who served longer durations. The exact reasons for this disparity are unknown (Shen et al., 2016).

Factors prior to enlistment and deployment can also impact the development of suicidal ideation. Nock et al. (2014) found that the majority of those surveyed disclosed suicidal ideation prior to enlistment (58.3% of men and 57.6% of women). A history of law violations prior to enlistment also appears to correlate with elevated suicidal intention (Shen et al., 2016).

Sexual Violence

The Department of Defense (2017) military sexual assault report demonstrates positive trends as there was a 10% increase in reporting from the previous year, while the prevalence of assaults decreased by 45% since 2012. These numbers imply that stigma around reporting is decreasing, as is the frequency of the assaults themselves. Nevertheless, sexual assault remains a significant issue in military culture. During screening with a Veterans Administration (VA) provider, one in four women reported sexual

trauma, compared to one in 100 men. Women with a history of military sexual trauma (MST) are nine times more likely to develop PTSD than women without a history of MST (APA, 2015).

Violence

Perhaps the greatest risk of vicarious trauma (VT) for counselors lies in service members' descriptions of violent acts both witnessed and perpetrated. VT occurs when counselors experience a cognitive processing shift as their beliefs, attitudes, and perceptions about safety, trust, and control change as a result of repeatedly treating clients with significant trauma (Newell & MacNeil, 2010). In counseling military clients, counselors may be overwhelmed and under-prepared for the intensity of the narrative histories of these clients. Death, violence, and atrocities may surface. Grossman (2009) describes the inherent human resistance to taking life, and the desensitization that occurs during combat training to assist military service members in overcoming that resistance. Still, service members who witness or perpetuate violence or killing, particularly at close range, and particularly when personal honor has been compromised (such as killing civilians) often carry guilt, shame, and trauma (Grossman, 2009). If trust and rapport are built with a counselor, the session may involve recall of traumatic events that are shocking or disturbing to the counselor who has not been exposed to military-level violence before.

Other Concerns. On the whole, about one third of OIF/OEF veterans report mental health concerns (APA, 2015). In active-duty military, mental disorders are the second leading cause of role impairment (including days out and visits to health care providers) after physical injuries. Among active-duty military, the 30-day prevalence for mental health disorders was 25.1%, compared to 11.6% among civilians. Nearly half (49.6%) of active-duty military surveyed had at least one disorder prior to enlistment (Kessler et al. 2015).

Utilization of Mental Health Services

A recent meta-analysis indicates that 60% of military personnel who struggle with mental health concerns do not seek treatment (Sharp et al., 2015). Stigma remains a significant barrier to mental health treatment for many active duty service members and veterans. Psychosocial barriers to treatment include cultural stigma (i.e. mental health issues seen as weakness), self-esteem issues (guilt or shame about needing help), concern about future advancement in the military if they ask for help, concerns about confidentiality, and concerns about weapons restrictions if they express thoughts of suicide or homicide (Fragedakis & Toriello, 2014).

In addition, a 2013 study demonstrated a lack of sufficient services to meet the mental health needs of active-duty service members and veterans, and insufficient training for providers in evidence-based practices (APA, 2015). Service members or veterans who feel their mental health counselors lack sufficient training or knowledge of military culture or trauma-specific treatment modalities may see counselors as untrustworthy, incompetent, or ineffective (Currier, McDermott, & McCormick, 2017). These perceptions, either real or imagined, are a significant issue that must be addressed in order to better meet the needs of military populations. Given this constellation of concerns, mental health counselors serving this population are in need of supportive mechanisms which equip them to encounter these concerns. Informed clinical supervisors are an essential tool for supporting military-affiliated counselors as they encounter these concerns and barriers to services. Apart from the mental health service concerns and other obstacles to care, the military environment presents a unique set of considerations worthy of attention.

Context of the Military

Apart from clinical concerns, the context of the military is a unique culture which infiltrates both counseling and supervision domains. This context has been indicated as a distinct culture by counselor educators (Hayden, Robertson, & Kennelly, 2018). The military melds a diverse array of cultural elements (e.g., race, gender, socio-economic class), and also

possesses unique and distinct cultural elements of its own. Military service members live and work in “The Fortress”, a unique cultural structure where these defenders of democracy do not function within a democratic system. Authoritarianism, hierarchy, and conformity are stressed (Hall, 2011). Counselors who have never served in the military or who have limited experience with military service members or veterans may be unfamiliar or uncomfortable with cultural aspects of the military. When working with military-affiliated clients, the counselor may be perceived as the authority (i.e., higher rank, officer) and thus building trust and rapport may prove challenging in establishing an egalitarian relationship with clients (Hall, 2011).

Military service members inherently possess or are indoctrinated into a set of self-expectations including the warrior ethos: Strength, emotional control, self-sacrifice, pride in accomplishing tasks without help, and fear of appearing weak (Cole, 2014). In the warrior ethos, honor is to be maintained at all costs. This commitment means that service members may struggle with guilt or shame about what they have seen or done and may be reluctant to share their actions with people outside of the military (Hall, 2011). In addition, frequent deployments may further distance active-duty military from family members and friends, straining those bonds and creating a sense of isolation once the service person returns home (Hall).

Though liabilities may result from military culture, beneficial characteristics exist that can assist the client in overcoming challenges and inform intervention. Once rapport is built with a counselor, military clients can engage qualities of strength, integrity, and honor to make real progress toward a healthier life. Learning the unique jargon, ethics, standards, and beliefs within military culture informs both counselor and supervisor of important aspects of this context that may influence the helping relationship. In relation to specific counseling strategies, incorporating strengths-based approaches or cognitive techniques that appeal to the progress orientation in the military leverages the context to the benefit of the counselor. Finally, focusing on short-term, evidence-based practices that bring concrete, rapid change (as long-term counseling might not be

possible for service members on the move) accounts for the reality of unanticipated termination due to deployment or reassignment (Hall, 2011).

Examination of Personal and Cultural Biases

Whether counselors are pro-military advocates, fierce pacifists, or somewhere in between, coming to terms with personal biases and stereotypes is an essential process in developing cultural understanding and awareness. The Multicultural and Social Justice Counseling Competencies developed by the Association for Multicultural Counseling and Development (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015) encourages counselors to examine their beliefs and attitudes, knowledge, and skills across three dimensions: counselor awareness of own cultural values and biases, counselor awareness of client's worldview, and culturally appropriate intervention strategies.

Supervisors can encourage counselors to self-reflect and enhance knowledge and skills in a variety of ways. Supervisors might perform a needs assessment to determine supervisees' perceptions of, and experience with, the military, uncovering any potential stereotypes or biases as well as areas for knowledge development (Strom et al., 2012). Opportunities for ongoing training to increase knowledge of military culture might include assigned readings, lectures, case study discussions, and field trips to area military organizations (Cole, 2014; Strom et al., 2012). Experiential knowledge might be gained through an immersive experience in the culture, e.g., volunteering on a military base or with a veteran organization. Though specific strategies are useful, adopting a theoretically-based approach when supervising counselors working with military service members and veterans provides a broader framework to inform supervisory interventions

Wellness-focused Clinical Supervision of Military-associated Counselors

Given the significant concerns inherent in military service members and veterans which will affect those who provide services, a Wellness-focused approach accounts for the impact of this work on counselors.

Models of wellness offer a holistic perspective by addressing physical, mental, social, emotional, and spiritual, as well as other aspects of individuals' lives (Ardell, 1988; Hettler, 1984; Myers & Sweeney, 2004; Myers, Sweeney, & Witmer, 2000). Wellness has been defined as a way of life focused toward optimal health and well-being. The body, mind and spirit are integrated, resulting in a life lived more fully within the human and natural community. This state of wellness exists on a continuum as opposed to an end state (Myers et al., 2000; Roscoe, 2009).

The Indivisible Self Model of Wellness (IS-Wel; Myers & Sweeney, 2004) is an evidence-based model of wellness (Hattie, Myers, & Sweeney, 2004; Myers & Sweeney, 2008) that can be applied to help supervisees address the conscious and unconscious effects of their counseling work as it relates to: (1) Coping Self (e.g., stress and burnout); (2) Essential Self (e.g., identity and self-care); (3) Creative Self (e.g., professional/work well-being and emotions); (4) Physical Self (e.g., physical health and eating habits); and (5) Social Self (e.g., interpersonal relationships and expressions of love). The IS-Wel model (Myers & Sweeney, 2004) is a holistic and interconnected nature of the model incorporating the opportunity for formal assessment of the five factors described above using the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005). A collaborative relationship that focuses on the strengths of supervisees also is a cornerstone to the wellness approach (Myers & Sweeney, 2008). An IS-Wel approach to supervision is structured to provide opportunities for supervisees to reflect on their emotional and cognitive resources to deal with the effects of their work.

Lenz and Smith (2010) introduced the Wellness Model of Supervision (WELMS) noting that when wellness is an essential part of the supervision process, the deleterious effects of trauma can be augmented or prevented. Educating supervisees about wellness, assessing supervisees' level of wellness, evaluating wellness throughout the supervisory relationship, and developing strategies to address supervisees' personal wellness are process elements of this approach. Investigation of the WELMS approach found that supervisees were better able to articulate their personal definition of wellness in comparison to other approaches as a

result of exposure to this framework (Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012). In addition, Wellness-focused supervision enhanced mental health counseling students' level of wellness (Meany-Walen, Davis-Gage, & Lindo, 2016).

The potential for vicarious traumatization and other associated effects warrant a holistic and wellness approach to the supervision of counselors assisting military service members and veterans. Hayden, Williams, Canto, and Finklea (2015) specifically described the manner in which a wellness approach can be utilized to address VT. To assist in understanding the dimensions of a wellness approach to supervision, specifically focused on counselors working with military service members and veterans, the following case study is provided to inform the manner in which to facilitate this process.

Case Study

To better understand the application of a Wellness-focused approach to supervising military-affiliated counselors, the following case study of a fictionalized clinical scenario is provided. The proposed application of this supervision approach is but one way to integrate concepts of wellness into counseling supervision.

Brian was a novice counselor working in private practice in a community within close proximity to a large military installation. He had extended family members and friends who served, but was not directly connected to anyone affiliated with the military. Recently, other members of the practice were primarily seeing military service members, veterans, and their family members who chose to seek services outside of military mental health to avoid potential concerns about stigmatization in seeking services. He had begun to serve military-affiliated clients due to need of the practice and his indicated interest in serving this population.

Brian's clinical supervisor, Tia, served in this role while he had been accruing hours toward counseling licensure in his state. Tia had served as a clinical supervisor for several of his clients and was confident in her capability to assist Brian. She operated from a wellness perspective both in her counseling work and in her supervision of other counselors. Focusing

on both prevention and remediation of supervisee concerns connected to their clinical work, indicating her own definition of wellness to supervisees, continually assessing supervisee's wellness, and providing support when issues of wellness are identified, characterized her work as a supervisor (Lenz, et al., 2012). They had been meeting weekly to process Brian's work.

In a supervision meeting, Tia noticed that Brian seemed less prepared for their meetings, with him not examining counseling notes beforehand and being somewhat withdrawn, evidenced by providing brief responses to questions as opposed to his usual manner of sharing expansive perceptions of his work. This occurred for a few sessions and Tia informally checked in with Brian about how he's doing and received minimal responses of "I'm okay" or "I'm a little tired, but doing alright." As Tia was concerned about his overall-wellbeing, she decided to formally evaluate Brian using the 5F-Wel assessment (Myers & Sweeney, 2014) to obtain a specific picture of his overall wellness. High scores on overall wellness along with specific dimensions indicate a greater degree of wellness.

Assessment

To obtain a comprehensive assessment of Brian's well-being across multiple domains, the 5F-Wel (Myers & Sweeney, 2005) was administered. Brian completed the 91-item measure rating the extent of his participation in wellness behaviors (e.g., exercise) or perceived wellness in different areas (e.g., self-esteem or social support) on a four-point Likert-type scale. He received scores on a 25–100 scale (with higher scores indicating higher wellness) for overall wellness, the five second-order factors, and the 17 third-order factors which provided specific information for Tia to inform her Wellness-focused supervision interventions.

The assessment data indicated Brian's well-being in relation to the IS-Wel model (Myers & Sweeney, 2004). Brian's overall wellness score was low, creating concern from Tia for his overall wellness. Results also indicated that Brian's Physical Wellness (i.e., exercise and nutrition) score was high. His Coping Self (i.e., leisure, stress management, self-worth, and

realistic beliefs) and Social Self (i.e., friendship and love) scores were low. His profile indicated high scores in the domains of Essential Self (i.e., spirituality and gender identity) and Creative Self (i.e., thinking, emotions, positive humor, work, and control). Tia shared the results of the assessment with Brian and he concurred that assessment results aligned with his perception of his current lived experience.

Wellness Plan

This information was used to guide specific interventions to support Brian. They collaborated to develop a Wellness plan to address his Coping and Social wellness. The plan was designed to inform both Brian and Tia of ways to support him in his overall wellness. While aspects of the plan focused on Brian, Tia also agreed to engage in certain actions to better support Brian's wellness. Tia indicated she would more consistently monitor the number of military-affiliated clients Brian was serving as it appeared aspects of this population's experience (such as exposure to trauma and significant stressors associated with the military experience) elicited a strong empathic reaction and detrimentally affected his well-being. Brian did not want to totally divest himself from working with military-associated clients, so he agreed that limiting the number and diversifying his caseload with civilian clients might improve his wellness in the domain of Coping Self.

Given the specific concerns of this population, Tia also provided Brian with information and resources on the culture of the military and the specific concerns service members and veterans encounter, such as PTSD and suicide. Given that Brian did not have first-hand knowledge of serving in the military, enhancing his awareness of their unique experience was beneficial as it contextualized these concerns and enhanced his competence in addressing these concerns.

Brian and Tia explored other strategies to address his areas of need indicated by the assessment. Brian indicated he would benefit from spending more time engaging in leisure activities, such as reading non-counseling related books and re-engaging with a running club to which he once belonged, as he valued exercising while also interacting with friends

with a shared interest. This would enhance his Coping, Physical, and Social Self wellness.

In addition, Brian shared that he had not spent time with several close friends as seeing clients on weekday nights and weekends to ensure he accrued necessary hours towards licensure did not align with their schedules. Brian and Tia discussed scheduling more daytime counseling appointments by participating in a school-based mental health counseling program that had recently been initiated in the practice. These strategies were targeted to improve Brian's wellness in the domains of his Coping and Social Self.

Case Study Outcome

Tia consistently checked in with Brian at subsequent supervision meetings to determine the effectiveness of the Wellness Plan. Brian was able to reconnect with the running group which was feasible for his work schedule and helpful with his Physical and Social wellness. His working more days as a mental health counselor in schools allowed more time to connect with friends which he reported enhanced his Social Self wellness.

Brian indicated he had not had as much time to read as he would like, but is aware of it and hopes to more fully enact this aspect of his plan. Tia encouraged Brian to do so, but would not be critical as she desired to support him in his wellness and affirmed that he had made significant progress.

In relation to Brian's work with military-affiliated clients, Tia was intentional in monitoring Brian's affective and cognitive reaction to his clinical engagement with members of this population. Brian became more willing to discuss these reactions as it became apparent this was an important aspect of his development as a professional counselor in relation to his overall wellness.

Continual monitoring occurred in future supervision sessions with Brian demonstrating steady improvement in his ability to deal with the stress of his work while living a fulfilling life. Though more growth was needed, his wellness improved making him better able to address the needs

of military service members and veterans while living a more balanced personal and professional life.

Conclusion

Providing services to military service members and veterans presents a specific set of considerations for counselors. To ensure quality services and counselor wellness, mechanisms of support such as clinical supervision are needed. A specific structure to supervision - such as a Wellness-focused approach - enables the supervisor to be intentional in the prevention, assessment, and remediation of threats to counselor-wellness stemming from contact with military-connected clients. Given the needs of that population and need for competent counselors to serve them, ongoing support is necessary for enhancing wellness both for those providing and receiving services.

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