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Article 86

# Are Private Counselors Comfortable Treating Combat-Related Trauma?

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Between 40% and 90% of Americans will experience at least one traumatic event at some point in their lifetime (Breslau et al., 1998; Ford, Stockton, Kaltman, & Green, 2006; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Resnick, Falsetti, Kilpatrick, & Freedy, 1996), with an adult average of four traumatic events (Breslau et al., 1998). However, certain subgroups of the population may be even more vulnerable to experiencing traumatic events and to developing a trauma-related mental health issue. In particular, over half of individuals with combat experience will develop a serious mental health issue; this number may jump as high as 96% depending upon the war in question (Sutker & Allain, 1996). Furthermore, the greater the intensity of the traumatic exposure to war, the greater the likelihood that an individual will develop a serious mental health issue as a result of their war-related trauma (Sutker, Uddo-Crane, & Allain, 1991).

As a result of the trauma severity of the wars in Iraq and Afghanistan, veterans' advocates and military doctors are predicting that similarly high percentages of veterans coming back from the current wars will suffer from mental health issues (Shane, 2004). In addition, Milliken, Auchterlonie, and Hoge (2007) reported mental health issues in veterans returning from Iraq and Afghanistan have been greatly underestimated by the Department of Defense, with conservative estimates of the percentage of returning veterans that require mental health treatment services ranging from 20% to 42%. A recent task force mandated by the U.S. Congress reported existing mental health facilities funded by the Department of Defense were overburdened, understaffed, and under-resourced (Defense Health Board Task Force on Mental Health, 2007). In fact, Shane

(2004) reported 86% of VA medical facilities are concerned about their abilities to meet increased demands for mental health treatments in the veterans returning from Iraq and Afghanistan. This means many veterans are falling through the cracks. In fact, a recent study reported that 60-77% of veterans suffering from mental disorders refused to seek treatment either because of the stigma (Hoge et al., 2004) or the fact that if they admit to having mental health issues, it delays their return home (Shane, 2004).

Even if they do seek treatment, it may not be enough (Maguen, Suvak, & Litz, 2006). Between one-third and one-half of individuals with severe trauma-related mental health issues, especially those who experience combat or physical attack, fail to recover even after many years of therapy (Davidson & Fairbank, 1993; Kulka et al., 1990; Sutker & Allain, 1996). Furthermore, a significant number of Vietnam veterans did not develop PTSD or other severe mental health issues initially, but did so in the years following combat (van Wormer, 1994). In fact, one study of Vietnam veterans found many veterans do not ever really "return home" (Hendrix, Jurich, & Schumm, 1995). Shane (2004) found that veterans' advocates and medical doctors are predicting the veterans returning home from Iraq and Afghanistan may require treatment for the next few decades, as they are already seeing an increase in the number of veterans returning with long-lasting, hard-to-treat mental health issues.

Therefore, it is not surprising many mental health care professionals are concerned about the care provided for the new cohort of American combat veterans returning home from Iraq and Afghanistan. Researchers, medical doctors, and VA administration are calling for the nation to improve care for war-related mental health issues such as PTSD (Collie, Backos, Malchiodi, & Spiegel, 2006). Unfortunately, van Wormer (1994) argues current models devised for crisis intervention and immediate problem solving leave counselors and social workers ill prepared to treat trauma survivors. Furthermore, Bruce (2005) reported that many clinicians find assessment and treatment of trauma challenging, if not daunting, as few graduate programs offer comprehensive training in trauma assessment and treatment. Webber, Mascari, Dubi, and Gentry (2006) argue trauma response and treatment skills need to be further included as a part of counselor training. In particular, the treatment should match the specific kind of trauma involved (i.e., treatment for combat trauma will likely differ from treatments developed for domestic violence or sexual abuse trauma). Moreover, successful treatment of trauma-related issues may be further complicated by the fact that individuals suffering from one trauma-related mental health issue, such as chronic PTSD, almost always have other psychological disorders as well as physical health issues, which may further hinder initial assessments, effective treatment and long-term outcomes (Davidson & Foa, 1991; Hayman, Sommers-Flanagan, & Parsons, 1987; Maguen et al., 2006; McFarlane & Yehuda, 1996). For example, 50%-80% of those diagnosed with PTSD also experience other forms of mental illness (Davidson & Fairbank, 1993; Helzer, Robins, & McEvoy, 1987; McFarlane & Yehuda, 1996; Sutker & Allain, 1996). These psychological disorders most commonly include depression, alcohol abuse, and other anxiety disorders (Breslau, Davis, Peterson, & Schultz, 1997; Breslau, Davis, Peterson, & Schultz, 2000; Davidson & Fairbank, 1993; Hayman et al., 1987; Sutker & Allain, 1996). In addition, veterans with PTSD may even experience arrested moral and psychosocial development (Taylor & Baker, 2007).

Marsella and Pedersen (2004) argue counseling education needs to alter its training protocol to meet the needs of changing global issues, such as war (see also Piachaud, 2007). More importantly, trauma treatments need to focus on not only the trauma victims, but their families as well. One study of Vietnam veterans found combat experience can have a long-term impact of well over 20 years not only on returning veterans, but also upon their families (Hendrix et al., 1995). In addition to individual counseling sessions with the veterans themselves, counselors need to be trained in leading family counseling sessions for combat-exposed veterans (Hayman et al., 1987).

Apart from a dissertation study by Bruce (2005), little research has examined counselor preparedness for dealing with war-related trauma. The purpose of this study was to examine counselor's exposure to trauma patients and their treatment protocols. Based on previous research (e.g., Rosen et al., 2004), we hypothesized that counselors would report experiences with both U.S. veterans and trauma-related symptomology. However, based on initial research by Bruce, we also hypothesized that counselors would feel unprepared to deal with war-related trauma.

## Method

### Participants

An invitation to participate in the survey was emailed to counselors who participate in one of three listservs directed to counselors or counselor educators. Thirty-five counselors completed the on-line survey. We were unable to calculate a return rate as we were unaware of how many counselors regularly participate in one of the three listservs. The Institutional Review Board approved all procedures before the study commenced. Anonymity was a guaranteed condition of participation, and consent was implied with completed survey participation.

### Measure

A 9-item survey was constructed by the authors. Questions pertained to counselor experiences with veterans and other clients suffering from trauma, how they treated trauma, and whether they felt prepared to deal with various types of trauma. Questions dealing with trauma were drafted from the *Diagnostic and Statistical Manual of Mental Disorders IV* (American Psychiatric Association, 1994). Questions asked for yes/no responses, with places available to elaborate upon their responses.

## Results

### Experiences with Treating Trauma Clients

Counselors were asked a number of questions relating to their experiences with clients suffering from some type of trauma. All of the respondents reported they had experience with treating trauma clients, and 64% of counselors had treated clients who were U.S. veterans. Counselors were then asked what types of trauma they had treated. 39% had treated clients with trauma as a result of war, 93% had treated victims of domestic violence, 96% had treated sexual abuse victims, 46% had treated victims of natural disasters, and 43% had treated other types of trauma (e.g., death of someone close, accident victims, physical abuse). Because Shane (2004) reported veterans'

advocates and military doctors (predict –instead of "are predicting")are predicting a high percentage of veterans returning from Iraq and Afghanistan will need treatment for their combat-related trauma exposure, we wanted to ascertain whether counselors have in fact seen an increase in trauma cases in the past five years. 37% had seen an increase in the number of clients with trauma as a result of war, 37% had seen an increase in victims of domestic violence, 47% had seen an increase in sexual abuse victims, 16% had seen an increase in victims of natural disasters, and 32% had seen an increase in clients who had experienced other types of trauma. Finally, counselors were asked what types of treatment they used to deal with trauma clients. 8% reported using complementary and alternative medicine with their trauma clients, 92% used cognitive behavior therapy, 35% used group therapy, 23% used exposure therapy, 69% used cognitive restructuring, 8% used Eye Movement Desensitization and Reprocessing (EMDR), and 35% use stress inoculation training.

**Training**

Counselors were asked whether they believed their training had adequately prepared them to deal with clients suffering from various types of trauma. Only 26% of counselors felt their training adequately prepared them to treat clients who had experienced trauma as a result of war, whereas 85% felt prepared to treat victims of domestic violence, 96% felt prepared to deal with sexual abuse victims, 63% were prepared to treat victims of natural disasters, and 56% felt prepared to treat clients who had experienced other types of trauma.

## Discussion

With increasing concern over the large number of veterans of the wars in Iraq and Afghanistan who are coming home with trauma-related issues (Milliken et al., 2007; Shane, 2004), researchers are beginning to investigate ways to treat war-related trauma and other mental health issues with more efficacy. The purpose of the present study was to examine counselors' exposure to trauma patients and their treatment protocols, as well as to ascertain their preparedness to deal with war-related trauma.

As hypothesized, all counselors reported having experiences treating trauma-related symptomology. In addition, 64% of counselors had treated U.S. veterans, nearly three-quarters of whom had suffered trauma as a direct result of war. Furthermore, 37% reported an increase in the number of clients with trauma as a direct result of war in the past 5 years. What is most alarming is that only 26% of the counselors surveyed felt their training prepared them to treat clients with war related trauma. While counselors are actively treating increasing numbers of U.S. veterans with war related trauma, there is a distressing disparity between the number of counselors who feel adequately trained to effectively treat war related trauma, and this growing demographic of veterans.

**Limitations**

There are several limitations to be addressed. This study included private counselors who subscribed to one of three listservs and chose to respond to the survey. Thus, it is unclear how representative our respondents' experiences actually are. In addition, respondents were voluntary. It could be that counselors who have had

experiences with certain kinds of trauma were more likely to respond to our study. Future research should endeavor to obtain a larger, more diverse sample of counselors with differing types of experiences. Researchers may also wish to study the experiences of private counselors compared to those employed by the Department of Veterans Affairs.

## Conclusion

Previous researchers suggesting that counselors should be trained to deal with specific types of trauma (e.g., Webber et al., 2006) seems supported by the present study, as the majority of counselors surveyed felt well-equipped to deal with trauma resulting from domestic violence or sexual abuse, but ill-equipped to deal with trauma as the result of war (see also Marsella & Pedersen, 2004; Piachaud, 2007). There is also a call for new treatments to be developed which are brief, simple, and effective for a long period of time (Collie et al., 2006). Marsella and Pedersen argue that counselor education needs to become more holistic in its focus, including issues such as spirituality and indigenous healing techniques, in more non-conventional training settings. Brooks and Scarano (1985) have even suggested that transcendental meditation may provide more relief than traditional psychotherapy techniques for war-related trauma. Furthermore, Oliver and Bourne (1998) suggest that counselors engage in reflective practice and be committed to receiving continual training to improve their skills. Regardless of the treatment method, it is clear from the present study that counselor education programs may need to reevaluate curriculum in order to spend more time focusing specifically on war-related trauma as the number of private counselors being called to treat these clients will only likely increase in the near future.

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