

Veteran-Clinicians Working with Veterans: When Veteran Identities Intersect in the Therapy Room

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Agenda

My Veteran Identity and transition to Veteran-Clinician

Survey of Veteran-Clinicians

Veteran culture

Clinical considerations

My Veteran Identity in the therapy room

Questions & Discussion

Family of Veterans

- ▶ Great –great- great - ??? - grandfather: German Hessian in U.S. Revolutionary War
- ▶ Great – great - grandfather: WW1
- ▶ Grand-father: WW II – Last horse-drawn artillery unit used in combat
- ▶ Father : Vietnam - Infantry Scout Dog Handler - 25th Inf. Div.
- ▶ Uncle : Vietnam - Infantry – KIA May 16th 1968
- ▶ Cousin: Iraq - Maj. In Medical Corp



My Veteran Identity

Active Army 2001-05

11bravo – Infantry

4th I.D. – Fort Carson, CO

Iraq: 2003-2004

Civilian: 2005-2007

Recalled on IRR status

“400 more days”

Iraq: 2007-2008

Attached to Maryland NG Unit

Convoy Security in Baghdad for MPs



Transition to Veteran-Clinician

Student-Veteran- Voc. Rehab Chapter 31

Carroll College – Psychology & Anthrozoology

Eastern Washington University – M.S. Psychology

Pacific University – Ph.D. Clinical Psychology

Military experiences shaped clinical and research interests

Veteran population PTSD and SUD

Mindfulness based interventions & Cannabis and PTSD

Currently – MIRECC Research Fellow



SSGT. Eddie Waldrop
Doc Stanley



Survey of Veteran-Clinicians

1. How does being a Veteran affect rapport building with Veterans you work with?
2. Do you disclose your Veteran identity to your patients? If so, what guides your decision?
3. Do you ever experience transference/countertransference? How do you manage this?
4. If you have a trauma history, have you ever done trauma treatment with a Veteran? How do you manage this in session? How about afterwards?
5. What are the advantages of being a Veteran-clinician working Veterans?
6. Any disadvantages?

Veteran Culture

Military culture characterized by unique norms, philosophies, customs, & values (Collins, 1998)

Hierarchical, authoritarian structure w/ clear order & repetitious responsibilities

Collective identity with focus on mission readiness

Complex intersection of military culture and veterans' other identities

Resulting in unique language, beliefs, values, and behaviors

Spectrum of identification



Veteran Social Bond

Veteran Social Bond (La Marr, 2019)

Military unlike any other way of life

People all over country and different ways of life come together for common goal

Removed from home, forced in close living quarters w/ others experiencing same stressors

Common experiences bases for “brotherhood” that forms throughout time in service

Camaraderie*

Sense of family or “band of brothers”

Forms through **shared experiences, humor, and mutual understanding of suffering** (Caddick et al., 2015)



Barriers

Stigma around help seeking and mental health in Veteran culture

Veterans can experience considerable ambivalence toward help-seeking

Part of military culture – “***Suck it up & drive on***”

Self-stigma

Preferring not to disclose military experiences with civilian providers

Feel less stigmatized when seek help from Veteran therapists (social bond?)

Stigma

La Marr, 2019

Looked at cultural barriers & help-seeking including societal & self-directed stigma

Survey with 34 Veterans

“What supports have been or would be helpful for you in accessing mental health resources?”

Most commonly identified theme to enhance treatment seeking:

▶ **Support from Veterans/Veteran groups/Veterans programs (38%)**

Responses included:

“My combat friends support each other”

“Competent therapist with combat experience who dealt with vets as a full-time job not some ass-hat civilian!”

Veteran Preference for Therapist

Veterans prefer another Veteran as their therapist* (Johnson et al., 2018; Reger et al., 2008)

Vet Center model * preferred over general VA mental health model (Botero et al., 2020)

Focus groups – Disparity between military & civilian life pointed out (Currier et al., 2017; Blais et al., 2014)

Challenge of explaining impact of significant events to non-Veteran therapists*

Prefer due to ease and understanding in communication (Botero et al., 2020; Johnson et al., 2018)

▶ Not needing to expand on cultural terminology

Survey: Advantages

- ▶ Intentions not questioned by my clients (if they know i'm a Veteran), my colleagues or community partners.
- ▶ Sense of community and shared experience. While everyone's experience in the military is unique, there are still commonalities that transcend branch or service, MOS, era of service, and other factors.
- ▶ Helpful for conceptualizing each Veteran who I work with and the factors that could be contributing to their current challenges in life.
- ▶ I think being a Veteran helps me to see the strengths and resiliency of these amazing individuals.
- ▶ I think one advantage is I have a bit more of a reference point to guide my assessment questions, particularly during an intake, or when using Socratic questioning in CPT to identify evidence to the contrary.
- ▶ I have a clear sense of how amazingly diverse the military community is and feel far more confident to ask clients questions about their experiences.
- ▶ We speak the same language; can use acronyms and also not need to interrupt Veteran to have them explain terminology, military dynamics, etc.
- ▶ Rapport; cultural aspects--I am direct, I know how to 'focus the mission,' I am straightforward, I treat veterans with respect, dignity, and commitment, I expect courage.
- ▶ Its hard to bullshit another Veteran.

Survey: Disadvantages

- ▶ Some Veterans will assume I share other identities that are the same.
- ▶ Can be difficult to sit with peoples attitudes about Veteran's. There have been times when clinicians, other VA employees have personal bias about VA benefits.
- ▶ Not that come to mind.
- ▶ I think it is important to make sure Veteran clinicians, like all clinicians, understand that everyone's experiences are different and the way those experiences impact each individual are different.
- ▶ It is hard to think about disadvantages.
- ▶ When Veteran clients make assumptions (positive or negative) about me based on my Veteran identity alone.
- ▶ Maybe not so soft and nurturing. Again, harder to generalize the relationship to a civilian.

Therapeutic Alliance

Forms from initial bond, therapist-client tasks, & between therapist/ client personalities

(Bordin, 1979; Taber et al., 2011)

Positive or Negative impact on treatment outcomes (Catherall & Lane, 1992; Taber et al., 2011)

Congruent identities, cultural beliefs, & similar experiences - positive impact on alliance

(Cabral & Smith, 2011; Taber et al., 2011)

Bond & task - Two primary components necessary for strong/ positive alliance (Hoffart et al., 2013)

Bond - *trust, attachment, & client and therapist liking each other* (Bordin, 1979)

Task - *collaboration regarding goals, therapeutic contracts, & agreement to achieve the therapeutic goals* (Bordin, 1979)

Therapeutic alliance within context of Veteran social bond

Survey: Therapeutic Relationship

- ▶ I do not need the Veteran to explain basic military jargon which helps them feel comfortable.
- ▶ I think being a Veteran typically has a positive impact on building rapport.
- ▶ Typically if one of the MSAs has told the patient that I am a Veteran (when they are scheduling an intake) or when I tell the individual I am a Veteran there is a sense of connection, an ability for the patient to disclose and discuss more freely, and a feeling that what they are saying is being understood.
- ▶ I found that it can both enhance and detract from rapport. It can enhance rapport by creating a kind of shortcut to establishing psychological safety or relieving the mental fatigue that can set in from explaining military terms, experiences, or culture. It can detract from rapport if my clients take such short shortcuts that they make assumptions about my experiences and, in turn, leave out important chunks of information or assume their experiences were my experience.
- ▶ I did not experience a sexual assault in the Army and I have worked with clients that were convinced I had this experience. It has also impacted rapport in a negative way if the Veteran I am working with had prior negative experiences with medical officers or officers in general.
- ▶ Easier to build rapport--maybe harder to generalize ("you understand because you are a veteran" doesn't help them help civilians understand.) So I am careful to address this limitation in our work, and challenge assumptions about civilians.

Self-Disclosure

Self-disclosure can improve therapeutic alliance

Therapists who connect successfully through disclosure do so by emphasizing who they are as person more than who they are as a professional (Lavik et al., 2017)

Disclosure can normalize discussions around stigma & reduce anxiety by showing similarities (Botero et al., 2020; Caddick et al., 2015; Coll et al., 2011; Johnson et al., 2018)

Perception of similarity can be heightened by using targeted self-disclosures around previous military experience (Lavik et al., 2017; Levitt et al., 2016)

For client to be willing to engage in exposure-based therapies, must feel safe & understood by the therapist (Hoffart et al., 2013; Joseph et al., 2014; McLaughlin et al., 2014)

Survey: Self-Disclosure

- ▶ I identify as a Veteran if I believe it will help the Veteran.
- ▶ I typically do not tell the patients I am working with that I am a Veteran. I do wear a lanyard with a military branch symbol and I have items in my office that display my previous experience as a Veteran.
- ▶ There are a few groups I facilitate, in those groups I typically mention that I am a Veteran. In a vast majority of my interactions with other Veterans, while working, it seems that when they find out I am a Veteran it either strengthens or at the very least is a neutral impact on the therapeutic relationship.
- ▶ When Veterans have had negative experiences with the VA, I am more likely to disclose that I am a Veteran. Additionally, if a Veteran directly asks me or if it seems important to the therapeutic alliance, I will disclose I am a Veteran. Just like I wear a wedding ring and I wear a lanyard, these are parts of my identity and I find most Veterans who find these elements important ask and I am always willing to share in a clinically appropriate manner.
- ▶ Not routinely with one exception. I routinely disclosed my identity as a service member and officer when I was still in the US Army Reserves while also working as a VA psychologist. My VA role was as the PTSD/SUD Specialist for the MH Division. Considering UCMJ, I wanted to provide adequate informed consent to Veterans seeking services who may disclose information that could be in violation of UCMJ.
- ▶ Other instances that arose wherein I disclosed my SM/Veteran identity: when a Veteran has requested to meet with a Veteran on staff and my team concurred; when specifically asked by a Veteran, and, if it seems clinically indicated and I can use the disclosure in a judicious manner.
- ▶ I disclose--I have USMC sword on the wall and USMC commission on the wall; my style tends to be self-effacing and transparent--"we're in this together." First session I ask what they want to know about me and tell them what they want to know. Haven't ever had someone ask something creepy. Sometimes people disclose biases (usually about officers) and we process. If I think there could be something there, I will ask.
- ▶ They usually know. Veterans can smell out other Veterans.

Transference/ Countertransference

Transference - unconscious redirection of feelings from patient to therapist

Countertransference - transference of feelings from therapist to patient

Both phenomena are based on human ability to recognize the outside world

Need to compare present perception with past experience in order to recognize

Context of similar military experiences

Veteran clinicians more intense & personal reaction to working with returning veterans

Survey: Trans/Countertransference

- ▶ Yes, there are times when Veteran's deployed to the same place at the same time. I do not share my experience, however am able to validate their experience in a very authentic way.
- ▶ At times, I will share what my MOS was so they don't have to explain related stress
- ▶ I am sure I experience some level of transference and countertransference. When this does happen it is typically minimal, I cannot think of a time that sticks out to me.
- ▶ On occasion countertransference has come up and primarily with feelings of positivity towards Veterans with similar MOS or deployments.
- ▶ Prior to joining the military, I had been working in the area of trauma for years and worked very hard on processing my own reactions to trauma-related stories in order to remain centered/grounded during an episode of care. This served me well when conducting therapy in a deployed/combat setting and translated more readily than I expected when I returned to the VA.
- ▶ Worked with a Veteran who was in same AO during deployment. Hard to stay present. Hard to not switch over to Veteran and Veteran, instead of Veteran-clinician and Veteran. Sitting with a brother instead of my patient.
- ▶ Yes-- I haven't worked with someone who has had really similar experiences--my deployment was pretty mild, I was in logistics. So most people I work with either have MST or combat trauma and were exposed to more than me. I don't typically talk about details of my time in service, but have disclosed with clients for whom the military was not a good fit, that it was not a good fit for me either!
- ▶ Worked with a Veteran who had very similar career in military. Found myself looking forward to sessions and my own gratification from talking about the "good old days."

Trauma Treatment

Known effects of trauma therapy on trauma clinicians

Secondary traumatic stress (STS) & vicarious trauma (VT)

Compassion fatigue & burnout related terms used interchangeably with STS and VT

Burnout more generally refers to occupational stress response & chronic workplace tediousness (Jenkins & Baird, 2002)

STS and VT are unique to working with trauma populations (Sabin-Farrell & Turpin, 2003)

More than one third of clinicians or trainees typically report personal trauma (Adams & Riggs, 2008; Linley & Joseph, 2007)

Conflicting findings on whether having trauma history as risk factor for developing VT (e.g., Linley & Joseph, 2007; Pearlman & Mac Ian, 1995)

Some evidence of personal trauma history as factor related to personal growth in trauma clinicians (Adams & Riggs, 2008; Linley & Joseph, 2007)

Survey: Trauma Treatment

- ▶ Yes, I have done my own work and have learned the importance of managing my affect in session.
- ▶ I have done my own work. There are times when I am intentional about days/times I schedule those Veteran's for appointments. Example, I do not schedule a Veteran who has similar trauma at the end of the day because that's when I start to lose energy. Sometimes after a particularly hard session I will take just a couple minutes to recalibrate by watching silly animal videos, odd animal couple videos or other hilarious things.
- ▶ I have a trauma history from the military and I have done trauma treatment. I engaged in therapy shortly after I was discharged from the military and I have engaged in therapy periodically over the last several years. For me, managing transference/countertransference has been managed and is managed proactively. Self-care, sleep, connecting with nature, and confiding people whom I trust. If I notice a reaction in session, which for me is typically rare, I mentally acknowledge it and process it later.
- ▶ I think the closest I have come to this is that I have delivered psychotherapy and MH triage in a combat setting. In this sense, I am enduring trauma while conducting trauma-focused care. The relative nature of constructs in trauma-focused treatment became more clear to me. For example, trying to address "objective safety" has an entirely different definition when a unit has sustained 60% loss.
- ▶ During this time, I found myself being far more honest about the state of things ("this is awful", "we may not return home") and admitting my own limitations ("changing your thoughts may not change anything but how can we make sure you are ready to go back out on the road tomorrow?"). I found that my own professional self-care included debriefing/consultation with other MH providers in country and I had to maintain a self-care routine but also I started smoking cigarettes again so clearly it had an impact. (I stopped smoking once I returned home btw)
- ▶ I do not have severe trauma but did experience a sexual assault. I did not have PTSD. I was groomed, and there were some difficult aspects of my experience re/ power/control, hierarchy, and how the institution responded. I do not feel particularly triggered or reactive, and I think it has given me a deep personal understanding of victim-blaming, rumor mills, and the labels people get (that are often unearned). I am grateful I have the experience I have and that it was almost "inoculation" because it was not so bad I have re-experiencing sx or trauma triggers, but it was bad enough I can empathize more deeply.
- ▶ My jaw hit the floor when Veteran was describing trauma similar to mine. I have worked on my past but hearing similarities threw me off guard and was tough staying present. Consulted afterwards and was more mindful of monitoring my reactions in session and increased self-care related activities after session. Playing guitar and working out at the gym helps.

My Veteran Identity in Therapy

Supervision as Prac student with Veteran-clinician on professional development

Used to be part of my of introduction

Clinical judgment guides self-disclosure

Information gleaned by delaying self-disclosure

Inadvertent reinforcement of belief *“I can only work with veteran providers”*

My Veteran Identity in Therapy

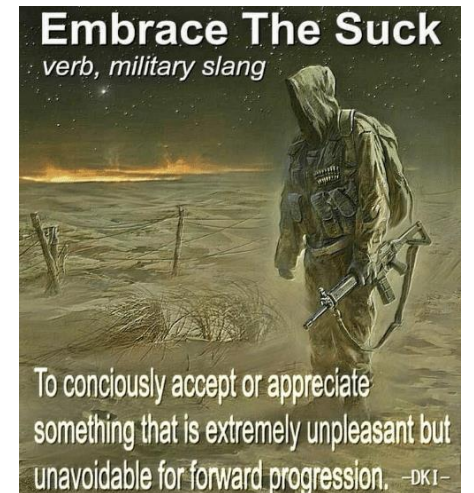
Using experience of PT in military as frame work for building Mindfulness practice

Radical Acceptance - "**Embrace the Suck**"

Creating S.O.P.'s for ADHD skills building

Threat Condition (green/yellow/orange/red)- perception vs. reality

Break contact / re-group/ re-engage





THANK YOU !

Questions?

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