

Revisting Social Work and the American Military Family

ABSTRACT

Before the September 11, 2001 terrorist attacks in the United States and the subsequent military invasions of Afghanistan and Iraq, authors Jo and David Pryce in a 1999 *Families in Society* article described the new American military family in the midst of changes undergone by the armed services.¹ They provided principles of practice, as well as general advice, for social workers responding to the needs of military personnel, active-duty and Reserve, and their families. Now, in a June 2006 interview with *FIS*, Jo and David Pryce update their assessment of the role social workers can play in addressing the needs of military personnel and their families as they face the spiral of deployment, separation, and reunion, and as increasing numbers of deployed veterans return home with psychological problems.

Background and Experience in Military Social Work

Q: What are your backgrounds?

Jo: My father was a career Marine. He joined the Marines in the 1920s and served until 1948. I was born in '51. He was a veteran of several battles in the Pacific including Guadalcanal and Peleliu, two of the worst. Needless to say, he had post-traumatic stress disorder (PTSD) and it was severe by today's standards, but in those days we didn't know what it was. So I pretty much grew up in a military community and he continued, even when he was retired, working on the local installations. Then later I married a military physician so I became a military spouse and lived on installations off and on. I've been involved with the military most of my life. I got my BSW and MSW from My Lady of the Lake University in San Antonio. I lived in Izmir, Turkey, where

NATO has a hospital that the military runs. I worked in the mental health department as a social worker counseling groups of community military personnel and their families, during 1983-1984. After this I was accepted at UC-Berkeley to pursue a doctorate in social welfare. The focus of my studies was stress coping and social support. My dissertation examined the mental health of pregnant military spouses. The findings indicated that many new mothers were going home following a healthy pregnancy and a healthy baby but

¹ Knox, J., & Pryce, D. H. (1999). Total force and the new American military family: Implications for social work practice. *Families in Society*, 80, 128-136.

"During the last two decades, the American military has changed from an organization that relied overwhelmingly on active-duty military personnel to defend or protect United States interests when the option of armed force was to be applied. That paradigm is now dated, replaced by what the Pentagon describes as the 'total force.' The total force relies heavily on reserve components (which include the Air and Army National Guard) to take major roles in American military operations at home and abroad....This change in defense policy is broad, pervasive, and profound."

with a lot of depression. One of the interesting aspects about the study was that when they were asked about social support the two primary sources of support they identified were God, first, and their families, second. This was very troubling because most of their families lived in other parts of the country and were not physically accessible to them. So it was clear that the military families needed to have a better support program.

I received my Ph.D. in 1990. While I was teaching—I taught at Berkeley for a couple of years—I also worked part-time for the California Extension Program. About the time the Gulf War broke out we became part of the project the United States Department of Agriculture Extension Service was doing with the Extension at Texas A & M. It was a project to develop materials about deployment of military families. The component I was initially involved in was writing children's books. We wrote four books that were developmentally age-appropriate for kids from three to teens. They had activities and ideas for coping when dad or mom was deployed. Later I wrote a book for pregnancy, babies, and toddlers also dealing with separation and deployment. The books involved experimental research and interviews with military family members and support personnel. It was about that time that I met David and learned about the National Guard Family Program and did background research on the total force, the whole concept behind it. The books were a real challenge because we had to write them for the total force, which meant that we were reaching out to three separate groups—the active component forces, the National Guard, and Reservists.

Then I moved to the University of Texas at Arlington where I became more involved with the Operation R.E.A.D.Y. (Resources for Education About Deployment and You) project providing social work consultation on separation and deployment issues. At the same time I started to do research on traumatic stress and veterans' issues. The Operation R.E.A.D.Y. materials have been hugely successful. Attending many of the National Guard national conventions for the family program I have been told repeatedly by the state family coordinators, as well as by volunteers, how much my books have been a help, and have helped them to assist, counsel, and talk with children and parents who have been deployed. It feels good to know that your product has had a positive impact.

Dave and I moved to the University of Alabama and the School of Social Work in the fall of 1996 and I started teaching in the winter of '97. I wrote a proposal to the Lois and Samuel Silberman Fund to study the National Guard Family Program in the context of the growing total force. I traveled to several states, interviewed many of the state family coordinators, and conducted a survey of all the coordinators they had at the time. This program is really unique in a lot of ways in terms of the military support program. It was started by a social worker in 1987. It is almost 20 years old. Dorothy Ogilvy-Lee developed the conceptualization of the program, one of the best I've ever seen. Her vision was to have social

workers take state family coordinator positions, but the Guard didn't do that. They put people in those positions regardless of their backgrounds. Most did not have social services backgrounds, or social work backgrounds. They put various people from colonels to privates to staff sergeants in the coordinator positions. Some of those coordinators understood the idea behind the family program early on while some did not. Consequently, the implementation of the program varied greatly as did the reception of the state coordinators by the families that they served. Some states are now hiring social workers to be part of their programs. North Dakota has two social workers that work as part of the family program. The state coordinators have also varied in the amount of effort they give to coordinating their families' needs and concerns with the local community of social services. Some do, some don't. I think that program has consistently improved through the years.

More recently, my studies of traumatic stress are leading me to be concerned about veterans on our campuses. We don't know in our colleges how these young men and women are adjusting to life after combat service. I have recently met three of my students—one a young woman who has a "thousand-yard stare" that worries me. She drove large fuel trucks to refuel tanks and other oversize vehicles. Another is a young man who, he and I have talked a bit, periodically has trouble with concentration. Sometimes he feels that he doesn't belong in a classroom with a bunch of folks who don't have a clue where he's been, what he's seen, and what he's done.

Q: Why don't you tell us what the thousand-yard stare is?

Jo: Where did that phrase come from?

Dave: The phrase comes out of the Vietnam War. The thousand-yard stare is a blank look that appears in people who have been traumatized. In their eyes they look as if they're looking at something way out in the distance. They're not focused. It's just a very blank stare.

Jo: There are times when I would be lecturing that she would just be a thousand miles away. I know she wasn't hearing what was going on. I tried talking to her a couple of times about it but she's not ready to talk yet. I did talk to her about the Vet Centers which we'll discuss in some detail later.

Q: Dave, did you want to cover your background now?

Dave: I'm a retired professional soldier. I retired with the rank of colonel in 1987. I was not a military social worker. My specialties were infantry and aviation. After retirement I was hired by the Hawaii National Guard to develop and manage the state's first federally funded family support program, which Jo referred to earlier. I had no qualifications for that except I know how to organize things, do things, and manage things. So I got into that and I did that for four years. I left that job in 1991. I think we made a significantly good program in Hawaii for family support for the National Guard.

In 1992 and '93 I developed educational curriculum for the United States Army on family support based on the experiences gained during the first Gulf War. Jo has described

some of that material and I will describe the rest. The material consisted of a family readiness handbook for commanders, as well as four training modules for soldiers and families. These covered the following areas: pre-deployment, before they are deployed to the battle zone; deployment, while they are there; post-deployment, when they come home and reunion being a big part of that—one of the major problems that soldiers and their families have is when they come home—and family assistance center operations, which established the structure for family assistance centers throughout the National Guard. These materials have been used from the time of publication in 1993 to the present time, although they have been revised somewhat and improved upon.

In 1995, after working with Jo for a while, she convinced me I was doing social work, so I decided I needed a degree. I got my master's degree in social work. My educational focus was on veterans and war-related post-traumatic stress. Jo and I have published on military families, veterans, and PTSD on several occasions in the past. For the past eight years I have served as a secretarial appointee member of the Department of Veteran Affairs National Advisory Committee on the Readjustment of Veterans. Jo and I, and a colleague, are currently finalizing a book on traumatic stress and child welfare work, culminating a 10-year period of training and research with child welfare professionals.

Q: Do you have direct experience providing social work services to military personnel and their families?

Jo: Yes, I did that when I worked in Izmir, Turkey. The Air Force runs a military hospital that has a counseling department. I worked with families overseas, for about one year.

Q: Approximately how many families would you say you worked with in that capacity?

Jo: That was some time ago and I couldn't begin to say because we did individuals' counseling and I had several clients there. I did couples' counseling and ran parenting groups and stress relief groups for some of the hospital personnel. I also did community-based work where I brought together Turkish women and some of us from the United States who were interested in exchanging cultural information. We used to have a bi-monthly, "brown-bag" get-together. It was really quite interesting. I found the Turks to be wonderful people.

Dave: I do have direct experience working in a social work capacity with military personnel and their families. Specifically the four years I spent with the Nation Guard Family Program which is a community development project. I also have direct experience in working with war veterans and to some extent with their families, as a clinician, primarily when I was in my master's program, and during the year after I graduated.

Q: What prompted your interest in military social work?

Jo: I guess it's just my whole life experience because I lived

in the military community and I've got a lot of admiration for the folks that do this work. These families are pretty remarkable. I don't think they get nearly enough support.

Dave: I accidentally got involved in military social work when I took that job developing the family program in Hawaii. So I really didn't have an interest in it at all until I started it. Then it just sort of caught fire with me, and I decided to keep doing it.

Military Families and Support Services

Q: What are the numbers of deployed active-component and reservist social workers?

Dave: According to Today's Military Web site (<http://www.todaysmilitary.com>), there are about 300 military social workers currently serving. Those would be people in uniform. Now this does not include civilian social workers under contract with the armed forces. We have no idea how many there are, but they must number in the hundreds.

Q: Off-hand, that doesn't sound like a significant number of people, but maybe that's just a false assumption?

Dave: Well, we couldn't find that number. We looked hard for it. As far as we know nobody's ever tabulated it. If you look in military publications, their house organs and sources like that, you will find advertisements and want ads for social workers to go all over the world. I don't know how their recruiting is doing and what the result is, but I know the demand is there.

Q: How about the level of stateside support of families?

Dave: Stateside support for families is essentially the same now as when we wrote the article in 1999, conceptually. To just review, active component families have a broad range of social services available on their bases. Reservists and National Guard members and their families usually do not live near military bases and so they have far less access to social support systems enjoyed by the active-duty families. Both active and reserve folks have placed more emphasis on taking care of families in recent years. So it's safe to assume the situation has improved in the past few years.

Two 2006 surveys on the Web site for the National Military Family Association (NMFA; <http://www.nmfa.org>) show that much improvement is still needed.² The survey respondents were family members of service members who have been deployed to combat zones and other areas in support of the global war on terrorism. Key findings from the survey include, and I'm paraphrasing, almost half of the respondents reported that they have used or would use counseling services. Two-thirds of the military families surveyed did not have contact with their unit during the critical pre-deployment stage. In other words, they were not at all prepared for

²National Military Family Association. (n.d.). *Cycles of deployment: An analysis of military family support from April through September 2005, and Serving the home front: Analysis of military family support from September 11, 2001 through March 31, 2004*. Retrieved June 9, 2006, from <http://www.nmfa.org>.

the deployment of their loved ones. Less than one-half of the respondents reported a consistent level of family support throughout the pre-deployment, deployment, and post-deployment phases, and a full 17 percent reported that no support was available. Many respondents were concerned about burnout, particularly among unit family support group volunteers. Family member volunteers play a key role in military family support. Many of them have no clue as to what it is to be a helper so they frequently burn out, and when they burn out they become ineffective and you have to go find somebody else. Families are really worried about how the reunions will turn out, yet at the same time many family members don't take advantage of returning reunions briefings and activities that are provided for them. Lastly, multiple deployments—that's two and three, for some National Guard units and Reserve units and the same thing is certainly true for the active component—are now very common for both active and Reserve forces and they're really having a negative impact on the affected military families.

Q: What issues come up most often in this work, regardless of the assignment, relating directly to post-9/11 military actions in the Middle East?

Jo: The standard issues that stress any military family are well documented. The research that's been done shows that the greatest stressor, of course, is separation, deployment and reunion in particular. We wrote an article in 1995 for *Social Service Review* about the changing American military family and opportunities in social work.³ In it we cited a lot of the stresses there. But to use a kind of colloquial way to describe this, what spouses will say—no matter what the separation is about, whether it's to the border, whether it's for training, or for combat—the first thing that will happen is that the kids get sick, the car will stop running, and then the washing machine or some other major appliance will stop working, and sometimes it happens all together. That's on a regular day. The families are required to adapt and find ways to cope with marital strains, becoming a single parent, or grandparents becoming parents to grandchildren, to cope with parental absence during birthdays, births, deaths of family members, and other major developments and events. The pressure to adapt and support those around you is great. Sometimes it is just too much and it leads to family violence and divorce. Separation from deployment and the subsequent reunions are unnatural events for families to experience. It wears at the foundation of any relationship and sometimes it just plain breaks it. Separation and deployment threaten the survival of the family. Now you add to that repeated deployments and it's just too much for some families, and that is not due to any shortcoming of their own. People are starting to experience what I would call "deployment fatigue," not unlike the equipment the Army and the Marines are now using. We're starting to see that that equip-

ment is getting fatigued, too, and a lot of it is breaking down. People are, too. Which isn't to say there aren't a lot of great folks out there who are managing as best as they can.

The cards are stacked against the family. In the NMFA survey of spouses, one of the respondents said "People don't realize how much happens in six months, let alone a year or more. Families cannot continue to make things work during multiple year-long tours. The whole concept of feeling defeated before you've even started is overwhelming. You feel as though the cards are stacked against you." And I do think the cards are stacked against these families. A family, by its inherent nature, is not supposed to be separated from each other. Then you separate people and throw them into combat and everything changes. I think the increase in divorce among today's military families is testimony to that also. You add to this, as Dave has mentioned, the deployments of one individual or two or more from communities of Reserve and Guard families. Their families may be invisible to the people around them as they go through separation, deployment, and reunion. At installations you have a spirit that everyone is in this together, but a Reserve or Guard member may not have that kind of support. As parents, Reserve and Guard members indicate that one of their greatest challenges during deployment is dealing with their children. I also think that is true for the active duty armed forces and their spouses.

One of the things that I think is a strain that nobody has really talked much about, identified, or even researched is the contrast with Americans who go about their lives with no awareness that there are families across this country who in many ways are suffering greatly because they have loved ones in combat zones. It's like the whole country is not involved in this war. Only a portion of our population is making any sacrifice. I think that in its own fashion can be a strain. I think we're supportive of the soldiers and the troops. That has changed since Vietnam. We've learned that lesson well. There are a lot of communities that have done some interesting things. I think it was in Washington State that a group of folks were planning a protest against the war. Some people in the community got concerned about the military families so they went and found one of the bridges and they decorated it for the military families, just to let them know that their protest was not against them. It was against the war in principle.

One of the interesting conceptual shifts that is evident from the NMFA survey of spouses is that the military is shifting reference from "deployment cycles" to "deployment spirals." What they are discovering is you never end up where you start. Everything changes. The whole family changes. The military member changes. The other thing that they're learning is that you don't just get better at it. It takes a toll. A lot of the concerns from the first deployment get spread into subsequent deployments and build up, even though people do make gains in acquiring skills. People get chronically fatigued trying to manage all of this turmoil.

Q: Are social workers assuming a greater role in the mental health assessment of combat soldiers?

³Knox, J., & Price, D. H. (1995). The changing American military family: Opportunities for social work. *Social Service Review*, 69, 479-97.

Dave: It's safe to say that, yes, they are. They are playing a much greater role and they're doing it up near the front lines, if there are any front lines. They have programs. The mental health teams have social workers, psychiatrists, psychologists, and a variety of health professionals, and social workers are certainly a part of that. They're trying to take this treatment for combat stress as far forward on the battlefield as they can.

Q: Reservists in the total force military are being increasingly looked at to provide combat readiness and duty, as well as response and support for natural disaster recovery and stateside border control. How do prevention and intervention treatments addressing these types of stresses differ from those of combat?

Dave: I can address that. This question brings to mind the television images of the Louisiana National Guard soldiers returning from Iraq combat duty and stepping off the plane immediately into Hurricane Katrina-ravaged New Orleans. Now this calls into question the whole concept of the "total force" as an effective pillar of our national defense policy. Guard members just cannot be in several places at once. Clearly, the absence of the Guard, during and after Hurricanes Katrina and Rita, adversely affected that particular state governor's response to those natural disasters. The second part of the question, prevention and intervention with post-traumatic stress, is no different for home-front traumatic events than in combat. Education about the reality and the prevalence of PTSD is the key. You do that in anticipation of traumatic events so it can be recognized and intervened early. Currently, what they're doing now in Iraq is removing the affected personnel from the site of the trauma and giving them what they're calling "three hots and a cot," which would be three hot meals and a comfortable place to sleep. In other words, it's rest and recuperation for a day or so and talk therapy if appropriate.

Q: How do they differ for family members?

Dave: Well, here's the difference. Secondary traumatic stress (STS), as a form of post-traumatic stress, as defined by Charles Figley, is the form of post-traumatic stress most likely to show itself in military families.⁴ STS, also known as compassion fatigue, is caused by repeated exposure to a person's suffering with well-developed PTSD, such as with a war veteran. Social workers with the Department of Veterans Affairs, especially the Readjustment Counseling Service Vet Centers, are authorized to treat family members of their client population, many of whom are living with post-traumatic stress. The Vet Centers—there are 209 of them located throughout the country primarily in urban areas and that's not enough but that's what we have right now—may be particularly valuable for Reservists, who have limited access to active-duty social support services that are found on a military base.

⁴Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In Figley, C. R. (Ed.), *Compassion fatigue: Secondary traumatic stress disorders in those who treat the traumatized* (1st ed., pp. 1-20). London: Brunner-Routledge.

Q: In your 1999 *Families in Society* article, you reported "families have not been considered a major policy issue for the Department of Defense....Basic services for families ...have deteriorated in the 1990s". Since 9/11 and the resulting invasions of Afghanistan and Iraq, has the deterioration improved or gotten worse?

Dave: Jo and I have not examined these particular trends since 9/11 as we have focused our research on traumatic stress with helping professionals and not specifically on military families. However, it can be noted by reading the newspapers the Department of Defense (DoD) is currently debating where to cut—not when to cut or how to cut—but where to cut the quality of life programs that serve military families to free up more money for weapons systems and overall modernization.

Jo: I think at the same time the military knows and understands the stresses military families are experiencing. I think they're pretty aware of what's available to people who are on installations and they're aware that there are a lot of Guard and Reserve folks who don't live anywhere near installations who may be out in rural areas and don't have access to support services. To the extent that resources allow they have worked to improve support for military families with emphasis on family readiness. In other words, they want to get families educated about deployment, separation, and reunions. They want families to learn as much as they can about how to better help children. A fair amount of research that came out of the first Gulf War is being applied to the current conflict.

The other thing that I've noticed is that we now have—which wasn't widely available during the first Gulf War—numerous Web sites that the military is using to increase knowledge of these resources, especially for Guard and Reserve families. As an example, there's a resource site called Military OneSource (<http://www.militaryonesource.com>) where anybody anywhere can log on to and post e-mails, and ask questions about either a concern they have or information they need. Other resources include the Military Family Research Institute (<http://www.cfs.purdue.edu/mfri>) that has been developed at Purdue University. The co-director, Shelley MacDermid, testified to Congress on June 24, 2003. She said, "There's much we do not know about reunion and readjustment. In general, we know little about the process of readjustment within families over time and how different approaches to intervention stack up." The Deployment Health and Family Readiness Library (<http://deploymenthealthlibrary.fhp.osd.mil/home.jsp>) is another resource for families, as is the National Military Family Association (<http://www.nmfa.org>). Lifeline Services Network (<http://www.lifelines.navy.mil>), which the Navy runs, is another good resource.

Q: Of the different family services available, what types have social workers become more or less involved in?

Jo: We do know that military social workers as well as civilian social workers can be of great assistance and the military knows it. They do a lot of the family advocacy and mental

health counseling. They're responsible for child abuse, substance abuse, and they also get involved with family readiness. It does appear that there is a question of just how much they're going to cut quality of life programs for military families in order to support the weapons modernization—the old guns-and-butter issue.

Q: You reported in 1999 that “an important attitudinal shift within the military is taking place today” by the military hierarchy in acknowledging the persistent stress of military life on families, resulting in the need for training and educational programs for coping strategies by families. Have these programs succeeded in helping families recognize “when to seek help and support from social work services”?

Dave: We know from our experience with Operation R.E.A.D.Y. and contact with persons who have used those deployment training modules that those educational programs have been very much appreciated. We have not measured the effectiveness of them but we know that they have enjoyed some success and that they have been well received. However, more needs to be done and there's evidence for that. The NMFA survey resulted in recommendations to the Department of Defense earlier this year. For example, expand program information outreach. Well, we must not be getting out the word to the extent that we need to if it has to be expanded. We need to educate families about what to expect before, during, and after deployment. That's what Operation R.E.A.D.Y. and other programs like it do. This survey response tells me that we're not using those materials appropriately or perhaps it's not getting enough command emphasis. Without command emphasis in the military nothing happens. NMFA also wants to direct more resources to support family volunteers. We talked about the effect of burnout earlier. NMFA wants the DoD to hire more paid professionals as counselors and administrators to work in family support programs. Again is the issue of 'address reunion and reunion issues throughout the deployment cycle'. Reunion is probably more critical than deployment. That's when domestic violence can occur. That's when the divorce rates are up. That's when the murders and suicides on bases have occurred during the past few years since this current war started. We need to do better about that.

Jo: I think one of the improvements that has occurred is the message has been sent to families, a positive message, regarding use of mental health counseling. In this recent survey by NMFA, most of the military spouses indicated they recognize counseling is an option and a healthy thing to do for the whole family, whether it's family counseling, individual, or children having their own counselors. Almost half commented that they had used counseling and would recommend it. Until recently that would have never happened. They also observed that the helping professional needs to understand and know something about military life and military culture. One of the more interesting findings from that study is that commanders are assuming that families know about the resources and services that are available to them.

But from the survey it appears that many people do not know what resources and services are available to them, and that's particularly true of the Guard and Reserves.

I think another aspect of this is that there are about 600,000 children of service members. Many are in civilian schools, whose staff may not be aware of a deployment. Many parents would like to see teachers better prepared or even trained to address some of the unique challenges these kids face. They also find that dealing with adolescents is another major challenge. A survey of adolescents shows that they need their own developmentally-appropriate support.

Q: Dave, why do you think the military has lagged behind, and possibly continues to lag behind, in the provision of reunion services?

Dave: I just don't think they understand it. Yet it seems obvious to me that the families are asking for it. They're worried about reunions. They're worried about how the returning spouse is going to be reintegrated into the family after roles have been changed and the family dynamics have certainly changed. I can't tell you why. You can find the rhetoric out there but my guess is there's just a lack of understanding.

Jo: I think there's something fundamental here. Psychologically, families are not supposed to be taken apart like this. In the old days, and this probably sounds awful for a social worker to be saying, they used to say, “If the Army wanted you to have a wife or a family they would have issued you one.” What we really had was a large body of males who didn't have family members and so the issues were very different. Now what we're doing is we're taking an institution, which is what the family is, and we're breaking it apart. We're repeatedly breaking it apart and then we're trying to patch it back together again during reunions. Then, to complicate that, people come back home with PTSD, unable to reconnect in meaningful ways, not sure about what to do about how they're feeling and how they're behaving. Some children don't recognize their parents anymore because this returning parent is not the same person who left. I'll never forget the day that I did a presentation to one of the Guard groups down here in the Southeast about three months before they were about to deploy. We were asked to emphasize family readiness and education about deployment. Specifically, we wanted to get the family members to talk to each other and their children, especially their adolescent children, about how things were going to change while the person was gone, but that when the person came back they would all have to come together again and figure out how to go on being a family. We shared that deployment is a threat to the survival of your family and it's important to prepare so that that threat doesn't become a reality. We encountered some hostile resistance from some people there because they just didn't want to hear that. At the same time, some of the more seasoned people who had already gone through deployment approached us. I'll never forget one fellow, a senior non-commissioned officer, shared that he and his wife both had gone through a deployment and in spite of the fact that they

loved each other when they got back together, they just couldn't continue to be together anymore. It had changed both of them so much. And he said, "These young people do not realize what they're about to face, and they don't want to hear it."

Q: What is the level of social worker involvement in those centers?

Dave: It would be easier for me to tell you who makes up those centers. I can't tell you for sure if the majority are social workers, but I would tend to think that. Social workers, chaplains, and other mental health professionals, as well as volunteers from the family member community and the local military retiree population, have staffed family assistance centers. During the first Gulf War, the National Guard established over 400 family assistance centers and they really went out to beat the bushes to find people to work within the centers. They had some professionals but primarily at that time they used a lot of retirees and family members because there had been no planning for paid professionals. Hopefully, that's better now.

Social Worker Principles

Q: Are there any new methodologies or research that add to or improve upon the eight social worker principles for practice with military families you discussed in your 1999 article?

Jo: I would say, in general, the first set of principles that we published is pretty much the same today as then. One of the crucial ones is to advocate for prevention and intervention without stigma. Reducing stigma about getting the assistance is to increase the likelihood that a person who is affected with PTSD would come to understand that they can affect their families through secondary traumatic stress. I know this personally because of stories my father would tell about combat in the Pacific when I was a child. I used to have dreams about combat, even though at 10 years old I had never been in combat. I think that service members, commanders especially, need to stress to their subordinates that one of their military responsibilities is to get a sense of when they need help. I think they also need to let them know there are ways that this can be done confidentially. Affected service members stand a chance of harming their family members and/or losing their family without such help.

Q: Why do you think you had such a vivid reaction to your father telling his war stories?

Jo: On the one hand, I'd say that I was an imaginative, sensitive child. But on the other hand, emotionally, he was not very well grounded when he had problems with his post-traumatic stress. As I was growing up I had a sense that there was something wrong with my father but I didn't know what it was. There were times when he was just emotionally distant. One night I woke up in the middle of the night and he was sitting in a chair at the kitchen table and he had his head in his hand and he was quietly crying. I asked him what was the matter. He proceeded to tell me about this battle he had been in on Peleliu. He had a good friend who was not too far from him, somewhere in the midst of this battle, and they were trying to climb up this mountainside with heavy howitzers and other equipment while under fire. He smelled something perfectly horrible and he realized that he had just crawled through his good friend's guts. The guy had been blown apart. There was his head and his neck and his shoulders. My dad has just crawled through his stomach. Now that's the kind of information that a person doesn't need to be sharing with a child. I'm sorry. That's a graphic story, but a true one. So what we want to do is to urge social workers to educate commanders in helping soldiers understand that good mental health is part of their responsibility.

In addition to the original eight principles, there are three more that I would add. One has to do with strengthening the connection between military families and community services and organizations, especially for Guard and Reserve families. In the Guard Armories and Reserve Centers, the people that work there need to be able to connect their families to whatever services are available. Sometimes, for example, a mental health organization that is in a rural community may not know that some of their local Guard members have deployed, and that they could do some outreach to the Guard members' families even by having groups for children in the armories or pulling together spouses to give them an opportunity to talk about what is going on.

Second is the importance for helpers not to assume that military families know what their current needs or future needs may be, or where resources and services are. It is the helpers' job to know families and to make themselves and their services available in a user-friendly way.

Third, it is becoming clear that children and adolescents need support from their home community and schools because they're going through difficult times. It's unnatural to try to reunite with your dad or mom every six months or every two years. Research shows that a lot of adolescents experience a fair amount of anger toward the deploying

Military social workers can be really effective at building links with community services. I think that's why they need to have more social workers in the military.

parent and that anger most often simply masks a fear that this person may be killed, or maimed.

Q: You've said, and it's been reported, and it's kind of obvious that the vast segment of the population is not sharing the burden in this particular deployment and perhaps in others, and will not in future deployments. Doesn't that make it more difficult, when you already have perhaps a hesitancy by the military to intercede, doesn't it make it more difficult to get public support and the public agencies that could be of assistance to pitch in?

Jo: I think that's absolutely right. I think that's where your military social workers can be really effective at building links with community services. I think that's why they need to have more social workers in the military.

There are some neat things that are happening. Recently, I read that the Boys & Girls Clubs of America and 4-H have been doing a lot of outreach to Guard and Reserve kids who aren't likely to have the youth centers available on military installations. I read that the Boys & Girls Clubs of America provided \$5.8 million in scholarships, gifts, and grants for military children in one year. I think that's pretty special. So there are some partnerships out there. There are some communities that are aware of what their families are going through and are reaching out to them. We just don't have that going on across the country. I think that, in and of itself, might help to strengthen our families. In many ways it's a form of social support to know that other people are concerned about you when you're going through a difficult time. You're going to be better able to get through that difficult time whether you're the parent at home, the adolescent, or the child.

Q: What are some examples of partnerships between the military and the private sector in program development and delivery of social services to military members and their families?

Dave: Jo and I don't have much experience with this but we can say the Department of Veterans Affairs is supposed to be working closely with the Department of Defense to ensure what they call a "seamless transition" for people leaving active duty. When war veterans are leaving active duty they become a part of the Veterans Affairs community. I know from my meetings and dealings with the national readjustment committee the process has not achieved the desired seamlessness. One of the problems is the Department of Defense. In its rush to get Reservists off its books, in other words so they don't have to pay them any more when they complete their deployment, DoD often neglects physical and psychological injuries that should be treated prior to release from active duty.

Jo has a student who just came back from Iraq. He's a Guard person and a very experienced non-commissioned officer. He was in the first Gulf War as a combat medic and now he's in the current war as a mental health specialist. He recently received a commission, making him an officer, and

he's getting a graduate degree. He tells us that if a soldier has a physical injury at discharge time the Department of Defense will declare what that injury is. But the DoD is reluctant to do the same with psychological injuries, therefore we've had people being discharged into the community who need mental health services. At some Veterans Affairs facilities there's a 90-day wait to see somebody. These veterans can't afford to wait like that. We emphasize that this is a personal report, a personal communication from someone we think is a very reliable person. But you can see it's not a seamless transition. It's almost a throw-away policy—"You have done what we asked you to do now get off our books so we don't have to pay you anymore and go on home." The Guardsman and the Reservist is going to go home because that's what they want to do. They're not thinking about what damage may have been done to them unless they lost an arm or a leg or something like that.

Jo: We were also told that they may identify symptoms of post-traumatic stress but they're not calling that a permanent diagnosis. They're considering it a temporary situation. That's one of the problems with all this. Post-traumatic stress doesn't necessarily show up immediately. If you have those symptoms you really do need to get help promptly. There is research that shows that if you get help early on you're going to be better able to manage the symptoms. You'll never get rid of it, but you will be better at managing it.

Q: It's a life condition?

Jo: Yes.

Dave: It is, but the fact is that you can learn to manage it and that's what you do. You don't ever get cured, but you can learn to manage it.

Addressing Stigma Within the Military

Q: Is there still a significant and pervasive military stigma associated with preventive and intervention services, whether for individuals or families?

Dave: The answer to that is yes. However, we see some rhetoric that perhaps the services are trying to reduce the stigma attached. I'm looking at a recent article that I retrieved from ArmyTimes.com dated June 5, 2006. The title of the article is, "Mental Health Teams Work Close to the Front." We talked about social workers doing that on these mental health teams earlier. This says the changes reflect drastic adjustments in the way the military approaches mental health among its soldiers today. Here's a quotation from an infantry battalion commander: "It used to be that if you went to a combat stress team you were a loser. Now we expect it." So there are indications that perhaps we're trying to get rid of that stigma. But I know from 30 years as an infantry soldier that it's going to take a long time for that stigma to be removed because it's the culture. It's the military culture.

I have another true-life story about stigma. A few days ago I was contacted by one of my previous students, a graduate from the school of social work who has a family friend who

just got back from Iraq, and was having some serious problems. She asked me to get involved in some way. Now I'm not a therapist but I know a lot about this issue. This is a young officer and is college-educated, so this issue is not just people who are poor or of a lower socio-economic class. He was in the Guard and he just got back from Iraq. He was in combat. I talked to his mother. She was worried sick. He wasn't acting right. He was drinking too much. He started smoking. He was very distant. He didn't want to get up and go to work. He was expressing a lot of guilt about having done things that he felt he should not have done. She wanted me to try to get him to seek help. I gave her information to try to get that young man to a Vet Center. He wouldn't do it. His mother said that he told her, "If I seek help for this I will not be able to stay in the National Guard and I will not be able to ever get a job because I'll have a mental illness." And all his friends think the same thing. So there's a real example of stigma at the very personal level. I still have not been able to get that young man the help that he needs and I don't know if I ever will. It's tragic and he's not the only one. This young man had 40 or 50 soldiers working for him. His soldiers have come back and they're having marital problems and they come to him and ask him for help, and he's not married and he's got his own issues. This story is personal and anecdotal, but I want everyone to understand what we're up against here.

Q: Dave, how do you convince someone like that officer that it's not on his permanent record and he won't be drummed out of the Guard and that he will be able to get a job in the future?

Dave: That's difficult to do because that's what they've been told. I know for a fact, because I was researching this to get him help, that if he were to go to a Vet Center and get help there, there would be no record that would be released from the Vet Center—period. But many veterans don't believe that. They don't believe that those records will be kept confidential. So it's going to be an education challenge, and I'm just beginning to realize how big of a problem it is.

Q: How much does the May 2006 leaking of personal information from the Veterans Administration (VA) impact on your arguments that this information will be safe?

Dave: That is an earth-shaking impact. I don't know whether you have heard this or not, but not only did we lose 2.6 million veterans' privacy information who had left the service since 1975, but also lost 80 percent of the active duty records. So the numbers are even greater than we thought.

Q: How can you keep things together over there when you get a news report like that?

Dave: It's mind-boggling. It's very, very difficult and it directly affects the readjustment of veterans. This is a readjustment issue. People who come back with PTSD often have trust issues. They don't trust anymore. They don't trust the government particularly. They don't trust the VA. They don't trust their family members. They just don't trust, period,

because of what they've seen and done. When the VA loses personal data it drives a wedge between veterans and any help they might need.

Jo: It's really devastating.

Dave: Yes, it's devastating.

Q: Recently in the *Journal of the American Medical Association (JAMA)* article, "Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan", it was reported that one out of three U.S. soldiers returning from active duty in Iraq needs mental health treatment.⁵ How can the military better utilize social workers to address these conditions as well as the associated stigma to seeking treatment?

Jo: I need to address that article. First of all, saying that they're ignoring mental illness is a bit extreme. I think it defeats the lessons we've learned from Vietnam. It also contradicts what they're trying to do with these combat teams. I think the military is very much aware of this. I think the question is, "What resources can you put where?" That's the struggle as the war continues on. I know DoD is constantly looking to shift money to fund the current war and soldiers, marines, and sailors. That struggle for dollars may adversely affect efforts toward psychological help.

The *JAMA* article reports that the prevalence was 19.1 percent among service members returning from Iraq, 11.3 percent of those returning from Afghanistan, and 8.5 percent from other locations. The strongest correlation was if you had had combat experience. They also reported that 35 percent of Iraq war veterans access mental health services within a year of returning home. Twelve percent were diagnosed with a mental health problem and 50 percent of those referred for mental health services received mental health care. It may be the case that some practitioners are not diagnosing people with PTSD, so that raises a question of how much is really out there. It also doesn't include the veteran who gets out of service, and it doesn't account for how many Guard and Reservist members who may be being treated elsewhere.

One of the things that the article didn't address either is that our 209 Vet Centers are providing services to a lot of veterans. In our May 2006 communications with Charles M. Flora, Assistant Director in the Readjustment Counseling Service (RCS) with the Department of Veterans Affairs in Washington, D.C., he shared some interesting data on what they're seeing. As of March 2006 they have seen 119,878 veterans. They've had 84,231 outreach contacts and have had 35,647 vet center clients. In 2003 they served 1,936 clients; in 2004, 9,611; in 2005, 36,717; and in 2006—up through March 2006—71,614. One of the primary services they offer is readjustment counseling, which is the treatment of PTSD.

⁵ Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295, 1023-1032.

So the numbers in that *JAMA* article really are not the best estimates of what the total force is actually experiencing. Another thing I'd like to mention is that the Vet Center—which is available to veterans' family members—does a lot of bereavement counseling. As of June 9, 2006 the RCS assistant director reported that they had served as many as 983 family members.

The other issue the article doesn't address is late onset of PTSD. It doesn't always occur immediately following exposure to trauma. It could be months or years before symptoms occur. I also don't know whether or not they measured social desirability, which would reflect the way some people would have responded because they may not have wanted to expose that they are having symptoms of post-traumatic stress.

In general, there's been a linear increase in the use of mental health services by soldiers and Marines. I think that's an important thing. Many times we've referred to soldiers and not Marines. They're different groups, but they both need services. The system is stressed, the VA is stressed, and we need more resources at the Vet Centers to do outreach in communities. That means we need more social workers in Vet Centers.

I think there needs to be better education at the front end before deployment, during deployment, and after deployment, ongoing, and that's where social workers can make a difference. They can work with military commanders so that they educate and lead their soldiers to good mental health. Commanders can encourage their soldiers that it's okay to get help. Social workers and communities can build contacts with their local Guard unit commanders and let them know where services are available.

Q: Other news reports in 2006 indicate that of those soldiers returning from active duty in Iraq and Afghanistan who report they are experiencing emotional and/or psychological problems only a small percentage actively seek assistance. Do we have a good idea of the percentage that does seek help?

Jo: I think they know somewhat from the study reported in *JAMA*—and they're going to replicate it at 90 and 180 days because they understand that the PTSD onset could be delayed. I think that if you look at what the Vet Centers are seeing and you examine the increase in clients, apparently the message is getting out to some of these veterans that the Vet Center is the place to go. Part of that has to do with the fact that veterans are learning that services are totally confidential and that no one but Vet Center staff has access to clients' records. The increase in contacts with the RCS is clearly linear, and to go from under 2,000 in 2003 to 71,614 by March of 2006 is a telling trend. Clearly, some veterans are learning the Vet Centers exist for them and their families.

Q: Can you put that in context in terms of how many are coming back? Has the return rate gone up significantly, too?

Jo: I know that attrition is a problem and that was something the *JAMA* article pointed out. But no, I don't know that. I don't know that anybody has that yet.

Q: Recognition of PTSD doesn't actually go back all that far, does it? We're talking 20 years or so?

Jo: Right. It was in the DSM-III [Diagnostic and Statistical Manual of Mental Disorders] 1980. The history of the diagnosis is really interesting. As veterans returned from Vietnam some of them started gathering together after a while and saying, you know, 'I'm not the same person I used to be. I'm not sure I know who I am.' And of course there were suicides, and divorces, and all of the rest of it. They started what they called rap groups. They started meeting and the veterans invited psychologists and social workers to join them. A social worker at the Boston VA started to realize that the veterans she was seeing were being diagnosed with schizophrenia among other things, and they were being put on medications that had nothing to do with what was really wrong with them—what we now know as post-traumatic stress. In their conversations these young people—and there were different groups across the country—started to realize that they had shared symptoms of a phenomenon that didn't have a name. They finally came up with a name for it. They called it 'post-traumatic stress disorder', and it has certain characteristics, certain features. If you have those symptoms for a period of three months or more you most likely are adversely affected. Next they approached the American Psychiatric Association and made the argument that PTSD was a real phenomenon. They joined with some of the other groups that worked with trauma, among them a doctor from the University of Miami Hospital who realized that the veterans' symptoms were what she saw in her burn victims. So with some others in tow they finally managed to get the diagnosis put in the DSM. My understanding is that it's been one of the most extensively field-tested diagnoses in the DSM.

Q: Did they ever take it back and actually apply it to the World War II vets, because, of course, it existed then, too?

Jo: Absolutely.

Dave: I can elaborate on that. In my job with the National Advisory Committee on the Readjustment of Veterans, we work very closely with Vet Center programs. I can tell you that when the Vet Center program was first implemented in 1979 the only people that were seen were Vietnam veterans. The population has been expanded over the years. They now see veterans from World War II, the Korean War, and any other conflicts. So it began with something that was happening to Vietnam veterans, and then World War II and Korea veterans began to see the good they were doing. They began to come into the Vet Centers and services were expanded to meet these other veterans' needs.

Social Workers and PTSD/STS

Q: All helping professionals encounter a certain amount of strain or trauma when working with affected clients, especially when working within restrictive environments or poorly-funded programs. How would you compare the relative levels of strain or trauma encountered among social

workers working with military members and their families?

Jo: The best person to talk to would be somebody who's actually delivering those services as of now. The one thing that I do have great concern about, which is related to this question, is that schools of social work in general have not been shaping their curriculum to educate about primary and secondary traumatic stress. We do here at the School of Social Work at the University of Alabama and I've been teaching a course on this for five years. We have a good friend and colleague, Kim Shackelford, who is an associate professor at the University of Mississippi and has just finished her dissertation on STS and social work. She did an assessment of how much social workers know about STS and found, astonishingly, very few had the necessary understanding. So we have graduating social workers who may know much about PTSD but may not know a lot about secondary trauma or how working with traumatized clients can affect them. It can affect their competence and services clients receive. Learning about self-care is crucial.

One of the things that happened in the 10 to 15 years that followed the DSM III was that a lot of the mental health professionals who did trauma counseling started to realize that they were being affected by their work. That's when Charles Figley and others began to understand that there is a phenomenon that McCann and Pearlman called "vicarious traumatization" (VT) and what Figley has labeled "secondary traumatic stress."⁶ Since that time there has been ongoing research demonstrating that this phenomenon of VT or STS is a real issue when doing trauma work with clients. We now know that if you're going to work in this area you're going to be working with people who have post-traumatic stress and in doing therapy you may also be affected by your clients' traumatic experiences.

Q: So is that the greatest cause of job stress for military social workers?

Jo: I would guess yes, but then we don't know conclusively because of lack of research.

Dave: But what we have done—and it goes back to the larger question of vicarious trauma and social workers' stress when working with military personnel and their families—is when you say all helping professionals encounter a certain amount of strain, we have done extensive work in the last 10 years with child protection workers. Our research has clearly shown that when child protection workers encounter traumatized clients, which they very often do, then they become affected and their symptoms are very much like the symptoms of post-traumatic stress. It's something that is indirect, about working with these people, a traumatized population. So military social workers are going to be affected in the same way.

Q: What support is there for those working with traumatized individuals and families in the military?

Dave: I honestly don't know. When I was in the military from '57 to '87, it was a totally different army. If there was a social worker in the Army, I didn't know it. I didn't know where they were—maybe at the hospital or someplace. Social workers were not a part of the military culture. Now I'm sure there were some out there, but I never saw them. I don't know if the command climate is such now that social workers will be accepted or if they're going to be thought of as some sort of an excuse. That's a hard one and I don't have the answer.

Q: So the stigma is alive and well?

Dave: Yes, the stigma is alive, but as we discussed earlier, it may be improving.

Q: What factors should be considered by new social workers who are considering involvement in the military as a career?

Jo: The most important thing to do is to familiarize themselves with the culture. In social work education we emphasize self-determination. We emphasize ethics. We emphasize confidentiality. Some of those things may not be applicable in a military service situation.

Q: What resources are available to help in their decision-making?

Jo: I think the best thing for someone to do is to talk to someone who's been a military social worker. They will be glad to discuss the work. Social workers are good about that.

Jo Pryce, PhD, is an associate professor at The University of Alabama. She primarily teaches research methods, social work practice, and traumatic stress in social work practice. She is currently working on a book on traumatic stress and child welfare practitioners with two colleagues. Professor Pryce can be contacted at jpryce@bama.ua.edu. Colonel **David H. Pryce** (U.S. Army, Retired) MA, MSSW, is a professional trainer, focusing on traumatic stress and the helping professions. He is a coauthor with Jo Pryce on a book dealing with traumatic stress and child welfare professionals. He is an active member of the Department of Veterans Affairs National Advisory Committee on the Readjustment of Veterans. Colonel Pryce can be contacted at our_odyssey@earthlink.net.

⁶Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In Figley, C. R. (Ed.), *Compassion fatigue: Secondary traumatic stress disorders in those who treat the traumatized* (1st ed., pp. 1-20). London: Brunner-Routledge.

McCann, I. L. & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. Philadelphia: Brunner/Mazel, Inc.

Appendix

Links to Sources of Information

- U.S. Department of Defense
 - Deployment Health Clinical Center
(<http://www.pdhealth.mil>)
 - Deployment Health and Family Readiness Library
(<http://deploymenthealthlibrary.fhp.osd.mil/home.jsp>)
 - Military OneSource
(<http://www.MilitaryOneSource.com>)
 - Military Family Resource Center
(<http://www.militaryhomefront.dod.mil/>)
 - Today's Military (<http://www.todaysmilitary.com>)
- U.S. Department of Veterans Affairs
(www.vetcenter.va.gov)
- U.S. Army Community and Family Support Center
Operation R.E.A.D.Y. (<http://www.armymwr.org/>)
- Military Family Research Institute
(<http://www.cfs.purdue.edu/mfri/>)
- National Military Family Association
(<http://www.nmfa.org>)

Principles for Practice With Military Families

1. Adopt a person- or family-in-environment approach.
2. Individualize the total force member and family.
3. Respect the limits of military confidentiality.
4. Establish a safe environment for communication.
5. Understand developmental issues and conflicts.
6. Support the limits of self-determination for military families.
7. Advocate for prevention and interventions without stigma.
8. Know and use military resources.
9. Strengthen the connection between military families and community services.
10. Don't assume military families know what their needs are or will be.
11. Children and adolescents need support from their home communities and schools.

U.S. Department of Defense 2004 Demographics Report

Total number of military personnel: 3.4 million
Active duty military personnel: 1.41 million
Ready Reserve and Coast Guard Reserve: 1.45 million

Marital Status:

Active duty military members who are married: 52.9%
Reserve Guard members who are married: 51.5%
