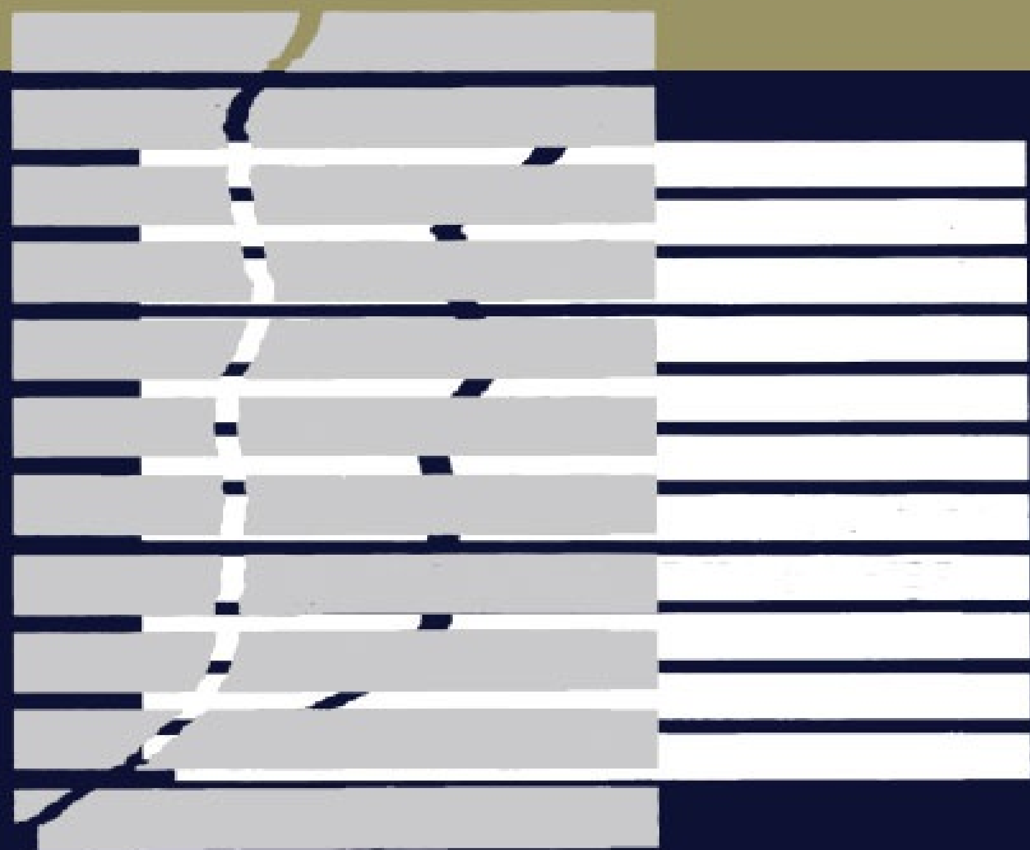
Counseling with Veterans



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"Is this client a veteran and, if so, are there special issues that may interact with the presenting problem, counseling techniques, and therapeutic goals?" That question is probably infrequently considered by counselors working with male clients unless one is a counselor in a Veterans Administration (VA) facility or a Veterans Outreach Center. Often men who are veterans are referred to VA sources since that is what the VA is "supposed to do." Unfortunately for many clients, a VA facility is not convenient and/or the veteran is not eligible for services. Thus the man seeking counseling may be a veteran with certain special issues originating from his service experiences that he may or may not present. Likewise, he may be a veteran whose concerns are addressed in other chapters in this book and are not specifically veteran related. This chapter is designed to (a) help the counselor understand the service and veteran experiences, (b) look at specific concerns of veterans, and (c) offer some suggestions about counseling with veterans.

So who are veterans? In the vast majority of cases they are males who have been drafted or who enlisted for a period of active duty in one of the military armed services (Army, Navy, Air Force, Marine Corps, or Coast Guard). Some may have served with national guard or reserve forces but also served for a period on active duty in order to be considered a veteran. According to data provided by the VA (1984), it is estimated there were 28,202,000 veterans alive in 1983. There have been four major conflicts/wars (Korea and Vietnam were never officially declared wars by the U.S. Congress) since the turn of the century. From World War I there are about 297,000 veterans still alive whose average age in 1986 is thought to be between 85 to 90 years old. For World War II there are about 10,978,000veterans whose average age is 66 years old. From the Korean conflict the estimate is 5,294,000 with average age at 55 years old. Finally, from the Vietnam conflict there are 8,238,000 veterans with an average age of 39 years old. There are smaller groups from the peacetime periods, and some veterans also served in more than one war. What all these numbers may really mean is that 1 in every 6 male clients between the ages of 17 and 100+ is probably a veteran, and 1 in 3 over the age of 55 is probably a veteran. Most veterans served during one of the periods in which America was at war. It may therefore be important to

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understand the military experience.

The Military Experience

Every male who has served on active military duty has had a unique experience. Veterans during different wars had different experiences. It is probably unfair to generalize or describe a typical experience, but it becomes necessary to make the attempt for brevity's sake. The typical military experience begins in the late teens or early twenties. Erik Erikson (1950, 1968) in his eight-stage model of psychosocial human development, posed two important tasks for this life period. Erikson's stages that correspond to the time of entry into the military service are establishing one's own individual identity versus being involved in role confusion (14-20 years) and establishing intimate relationships versus being socially isolated (20-40 years). Most veterans had lived within a family context with a set of instilled values, mores, and beliefs until they made a break and were sworn into the armed forces. Culture shock began immediately.

Upon entry onto active duty, the young person goes through a period of basic training: generally an eight-week period of intense physical and mental indoctrination and training that is designed to turn a young civilian lad into a competent American fighting man whose job is to fight in wars. For most recruits (the name given to a new soldier in training) basic training is bewildering, scary, and physically demanding. There is much to learn, with immediate negative reinforcement for the slightest mistake delivered by a fierce-looking drill sergeant whose demeanor commands fear and respect. The young recruit is being trained for combat and his mission will be to kill the "enemy." This becomes the first major value conflict that a young man must resolve. For 18 years he lived in a society in which killing was wrong, and yet now killing is what he is supposed to do (cognitive dissonance to the nth degree; Festinger, 1957). The military helps to resolve this conflict by first depersonalizing the "enemy." The enemy is never referred to as a person or anything that gives humanlike qualities to the object of our violence. Nicknames are given to the enemy to dehumanize them. Second, the military (and ultimately the whole country) instills a cognitive set of "we are right, we are the good guys, we do no wrong, and our cause is just." An additional mindset is that "soldiers obey orders." Recruits are trained to respond instantaneously to an order from a superior without thinking about the order. Failure to obey can lead to judicial punishment. Besides no place for thinking, there is no place for emotions. Learning to shut

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emotions off becomes a required task to master. Finally, the group in which he now exists establishes a norm that killing the enemy is the right behavior for this group. If a young man resists this norm, he quickly becomes a group deviant, becomes singled out for “extra instruction” by his drill sergeant, or is discharged from military service because of failure to adjust.

Although a counselor may become angry, upset, or empathize with how awful that situation must be for the young male, one needs to remember that there are reasons for all of those resolving mechanisms. Primarily the training helps with the physical survival of the recruit and his fellow recruits when they enter a combat situation. A moment’s hesitation as one stops to “think about” a situation may lead to a horrible wound or death. In the survivalistic environment of war, reactions are often more important to the individual soldier than are his cognitive abilities. The military trains reactions that save friendly lives while destroying the enemy. Most people want to live and so adopt the reactions. Almost of equal importance as the physical survival is the psychological survival that the training provides. If the military says to the recruit, “Your country wants you to go and kill 18-year-old boys, who just graduated from high school, who have a mother, father and two sisters, and who pray to the same God as you do,” the value conflict would be so intense that the recruit would not function effectively in combat. A massive guilt complex would likely develop. Psychological survival would be in grave jeopardy. Instead, the coping mechanisms the military provides usually help young men to do what their country wants them to do: to fight a war, to kill the enemy.

Besides killing, there are other value conflicts that arise for young men. Many men had never lived outside their own community before entering the military. Suddenly, they are thrown into a new community with other young men from different communities and backgrounds. Values, beliefs, and mores different from one’s own may become the new norm. One’s individual identity, different from one’s identity within the family, may create the role confusion Erikson (1950, 1968) proposed. To use alcohol, marijuana, or other street drugs may now become the “manly” thing to do. To engage in sexual activity with prostitutes may be the accepted group norm. To get into fights at local hangouts may be the merit badge required to show manhood. Many of these same dilemmas are faced by young men not in the military as well, but the group pressure of military “esprit de corps” and morale make it sometimes more difficult to resist. Finally, travel to foreign countries exposes young soldiers to new cultures with different customs, values, and mores that may also present value conflicts.

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The most significant part of the military experience is being involved in combat. Combat strips away almost all vestiges of humanity. It is the ultimate "game of survival." Life and death occur randomly with little rhyme or reason. There may or may not be a geographical objective/purpose on the large scale; for the individual soldier the objective becomes kill or be killed. Most of the time nothing else matters. Men in combat are regressed to more primitive levels of thinking and behavior. The environment is no longer safe. Naturalistic dangers are often as deadly as man-made dangers. The most basic need on Maslow's hierarchy (1943) becomes threatened. Behavior becomes motivated to satisfy the physical needs for survival. Horrors, pain, and suffering beyond human comprehension occur routinely. After leading his famous Civil War "March to the Sea," General William Tecumseh Sherman is supposed to have stated, "War is hell." The destruction and devastation he witnessed in the aftermath of his army's movement became overwhelming for him to contemplate. For most people who believe in hell, combat surpasses their concept of what hell is. Combat is hell on earth but far worse. Nothing man does compares to it as a human activity. Think of the worst situation one can. Combat is worse!

One could write an entire chapter—an entire book—on describing what combat is like. That would only tell what combat, at that time, in that place, in that war, was like. The next war would be the same, yet different. Suffice it to say that war is, on the one hand, exhilarating for some men, giving them a God-like feeling of the power of life and death over another; and on the other hand, a feeling of the devastation and helplessness as the power of life and death is in the hands of the enemy. The adrenaline rush caused by the anxiety of combat can also become debilitating, making it difficult to cope with the stresses of everyday life. More will be stated about combat in the next section.

After a war, veterans either return to civilian life or continue with a career in the military. Reintegration into civilian life often leads to feelings of alienation and differentness. Friends and relatives who did not go to war have continued their lives without interruption. Their existence may not have been affected unless a son or brother or husband was wounded, taken prisoner, or killed in the war. The returnee wants to get on with his life, putting the war behind him. Unfortunately that may be easier said than done. The family may not want to talk about what happened in the war because they may have seen some of the horrors of war on the nightly news and do not want to explore the possibility that their veteran had been involved in such events. The veteran may quickly pick up on the unspoken message that talking about the war is taboo. Feelings of not being accepted or that by serving their country they

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had done something wrong may develop and lead to further isolation. The mundane activities of a noncombat world may be boring and unchallenging to the veteran. The tremendous responsibilities he had in the military may not transfer to equal responsibilities in civilian life. Finally, in terms of social interactions, the veteran may either want to "sow his wild oats" as he did in the military or feel that it is time to settle down and get married. Yet the lack of common experience may interfere with developing profound relationships. Also, the behaviors learned in a military environment, which were adaptive in that environment, may not transfer well into the civilian world. Thus the veteran may feel as if he does not fit in at home, on the job, on campus, or in relationships. He may not completely understand why he feels different; he just does, and it causes difficulties for him. Seeking counseling may not be on his list of possibilities of things he can do to change. As for many clients, counseling may be cognitively equated with being "crazy" to the veteran, and he does not want to be labeled "crazy" so does not seek counseling. He may eventually adjust or may turn to other ineffective coping mechanisms, such as alcohol or drugs, which may then lead to other problems.

Those veterans who remain in the military may experience many of the same problems as veterans who get out. Military life away from combat may be seen as "Mickey Mouse," which translated from military slang means "unimportant, comical, and inane." Spit and polish, strict discipline, and "fill the time" activities of a peacetime military do not compare with the excitement and meaningful activity of combat. Again, discipline problems may develop to include alcohol and/ or drug abuse. The serviceman may be referred to counseling, may make an adequate adjustment, or be discharged from the service. If he stays in the service until he retires, he may then face adjustment problems in his move into the civilian world. The closed society of the military has provided a safe comfortable environment in which he has lived for at least 20 years. The customs and traditions within the military community may be different from those in the civilian world. The lack of common experiences, the military behavioral repertoire, and the different view of the world may also lead to adjustment difficulties. Retirement issues may also be encountered by veterans, as well as the difficulties of starting a second career in the middle years or older age level. A similar view of "counseling is for crazies" often prevents a retired veteran from seeking the counseling that could help him become as successful in civilian life as he had been in the military. The military experience generally ends for most males back in the civilian world from which they entered the military. That does not necessarily mean the same hometown in which they were raised, but

the civilian world. They are now veterans and may appear as a client with any of the presenting unique problems because of their experiences as veterans. The next two sections present information on those unique problems.

Post-Traumatic Stress Disorder

The most common presenting problem of male veterans seeking counseling and psychotherapy may not be easily identified by the veteran or the counselor. A variety of symptoms or behavioral patterns may be presented that may lead to different conceptualizations or diagnoses. The veteran may be reluctant to tell every detail to the counselor unless asked and asked in the right way. Without the right questions, the core problem will not be identified and thus not addressed in counseling or therapy sessions. The right questions focus on military experiences, especially about combat or hazardous duty in which the veteran may have participated or had been in a support role in which he dealt with the carnage of war. Because of the reluctance to talk about the war, it may require an extended evaluation session or several sessions before the veteran (client) begins to develop the therapeutic trust in the counselor. Many veterans are not only afraid that they will be considered "crazy," they also fear that what they tell will either cause a feeling of disbelief in the counselor or the counselor will think they are terrible people for having done what they did in combat. Sarah Haley (1978) and Arthur Egendorf (1978) present excellent chapters on the therapist-veteran interaction during treatment sessions, especially when the horrors and atrocities are revealed. Carl Rogers's (1951) concept of "positive regard" may never be more greatly tested than when listening to a veteran talk about killing eagerly, as if he had enjoyed it, or with total lack of feelings. It is best if the counselor keeps in mind just how horrible the experience of combat is. In combat man often regresses to a more primitive man whose main concern is the survival of his physical and psychological self. The biggest legacy of combat is the experience of trauma. Trauma to the physical self and trauma to the psychological self. Combat trauma is often painful to even think about, let alone talk about with a stranger. The counselor needs to be aware of the veteran's issues about war as well as their own issues about war.

For many veterans the experience of combat trauma overwhelms them and results in a variety of symptoms. At various times throughout military medical history the cluster of symptoms has been called by different names such as "shell shocked," "combat fatigue," "combat exhaustion," "traumatic neurosis,""

operational fatigue,” and others. In 1980, a new disorder called “Post Traumatic Stress Disorder” (PTSD) was added to the DSM-III. The counselor is referred to DSM-III for a detailed description of the symptoms of PTSD (American Psychiatric Association, 1980).

Besides the symptoms of DSM-III, others have suggested that additional symptoms need to be included. Silver and Iacono (1984) reported depression and anger as additional symptoms, especially in Vietnam veterans. Horowitz (1986) discussed rage reactions and extreme irritability. The Roche Report (1980) reported cynicism, alienation, and anomie as common problems for some veterans. Another PTSD-associated symptom given by Jellinek and Williams (1984) is substance abuse, including alcohol abuse. The debate about PTSD symptoms will likely be a long one.

In closing this section, three symptoms that are frequently seen in counseling are reviewed. The first is anomie, which can be described as a loss of interest, a loss of a sense of purpose, or a loss of direction. After the combat experience, nothing else compares to it. In the best and worst senses, combat is probably the highest level of feeling alive. The best sense is in terms of the development of the greatest love between human beings undergoing the worst human experience. Every sense is heightened to the highest degree, and the combatants become mutually dependent upon one another for survival. The bond goes beyond family and marital love. It is a love in which one will sacrifice one’s own life without thinking in order to save another. On the other hand, combat allows one to see the worst side of humankind in terms of the killing and atrocities one human being does to another. After reaching the acme and the nadir of human experience, many veterans present themselves in a depressed state. They go through the motions of living, yet appear almost zombielike, as if nothing seems to matter to them. It is as if they are burned out on life. A similar response is the veteran who is overly concerned, overly identified with another person. Often it is with a child, and the veteran’s life becomes enmeshed with the child’s life. The sole sense of purpose becomes the protection of the child. The counselor’s investigation may lead the counselor to events from the traumatic experiences involving children, which helps explain the veteran’s behavior. Finally, another symptom is the veteran who is a bomb waiting to explode. Rage reactions, super irritability, and continual anger become the norm for some veterans’ behaviors. It appears almost as if they are addicted to this energized state, and some do seek the “thrill of combat” by frequenting places in which fights are more likely to happen. Their negative feelings are often blamed on others; yet this may only be a way to protect the psychological self from self-condemnation for actions

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performed during traumatic events. Often, acting-out behaviors are symbolic reenactments of the traumatic events. As counselors, it is important to see beyond our own emotional reactions when a client becomes enraged, and to understand what has happened to trigger such behavior. It is not an easy task but a necessary one when a client is in that much pain.

Counseling with PTSD Veterans

There have been several excellent books and articles published on doing therapy with war veterans, especially Vietnam veterans. John R. Smith (1985) described four major themes of PTSD treatment that arise in psychotherapy from a cognitive therapy perspective. In the same book (Sonnenberg, Blank, & Talbot, 1985), Smith also described rap groups and group therapy, which have often been the recommended treatment milieu for survivors of traumatic events. A third chapter in the book, written by Candis M. Williams and Tom Williams, focused on family therapy. Keane and Kaloupek (1982) discussed using a behavioral approach of flooding in treating survivors. Silver and Kelly (1985) presented their use of hypnotherapy with both World War II and Vietnam veterans suffering from PTSD. Schwartz (1984) edited an entire book to the psychoanalytic interpretation and treatment of PTSD in combat veterans. Arthur Egendorf (1985) also presented his views on how to heal the trauma of war for veterans. Horowitz (1973) presented a phase model of treatment for stress response syndromes that can also be applied to the counseling of veterans with leftover symptoms of their combat experiences.

The list of references could go on for pages. Counselors will, however, pick and choose what method will work for them and apply it, just as they do with any client. With the male veteran who has PTSD, certain issues may be more prominent and so I will devote some time to each.

THE “I WONT TALK ’CAUSE YOU ARENT A VETERAN” ISSUE

Many veterans offer stiff resistance to entering into a counseling relationship. It may be sex, age, or a nonveteran status of the counselor that seems to be the stumbling block. Some veterans honestly believe no one who has not been through combat could understand what they still struggle with daily. Others use this issue as a defense against being rejected or viewed as animals because of what they did in order to survive while in a combat situation. Yes, it is true that most people who have not been in combat cannot

fully understand it, but no one—not even another veteran—can completely understand what another's time in the hell of combat was like. My most competent professional associate, however, is a young nurse with a master's in counseling. Sue successfully treats many combat veterans not because she understands everything about combat, but because she cares and transmits that message to the veteran. When confronted with this issue, she makes statements along the line of, "You are right, I was not in combat and do not understand everything about it. I am willing to listen and understand what it is like for people to be in pain. I want to try and help. We can go at your pace until you feel comfortable with me." Such statements usually will begin to engage the veteran in the counseling relationship.

THE "LET ME TELL YOU THIS HORROR" ISSUE

Sometimes veterans will attempt very early in counseling to test the counselor. In a bizarre kind of way, the veteran almost sets himself up for rejection, which is just the opposite of what he really wants. Because he has such poor self-esteem and may have had many rejections by people in his life, it is almost a form of self-punishment to relate an involvement in an atrocity or vivid description of the carnage of combat, hoping the counselor will be horrified and hence either reject or feel the pain of the veteran. His self-evaluation will be confirmed, and he may then continue to behave in social and/ or antisocial ways. If the veteran gives gory details with enthusiasm, then further evaluation of an antisocial personality disorder needs to be considered. Most veterans who have horror stories take several sessions before they feel comfortable enough to begin to talk about a traumatic event. Instead of enthusiastically giving details, the veteran will do it matter-of-factly, without emotion, or become very labile and angry while recalling the events. Usually the anger is verbal but needs to be monitored for escalation, in which case the counselor may need to apply gentle but firm limit setting. The counselor needs to keep in mind that all veterans have been trained in the use of weapons and violence. Those that have been through combat learned that returned violence was a way to cope with intense fear and anxiety. By listening with a therapeutic ear and paying attention to one's own system, the counselor can prevent a blow-up that neither the veteran nor the counselor would find helpful. If this issue arises or even before it does, a reading of Haley (1978) can provide guidance.

THE "WHY" ISSUE

Many veterans spend a great deal of time ruminating about situations looking for the answer to a "why" question (e.g., Why did Joe, who was married and had a kid, get killed and I didn't? Why did Tom take my place on point? I should have been hit by the sniper. Why did that little kid have a live grenade and try to kill my friends?). As in everyday life, there is often no answer to be found. Why a bullet missed by an inch and killed the one behind is almost a random event in combat. Some fatalists will attribute it to "fate." One can almost never ask the person on the other end of the gun why and receive a response. Often the "why" questions center on traumatic events with many "shoulds" and "should not haves." This post facto second guessing may be treated with the cognitive therapy of the "shoulds" and "should nots" (Ellis & Grieger, 1977). Veterans want to change the outcome of the traumatic event and reduce their survival guilt. More global "why" questions may have a more existential basis and the treatment of such is discussed by Yalom (1980). For most veterans, the therapist may tell them "why" is the wrong question because they will probably never find the answer and hence nothing will change. After discussing the event, possibly more than once, the therapist may encourage them to change the question. Something along the line of, "Now that that event happened, what am I going to do about it?" By re-shifting the focus away from the quagmire of the past onto the present, an attempt is made to help the veteran move forward with his life and to break the hold the past has on him.

THE "I FEEL LIKE EXPLODING" ISSUE

A common problem for veterans is the buildup of tremendous tension and anxiety. Some veterans turn to alcohol or drugs as a way to "keep a lid on." Some go looking for trouble in order to release tension by fighting. Others try to hold it in and control it but become very irritable and then go into a rage reaction. During the rage, they may direct much of their energy to verbal harangues, destroying furniture or structures (more than one veteran has told me about punching his fist through a plaster wall or kicking down a door), and unfortunately some have physically abused a significant other. The veteran reports feeling out of control, and after it is over, feeling guilty and self-deprecating. Teaching relaxation is invaluable. Helping the person learn the cues to increased tension and teaching other types of control can often defuse the imminent explosion. The cues need careful investigation to determine the etiology, the behavioral learning history, and the reinforcement potential for the explosion. By the time most

veterans come into counseling, they realize their previous coping attempts do not work and often increase the problems, and they are now willing to try to learn some other techniques.

THE "I AM A VICTIM" ISSUE

This particular issue can take two forms. In the first form, a veteran will truly believe he is a helpless victim of traumatic events. There is nothing he can do about it, and so attempts to deny self-responsibility for his actions and for his efforts to change. He may express confusion as to what happened and to how he became involved. In the second way, the victim responds with much anger and frustration, often directed at those who sent him, those whom he fought alongside with and/or against, his family, and in some cases the nation as a whole. When the "boat people" refugees were brought into this country from Southeast Asia, many Vietnam veterans viewed it as a personal insult, an affront to their service. Many negative stereotypes were formed by veterans about the refugees, based upon lack of information or on overgeneralizations. It became easier to blame the refugees than for the veteran to accept the self-responsibility for not having achieved his own expectations. In either way the term *victim* gives a sense of helplessness to a veteran and keeps him oriented toward the past traumatic events. If veterans are viewed as "survivors" of a "hell on earth," it imparts a sense of strength to them. It also allows for an attitude of "Okay, that is over; now let's get on with life." A victim is not attributed control over his life, whereas a survivor is attributed a willingness to overcome adversity and hence has some control. When working with any PTSD client, talking about the experience in terms of being a survivor is therapeutically more beneficial. The counselor can attribute strength to the client in that since the client survived the traumatic event, he can survive his current life situations. The instillation of hope is important for many clients, and for PTSD clients it renews their willingness to try and readjust.

THE "I CANT GET TOO CLOSE" ISSUE

This issue focuses on difficulties with relationships that many PTSD veterans have. Many veterans will talk about how close they had been to certain guys they served with in their combat units. The camaraderie developed was frequently very strong because they were sharing life-threatening experiences and depending upon each other. Fighting not only the enemy, but the threatening elements of the environment, veterans learned to share their last bit of food or water, to talk about their plans for

the future, and to huddle together to ward off the elements. Many veterans report feeling closer to their comrades than to any other friend or even their own brothers. Then in the suddenness of combat, a friend is killed or horribly maimed. The veteran may experience intense emotional pain at the loss, but military training does not support showing those emotions. Later in another engagement, another comrade is lost, and then another. Each time there is unreleased intense emotional pain. For many veterans, the emotional pain becomes too much and psychic numbing or a shutting down of emotions occurs. They no longer allow themselves to become friends because they do not want to care so much about anyone again. They develop a belief that if they get close to someone, that person gets hurt, and the intrapsychic pain is unbearable. That learning unfortunately becomes transferred to all close relationships. Upon return from combat, many veterans get on with their lives by marrying or living with someone. Because they have not resolved their PTSD issue, they do not easily share positive emotions or profess their love for their partners. Often the only emotions are irritability, depression, fear, or rage. Such an emotional environment is generally not conducive to long-term close relationships. Divorce is a significant problem for many PTSD veterans.

For Vietnam combat veterans, negative experiences in which children, women, and elderly were used as weapons by the enemy often led to a deep-seated mistrust for all strangers. Involvement in atrocities also instilled dysfunctional behavior based on guilt. Finally, for many veterans disenchantment and feelings of being used by their government and country caused feelings of suspiciousness. Then upon return to an unfriendly, unsympathetic country, strong feelings of alienation developed, and veterans tended to isolate themselves. Often these veterans talk about their desire to live “off up in the hills” or “out in the country,” away from everyone. Another common statement is, “I just don’t fit in here.” Such a cognitive-affective learning experience makes relationships difficult. In some ways, it is almost as though the combat veteran went from age 19 to age 40 without the learning of the intervening years. The veteran’s perceptions of relationships and of how to act his role within a relationship is clouded by his combat experiences.

The counselor may become involved in a long-term relationship (with many ups and downs) with a combat veteran. The workings of this relationship can be generalized to a significant personal relationship of the veteran. Communication skills, assertiveness' skills, affective awareness training, and anger control may all need to be covered. Cognitive restructuring work, as well as couples and/or family

therapy, may be needed. The psychological defensive wall erected to keep out emotional pain needs to be carefully taken down one piece at a time. Beginning to be aware of emotions may be the first true step in healing and breaking the chains of the traumatic events from the past.

Other Problems with Veterans in Counseling

Besides PTSD, there are a few other problems that often occur in counseling with veterans. These problems are not related to traumatic events. Instead, they are based on living in a military society with its peculiar rules and behaviors that can become deeply ingrained. Arguments could be made about certain personality characteristics that might lead an individual into the military service. A high psychological need for order, love of excitement and adventure, a desire for a camaraderie, self-sacrifice, and patriotism may be just a few. On the one hand, the military does everything and provides everything. Just do as one is told to do—don't think; just follow orders. It is a great provider; the ultimate parental figure. As some old-timers would say, "If the service wanted you to have a wife, they would have issued you one." Such mentality or belief system can create certain problems in counseling with veterans, and several of these problems will be discussed.

The biggest problem is that veterans *may not be in contact with their feelings.* Much of counseling focuses on the affective level. But millions upon millions of veterans have been trained to block out and deny feelings. Thus a veteran may not be able to discuss how he "feels" about some issue. He will tell the counselor what he "thinks" about the situation but seems at a loss to respond about effect. As a counselor, one may need to teach or offer affective alternatives to sensitize a veteran at the affective level. A veteran may talk about being uncomfortable but may need careful intervention to clarify whether he feels depressed, sad, tense, uptight, angry, frightened, anxious, irritable, explosive, or another affect. By taking the time to clarify, the counselor helps to educate the veteran and helps him better understand what is going on inside. A great number of veterans do not realize how tense/anxious they are until they are taught some relaxation skills. The idea of stress management provides therapeutic insight and treatment. Additionally, becoming aware of their affective self is beneficial, but scary as well.

The *fear of becoming emotional* is the second problem area often encountered. The military has trained the veteran to be in command, to show no weakness, and to know what is right. A super-

masculine image is the standard by which veterans are judged. There is a place for women, and women should stay in their place. That place is not in the military and certainly not in combat. The male supremacy is reinforced constantly throughout their military career, and suddenly in counseling the veteran "thinks" of himself as a failure. There have been many times veterans have said to me, "I felt like crying but could not do it." Whether from fear of losing control or of viewing himself as weak if he cried, the veteran may initially resist getting in contact with his emotions because he wants to retain his self-image as a man. Instead of feeling anger at such a chauvinistic view, the counselor is recommended to view it as a part of the veteran with which he has not been in touch for a long time. The affective side is as important for a veteran as it is for any client. Just realize it may take time to help a veteran find and become accustomed to that new part of himself.

A third problem is the *anomie* that many veterans have following combat or an exciting career in the military. Nothing seems as important, as challenging, or as exciting as it was during his service time. His level of responsibility may have gone from being totally responsible for $30 million worth of equipment and personnel to being the low man in an occupational setting in which he has no input to decision making. The veteran may also be having problems adjusting into a "civilian" world. His entire lifestyle has abruptly changed, yet he may have little insight into any cause-and-effect relationship between such a change and how he feels. Often a true adjustment disorder as described in DSM-III is easily diagnosed for retired or recently released servicemen. Counseling can prove very beneficial to alleviate adjustment problems. Glasser's Reality Therapy (1965) is often effective in helping servicemen look at their expectations of what civilian life would be like. There are usually unrealistic expectations that can be corrected by soft confrontations. Encouragement of involvement in activities and/or organizations can also be helpful. Many retired servicemen move near military bases or into retired military neighborhoods, which can help to ease the transition. The anomie may be initially difficult to overcome, but once the stationary inertia is set into motion the problem generally resolves itself.

The final problem centers on issues of *authority.* Because counseling is often a new experience for a veteran, he may view the counselor as an authority figure. As an authority figure, the veteran may want the counselor to tell him what to do, just as his commanders in the military did. On the other hand, the veteran may have a need to resist the counselor because he is tired of "taking orders." In either case, the counselor will benefit from explaining what counseling or psychotherapy is about and what each

member's role is in the therapeutic relationship. For many veterans the idea of counseling is anathema because in the military, seeking counseling was thought to lead to loss of a security clearance and hence the end of a chance for promotion. Difficulty taking orders may develop in a new work situation because the veteran may view the boss as inept or not knowing that there is a better way to do things. (Better in terms of the way it was done in the military.) The old military formula of instilling discipline—"kick ass and take names"—does not transfer to the civilian world. No longer does military rank provide power to command with the military justice system to back up orders with punishments for those who failed to respond. Again, reality therapy can be useful. Playing on the veteran's pride can also be used by the counselor. By pointing out to a veteran that in his long, successful career, he made many moves and served under many commanders, the counselor can point out to the veteran how he learned to adapt in each new situation. After achieving agreement with that point, the counselor can discuss with the veteran what the new environment is like and what he needs to do to succeed. Usually such an approach removes the blinders (resistance) for the veteran, and he can begin working on his adjustment. Not everything is "black and white," as many veterans believe. There are grays, and there are different ways of dealing with authority.

A sub-issue under authority is a veteran who runs his family as he did his military unit. Spit and polish, Saturday morning inspection, stern discipline, a "yes, sir; no, sir; no excuse, sir" environment often leads to family problems and needs to be dealt with in family therapy. There needs to be work done on the ego differentiation between the service and the family when the veteran becomes too authoritarian. It may be difficult to move him from his rigidity, but he would probably not be in counseling unless he wanted to change.

Other Resources

When faced with a veteran client whose main concerns are veteran related, it may be helpful to refer the veteran to a Veterans Administration facility within reasonable distance or at least provide a phone number to the veteran for him to call and check on his eligibility for treatment. It may prove beneficial for the counselor to call and consult with a psychologist, social worker, psychiatric nurse clinical specialist, or a psychiatrist about a particular case. If one is located in or near a large metropolitan center, there is probably a VA facility there. If not, then one can call the following telephone number to

obtain the phone number of the nearest facility: VA INFORMATION—(202) 233-4000.

Similarly, if working with a Vietnam veteran or any combat veteran, a consultation with or referral to a local Vet Center may be of benefit. A Vet Center is an outreach counseling center providing free counseling services to veterans who are still struggling with their combat experiences. PTSD is the largest category of presenting problems and the reason the Vet Centers were created. Call the same VA information number and ask to talk with someone familiar with Vet Centers.

If the counselor wants or needs to do a PTSD evaluation, there are several available. Figley's (1978) Appendix B has a suggested format focusing primarily on Vietnam but is easily adopted to other traumatic events with a few word changes. Another format is provided by Scurfield and Blank (1985) to obtain a good military history.

Conclusion

Veterans are people who have been through some special experiences that have affected their lives. Although many veterans are resistant to counseling/psychotherapy, they often become appreciative clients who respond well to counselors' efforts. Do not try to fool them or not be "up-front" with them. Their experiences, especially in combat, seem to allow them to know when someone is not being honest with them. They often present a very stern, gruff exterior and much pain can be seen in their eyes. Combat certainly ages them beyond their years. Some problems they present may seem intractable because of the many intervening years. An empathic counselor can often ease their burden, simply by caring and showing a willingness to listen. As Fielder (1950) indicated, it does not seem to matter which therapy or technique of counseling is utilized, the concern of one human being—the counselor—for another—the client—appears to be the most important therapeutic factor. As with most clients, if treated with dignity, they respond with dignity. Veterans have shouldered the nation's burdens and at times may need help to unload a burden that has become too heavy. As counselors and therapists, we can help lighten the burden and in so doing, say thank you for the sacrifice the veteran made. Sometimes that is all that is really needed.

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