

Short Communication

A Review of Mental Health Challenges and Issues Facing College Enrolled OIF and OEF Veterans One Decade Later

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ABSTRACT

In 2007, a study was conducted at a major Southern Californian four-year university with the assistance of a student veteran who had just returned from service in the Iraq war. Through his connections with other college enrolled veterans, the author was able to obtain data from 39 veterans attending classes during the 2007-2008 school year. This was not a clinical population known for receiving mental health services. It was found that 21% met the criteria for PTSD and 27% met the criteria for Major Depression as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) 4th Edition. Ten years later, much has changed in the way

that PTSD is diagnosed according to the newly revised DSM 5. Additionally, much information has been researched about the needs of these veterans, including college enrolled, civilian employed, and those still serving. The author has published numerous articles, textbooks, and conducted 3 different videos demonstrating sessions with veterans using her ABC Model of Crisis Intervention and Sand Tray to work with their continuing PTSD and Depression. In this article, the author discusses the history of her research with this population and her current views on best practices ten years after her initial study.

Introduction

In 2007, I became interested in understanding the mental health issues and needs of the returning veterans who had served in the Iraq (OIF) and Afghanistan (OEF) wars starting in 2001 after the attacks on the World Trade Center on 9-11. A student in my Crisis Intervention course during the Fall 2006 semester, had served in Iraq and would often share about his experiences, in particular his challenges in overcoming Posttraumatic Stress Disorder (PTSD). I had been working with PTSD in many traumatized clients over the past 25 years as a practicing psychotherapist, and this population had been on my radar since I worked with the families involved in the 1991 Persian Gulf War for my doctoral internship.

I asked this student veteran to assist me in distributing a survey for the other college enrolled veterans who had recently been meeting together in the University Women's Center. At some point, the director of that center along with some other key administrative staff, wrote a grant and funding was given to start a Veteran's Center on campus. This veteran student became the coordinator of that new center. I filmed a video in which I conducted a session with this veteran, who had a PTSD relapse which had been triggered by a newspaper reporter asking him if he had killed anybody in war, using my already established approach- the ABC Model of Crisis Intervention [1]. After this video was completed, I published the results of the survey we had distributed over the course of two semesters in several journals [2-5], in my fourth edition of *A Guide to Crisis Intervention* [6], and presented my findings at two national conference [7,8].

In 2012, I produced a new video in which Sheila McCabe,

a specialist in Sand Tray Therapy, worked with a veteran and his wife [9]. This veteran was still suffering from PTSD from his service in the Persian Gulf War and subsequent security operations as a sniper. Both the veteran and his wife expressed great relief after the Sand Tray work that continued for several months. Doing this video triggered interest in me to continue researching current needs of veterans and new, effective interventions.

By the time my textbook was due for a new edition [10], I was able to offer very recent statistical findings related to these OIF (Operation Iraqi Freedom) and OEF (Operation Enduring Freedom) veterans needing mental health care, and now an entire chapter was devoted to veteran issues rather than just a section in the PTSD chapter. During my revisions, I incorporated the recent revisions provided by the American Psychiatric Association to the diagnostic and Statistical Manual of Mental Disorders (DSM 5), [11]. The category for PTSD was changed from being an anxiety disorder to a trauma related stress disorder. PTSD now included affective and mood instability. These changes created a shift in understanding PTSD especially with these veterans who were demonstrating significant depression and suicidal ideation and completions.

Current views on veteran needs

While my interest in veterans began with understanding the mental health needs of college enrolled veterans, I came to realize that these college enrolled veterans would soon be joining the civilian workforce, and would be bringing their military traumas with them. I expanded my interest to include all of the returning veterans, and in 2016, I created a new video and conducted a session with an OIF veteran [12] using the ABC

Model of Crisis Intervention, which has been updated along with my knowledge of veteran issues. This session, filmed almost 10 years after the first video, incorporates much of the new material I had learned during my ongoing research. Additionally, my 6th edition of *A Guide to Crisis Intervention* due to be published in 2018 [13], includes much of the latest treatment approaches for veterans and emphasizes the importance of understanding the invisible wounds such as PTSD, depression, suicide, traumatic brain injury, substance misuse, and Military Sexual Trauma (MST). MST was not as highlighted in prior works as this experience was not discussed by the victims widely and understanding the ramifications of MST was not known. Once the movie, *The Invisible War* was released, it became apparent that this phenomenon had to be addressed and understood by mental health professionals. MST is discussed at length in this new edition of my text because the number of reports of this has increased and often create more severe symptoms of PTSD than other military experiences. Since women are more likely to suffer from MST, knowledge about the special issues facing female veterans is vital for all mental health workers, whether working for the Veteran's Administration (VA), colleges, private counselling agencies, or public mental health facilities. In fact, because many females who have reported MST have lost their jobs, or have been negatively judged by superiors, they may prefer to receive mental health counselling from therapists not affiliated with the VA [14].

While researching latest statistics and other data related to veterans, I have continued teaching at a 4-year University in California and am always mindful of the needs of college enrolled veterans. Focusing on college enrolled veterans is significant because once these veterans complete their military service, they will be seeking employment in the civilian world. This often means using employer provided medical insurance that may assist them in receiving continuing mental health services and discontinuing counselling services through the VA. The implications for general mental health practitioners are huge. Psychologists, Marital and Family Therapists, Licensed Clinical Social Workers, Licensed Professional Counsellors, and Psychiatrists in the private sector will now be treating these veterans and their families, not just the VA. In fact, many veterans have stated they prefer to get away from services at the VA due to the bureaucratic processes and the distance and inconvenience in receiving services at the VA.

In my view, in the past ten years it has become obvious that treating veterans is now a focus for nonmilitary mental health professionals. Most professional associations have been regularly offering conferences and professional articles dealing with how to treat veterans and their families. It is clear that the VA is not the only place for veterans to seek and receive effective treatment for PTSD, Depression, and other issues related to military service. In light of this, many practitioners are also researching and learning about how to intervene with this population. In fact, I created a course entitled "Servicing Veterans and Their Families in 2014" that specifically guides students into learning about how to specifically work with these types of veterans and their families [5]. Since then, I have

collaborated with a variety of professionals in the community also interested in effective intervention for these veterans and their families.

Discussion

In light of the accumulation of data about the needs of OIF and OEF veterans and their families, I have formed a variety of ideas and views about best practices for this population. Of course, utilizing the VA and other military oriented services from VET Centers, TRICARE, and Military One Courses remain as viable resources for these clients [15]. Many veterans have benefitted from the virtual reality computer generated programs that replicate scenes from Iraq and Afghanistan that the Department of Defense (DOD) has developed. Additionally, many have received medications and suicide prevention services offered by the DOD.

Fortunately, veterans and their families do not need to rely solely on VA services. In cases of MST, the victims might actually feel safer and more open to dealing with these traumas with non-military counsellors where sanctions against them for disclosure are not as likely. As civilian counsellors become trained about military culture and the particular needs of these veterans, the VA may not have to treat all of the veterans. Even college campus counsellors are becoming aware of how to intervene with veterans enrolled at the college. University administration has also become aware of the special issues that may arise for these veterans as college students.

My perspective in no way means to discredit the VA. Many veterans have received effective care from the professional staff at the VA and other DOD funded agencies. My view is intended to create optimism that veterans and their families now have more options that may suit them better than just the option of going to the VA. Whether the private agency practitioner or school counsellor offers Sand Tray Therapy, Eye Movement Desensitization Reprocessing (EMDR), Cognitive Behavioral therapy, Exposure therapy, Crisis Intervention, or traditional counselling, these veterans, whether college enrolled, newly employed, or other, have choices now on best treatment for that particular veteran from a variety of skilled and motivated counsellors.

Conclusion

Since 2007, when I first began researching, treating, and writing about veterans of the Iraq and Afghanistan wars, I have learned many valuable things that have implications for mental health practitioners. I first learned that college enrolled veterans continue to suffer from PTSD and Depression and Traumatic Brain Injury, and this may affect school performance and social engagement. Creating Veteran's Centers on campuses seemed the best approach to begin addressing these veteran issues. Then, training college counsellors and other administrative staff about these issues followed to strengthen the likelihood of the veteran's completion of their college degree.

It soon became apparent that the veterans would continue to need services once they graduated from college and became

employed and integrated into civilian life. This requires that non-military agencies and clinicians become aware of the special needs of this population. Tailoring therapy to these veterans has now become mainstream. Many approaches may be effective such as virtual exposure therapy, cognitive behavioral therapy, sand tray therapy, EMDR, crisis intervention, and other traditional counselling approaches. What seems to matter most to a veteran is for professionals to understand military culture and the “invisible wounds” that are part of combat stress such as PTSD, Depression, and TBI.

In order to help this veteran population, integrate back into non-military culture, they need guidance on readjusting and help in overcoming symptoms created due to exposure to war, and other traumas.

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