Basic Training for Building a Program in Military Social Work

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Basic Training for Building a Program in Military Social Work

Marjorie R. Sable and Victoria A. Osborne

Since 2003, nearly 2 million service members have deployed to Iraq and Afghanistan for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). More than 4,000 have been killed and more than 30,000 returned from combat with a range of visible wounds and permanent physical disabilities (Department of Defense, Defense and Veterans Brain Injury Center, 2011a). In addition, it is estimated that 25-40% experience less visible wounds of psychological and neurological injuries associated with Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI; National Council on Disability, 2009; Tanielian & Jaycox, 2008).

The psychological stress experienced by military personnel and their families has recently received a great deal of attention in the news and has been documented in professional literature. Deployment and combat can result in PTSD, depression, and other mood disorders, as well as family stress that in turn leads to substance abuse, child abuse, domestic violence, divorce, and homelessness. Almost one in five military personnel serving in Iraq and Afghanistan return from deployment with PTSD, major depression, or TBI; and 5% reported symptoms of all three (Jaycox & Tanielian, 2008). In addition, family members experience secondary trauma (Franklin, 2009; Shea-Porter, 2009). Multiple deployments, representing 37% of those who have served in Iraq and Afghanistan, take a mental health toll on both the service member and their families (Shea-Porter, 2009). Female veterans may face additional stressful situations such as sexual harassment, sexual assault, and rape, posing challenges to their mental health (Franklin, 2009).

In this paper we discuss some of the health and behavioral health issues associated with deployment, the impact that the large numbers of returning veterans will have on the training needs for social workers, and how one School of Social Work has responded to this need.

Background and scope of the problem

Military-related traumatic brain injuries (TBIs) have dramatically increased over the past decade. The Department of Defense reports that between 2000 and 2011 there were a total of 212,742 TBIs, with 177,479 of these occurring after 2003, after the United States entered the Iraq and Afghanistan wars. The annual number of TBIs increased from 12,898 in 2003 to 31,243 in 2010, with the vast majority of TBIs occurring to those in the Army, as compared to other branches of the armed forces (Department of Defense, Defense and Veterans Brain Injury Center, 2011b). Soldiers exposed to improvised explosive devices (IEDs), land mines, mortar rounds, and rocket propelled grenades are at increased risk of sustaining a TBI, which can result in physical, cognitive, social, emotional, and behavioral challenges. Closed head injuries comprise 80% of TBIs and symptoms can range in severity (Van Dillen, 2010). Depression, PTSD, anxiety, and substance abuse are common for TBI patients (Van Dillen, 2010). Because of the variability in severity and co-occurring conditions, there is no one standard of care for intervention. However, early intervention and prompt and effective therapeutic techniques are important for enhancing resiliency and mitigating the effects. (National Council on Disability, 2009; Van Dillen, 2010).

PTSD and TBIs often occur together. The symptoms are similar and sometimes difficult to distinguish (National Council on Disability, 2009; Force Health and Readiness Protection Policies

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Table 1. Differentiating symptoms of psychiatric illness from traumatic brain injury

SURVIVORS OF TRAUMATIC BRAIN INJURY (TBI) MAY DISPLAY...	WHICH MAY BE CONSTRUED AS SIGNS OF...
Anxiety and sadness as they adjust to changes related to their recent TBI	Mood disorder such as clinical depression or anxiety
Changes in expressive/receptive language (e.g., monotone voice or lack of prosody)	Flat affect/Depression/Diminished intelligence
Diminished cognitive, physical, or behavioral (e.g., decreased tolerance for frustration) functioning when tired or over stimulated	Depression/Indication of the person's optimal ability level
Fluctuations in mood	Manic episode/Bipolar disorder
Diminished tolerance for social interaction or changes in social ability or personality	Depression/Personality disorder
Sleep disturbance or changes in sexual functioning	Depression
Sensory dysfunction (e.g., ringing in ears, blind spots in visual field)	Psychotic/Mood disorder
Changes in speech or diminished physical ability (e.g., hemi paresis or decreased balance)	Alcohol/Substance abuse
Apathy or diminished motivation and initiation ability	Depression
Changes in aspects of attention (e.g., divided attention)	Attention deficit disorder
Verbal/behavioral impulsivity	Suicidal or homicidal ideation/Mood disorder/Attention deficit disorder
Source: Missouri Department of Health and Senior Services. For more information go to: http://health.mo.gov/living/healthcondiseases/tbi/relatedlinks.php	

and Programs, n.d.; Missouri Department of Health and Senior Services, n.d.). Table 1 presents symptoms of traumatic brain injury and how they may be construed as signs of psychiatric illness.

Mental Health Concerns

Suicide among both veterans and active duty soldiers has been identified as a major public health problem. Recent research has revealed that both male and female veterans are more likely to die from suicide than are their civilian counterparts (Kaplan, Huguet, McFarland, & Newsom, 2007; McFarland, Kaplan & Huguet, 2010). The *Army Health Promotion, Risk Reduction, Suicide Prevention Report 2010* (Army, 2010) documents the high numbers of attempted and completed suicides and provides extensive information, sta-

tistics, and risk factors associated with suicide. Alarmingly, suicides and accidental deaths resulting from high risk behavior account for more deaths than combat deaths. The report notes that high risk behavior such as self-harm, illicit drug use, binge drinking, and criminal activity were factors in most of these deaths, calling for early identification of stress and a holistic approach to prevention of suicide and high risk behavior that leads to death (Army, 2010).

Substance abuse is a particularly important concern for military leaders. Higher rates of alcohol and drug use are observed in the military than in the general population, partly due to stressful issues such as being separated from family as well as deployment-related experiences including those in the combat theatre (Ames & Cunradi, 2004). Although alcohol misuse is common during military enlistment, it seems to be more prevalent during times of pre-deployment (e.g., Hoge et al., 2004). Similarly, heavy alcohol use during post-deployment is higher among those who were deployed than those who were not (Federman, Bray, & Kroutil, 2000).

Self-medicating the deployment stress (i.e., "drinking to cope") appears to be worse among Reservists and National Guard personnel. Typically, these military members have fewer resources available for dealing with deployment stress. They may not live near a Veterans' Administration facility and/or may not have access to or be eligible for certain services. Additionally, these military members return from deployment to civilian jobs and personal lives outside of the military (Ferrier-Auerbach et al., 2009; Jacobson et al., 2009), which may further distance them from services and other military personnel experiencing similar issues. Thus, they have less social support than enlisted men and women. Because National Guard and Reservists hold non-military jobs, they typically utilize their private health insurance rather than trying to partake of any military-related health services for which they may be eligible, adding to this emotional distance.

High rates of eating disorders are also seen among military men and women, as they often co-occur with substance use disorders, PTSD, and mood disorders (Streigel-Moore, Garvin, Dohm, & Rosenheck, 1999). Research suggests that men and women in the military have greater symptoms of bulimia nervosa than do civilians (Peterson, Talcott, Kelleher, & Smith, 1995). Indeed, among active duty Navy nurses, McNulty (2005) found a higher prevalence of anorexia nervosa and bulimia nervosa as well as eating disorders not-otherwise-specified (NOS). While deployed, military personnel typically do not eat balanced meals and may not participate in regular exercise, which may put them at risk for gaining weight. However, enlisted soldiers do have periodic fitness testing and weigh-ins. Studies have shown that around the times of these tests, soldiers have exhibited increased rates of disordered eating patterns including binging and purging, fasting, and using laxatives (Garber et al., 2008). In fact, a study by Carlton et al. (2005) revealed enlisted Navy men and women to have higher rates of disordered eating particularly before weigh-ins ("making weight") and fitness tests. Recent research has also shown high rates of obesity and overweight among military members. To that end, military bases such as Fort Leonard Wood in Missouri have begun fitness programs for military members to help them with exercise and nutrition regimens (Scher Zagier, 2010).

Sexual Harassment and Sexual Assault

Both military men and women are victims of sexual harassment and assault, though rates are higher for women (Murdoch et al., 2006). While the perpetrators can be residents of the country where personnel are stationed, they are more commonly colleagues or superiors. Actual rates of assault and harassment are unclear, as many are afraid to charge their fellow soldiers—or worse, their superiors—with crimes. Although the Armed Forces have recently put a great deal of effort into sexual assault reporting practices, military men and women are still hesitant to bring charges against their fellow soldiers or their superior officers. One particular type of sexual assault that occurs quite frequently—again, moreso for women than men—is military sexual trauma (MST), which includes rape, assault, or sexual

harassment by one member of the military upon another.

The Department of Defense established the Sexual Assault Prevention and Response Program (SAPR) in 2004 to encourage men and women to report sexual assault; however, military personnel who are MST victims are hesitant to report these incidents. Although medical assistance and counseling are available without having to disclose the name of the perpetrator (Williams & Kunsook, 2010), if the victim of MST wants to press criminal charges, s/he must file an unrestricted, non-anonymous report. Thus, many victims choose not to reveal the perpetrator's identity for fear of retaliation by the perpetrator or the victim's colleagues and superiors (Service Women's Action Network, 2010). Consequently, the victims often do not report MST because they do not want to risk losing their careers or having to cope with a hostile work environment.

Another concern with SAPR is that only active duty soldiers are eligible to use the system (Williams & Kunsook, 2010); thus, Reservists and National Guard members have limited access to services. The current system is such that victims who are Reservists or members of the National Guard report incidents to the military chaplain's office, not licensed clinicians or qualified rape counselors.

Concerns for families and children of military personnel

Children and families of active duty, Reservists, National Guard and veterans are also affected by deployment. The Citizen Soldier Support Program (CSSP) notes that many of the problems of returning combat veterans are functional problems rather than clinical ones. These problems impact quality of life and include:

- marriage, family, or relationship problems;
- unemployment issues or work stress;
- financial issues;
- educational or training needs;
- intrusive questions from family and friends;
- guilt, shame, or anger;
- lack of structure;
- feelings of isolation;
- nightmares or sleeplessness, lack of motivation, forgetfulness; and
- irritability or anxiety (CSSP, n.d.).

A RAND study among children and caregivers who applied to attend a free camp for children of military personnel found that these children and their caregivers had challenges related to their emotional well-being and functioning. Specific factors related to greater youth or caregiver difficulties included poorer caregiver emotional well-being, more cumulative months of employment, National Guard or Reserve status, and poor family communication (Chandra, Burns, Tanielian, Jaycox, & Scott, 2008; Chandra et al., 2011). Typically, National Guard members and Reservists volunteer for deployment rather than being called to duty; this can put more stress on the member's spouse and children.

Currently, there are more than 1 million children who have or have had at least one parent deployed at least once (CSSP, n.d.). According to a 2009 Pentagon report, military youth sought outpatient mental health treatment 2 million times in 2008, which is double the number of visits reported in 2003. Further, inpatient hospitalization among military children increased by 50% during the same period (Sherman & Glenn, 2011). Children with a recently deployed parent, as well as those with parents who were already deployed, exhibited elevated separation anxiety and physical symptoms compared to civilian children (Sherman & Glenn, 2011; Chandra et al., 2010; Lester et al., 2010). Another study found that mental health outpatient visits increased by 11% when a parent was deployed. Furthermore, visits for behavioral disorders increased by 19% and visits for stress disorders increased by 18% (Gorman, Eide, & Hisle-Gorman, 2010). Other studies found higher rates of mental illness such as depression, sleep disorder, anxiety, adjustment disorder, and acute stress reaction among Army wives whose husbands were deployed compared to those whose husbands were not deployed (Sherman & Glenn, 2011; Mansfield et al., 2010). In addition, studies found increased risk of child abuse and neglect by at-home care-givers (Gibbs, Martin, Kupper & Johnson, 2007; Sherman &

Glenn, 2011).

Special issues related to National Guard members and Reservists

Throughout this paper, we have referred to differences between active duty enlisted military members and National Guard and Reserve members. : This section will elaborate on special challenges that exist for Reservists and National Guard members, as they have little or no access to Department of Defense or VA assistance. These challenges are a particular focus for social workers.

Though they comprise nearly half of all forces in OIF (Stetz, Castro, & Bliese, 2007), members of the National Guard and Reservists (those who serve in the Reserves corps of all branches of the military) do not commonly refer to themselves as being a part of a "military family" as many have full-time jobs which are not of a military nature. This lack of association with military culture, as well as living far from duty stations and military bases, may limit their access to military services and support (Huebner et al., 2010). This is important to note especially as National Guard members have higher risk for PTSD and other mental health problems than do active duty men and women. Milliken, Auchterlonie, and Hoge (2007) found nearly 42% of OIF National Guard troops and Reservists are battling mental health concerns. Additionally, Reservists and National Guard members typically are older than their full-time enlisted counterparts (Kehle & Polusny, 2010).

OIF/OEF has seen a large number of civilians who serve overseas as Federal Technicians and Civilian Contractors as well as war correspondents and journalists. Studies have shown higher lifetime prevalence of major depressive disorder and PTSD among war correspondents than the general population (Feinstein, Owen, & Blair, 2002). Feinstein and Nicolson (2005) studied embedded and non-embedded journalists in OIF and found a high risk of mental health problems in both groups. Additionally, contractors working in war zones report higher stress levels and experience more symptoms of PTSD than contractors who did not serve in war zones (Feinstein & Botes, 2009). Like National Guard and Reservists, most civilian contractors are not eligible for VA services and/or do not access them, which may decrease their social support and ability to deal with mental health concerns after returning home (Feinstein & Botes, 2009).

Despite the soaring need for social work services in the armed forces, military bases have a shortage of professionally trained social workers, and many positions continue to go unfilled (Walter Clark, Director of Behavioral Health, Ft. Leonard Wood, personal communication, October 2, 2009). Dr. Dexter Freeman, Director of the Fayetteville State-U.S. Army Masters in Social Work Program, estimates that social work is operating at only 75% strength for the military (personal communication, November 6, 2009).

Responding to the Challenge

Following the lead of the University of Southern California, many Schools of Social Work have responded to the challenge of working with the reintegration of troops and veterans and to preparing professionals as service providers by infusing content into the graduate curriculum. The Council on Social Work Education (CSWE) developed advanced competencies on Military Social Work to assist Schools of Social Work in providing training to students on military social work knowledge and evidence-based practice behaviors (CSWE, 2010). At the time of this writing, over 20 Schools of Social Work identified content on Military Social Work in their MSW curriculum or offer a course in it. Significantly, two schools—the Army-Fayetteville State and the University of Southern California—have concentrations in Military Social Work (Dr. Anthony Hassan, Director, Center for Research and Innovation on Veterans and Military Families, University of Southern California, personal communication, January 14, 2011).

Developing a Graduate Certificate in Military Social Work

The School of Social Work at the University of Missouri has responded to the compelling need

for training by developing a Graduate Certificate in Military Social Work. The Graduate Certificate is designed to expand the pool of professionals qualified to work in settings with military personnel, veterans, and their families. Further, the training focuses on clinical practice strategies of social work intervention with military personnel and their families to improve the mental health and health of this population.

This certificate is available both to students enrolled in the University of Missouri School of Social Work Masters of Social Work (MSW) Program as part of their clinical social work graduate training, as well as a stand-alone entity to civilian graduate level clinical social work practitioners who wish to augment their knowledge and skills in this area. The purpose of the certificate program is to advance the training of social work students and practitioners in this unique field of practice so they will be better prepared to meet the health and behavioral health needs and family functioning of service members, veterans, and their families. Coursework for the certificate began in the Fall 2011 semester.

The coursework consists of 12 credit hours of coursework with three required classes and one elective class. In addition to coursework, MSW students seeking the certificate will complete their practicum in a setting that serves these military populations. By furthering the education of social workers in the military and veterans arena, there will be more and better-prepared social workers to staff the clinics and hospitals at which these positions are currently unfilled.

The coursework for the certificate includes the three required classes: 1) Military Culture, 2) Military Social Work, and 3) Trauma Practice and Crisis Intervention. Students choose an elective course from among existing classes that focus on domestic violence, child abuse and neglect, family therapy, addictions and disabilities, focusing their course assignments on veterans and military families.

Summit

A national summit, entitled "Meeting the Needs of Veterans and Military Families: A Summit for Health and Human Services Professionals," was held on November 12, 2010 in Columbia, Missouri, to identify curricular and research needs for future attention. Welcoming remarks were given by a representative from the University of Missouri Student Veterans Center and by a representative from The Mission Continues organization. The Adjutant General of the Missouri National Guard delivered the keynote address.

Three national speakers addressed 1) Army Behavioral Health 2010: PTSD, TBI & Suicide, 2) Formal Systems and Informal Networks of Support, and 3) Competencies for Helping Professionals. This last presentation, developed by the University of Southern California, included the use of technology and avatars in skills training for social work. Summit participants were primarily social workers, but it attracted an interdisciplinary audience including psychologists, nurses, physicians, and other health professionals. A panel discussing Provider Perspectives included social workers from two Veterans Administration Hospitals in Missouri, a Vet Center, and the TBI Program of the Missouri Department of Health. A panel discussing Synchronization of Services included representatives from the Missouri Veterans Commission, the Veterans Benefits Administration, the Missouri Association of Veterans Organizations, the Military Family Life Consultant (MFLC) and Military One Source (MOS) programs of the Joint Family Support Assistance Program, and Community-Based Outpatient Clinics.

Prior to the Summit, a sub-committee of the planning committee developed a *Roadmap to Military Resources* (Missouri Department of Health and Senior Services, 2010), which identified national, state, and county-community level resources for veterans and military families. The *Roadmap* was printed and distributed to all Summit participants and sent out widely for distribution to agencies and organizations serving veterans and military families throughout Missouri. This *Roadmap* can be retrieved from the Missouri Department of Health and Senior Services website.

Raising Money for a Student Scholarship

In conjunction with the Summit, a fund-raising event was held to endow a scholarship for students pursuing training in Military Social Work. The event, Helmet Heroes, featured 15 metal helmets, decorated by local artists, and auctioned in live and silent auctions. Helmet Heroes netted $20,000 towards the $25,000 necessary to endow a scholarship, and we are seeking additional donations to complete the endowment.

University and Community Partnerships

The development of the Graduate Certificate and the sponsoring of the Summit and Helmet Heroes led to the forging of numerous partnerships to build capacity for innovative service delivery. The School worked closely with social workers from nearby Ft. Leonard Wood Hospital and the local VA Hospital in the development of the syllabus for a course in Military Culture, and continues to involve them in the development of the subsequent course syllabi.

The Summit planning committee included wide representation from academic departments on our campus, other universities, community agencies and veterans' organizations to co-sponsor the summit. Inter-disciplinary partnerships were formed among the various university departments and units represented on the planning committee including Social Work, Nursing, Medicine, Law, Public Health, Psychological Sciences, Health Psychology, Human Development and Family Studies, Human Environmental Sciences, Education, the University of Missouri Student Veterans Center, University Extension (Operation Military Kids and 4H), Center for Health Policy, the Missouri Orthopaedic Institute and the Office of the Provost. Community partners included Lincoln University, the Veterans Administration Heartland Network, social workers from the VA and Ft. Leonard Wood, the Missouri Veterans Commission, Missouri Association of Veterans Organizations, the Missouri Department of Health and Senior Services (Traumatic Brain Injury Program and Adult Head Injury Program), the Missouri Department of Mental Health, Missouri Military and Family Life Consultant, and the U.S. Army.

Corporate partnerships were forged through corporate sponsorships of Helmet Heroes. These included banks, law offices, insurance companies, wheelchair businesses, social service and mental health agencies, health clinics, wine distributors, and other businesses and individuals. In return for their support, corporate sponsors were given free tickets to the event and were listed in the program.

Student partnerships were formed by including them in the fundraiser preparations and assisting at the event. Several of our student partners were either veterans, married to a veteran, or from a military family, and their participation raised their awareness of the Military Social Work initiative at the School and generated an enthusiastic response to the program. Although they will have graduated by the time the first course in the Graduate Certificate sequence is offered, these students provided insight and suggestions for the initiative. One of the students informed her father about the Graduate Certificate in Military Social Work and he made a donation to the scholarship for future students.

This was the first fundraiser of its kind in the history of the School of Social Work, and the many partnerships formed have raised awareness about the Graduate Certificate in Military Social Work in the community. Many of these corporate sponsors and Summit partners were unaware of the School of Social Work, and these events served to educate the community as well as the participants.

Challenges and Opportunities

Significant support has been received for this military social work initiative from the university and community at large. The Graduate School supported development of the graduate certificate. Enlisted and retired military personnel and social workers with military/veterans agencies volunteered many hours planning for the Summit and consulting on course content. Student volunteerism was high. Local artists enthusiastically donated their work for the auction fundraiser. Media coverage of the Summit and Helmet Heroes fund-

raiser was extensive, and attendance at both events was standing room only.

Although the response to these training initiatives has been overwhelmingly positive, there have also been some challenges. It is important to separate the issue of training students and practitioners to meet the needs of veterans and military families from people's feelings about war in general, and the recent wars in Iraq and Afghanistan in particular. Many of those involved in military social work initiatives do not support the recent wars. But the need for caring for the victims of these wars is generally recognized. Nevertheless, there has been some criticism that reflects negative attitudes towards military social work training initiatives. It has been important to remind critics that providing social work training in best practices to address the human consequences of war may also help them to advocate on behalf of their clients to maximize their recovery and get the services that they deserve. As stated by Ron Savage, editor-in-chief of *Brain Injury Professional*, "No matter how we personally feel about the wars, we must be committed to fully supporting our returning veterans, especially those who have been injured, no matter what the cost" (Savage, 2010).

It is imperative that social workers understand and recognize the similarity in symptoms for PTSD and TBI. Social workers should also be familiar with child development and the kinds of responses that children have to a parent's deployment and the impact that deployment(s) can have on family functioning. The Citizen Soldier Support Program has an online training program with courses on "Treating the Invisible Wounds of War" and "Issues of Women Returning from Combat" that offers free continuing education credits and is aimed for primary care and behavioral health professionals (CSSP, n.d.). Furthermore, there is clinical translational research being conducted to mitigate, treat, and rehabilitate those with TBIs (Department of Defense, Defense and Veterans Brain Injury Center, 2011c), and social workers should be aware of these and stay abreast of new developments in this area.

The vast number of veterans returning from the OIF and OEF missions, as well as older veterans from previous wars with health and behavioral health needs, mandate that social workers become culturally competent regarding the context of both the visible and invisible wounds and some of the barriers to seeking help. The need for training for social workers on military culture and best practices to serve veterans and military families is essential as evidenced by the growing number of Schools of Social Work that are offering classes in Military Social Work or infusing this content into their curricula. This is further evidenced by the recent program announcement from the National Institutes of Health (NIH) for applications for *Research on Children in Military Families: The Impact of Parental Military Deployment and Reintegration on Child and Family Functioning* including support for conferences and scientific meetings (NIH, 2011). The Council on Social Work Education Annual Program Meeting has a track on Military Social Work and these sessions provide excellent opportunities for faculty to network and share resources for training. Such opportunities are critical to help educational programs prepare current and upcoming social workers to address this important unmet need.

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