Abstract
In the following pages, I will use the story of my patient Lee, who I have been treating in my role as his therapist for a period of three and a half years. This case study will be used to illustrate the difficulties that service members face when transitioning back into the community. I will also challenge some of the current, leading paradigms that are used for treating individuals with symptoms related to their combat experiences. This case will highlight the importance of individualized, culturally competent treatment within the context of a strong therapeutic alliance and the absence of possible secondary gain. Through a person-in-environment and with a historical appreciation, this case will explore Lee’s journey in the hope of providing some generalizable knowledge and offering a different way to conceptualize traumatic experiences and individuals’ responses to them.

Keywords: Military Mental Health, Substance Abuse, Integrative Therapy, Domestic Violence, Reintegration, Deployment, PTSD, Dual-Diagnosis

*Privacy Disclaimer: Names and identifying information have been altered to protect the identity of the client.

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memory recall heightened following prompting by another person’s chronicle of the event (p. 191). Lee's scattered memories were slowly pieced back together in the next several weeks.

To most, the U.S. military instills an esteemed sense of discipline, loyalty, and self-sacrifice. As for myself, I think of the spit-shined boots, high and tight haircuts, and the good ol’ boys’ club that parties as hard as they work. But within this culture, order is strictly maintained. Here, individuals are confronted with a mandated yet abstruse task: to follow orders fearlessly, albeit blindly, without regard to the long-instilled primal instinct of self-preservation. This environment has to be one that emphasizes country and allegiance over personal autonomy and one that strips personal agency away by necessity in order to accomplish the mission. How else could we have such a diverse group of people who work so closely together accomplish a task that goes against basic human instinct? Benefitting from the knowledge of studies across the millennia, this particular chapter in the art of war is quite straightforward. Peel away culture and instill something even more powerful by way of fear, training, and rite of passage. A new culture and meaning of life is born in the fierce, disciplined, loyal force that we call the U.S. military, where the training is intense and the indoctrination process is most calculatedly deliberate.

In the following pages, we will explore the following questions: can the military Department of Defense (DoD) and Veterans Affairs (VA) systems provide a clinical environment where active-duty soldiers and veterans can be both free from the ridged clinical confines, employment, and benefit gains/losses, and, in addition, heal from traumatic combat experiences and exposure suffered in war? Is the system that makes a civilian into a soldier the appropriate system to transition a soldier back to a civilian? We must question if it is even possible for the same system to do both. Through a historical lens and a person-in-environment perspective, this manuscript will examine these questions as they apply to present day veterans. I will address the necessity of individualizing treatment, thus allowing for autonomy and personal agency in treatment.

**War and Veterans in U.S. History**

Sadly, since America’s inception in 1776, we have been engaged in war or conflict for 217 years as compared to our 21 years of peace (Congressional Research Service, 2012). As a nation, we have spent over 90% of our time in conflict. One would assume that we are pretty efficient and accustomed to the collateral damage that is caused by war. Currently, 2.5 million Americans are active duty or in the reserves (Office of the Deputy Assistant Secretary of Defense, 2013). While it sounds like a high number, in reality, it is less than 1% of the U.S. population. Does this mean we write-off the 1% as war's causality and political rhetoric? I assure you that the answer is no. As a nation, we owe it to the few who have served for the benefit of the majority. Not only are we only as strong as our weakest member, but we also owe it to our communities and service members to support and appropriately offer services to reintegrate and rehabilitate our warriors.

In 1944, George Pratt, MD, published, “Soldier to Civilian, Problems of Readjustment.” With unprecedented foresight, this book was written to help the layperson understand and assist veterans in their transition back into their communities. For me, it addresses some very important factors that continue to be overlooked, and moreover, Pratt’s book had an impressive predictive value. Pratt (1944) asserts the following:

No book can outline specific steps on how a person might treat any or all veterans. After all, each man is a distinct individual, and his reactions to his experience are to a great extent dependent upon the manner in which he reacted to varying experiences previous to his induction. His treatment needs should be determined by the facts of an adequately compiled case history that brings out many experiences of his earlier life. And a psychiatrist or a professionally trained social worker is usually the most competent person to under-take this. (p. 196)

Dr. Pratt was the father of a deployed soldier at the time he had written this book, which dared not to give answers but, instead, to offer suggestions to help create an environment for an individual to successfully reintegrate. He wrote about the importance of the community and the importance of not continuing to make individuals dependent, which he convincingly argued was the result of fostering the service members’ dependence on the government. Instead, he encouraged giving veterans the tools and support to have the ability to transition back into the community and become civilians after being faced with the many traumas of war.
In 1949, stigma, ignorance, and lack of appropriate services were the biggest barriers to mental health care for veterans. In 1944, "Nearly one half, i.e. 45 percent, of all medical discharges from the armed services [were] for some psychiatric reason" (p. 15). "World War I... found mental and emotional disorders (they were called shell-shock in those days) taking a more terrible toll of American troops than enemy bullets" (p. 16). Interestingly enough, these statistics appear to remain accurate in contemporary culture. We can cite damning statistics all day long on how American wars have affected our service members, their families, and communities. But, this paper has another purpose. Here, the goal is to help the reader understand and create an environment where an individual service member can heal from their traumas and reintegrate back into the community. And the individual needs to be assessed and treated as just that: as one unique person with unique experiences and needs. In order to elucidate some of these aforementioned problems and bring the focus back to the individual, I will focus on one man’s story.

An Honorable Soldier, Professional, and Family Man

In Lee’s presence, one would generally notice a well-kept professional man in good physical shape who was confident, yet unassuming. Upon first impression, he presents as a culturally diverse American with strong Asian features. A man of girth, Lee appears highly introspective and walks with intention. He dresses professionally. He is casual and neat. He has a calculating manner about him, exemplifying a stark attention to detail. His smile and laugh appear as genuine as anyone else’s, a skill set that Lee has admittedly mastered. A deeper analysis is more telling. Unmask the facade of confidence and poise and a less flattering person emerges. His kindness, while authentic, is overshadowed by an all-encompassing feeling of disconnect between himself and everything else, where he envisions himself banished as the sole outcast. Originally misconceived as strength, an aggressive demeanor is present, born out of the necessity of self-preservation and fine-tuned throughout the many years of Lee’s traumatic past and extensive military training.

Going back to day one, Lee initially began therapy with an entirely different set of goals. Unbeknownst to me at the time, Lee was prompted to seek therapy solely to satisfy a hidden agenda, having secretly despised therapists after several distasteful experiences, both on base (military mental health) and at the VA. Originally, he presented to me with alcohol abuse and dependence issues and anger management concerns related to alcohol consumption. It was obvious when discussing treatment objectives that Lee was only interested in fixing current behaviors but not looking at underlying reasons or drives. While trying to figure out a theoretical frame to utilize, I asked probing questions to help motivate Lee to examine his feelings and drives, inquiries that Lee staunchly resisted.

"To help me understand you, can you tell me a little about your childhood?"

"Nope.”

"Did you have a ‘happy childhood’?”

Silence.

"Were you raised by both parents?”

More silence, with an accompanying glare.

"What triggers the drinking?”

"Typically, I am thirsty. Don’t you drink when you are thirsty?” Lee grinned, proud of his wit.

And so it went. Lee resisted my line of questioning as though it was an enemy interrogation, and I was his captor.

Eventually, during that first session, Lee became slightly more willing to converse as he gradually became more at ease. Following a discussion of treatment goals, interventions, and theoretical orientations, we initially focused on anger management, the creation of improved coping strategies, and managing alcohol consumption responsibly. It didn’t require my reading between the lines to sense Lee’s uneasiness with addressing his traumatic past. Lee was vehemently opposed when pressed to explore the underlying possibilities for his behavior. Fearing that further insistence to evaluate core issues would inadvertently discourage Lee from therapy, I did not press the matter. At this point in time, Lee wanted to field dress his wounds to be able to eliminate the scouts while disregarding the enemy battalion, something Lee had been doing his entire life.

In later sessions, Lee was mostly reserved and talked about his many deployments as a Green Beret with a Special Forces unit, arguably one of the most arduous and skilled roles in the U.S. Army. He had risen up the ranks and had been a team leader for most of his deployments. He had seen a great deal of combat and had been through significant associated trauma and loss in the military. After retiring from the military, he founded his own contracting firm, which became a
multi-million dollar venture, currently operating worldwide. Lee was wildly successful in both careers: promoted to the highest achievable enlisted rank in the U.S. Army and CEO in the civilian world. Upon first look, Lee set the measure for success.

But upon closer inspection, Lee brushed over his struggles of being born and raised until the age of seven in Vietnam during the 1960s. His challenges of coming to America and living in South Carolina in the 1970s as half-Vietnamese by an overtly racist and unattached father were nothing short of significant. An unattached mother who did not speak English and a home that was riddled with arguments, violence, intimidation, and invalidation further confounded Lee's family of origin issues. Initially, exploration of his social history was met with stark resistance and minimization. On more than one occasion, Lee stated that he was, "Not ready to deal with this... this [was] not the issue." After all, the issue, according to Lee, was recent binge drinking and anger management. One of the discussions in therapy exemplified this controlling ideation.

In session one day, Lee stated in an irritated tone, "It's stupid! I don't ever do anything I don't mean to do. I mean, when I got the DUI, I did that for a reason. I was mad and my wife wasn't listening, so I figured I needed to get her attention".

Intrigued, I stated, "That must have made you very upset. How did you get her attention?"

Smirking, Lee replied, "I drank and drank and drank until I knew I was good and wasted. All while fighting with her. I listened to my police scanner—I knew they were out trying to arrest the illegals to send them back down South. I found out where the nearest checkpoint was and drove straight to it. [Lee chuckled.] I told them I was drunk, and I got arrested." To which I replied, "Were you successful?" Lee grinned and said, "Yea, I got arrested, didn't I!"

Realizing that we were talking about two separate goals, I clarified, "I mean, did it get her attention?"

Lee continued, "Well for about a couple of days it did." Lee paused and in a deflated voice explained, "I guess I can't go out and get DUI's every time I need her attention, huh?"

Both of us were now looking at each other in bewilderment. After a pause, I spoke. "I suppose it's not the best way to deal with marital issues... So, let me clarify. Since this was intentional for you to drink too much and get a DUI, you think you can control your drinking and it's not a problem?"

Lee gave me a look, as though he was getting upset with me for not catching onto his flawed logic, and asked, "Didn't I just prove that to you?"

Without so much as a hint of sarcasm, Lee genuinely questioned my lack of acceptance for his evidence. Further sessions with Lee more thoroughly delved into his maladaptive, nonchalant attitudes related to alcohol use. While alcohol consumption is often glamorized in the military and embedded in its culture, Lee's exposure to binge drinking began far earlier in childhood, a confounding risk factor for adult alcohol abuse (Anda et al., 2002, pp. 1001-1009). When prompted, Lee estimated that about half of his time spent drinking resulted in blackouts. After all, "What else is the purpose of drinking?" Lee would question. In fact, upon prompting, Lee could not recall a family gathering that did not entail drunken debauchery.

Glamorization of alcohol abuse within military culture, while decades in the making, is just now being addressed by the military following increased public scrutiny. The Department of the Army report (2012) on generating health states that 43% of active-duty soldiers reported binge drinking within the last month alone. The same study claimed that veterans with drinking problems were 2.7 times more likely to develop PTSD (p. 30). Lee essentially had every known risk factor ever published for the development of PTSD.

In another conversation, Lee spoke of the few times where he felt like he fit in.

"Lee, can you tell me a time when you felt like you really belonged, like you were a part of a family?" I asked, as it was in context of a larger conversation.

"Yeah, that's easy. I remember having barbecues all the time. Every Friday, all of the joes [junior level enlisted soldiers, usually in their late teens and early twenties] would come over to Pop's house." Lee happily referred to himself in the third person by his beloved military nickname. "I would be grilling for all of them, like the whole unit. All of us and them, we would eat and drink until we couldn't drink no more. Beer pong all night or until we blacked out... You remember those days, right? Everyone would crash at the house, ya' know, too intoxicated to even walk. Don't need any trouble from the MPs [military police]. They all loved coming to Pop's house. I must have bought several hundred dollars of meat and beer. Every Friday."
“Wow, that sounds like you really offered the guys a place to go,” I interjected. “When did it end?”

“Well, I had to case the colors on my last unit, ya’ know,” referring to how he had to close up the unit. “Had to account for everything so we could disband the unit and find new homes for everyone. It was damn depressing. That’s how I ended my career, everything died. The whole unit, gone.”

After a short silence, I asked, redirecting back to the topic at hand, “The drinking has always been an issue?”

“No, not for me. We all did it. That’s what you do.” Lee said almost defensively.

“So how much alcohol are we talking about?” I questioned in a non-confrontational manner.

“Oh ya’ know, a case every night or two or a half gallon of the good stuff. We all have seen a lot, and it makes it easier this way, I guess,” Lee explained.

“A lot in the terms of war, loss...?”

After looking at me for a good 30 seconds, Lee said, “I don’t know—I guess we all just... Want to pretend it isn’t there.”

“Does that work? Does it make it easier?” I continued to prod Lee.

Chuckling, he stated, “Funny, I guess it doesn’t—just makes more issues, I expect.”

“And the blackouts, when did they begin?”

Lee took a deep break and sighed, looking at me for a bit of a reprieve. “I am not sure, I can’t remember. [Laughing.] I guess when I joined the military. Anyway, that is not why I am here. I just really need to control my anger, and that is what I need help with. I can control what I put in my body.”

As much as I was not fond of the treatment objectives and methods for how to reach them, I respected Lee’s goals and boundaries for his treatment. Inwardly, I hoped I would be able to ease him into exploring more of the underlying issues as treatment progressed and as a solid therapeutic alliance was built.

About a full month into treatment, Lee had finally admitted his hidden agenda: that his true motivation was his lawyer’s insistence that he get into therapy in order to demonstrate mitigating factors in court, pending DWI charges. Lee had previously sworn to himself that he “would never talk to a shrink again” and elaborated on some of his experiences with “bad medicine” that comprised therapy in Lee’s mind. He explained that on one occasion he was desperate enough to reach out for help at an Army facility; he was expected to talk about his issues on their rigid time-limited schedule. He was upset with the depersonalization and lack of control he had in therapy, and he felt like “just another Joe,” checking off the blocks. Feeling depressed? Yes. Trouble sleeping? Yes. Please state your name, rank and command... A review of symptomology without regard to causation. He also talked about how he felt pressure to downplay his symptoms or face losing his career and promotions. Confounding the issue was the lack of confidentiality between his therapist and command. He was upset that his commanders knew he was having a hard time going through a divorce post-deployment, after discovering his wife’s infidelity. Separation between his professional life and home life was virtually nonexistent, again begging the question whether or not the military employer is the most appropriate one to aid the individual when, and not if, a conflict of interest rises between the person and his or her profession.

Stories of Lee’s reportedly incompetent therapy were copious, especially given that the number of sessions was so few. All things considered, I was quite happy that Lee was actually giving therapy another chance and not just listening to his lawyer’s advice anymore. As time passed, I continued to gain insight into his complicated resistance. Although the trial date for the DWI came and went, Lee opted to remain in treatment an additional two months, as he was “feeling better and doing better than [he] thought”. Our individual therapy was in addition to his required substance abuse treatment, which was court-mandated, following conviction of his DWI charge. In addition, he admitted that he, “really didn’t believe in therapy until coming in.” Indeed, his buy-in to the immediate benefits of therapy felt like a small victory but not the larger one that I had hoped for on Lee’s behalf.

Lee came to weekly sessions religiously for four months. We closed the sessions once Lee felt like his life was manageable again, with the crisis subsided. Lee believed he was now equipped with a greater knowledge of himself and a greater awareness of triggers and how to prevent and cope with crisis and adversity. We were able to develop techniques to control, reduce, and channel his anger in a positive way. Together, we developed his communication skills to allow him to better convey his wants and needs to others and were able to cease his problematic drinking, which otherwise resulted in an inappropriate release of emotions when inebriated. With this, we terminated treatment, and I extended the offer for Lee to come back when he was ready to explore
some of the root causes contributing to his anger and his maladaptive coping with alcohol.

Roughly a year later, Lee was again sitting across from me, pledging an affirmation after recounting all he could of the violent choking of his wife. “You were right. There is a lot more here to deal with. I am ready and I am not holding back. Not this time”. While it was unfortunate that this realization came at the cost of a brutal episode of domestic violence, I was excited that Lee returned at all.

During Lee’s account of that horrific night, he was very matter-of-fact, unemotional, aloof. In fact, Lee has always presented as strong and emotionally indestructible. Perhaps it was the many military deployments, traumatic childhood experiences, deaths of soldiers, and losses of friends. Quite possibly, this emotional numbing was the only way Lee knew how to cope with life. As Litz et al. (1997) describe, “Emotional numbing in posttraumatic stress disorder is a cluster of debilitating symptoms involving problems in the experience and expression of emotion.” They further state, “symptoms may result from chronic avoidance of environmental and experiential reminders of the trauma, which could reduce exposure to emotion-eliciting situations or serve to suppress the internal experience of emotion” (pp. 607–608). In Lee's case, emotional numbing looked like indifference, the inability to connect with emotional experiences in life, and the incapacity to grasp the pain he caused.

This story of Lee's outburst was certainly not representative of the intellectually acute, exceedingly personable, and generally likeable Lee that I knew. It was not the same man as he initially presented. As his therapist, I could envision him protecting his country and being a great and proud warrior who was afraid of nothing. I could not, however, picture this man before me, with his strong, chivalrous ideals, committing these acts on a woman.

As with most people, I, too, had a visceral response to the violent descriptors of the event detailed in Lee’s session. Being aware of my countertransference, I allowed for a continued moment of silence to reflect on the gravity of the situation. Knowing that all he has wanted in life was to belong and have a family, I knew this was Lee fighting himself and his demons. He was making sure to self-sabotage any chance he had at a “normal life” in an attempt to nullify his emotional vulnerability.

In this first return session, we immediately engaged in the therapeutic process following the processing of the violent event. Certainly, I was more than happy to assist Lee in the deeper exploration to understand these harmful patterns in his life. Lee described how he was motivated by the recent separation with his current wife and his ultimate desire to understand himself in order to correct and prevent any more reoccurrences of his unacceptably violent behavior.

As we concluded the first session following the violent incident with his wife, I had Lee identify positive aspects and support figures in his life, assessed for safety, and put a safety plan in place. Two sessions later, I felt like Lee was ready and was thus given his first homework assignment. This was done in part to address resistance, with a secondary benefit of empowering Lee in the therapeutic process by having him identify life events that he deemed appropriate for further exploration. My request was for Lee to complete a timeline of life events that stood out for him, both good and bad. The assignment was left open-ended, as I wanted him to interpret and identify the important events for himself. Lee, being the overachiever that he was, emailed me his timeline three days after the assignment so that I could review it well in advance of his next session. In his trademark fastidious fashion, Lee neatly and objectively described his life starting from the age of three onward.

Upon receiving the timeline, I was both alarmed and disheartened to read his matter-of-fact, emotionless statements that comprised his life. I slowly read the pages of his disjointed life events, perplexed that so many of them had not been so much as mentioned, even in passing, like the memories of how his mother held his father at gunpoint in front of him or the countless, savage beatings he and his mother had endured at his father’s hands. In several sessions, Lee recounted one such story:

“I remember one time when my mom caught my dad cheating on her. Mom grabbed a butcher knife, chased him around the house. She finally caught him and stabbed him full-force, right in the arm. My dad slowly pulled the knife out and casually inspected it, as if it hadn't hurt a bit. He was just bat-s**t crazy. Calmly stating that the knife was dirty, he made me go and get a lighter. He used it to burn the knife clean. He then made me watch—yelling every time I turned away—as he cut a thick sliver out of his arm right on the spot. He was determined to 'make a man' out of me. Crazy bastard. Mom and I were just standing there as he hands me over a half-inch piece of his goddamned arm to dispose of it, as if
the stabbing wasn’t enough. This was his way of punishing us. Sometimes, I had wished she would have shot or stabbed him to death. Not that she didn’t try a million times.”

“How old were you?” I questioned.

“No more than eight”, Lee answered thoughtfully.

After a small silence, I continued, “So your normal life experience has been crisis?”

Lee replied, “I guess so. I have never really thought of it like that. Maybe that is why I did so well in the Army?”

Elated with Lee’s newfound introspection, I continued my questioning. “I am sure the horrors you have survived have helped you in other ways. I hear you are tired of life repeating itself and that you want this to change. Do you think this relationship pattern may have started in childhood?” I gently pushed Lee to continue his thoughtful self-analysis.

This idea was novel to Lee, and he spent a few moments contemplating it. Apparently primed for childhood recollections, Lee continued with a second story:

“Ya’ know, I remember coming over here from Vietnam. We were getting off the plane after landing in the U.S. for the very first time. My dad’s parents were there, waiting for him. We got off of the plane, and they immediately looked straight at me and my mom and said, ‘Go home, Gook.’ At the time, I didn’t know what it meant—it was the only English I had ever heard. Happily, having learned my first English words, every time I was at school or outside where the neighborhood kids were, I would say, ‘Go home, Gook,’ to all of the white kids, thinking at least I knew something to say. I mean damn, I was an idiot.”

Lee was really down on himself, and his shame somehow emanated throughout the room. I was quick to reassure Lee, “You had no idea. You were just a child.”

“Ya’ know, all that time, not one person, not one teacher, not one single person pulled me aside and told me what that meant or not to say it. Not even my parents. No, I didn’t know. But boy, do I feel stupid. I didn’t fit in anywhere, and I still don’t.” At this point in the discussion, Lee looked tragically broke and vulnerable, a rare occurrence during our time together.

Also memorable to Lee was that he was made to attend three years of speech therapy to expunge his Vietnamese accent, which he was told was “not appropriate” for a rural South Carolina school in the 1970s. In retrospective conclusion, Lee stated that he did not fit in anywhere and everywhere he went, someone bullied, harassed, and attempted to physically harm him. Except for the army, where he was a soldier, like everyone else, one of the same. To him, that was home.

Overall, Lee admitted that the creation of the timeline was emotionally taxing and stated that he never took the time to realize all the things that he had endured. “I just kept on pushing, trying to forget, trying to make my life... me... something different. I haven’t escaped any of it, have I?” We began to process some of these occurrences that Lee singled out. Crying, he looked at me and said, “I have wanted my whole life, just to be loved and accepted. I will never get that.”

I explained to Lee that his emotional response is not unusual—that combat vets often have difficulties making meaningful emotional connections after the intense “closer than brother” camaraderie that he experienced in the military (Finley, 2011, p. 108).

Subsequent sessions focused on more detailed personal exploration of Lee’s traumas and motivating factors. Lee had been able to cope with the many major traumas in his personal life while remaining highly successful in his professional life. However, when alcohol was introduced, Lee was unable to control his repressed anger. Uncontrollable violent acts ensued, where no one was safe in those moments of Lee’s rage. Elbogen, Wagner, Calhoun, Fuller, and Kinneer (2010) state, “alcohol abuse mediates the relationship between PTSD and aggression and PTSD may be related to anger and hostility only when heavy drinking is involved” (p. 6). For Lee, the hostility loomed just under the surface and, as Elbogen et al. suggest, it was the alcohol itself that allowed Lee’s aggression out. This time around, Lee had finally verbally acknowledged his own powers of destruction and expressed a desire to prevent this loss of control, which was utterly humiliating to him. Additionally, Lee was able to acknowledge the years of repressed anger, sadness, and loneliness but was now equipped with a realistic, yet aggressive goal to confront these deeply rooted issues head-on. He was now ready to eliminate the enemy battalion.

Despite the initial strides made increasing Lee’s positive anger management, the more pressing issue of his alcohol abuse was slower to progress. Admittedly an alcoholic, Lee vocalized that, like all things external, he could quit alcohol on his own. Naturally, I was not particularly fond of Lee quitting alcohol in an uncontrolled and unsupervised environment due to the medical
issues associated with withdrawal. To confound the matter, he was quitting in an environment that housed an alcoholic friend who actively used alcohol. Upon my insistence, Lee and I consulted with his primary care physician on a close basis while he abruptly stopped drinking, to monitor for safety. As Lee predicted, this would be the seemingly easiest part of this journey. He quit the night of the incident that brought him back in for treatment and that was, in his opinion, the demise of his alcohol problem. Despite his affirmation to explore underlying issues, Lee once again elected not to pursue this issue further, as he felt like the "other emotional issues [were] of greater importance". As the clinician, I vocalized my concern for how Lee would replace the void that alcohol consumption temporarily and recklessly filled. Without an answer, Lee obliged my exploration of his maladaptive coping mechanism to better construct a more beneficial set of coping skills.

A Warrior in the Making

War stories and post-traumatic stress disorder are anything but new to me as a clinician working just outside of Fort Bragg. For Lee, trauma permeated every aspect of his early life, and his role as prodigal outcast primed him as an ideal military recruit, already malleable through his desperation for uniformity and acceptance. The perpetuation of Lee's traumatic experiences was ensured the minute he swore the Oath of Enlistment for military service. Unfortunately, domestic violence associated with military service members is also generally par for the course. According to the official Department of the Army (2012) publication, Generating Health and Discipline in the Force, the U.S. Army reported a damning 50% increase in the number of referrals for domestic violence cases and a 62% increase in the cases of child abuse between a relatively short timeframe of three years, between the fiscal years of 2008 and 2011. Furthermore, the report states a 54% increase in alcohol-associated domestic violence between fiscal years 2001 and 2011 (p. 146). From their report, many would argue that these statistics show that war challenges our moral fibers and that the current reintegration efforts are simply not working.

Lee is distinct in that he has had a life that has been spawned and entirely defined by war. Lee's continual exposure to war and violence, commencing from birth in a war zone in Vietnam, through a highly traumatic, militarized childhood, to multiple deployments as a U.S. soldier, and now as a military contractor were quite excessive and set a new standard for traumatic exposure. In a veteran-specific study, the prevalence of three main factors was considered to predict onset of PTSD syndrome, a long-term persistence of PTSD symptoms. Pre-war vulnerability (including reported physical abuse as a child and alcohol abuse within the family), wartime combat exposure, and involvement of the veteran in hurting others were all major factors in the development of PTSD. Interestingly, combat exposure was necessary, but not in itself sufficient, for the development of the disorder in this study. With an exceedingly high predictive value, a staggering 97% of those exposed to all three main factors reported developing PTSD. Additionally, the service member's age when entering the war was another substantial risk factor, with men under the age of 25 having seven times the likelihood of developing the disorder (Dohrenwend, Yager, Wall, & Adams, 2013). Based on this, Lee was essentially destined to develop PTSD. However, PTSD as a diagnosis was not a topic of discussion in Lee's case, as to pathologize him would have been to cast a scarlet letter and to further label him. According to Lee, "PTSD was for the weak and broken." Lee could accept being a "monster" much easier than being weak or broken. Furthermore, Lee thought that when warriors wanted or accepted PTSD it was to "screw the system" and "accept welfare," something Lee would never do, especially to the only family with whom he ever identified. Free of labels, our unhindered therapy sessions proved fruitful, investigating multiple aspects of Lee's life.

"So you're a Deployment Man," I stated to Lee at the start of our third month of renewed sessions, with somewhat inquisitive intent. While the term is of my own invention (to my knowledge, at least), the idea is certainly prevalent throughout military culture. Not that deployment to war zones is universally appreciated, but there are some service members who are known to flourish in this environment filled with risks and challenges. More complex than the simple "adrenaline junkie" seeking adventure and danger, Deployment Men yearn for the opportunity to be the protector, the crusader, or the hero.

"Yes, I love deployments," Lee said, having eagerly accepted the coined title. "Down range, I was in a family that I would die for and they would die for me. It was the only thing that ever made sense in this life." In an unusual display of emotion, Lee began tearing up as he revealed the death of...
family, as he only ever knew it. "I will never get to deploy again."

Lee’s feelings are not unusual in this regard. In Friedman’s (2006) case study, “Posttraumatic Stress Disorder Among Military Returnees From Afghanistan and Iraq,” regarding a recently deployed soldier, he states, “Mutual interdependence, trust, and affection forged in the crucible of ongoing life-threatening combat altered his sense of personal and social identity” (p. 587). An excerpt from yet another soldier’s story illustrates the sometimes-addictive nature that combat has on a soldier and the camaraderie that accompanies:

A few [soldiers] wish to admit to having a taste for war. Yet many men both hate and love combat. We know why we hate it. However, it is harder to know and harder to articulate why we love it…For veterans of all wars, combat has been one of the greatest passages in their lives. For those of us who have experienced war, as well as the camaraderie, that makes soldiers closer than brothers. (Campbell, 2006, p. 9)

Like the majority of active duty soldiers I have treated, Lee came from a broken home that was riddled with attachment issues, violence, and a poor foundation. Culturally, he was a minority who has dealt with adversity and yearned to find both a family and a purpose. Lee found all this and more when he joined the army. As an added bonus upon enlistment, life became simplified. Lee once stated, “In war you know your enemy, your objective, and mission. If you mess up, you die. You don’t think—you just follow orders. Not like life here [as a civilian], nothing is simple, nothing is straightforward.”

Relapse, Take II

Lee walked into the morning’s session grinning widely, towards the middle of his fourth month of continuous sessions. “I had quite the weekend,” he exclaimed with a crooked smile that made me initially wary. Skeptical of Lee’s version of sarcasm, I was immediately hesitant. Lee went on to tell me that the police and EMS were called to his home the previous night because he had yet another alcohol-induced blackout. He reported taking some pain pills and drank several beers, unsure of the quantity. He was again recounting from third-hand narration; this time, it was his roommate serving as storyteller. The roommate reported that Lee had destroyed his condo in an obsessive quest to locate his firearms and ammo, all the while cursing at his roommate who had rather effectively hidden these items from him. Lee stated his roommate said he was trying to find a gun to “blow my brains out.” Lee’s roommate called his sister, who in turn alerted the authorities, resulting in their prompt arrival at Lee’s home. Even when inebriated, Lee proved himself a skilled orator and managed to calm down and convince the police that he did not necessitate a hospital admission. Lee reported that until last night, he had not had a drink since the incident where he almost killed his wife. The reason for this misadventure was again centered on his spouse. Upset that he hadn’t seen the wife all weekend, Lee made the conscious decision to “get inebriated.” While obviously a major setback in recovery, I was appreciative that Lee was so forthcoming with the information. Utilizing motivational interviewing techniques and harm reduction principles, I endeavored to persuade Lee to understand the impact and consequences of using and abusing alcohol and other substances to cope with life.

In reference to his drinking, Lee stated that he understood what he was doing and what he was risking. To him, risking it all is still risking very little, betting with his life “all in.” Lee talked about the futility of life, how he has no one who “gives a damn about me,” and that “I have no one that I can talk to about this stuff, except you… Once a week, for an hour.” He laughed. We explored ways for Lee to expand his social support and discussed the value of requesting help from others. Lee continued to be resistant to this idea of being vulnerable or asking other people for help, stating, “Pain is weakness leaving the body… oh, and… Pain is temporary, pride is forever.” Again, he employed humor as he spoke. Lee has a penchant for using these types of silly, avoidant techniques when he felt uncomfortable and vulnerable. As it became a weekly ritual, I assessed for safety issues and re-confirmed that Lee’s guns and ammo were not in his possession. We left the session with a focus on safety and a blueprint for improving his social-support system. Because of the complex nature of this case, Lee’s progress was gradual, but gains were being realized.

In a later session, Lee had finally and rather abruptly appeared more open to the potential of reducing his alcohol use. Several sessions after the police house call, I asked Lee what he thought was the primary barrier to mending the marriage with his wife, in his wife’s opinion. He smirked and said,
“My drinking… I should not drink at all, even though it is nice to have just one sometimes. I shouldn’t open that door”. To which I asked him, “Do you often just have one?” With a chuckle he stated, “No, that’s not why I drink.” Finally, a moment of insight. According to Tatarasky and Kellogg (2010):

Integrative harm reduction psychotherapy has the goals of identifying the psychological, biological, and social currents that contribute to the addictive process, clarifying the multiple meanings of the substance abuse, and individually tailoring psychotherapy to the unique needs of each patient. (p. 123)

This was an obvious fit for this case, as it complemented the current therapeutic framework that we had been utilizing, and it also appreciated Lee’s autonomy.

After examining possible triggers and processing events and consequences of his drinking, we then came up with a plan to assist Lee in his desire to reduce his alcohol consumption, all the while continuing to utilize the harm reduction principles. While Lee frequently vacillated on whether or not to aim for complete abstinence or merely a reduction of binge drinking, at least he had finally acknowledged that his drinking was a problem and a major risk to his marriage.

Selection of Therapeutic Modality

Looking back, the progress that Lee has made is nothing short of remarkable. His case began complex and, with time, became nothing short of convoluted. Lee’s needs were multifaceted, and it was immediately apparent that he would benefit from an integrated approach, incorporating therapeutic components from multiple suitable modalities. To aid in decision-making, patient choice, and intentionality, I had Lee fill out a Multidimensional Survey for Psychotherapy Clients (Brooks-Harris, 2007). With this information in hand, along with my clinical impressions, I formulated a plan utilizing the multi-theoretical psychotherapy (MTP) framework. According to Brooks-Harris, “MTP is a pluralistic and pragmatic approach to psychotherapy, drawing upon diverse theoretical perspectives and identifying practical strategies from each other” (Brooks-Harris, 2008, p. 2). In practice, I have found that the framework is a highly effective means to conceptualize a case and employ interventions into practical use in an intentional way. It is a very straightforward tool to aid in putting theory into practice, as it acts as a guide and assists the patient in understanding and giving informed consent to the treatment he is receiving. For Lee, it provided a highly objective and structured format that he could easily engage with and understand.

However, it is prudent to be aware that clinicians cannot choose an integrated approach alone and expect success without first establishing the therapeutic alliance. I contend it takes a recipe of factors to effectively treat patients. Some factors we, as the clinicians, are in control of and others we are not. Mental health therapy is as much an art as a science and necessitates a strong therapeutic rapport, a menagerie of tools, a complicated theoretical and philosophical approach, a cultural lens, and involvement with and attention to environmental factors to include case management where indicated. As the therapeutic rapport gradually developed between Lee and I, we were able to lessen the rigidity of the MTP framework to allow for fluidity to engage Lee’s individuality and needs as they presented. While MTP was a useful frame, it is not the focus of this paper but a mere example of a tool that had therapeutic value in Lee’s particular case.

As a clinical social worker that practices patient-in-environment, I believe that the single most important factor in therapy is the therapeutic relationship. Certainly, the research supports this (Safran, Muran, Wallner, Samstag, & Stevens, 2001, p. 41). The relationship is what keeps patients coming back for continued therapy and allows for vulnerability and trust. If you put a manual between a patient and a therapist, there is no bond and no relationship. Instead, there is a protocol that may complicate trust, growth, and the therapeutic alliance. A manual can also force a patient to look at traumas when they are simply not ready.

While I could cite voluminous examples of therapeutic failures in service members, I elected for the use of integrated MTP with Lee for several reasons. With this approach, the patient has a conscientious choice and decision-making capabilities in the treatment planning. Lee was informed of what orientation we would be using and what the intended outcome was, allowing him to have power and choice in the process, a required element for his success and buy-in. He would also not be rushed and limited in session number, as with therapeutic modalities employed on base and the VA.
Prolonged Exposure (PE) is one of the few "government-approved" modalities. According to Navy Capt. Paul Hammer, MC, director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, "We have to come to terms with the fact that exposure-based therapy is really difficult stuff for both the patient and the therapist, too...It’s more like chemotherapy than just giving someone a pill for pneumonia" (quoted in Levin, 2012). I understand that desperate times call for desperate measures. However, chemotherapy is not a first-line approach to cancer, and it is always the patient’s choice to receive this treatment or opt for another. It is my experience with active duty members that they often do not get a choice on what treatment is used and how it is used. The Captain’s metaphor is perhaps less critical than it should be—even with chemotherapy, the treatment is tailored to the individual as opposed to the military’s manualized system and exposure therapy. I am not saying that PE does not have its place (it has most certainly been beneficial for many), but I am suggesting that we do not experience and react to trauma in the same way so we cannot be treated in the same way, either. In a somewhat questionable attempt to think outside the box, the DoD appears to have developed a newly vested interest in mobile app programming and the creation of psychodramas, comics, videos, chats, texts, etc. to try and combat this issue of military trauma. They have spent millions of dollars on this effort and that should be applauded. However, it is my personal opinion that it is all well intentioned but missing the mark (U.S. Department of Veterans Affairs, 2014).

**Case Theory**

Due to the ever-changing behavioral health environment, demands on managed care, and the complexity of patient issues and practice theories, the field of mental health counseling (and in my particular case, clinical social work) is trending to a more integrative or eclectic approach (Norcross, 2005). I would argue that we cannot expect to make sense of such a complex world or provide for unique patient needs through a singular rigid lens or theory. To say only one theory is applicable one hundred percent of the time is to disregard the individualized complexities of the human mind and experience. Furthermore, the systematic and thoughtful use of the MTP approach was crucial to the successful initial treatment of Lee, as he needed to initially have a blueprint for treatment to ensure his buy in. The MTP approach is not merely a random pick-and-choose buffet of theory and strategies, but instead incorporates thoughtful assessment and application of many leading theories in an individualized plan in an intentional manner (Brooks-Harris, 2008). This dynamic therapy provides for the ability to meet patients’ needs with a broader theoretical framework, resulting in some of the most personalized and informed treatment available.

Also of note in this case, I did not utilize the highly studied sequential model that requires a sustained abstinence from substances for a period of time (typically six months). I utilized an integrative treatment model where both disorders, mental health and substance abuse/dependence, were simultaneously treated (Back et al., 2012, p. 690). This model was required to treat Lee, as his mental health and substance abuse issues were so intertwined and interdependent with the other.

In large part, it is the clinician’s job to allow for patient self-determination and goal setting. Although I may not have favored the exact progression of this case, I do believe that without the flexibility and adaptability of MTP, Lee would not have returned to therapy, and his outcome may have been far less favorable. Theory in the practice setting is much more difficult to record and carry out as it is embodied. It must be realized that practice does not exist in a vacuum, and a single theory or modality cannot realize the possible dynamics that exist in a practice situation. This has led me ultimately to practice with a multi-theoretical orientation, which I consider best practice.

Conceptually, MTP does not have to be the be-all-end-all, nor should it. It should be a valuable way to communicate and educate the patient and, together, come up with a patient-centered plan about which the patient can be informed and to which he can consent. In Lee’s case, it provided a structured approach that Lee required. The treatment plan should be dynamic and flexible, just as patients’ lives are. It should serve as a way for the therapist to narrate his or her intentions and for the patient to understand that therapy is intentional, scientific, and more than “smoking and joking.” It should serve as a way to measure progress and keep both the patient and therapist on task, with a mutual understanding of steps and goals. Certainly, a therapist may not be schooled in every possible modality, theory, or intervention, but he or she must always stay within his or her scope of expertise and continue to increase this scope whenever possible. Brooks-Harris (2007)
has “Skills Rating Worksheets” for clinicians to self-select skills that they feel proficient in and areas they are not in order to determine a treatment progression. If MTP is allowed to work based on the clinician’s strengths, it can be a wonderful and intentional way to conceptualize a case and work towards common patient-centered goals. Brooks-Harris (2008) lists five principles for integration, including: intentional, multidimensional, multi-theoretical, strategy-based, and relational.

The current emphasis for treatment of PTSD for military members is Cognitive Processing Therapy, Prolonged-Exposure Therapy (PE), or Eye Movement Desensitization and Reprocessing. While all are evidence-based practices and have a proven track record in treatment, I would challenge the singular thinking and always question what was missed when not looking at a patient through a holistic, multi-theoretical lens. In saying this, I do want to stress that some remarkable research and efforts have been undertaken to help this population. Clinicians who treat this population need to be mindful of the recent research and utilize the tools as appropriate. As social workers, it is important to meet the patient where they are and respect their goals. It is only through a skilled use of eclectic, integrated, or multi-theoretical approach that I feel this can truly be achieved. Where is the individual patient choice when sessions commence, are scheduled for precisely twelve sessions, and utilize only one (i.e., PE) of a multitude of potentially beneficial modalities? Here, patient choice simply does not exist. The highly trained therapist might as well be an automated technician, with eyes only for the exceedingly limited scope of traumatic combat exposure.

If we examine the way we train our elite combat forces, we can surmise why repetition and training passed exhaustion to allow muscle memory to kick in is effective. Psychologically speaking, we can also look at Freud's theory of displacement and understand it has a place in military training. If we can get a warrior in battle to react with aggression when scared or threatened, it is an amazingly effective tool. We train out intentionality and work relentlessly to ensure the chain of command is enforced. We have learned that so many of the characteristics for what makes a good soldier do not necessarily translate to a productive civilian. Unfortunately, the psychological techniques utilized to make a soldier cannot be so easily undone. Further, U.S. warriors do not become civilians, they become veterans, yet another identity and transition.

**Battle Buddies: The Battle Within**

“Get your head out of your ass and soldier up,” Patrick challenged Lee. He continued, “Either that or kick sand.”

Lee looked puzzled that he was being challenged—especially by someone of a lower rank. Lee angrily fired back, “Have you lost your damn mind, soldier?” Both men were uncomfortably chuckling at this point, as we were discussing the label of PTSD and how this affects a soldier.

“Well, I am pissed. Damn pissed that some nitwit half-brained psycho doctor, who has never served a day in his goddamn life diagnosed me with some hocus pocus PTSD bullshit,” Lee ranted angrily, leaning forward in his seat returning the challenge to Patrick.

“Look man,” Patrick said, more serious now, “You know that sometimes you just have to embrace the suck. Get all the intel possible and execute the mission. PTSD, battle stress, anger issues, alcohol abuse, its all the same. Come on. Look at us in this room—most of us on our third marriage and that one isn’t going well, either. Own it man, then fix it.”

Patrick was six, short months away from retirement, has shown to be a true leader, and was very serious about his philosophy of “identify, plan, and execute.”

“I mean, isn’t admitting you have a problem the first step in getting better?” Patrick looked at me for backup.

“This is a process—this is why we are here in the group. There is so much to learn from each other’s perspectives and strength in having similar experiences,” I explained. Yet, I also attempted to remain impartial and let the group process take root. At this point, Jeff also began to talk about his struggle with being diagnosed, knowing he was a proud and decorated warrior, but being virtually unable to function in a world outside of war and work. He had lost all of his friends and became completely isolated, refusing to talk with his family or see his children. Nightly, he was drinking himself to sleep and taking a slew of pain pills and sleeping medication prescribed by army doctors. He went on to describe some domestic violence issues he had had while Patrick chimed in and shared some violence that he too had perpetrated against his wife.
I looked at Lee to see where he was at in this whole process, and he had tears in his eyes. Lee simply said, “Thank you, thank you all. I thought I was a monster, I thought I was weak... Broke. I had no idea others actually felt this way and were successful in your careers.”

By the end of this session, we talked about physically and verbally attacking loved ones and how alcohol and the misuse of medication played a role.

Here in the group process, I really began to see mentalization take place for most of these men—where they’ve been able to evaluate the “whys” behind their recent actions and can even begin to extrapolate that knowledge to predict their own future behaviors. According to Palgi, Palgi, Ben-Ezra, and Shrir(2014):

Mentalization is defined as a form of mostly preconscious imaginative mental activity, namely the perceiving and interpreting of one’s own behavior as well as those of others as emanating from intentional mental states (e.g., needs, desires, feelings, and beliefs) ...individuals who suffer from PTSD experience a collapse of mentalization. (p. 173)

They were thinking about their thinking, something that I struggled in individual sessions with each one of them. Interestingly enough, being in the community and seeing fellow soldiers struggle with similar circumstances in the civilian world allowed Lee and the others to see things that they could not see in themselves. As Palgi et al. points out, the mentalization process is one key piece to recovery from traumatic stress symptoms.

**Current Issues Within The DoD and VA Systems**

There has been major attention in the recent months regarding the VA and military’s ability to effectively address the issues that plague these two major systems. From on-post shootings to fake, truncated waiting lists, the evidence speaks for itself. I do personally believe that both systems are doing the best they possibly can. But, as I have previously stated in this paper, such massive and burdened bureaucratic systems cannot possibly give the appropriate personal attention these men and women need. For these service members, they cannot be just another number engaged in the “hurry up and wait” game while also in the healing process.

In Lee’s case, he tried talking to a therapist on two occasions while “in service,” which, both times, resulted in discovery by his commanding officers. His fears of being passed over for a promotion and being questioned about his personal life at work made it so he never returned for additional appointments. Others in my current military group frequently speak of the inefficiencies of the military and VA system (acerbically referred to as the Veteran’s Adversary within my military group) and how it has made it difficult, if not impossible, for them to seek counseling.

MacLeish, an ethnologist who wrote his ethnographic dissertation at Fort Hood, writes of military medicine:

Indeed, in a way it is the primary goal of military medicine to maintain the interchangeability of individuals by restoring their broken bodies to a uniform standard, and even that would seem to have its depersonalizing dark side. Ultimately what it produces, however, is a confusion of means and ends: instead of the categories being instruments that serve healing bodies, the bodies become raw material for the satisfaction of the categories. And sometimes this satisfaction is accomplished by bending and rewriting the categories so that they can accommodate bodies that would not otherwise have been suitable. (2010, p. 151)

Here, MacLeish points out that the mission of military medicine is to fill positions and not to provide competent or individualized care. He continues later, discussing PTSD, “The diagnoses exists separately from the lived condition, not just because it fails to adequately encompass soldiers’ experience, but because soldiers know full well how readily the Army will bend and reshape diagnostic categories to suit its own purposes” (2010, p. 165). Certainly, MacLeish has some strong convictions concerning military treatment; however, these convictions are coming from our service members and their experiences and perceptions of military treatment. Military medicine is by no means incompetent or unimpassioned. It is, however, a bureaucracy that has a different mission than community-based mental health programs. I ascertain that the military has little incentive to deprogram its “raw materials,” restoring individuality, and should not be charged with the facilitation of the transition to civilian life.
Although I believe that soldiers and veterans should have a choice where they get treatment, I do believe that for disability benefits and fitness-for-duty evaluations, these systems are the most appropriate to lead in this process. I feel that the money and benefits cannot and should not be tied to the practitioner that treats the service member. This idea is not novel. According to The National Committee on Service to Veterans (1944), “It should be clear...that veterans are free to go directly to any agency they choose, without first going to the center” (p. 219). So, why in 2014 are we still wrestling with this idea of veterans being in charge of their care and services? Maybe if veterans were allowed some power and personal agency in their treatment, this would translate in their lives and aid in transitioning to a civilian. Further, Dr. Pratt comments about how a simple rule in the military system of “asking for help” is perverted and completely ineffective due to the bureaucratic nature and dueling interest of the military versus the person. However, those on active duty continue to be plagued by this line of thinking and, thus, do not receive the services needed, often at dire consequences (1949, p. 77).

Future Directions and Call to Action

Truly, this is not a war story at all. At least, not in terms of war in the sense of our country’s men and women against another’s. This war was fought within Lee and countless other service members and causalities abound. Lee’s childhood experiences were so traumatic that our country’s war in the Middle East brought Lee relief and structure. There were codes of conduct and rules of engagement that were clearly defined and followed. The consequences for not obliging were straightforward—kill or be killed. For Lee, like so many others, a game of Russian roulette made more sense than facing matters of the heart.

To Lee, the events of that night that brought him back into therapy were so clouded and depraved that he wanted nothing more than to neatly stuff them down next to all the other traumas he was holding. However, to stop reoccurrences of aggression and emotional pain, Lee had to dig deep and process the loss and hurt that he had experienced. He had to tear down and rebuild on a new foundation, one that was rooted in acceptance and love. Lee continues to make painful gains with the insight from multiple theoretical approaches; I believe that we have made very good strides.

Had Lee sought out treatment at the VA or DoD this time, the use of one unalterable, manualized approach would most certainly have dissuaded him from returning once the ink dried on his DWI letter. Government bureaucracies, such as the VA, employ an especially rigid version of manualized therapy, insomuch that it might be considered “militarized therapy.” While the one-size-fits-all approach has validity in the indoctrination process of forming a homogenous, “Army of One” entity, stripped of individuality (Britt, Castro, & Adler, 2006), it is antithetical to the restoration of the mentally well, contributing person. I argue that the depersonalization, rigidity of sessions, imposition of formality, and pressure for patient and therapist to conform to and experience the same pathway towards healing is overall unachievable.

In addition to questioning the specific modalities employed by the military behavioral health institutions, another series of questions are necessary: Can one get better in a structured environment that was a part of the traumas? How can the military effectively take someone who they trained to kill, trained to die, and then make them a fully functioning and peaceful member of society? I contend that this is a tall order. Healing needs to occur in an environment that is far different from the military structure—one that allows the soldier to build a new community and culture in the community to which they ultimately return. The military, where “you are not paid to think,” “if we want you to have an opinion, we will issue you one,” and “pain is weakness,” may not be the best place for a safe, therapeutic environment. Further, when symptomology and diagnoses are tied to benefits, monetary gains, early retirement, or being kicked out of the service, how can this become an environment that enables service members and veterans to be open and honest about their experiences? How can a clinician be asked to sort motives and simultaneously function as gatekeepers and healers? The soldiers under my care are comfortable in knowing that not only will nothing get back to their command but they will also continue to be promoted regardless of attendance. In my practice as a civilian, unaffiliated clinician, they are not a number but a person, unique and original. The military, I contend, cannot be this safe place. It must instill order, fear, resiliency, and strength in order to accomplish the mission. Entrusting outsiders with this monumental task is a huge leap of faith. Risk of political fallout, diminishing budgets, and loss of control are all very worthy reasons to keep the
status quo. In conclusion, a final question to ask: can mentally well individuals return to war as an effective soldier, be prepared to kill, and be prepared to die so easily? If the military were half as skilled at making a civilian out of a soldier as vice versa, we would be having a very different conversation. But, after all, that’s not the business they are in.

For Lee, a safe and therapeutic environment was created in our small, non-profit practice. He was seen as an individual with specific, individual needs and consideration. Equipped with specialized knowledge and experience with military culture, we work with the community and other clinicians to link them up to resources and services. In this environment, the healing can begin and the reintegration to a world that is far outside of the confines of the military can commence.

I would challenge practitioners to begin to think in a more multi-theoretical manner, all the while being mindful that the approach must include structure, intentionality, and be rooted in patient preference and a strong, trusting therapeutic alliance.

Concerning the issues related to military mental health treatment, I assert that we cannot fight a war overseas without substantial collateral fallout at home. I feel that it is our duty as social workers and clinicians to know and understand how the dynamics of being at war for over a decade has affected our soldiers, families, children, and communities. We all need to be aware of how to treat this population competently and to serve those who have answered the call. We also need to be clear on how to assess risk and put in plans that will effectively mitigate these risks.

Concluding this case study, I will leave you with a quote from Herbert Kaufman, from “Not Charity—But a Chance,” for the magazine “Carry On,” published in June 1918. Kaufman states, “A civilization that won’t do its duty by its defenders isn’t worth fighting for—prepare to prove that this one is. They don’t want your charity—they demand their chance” (p. 12). Kaufman wisely addresses the concern of making soldiers dependent on charity and the vast therapeutic value of people being independent and productive.

References


