The Potential of Person-Centered Therapy for Active Duty Service Members

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Abstract

The purposes of clinical social work services for active duty military personnel, are to promote individual and unit psychological readiness, provide support during duty assignment transitions, and intervene during periods of extreme stress. Evidence-based practices, are most valued, because the military invests time and money to credential and train social workers, to provide services that are likely to support the military mission. However, many service members do not readily seek help for their problems, and current practices based specifically on mission readiness may not effectively address many of the psychological stresses faced by men and the growing numbers of women serving on active duty. This paper argues, that person-centered therapy, may serve an important function in goal-focused military settings, because of its non-judgmental nature and valuing of the perspective of the client.

Keywords: Person-centered therapy, military social work, evidence-based practice

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Military service is demanding. The experiences of combat and operational stress are routine and even integrated into training environments to improve personnel's capacity to manage them. (Figley & Nash, 2007) Adaptation is highly valued and expected, although some personnel experience major challenges to coping with military life. These challenges include crises (such as suicidal ideation and the experience of victimization); individual, family, or unit level challenges (related to stress management, post-deployment reintegration, relationships, and communication); and issues such as substance abuse, domestic abuse, sexual assault, depression, anxiety, grief, and loss, and their subsequent negative effects on unit cohesion. (Council on Social Work Education, 2010) The major purposes of clinical services delivered to active duty military personnel are to promote individual and unit psychological readiness, provide support during duty assignment transitions, and intervene during periods of extreme stress.

Social work services in the military, are provided at all levels of intervention, including prevention (usually facilitated by large group briefs, psycho-educational support groups, and trainings), early intervention (provided at base military and family support centers and behavioral health clinics), and tertiary efforts (assessing, diagnosing, and treating mental disorders). The military has historically embraced empirically-based interventions focused on improving resiliency, coping, and adaptation to maintain mission readiness. (Figley & Nash, 2007; Freeman, Moore, & Freeman, 2009) Evidence-based practices are valued, because the military invests time and monies to credential and train social workers to provide services that are likely to support the military mission. However, many service members do not readily seek help for problems they are experiencing (Zinzow, Britt, McFadden, Burnette, & Gillespie, 2012) and current practices based specifically on mission readiness may not effectively address their broader range of possible stresses. (Street, Vogt, & Dutra, 2009) Person-centered therapy, while not officially endorsed by the military, could provide a means of assisting these persons and, in so doing, further enhance the goals of military social work.

Military Culture

All branches of the U.S. military, share aspects of culture that distinguish them from civilian culture. One important aspect is discipline, which forms the basis for the military’s organizational structure. Values such as loyalty, courage, commitment, honor, and self-sacrifice are important for maintaining order, especially in times of war. (Pryce, Pryce, & Shackelford, 2012) Additionally, customs are practiced to create and maintain common identities in the military environment. The emphasis on teamwork, esprit de corps, and group cohesion are important aspects of military culture. These characteristics are evident in military language (branch-specific acronyms and slang), rules governing civilian and military attire (which delineates leaders from subordinates), and expectations of certain interpersonal behavior whether the person is on or off duty. (Kudler, 2010) Adherence to a common belief system is required for successful adaptation to military life. Yet, cultural mottos such as “Army Strong” and “Semper Fidelis” may also prevent service members from seeking help for emotional problems for fear of being seen as weak, or unable to effectively master the challenges required to serve the organization’s mission.

The issue of stigma, represents a barrier unique to military culture, that may cause service members to avoid accessing psychological support. (Zinzow et al, 2012) Service members may avoid seeking help for fear of experiencing adverse consequences to their careers and negative judgments by others. (Pryce et al, 2012) They may perceive themselves as somehow deficient and not worthy of help. If care is sought, the military member may no longer be viewed as an asset to the unit. Some negative consequences of stigma, include increased suicide rates in the military population, now reported as occurring at a rate of nearly one per day. (U.S. Department of Defense, 2012) Those who have committed suicide have not all been deployed, but were typically facing issues related to financial or relationship problems. (Parrish, 2012) These problems may not be readily acknowledged, if the military person perceives behavioral health care as stigmatizing or a sign of weakness in character. Service members may also be concerned that mental
health services are not confidential. Understanding these aspects of military culture may indicate how therapies not traditionally embraced in that system, specifically person-centered therapy, might be beneficial for many presenting problems.

**Person-Centered Therapy**

PCT is not a formally recognized treatment approach in the military behavioral health system, but it can be helpful in the formidable task of addressing moral injury and repair, relationship and psychological coping challenges often faced by those returning from combat deployments (Litz et al, 2009), issues such as discrimination and harassment that are unique to military women (Street, Vogt, & Dutra, 2009), and supporting those who might contemplate self-harm. Military social work practitioners are needed who can “work patiently to gain the trust of returning service members and attempt to understand what they have experienced during their deployment.” (Danish & Antonides, 2009, p. 1080) At present formal assessment, diagnosis, and cognitive and behavioral treatment approaches are widely accepted and used in military behavioral health practice (Freeman, Moore, & Freeman, 2009), but some active duty service members whose problems are not directly related to mission readiness may benefit from a less directive approach.

PCT facilitates a therapeutic relationship that supports the military person, with empathic responses and unconditional positive regard however the client defines the problem. (Rogers, 1986a) Its focus on self-actualization and congruence may increase the likelihood that military personnel will adjust to the challenges of military life by feeling better understood and accepted. Further, PCT may be helpful to service members who are struggling with spiritual issues made manifest by the circumstances of military life. One author writes that person-centered theory is a philosophy of living, suited to those who are in search of life’s meaning but may or may not be inspired by traditional religious thought. (van Kalmthuizen, 2008)
The purpose of PCT is to enhance a client’s congruence relative to a presenting challenge. (Rogers, 1957) The practitioner first needs to assess whether a client is capable of engaging in the approach. (Wilkins & Gill, 2003) If the social worker and client are in psychological contact, and the client can perceive the practitioner’s empathy, conditions are sufficient for constructive change. The social worker listens and responds with acceptance and empathy, and does not set out to diagnose, judge, direct, attempt to solve, profess to know precisely what is “wrong,” or claim to have clear answers to the client’s concerns.

The “person of the therapist” is the most important ingredient in the intervention. Its articulation of the appropriate nature of the practitioner-client relationship is, of course, considered by many to be PCT’s most enduring contribution. (Kirschenbaum & Jourdan, 2005) Throughout their interaction, the social worker respects, nurtures, and fosters the fragmented aspects of the client’s notion of self, while modeling an integrated sense of wholeness. More specifically, the social worker demonstrates the characteristics of empathy, unconditional positive regard, and congruence. (Rogers, 1957) By demonstrating genuineness, the social worker conveys a message of sincerely wanting to understand and work with the client. The social worker models congruence to the client, when he, or she is consistent in communicating feelings, thoughts, and behaviors. All of these qualities demand, that the social worker has a high degree of self-awareness and self-confidence.

The social worker does not utilize specific intervention techniques, but, by establishing the above conditions, provides a facilitative setting where the client can engage in more open and authentic reflection, to achieve greater congruence. The client feels increasingly free to express his, or her thoughts and feelings, the most significant of which, are about the self in relation to others. These feelings bring to the surface the client’s awareness of new potentials and the incongruity between current behaviors and the self-concept. The client’s self-concept begins to reorganize to become more congruent with his or her experiences. He, or she then reacts to his or her life experiences, less in terms of conditions of
worth and more in terms of valuing innate strivings toward self-actualization.

**Case Illustration**

Corporal Smith has served in the United States Marine Corps for four years as an infantryman. He successfully navigated the rigors of recruit training to earn the title of Marine and then, completed additional training to serve in the junior enlisted ranks as an infantryman. Corporal Smith is 22 years old, single, and currently assigned to an infantry battalion. Since joining the USMC, Corporal Smith has ‘hit the ground running,’ given the high and intense operational tempo that included intense trainings and participation in two consecutive combat deployments. He returned from his second combat deployment tour in Afghanistan, 12 months ago. Corporal Smith contacted a behavioral health practitioner, after speaking with his platoon sergeant about increasing anxiety and self-doubt that was beginning to affect his ability to focus on work tasks and left him with ‘awkward’ feelings of discomfort around peers. Corporal Smith was spending more time alone, isolated from social activities. He could not understand why he didn’t feel good about himself, in spite of regular promotions and no reports of misconduct during his time in the military.

Corporal Smith requested counseling, when encouraged by his platoon sergeant, who hoped the corporal might develop a greater sense of cohesion with the rest of the platoon. He also hoped that Corporal Smith’s symptoms, wouldn’t exacerbate to the point that his work performance began to diminish. After suggesting the referral, the platoon sergeant only wanted to know if the corporal initiated seeking help; he did not want to know anything about the corporal’s intervention, and thus the corporal had no immediate concerns about confidentiality. This threat would only have arisen, if the social worker noted a safety issue, or the corporal chose to share his process with others. The platoon sergeant would of course be alert to changes in the corporal’s demeanor, that might affect the platoon. It should be noted that the Marine Corps is the only service branch that does not have uniformed social workers, and the Navy provides these. Clinical social workers, who serve in the Navy, are

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always officers, likely at the rank of lieutenant or higher, but this fact does not appear to intimidate clients seeking services. While a rank difference could become an issue for a client regarding trust, it is also true that military personnel tend to feel more comfortable with military health providers.

While, as noted earlier, the military emphasizes the use of evidence-based interventions, any social worker, as a professional, may select an intervention that is suitable for a particular client. Lieutenant Harper, based her choices for intervention, on each client’s assessment, and she was open to the use of PCT. In their first session, the social worker focused on building positive rapport, conducting the assessment, and affirming Corporal Smith’s perception of his experiences and view of the problem. Her history-taking, included learning about any aspects of Corporal Smith’s history, that he was willing to share. Lieutenant Harper attempted to interact with the client non-judgmentally, explicitly demonstrating positive regard and acceptance. Their rapport resulted in her acquisition of a comprehensive personal history.

The social worker determined that Corporal Smith’s problem was not significant to the performance of his duties, but was related to general issues of self-esteem, and thus, she decided to proceed with person-centered therapy. She was required to consider a diagnostic classification, given military protocol, although PCT recognizes that diagnostic categories tend to dehumanize and label individuals. Seeking opportunities to consider less stigmatizing ways to classify the client’s presenting symptoms, she recorded a diagnosis of Adjustment Disorder. The intervention proceeded successfully. An example of one of their early exchanges is described below.

**Corporal Smith:** “Today was horrible. I don’t feel like I measure up to everyone else in my platoon. No matter what I do it seems to get worse. I just don’t get it.”

**Social Worker:** “I understand that you feel horrible. This can be a challenging time for you and I wonder if you may feel afraid, not really sure why you feel this way and not knowing what is wrong.”
Corporal Smith: “I don’t like to feel afraid, I am supposed to face fear. I don’t like feeling like I cannot control how I feel about myself and don’t want to talk to anyone because I feel like no one around will understand how I feel or tell me I’m an idiot for feeling this way.”

Social Worker: “Right now things may seem like they are too much for you to handle and you feel like you have no one you can open up to that understands how you feel, so it makes sense that you don’t see the point in sharing how you feel with them.”

Corporal Smith: “Yes, they just don’t get it. Maybe I’m just not worth even listening to or someone else caring about.”

Social Worker: “I believe you are worth listening to and being cared about. I think it’s good that you come for sessions and share your thoughts and feelings. It takes courage to reach out and share who you are with others. I believe you are capable of making your own decisions about who you want to speak to and when it is the right time to do it.”

Corporal Smith: “Why would you be confident in my abilities? I’m afraid I am screwing everything up and you aren’t.”

Social Worker: “You are competent and capable of determining the right choices for you.”

Corporal Smith: “Well I could try to think that way and maybe even start to believe it one day. I really want to believe that I am worth it and can feel good about myself and my decisions.”

Social Worker: “Your courage to try is impressive.”

Lieutenant Harper focused on hearing Corporal Smith’s perspective with unconditional positive regard and empathy, and creating a comfortable space for him to explore and express himself without worry of judgment. This approach enhanced Corporal Smith’s potential to value his thoughts and feelings and decide when to interact with others and what to share about himself. Corporal Smith regained a sense of personal control in his life and became more open to relating with others. The intervention proceeded for five session and resulted in the Corporal’s enhanced acceptance of
self. This improved his ability to engage with others and confidence in his abilities to perform his work tasks.

**Evidence of Effectiveness**

The American Psychological Association, has systematically evaluated the significance of the practitioner-client relationship in determining intervention effectiveness. (Norcross & Wampold, 2011) The emphasis on treatment specificity, puts PCT as a “complete” intervention at a disadvantage, as it is considered too general in its theoretical position. Still, a panel of experts concluded, after a series of meta-analyses, that relationship variables consistent with PCT were demonstrably and probably effective. To summarize five decades of research on PCT, it has been found that the relationship between the client and practitioner, in combination with the resources of the client (extra-therapeutic variables such as social and material supports), account for approximately 70 percent of the variance in successful intervention, with specific technique accounting for only 15 percent of the variance. (Miller, Duncan, & Hubble, 2005) That is, effective intervention is predicated on the nature of the practitioner-client relationship in combination with the resources of the client, and technique may add relatively little to client outcomes.

**Conclusions**

The military emphasizes adaptation, resilience, teamwork, biological, psychological, social, and spiritual well-being, as well as prevention of tragedies such as suicide, domestic abuse, substance abuse, and accidental death and injuries that may result from reintegration issues post-deployment. PCT may help build resilience, an essential ingredient emphasized by the Naval Center for Combat & Operational Stress Control (2012) and in Total Force Fitness to maintain the individual well-being needed to sustain military missions. (Roulo, 2012) It allows for a unique focus on how the military individual lives, perceives and reacts to stress, and develops insight about how his or her emotional well-being has changed. PCT
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represents a therapeutic approach for improving the member's self esteem, attitudes related to working with diverse groups of people, and leadership abilities by developing enhanced self efficacy and the sense of unit belonging. This form of therapy can assist members in developing a meaning and purpose that may otherwise not be addressed (or has changed due to traumatic military experiences) to better adjust to the military culture, perform their duties, and cooperate with others. These are all critical elements for service in the military to meet demands for mission readiness.

Certain behavioral health service providers in the military may perceive limitations in PCT, given that it is not behavior or performance focused. However, PCT may be useful for seasoned social workers who have a well developed sense of command culture, solid relationships with command leadership, and expert clinical judgment. When this is the case, the social worker will be trusted by the command element to make informed decisions that are supportive of the command's mission to readiness but also the client's own sense of well-being. For this reason the military would support the use of PCT as a method to achieve Total Force Fitness and Spiritual Fitness. (Jonas, Deuster, O'Connor, & Macedonia, 2010; Roulo, 2012)
References


