Treating Veterans using Animal-Assisted Therapy:

A Social Learning Theory – Based Proposal

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Abstract

Veterans are often seen as heroes but are very much of an underserved population. Upon returning from combat, many soldiers experience symptoms of mental illness such as post-traumatic stress disorder (PTSD), depression, anxiety, and addictions. Traumatic brain injuries (TBI) often occur with mental illness and exacerbate symptoms. Veterans face an increased risk of violence and homelessness, often due to untreated mental illness. The effects of symptoms affect not only the veteran but relationships with others. Even with so many veterans in need of treatment, few actually receive help for mental illness due to stigma or limited accessibility of resources. The proposed interventions include the social learning theory and animal-assisted therapy (AAT) as a means of providing education, changing stereotypes, reducing stigma, and encouraging change from non-judgmental helpers (i.e. animals). With training and treatment, it is hoped that veterans' symptoms will be alleviated and healthier lives can become realities.

Keywords: Veterans, mental illness, stigma, social learning theory, animal-assisted therapy.

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War and combat experiences have a way of changing lives in dramatic ways. Deployments can range in length but experiences during those times can forever change a soldier. For veterans, the consequences of combat can be long lasting. For some, the effects can be deadly. And yet, even for those who survive combat, what about life after the military? What about a veteran's quality of life? The disturbing possibility is that some will remain forever damaged by their experiences. Some may self-medicate in order to ease the pain. Some may lash out and become violent. Others may become homeless. Consequently, the question becomes this - what can be done to prevent or treat such issues? An obvious answer may be therapy but even that can be challenging for many veterans because of the many obstacles to receiving such help. For those who do receive help, what are the best modes of treatment? While the need for treating clients may seem to outweigh the importance of educating clients, both solutions should be examined because one can complement the other. While training for combat, soldiers have learned what is expected of them and how they should act, not only on the battlefield but also in daily life (Appiah, 2000; Campbell, 2008). For this reason, the social learning theory could prove to be of great help when educating veterans about stereotypes and social influences on behaviors as well as taking great care to empower veterans (Kaczinksi, Rosenheck, & Resnick, 2009). Addressing such lessons and ways of thinking and feeling could be an important part of therapy. One therapeutic approach that is currently receiving greater attention is animal-assisted therapy (AAT) (Klontz, Bivens, Leinart, & Klontz, 2007; Sockalingam et al., 2008). This approach combines the use of animals (e.g. horses, dogs, or cats) with therapy. In order to first understand what must be done for veterans, it is crucial to identify the multiple ways in which veterans

might be damaged from military-related experiences. By listen to their stories, the hope is that change will occur, not only in their lives but also within the military system (Brooks, 1991; Cully, Henderson, Kunik, Tolpin, Jimenez, & Peterson, 2008).

Overview of issues

Mental illness. It is impossible to fully cover all issues that veterans might be faced with during and after combat. However, certain issues have received widespread attention because of their prevalence among veterans. Post-traumatic stress disorder (PTSD) is one specific disorder that has been shown to be extremely rampant among soldiers returning from combat (Tanielian & Jaycox, 2008). PTSD involves the development of problematic symptoms in response to extremely traumatic events in which death was threatened or actually occurred. These types of experiences are often descriptive of combat situations. Critical symptoms used to diagnose PTSD are repeatedly reexperiencing the traumatic event, continued avoidance of situations associated with the trauma, numbing of general responsiveness, and ongoing increased arousal that did not exist before the traumatic event (American Psychiatric Association, 2000). Feelings of fear, helplessness, horror, distress, anger, and detachment make daily life an intense struggle for veterans with this disorder (Corrigan & Cole, 2008).

According to a recent study conducted by the RAND Corporation, *Invisible Wounds of War*, it was estimated that 1 in 5 of the soldiers, or 20% of the 300,000 soldiers surveyed, returned from Iraq and Afghanistan with symptoms of PTSD or depression (Tanielian & Jaycox, 2008). Brancato and Wheeler (2008) reported that one-third of veterans in their study reported hyperarousal symptoms. Another quarter of them reported reexperiencing their past combat events. Finally, almost one-third of those surveyed felt emotionally numb. Overall, 13% of the

veterans qualified for a diagnosis of PTSD. The high prevalence of PTSD among veterans demonstrates the need for treatment which is available, accessible, and effective for veterans.

PTSD has also been shown to often co-exist with traumatic brain injuries (TBI) (Corrigan & Cole, 2008). This disorder occurs when the brain is injured by a traumatic event, which can likely happen in combat situations. Neurological deficits produce several symptoms including disordered social behaviors, uninhibited emotions, slowed cognitive processes, and the inability to multitask. Even tasks that used to be simple can be overwhelming and difficult, consequently producing frustration (Corrigan & Cole). Among veterans returning from Iraq and Afghanistan, Tanielian and Jaycox (2008) found that 19.5% of veterans reported symptoms of TBI and 7.3% reported symptoms of both TBI and PTSD or depression.

PTSD and TBI are both disorders that are often form relationships with other illnesses, such as addictions. Substance use disorders, PTSD, and TBI are often found together among military as well as civilian populations for a variety of reasons (Corrigan & Cole, 2008). The appeal of substances, for example, is often the hope to make things better, even if the benefits are only temporary. Self-medicating behaviors can ultimately become a "have to" rather than a "want to." The most widely used substance is cigarettes which account for more deaths in the United States than any other substance (McGinnis & Foege, 1993; Mokdad, Marks, Stroup, & Gerberding, 2004). Boredom and stress often play a role in the development of a soldier's smoking habit while on deployments (Forgas, Meyer, & Cohen, 1996). While 14.3% of civilians smoke on a daily basis, 18.8% of veterans engage in the same habit. Another addiction which receives less attention is the addiction to prescription drugs. Zoroya (2008) reported that one-third of soldiers in the 509 Engineer Company at Fort Leonard Wood in Missouri were abusing prescription narcotics. Additionally, many of them were also illegally distributing the drugs.

Addictions to alcohol and illicit drugs receive much more attention. Wagner, Federman, Dai, Harris, and Luna (2007) found that even when taking into account age, gender, and geographic region, veterans reported higher rates of alcohol use than civilians. Approximately 56.6% of veterans reported using alcohol in the past month while only 50.8% of nonveterans reported drinking within the previous month. Of those studied, 7.5% of veterans reported engaging in heavy alcohol consumption compared with 6.5% of nonveterans. As for using marijuana, 3.5% of veterans reported using marijuana during the past thirty days compared to 3.0% of nonveterans. Additionally, 13.2% of veterans also reported driving under the influence of alcohol or drugs as compared with 12.2% of civilians. Overall, veterans reported higher levels of drug use, thus bringing about concern regarding the lasting consequences of combat and how to help veterans in need.

Effects of problems. Deployments and military service can ultimately change the families of soldiers. For some, family relationships might be strengthened by the separation. However, for others, relationships suffer and families experience negative consequences and dysfunction. Shaw and Hector (2010) found that although it was unclear how many veterans experience severe marital problems, many veterans in their study spoke of the high rates of divorce and family-related problems. Some possible causes for dysfunction within the families had to do with communication while on deployments. Greenberg and colleagues (2003) found that 98% of military personnel talked about their experiences with military peers. Another 95% reported talking to their spouses and 76% talked to other family members. Only 8% talked to medical or welfare professionals. Because deployments inhibit the accessibility of some of these resources, communications between families can break down, thus influencing the welfare of families.

Other ways in which the disruptions of deployments can affect relationships following deployments are the intense feelings of disconnection and detachment from family members (Shaw & Hector, 2008). Even though military members are now physically present with significant others following deployments, an emotional distance might still exist. Veterans might feel as if they are not able to relax or have fun, thus also limiting their interactions with others. Stress related to past combat experiences can disrupt both home life and employment by bringing about sleeplessness, anger, lack of concentration, and difficulty when interacting with others. Additionally, lack of financial stability may add to veterans' levels of stress, thus exacerbating an already intense and difficult readjustment to civilian life (Shaw & Hector). Finally, when soldiers with mental illness return home, readjustment might prove to be even more difficult than for soldiers without mental illness. Therefore, not only is the individual solider affected by combat experiences but also his or her relationships.

For struggling veterans, another possible result is becoming homeless. This well-documented problem (Gamache, Rosenheck, & Tessler, 2001) has been shown to affect a large number of veterans. In the 1999 National Survey of Homeless Assistance Providers and Clients conducted by the Urban Institute, it was reported that 23% of homeless individuals are veterans. Of homeless veterans, an overwhelming 70% of them deal with alcohol or drug use. Furthermore, 45% struggle with mental illness ((Brown, Campanelli, & Skinner, 2008). Mental health problems include but are not limited to disorders such as depression, PTSD, schizophrenia, and bipolar disorder. Often, addictions and mental illness occur together These are some of the many factors that may affect a person's unstable living conditions. Sadly, among the general homeless population, basic needs are often not met and 28% of homeless individuals report often not being able to afford food. Roughly 40% even went one or more days

within the last month without eating. Other problems besides hunger also affect the homeless. They are also at an increased risk of being victims of physical and sexual assault. Among homeless individuals, 22% have been physically assaulted and 7% have been sexually assaulted. Another staggering figure regarding the population relates to gender. A disproportionate number of males are homeless, making up 98% of the homeless population (Bur et al., 1999). These statistics reflect the problems for the homeless population, specifically veterans. Many veterans who become homeless do not receive the necessary help because of the thought that only the Veterans Affairs (VA) should and does assist veterans (National Coalition for Homeless Veterans, 2004). As a result, those in need of the most assistance often do not find necessary help, thus only perpetuating the cycle of dysfunction.

Mental illness and homelessness are extremely disruptive alone, but they can also play a role in exacerbating additional issues such as violence and disturbed relationships. Elbogen and colleagues (2008) found that there is a link between unstable living conditions and violence among veterans. This risk of violence was further elevated by severe mental illnesses (SMI) such as PTSD. The risk of violence was doubled when veterans with TBI also has PTSD. Examples of other forms of SMI included schizophrenia, bipolar disorder, and depression with psychotic features along with other psychotic disorders. Violence can be directed at self or others such as spouses and families or manifest themselves in other criminal acts. The shooting of eight people at Fort Carson, Colorado, by six soldiers has gained national attention as an indication of the worst possible scenario: hurting others because of hurting within oneself (Pine, 2009). With the high prevalence of mental illness and homelessness among veterans, the possibility of violence should be thought of as a social issue rather than strictly as a military issue.

Barriers to getting help. Even with the multiple reasons that veterans might have for getting help, a small percentage actually do. Although treatment may be available for veterans, the number of those who do not receive treatment is overwhelming. Of the 300,000 Iraq and Afghanistan veterans in the study by the RAND Corporation, as many as half of the men and women with symptoms of mental illness did not receive the care that was desperately needed (Tanielian & Jaycox, 2008). Other studies have also demonstrated the large percentage of veterans who do not seek treatment for mental health issues. Cully and colleagues (2008) found that 78% of veterans surveyed did not receive any treatment for symptoms of anxiety, depression, or PTSD within the year following their diagnosis. Essentially, only one in five veterans receive help for mental illness, thus demonstrating that treatment is not the usual course of action among struggling veterans and essentially "normalizing" silence and suffering.

As for addictions, the numbers are equally discouraging. According to the National Survey on Drug Use and Health (NSDUH) in 2003 by Substance Abuse and Mental Health Services Administration (SAMSA), only 0.8% of veterans underwent specific treatment for substance use even though 3% reported problems with substance abuse or dependence. However, this statistic only represented individuals in military healthcare facilities. A strong possibility is that this number is probably much higher due to substance use issues being under reported among veterans (Briggs & Reneson, 2010; U.S. Department of Health and Human Services, 2005).

The stigma of receiving help for mental illness and addictions is a well-documented problem (Briggs & Reneson, 2010; Campell, 2008; Hazelden Foundation, 2007; Pine, 2009). In order to be a strong soldier, seeking help can be a sign of weakness and should thus be avoided (Campell, 2008). The stigma of needing help prevents many soldiers from seeking it.

To admit that one is struggling with substance abuse could falsely indicate that the soldier is weak and thus possibly incapable of protecting fellow soldiers (Hazelden Foundation). Seal and authors (2008) compared the stigma of receiving help for mental health issues to an unofficial "Don't Ask; Don't Tell" policy regarding mental illness. In other words, it is better to suffer in silence than to possibly suffer backlash from others, including civilians or military personal, for seeking treatment. Many soldiers also fear that their careers might be damaged by such actions (Forrestal, 2008). The presence of negative attitudes and barriers allow one to better understand why a veteran might not seek help for mental health issues. Even if nonveterans cannot find the reasons for avoiding treatment to be rational, nevertheless, the reasons are serve a purpose, albeit dysfunctional and potentially harmful, for the veteran.

Once veterans make the decision to get help, an entirely new challenge exists which is where to find help. For some, this may mean accessing help from a local VA clinic. Some of the multiple barriers that can inhibit treatment are family, work, or school responsibilities as well as the location of service (Seal et al., 2008). Especially for veterans in rural areas, treatment might seem like an unrealistic option because of the distance between home and help for mental health problems (Ingoglia, 2008). In addition to this problem, a question remains – are the conversations kept confidential? In order to secure confidentiality, veterans will often seek assistance at civilian centers in order to avoid unwanted attention from military personnel (Lewis & McCarthy, 2007).

Another difficulty with getting help is the limited number of mental health providers within the VA system (Pine, 2009). The unexpected number of veterans needing help has overwhelmed and exhausted the military's resources. However, help for mental health problems does not come exclusively from the military and many veterans rely on non-VA assistance

(Wagner et al., 2007). Therefore, as veterans turn to civilian providers, the challenge can be to connect with a professional who is aware and open to veterans' experiences. Shaw and Hector (2010) asserted that while military psychologists deal with military clients on a daily basis, non-military clinicians might have limited experiences with soldiers and thus are unfamiliar with the psychosocial effects of combat. For this reason, community counseling centers are attempting to better educate and prepare themselves in order to better serve veterans (Brancato & Wheeler, 2008; Ross, Meyer, & McLaughlin, 2008). The additional services from providers outside of the VA system allows more veterans to receive help by reducing some of the barriers, such as privacy or distance to treatment, that have hindered soldiers from getting treatment in the past.

Methodological interventions. There are many methods of treatment that have been used and proposed for treating veterans with mental illness. Because so many veterans suffer from PTSD, TBI, and addictions, it is critical to examine the methods that have been shown to benefit individuals with one or all of these disorders. The comorbidity of these disorders has often challenged the idea that there is a single mode of treatment that is superior to other treatment methods and as a result, multiple models and methods have been used with veterans.

Cognitive behavior therapy (CBT) has been used to treat individuals with both PTSD and TBI. Corrigan and Cole (2008) reported that CBT is often used for those with PTSD by helping the client to address traumatic memories, change erroneous thoughts, and develop better skills for coping with anxiety. As for relieving symptoms of TBI, imaginal exposure to traumatic events, gradual exposure to avoided situations, and cognitive restructuring proved to be of some benefit for individuals with related symptoms. The CBT approach has also been used in conjunction with medication to treat symptoms of PTSD and depression (Seal et al., 2008).

Another approach to veterans' issues has been group and peer counseling. The VA has relied heavily on group treatment because of the increased number of patient-to-patient interactions as compared to individual therapy. The approach is also much more cost effective and patients receive more sessions for a longer period of time than in individual counseling (Cully et al., 2008). Peer support has also been recognized as a vital element of effective treatment for veterans. Another form of group counseling has been peer counseling, which has the advantage of utilizing leaders who have first-hand experiences of what many veterans are struggling with following deployments. Leaders can assist clients by strengthening social skills and providing vocational training (Ibson, 2008). Another benefit of these groups is that families can be an integral part of the treatment process by helping families connect with other loved ones in similar situations (Earls, 2008). In these approaches, veterans can learn from the experiences, struggles, and successes of fellow soldiers, hopefully encouraging and aiding recovery.

Briggs and Reneson (2010) proposed utilizing bibliotherapy and distance counseling as additional modes of treatment for veterans with mental illness. Bibliotherapy refers to the use of books as part of treatment. Patients can access these books on their own time and between therapy sessions, therefore developing skills and insight even when face-to-face interactions with a therapist are not occurring. Distance counseling can include both telephone and internet communications. The benefits of these approaches are that they can offer a more private means of treatment, especially for those who might otherwise avoid treatment because of stigma. Both approaches can also be accessed regardless of the client's location, hence alleviating some of the physical barriers to treatment.

Although CBT, group counseling, bibliotherapy, and distance counseling have been shown to often treat and alleviate symptoms of treating illness, they cannot be thought of as all-

encompassing forms of treatment and capable of treating every issue presented by veterans in need. Rather, there is a need to continue to evaluate other possible interventions. Two possible interventions involve evaluating and implementing social learning experiences as well as bringing animals into the therapeutic process. The first proposition is the use of education within the framework of the social learning theory. Because there is such a strong stigma among veterans regarding mental health, addressing stereotypes could possibly aid in reducing the stigma by challenging stereotypes (Campell, 2008). Education using concepts of the social learning theory has also been shown to affect individuals' attitudes (Demirbas & Yagbasan, 2006) therefore providing greater support for evaluating this approach with veterans. Finally, empowerment and confidence are associated with an increased chance likelihood of recovering from mental illness (Kaczinski, Rosenheck, & Resnick, 2009). The second proposed intervention is AAT. This approach has been widely used with diverse populations, various ages, and psychological disorders (Kawamura, Niiyama, & Niiyama, 2007; Kovacs, Kis, Rozsa, & Rozsa, 2004; Lefkowitz, Paharia, Prout, Debiak, & Bleiberg, 2005; Motomura, Yagi, & Ohyama, 2004). The use of animals has provided benefits such as decreased loneliness, depression, and increased levels of trust. For veterans struggling with similar symptoms, animals could possibly reach individuals who might not respond to other therapists or peers. It is valid to consider that these same factors could also help veterans and should thus be evaluated as playing a role in treatment.

These approaches have demonstrated success by alleviating symptoms of mental illness for several groups of individuals and with such a large number of veterans in need of treatment, the methods should be considered as another means of servicing this growing population. For this reason, AAT and the social learning theory will be evaluated for their effectiveness and

future uses within treatment. Hopefully, as veterans and their issues are better understood, the greater the likelihood that they will find relief from symptoms and a better quality of life.

Discussion

Social learning theory

The first proposed approach to treatment stems from the influence of the social learning theory. The social learning theory purports that behaviors are learned through the observation and modeling of other individuals. Not only are the behaviors are observed but also the consequences of those behaviors, either positive or negative (Bandura, 1977). Both the observed behaviors and consequences play a crucial role in the development of future behaviors, personal identities, and gender roles (Bigler & Liben, 1992; Bryan & Luria, 1978; Kay et al., 2009; Dereli, 2009).

Learned behaviors. As one develops and learns about him or herself, he or she also learns and makes assumptions about others. These assumptions may or may not always be true and yet one might make judgments based on stereotypes or socially-constructed and inaccurate beliefs (Appiah, 2000). For veterans, stereotypes and resulting stigma can dictate behavior by causing one to act in a certain way not because of what is true but because of what is socially expected (Campbell, 2008). The environment of the military is known to encourage strength and courage and is reported to be its own culture, incorporating distinct norms and roles. These factors strongly influence how likely a solider is to get help when he or she is struggling with a range of issues, especially mental illness, of which there is an even stronger stigma (Campbell). Many do not seek help for such disorders because of the stigma they face in their military environments (Briggs & Reneson, 2010; Campbell, 2008; Hazelden Foundation, 2007; Pine, 2009; Seal et al., 2008). Soldiers are strongly influenced by the modeling of others and the

training that they receive by the military. Even though such training is necessary to prepare soldiers for combat, there is also the possibility that what is seen by others becomes what is expected of self and fellow soldiers. Stereotypes are an example of how preconceived notions about others significantly influence personal attitudes and actions. Veterans are especially at risk of falling prey to stereotypes (Taranto, 2008). Whether it is the assumption that all veterans will return mentally healthy or that only weak soldiers, unlike the strong ones, are susceptible to problems, the stereotypes can ultimately negatively affect the solider by fostering an already dangerous stigma of mental illness (Briggs & Reneson, 2010).

Gender roles are especially sensitive to the influences of others, both by modeling and reinforcement, such as rewards or punishments. Children will pay selective attention to the demonstration of gender roles, thus perceiving and adjusting to similar roles. In other words, boys learn what is expected of boys and girls learn what it expected of girls (Bryan & Luria, 1978). The social information that children receive determines not only what they expect of themselves but also what they expect of others (Bigler & Liben, 1992). Adolescence brings about even more pressure from peers, family, and society in general to conform to prescribed gender-appropriate behaviors (Hyde & Jaffee, 2000). The expectations for genders continue long into adulthood, forming attitudes and beliefs about men and women. The thought is that because men or women should be a certain way means that they are a certain way, thus determining what is desirable but not necessarily what is realistic or absolute (Appiah, 2000; Kay et al., 2009).

Aggression is another behavior that is proposed to have a social component. Vicariously learned aggression by means of familial and environmental observations increase the likelihood that an individual will display aggressive behaviors in the future (Bandura, 1977). Additionally, in children, the use of strength or force is more likely to reoccur if the consequence is positive.

Their environments thus influence their behaviors but also their ways of thinking about themselves and others, even if such cognitions are erroneous (Dereli, 2009). This information regarding aggressive behaviors is especially critical to evaluate in considering problems for veterans, whose survival skills during combat may not end upon returning home, thus creating additional issues and possibly violent actions (Pine, 2009). Understanding how the social learning theory can help in changing ways of thinking and acting ultimately involves evaluating how the same theory can explain what led to the beliefs and behaviors in the first place. If soldiers are taught to fight and kill, it is no wonder that changing what has been drilled into them could prove to be a difficult albeit necessary task for practitioners who treat veterans.

Applications. Considering the multiple areas in which veterans may be challenged, it is rationale to consider how to help this population dealing with PTSD, TBI, addictions, or other forms of mental illness and behavioral problems. If social information can be strong enough to determine behaviors, might it be possible to change those behaviors using the factors that conditioned such attitudes in the first place? Bigler and Liben (1992) found that it was possible to revise children's views of gender roles with social training and the presentation of counter-stereotypic models. Dereli (2009) found similar results in regards to re-training individuals by concluding that social skills can be changed and improved with social skills training. Similar training has also been conducted with veterans. Perlman and colleagues (2010) found that veterans who participated in group treatments demonstrated increased levels of mental health and social role functioning. The increase was attributed to the mutual support, sharing, and social relationships that were offered by fellow veterans who could relate with each others' experiences. Training veterans as group leaders to work with other struggling veterans has also been shown to offer many benefits. Veterans are able to learn and strengthen social skills from

the examples and teachings of their veteran peers and leaders. This style of help can be effective because as veterans are able to relate to each other, they can better learn to connect to those important in their personal environments (Earls, 2008; Ibson, 2008). The verbal support that can be gained in groups can be a positive step toward healing by changing unhealthy behaviors (Ullmann, Krasner, & Collins, 1961).

Stereotypes of veterans should also be a focus of attention when using the social learning theory as part of training and treatment. Due to the fact that veterans will sometimes avoid getting help because of stereotypes (Campbell, 2008), evaluating the truth or lack thereof about stereotypes is essential for understanding the social components of attitudes and behaviors. Veterans face a number of obstacles to getting help including perceived military expectations, gender-related stereotypes, and the stigma of mental illness (Briggs & Reneson, 2010; Campbell, 2008; Kay et al., 2009). The stereotype of always being strong and the expectation that veterans should not succumb to mental illness means that many will simply not get help (Campbell). Therefore, it is imperative to address and evaluate the fact that stereotypes are simply that – stereotypes. Appiah (2000) contended that stereotypes are really just false beliefs about a group. Any actions that do not match the stereotypes are considered abnormal, unusual, and even wrong. Being that veterans are more at risk for stereotypes (Taranto, 2008), correcting them is an essential component of holistic treatment.

Much of the training in treatment that is proposed ultimately involves dealing with perceived gender roles. This is because of the purported relationship between gender roles and the roles of soldiers (Brooks, 1991; Fitzpatrick, 2010). Both men and women are subject to stereotypes and gender role blindness. Men face the challenges of adapting to a certain model of masculinity upon returning home. Toughness, strength, and the absence of all characteristics

considered to be feminine, such as emotions and feelings, are examples of the traditional male model (Deering & Cannon, 2005). Another example might be the traditional idea that men are meant to take care of the family which might lead to familial and personal dysfunction when male veterans feel as if they cannot even take care of themselves, much less a family (Brooks, 1991). Female veterans face the additional challenge of coping with a healthcare system that is still tailored to the needs of men. When the women do seek help for mental health issues, they often do not receive the necessary help because their concerns are still not fully understood or addressed by treatment providers within the VA (Fitzpatrick, 2010). For both male and female veterans, sensitivity to gender roles must guide the treatment process in order to combat not only the stigma toward mental illness but also gender-based stereotypes. While this is not to say that gender roles are the source of all symptoms, it is important to keep in mind that such roles might be a source of conflict for an individual, thus causing a need for addressing gender roles within treatment.

Aggression is another behavior that must be addressed during treatment. With such a large proportion of veterans with PTSD, TBI, and other forms of mental illness coupled with the finding that such disorders are linked to an increased level of violence (Elbogen et al., 2008), it is imperative to include education about aggression. Abbassi and Aslinia (2010) promoted emphasizing healthy adaptive behaviors and discouraging maladaptive behaviors in order to end the cycle of violence. They encouraged counselors to address the myths and stereotypes that often surround violence, such as the belief that violence is always committed by males when in fact females are also prone to aggressive behaviors. The incorporation of the family can also be used as part of the healing process by teaching the social component of the perpetuation of

violence. It is hoped that when education brings about insight, the aggressive attitudes which precipitate violence will be replaced with healthier means of coping during stressful situations.

A final discussion regarding the education of veterans from a socially-based approach is a proposal to develop individuals' levels of empowerment during treatment. Perkins and Zimmerman (1995) defined empowerment as encompassing wellness, competence, and strength. Kaczinksi, Rosenheck, and Resnick (2009) found that empowerment and confidence play a crucial role in veterans' recoveries from mental illness. Being that a great number of veterans returning from combat experience mental illness and personal problems (Tanielian & Jaycox, 2008), empowering them could hopefully not only alleviate symptoms but also stop the cycle of illness, addictions, homelessness, and violence among veterans.

Empowerment is important not only for individuals but also for communities. Perkins and Zimmerman (1995) concluded that empowerment is widely studied and that it can be an effective tool for helping communities solve problems, such as substance abuse. When more people within a community feel empowered, there is a greater likelihood that individual members will feel a greater sense of connectedness (Peterson & Reid, 2003). Thus, empowerment could play an important role in bringing together veterans who might be feeling isolated because of mental health issues, improving quality of life not only individuals but also for those in their support networks. Educating and empowering soldiers will hopefully improve the likelihood that soldiers will recognize and seek help for mental illness, addictions, and aggression. By empowering and educating soldiers about these problems faced by some veterans upon returning home, it is hoped that soldiers will realize the personal, familial, and social effects of the problems and receive the necessary support for healing.

Changing long-standing personal beliefs is not impossible but is difficult. Repetition is key for adjusting and correcting inaccurate or dysfunctional cognitions. In essence, one might be "re-learning" an entire lifetime of learned thoughts and behaviors, not just because of what one has experienced but also because of what an individual observed – the central component of the social learning theory (Hardin & Greer, 2009).

Animal-assisted therapy (AAT)

In the helping profession, especially the field of counseling, no one method or therapeutic technique is appropriate for every client. For this reason, a holistic treatment method that could serve as a valuable tool in a veteran's recovery is AAT. This method has been shown to be effective for a number of diverse populations. Additionally, the benefits of AAT have been demonstrated with individuals in various age ranges and with a wide number of psychological disorders (Sockalingam et al., 2008). Chandler (2005) defined AAT as the incorporation of animals into the counseling process as therapeutic agents. The animal often but not always belongs to the therapist and can be included in group and individual counseling sessions. Interactions with the animal can be structured or unstructured depending on a variety of factors, such as the abilities of the client or the purpose of therapy (Walsh, 2009).

Walsh (2009) provided support for AAT by addressing the benefits of the treatment. It was determined that much can be learned about a patient or client by observing his or her interactions with an animal. Patterns or behaviors and ways of coping can be seen in a natural and unobtrusive manner. During sessions, the animal will act as a metaphor for the underlying concerns of the client or clients. Stress and anxiety are often eliminated simply by having an animal present in both individual and group therapy. This is purported to be due to the fact that the ability to physically touch an animal reduces symptoms of hyperarousal and helps to calm the

individual, both emotionally and physically (Becker, 2002). Walsh stated that "animals act as a catalyst for a release and discussion of deep emotions and suffering" (p. 495). The benefits that animals can offer ought to encourage further discussion and research by clinicians about this therapy.

A variety of animals have been used in conjunction with therapy such as dogs, cats, birds, rabbits, and horses, but dogs are most often used due to their simple training, temperament, and the fact that less individuals have allergic reactions to dogs as compared to cats (Sockalingam et al.). Larger animals, such as horses, are also used in therapy. When horses are used, the therapy is called equine-assisted therapy (EAT) (Macauley, 2006). This form of therapy allows clients to work through unfinished business, relieves psychological distress, and correct dysfunctional patterns of behavior (Klontz, Bivens, Leinart, & Klontz, 2007). Another term for EAT is known as hippotherapy. As with other forms of AAT, hippotherapy involves addressing a person's physical, psychological, cognitive, social, and behavioral problems. In EAT or hippotherapy, the horse acts as a metaphor for developing personal empowerment by overcoming large obstacles and stressful life situations. A balance must be achieved between strength and control, both with the animal and with outside life, making therapy with horses as well as other animals a unique mode of healing and development (Becker, 2002). Animals may also serve a purpose in helping to reduce clients' resistance to treatment (Lefkowitz, Paharia, Prout, Debiak, & Bleiberg, 2005). This is especially important to consider for mandated clients whom might demonstrate strong opposition to therapy.

Populations. For victims of trauma, AAT has been shown to offer some relief for related symptoms. Lefkowitz and colleagues (2005) found that AAT was helpful for victims of assault by decreasing anxiety and improving the therapeutic relationship. The authors stated that for

women, trauma most often involves sexual assault. For these victims, trust in others is often broken, thus requiring special attention to how to best treat the individual in a safe and comfortable environment in which the client is at ease with the therapist. An animal may act as a tool to encourage security within the therapeutic relationship. This is especially important to note because of the fact that often, the strength of the therapeutic relationship has been linked to a better outcome in treatment (Sockalingam et al., 2008).

As for mental illness, AAT has been documented as helpful for individuals with mood disorders and schizophrenia. For those with mood disorders, especially depression, improved mood and increased optimism were reported following AAT sessions (Becker, 2002; Sockalingam et al., 2008). Additionally, anxiety levels were decreased and motivational levels increased. Among individuals with schizophrenia, increased levels of domestic and health activities were present after AAT sessions (Kovacs, Kis, Rozsa, & Rozsa, 2004), thus improving aspects related to one's quality of life. The number of patients' social interactions also increased. As the clients began to understand the animals, they also began to better relate to each other.

In the elderly population, AAT has been shown to offer not only cognitive but also emotional and social benefits. Kawamura and colleagues (2007) demonstrated that AAT helped to improve the mental functions of elderly adults dealing with a gradual loss of cognitive skills due to age. Banks and Banks (2002) found that AAT reduced widespread feelings of loneliness in elderly adults, especially those without strong social support networks. Decreased apathy has also been noted among elderly patients who received AAT sessions (Motomura, Yagi, & Ohyama, 2004). Becker (2002) observed that animals often increase their owner's quality of life by providing a source of support, trust, and companionship, especially for the elderly.

Finally, other individuals with whom AAT has shown some promising results are children and people with developmental disabilities. Developmental levels among children vary and for those who have not yet fully developed communication skills, AAT can offer a more age-appropriate form of therapy. Parish-Plass (2008) concluded that in children, AAT has been shown to provide additional "tools" that children may lack, especially concerning language or coping mechanisms. For children, interactions with animals can facilitate better self-control and improve their abilities to understand the feelings of others by first understanding and caring for an animal (Flom, 2005). Additionally, for those with mental retardation, AAT offers help by aiding the healing process for individuals who might not possess the cognitive skills necessary in traditional "talk therapy" (Becker, 2002). Another example of the effectiveness of AAT was documented by Macauley (2006) who found that AAT was helpful for individuals with limited speech due to stroke and aphasia. Not only was AAT found to be as effective as traditional therapy, but patients also demonstrated more emotions during sessions and looked forward to sessions in which the animal was present. Communications between members improved and clients were less likely to be hindered by their limited vocal abilities. This example serves as further evidence for why AAT could be useful in treating veterans who might otherwise be silent or unengaged in therapy.

AAT and veterans. Because of the effectiveness of AAT with other populations plagued by trauma, mental illness, or loneliness, the potential benefits of this form of treatment for veterans should be explored. Walsh (2009) stated that animals have the unique ability to help individuals during times of stress and crisis and to facilitate coping, recovery, and resilience. Bonds with animals can offer unconditional affection, comfort, and security. This is especially true for military families. During times of separation or relocation, such as deployments, animals

provided support and stability for their owners (Walsh). The healing that pets and animals can facilitate offers hope for veterans who might otherwise feel excluded and doomed to forever suffer from mental illness.

For veterans who have been traumatized by their combat-related experiences, AAT might prove helpful in aiding the development of trust such as is the case with civilians who have been traumatized in some manner. Physical and emotional trauma may occur as a result of combat but for female veterans, the trauma often involves rape and sexual assault. Fitzpatrick (2010) reported that 22% of women seeking treatment at VA clinics have been sexually assaulted. They are nine times more likely to experience symptoms of PTSD than those without sexual trauma. Because of such severe and possibly debilitating trauma, it seems appropriate to consider the possibility of AAT because of how successful the treatment has been with civilian victims of trauma, especially women (Lefkowitz et al., 2005).

Because a large number of veterans currently suffer from mental illness (Tanielian & Jaycox, 2008) it is imperative to consider other treatments, such as AAT, when past treatments have proved to be unsuccessful in alleviating symptoms (Lefkowitz et al., 2005). The emotional and physical benefits of AAT that have been demonstrated with patients with mental illness such as anxiety, depression, and schizophrenia (Becker, 2002; Sockalingam et al., 2008), might also prove to be helpful for veterans in need of help for mental health issues. The stigma of mental illness been identified as a major deterrent to seeking treatment in the military (Campbell, 2008). A major benefit of AAT is that animals do not see or care about stereotypes. Unlike people who might make judgments based on stereotypes, animals react only to the feelings of the individual (Pointon, 2005) without being impacted by inaccurate social standards of behavior.

Becker (2002) reported that animals can assist one in truly feeling emotions. Often, emotions can entail extreme sadness or fear. To allow such feelings would be awful because to feel those things would mean that control over them would be lost and thus the pain would be unbearable. In these situations, animals can serve as an example of how to experience feelings, rather than suppressing them, in order to release them (Becker). Just as the elderly might experience loneliness and isolation (Banks & Banks, 2002; Kawamura et al., 2007), so might veterans who feel as if no one is able to relate to their situations (Perlman et al., 2010). Animals can provide long-term relief from stress and social support by making the person feel loved and cared for without obligations or judgments (Lefkowitz et al., 2005). For veterans struggling with stereotypes and stigma (Campbell, 2008), animals might prove to be a non-judgmental companion in therapy.

Veterans may also be unwilling or unable to talk about their experiences (Greenberg et al., 2003) and possibly not had the opportunity to develop healthy coping mechanisms, such as is the case with children and individuals with developmental disabilities. Lefkowitz et al. (2005) concluded that one reason why AAT is effective is because clients do not need to possess social skills in order to communicate with an animal. Additionally, AAT has been shown to positively affect those with limited speech due to either choice or lack of ability (Macauley, 2006). This same principle could help veterans when communicating with others, thus hopefully aiding in the healing process by strengthening communication skills.

An additional benefit of AAT may be for veterans with physical disabilities following combat. For individuals with such disabilities, riding horses is often encouraged in order to promote better physical healing and recovery (Becker, 2002). For veterans with physical

disabilities, limitations are well recognized by people but not by animals (Lefkowitz et al., 2005), thus allowing healing without judgment based on physical abilities or lack thereof.

Conclusion

Utilizing AAT and education within the framework of the social learning theory could offer another avenue of treatment for a deserving population in need of help for mental illness. The number of veterans requiring treatment continues to expand (Tanielian & Jaycox, 2008) and with ongoing combat situations, it seems likely that these numbers will continue to grow. Even with the extensive amount of information concerning the proposed interventions for veterans, it cannot be assumed that these theoretical and treatment proposals will work for all veterans and several limitations exist for both the social learning theory and AAT.

Limitations

To begin with, regarding the social learning theory-based proposal involving education and training, much more research is needed concerning the effectiveness of this approach with veterans. Even though the theory has been shown to work well with children and students (Bigler & Liben, 1992; Dereli, 2009; Demirbas & Yagbasan, 2006), there has been little support for using this approach with veterans. Additionally, this approach may be difficult and time-consuming for practitioners and clients, due to the fact that changing long-standing attitudes and beliefs will not occur overnight and will require work from all parties involved (Hardin & Greer, 2009).

Even though AAT can play a positive role within treatment, the treatment may be inappropriate for some individuals because of a fear of animals or medical conditions, such as allergies (Minatrea & Wesley, 2008). For the safety of the individual as well as the animal, AAT might prove to do more harm than good in such situations (Lefkowitz et al., 2005). Additionally,

although it has been beneficial for many clients, it is not a miracle treatment and may not be the most appropriate option for all clients (Fischman, 2005). However, counselors might find other populations besides veterans in which AAT might prove necessary to increase both verbal and non-verbal communications within the counseling relationship (Minatrea & Wesley, 2008). Ultimately, practitioners must recognize and affirm the individuality of clients, thus realizing that no one treatment method is always superior to another, therefore proceeding with treatments that are most appropriate for an individual.

Implications for practitioners

It is evident that effective treatment is necessary for veterans with symptoms of mental illness. Regardless of what therapeutic approach or techniques are used in treating veterans, Shaw and Hector (2010) proposed five strategies for successful and empathetic treatment. First, it would be useful to learn what the veteran's job was in the military. This may help to give the practitioner a better picture of the client's military-related experiences. Second, clinicians are encouraged to explore the meaning of the veteran's experiences, both before, during, and after deployments. A third suggestion is to involve family members and significant others within treatment in order to support all parties involved with the situation. Fourth, it is imperative to re-define roles and daily schedules, being that while on deployments, military members' schedules are often set and specific to the day. Finally, it is suggested that practitioners determine the dangerousness of the veteran's experiences while assessing possible mental health problems.

In order for a veteran to experience healing and relief, one has to first get to treatment. This must involve addressing stereotypes and stigma. In order to provide effective treatment, it is imperative that mental illness be understood for what it is – genuine illnesses with painful symptoms that can be treated. The possible effects of untreated mental illness, such as violence,

homelessness, and relationship problems, have to be recognized as personal, familial, and social issues. In order to change the problem, one must first help the person. Treatment must come from both military and civilian practitioners. Stigma, stereotypes, and inaccessible resources cannot continue to be reasons for not receiving help for mental illness. The false expectations and stereotypes that keep many veterans silent have to be addressed in order to open the door for more veterans in need of help. Additionally, help does not need to only come from clinicians but also from animals. The lack of judgment that animals offer can aid healing for isolated and traumatized veterans. In conclusion, it is hoped that with better treatment, education, and research, veterans will receive the help that is very much needed and deserved.

References

Abbassi, A., & Aslinia, S. D. (2010). Family violence, trauma and social learning theory. *Journal of Professional Counseling, Practice, Theory, and Research, 38*, 16-27.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC: Author.

Appiah, K. A. (2000). Stereotypes and the shaping of identity. *California Law Review, 88*, 41-53.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.

Banks, M., & Banks, W. (2002). The effects of animal-assisted therapy on loneliness in an elderly population in long-term care facilities. *Journal of Gerontology, 57*, M428-M32.

Becker, M. (2002). *The healing power of pets: Harnessing the amazing ability of pets to make and keep people happy and healthy*. New York, NY: Hyperion.

Bigler, R. S., & Liben, L. S. (1992). Cognitive mechanisms in children's gender stereotyping: Theoretical and educational implications of a cognitive-based intervention. *Child Development, 63*, 1351-1363.

Brancato & Wheeler (2008, July). Maine survey of veterans reveals critical needs. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazinegallery/NC%20Mag%20Veterans%20Final.pdf

Briggs, C. A., & Reneson, S. (2010). Counseling addicted veterans: What to know and how to help. Retrieved from http://counselingoutfitters.com/vistas/vistas10/Article_88.pdf

Brooks, G. R. (1991). Therapy pitfalls with Vietnam veteran families: Linearity, contextual naivete, and gender role blindness. *Journal of Family Psychology, 4*, 446-461.

Brown, C., Campanelli, P., & Skinner, D. (2008, July). New York creates safety net for homeless veterans. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazinegallery/NC%20Mag%20Veterans%20Final.pdf

Bryan, J., & Luria, Z. (1978). Sex-role learning: A test of the selective attention hypothesis. *Child Development, 49*, 13-23.

Bur, M., Aron, L., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999, August). *Homelessness: Programs and the people they serve*. Urban Institute. Retrieved from http://www.urban.org/UploadedPDF/homelessness.pdf

Campbell, J. (2008, July). Veterans speak out about stigma. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazine gallery/NC%20Mag%20Veterans%20Final.pdf

Chandler, C. (2005). *Animal assisted therapy in counseling*. New York: Routledge.

Cully, J., Henderson, L., Kunik, M., Tolpin, L., Jimenez, D., & Peterson, L. A. (2008). Psychotherapy in the veterans health administration: Missed opportunities?. *Psychological Services, 5*, 320-331.

Deering, C. G., & Cannon, E. J. (2005). Gender and psychotherapy with traditional men. *American Journal of Psychotherapy, 59*, 351-360.

Demirbas, M. & Yagbasan, R. (2006). An evaluative study of social learning theory based scientific attitudes on academic success, gender and socio-economical. *Educational Sciences: Theory and Practice, 6*, 363-371.

Dereli, E. (2009). Examining the permanence of the effect of a social skills training program for the acquisition of social problem-solving skills. *Social Behavior and Personality, 37*, 1419-1428.

Earls, E. (2008, July). Rhode Island emphasizes peer counseling and training. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazinegallery/NC%20Mag%20Veterans%20Final.pdf

Elbogen, E. B., Beckham, J. C., Butterfield, M. I., Swartz, M., Swanson, J. (2008). Assessing risk of violent behavior among veterans with severe mental illness. *Journal of Traumatic Stress, 21*, 113-117.

Fischman, J. (2005, December 12). The pet prescription. *U.S. News & World Report, 139*, 72-74.

Fitzpatrick, L. (2010, July 12). We stand behind our stereotypes. *Time, 176*, 42-45.

Flom, B. (2005). Counseling with pocket pets: Using small animals in elementary counseling programs. *Professional School Counseling, 8*, 469-471.

Forgas, L., Meyer, D., & Cohen, M. (1996). Tobacco use habits of naval personal during Desert Storm. *Military Medicine, 161*, 165-168.

Forrestal, D. (2008, July). Colorado fills service gap for veterans in rural areas. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazinegallery/NC%20Mag%20Veterans%20Final.pdf

Hardin, M., & Greer, J. D. (2009). The influences of gender-role socialization, media use and sports participation on perceptions of gender-appropriate sports. *Journal of Sport Behavior, 32*, 207-226.

Hyde, J. S., & Jaffee, S. R. (2000). Becoming a heterosexual adult: The experiences of young women. *Journal of Social Issues, 56*, 283-296.

Gamache, G., Rosenheck, R., & Tessler, R. (2001). The proportion of veterans among homeless men: A decade later. *Social Psychiatry and Psychiatric Epidemiology, 36*, 481-485.

Greenberg, N., Thomas, S. J., Iversen, A., Unwin, C., Hull, L., & Wessely, S. (2003). Do military peacekeepers want to talk about their experiences? Perceived psychosocial support of UK military peacekeepers on return from deployment. *Journal of Mental Health, 12*, 565-573.

Hazelden Foundation. (2007, June 11). *U.S. combat soldiers return as 'walking wounded.'* Retrieved from http://www.hazeldon.org/web/public/aficc70611.page

Ingoglia, C. (2008, July). Veterans mental health outreach and access act. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazinegallery/NC%20Mag%20Veterans%20Final.pdf

Ibson, R. (2008, July). Peer support: A better way to meet veterans' mental health needs. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazinegallery/NC%20Mag%20Veterans%20Final.pdf

Kaczinski, R., Rosenheck, R. A., & Resnick, S. G. (2009). A psychometric study of empowerment and confidence among veterans with psychiatric disabilities. *Journal of Rehabilitation, 75*, 15-22.

Kay, A. C., Gaucher, D., Peach, J. M., Laurin, K., Friesen, J., Zanna, M. P., & Spencer, S. J. (2009). Inequality, discrimination, and the power of the status quo: Direct evidence for a

motivation to see the way things are as the way they should be. *Journal of Personality and Social Pyschology, 97*, 421-434.

Kawamura, N., Niiyama, M., & Niiyama, H. (2007). Long-term evaluation of animal-assisted therapy for institutionalized elderly people: A preliminary result. *Japanese Psychogeriatrics Society, 7*, 8-13.

Klontz, B., Bivens, A., Leinart, D., & Klontz, T. (2007). The effectiveness of equine-assisted experiential therapy: Results of an open clinical trial. *Society and Animals, 15*, 257-267.

Kovacs, Z., Kis, R., Rozsa, S., & Rozsa, L. (2004). Animal-assisted therapy for middle-aged schizophrenic patients living in a social institution. A pilot study. *Clinical Rehabilitation 19,* 483-486.

Lefkowitz, C., Paharia, I., Prout, M., Debiak, D., & Bleiberg, J. (2005). Animal-assisted prolonged exposure: A treatment for survivors of sexual assault suffering Posttraumatic Stress Disorder. *Society & Animals, 13*, 275-295.

Lewis, R., & McCarthy, K. (2007, November 26). *War vets fighting addiction*. Retrieved from http://www.military.com/features/0,15240,156956,00.html

Macauley, B. (2006). Animal-assisted therapy for persons with aphasia: A pilot study. Journal *of Rehabilitation Research & Development, 43*, 357-366.

McGinnis, J., & Foege, W. (1993). Actual causes of death in the United States. *Journal of the American Medical Association, 270,* 2207-2212.

Minatrea, N., & Wesley, M. (2008). Reality therapy goes to the dog. *International Journal of Reality Therapy, 28*, 69-77.

Mokdad, A., Marks, J., Stroup, D., Gerberding, J. (2004). Actual causes of death in the United States. *The Journal of the American Medical Association, 291,* 1238-1245.

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 74*, 898-907.

Motomura, N., Yagi, T., & Ohyama, H. (2004). Animal-assisted therapy for people with dementia. *Psychogeriatrics, 4*, 40-42.

National Coalition for Homeless Veterans. (2004, February 18). *Mental health and addiction services needs of veterans experiencing homelessness*. Retrieved from http://www.nchv.org/content.cfm?id=26

Parish-Plass, N. (2008). Animal-assisted therapy with children suffering from insecure attachment due to abuse and neglect: A method to lower the risk for intergenerational transmission of abuse. *Clinical Child Psychology & Psychiatry, 13*, 7-30.

Parshall, D. (2003). Research and reflection: Animal-assisted therapy in mental health settings. *Counseling and Values, 48*, 47-56.

Perkins, D. D., & Zimmerman, M. A. (1995). Empowerment theory, research, and application. *American Journal of Community Psychology, 23*, 569-579.

Perlman, L. M., Altiere, M. J., Brown, S. R., Cohen, J. L., Brennan, J., A., & Mainka, J. B. (2010). A multidimensional wellness group therapy program for veterans with comorbid psychiatric and medical conditions. *Professional Psychology: Research and Practice, 41*, 120-127.

Peterson, N. A., & Reid, R. J. (2003). Paths to psychological empowerment in an urban community: Sense of community and citizen participation in substance abuse prevention activities. *Journal of Community Psychology, 31*, 25-38.

Pine, A. (2009). Getting inside their heads. U.S. *Naval Institute Proceedings, 135*, 52-57.

Pointon, C. (2006). Animal bereavement. *Therapy Today, 17*, 36-38.

Ross, R., Meyer, P., & McLaughlin, M. (2008, July). Montana's community providers expand veterans' mental healthcare. *In National Council Magazine: Veterans on the Road Home* from http://www.thenationalcouncil.org/galleries/NCMagazinegallery/NC%20Mag%20Veterans%20Final.pdf

Seal, K. H., Bertenthal, D., Maguen, S., Gima, K., Chu, A., & Marmar, C. R. (2008). *American Journal of Public Health, 98*, 714-720.

Shaw, M., & Hector, M. (2010). Listening to military members returning from Iraq and/or Afghanistan: A phenomenological investigation. *Professional Psychology: Research and Practice, 41*, 128-134.

Shlomo, K., & Shlomo, K. (1994, June). Attitudes toward Israeli war veterans with disabilities: Combat versus noncombat military service and responsibility for the disability. *Rehabilitation Counseling Bulletin, 37*, 371-380.

Sockalingam, S., Li, M., Krishnadev, U., Hanson, K., Balaban, K., Pacione, L., & Bhalerao, S. (2008). Use of animal-assisted therapy in the rehabilitation of an assault victim with a concurrent mood disorder. *Journal of Mental Health Nursing, 29*, 73-84.

Tanielian, T., & Jaycox, L., eds. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. RAND Corporation. Retrieved from http://veterans.rand.org

Taranto, J. (2008). We stand behind our stereotype. *American Spectator, 41*, 60-61.

Ullmann, L. P., Krasner, L., & Collins, B. J. (1961). Modification of behavior through verbal conditioning: Effects in group therapy. *Journal of Abnormal and Social Psychology, 62*, 128-132.

U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration. (2005, November 10). *The NSDUH report: Substance use, dependence, and treatment among veterans*. Retrieved from http://www.oas.samhsa.gov/2k5/vets/vets.pdf

Wagner, T., Federman, B., Dai, L., Harris, K., & Luna, Y. (2007). Prevalence of substance use disorders among veterans and comparable nonveterans from the national survey on drug use and health. *Psychological Sciences, 4*, 149-157.

Walsh, F. (2009). Human-animal bonds II: The role of pets in family systems and family therapy. *Family Process, 48*, 481-499.

Zoroya, G. (2008, October 21). GIs' prescription-drug abuse hits Mo. unit hard. *USA Today,* A2.