

EDITORIAL: Embracing the Diversity of Military Social Work

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This special issue illustrates the wide diversity of the field of military social work. Military social work has spanned more than 60 years (Daley, 1999; Maas, 1951; Rubin, Weiss, & Coll, in press) and social workers were working initially in World War I as Red Cross staff (Harris, 1999). Uniformed social work officers serve in the Army, Navy, Air Force, Coast Guard, Guard/Reserve, and Public Health Service in a wide range of jobs. Civilian military social workers work within many social service programs serving the military, veterans, and their families. Many countries have uniformed and civilian social workers and programs to aid and care for the military and their families (Daley, 2003). Despite a diverse range of programs provided by and often developed by military social workers, very little is shared in the professional literature or identified as “military social work.”

In recent years, there has been a rapidly growing emphasis on the challenges of military personnel, veterans, and their families. Textbooks have begun to multiply, particularly focused on military families (e.g., Blaisure et al., 2012; Everson & Figley, 2011; Hall, 2008; Martin, Rosen, & Sparacino, 2000) and on the impact of war (Kelly, Howe-Barksdale, & Gitelson, 2011; Pryce, Pryce, & Shackelford, 2012; Slone & Friedman, 2008). Intervention protocols are being suggested (e.g., DeCarvalho & Whealin, 2012; Whealin, DeCarvalho, & Vega, 2008). Special issues of journals have highlighted military concerns and coping (e.g., *Smith College Studies in Social Work*, 2009) and a chapter on military social work in each edition of the Encyclopedia of Social Work is noteworthy.

There have been some significant efforts to sharpen the vision of what military social work is. The Council on Social Work Education (CSWE) formed a series of committees and developed a guideline called *Advanced Social Work Practice in Military Social Work* that identified competencies in military social work (link to CSWE document is <http://www.cswe.org/File.aspx?id=42466>). The document includes a broad definition of “military social work.”

Military social work involves direct practice; policy and administrative activities; and advocacy including providing prevention, treatment, and rehabilitative services to service members, veterans, their families, and their communities. In addition, military social workers develop and advance programs, policies, and procedures to improve the quality of life for clients and their families in diverse communities. Military social workers provide assistance and treatment in the

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transition from military to veteran status, including a continuum of care and services for military personnel and their families (CSWE, 2010, p. 2).

This special issue strives to further strengthen the public awareness of the complex issues and program initiatives facing our servicemembers, veterans, and their families. Nedegaard and colleagues report on the key issues navigated in a multi-national mental health program for troops in Afghanistan. Van Breda outlines the military social work approaches and thinking in South Africa. Issues of military families are well represented including child-parent relationship training for military families (Jensen-Hart et al.), single parent issues (Blanchard), spousal communication (Ponder & Aguirre), and building marital resilience (Ponder & Aguirre). The effects of trauma on military women are explored (Osborne et al.). Community resources are explored such as a home-based reintegration program for military families (DeVoe et al.) and building better informed civilian providers of care for military or veterans (Luby). Veterans issues are well represented with articles on rural veterans (Stotzer et al.), developing a student veterans study and helping veterans in academic settings (Smith-Osborne), assessing PTSD in older veterans (Yarvis et al.), and strategies for helping veterans (Hazle et al.). Beder's article discusses hospital-based social workers working in military hospitals and the issues of compassion fatigue. Whitworth and colleagues outline a framework for teaching military social work in a school of social work. In sum, this special issue provides for the reader a rich sampler of military social work. Each area is a portal to understanding a portion of the vast terrain that is military social work.

There are other initiatives evolving. The Council on Social Work Education (CSWE) is seeking to develop a list of schools of social work that have educational content on military social work (ranging from a course to a full concentration in military social work). There have been special panels focused on military social work at CSWE's annual conferences, the Society for Social Work and Research annual conferences, and various regional workshops on helping military, veterans, and/or their families. There is a multidisciplinary military and family collaborative called the Alliance of Military and Veteran Family Behavioral Health Providers (<http://www.ecu.edu/che/alliance/>) that is developing suggested resources for clinicians that work with military personnel, veterans, and their families. First Lady Michelle Obama has made military families a priority and developed Joining Forces (<http://www.whitehouse.gov/joiningforces>) to support and recognize the issues of military families. In short, the topic has transformed from a benignly neglected field of practice to a hot topic in the country.

There are good reasons for the heightened attention. This country has been in a prolonged series of "operations" (e.g., Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF)) that have produced more than ten years of combat with an all-volunteer force. The military demands are delivered by a small proportion of our population (commonly called "the 1%" indicating that only one percent of the population is serving in the military). The November 21, 2011 edition of Time magazine called the servicemembers "the other 1%" and defined them as "an army apart." The basic message is that combat veterans are transformed by the experience and return to face an isolated adaptation in hometowns that are not certain how to relate. Further, the National Guard and Reserve troops have an unprecedented volume and frequency of deployments. Unlike

active duty troops who return to a military base, the Guard/Reserve often return to small communities naïve to what the military person has been through and insensitive to the struggles the military families have endured throughout the deployment. Troops are facing repeated deployments, extension of time on deployments, and loss of civilian jobs when they return home. Post traumatic stress disorders, traumatic brain injuries, and suicides have risen in military personnel.

The organizations to support and care for veterans are seen at times as a poor fit for veterans with OEF/OIF issues and identity. Some young OEF/OIF veterans see the Veterans Administration (VA) programs as not geared for their needs. The American Legion and Veterans of Foreign Wars organizations are finding many of the young veterans as hesitant to join. Young OEF/OIF veterans have created their own support system in the Iraq and Afghanistan Veterans of America (<http://iava.org/>). The VA has developed special OEF/OIF programs and separate check in procedures. The VA is preparing for the inevitable onslaught as the 2.4 million veterans will possibly seek benefits and care. According to IAVA, each year 300,000 individuals complete their military service and there is a growing backlog on claims for benefits (<http://iava.org/>).

Families of servicemembers and veterans are often stressed and can feel isolated during the deployment cycle (Matsakis, 2007; Pavlicin, 2003; Pryce, Pryce, & Shackelford, 2012). They are the primary support system and are caught between the servicemember's struggles and the naïve view of the community. Financial strains, the accordion experience of deployments, and monitoring the wellbeing of the children often fall on their shoulders. Support systems targeted to military families can range from family support centers to only phone advice depending on their location. When servicemembers transition to veterans, the family struggles with benefits and the servicemember's new identity as a veteran. Often there are few resources targeted for the family within the VA system.

Military social work deals with all the issues described above from individual, to family, to community. Servicemembers and veterans rely on our commitment and expertise in creating safety nets for them as they navigate the care systems that are available to ease their challenges. The articles in this special issue are exemplars of efforts to understand and assist servicemembers, veterans, and their families. This generation of veterans needs the help of every social worker and each of us needs to be better trained and savvy to the needs of these veterans. Our work has truly just begun.

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Social Work with Veterans in Rural Communities: Perceptions of Stigma as a Barrier to Accessing Mental Health Care

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Abstract: *The nearly decade long efforts in the Global War on Terror have led to increasing numbers of Veterans of the armed services returning to rural locations, but little is known about their needs. However, recent research suggests that rural Veterans face a host of issues, but perhaps more importantly, are facing heightened levels of stigma in rural areas related to their health and mental health. This paper examines how mental health stigma in the military may feed into stigma in rural communities and serve as an additional barrier for Veterans in rural areas who are struggling with mental health concerns. Recommendations for the unique role of social workers in serving these Veterans, as well as addressing community issues around stigma, are addressed.*

Keywords: Mental health stigma; Veterans; OIF/OEF; rural social work; barriers to care

INTRODUCTION

The Global War on Terror's nearly decade of conflict in the Middle East has resulted in an increased number of Veterans returning from deployments with a variety of mental health issues. However, help for those issues is not evenly distributed across Veterans. Over 40% of the Veterans of the wars in Iraq and Afghanistan are from rural areas, and existing research shows that rural Veterans Health Administration (VA) patients report poorer mental health status and reduced access to care compared to VA patients in urban or suburban areas (e.g., Weeks, Kazis, Shen, Cong, Ren, Miller, et al., 2004; West & Weeks, 2006). Obviously, logistical factors, including longer waiting periods, limited choice of health professionals, and poorer public transportation, limit access to and use of services in rural settings (Aisbett, Boyd, Francis, Newnham, & Newnham, 2007). However, efforts by the VA to overcome logistical barriers by expanding services to rural areas have not led to the expected increase in service utilization (Fisher, 2003). Identifying logistical barriers answers questions about whether or not a Veteran *can* access care, but offers little insight into whether or not a Veteran *will* access care.

This information is particularly troubling given the research that demonstrates the high level of need among rural Veterans. Research has suggested that Veterans located in rural settings generally have worse health-related quality of life than Veterans living in urban locations (Weeks, et al., 2004). Although in greater need of mental health care services, rural Veterans face many challenges to receiving care that are different from

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urban Veterans. Few studies have looked beyond the logistics of care delivery in rural settings to understand the reasons why rural Veterans may or may not choose to utilize existing services. In non-Veteran populations, rural people have been identified to have three main factors that can act to prevent them from accessing care: sociodemographic factors (e.g. gender, age, and marital status), illness-related factors (e.g. comorbidity, psychological distress), and attitudinal factors (e.g. stigma, stoicism, self-efficacy; Jackson, Judd, Komiti, Fraser, Murray, Robins, Pattison, & Wearing, 2007). Of these three factors, attitudinal factors are the least understood, but research suggests that the more stigma a rural-dwelling person perceives, the more their reported negative attitudes toward help-seeking (Wrigley, Jackson, Judd, & Komiti, 2005).

Research focusing on rural communities and their attitudes toward mental health and mental health services, as well as existing research on military culture and attitudes toward mental health and mental health services, suggests that rural Veterans may face significant social challenges in attaining services in their communities. Both sets of cultural values, rural and military, emphasize stoicism, self-reliance, and negative attitudes toward help seeking, as well as issues related to privacy concerns, confidentiality, and heightened perceptions of community-based stigma. Given social work's unique place and expanded role in rural environments, particularly in community mental health (e.g., Jerrell & Knight, 1985; Landsman, 2002; Riebschleger, 2007), rural social workers can serve as a key point of outreach, advocacy, and treatment for rural Veterans. However, there is little social-worker specific information currently available to help guide providers in their attempts to serve active military, national guard, reserve, and Veteran populations (Savitsky, Illingworth, & DuLaney, 2009). The purpose of this paper is 1) to review existing research on mental health stigma, 2) to outline the significant challenges that rural Veterans face compared to urban counterparts, and 3) to offer suggestions for social workers working in rural areas to facilitate rural Veterans finding and receiving the benefits and treatments they earned following their service to their country.

STIGMA AND MENTAL HEALTH

Stigma concerns negative stereotypes, social status loss, and discrimination related to a particular perception of difference (Link & Phelan, 2001). It is a multidimensional concept that brands certain classes of people as inherently "different." Goffman (1963) argued that stigma "spoils" a person's identity, and asserted that "we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination through which we effectively, if often unthinkingly, reduce life chances" (p. 5). Jones, Farina, Hastorf, Markus, Miller, and Scott (1984) explained that we all are "marked" in some way, whether it is simply having blue eyes, being tall, etc., but stigma is the application of a negative valuation on that mark. Thus, stigma is based on assumptions, stereotypes, and value judgments about this marked identity that are shared among a wide population as well as understood by the person bearing the marked identity.

Stigma toward those with mental health issues has been found to be pervasive and often severe (Wahl, 1999). A variety of negative stereotypes have been applied to people

struggling with mental illness, such as the perception that mental illness leads to violence, even though research suggests that people with mental illness are not more violent than the general population (Levin, 2001). Mental illness has been called a “concealable” stigma, because in most cases it is not obvious to a stranger (Hinshaw, 2007). A person who is dealing with mental health concerns often spends a large portion of mental and emotional energy attempting to conceal their mental health concern, and attempting to judge others’ opinions and perceptions of their behaviors (Smart & Wegner, 1999). A large motivator for keeping their mental health concern concealed is to avoid a label being applied to them. The desire to maintain concealment can result in refusal to acknowledge an issue or pursue mental health treatment to avoid being affiliated with the stigmatized group (Corrigan, Watson, Byrne, & Davis, 2005). This desire to conceal an identity that is stigmatized is pervasive, even when disclosure can result in many mental health benefits and well-being (Chaudoir & Quinn, 2010). In a general population, greater perceived and self-stigma is related to reduced help-seeking from professional sources (Barney, Griffiths, Jorm, & Christensen, 2006). Although most populations are aware of, and suffer the consequences of mental health stigma, military-related populations are at particular risk for experiencing the negative effects of stigma, and as a result, avoid seeking care to prevent real or imagined discrimination and/or loss in social status.

Veteran and Military-related Mental Health Stigma

Traditionally, the military services have embraced normative beliefs consistent with the masculine gender role identity. Traditional attitudes common in military groups include valuing independence, self-reliance, competition, power, strength, and emotional control. Although recent outreach and education efforts by the military and VA have begun to change this culture (e.g., Adler, Bliese, McGurk, Hoge, & Castro, 2009; Reivich, Seligman, & McBride, 2011), traditionally military groups tend to eschew mental health services. Instead, coping tactics viewed as suitable means for dealing with stress include behaviors such as emotion suppression and substance abuse (Lorber, & Garcia, 2010). Not surprisingly, conformity with masculinity norms is associated with less use of health care services (Boman & Walker, 2010).

The belief that one ought to be able to handle mental health problems on their own continues to be a commonly reported barrier to care (e.g., Sayer, Friedemann-Sanchez, Spoont, et al., 2009; Stecker, Fortney, Hamilton, et al., 2007). Beliefs held by Veteran and military groups suggest that this belief may most strongly reflect concerns about the mental health attitudes of, and potential discrimination by, others, as opposed to internalized beliefs. In one of the most comprehensive studies about Veterans and mental health stigma to date, Hoge, Castro, Messer, McGurk, Cotting, and Koffman (2004) evaluated Active Duty Soldiers and Marine units returning from Iraq or Afghanistan ($N=6,153$) to identify specific barriers to mental health care. The most commonly endorsed items indicating stigma included “My unit leadership might treat me differently” (36.5%), “I would be seen as weak” (35.4%), “Members of my unit might have less confidence in me” (34.2%), “It would harm my career” (27.0%), followed by “There would be difficulty getting time off from work for treatment” (26.3%). Their findings

indicated that the majority of the returnees acknowledged a need for help with mental health issues (78-86%). However, less than one third of returnees (13-27%) who acknowledged a need for help accessed available mental health services. When asked about the barriers to obtaining treatment, the service members classified as in need of mental health care endorsed negative stigma about treatment as the greatest barriers to service utilization (Hoge, et al., 2004). Warner, Appenzeller, Mullen, Warner, and Griege (2008) had similar findings in a study of 2,678 soldiers deploying with a brigade combat team, soldiers ($n=2,678$) reported their concerns were that "Members of my unit might have less confidence in me" (20.8%), "My unit leadership might treat me differently" (22.4%), "It would harm my career" (18.5%), and "I would be seen as weak" (17.8%).

These perceptions of stigma from unit members and superiors have direct behavioral effects. Among previously deployed national guard soldiers who screened positive for PTSD, depression, or alcohol dependence, many reported significant discomfort reporting mental health symptoms and a belief that their superiors would not encourage mental health treatment (Kline, Falca-Dodson, Sussner, Ciccone, Chandler, Callahan, & Losonczy, 2010). Additionally, 59% of this group indicated that they did not report symptoms during military Post-Deployment Health Reassessments in order to avoid "medical hold." Nearly half of those screening positive for PTSD and almost 90% of those screening positive for alcohol dependence reported no treatment in the past 12 months (Kline, et al., 2010).

Recent research with OEF/OIF military populations (e.g., Wright, Cabrera, Bliese, Adler, Hoge, & Castro, 2009) suggests that military community attitudes and internalized-stigma are two interacting factors that influence service members' willingness to get help. Thus, there is a tremendous need to better understand factors known to impact Veterans' decisions to access mental health care. Notably, Active Duty Service Members and Veterans with mental health problems, arguably those most in need of care, are up to twice as likely as those without mental health problems to report stigma as a barrier to health-care use (e.g., Hoge, et al. 2004). Pietrzak, Johnson, Goldstein, Malley and Southwick (2009) examined beliefs about the effectiveness of mental health care in a sample of 272 predominantly reservist and national guard OEF/OIF Veterans in Connecticut. The participants who screened positive for a psychiatric disorder scored higher on scales measuring perceptions of stigma and logistical barriers to care. Additionally, negative beliefs about the effectiveness of psychotherapy and psychotropic medications predicted increased stigma and barriers to care. Negative beliefs about mental health care were also associated with decreased likelihood of psychotherapy and medication visits. In a sample of Vietnam and OEF/OIF Veterans, Stecker, Fortney, Hamilton, and Ajzen (2007) found that the belief that one "ought to be able to handle mental health problems on their own" was the most commonly reported barrier to care. In a qualitative study examining the determinants of PTSD treatment initiation in Veterans (Sayer, et al., 2009), pride in self-reliance was a strong deterrent to treatment seeking.

These studies highlight the concerns of service members, and the degree to which they are attuned to perceptions of mental health stigma in their environments. In addition, the elevated levels of psychological problems reported by new OEF/OIF Veterans

emphasize the need to reduce the stigma as members of this population separate from the military and return to civilian communities. To date, however, relatively little research has been conducted to assess the link between civilian community factors and perceptions of stigma and barriers to care. However, an emerging body of research suggests that rural communities may have a heightened level, or produce the perception of a heightened level, of mental health stigma.

Rural Culture and Perceptions of Community Stigma

Most studies evaluating rural populations do not attend to the contextual community characteristics of rural settings that likely play a role in impacting individual attitudes about and willingness to use mental health services (Boyd, Hayes, Sewell, Caldwell, Kemp, Harvie, et al. 2008; Jackson, et al., 2007). The source of stigma does not appear to be the mental health system itself, but rather the communities' beliefs and attitudes about mental health (Crawford & Brown, 2002). Evidence suggests that rural residents incorrectly underestimate the prevalence of mental health problems in their communities (Bartlett, Travers, Cartwright, & Smith, 2006), perhaps implicitly contributing to the stigma by demonstrating a "that doesn't happen here" attitude. Regardless of severity of mental illness symptoms, and despite similar rates of mental illness, rural residents are also less likely to access mental health services than urban residents (Dahlberg, Fosell, Damstrom-Thakker, & Runeson, 2007). This may be due in part to the high levels of perceived stigma in rural communities, where rural residents with mental health problems still strongly identify with their rural communities and want to belong (Ekeland & Bergem, 2006).

Although the perception of stigma has been found in the general population as a barrier to seeking services (e.g., Barney, et al., 2006), in rural settings, recent research has identified fundamental, contextual factors that result from characteristics of social networks that impact help-seeking and service use (Boyd, et al., 2008). For example, in rural settings, community members, despite being separated by many miles due to geographical constraints, can have intimate knowledge of each other's lives due to local gossiping networks (e.g., Aisbett et al., 2007; Parr & Philo, 2003; Parr, Philo, & Burns, 2004). This is the opposite social geographical characteristics experienced in urban settings, where community members may be physically proximate but are often socially distant from each other. As a result, contextual factors of rural settings – including a combination of being socially visible and having strong social networks – have the potential to heighten both community social stigma and internalized stigma related to use of mental health services.

Research on non-Veteran populations supports the role of contextual factors in impacting attitudes about and use of mental health services (e.g., Boyd, et al., 2006; Boyd, et al., 2008). Wrigley et al. (2005) found that the two main reasons not to seek help from a general practitioner for mental health problems were 1) embarrassment (see also Hoyt, Conger, Valde, & Weihs, 1997) and 2) not knowing who to seek help from. At the same time, they found a relationship between perceived stigma such that those who reported higher rates of perceived stigma also demonstrated more negative attitudes toward help seeking, drawing a link between stigma and its impact on help-seeking. To

give additional evidence for these qualitative results, another study asked rural residents to evaluate a vignette of a man exhibiting symptoms of mental illness, and 67% of rural residents said he would be discriminated against in their community (Bartlett, et al., 2006). In Hoyt et al. (1997), when "place" and both measures of stigma and loss of privacy were entered into the same regression model, the effects of place disappear, suggesting that issues of embarrassment related to confidentiality and anonymity moderate the relationship between place and help-seeking.

Qualitative studies consistently reveal that recognition as a person with a mental health issue via a community's informal social networks has a stigmatizing effect. One qualitative study of rural and urban adolescents indicated that those in rural settings identified rural gossip networks as limiting anonymity. In addition, among rural adolescents, fear of social stigma and exclusion after revealing a mental health problem was seen as a barrier to obtaining services (Quine, Bernard, Booth, Kant, Usherwood, Alperstein, et al., 2003). In another study of rural college students, participants noted that gossip networks and social visibility within rural settings play an extremely influential role in stigmatizing those who had received mental health services (Aisbett, et al., 2007). Furthermore, qualitative studies that have been done with non-Veteran populations suggest that those in rural settings are more likely to see those who use mental health services as weak and that their use of services suggests a lack of self-reliance (Boyd, Aisbett, Francis, Kelly, Newnham, & Newnham, 2007). For example, Wrigley, Jackson, Judd, and Komiti (2005) found that more negative attitudes toward help-seeking for schizophrenia and depression were related to higher endorsements that these problems were caused by a weakness in character.

Fuller, Edwards, Proctor, and Moss (2000) found that a rural culture of self-reliance was composed of two features, first, not being allowed to be weak, and second, being suspicious of outsiders (including mental health providers from outside the community). This attitude leads to stigma and decreased probability that rural people will label their mental distress as a mental health problem. Fuller et al. (2000) suggested that even in the cases where rural residents recognize their mental distress despite the stigma, they may still not see the "system" as a source of help because of their resistance to be seen as the community "nutcase." When broken apart, attitudes about the importance of stoicism and general self-efficacy were found to be important predictors of help seeking (Judd, Jackson, Komiti, Murray, Fraser, Grieve, & Gomez, 2006). However, the values of self-reliance are not insurmountable. For example, having sought help in the past for mental health concerns was related to more positive attitudes toward help-seeking (Jagdeo, Cox, Stein, & Sareen, 2009), though this may not be a consistent relationship for men, who may be more prone to believe in agrarian values (Hoyt, et al., 1997). These studies highlight how rural community values and attitudes that prevent help-seeking can be assuaged by positive interactions with mental health systems.

There was evidence that in rural settings many people felt that the resources available to them were inadequate or of poor quality, hence keeping them from seeking help. Human and Wasem (1991) in an overview of rural health concerns in the United States wrote that there is often a difference between accessibility, which is whether or not a client is able to access services, vs. acceptability, which is whether or not a service is

being offered in a manner consistent with local values and for a rural setting. Bartlett et al. (2006) in a survey in rural Queensland found that 58% of respondents felt that available services were of poor quality. Wrigley et al. (2005) found that when inquiring about why people did not go to a general practitioner (GP) for help with mental health issues, those who felt that their GP would not be helpful with mental health related inquiries were 91% less likely to discuss mental health concerns with their GPs. The size of the community may also play a role in the perception of service availability as well as confidentiality and privacy – the smallest communities and the largest rural locations have been shown to have the lowest rates of access compared to moderately sized locations (Hoyt, et al., 1997; Judd, Jackson, Komiti, Murray & Fraser, 2007).

In regard to rural social work in particular, the role of rural social workers is varied. Fiske (2003) identified many of the strengths (such as the strong connections made with other professionals, strengthened professional teamwork, etc.) and challenges of being a social worker in a rural area (such as being the only social worker, confidentiality concerns, etc.). Authors have argued that “as specialist services are few, rural social workers work across a range of methodologies and interventionist strategies” (Green, 2003, p. 10) and that this focus on generalist models of interdependence, cooperation, and teams are in fact most consistent with rural values. In contrast with the stigma, attitudes, and beliefs held by rural persons, a study of rural social workers (Riebschleger, 2007) found that rural social workers also had concerns about stigma *against themselves* as mental health professionals. The author indicates rural dwellers’ barriers to care can stem from the perception that mental health and social service providers (including social workers) would see them as simpletons, critique their dialects, or assume they are like the stereotypes of rural people in the media (such as hillbillies). Green (2003) argues that social workers who are clearly integrated into the community, and are seen as citizens (as opposed to “visitors” or “organizers”) can effectively counteract some of these common concerns with “outsiders” looking down on rural residents who are in need of services.

RURAL VETERANS AND STIGMA

Although there is burgeoning research on rural environments and a long history of research on Veterans, few studies have focused specifically on rurally located Veterans. However, similar to findings about non-Veteran rural population, patterns of care utilization have shown that rural Veterans access care less often than urban Veterans, and that older Veterans were more reliant on VA care while younger Veterans used the private sector (Weeks, Mahar, & Wright, 2005). Given that military culture and rural culture share many features that promote perceptions of mental health stigma and discourage mental health treatment-seeking, it seems likely that Veterans residing in rural locations may experience stigma as a barrier to care at a heightened level than the general population.

Among the few studies that addressed rural Veterans specifically, there is some indirect evidence that rural community characteristics impact Veterans as well. For example, Weeks et al. (2004) found that rural Veterans had lower overall health (looking at both physical and mental health) related quality of life compared to urban or suburban Veterans. Wallace, Weeks, Wang, Lee, and Kazis (2006) found that although Veterans in

rural settings had less frequency of psychiatric disorder, for those who did, they bore a much higher disease burden as measured by poorer quality of life. One qualitative study which examined implementing integrated health care services in rural communities (Kirchner, Cody, Thrush, Sullivan, & Rapp, 2004) noted that contextual factors related to the culture of the community were important in the success of clinical interventions. This highlights how not all rural communities may be contributing to heightened levels of stigma. It also suggests the need for community interventions targeting rural communities in regard to mental health education.

Studies have also found some differences in rural Veteran's experiences that highlight additional areas for intervention. For example, research (e.g., Costello, Pugh, Steadman, & Kane, 1997; Molinari, Boeve, Kunik, & Snow-Turek, 1999) suggest that Veteran's social networks are stronger in rural vs. urban settings. Comparisons between chronically ill, older male Veteran patients (43 from rural settings and 48 from urban areas) found that rural Veterans reported more social contact in their home communities than urban Veterans, despite the fact that the Veterans in the rural sample were more likely to be older, widowed, and living alone (Costello, et al., 1977). These results suggest that in addition to strengthening communities, social workers can help rural Veterans by creating interventions that promote strong social networks and social supports.

VA attempts at reaching rural Veterans and providing high quality care have met with significant challenges. In an examination of the Community-based Outpatient Clinics (CBOCs), Chapko, Borowsky, Fortney, Hedeen, Hoegle, Maciejewski, and Lukas (2002) found that CBOCs rated similarly to their parent VAMCs on many factors, (e.g., perceptions of access, emotional support, care coordination, etc.), but were still rated as having lower average quality of care scores. Mohamed, Neale, and Rosenheck (2009) conducted research on the Mental Health Intensive Case Management (MHICM) program, which is national in scope, in order to identify variance in rural Veterans receiving services and service delivery. Veterans residing in rural areas had less contact with MHICM staff and they were less likely to receive recovery-oriented services such as rehabilitation services, psychotherapy, crisis intervention, screening for medical problems, housing, or vocational support. Mohamed et al. (2009) argued that although these national programs have been established by the VA, that rural Veterans face specific challenges in accessing these services, and that there is an ongoing need for intensive case management services.

DISCUSSION

Many Veterans lived in rural communities when they chose to enter the military, and many return to rural communities after they have completed their service. With the high level of stigma against seeking mental health services in rural communities and within the military, rural Veterans who are suffering from mental health disorders are at risk for discounting their problems, regardless of their severity. Social workers are in a unique position, due to their training at all levels of practice, to educate rural Veterans, families, and communities in order to help overcome stigmatizing attitudes and fears.

Most social workers are not trained specifically to deal with rural issues, and social workers in the community are in need of resources to better understand and meet the needs of active military, national guard, reserve, and Veteran populations (Savitsky, Illingworth, & DuLaney, 2009). In recognition of the unique needs of rural Veterans, the Office of Rural Health within the VA was created in 2006 to improve access and the overall quality of care for Veterans in rural and remote areas. ORH develops evidence-based policies and innovative practices that support the unique needs of those residing in rural areas. In the past two years, \$500 million was appropriated for new health initiatives for rural Veterans ranging from expansion of specialty services provided via telehealth to community and rural provider outreach and education. Additionally, other centers of excellence within the VA provide educational materials to providers who work with military populations. For example, the National Center for PTSD provides Clinicians' Manuals, as well as a variety of on-line courses on topics such as treatment for PTSD and understanding military culture online at <http://www.ptsd.va.gov/professional/index.asp>. Because up to 50% of rural locations in the United States are still without Internet access, many of these materials are available on CD upon request. Finally, this literature review suggests that there are many strategies that both civilian and non-civilian social workers can employ to best serve the Veterans in their rural communities, and to combat both the military and rural stigmas against mental illness and mental health treatment-seeking.

Prevention

There is emerging evidence that addresses the need to prevent Veterans from suffering negative mental health as a consequence of their military service (Warner, Appenzeller, Mullen, Warner, & Grieger, 2008). Of the soldiers who had previously deployed, 20.7% had sought MHC upon their return and 84.8% reported that they had received Army psychoeducational "Battlemind" training, now called "Resiliency Training" (Adler, Bliese, McGurk, Hoge, & Castro, 2009). Soldiers in this brigade who received this training were 1.56 times more likely to report that they would seek treatment if screening results were positive or if they perceived a problem. Warner and colleagues (2008) conclude that efforts to reduce stigma via education prior to a problem emerging may be helping to decrease stigma and then increase treatment seeking.

Culturally-appropriate Therapeutic Intervention

Culturally-appropriate care for rural military populations involves understanding the Veteran's values and belief system. For some Veterans, this may mean respecting the role that independence, self-reliance, strength and emotional control has in a Veteran's life. At the same time, social workers should understand that once trust is established, a Veteran may be more open to broach subjects related to mental health symptoms when asked. It is helpful to openly discuss concerns a Veteran may have about stigma and confidentiality, especially in rural areas where "everyone knows everyone." When a Veteran who endorses mental health stigma is suffering from mental health problems, it is helpful to normalize both the commonality of the symptoms and the discomfort with talking about them. Finally, in therapy it may be helpful to openly discuss that, while independence, self-reliance, and emotional control can be strengths, rural and military values applied too

rigidly to everyday civilian situations are maladaptive. For instance, research shows that willful suppression of emotions tends to lead to higher levels of disturbing thoughts and emotions, and is implicated in PTSD (Shipard & Beck, 2005). Once Veterans feels that they have 'permission' to confidentially discuss symptoms, they will be better able to identify and address their problems (Lorber, & Garcia, 2010).

Strengthening Social Relationships and Networks

The existing literature highlights the need for both honoring and utilizing existing social networks and supports for Veterans in rural locations. Those relationships, although at time can lead to a perception of increased "gaze" from other community members that raise concerns about treatment seeking, can also serve as significant strengths in finding mechanisms to provide care to rural Veterans. In regard to stigma specifically, Veterans repeatedly cited their concerns that admitting mental health concerns would result in lost face to peers, superiors and families, decreased sense of masculinity, and concerns about their job. Interestingly, a study examining Active Duty Soldiers three months after deployment showed that Soldiers who rated their leaders more favorably and who reported higher unit cohesion were more likely to report lower stigma scores (Wright, et al., 2009). These results highlight how critical relationships are, before separating from the military, as well as post-separation. Social workers are in a key position of being able to work with service members and their families to provide services that use strong existing relationships among Veterans that can help counteract the negative stereotypes about treatment-seeking. Community leaders (such as clergy), cultural brokers, and strong Veteran role models all serve as excellent collaborators in such endeavors. Given that social workers, particularly civilian social workers, often serve multiple roles within a health care system in rural areas, they have a significant opportunity to intervene with Veterans and families in ways that directly target family functioning, and in the long run may decrease perceptions of stigma, and overcome a barrier to care for some Veterans.

Coordinating Military and Civilian Services

As the VA recognized the difficulty in providing adequate and high quality services to rural areas, it has begun exploring the variety of mechanisms to provide services outside of simply starting entirely new facilities. The possibility of coordinating with existing community mental health services and systems has been strongly encouraged by policy groups such as the National Rural Health Association (2004). This policy organization has been advocating for policy changes that would allow the VA and other services (such as local community health centers, vet centers, and other rural providers) to cooperate in a more meaningful and coordinated fashion. Savistky et al. (2009) stated that "civilian social workers must acknowledge their responsibility to reach out to their military counterparts in an effort to achieve the most streamlined system of care possible. When military and civilian systems operate in isolation, an opportunity to coordinate well-informed and effective intervention is lost" (p. 337). In their generalist roles, rural social workers often interact with many systems and professions. In this space, rural social workers are poised to help build those connections between systems. However, this

requires civilian social workers to become at least marginally versed in the language and systems of the military and the VA. In order to best serve Veterans, particularly those who have seen combat over the last decade, all social workers need a basic understanding of the military and VA. However, where urban social workers may more easily be able to refer urban Veterans to VA services, rural social workers need to 1) look harder for Veterans who may not be accessing because of stigma concerns, and 2) may need to have an increased level of knowledge about military and VA systems since community access to those resources and information may be limited. This may mean becoming knowledgeable about the VA's current proliferation of online services (such as My HealthEvet), the possibilities for telehealth (such as completely online individual and group therapy available via teleconferencing), and emedicine as means to overcome logistical barriers to care. The more clearly rural providers know about options for Veterans, even in their rural communities, the less stigmatizing treatment-seeking will become as it is normed in the community.

Community Advocacy and Education

Mental health care providers need to consider community interventions, not just individual interventions, to decrease the overall community-based stigma as well as the perception of stigma. As some articles have suggested, providers need training to work against the effects of stigma as a part of their job (Crawford & Brown, 2002). Although mental health stigma is pervasive in the United States, this research highlights how that stigma may be magnified in rural communities where confidentiality concerns are high. It is not enough for social workers to simply address the concerns of any Veterans that come in their door – there are many more who are suffering and *not* seeking care. Working to reduce stigma throughout the community in ways that honor Veterans for their service and does not cast all Veterans as “in need” of mental health services can serve to address community-based stigma (or perhaps the perception of that stigma) for Veterans who may be have been deterred from treatment-seeking because of reputational concerns. Unlike doctors and other health and mental health providers, social workers have a strong history and training in community organization, group work, and advocacy. Given that many Veterans in rural areas make contact with their GPs as a point of entry into mental health services, it is particularly important for social workers to advocate and educate people within the health/mental health care system first, but to also address issues of stigma in the general community as well through culturally appropriate advocacy and education efforts.

Research about Stigma

Last, there needs to be more research about mental health stigma that impacts Veterans, and how the perception of others' beliefs is impacting the medical choices made by Veterans. In particular, there remains a need to better understand the specific reasons for the disparity between the need for treatment and the lack of mental healthcare service utilization among Global War on Terrorism Veterans. For example, suicide rates among this population continue to rise despite increased access to healthcare, and coordination of care seems more critical than access alone (Mills, Huber, Vince Watts, &

Bagian, 2011). Research has historically focused on the perceptions and beliefs of individual Veterans, but they are deeply embedded in communities that may or may not share their beliefs about seeking or receiving mental health care. More research needs to address how community stigma is impacting the rural Veteran treatment-seeking in ways that are similar to, or different, from urban Veterans.

CONCLUSION

Based on the evidence presented that stigma is a major influence in deterring treatment seeking, rural Veterans potentially face compounded challenges of experiencing both community stigma and military-related stigma. Community health care providers must understand the societal and systemic processes that influence Veterans' decision to seek mental health care and how community factors may be influencing these decisions. Rural Veterans already face many logistical barriers to care, but military and rural cultures promote values that can serve as significant psychological and social barriers to accessing treatment. Social workers have many key roles to be played in rural environments to help prevent stigmatizing attitudes and fears, to promote better organizational coordination of rural systems and social networks for Veterans, to strengthen Veterans and family members via culturally-sensitive case management and treatment services, and to conduct advocacy and education at the community level to decrease stigma at all levels in the community.

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Military Social Work Thinking in South Africa

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Abstract: Military social workers in South Africa have developed distinctive ways of thinking about military social work. These developments have been influenced by various contextual factors, such as the transition of South Africa to a non-racial democracy in 1994 and the establishment of a military social work research capacity. These factors contributed to new ways of thinking, such as the recognition that military social work has a mandate to facilitate organizational change and the adoption of a resilience perspective. A central development in military social work thinking in South Africa was the formulation of a Military Social Work Practice Model, which is described and illustrated in some detail. This model emphasizes binocular vision (focusing on the interface between soldiers and the military organization) and four practice positions, derived from occupational social work theory. The author notes the importance of creating appropriate contexts that facilitate further developments in military social work theory.

Keywords: Military social work, ecosystems, person-in-environment, occupational social work, South Africa.

INTRODUCTION

The ten to fifteen years since 1994 have evidenced substantial growth in thinking about military social work (MilSW) in South Africa. South Africa's relative isolation from the rest of the world, due partly to our location on the southern tip of Africa and as a result of the sanctions during the dying years of Apartheid, resulted in the development of a rather distinctive approach to MilSW. This paper will show this distinctive approach and the kinds of factors that have influenced it.

This paper is focused primarily on how military social workers in South Africa *think* about MilSW practice, rather than in describing the history, structures and staffing of MilSW. It is the practice theories and approaches that are central to this paper. The paper will contend that MilSW thinking emerged in a particular context and evolved in ways that are distinct (though not entirely different) from militaries elsewhere in the world.

The paper opens with four contextual factors that I believe facilitated the evolution of MilSW in South Africa. Particular attention is then given to a practice model of MilSW, which has been the guiding framework for all MilSW thinking and practice over the past 15 years, and brief practice examples illustrate how this thinking about MilSW guides the activities of social workers in South Africa. The paper concludes with some reflections on furthering the growth of MilSW thinking.

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THE SOUTH AFRICAN MILITARY SOCIAL WORK CONTEXT

Military social work has formally existed in South Africa since 1968 (De Klerk, 1991). In the years leading up to 1994, seven separate military organizations were established in South Africa, including the South African Defence Force (SADF), the militaries of the four homeland states (the Transkei, Bophutatswana, Venda and Ciskei Defence Forces) and the armed wings of two liberation movements (Umkhonto we Sizwe (MK) and the Azanian People's Liberation Army (APLA)). Few social workers were employed by the homeland state militaries; most social workers were employed by the SADF, MK and APLA. It is of course true that during these years there was no partnering between social workers in the SADF and social workers in MK and APLA.

In 1994, with the collapse of Apartheid, these seven military organizations began a process of integration into the South African National Defence Force (SANDF). Currently, the SANDF employs approximately 130 social workers, most of whom are uniformed members and a handful are civilian employees. Ranks range from Lieutenant (the most junior rank for an entry-level military social worker) to Brigadier General (the Director Social Work).

The 10 or so years, starting from 1994, evidenced a rapid growth of thinking among military social workers. This is not to say there was no development before 1994 or in the past several years; rather, I have observed an intensification and flowering of new ideas during this ten-year period. One may go so far as to term this a 'golden era' in MilSW in South Africa. In this section I point to four major contextual factors that facilitated the growth and development of MilSW (Table 1).

Table 1. Developments in South African Military Social Work (MilSW)

Contextual Factors	Development of MilSW
Macro changes in South Africa in 1994	Expanded insights into the role of MilSW
Engagement with military families	New insights into deployment resilience
Establishment of a MilSW research department	New MilSW social technologies
Social work supervision course	A new model of MilSW practice

Macro Changes in South Africa

In 1994, the first democratic elections took place in South Africa, resulting in a handover of power from the National Party to the African National Congress. At the same time, and over the following years, the SADF was transformed into the SANDF, a composite of the seven former forces, welded into one new military force (Uys, 1997). Two key macro changes occurred that influenced MilSW thinking, through a change in the composition of MilSW personnel and shifts in the national welfare approach.

The integration of various forces and of various departments of social work introduced new thinking and insights about the nature and purpose of MilSW. SADF social workers had perhaps been conservative in the extent of change they felt free to

facilitate, giving primary emphasis to micro-level change without challenging the status quo. By contrast, MK and APLA social workers had a much greater investment in social change, social justice and social action. These social workers grew up in the liberation movement and had embraced the liberation themes of transformation and revolution. Consequently, the understanding of the social work target system expanded from primarily individuals and families, to include the whole military system and even surrounding communities and society itself. A much more expansive sense developed of who social work served. Military social workers also appropriated a mandate for organizational change, ensuring that the social environment of soldiers (which is used as a collective noun in this paper, including all military employees and their families) was conducive to well-being. A somewhat more radical approach to social work thus evolved after 1994.

Post-1994 social workers got involved in the ANC government's Reconstruction and Development Programme (RDP), which called for a much more holistic engagement with the needs of all peoples and for work at a structural and institutional level, not just at the level of individuals and communities (ANC, 1994). The RDP led, a few years later, to the White Paper for Social Welfare (RSA, 1997), in which South Africa adopted a developmental approach to social welfare (Midgley, 2001). Much effort was invested in coming to terms with what this approach meant for MilSW. Developmental welfare calls for a bridging of the micro-macro divide (Patel, 2005), which had been characteristic of pre-1994 MilSW in the SADF. Furthermore, it advances a rights-based approach and an increase in democracy and people's participation in their own welfare (Patel, 2005), supported by the Bill of Rights and the South African Constitution (RSA, 1996). This further facilitated a shift from paternalistic social work towards a more radical approach to social work.

As a result of these macro changes, MilSW thinking became more radical, more willing to challenge the status quo, more willing to engage in macro change processes and more committed to listening to and being guided by the needs and rights of the military workforce.

Engagement with Military Families

A second paradigm shift emerged in response to the engagement of military social workers at the Institute for Maritime Medicine with military families in the mid-1990s. Naval wives had established a support network to help them deal with the absence of their husbands (at that time only men could serve on naval vessels). Navy social workers were invited to partner with this network and together evolved a comprehensive system of support to Naval families. This engagement with a group of women who had taken the initiative and in which social workers were 'tagging along' facilitated a new recognition of the coping resources of military families. An article by Logan (1987) was particularly influential in prompting the study of resilience literature (McCubbin's work was particularly influential, e.g. McCubbin & Lavee, 1986).

MilSW's engagement with resilient families and encounter with literature on family resilience led to the coining of the term 'deployment resilience'. Previously, social workers were interested primarily in the ways in which deployments stress families and contribute to their breakdown (Van Breda, 1997b) – what Antonovsky (1988) calls a pathogenic perspective. However, from the mid-1990s emphasis shifted

to uncovering and then developing mechanisms that families had evolved to cope with deployments (Van Breda, 1998; 1999).

Resilience theory (Van Breda, 2001) sparked a new way of thinking about military families. They were not passive victims of the military system. Nor were they inevitably dysfunctional and damaged. Rather, families were recognized as having inherent skills, abilities and talents, which helped them thrive in the face of the challenges of living in a military environment. This new way of thinking about military families, and about the military itself, emerged at around the same time as Saleebey's book on the 'strengths perspective' in social work (Saleebey, 2008).

The practice implications of a resilience approach to social work practice became rapidly evident and have continued to impact on MilSW in the SANDF. The first was the design of a Deployment Resilience Seminar (Van Breda, 1999), a one-day program aimed at teaching all military families the coping skills and patterns that resilient families had discovered for themselves. Several other resilience programs were developed thereafter, for example, focusing on single soldiers or soldiers whose families lived far away from the military base, often in rural areas.

Some years later, military social workers developed an assessment model and scale for screening soldiers prior to deployments, as part of the military's concurrent health assessments (Van Breda, 2002b). This process, which included a conceptual model for assessment, a standardized rating scale and a standardized clinical interview schedule, was similarly grounded in resilience theory (Van Breda, 2008; 2011).

Through their close engagement with military families, MilSW began to incorporate an appreciation for the strengths and coping resources of military families. This was enriched through intensive reading on resilience, and particularly international literature on the resilience of military families. MilSW thinking became more strengths-oriented and this has influenced virtually all subsequent developments in MilSW in South Africa.

Social Work Research Department

A third key factor that facilitated the development of MilSW thinking was the establishment of the first social work research department in the SANDF in 1997 (Van Breda, 2002a). Initially staffed with just one social worker, and located in the Military Psychological Institute, the department grew over the subsequent four years to five posts. This initiative was vital to the growth of MilSW, in setting aside a team of social workers, each with several years of MilSW practice experience, to give dedicated attention to thinking about MilSW and to develop new knowledge and interventions for the organization. Social work practitioners are preoccupied with practice in their own sphere of responsibility; social work managers are preoccupied with performance management and the budget; social work researchers have the space to think and innovate.

This department, during its first several years of existence, developed the concurrent health assessment model and tools mentioned previously, a new management information system based on a model of MilSW practice, a range of new courses and interventions (such as a program for soldiers with financial challenges), research on family violence, HIV KAP studies, and a massive HIV peer-training

program. In recent years, much effort has been invested in monitoring and evaluating PEPFAR-funded HIV programs in the SANDF.

The provision of a dedicated research capacity within social work opened up space for intensified thinking about MilSW and the translation of these ideas into models and tools for social work practice and management.

Social Work Supervision Course

The fourth contextual factor that facilitated growth was the implementation of a series of social work supervision courses, headed by Arista Bouwer, a military social worker with a wide vision for social work. The courses were run to develop a cadre of senior social workers who could supervise younger social workers and contribute to the development of the quality of social work services in the SANDF. In the 1990s, this course incorporated the requirement to develop new social technologies for the social work department, thus serving to stimulate new thinking about and the evolution of MilSW.

In 1997, Alida Kruger and I (who were students on this course) were tasked to develop a model of MilSW practice. This model was widely reviewed by social workers throughout the SANDF and underwent a number of revisions. It has become the foundation of MilSW thinking and practice in the SANDF, guiding practice and shaping reporting requirements (Kruger & Van Breda, 2001). For example, the model is a key element of the induction training provided to all new social workers. In addition, a management information system was developed that required practitioners to report on their professional activities according to the four practice positions of the model.

Part of what was distinctive about this model was that it was grounded in occupational social work theory. Occupational social work was burgeoning in South Africa at the time, particularly in the mining industry, thanks in particular to Angela du Plessis, who ran a masters program in industrial social work at the University of the Witwatersrand (Du Plessis, 2001). Several SANDF social workers did this course and brought this theory into MilSW thinking.

This marrying of military and occupational social work lent a distinctive flavor to how social workers in the South African military think about their practice. Some military social workers in the USA, for example, have shaped their understanding of MilSW on clinical social work (e.g. Applewhite, Hamlin, BrintzenhofeSzoc, & Timberlake, 1995) or employee assistance programs (e.g. Ortiz & Bassoff, 1987). Both of these forms of social work tend towards a micro and therapeutic approach to social work practice. By contrast, occupational social work endeavors to work not only with employees, but also with the organization as client, promoting a more integrated and holistic approach to social work practice.

The provision of intensive training opportunities that incorporated an expectation of innovation in MilSW facilitated the development of new technologies for MilSW practice. The incorporation of occupational social work theory lent MilSW thinking a distinctive flavor, through its interest in facilitating organizational change.

THE MILITARY SOCIAL WORK PRACTICE MODEL

In the preceding section I proposed four key contextual factors that occurred in South Africa in the years following 1994 and the ways in which these factors contributed to the evolution of MilSW thinking in the SANDF. In this section I aim to give particular emphasis to one of those developments, namely the Military Social Work Practice Model (MilSWPM).

Occupational Social Work

As previously mentioned, MilSW in the SANDF has been influenced by occupational social work literature, though not uncritically. MilSW's initial thoughts about occupational social work were influenced primarily by the theoretical models developed by Googins and Godfrey (1987) and Ozawa (1980). Both models describe the development or "evolution" of occupational social work practice "along the continuum from micro to macro" (Du Plessis, 1994, p. 91). These models were valuable in shaping the evolution of MilSW in South Africa, and especially in challenging social workers towards more organizationally-based, macro activities. Nevertheless, they were found to be insufficient to guide military social work practice.

The key concern was with the notions of 'phases' or 'stages' (Googins & Godfrey, 1987; Ozawa, 1980). Military social workers in the SANDF tended to understand these terms to mean that in order to progress towards the higher and more sophisticated levels of practice they must abandon the individual as client in favor of the organization as client. These terms suggest that when one moves on to a next phase, the previous phase becomes of lesser importance or even irrelevant. Stage models of occupational social work are flawed because they are progressive, not additive – that is, they involve leaving one stage to progress to the next, rather than adding the stages together.

This tendency is mirrored in the use of the expression 'micro-macro continuum' (Du Plessis, 1994; Googins, 1987; Googins & Davidson, 1993). Du Plessis (1994, p. 169) locates occupational social workers along this continuum based on their emphasis on micro versus macro practice. A continuum, however, is a linear, two-dimensional construct that does not correlate with our organic and multifaceted reality. Postmodernist and systems theories reject linear models for this reason. When one places micro interventions at one end of a line and macro interventions at the other, micro and macro become polarized and thus mutually exclusive. Writers who use the micro-macro metaphor are forced, by the essential limitation of the metaphor, to repeatedly stress that macro interventions should be added to, rather than replace, micro interventions (e.g. Du Plessis, 1994, p. 169; Googins, 1987, p. 49).

These metaphors of 'stage' and 'micro-macro continuum' inadequately reflect the reality of social work practice, consequently confusing the developmental aspirations of social workers. In essence, they do not allow for the integration of different forms of intervention. This is reflected in the on-going debate in the literature regarding "Who is my client?" The answer has centered on the micro-macro distinction between the 'employee-as-person' and the 'person-as-employee' (Spiegel, in Du Plessis, 1994). This has been augmented by the notion of the 'organization as client' (Googins & Davidson, 1993). While these three conceptions of the occupational

social worker's clients are helpful, they are not integrated, and thus inadequately guide MilSW practice.

In response to these limitations, the SANDF developed a new MilSWPM in 1997. The MilSWPM aimed to integrate the various 'stages' of occupational social work, in line with developmental social welfare's call to bridge the micro-macro divide, to transform the micro-macro continuum from a line to a circle, and to address all potential client systems. It was hoped that the model would shape an understanding that MilSW development is not through a series of stages along a continuum, but rather, that development involves an expanding role, in which one gradually grows into a more comprehensive practitioner.

Binocular Vision

Social work is guided by various theories, most central of which is, arguably, ecosystems theory (Gitterman & Germain, 2008). Central to ecosystems is the notion of what Gordon Hamilton termed 'the-person-in-situation' which highlights the "threefold configuration consisting of the person, the situation, and the *interaction between them*" (Hollis & Woods, 1981, p. 27, emphasis added). However, social workers frequently struggle to think ecosystemically, and have a tendency to focus on either the person or the environment (i.e. the soldier or the military system), rather than on the integrated person-in-environment. Consequently, the MilSWPM proposes a new metaphor to facilitate the grasp of the notion of person-in-environment, viz. 'binocular vision'.

Wilfred Bion, the British psychoanalyst, proposed the term 'binocular vision' to describe a way of simultaneously seeing one thing with one eye and another thing with the other eye (in Casement, 1985, p. 4). This metaphor is adapted to suggest that the one lens is microscopic (looking at the individual and family), while the other is telescopic or 'macroscopic' (looking at the military organization). Binocular vision occurs when we simultaneously look through the microscopic and telescopic lenses. To close one or other eye is to lose one's depth perception, to lose half one's vision, which is to become handicapped in one's work.

Bateson used the metaphor of binocular vision in a similar way. He says (in Keeney, 1983, p. 37), "It is correct (and a great improvement) to begin to think of the two parties in an interaction [e.g. the soldier and the military] as two eyes, each giving a monocular view of what goes on and, together, giving a binocular view in depth. The double view is the relationship."

Binocular vision thus enables one to see a whole situation in greater depth, enhancing the quality and scope of assessment and intervention. It also shifts the focus off the two separate client systems and onto the relationship or interface between them. This relationship then becomes the client, much as in marital counseling the relationship is often defined as the client. Inherent in binocular vision is social work's commitment to promoting the fit between people and their situations or environments.

The utility of binocular vision for the military social worker is to provide a metaphor that will assist in making sense of the tension between commitment to the soldiers' interests and commitment to the military's interests. The MilSWPM contends that there ought to be tension in this area of MilSW, since it is only in the presence of

tension that true binocular vision is achieved (Googins, 1987). At the fulcrum of soldier-and-military lies the immense creative potential of MilSW. The metaphor of binocular vision assists military social workers in South Africa to remain at this fulcrum.

Binocular vision's creative potential can be realized by seeking out the most problematic point of interface between soldiers and the military. The cutting edge of MilSW can be located at this point. The following four questions can assist in identifying this point:

- ❖ What are the unique demands the military places on its members?
- ❖ What are the unique demands soldiers place on the military?
- ❖ What human skills are required by members to be effective in their work?
- ❖ What organizational systems/structures are essential to ensure military readiness?

By addressing themselves to the point at which the military and soldier fit least well, military social workers are able to ensure that they play a pivotal role in the achievement of the military's mission and in the well-being of soldiers and their families. In business terminology, the social worker's ability to facilitate these problematic points of interface is one of the organization's critical success factors.

The Military Social Work Practice Model

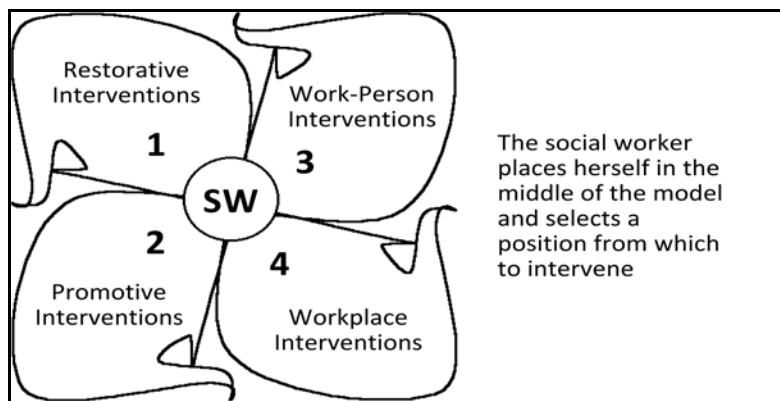
The MilSWPM endeavors to move away from the language of 'stages' that was found to be a limitation of much occupational social work literature. Instead, the model uses the term 'position', which was coined by Melanie Klein (the post-Freudian child analyst). Klein (in Hinshelwood, 1991, p. 393) used the term to avoid the sense of prescriptive progression through Freud's psychosexual stages of development, as well as to describe the positions from which a human child or adult may view the external world and experience the internal world.

The MilSWPM's preference for the concept 'position' is not mere semantics. It allows for a greater fluidity of movement between positions. Positions are less value laden, so that one position is not necessarily better or more important than another position, merely more appropriate. A practice model comprising positions is more organic and holistic than one comprising stages/phases. It avoids the pitfalls of linear thinking by ensuring circularity.

The MilSWPM, therefore, comprises four practice positions from which a military social worker may intervene (Figure 1). Each position describes a different way of perceiving a problem, a client, an intervention or one's own role. The four positions, which will be described below in some detail, are:

Position One:	Restorative Interventions
Position Two:	Promotive Interventions
Position Three:	Work-person Interventions
Position Four:	Workplace Interventions

Figure 1. Military Social Work Practice Model



Position One: Restorative Interventions

In this position the military social worker renders a problem solving service to people who have an identified biopsychosocial problem. The intervention is aimed at restoring the client's problem solving and coping capacities. The soldier is viewed first as a person, and only secondly as a soldier. Any intervention that addresses people's problems at a personal level falls into this position.

The presence of a problem may suggest that all position one interventions are therapeutic. Therapy, however, is only one form of problem resolution and is typically individually focused. Not only individuals, but also couples, families, groups and even whole communities can have problems. The size of the client system is irrelevant in the MilSWPM. When people request assistance in resolving their personal problems, a position one intervention is typically appropriate. It should be clear, then, that I avoid micro-macro distinctions in the MilSWPM. Case, group and community work all have a place in position one.

In order for a problem solving intervention to be located in position one, it should not directly address the work-person interface. Position one interventions thus address problems that are primarily of a personal nature, e.g. substance abuse, marital distress, adjustment difficulties, child abuse, family problems, financial difficulties, poor sanitation, and high crime rates. Work-related problems may be addressed, but the intervention in this position does not directly aim to facilitate the work-person interface. If, for example, a client presents with alcohol dependency that is influencing his/her work, a position one intervention could be to enable sobriety. As soon as the social worker focuses directly on the fit between the soldier and his/her work (e.g. should the worker be dismissed or not?), s/he has moved to position three. Because binocular vision is relevant at all four positions, it is important to note that although position one interventions address the employee-as-person, the person is also an employee. It is thus likely that her/his functioning in the workplace will also be impacted by the intervention, albeit indirectly.

In brief, then, position one interventions are directed at helping people resolve their problems at a personal, non-work-related level so as to restore healthy psychosocial functioning.

Position Two: Promotive Interventions

In this position the military social worker renders a preventive, educational and developmental social work service. These interventions are aimed at promoting or enhancing the social functioning of people. These people have psychosocial needs that the social worker assists in fulfilling. As in the previous position, soldiers are viewed first as people and only secondly as soldiers. Any intervention that addresses the needs of people (rather than their problems) at a personal level falls into this position.

Positions one and two are similar in most respects, except one: rather than problem resolution, position two focuses on promotion of need fulfillment, thus an emphasis on building resilience and adopting a strengths perspective. Promotive interventions may aim to prevent the escalation of a social problem that would require restorative interventions, thereby promoting the human need for well-being. The social worker may also assist clients who have an unalterable problem, but who desire to live more fully despite the problem. A psychoeducational intervention for the families of schizophrenic patients is an example of this.

A broad range of interventions is possible in position two. The military social worker may make use of case work, group work, community work, psychoeducational workshops, lectures, seminars, pamphlet and poster campaigns, and exhibitions. As in position one, the client system covers the full micro-macro range and interventions are addressed at a personal level; interventions that directly address the worker-work interface fall into position three (although binocularity simultaneously argues that a position two intervention will, indirectly, impact on the clients' job performance).

In summary, position two interventions aim at promoting healthy psychosocial functioning and resilience by facilitating people's needs at a personal, non-work-related level.

Position Three: Work-person Interventions

In this position the military social worker addresses the systems of interpersonal relationships within the workplace in order to produce a productive work community. Interfaces between the workplace and other systems (e.g. the family or community) are also important in this position. Any intervention that addresses people in relation to the work setting falls into position three.

The fundamental distinction between the first two and last two positions is that the military social worker's attention now shifts to the interface between the soldier (worker) and the military (workplace). As soon as an intervention seeks to facilitate the ability of people to fit with the workplace (including colleagues, managers and the organization itself), the social worker has moved to position three.

Conceptually, the military social worker endeavors to facilitate the interfaces between the workplace and people (hence Work-Person Interventions). The interface will often be between workers themselves, or between a worker and the workplace.

Position three interventions may also focus on the interface between the workplace and the soldier's family, particularly when families are helped to tolerate or transcend military demands (e.g. the Deployment Resilience Seminar).

In this position the military social worker may utilize group work techniques, problem solving processes, experiential exercises, community development, team building, community building, negotiation, mediation, and participation in committees and workgroups.

In brief, then, position three interventions strive to promote a healthy work-person interface by addressing soldiers in relation to the military setting.

Position Four: Workplace Interventions

In the fourth position the military social worker focuses on the military as an organization so as to create a conducive work milieu. Here the worker is interested in establishing standard practices, structures, processes and policies that will benefit the functioning of the organization and thereby also the employee. This entails a more radical approach to social work practice, focused on structural or systemic changes at macro level. Any intervention that addresses the workplace itself falls into position four.

Positions three and four are similar inasmuch as both address the work-person interface. While position three focuses on people, however, position four focuses on the workplace itself. Where position three endeavored to enable soldiers to adjust to the needs of the military, position four endeavors to enable the military to adjust to the needs of soldiers.

The military social worker works with the organizational dimensions within which soldiers function. While there may be a complete turnover of soldiers in a particular unit, the unit itself remains the same; individual soldiers are simply present in the unit at this point in time. These organizational dimensions can include the structure or hierarchy, culture, processes and procedures, policies, politics, setting, and physical layout.

The role of the military social worker is that of change-management consultant, social activist, social engineer, policy maker, systems analyst, researcher, and organizational development consultant. The social worker assists the workplace in developing a structure or way of working that promotes optimal productivity, effectiveness, morale and social well-being among employees. The worker plays an integral part in the management of the workplace, being a specialist on the interface between an impersonal organization and a personal workforce. In focusing on this interface, the social worker humanizes and may serve as the social conscience of the organization.

In conclusion, position four interventions target the workplace itself for the reciprocal benefit of both the military and the soldiers (and their families).

PRACTICE EXAMPLES

The SANDF is one of the largest employers of military social workers in South Africa. A complete range of social work services is provided to military employees, their families and the SANDF itself. Only statutory cases are referred to outside

welfare agencies. This section provides brief practice examples for binocular vision and the four positions.

Binocular Vision

Previously I suggested that the creative potential of binocular vision could be realized by seeking out the most problematic point of interface between soldiers and the military. In most military contexts this point is located at the military's requirement of *operational readiness*. Operational readiness is the military's demand that all employees are able to perform operational duties (e.g. peace keeping missions and combat operations) at any time (Segal & Harris, 1993).

The SANDF has addressed itself largely to ensuring that soldiers are capable of performing their tasks and functions during military operations. Limited attention has been given to the emotional dimensions of operational readiness, let alone to the effects on and role of families.

As a result, in the mid-1990s SANDF social workers conducted several research projects to evaluate the impact of operational readiness on employees and their families, to evaluate the effect of families on the operational readiness of the organization and on the characteristics of a good fit between families/soldiers and the organization in terms of operational readiness (Herbst, 1995; Kruger, 1997; Mathee, 1997; Van Breda, 1997a).

In this research we can clearly see binocular vision at work. The studies were able to assess both the military's and the family's contribution to operational readiness and the factors which social workers needed to promote to ensure (a) well functioning families and soldiers, (b) an operationally ready organization, and (c) a good fit between soldiers and the military.

Position One: Restorative Interventions

Vignette 1. One social worker worked with a young man whose chaotic childhood had left him with a disordered personality, which impacted on all areas of his life. The social worker focused on the client's personal relationships and self-esteem. The client's sense of adequacy improved which reflected positively in his private and work lives. The intervention aimed at restoring the client's ability to relate to others in a positive and productive way.

Vignette 2. Another social worker was struck by the number of battered wives seen in her unit. She therefore began a weekly treatment group for these women that replaced their individual therapy. The social worker taught the women about the cycle of battering, their legal rights and the community resources available to them and facilitated on-going problem solving. This group work intervention entailed the restoration of personal power.

Position Two: Promotive Interventions

Vignette 1. One social worker ran a stress management course for the management team of his unit at the request of the Commanding Officer, who wished to enhance the well-being of his team members. The course ran for three days and addressed a broad range of principles and techniques of stress management. In the process, a more personal level of interaction developed in the management team that

had not been evident before. This course was intended to enhance and promote the clients' personal functioning.

Vignette 2. A clinical social worker was approached by a soldier who was interested in her dreams. The social worker assessed the client's functioning and found no significant psychosocial problems. They worked for several months, making sense of the client's dream life. The social worker sought to promote the client's individuation or self-actualization.

Position Three: Work-person Interventions

Vignette 1. I developed a psychoeducational program that contributes to the operational readiness of military employees and their families (Van Breda, 1997a, 1999). The program develops seven factors that are present in families who are resilient to the repeated separation of a soldier from the family unit. In so doing, this program promotes the family's ability to fit with a stressful organizational demand.

Vignette 2. Another social worker was consulted by a soldier who had significant frustrations with his supervisor at work. After assessing the problem, it appeared that there was a conflict of interest between the client and his supervisor. The social worker suggested that she mediate between them. Both the soldier and his supervisor agreed that the mediation was valuable in ameliorating a long-standing work conflict between them.

Position Four: Workplace Interventions

Vignette 1. One social worker heard repeated complaints from black African members of her unit that only Western food was being served in their living quarters. The social worker formed a joint employee-management committee and facilitated discussions, which led to a change in the unit's provision of food – traditional African food was also served. This worker used community work processes to address a problem of organizational culture.

Vignette 2. A social worker was concerned that naval management should address its own role in the operational readiness of naval families. He therefore wrote several reports to his unit and to naval headquarters, making recommendations on how to reduce the deployment stress of sailors and their families. In meetings he emphasized how executing these recommendations would enhance the operational readiness of the unit (thereby emphasizing the problematic point of interface). This led to the formation of a work team at naval headquarters to address the matter.

CONCLUSIONS

MilSW in South Africa has evolved over the years with its own distinctive flavor. This evolution has been shaped by a variety of contextual factors, particularly the transition from Apartheid to a non-racial democracy in 1994. Three other relevant contextual factors include engagement with military families, the establishment of a dedicated MilSW research capacity and the implementation of a series of social work supervision courses. In raising these four contextual factors, I hope to have shown how MilSW thinking takes place within particular local contexts and does not exist in the abstract.

The implication is that if we hope to see further evolution in MilSW thinking (including theory development) militaries need to create or capitalize on existing contextual factors. It is noteworthy that two of four factors identified involved creating spaces for social workers to step away from action and into reflection. A third factor involved social workers taking a ‘one-down’ position and learning from their clients. A fourth factor involved locating MilSW more squarely in the mainstream of developments within social work and social welfare at national and international levels. All four of these factors disturbed the MilSW status quo and demanded new ways of thinking about practice.

The MilSWPM has been advanced as a central exemplar of this kind of new thinking in South Africa. It illustrates MilSW’s engagement with a body of theory (primarily occupational social work, but also elements of developmental social welfare, ecosystems, cybernetics and psychoanalytic theories) and the critical integration of selected aspects of this theory into our own understanding of MilSW. The new thinking is also spurred on and informed by real-world practice concerns, such as the tendency of military social workers to ally with either soldiers or military management or the perception that good MilSW practice involves abandoning micro practice in favor of macro practice.

In addition, most of the developments noted in the preceding section have influenced the conceptualization of the MilSWPM. For example, the notions of working to change the military system itself, rather than aiming to change only the individuals within the system, were informed by the transition to democracy, the emergence of developmental social welfare, and a greater commitment to social action and structural change. The notions of resilience shaped the understanding of Promotive Interventions and Work-Person Interventions, both of which emphasize a striving for balance, rather than the elimination of pathology.

The MilSWPM, in itself, serves to advance our thinking about MilSW. It is the only substantive model of MilSW available in the literature. While it has been discussed in various publications (Daley, 2003; Kruger & Van Breda, 2001; Van Breda, 2009; Van Breda & Du Plessis, 2009), this is the most comprehensive published presentation of the model. It is hoped that the model may expand and guide MilSW practice in other militaries, stimulating the development of new knowledge and theory.

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Supporting Resilience in the Academic Setting for Student Soldiers and Veterans as an Aspect of Community Reintegration: The Design of the Student Veteran Project Study

Alexa M. Smith-Osborne

Abstract: *The Post 9/11 GI Bill is leading an increasing proportion of wounded warriors to enter universities. This paper describes the design and development of an adapted supported education intervention for veterans. The intervention trial was one of two projects which grew out of a participatory action research process aimed at supporting reintegration of returning veterans into the civilian community. This intervention is being tested in a foundation-funded randomized controlled trial in a large southwestern university, with participation now extended to student-veterans at colleges around the country. Some protective mechanisms which were found in theory and in prior research were also supported in early results. SEd intervention was associated with the protective mechanisms of support network density, higher mood, and resilience. Practitioners may benefit from the lessons learned in the development of this supported education intervention trial when considering implementation of this complementary intervention for veterans reintegrating into civilian life.*

Keywords: *Veterans, resilience, supported education, psychiatric rehabilitation, GI Bill*

INTRODUCTION

The Department of Defense (DoD) has initiated innovative efforts to support mission readiness and prevent mental health problems among troops in current conflicts. These efforts use two theoretical frameworks, resilience and positive psychology, which show goodness of fit with military emphasis on proactive preparedness and adaptive fitness and training (e.g., Britt, Adler, & Bartone, 2001; Castro, 2008; Cornum, Matthews, & Seligman, 2011; Mojica, 2010; Office of the U.S. Army Surgeon General, 2003, 2008, 2009; Orsingher, Lopez, & Rinehart, 2008).

Community institutions which serve military members and families, taking over educational, health, and social service delivery from DoD institutions when military service is done, may enhance continuity of care and community reintegration by adopting service models consistent with these theoretical frameworks. Choice of theory has important implications for measurement (Luthar, 1993, Luthar & Cushing, 1999), goodness of fit of intervention with target group (Greene, 2007; Holter, Mowbray, Bellamy, MacFarlane, & Dukarski, 2004; Luthar, Sawyer, & Brown, 2006), and fidelity of intervention implementation (Bond, Evans, Salyers, Williams, & Kim, 2000; Borrelli et al., 2005). Academic settings are one important community institution for returning service members, as pursuing higher education has been identified as a key goal for

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today's All Volunteer Force (AVF) soldiers (Asch, Fair, & Kilburn, 2000; Fernandez, 1980; National Priorities Project, 2006), including those with this combat era's signature conditions (Hall, 2009; Tanelian & Jaycox, 2008). This paper describes the design and development of an innovative intervention utilizing a resilience theoretical framework to support community reintegration via the academic setting, and reports first wave results.

THEORETICAL CONSIDERATIONS: WHO MAY BENEFIT FROM SUPPORTED EDUCATION FOR VETERANS AND THROUGH WHAT MECHANISMS

This author's prior resiliency-based research has suggested several potential protective mechanisms which may operate to support educational attainment for AVF veterans with mental health risks and service-connected disabilities (Smith-Osborne, 2009a; 2009b). Further, evidence-based practices in supported education (SEd) have already been established for the civilian college population with psychiatric disabilities (Anthony & Unger, 1991; Holter, Mowbray, Bellamy, MacFarlane, & Dukarski, 2004; National Public Radio, 2002); approaches to their wider dissemination have also been investigated (Mowbray, Bellamy, Megivern, & Szilvagi, 2001; Mowbray, Moxley, & Brown, 1993). How might supported education, adapted to a resilience theory framework consistent with military prevention programs, operate to promote recovery, community reintegration, and advancement for military/veterans in the academic setting?

The resilience theoretical paradigm would indicate that supported education can operate by four protective processes against mental health risk (Rutter, 1990). Initial findings from this intervention trial (reported below) suggest that supported education intervention for this population may operate by several of these processes. The first type of protective process reduces the risk impact, which could be suggested in this intervention trial by reduced or stable levels of symptoms (e.g., post-test PTSD symptoms) for the intervention group compared to unchanged or increased symptoms for the control group while functioning in the academic setting. Operation of the second type of process, to reduce negative chain reactions stemming from the risk factor, would be suggested by unchanged or decreased post-test resilience scores in the control group compared to increased or sustained scores in the intervention group. The third type of process promotes resiliency traits, which could be suggested by higher posttest scores on resilience and associated evidence-based protective factors (such as informational support network measures) for the intervention group. The fourth type of process operates by setting up new opportunities for success. The recent passage of expanded financial aid benefits under the new post 9/11 GI Bill represents one such opportunity (McChesney, 2008; Merrow, 2008). However, prior research suggests that the GI Bill alone may not be sufficient to support veterans' access to higher education without effective collateral social, health, academic, and income support systems (Smith-Osborne, 2009a; 2009b). Brokering of concrete and informational resources necessary to educational success (e.g., internships, scholarships, faculty mentoring, family income support, and child care) is a component of supported education models (Anthony & Ungar, 1991; Mowbray, 2002). Intervention effects on educational attainment variables such as college entry, use of non-

VA as well as VA financial aid, grade point average, and retention could provide evidence that supported education operates by this process.

A parallel theoretical paradigm which may be useful is the job control model for high demand and ambiguous work contexts (Dubow, Schmidt, McBride, Edwards, & Merk, 1993; Karasek, 1979). Ambiguity may characterize academic settings as contrasted with the more highly structured and directive military occupational setting (although both are high demand). This model suggests that increased latitude (relative flexibility and autonomy) in making decisions about work methods and scheduling mediates ambiguity and conflicting demands so as to prevent burnout. From this perspective, a preventive mechanism by which supported education could support resilience is through providing targeted consultation and mentoring to student veterans in exercising decision latitude in their educational decisions, thus preventing emotional exhaustion which may be related to school drop-out (Hobfall, 1989; Hobfall, Johnson, Ennis, & Jackson, 2003; Meilman, Manley, Gaylor, & Turco, 1992). Thus, a supported education model such as the Choose-Get-Keep program (Collins, Mowbray, & Bybee, 1999), which utilizes an explicit goal-setting and decision-making protocol, may operate via increasing decision latitude to prevent emotional exhaustion and (potentially) college drop out.

A higher proportion of AVF troops are married with families, compared to earlier combat era cohorts (Defense Manpower Data Center, 2008; Karney & Crown, 2007), suggesting that family resilience may also need to be addressed in order to support student veteran resilience. Lavee, McCubbin, and Patterson's double ABCX model of Family Adjustment and Adaptation (1985) has been used to investigate military families under stress and to suggest ways to enhance family resilience in earlier conflicts (McCubbin & Dahl, 1976; McCubbin, Dahl, Lester, Benson, & Robertson, 1976; McCubbin, Hunter, & Dahl, 1975). The double ABCX model highlights the importance of family appraisals of the associated hardships, and of the perceived resources and vulnerabilities for dealing with them, rather than solely the stressors themselves. The later revised version, the Resiliency Model of Family Adjustment and Adaptation, includes post-crisis variables descriptive of the long-term adaptation phase (McCubbin & McCubbin, 1991), suggesting goodness of fit for supported education intervention.

STUDENT VETERAN PROJECT INTERVENTION DESIGN

Current service delivery systems and models are reported to have limitations in reaching and serving AVF personnel with service-connected co-morbid conditions (Batten & Pollack, 2008; Hoge, Auchterlonie, & Milliken, 2006; Seal et al., 2010). Design and development of innovative interventions for this population must address these limitations, as well as be based on applicable substantive theory and empirical efficacy and effectiveness evidence. Therefore, the design of the target intervention began with a participatory action research (PAR) approach (Viswanathan et al., 2004) to engaging a range of stakeholders in the community, the VA, and higher education settings in the identification of these limitations and how they could be addressed in connection with veterans' educational goals (Smith-Osborne, 2009c). From this process emerged two trajectories: the development of efforts to enhance a veteran-friendly campus at the host institution under the auspices of a newly created interdepartmental

steering committee (being studied as implementation research [Fixsen, Naom, Blase, Friedman, & Wallace, 2005] using mixed methods) and the development of a randomized clinical trial of an adapted manualized supported education program with a comparison “usual care” group and a wait-listed control group. This paper reports on the second effort.

The clinical trial, entitled the Student Veteran Project, selected the Choose-Get-Keep supported education model (Sullivan, Nicolellis, Stanley, & MacDonald-Wilson, 1993) as the experimental intervention due to its established efficacy and effectiveness with civilian populations, the consistency of its goal-setting emphasis with the job control theoretical model, and its consistency as a psychosocial rehabilitation program with resilience and family resilience theory (Carpenter, 2002), as described above. This Choose-Get-Keep model has a manualized protocol developed by the Boston University Center for Psychiatric Rehabilitation (Knighton, McNamara, & Nemec, 2002) which is being slightly adapted for veterans with the participation of a student-veteran advisory group. The manual identifies more than 70 practitioner skills that facilitate client success in the educational environment; examples are requesting assistance, taking notes, developing a study plan, budgeting, recognizing conflict signs, disclosing disability information, requesting feedback, and responding to feedback. In the interest of fidelity and generalizability, the adaptations are limited to the skills practice components (e.g., role play scenarios) of the lesson plan modules. They are modified to reflect typical student veteran environment: for example, a house share with other veterans, some of whom are non-students, rather than a residential rehabilitation program, and budgeting which includes a VA disability pension instead of a Supplemental Security Income benefit.

A protocol for the comparison group was developed based on information and referral case management strategies commonly used in academic advising and retention of non-traditional students (Astone & Schoen, 2000; Calloway & Jorgensen, 1990; Ofiesh, Rice, Long, Merchant, & Gajar, 2002; Paul, 2000; Rummel, Costello, Acton, & Pielow, 1990; Swail, Redd, & Perna, 2003; Weiner & Wiener, 1997). Such strategies typically use student-accessed online information platforms, and case management through email and telephone follow-up, so this “usual care” group protocol emphasizes these technology-mediated contacts.

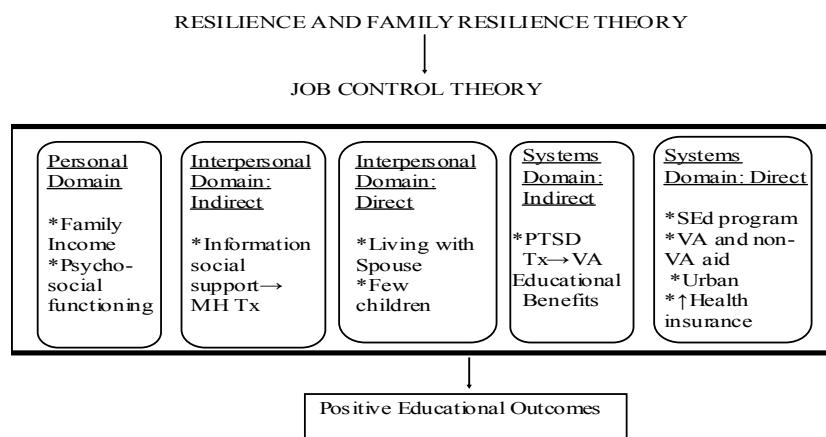
Prior research (Smith-Osborne, 2005; 2009a; 2009b) provided the foundation for intervention design, identifying resilience protective mechanisms moderating or mediating the impact of mental health risk factors on educational attainment at the personal, interpersonal, and systems (see Figure 1); they are incorporated in both the target intervention model and in usual care, and are communicated in study recruitment as well as during the setting of intervention goals.

METHOD

Design

As introduced above, one result of the PAR process was the development of a three group randomized controlled clinical trial of SEd for veterans returning to college. Procedures for random assignment and allocation concealment are described in Smith-Osborne (2008; 2009c).

Figure 1. Empirically identified protective factors applied within the selected theoretical frameworks incorporated within the target and comparison interventions.



MH = mental health; Tx = treatment; PTSD = Posttraumatic Stress Disorder; VA = Veterans Administration; SEd = supported education program.

Sample Recruitment

Approval was obtained from the author's Institutional Review Board (protocol 07.225s). Participants are recruited at community events, employment offices, veteran services, and colleges (see Figure 2).

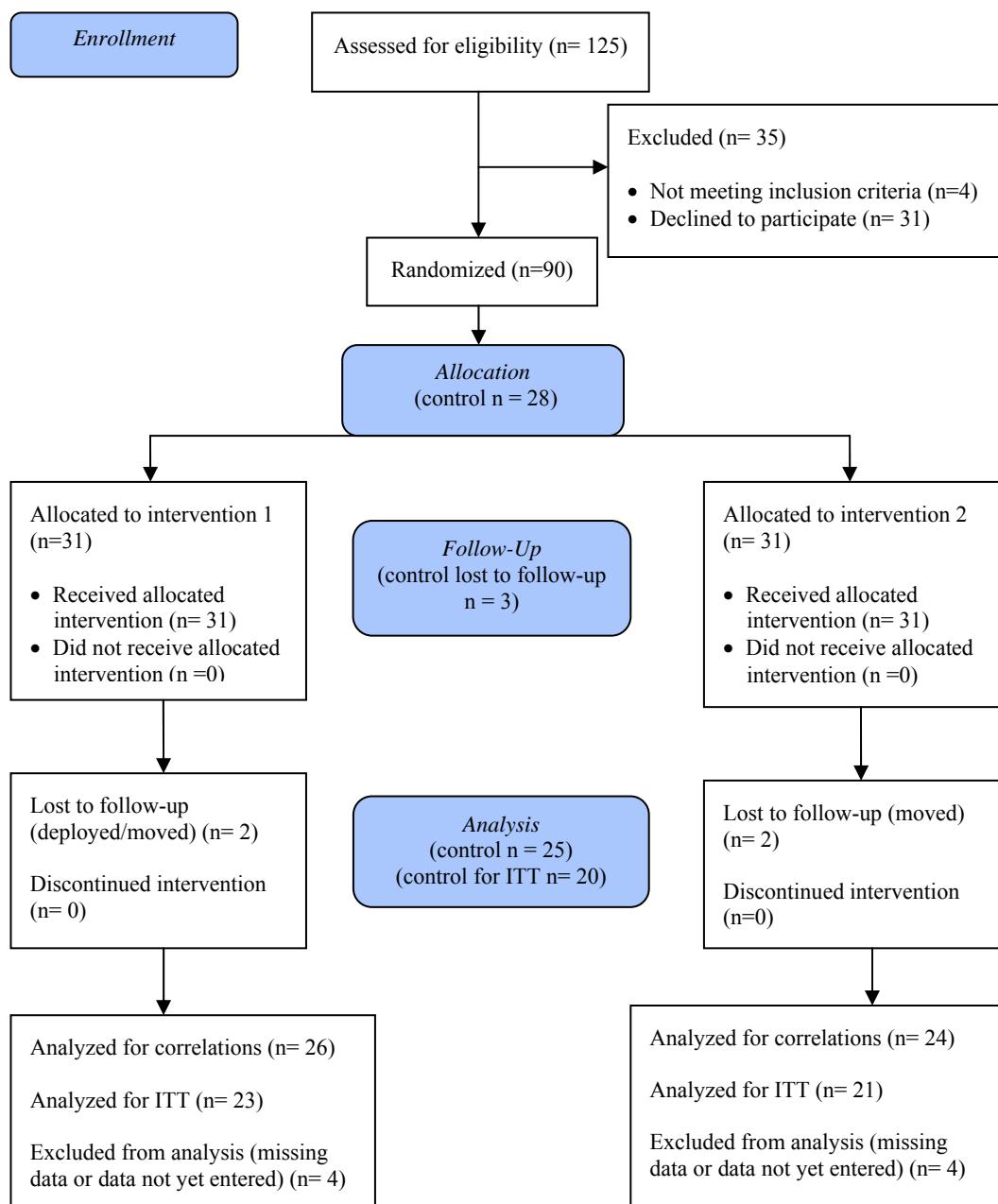
MEASURES AND PROCEDURES

Measures

Participants complete questionnaires at pre-random assignment, post-intervention period, 6 months follow-up, and 12 months follow-up. Data on contact frequency and type ("dosage"), health status, and mental health treatment engagement are collected from case records maintained during the intervention period and from qualitative interviews. Baseline analyses examine demographics and measures of resilience (Resilience Scale for Adults), social support (Perceived Neighborhood Scale), social

network density (Density of Support), PTSD (PTSD Checklist-Military), mood (Short Mood and Feeling Questionnaire), and substance abuse (CAGE-AID). A complete description of measures may be found in Smith-Osborne (2008) and of the conceptual and logic and measurement model in Smith-Osborne (2009c).

Figure 2. Participant flow chart following Consolidated Standards of Reporting Trials guidelines. ITT = intent to treat.



Intervention Fidelity Strategies

Fidelity procedures were developed and progressively refined during this design phase of the project (Smith-Osborne, 2011). Fidelity ratings enhance validity in clinical trials, and provide an important base for translation of results to implementation as evidence-based practices by community providers (Borrelli et al., 2005; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Mowbray, Holter, Teague, & Bybee, 2003). Fidelity strategies recommended by Borelli et al. (2005) were utilized. Intervention adherence was assessed for the following standards. Intervention dose consists of a standardized 1 hour intake interview, followed by contact sessions over 26-30 weeks. The minimum 4 sessions for the manualized intervention (group 1) are 1.5-2 hour sessions. The minimum 4 sessions for group 2 are delivered through an online platform, email, telephone, and face to face contact. Contact \geq 30 minutes addressing an intervention goal are counted and online platform use is tracked. Videotapes of the experimental intervention and progress notes of the usual care comparison were also rated by a trained practitioner panel using a standardized checklist.

Staff Training

During the PAR phase of intervention development, prior to intervention delivery, online training modules were developed and pilot-tested for this study to provide training in military culture and benefit structures, to support implementation of the Choose-Get-Keep manualized protocol with a military population, to support uniform implementation of the usual care services, and to provide grounding in the theoretical framework and targeted protective mechanisms. All providers used a standardized intake format (Cournoyer, 2008) and Study-specific multi-component (Herschell, Kolko, Baumann, & Davis, 2010) training and supervision.

DATA ANALYSIS

Baseline Data

See Table 1 for sample characteristics. This population resembles the average demographics of AVF veterans, except for higher educational level at time of study enrollment (AVF average is 14 years, the same as draft-era Vietnam veterans; Smith-Osborne, 2009a). Descriptive, bivariate ($n = 75$), and multiple regression analyses ($n = 26$) using SPSS 17.0 of the developmental phase sample examine demographic and key risk and protective factors for baseline and short term (pre/post) completers (Little, 1995; Pocock, 1992; Schulz & Grimes, 2005a, 2005b).

Exploratory analyses of the key factor of resilience were repeated using intent to treat procedures ($n = 64$). Intent to treat analyses use the entire sample that was randomized regardless of intervention dosage/participation. These linear mixed model repeated measure analyses for the two time points with multiple imputations for missing values were conducted using SAS 9.0 (Abraha & Montedori, 2010; Cook & DeMets, 2008; Singer, 1998). This type of intent to treat analysis is more robust in handling groups of

unequal sizes, non-normal data, and categorical and continuous variables in longitudinal data in clinical trials, thus reducing error and increasing statistical power (Beunckens, Molenberghs, Verbeke, & Mulinckrodt, 2008; Frison & Pocock, 1992; Keselman, Algina, & Kowalchuk, 2001). Effect sizes Cohens *d* statistic were calculated for T1 versus T2 for each condition for *t* test and mixed model analyses.

Table 1. Baseline Characteristics by Group (n=75)

Variables	Group 1 (n=26) % or <i>M</i> (SD)	Group 2 (n=24) % or <i>M</i> (SD)	Group 3 (n=25) % or <i>M</i> (SD)
Gender:			
Male	84%	56%	88%
Female	16%	40%	8%
Age	32.68 (10.92)	31.83 (8.45)	32.67 (11.44)
Ethnicity:			
Non-minority	52%	64%	56%
Minority	48%	32%	36%
Marital Status			
Married, Living with Spouse	32%	32%	36%
Other	68%	64%	56%
Education in Yrs. (range 12-18)	14.12 (1.54)	14.15 (1.39)	14.11 (1.29)
Used nonVA Aid	40%	64%	36%
Used VA Aid	84%	72%	76%
Learning Disability	24%	24%	32%
Health Status (range 1-4)	1.76 (.83)	1.92 (.88)	1.91 (.95)
# Health Conditions	2.04 (1.34)	1.42 (.83)	2.00 (1.27)
Resilience (range 74-210)	161.18 (31.49)	157.41 (34.56)	137.50 (40.26)
Mood (range 19-39)	34.95 (3.41)	33.94 (16.45)	34.00 (5.05)
Social Support (range 4-46)	28.44 (12.85)	24.61 (10.35)	28.22 (13.19)
Network Density (range 0-16)	8.33 (4.79)	6.91 (4.79)	5.95 (5.08)
Alcoholism (range 0-2)	1.00 (.00)	.58 (.33)	.88 (.6)
PTSD (range 17-26)	36.09 (19.82)	34.61 (19.13)	35.10 (18.76)

Note. Percentages may not total 100% due to missing data.

Completion Rate and Fidelity of Implementation

Eighty percent of group 1 participants and 83% of group 2 participants completed the minimum four contact sessions. One control group member and no intervention group members who were enrolled in college in the pilot phase at Time 1 dropped out by Time 2. Fidelity for the group 1 manualized model was rated as moderate overall ($M_{range\ 1-5} =$

3.67, $SD = 1.34$), although interrater agreement on the dichotomous items (e.g., worker referred to lesson plan during session: yes/no) was low (Fleiss's kappa = 0.22; Fleiss, 1971). Eighty-three percent of participants in the pilot phase met both fidelity criteria of completion rate and contact content analysis findings.

Protective and Risk Factors

Initially, after analyses for descriptive statistics and assumption tests were done, Pearson's r correlations were analyzed to focus on one risk and one protective predictor variable identified in prior cross-sectional research and resilience theory and on experimental condition (group) that had significant relationships at the .05 level with the risk and potential protective factors. The predictors found to be significant in the bivariate analyses were intervention group assignment, which was correlated with the potential protective factors of denser support networks ($r = -.41$, $p < .05$), and control group assignment, which was correlated with higher levels of the risk factor PTSD symptoms ($r = .47$, $p < .05$).

In multiple regression completer analyses ($n = 26$), intervention was significantly related to higher post social network density scores ($B = 3.66$, $p = .04$, $R^2 = 18.5\%$, Adj. $R^2 = 14.8\%$) and control group with higher post PTSD symptom scores ($B = -15.54$, $p = .03$, $R^2 = 17.4\%$, Adj. $R^2 = 14\%$). Consistent with prior cross-sectional research, these findings suggest that supported education interventions may increase social support as a protective factor and reduce PTSD as a risk factor for educational attainment. The effect size is weak to moderate (Cohen, 1988).

Resilience is a key protective factor postulated by the theoretical framework of the trial. Therefore, exploratory completer and intent to treat analyses were performed. Paired sample completer t tests ($n = 26$) suggested that neither intervention group had significantly changed in resilience scores ($t_{25} = .057$, $p = .96$), whereas the control group decreased significantly from pre to post ($t_{25} = -3.30$; $p = .01$). Findings suggest that supported education intervention may support resilience in the experience of stressors associated with reentry into the civilian life trajectory of college attendance. Intent to treat analyses were conducted using the SAS multiple imputation procedure for missing data. Mixed models with six fixed effects, plus intercept, were fit to these data. The six effects were group assignment, gender, race, marital status, time (1 and 2), and GPA, with experimental groups 1 and 2 contrasted to control group 3. Mixed repeated measure group effects for resilience in the intent to treat group and in the paired sample t test for the completer group were statistically significant. These data suggest that intervention (both groups combined) compared to wait list is significantly associated with higher resilience scores at posttest. The effect size is moderate for both conditions, consistent with the literature.

LESSONS LEARNED AND APPLICATIONS TO PRACTICE

Completion rates of the minimum intervention "dosage" were acceptable. Early non-utilization rates led to an additional search of the clinical trial literature (e.g., Cooper et al., 2009) and early adoption of an evidence-based procedure of conducting pre-

randomization and then final randomization assignment after eligibility confirmation, informed consent completion, and completion of the intake interview for all participants. Fidelity findings were mixed for the manualized protocol, leading to plans for the addition of a fidelity checklist to each group 1 case record, as well as protocol readiness checklist at each training session. Fidelity levels for usual care met expectations, both for common treatment elements (Hart, 2009) and elements specific to technology-enhanced services (Parasuraman, Ziethaml, & Malhotra, 2005). Fidelity and attrition prevention will be further supported by addition of an automated voicemail and cell text service, currently in field testing, to issue reminders for referrals, appointments, and posttests and collect data on responses to monitor follow-through. This interactive web phone technology will be used in applications to prevent or determine the cause of missed classes/appointments and to inform participants' case managers.

This report on project development examined a limited number of protective factors targeted in intervention from Time 1 to Time 2. Some protective mechanisms which were found in theory and in prior cross-sectional and meta-analytic research were also supported in these findings: intact nuclear family, resilience, and VA and non-VA financial aid were correlated with educational attainment, while SEd intervention was associated with support network density, higher mood, and resilience. This may suggest that practitioners, be proactive in providing or brokering couples and family counseling and support services for families of student veterans, despite eligibility limitations on university mental health services, some private health insurance, and some VA services which exclude couples counseling or a non-student spouse for services. Practitioners with this population need to attend to concrete resources, including all forms of financial aid, concomitantly with clinical services, consistent with a generalist social work model. Of course, these preliminary findings are cautiously reported due to their consistency with the prior literature, since instability of results can characterize early phases of a longitudinal clinical trial. Results become more reliable and stable as sample size increases (Schulz & Grimes, 2005b).

Next steps in this research will implement examination of possible differences in effectiveness of the two experimental conditions in an enlarged sample over additional time points. Since the study will include multiple measures of several key variables, it will be possible to consider differences among outcome variables depending on measure, which were beyond the scope of this initial report. Future reports will also address theoretical implications of the results for resilience theory development and suggest future research to examine the alternative decision-making model using, for example, emotional exhaustion measures.

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Child Parent Relationship Training (CPRT): Enhancing the Parent-child Relationships for Military Families

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Abstract: *Military families experience increased stress when facing issues of deployment, separation, and reunification. The increased stress impacts the parent-child relationship as well as child behavioral and emotional well-being. Although recognizing the resiliency of military families, research points to the need to monitor parental stress both pre- and post-deployment and highlights the inherent risks that separation and reunification pose for the parent-child relationship bond. This pilot study was designed to explore the effectiveness of the Child Parent Relationship Therapy (CPRT) Training Model as a proactive method of enhancing parent-child relationships, reducing parental stress, and preventing negative impact of military separations on children.*

Keywords: *Child-parent relationships, filial therapy, military families*

INTRODUCTION

As growing numbers of children are affected by parental military deployment, it is essential that social workers implement effective practice methods to prevent negative impact on the parent-child relationship in military families. The impetus for this pilot study was the growing interest in providing on campus programming to address the needs of military families particularly as a number of military parents were attending the university. The purpose of the project was to contribute to expanding and refining the knowledge base in the field of social work with military families. Given research findings supporting the effectiveness of Child Parent Relationship Therapy (CPRT) Training, groups based on this model were offered on campus for military families. Specific research questions explored were: 1) Does military parental participation in CPRT impact the parent-child relationships, level of parental empathy and stress, and the adjustment of children to family stress and/or disruption? 2) What adaptations can be made in the recommended CPRT ten-week model in order to meet the needs of military families on campus? 3) What are the specific challenges in maintaining and enhancing the parent-child relationship for military families on campus?

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LITERATURE REVIEW

Strengths and Needs within the Military Family

Military families exhibit unique strengths but also face unique challenges (Cozza, Chun, & Polo, 2005). Military families experience increased amounts of stress in confronting issues of anticipated deployment, resulting separation, and post-deployment reunion (Packman, Paone, LeBeauf, Smaby, & Lepkowski, 2006; Palmer, 2008; Rotter & Boveja, 1999). Although recognizing the resiliency of military families, research also points to the need to monitor parental stress both pre- and post-deployment and highlights the inherent risks that separation and reunification pose for the parent-child relationship bond. Flake, Davis, Johnson, & Middleton (2009) found that the most significant predictor of child psychosocial functioning during military deployment was parental stress. The impact on children of wartime separations depends largely on the remaining caregiver's ability to respond to the needs of the child (Yeary, 2007). The heightened stress often experienced by nondeployed spouses can impact children who may sense the tension within the family household. Studies have raised concerns regarding the increased prevalence for children, ages three through five with a deployed parent, to exhibit symptoms of behavioral problems (Chartrand, Frank, White, & Shope, 2008). In studies looking at child abuse, researchers have found that the most common predictors of child abuse potential among military parents were parental depression, parental distress, and family conflict (Schaeffer, Alexander, Bethke, & Kretz, 2005). For military personnel experiencing Post-Traumatic Stress Disorder (PTSD), the children may be at greater risk due to negative parent-child interaction related to the impact of parental PTSD on parenting skills, attachment, hostility, and violence (Palmer, 2008).

The increased use of National Guard and Reserve Units in current conflicts has led researchers to consider the possible differences in stressors experienced by these families as contrasted with active military families (Vogt, Samper, King, King, & Martin, 2008). For active military families, deployment may be considered a developmental or "normative" crisis as serving in a war effort is part of the job (Chapin, 2011, p. 528). In contrast, Reserve members hold civilian jobs and families are integrated to a lesser degree into military life and military support systems. In addition, National Guard/Reserve members tend to receive different training and typically experience fewer separations (Vogt, et al., 2008).

The literature urges researchers and practitioners to look for effective practice methods to help military families positively negotiate the challenges posed by family disruption (Chartrand, et al., 2008; Everson & Figley, 2011; Packman, et al., 2006; Palmer, 2008). Palmer (2008) encourages practitioners and researchers to consider utilizing a theoretical pathway that assesses risk and resiliency factors in order to assist in addressing the unique needs for military families. Such a theoretical pathway suggests the effects of military life on child outcomes may follow an indirect path, involving parental stress and psychopathology, rather than military life itself directly negatively affecting children of military parents. Treatment implications in adhering to such a model include increasing support during times of intensified stress in an effort to ameliorate negative effects. Since the parent-child relationship serves as the mechanism by which risk and

resiliency factors impact military children, the interaction between parents and children is a key issue in military children's well-being (Palmer, 2008). Increased parental functioning leads to better child outcomes. Research indicates that coping, parenting skills, and parent-child relationships may be important foci of resiliency-based interventions (Palmer, 2008).

The Child Parent Relationship Therapy (CPRT) Training Model

Consistent with this theoretical pathway, the Child Parent Relationship Therapy (CPRT) training group offers a strengths-based model to build resiliency while at the same time addressing risk factors associated with parental stress during the deployment cycle. CPRT may be considered a type of inoculation in building resiliency as learning is focused on developing positive interactions and parenting skills which parents can utilize now and in the future to continue building positive relationships with their children.

The Child Parent Relationship Therapy (CPRT) Training model is a well-established, evidence-based program designed to improve parent-child relationships (Landreth & Bratton, 2006). The foundational elements of CPRT were established in the filial therapy treatment model designed by Bernard and Louise Guerney in 1967. Filial therapy is a therapeutic approach utilized by trained play therapy professionals who, in turn, train parents to be therapeutic agents with their own children (Landreth & Bratton, 2006). In 1991, Landreth proposed a ten session filial therapy model called Child Parent Relationship Therapy (CPRT) Training. The CPRT process entails both didactic and group process components offered in the context of a safe, supportive environment that encourages parents to explore feelings, attitudes, and perceptions of themselves, their children, and parenting (Landreth & Bratton, 2006). CPRT offers parents the opportunity to learn how to create a nonjudgmental, accepting environment that enhances the parent-child relationship and facilitates personal growth and change for both child and parent. Through group training and structured play sessions with their children, parents learn basic child-centered play therapy skills, such as reflective listening, recognizing, and responding to children's feelings, therapeutic limit-setting, and building children's self-esteem. In an age of precarious funding for social services and mental health programming, CPRT training teaches enduring relationship skills to parents, thus empowering them to become therapeutic agents with their own children and effecting long-term positive change.

CPRT is one of the more well-researched treatment models within the field of child psychotherapy. In 33 studies involving over 800 subjects, the efficacy of this treatment methodology supports its usefulness with a variety of issues and with diverse populations (Landreth & Bratton, 2006). Research demonstrates that the CPRT model, drawn from filial therapy principles, has had positive impacts with populations in several settings including fathers incarcerated in prison (Landreth & Lobaugh, 1998), mothers incarcerated in jail (Harris & Landreth, 1997), and single parents (Bratton & Crane, 2003). In addition, a descriptive report of utilizing the CPRT as a practice method specifically for military families supports its effectiveness (Packman, et. al, 2006).

Relationship to Social Work Theoretical Foundations

The ecological approach, a foundational theoretical framework utilized within the field of social work, considers the person in the environment. Social workers operate upon the premise of considering the impact of interactions between systems, including family, job, living environment, and school. Social workers strive to advocate for prevention and provide services which mitigate negative system impact for vulnerable populations. Thus, research looks at a vulnerable family system in response to its environment and seeks to alleviate sources of tension within the system and the environment, thus improving the family's overall well-being. Social work also relies on the Strengths Perspective which focuses on seeking opportunities to build resiliency. The Ecological Systems and Strengths Perspectives are helpful in understanding resiliency of military families as a dynamic process that is influenced by new challenges, strengths, opportunities, vulnerabilities, and new competencies (Saltzman, Lester, Beardslee, Layne, Woodward, & Nash, 2011). The resiliency of military families may be influenced by the degree of family and community social support, developmental stages of children, strength of marital relationship, and other current dynamics within the system. Repeated deployments may influence the system by either leading to new competencies or increased stress upon the system.

METHODS

This project utilized qualitative research methods. Data collection strategies included observations of participant activity in group sessions as well as videotapes of parent-child interactions, interviews in the form of a focus group, and thematic coding of process notes taken by the primary researcher, student research assistants, and participant weekly written feedback of sessions. Thus, trustworthiness and credibility of qualitative data were enhanced through observer and data triangulation in that several perspectives were compared in order to accurately represent data collected from different sources (Padgett, 2008). Data analysis was conducted by the lead researcher and student assistants. Patterns in participant comments were determined by the three student assistants and lead researcher which enhanced validity. Overall themes consistent in multiple data sources were coded by the lead researcher and corroborated through patterns identified in research assistant notes.

In researching the feasibility of this project, the need for immediacy and flexibility in group formats was identified because military family life is often unpredictable given immediate deployment and relocation issues. Thus, in addition to exploring the impact of CPRT for military families, this pilot project also sought to determine effective procedural methods in delivering the CPRT material for military families on a university campus. The CPRT model calls for a ten-session intervention format. However, adaptations to the model may be necessary for military families in order to respond to the immediacy needs of this population. The literature provides some support in adapting the filial therapy model and CPRT specifically in response to client needs. For instance, a five-week, bi-weekly session model was utilized with incarcerated mothers (Harris & Landreth, 1997). In another study, a three-week, twelve session intensive model was used with parents and children living in a domestic violence shelter (Smith, 2000). Jang (2000)

reported on a condensed version of CPRT that utilized a four-week, eight session model for Korean parents and demonstrated improvements in enhancing parent-child relationships. Since challenges in terms of time and schedule exist for military families, in this project three different formats were offered to participants: a ten-week group format for 1.5 hours each session, a five-week format with condensed material for two hours per session, and a brief three-session format with condensed material for three hours per session. Because of these adaptations, fidelity to the recommended ten-week CPRT model was not present. However, central CPRT skills consistent with the foundational model of filial therapy were taught and practiced in each of these session formats. The essential skills which have been consistently supported by literature and were covered in the sessions included structuring play time to support relationship building, empathic listening, encouraging imaginative play, and limit-setting. Chawla and Solina-Saunders (2011) reviewed the literature on the effects of deployment on child well-being and the parent-child relationship as well as major parent-child interventions and subsequently provided a rationale for the use of filial therapy with military families (p. 179).

In addition to session content teaching CPRT skills, focus group discussion also occurred during the last session with participants in order to evaluate perceptions of needs for military families within the community and the effectiveness of the project. It was hoped that 25 participants would be recruited for participation. However, after extensive recruitment efforts detailed below, only seven participants completed the sessions.

Procedures

The principle investigator has a background as a clinical social worker with twenty years of experience working with children and families including training in play therapy as well as specific training in the CPRT model. The principle investigator had started and sustained successful groups in response to client and community needs throughout her practice career. Professional training in play therapy skills is necessary for primary facilitators in order to implement this group model.

In assessing the need for this project and to ensure services were not being duplicated, several interviews were conducted with key personnel on the university campus including the director of the Veteran's Sanctuary Program, the Student Counseling Center, and the Psychology Department. It was determined that given the number of veterans on campus and few existing resources for parents and children that the group may serve an important need especially since the local National Guard was set to deploy within the year.

During month one of the research grant period, materials were ordered and prepared. The CPRT resource book and parenting manual (Bratton, Landreth, Kellam, & Blackard, 2006) were procured along with recommended videos and play kit toys. Student research assistants were hired during month two of the project. In order to find research assistants, the principle investigator garnered names of junior and senior social work students who were recommended by past professors as students who held excellent beginning

interview skills and good oral and written communication skills. E-mails were sent to this list of recommended students inviting them to contact the principle investigator if they were interested in the project. Grant funding allowed for hourly reimbursement of research assistant time. Three students indicated interest in the project and requested an interview. The interview consisted of questions regarding student interest, skills, and experience as well as information regarding the project details and expectations. The three students, one female and two males, who interviewed were selected as research assistants. The female student had personal active duty military experience in the Army. She had been deployed to Baghdad twice. Her skills and experience were invaluable in recruiting participants, educating research staff as to proper terminology, and establishing initial rapport with participants. One of the male students' fathers had served in the military in Vietnam. The third male research assistant did not have personal military experience but held great respect for those serving in the military and was a father of three children. Thus, the research team brought individual strengths which when combined provided a valuable base of experience needed to work with this type of group and population.

Training of research assistants also started during month two. Assistants were trained in research ethics, the CPRT model, and assessment/evaluation tools. Six training meetings were held for two hours per meeting. Assistants completed readings regarding the CPRT model, articles, and ethics. Recruitment of group participants also began. Recruitment at this stage involved contacts with the University Veteran's Sanctuary coordinator, University Counseling Center therapists, ROTC and Military Science Programs, Officers in the Veteran's Club, and community agencies serving veterans and military families including The Family Assistance Center, County Benefits, and VA Vocational Rehabilitation.

In community contacts, it was discovered that the local Guard unit was set to be deployed during the first month in which groups were planned to start. Thus, attempts were made to offer the group earlier in order to be available to Guard members prior to deployment. Although Guard members facing deployment did not sign up, word about the groups spread and once the Guard was deployed, their spouses made up the majority of participants in the CPRT groups offered. Additional recruitment efforts included posting flyers around campus and visibility of a booth at the Community Military Appreciation Day. A display was set up with group information which allowed military members and spouses to stop by the table and ask questions.

The groups were offered free of charge and included materials at no cost. After initial recruitment did not result in great numbers, additional incentive was added through offering optional course credit and babysitting services. Parents who took advantage of the babysitting signed a liability release form and volunteers from the Student Social Work Association provided services in an adjacent classroom to where parent sessions were held.

Participant Description

A total of seven (N=7) participants, six female and one male, participated in the groups. Five of the females were currently spouses of deployed National Guard members (N=4) or Army (N=1). One of these females was also a veteran and had been previously deployed. Another female (N=1) was active military and had recently returned from overseas deployment. The male (N=1) was military and had returned from deployment within the last two years. All participants were Caucasian. Participants were informed that the group was offered as a pilot research project and that the recommended ten-session CPRT model was being condensed in an attempt to explore different formats which may meet the needs of military families.

The ten-week group was first offered in October. Due to few participants, the start date was held off for two weeks in hopes of gathering more participants. Several parties called but were more interested in the five-week format because of child care difficulties and travel distance. Thus, the ten-week model was delivered as an eight-session format for 1.5 hours each session with one participant actively engaged. The participant was the wife of a National Guard deployed member. This participant had two children, ages three (3) years and ten (10) months. The child of focus was the three year old female. Child care was provided for these sessions. Parent and child taping were completed on two occasions as pre/post evaluation. Mother attended six of the eight sessions due to child illness and being out of town visiting her husband prior to overseas deployment. Content was made up during subsequent sessions and was achievable because she was the only participant. The principle investigator and one student research assistant worked with this individual. Although skills were able to be taught, the true nature of a group with involves social support was not able to be realized.

The five-session format had five participants. Two participants attended all five groups. Three of the participants attended four of the sessions as one session overlapped with visits to deployed husbands prior to going overseas. The male participant had one female child, age eighteen (18) months. The active duty veteran female participant had one female child, age five (5) years. The other three participants were wives of deployed National Guard members. One of these participants had two male children, ages three (3) years and sixteen (16) months with the three year old being the child of focus. Another had one male child, age eighteen (18) months and a stepdaughter, age eight (8). The third had one female child, age three (3) years. Two student research assistants helped the principle investigator facilitate this group. Research assistants and other student volunteers took turns providing babysitting services on the premises.

The three session format ended up with one participant. Several additional people had indicated interest by signing up for the group but did not actually attend sessions because child care was not available for this group. The female participant had been active military with two deployments. Her husband was currently deployed. She had two male children, ages three (3) years and eight (8) months. The child of focus was three years old. The principle investigator and one of the students facilitated these sessions.

Sessions were held on the main campus or a satellite campus location within a conference room or small classroom setting. Video equipment and a play room were

available for participant use in taping play sessions. Several parents opted to tape sessions at home for convenience and less disruption for their child. These videotapes were shared with facilitators as well as group participants during group sessions.

The CPRT curriculum material (Bratton, et al., 2006) was compacted through focus on skills in manual sessions one through six with brief review of skills detailed in subsequent sessions. As indicated in the initial research questions regarding adaptations for military families, specific information pertinent to military family needs such as an overall understanding of the potential impact of separations, unique stressors, and ways to maintain contact between child and active duty parent was included as an educational component in group sessions. It should be noted that this additional information deviated from the traditional CPRT curriculum. For participants with children under age two, play session length, and toy content was modified for developmental appropriateness. Parents were informed that the model addressed needs of children ages 2 through 10 years. Although not substantiated by research on the CPRT model, parental pre-learning of skills and relationship development may be considered a preventative approach.

Participants completed session feedback sheets following each session by writing answers to questions regarding what was most helpful, least helpful and suggestions. Per model, play sessions were recorded and viewed in the group so that facilitators and group members could provide feedback, particularly focused on strengths. Student research assistants and the principle investigator completed process notes regarding training procedure, recruitment, and session participation. Finally a semi-structured interview guide was used to conduct focus groups regarding assessment of needs of military families and impact of group model participation at the completion of groups. Following the completion of all sessions, the research team met for verbal processing regarding weaknesses and strengths of the groups and research process.

RESULTS AND DISCUSSION

Intake Concerns of Participants

Participants expressed concerns for their children at the beginning of group sessions including emotional expression, i.e., temper tantrums, yelling, hitting, screaming, no expression of feelings, (N=5), school behavior problems (N=1), sleep difficulties, i.e., nightmares, not going to bed, (N=2), and not feeling connected with child (N=1). Student notes from the first session corroborate these expressed concerns:

During the first session group members talked about the concerns they have with parenting...transitioning, worries about spoiling child while father is deployed, kids always want attention, school behavior and attachment issues from previous deployment.

Themes of Improvement

Understanding child's strengths and interests. The CPRT curriculum encourages parents to focus on their child's strengths. In doing so, participants gleaned new understanding about their own child's personality. One mother delighted in her focused

observations during home play sessions, “(My child) loves being in charge. (She) loves to flutter; very imaginative. (She) tells stories with the toys. (It's) a real joy when not having to “mom” her. She loves her (play) time with mommy that is different.”

Other parents commented on seeing their child’s enjoyment in play, “(My) son loved the attention he received during the play session.” “(I) learned about myself as parent... (I) want to do play time more often because she (my child) loves it.”

Parents of children younger than two learned to consider their child’s developmental stage in play. One parent “improvised and had less structure of session.” Another entered play with her 18 month old son with the expectation that sessions would be shorter (5 to 10 minutes) to accommodate for his developmental age. Once the child appeared to lose interest, she would end the play session.

Imaginative play. Three parents noted that their child’s imagination and general play outside of “special play times” were encouraged by participation in the CPRT group.

A student research assistant observed in a videotaped play session:

I was able to see with her how she (the 3 year old child) was not only able to use her imagination but by mom reflecting it back on her, she was encouraged to use her imagination...Anyways the little girl had picked up a pair of handcuffs and asked her mom what they were for. Mom responded ‘what do you think they are’. The little girl used them to pick things up like a claw. It was one of those moments when you’re like ‘oh I see now how that works.’

Process notes from the second session of the five-week format indicated that parents commented positively on their child’s imagination in structured play sessions at home. The children appeared to love the attention and became more talkative. The participant in the three-session format noted, “(My) child is asking for me to play more instead of demanding attention... recognizes he is noticed-not wanting to watch TV as much-wants to play even if I’m not playing.”

Use of relationship-building skills and generalization. Skills which parents learned in the first session began to generalize to time outside of play sessions. The 30-second Burst of Attention (Bratton, et al., 2006) was particularly helpful to parents. When using the 30-second Burst of Attention, parents stop what they are doing in response to a child initiating needs for attention. The parent turns to face child, makes eye contact, listens, and reflects. Parents find that within 30-seconds the child’s needs have most often been met. One mother noted that the frequency of temper tantrums decreased almost immediately through using reflection, the 30-second Burst of Attention, and choice giving. Another mother commented that she is thinking more about her response, rather than impulsively reacting, when the child is mean to his little brother.

Generalization of skills seemed to be related to parent personality and stress level as well as the number of sessions overall which the parent attended as indicated by student notes, “After the first session the little girl looked forward to coming to the school and couldn’t wait for her playtime with mom. Mom also was very positive about the program and came prepared every week and was very involved.” In contrast, this student noted,

"The mom in the other group was not nearly as energetic and seemed to be under a great deal of stress." Another student progress note points to skill development:

By the time we were done with this group (8-session) the mom was an old pro. She picked up the concepts so well and was able to implement them into their play sessions extremely well. She was always so fun and positive about what she was learning and told us several times that she thought the group was a great asset to her and her daughter.

In addition student research assistants were able to observe increased use of skill in the videotaped play sessions, "I also was able to see the progress made by the participants from one (session) to the next. It was easy to see the improvements and the increased use of what was taught after they had had the time to practice in between taping."

The CPRT curriculum also encourages focus on parent strengths which tends to increase parental confidence and further motivates using the skills as student notes indicate, "One participant's child just cried the whole time on the video, but it was good to see how the parent comforted the child and just held her until she felt better. It was a good teaching moment because the parent was concerned that it was a total failure." Another student observed the growing confidence of parents:

I enjoyed seeing the progress that the participants made with each of their children as the sessions progressed. In the beginning session, the participants seemed uneasy, and I don't think they were prepared enough to start doing the play sessions as quickly as we had them do it. As the sessions went on and the participants grasped the concepts better, they were able to improve their play sessions and also their relationships with their children. I liked seeing how at first the participants were awkward in their play sessions, and then towards the end they were comfortable and were able to more fully interact with the children.

During focus group sessions, parents made the following comments regarding the impact participation in CPRT had on their parent-child relationship: "(The group) has made a huge impact and has given me tools needed to continue building relationships in the future." "I am communicating **with** her instead of **at** her." "It has been positive...I have more insights into myself and my kids."

Behavioral issues. Parents noted that behavioral issues which had been of concern demonstrated improvement as indicated in focus group comments regarding the impact of utilizing skills learned in CPRT on their parent-child relationship. One parent noted, "Behavior better with child...more open and willing to talk about feelings."

Student observation notes indicate similar improvement:

The participants are starting to get closer to their children through these play sessions and one parent expressed how she has been getting more information from the child as to behavioral problems at school. This therapy is starting to show its worth and benefits to the participants.

Format Preferences

Although the five-week and three-week condensed formats initially appeared more attractive to participants because the shorter duration was conducive to family time needs, these formats did not provide participants the depth of skill level and practice necessary. Participants expressed that they wished they had done the longer group. Student research assistants noted that the shorter duration also did not provide enough group time to establish solid rapport with participants. Although offering child care increased participation, it was a challenge due to physical space limitations, inconvenient bathroom set-up, and sessions being too long and too late at night for children. Such a need for childcare, however, highlights the needs identified of military families for support. Participants were concerned about burning out family members and friends so did not want to ask them to babysit.

Student research notes are consistent with focus group feedback:

Five week sessions were too short and did not give them enough time to practice and develop the skills learned. The two hour sessions were too long; 1.5 hours suggested instead. Most thought they would prefer a 10-week group. The five-week group was preferable for participant who had to travel long distance.

Thus, the session format tended to be the primary concern with parents feeling like the five and three session trainings contained too much information with not enough practice time in between sessions to fully integrate the skills.

Challenges of Military Life

Participant comments in this pilot project support literature findings regarding common stressors for military families such as incomplete understanding of the impact of deployment, impaired family communication, and impaired parenting (Saltzman et al., 2011).

Not knowing; uncertainty. Participants shared insights into the challenges of military life including unpredictability, “(I) didn’t expect him to be deployed when married.”

In addition, participants expressed concern about how separations would impact their children as indicated by the following parent comments: “Will issues come out—if so, what do I do?” “Not knowing how or when kids will react. Not sure how future will play out; general uncertainty.” “Military thing is unexpected—not planned.” Parents also noted concerns that other people sometimes carried a “misunderstanding of what service member is doing.”

Parenting concerns regarding balance of discipline. Parents expressed concerns regarding the difficulty in achieving a healthy balance in discipline. One parent who had lived on a military base said, “After living on base I was concerned that some families ‘had it together’...this is the way it is...and other families overcompensated and gave way too much...spoiled...military brats.” Another stated she “worries about kids becoming ‘army brats’; finding balance between too harsh and too lenient.”

Students also noted these concerns in research notes:

Everyone in the group agreed that juggling obligations will be one of the specific challenges faced when trying to maintain the skills used and live a military lifestyle.

The male participant said he has anxiety which interferes with the amount of time and energy that he can focus on his daughter.

Adjustment issues including maintaining connection with child when deployed.

The focus group discussions provided insight into challenges and adjustments required of military families particularly in maintaining a positive relationship with their children. Comments from parents reflect these concerns: “(I) am short-tempered; react too quickly—react instead of think through things so catching self better.” “(I have a) hectic schedule...adjustment to ‘single’ parenting.” Regardless of whether a parent works at home or outside of the home, deployment created stress as indicated by parent comments: “A stay-at-home parent has no break.” “When I work, I have no time or energy.”

Parents pointed out concerns about maintaining connections between children and deployed parents who are overseas. For instance, one parent said, “(I am) concerned about kids relationship with their father (who is away). How strong or weak relationship will be because of absences.” Several mentioned concerns about the separation and resulting impact on relationship. Reintegration also posed difficulties as one parent described, “Homecomings-reintegration with everyone is challenging and an adjustment... (kids are at) different developmental stages when return.”

Parents discussed difficulties in maintaining connections due to time differences. For instance, young children may often be in bed when the deployed spouse is able to telephone.

Parents shared ideas on particular needs that they and their family have now as a result of involvement in the military. Parents agreed that support and help in practical ways such as childcare and home maintenance were needed. Parents felt they had little time for themselves and were reluctant to ask others for help too often. They also felt the need to release anxiety through exercise or being able to talk about personal and emotional needs with friends.

Needs CPRT could address from these voiced challenges. Techniques within the CPRT curriculum which were particularly helpful as voiced by parents within this pilot study include reflective responding, structuring play sessions, limit-setting, and choice-giving. CPRT can be of assistance to military families in coping with the challenge of uncertainty of military life as noted by student research assistant notes:

The techniques and skills used in the CPRT sessions seem to be really valuable, and I think it can be a beneficial part of helping military families transition. The members of the group seemed to express this also. Several members said that their child/parent relationships have progressed since the beginning of the group.

Everson and Figley (2011) note the importance of nondeployed spouses in considering the role of the family and spouses in maintaining morale and mental focus of military family members. Additional factors highlighted in their research include the potential impact of multiple deployments on family stress as well as the acculturation process that must take place within military families in terms of learning a new language, adjusting after relocation, and required adaptations within the deployment cycle. Learning proactive parenting skills such as those taught in filial therapy and CPRT may assist military families in making healthy system adjustments in times of stress and change (Chawla & Solinas-Saunders, 2011).

Although distinct issues may arise for active military families and National Guard/Reserve families, the unique needs of military families overall were considered in this pilot project. For instance, military toys and figures were included in the toy kits. Awareness of the challenges faced by military families and the culture were essential to integrate as indicated by student notes, “(The lead facilitator) integrated military thinking in with the session handouts. I think this was a nice touch to the group session and helped the group members relate more with one another.”

Session evaluations by participants indicated that it was helpful to learn more about play and particular skills such as letting the child lead in play, the whisper technique, limit setting and giving choices. Participants found the open discussion and conversation with other participants helpful in releasing concerns and frustration. Three parents also commented on the benefit of viewing the videotapes of self and others as being a way to identify their own strengths as well as learn from others.

Student notes corroborate participant feedback, “I think the parents that participated in the group process had a strong desire to improve or change some aspects of the way they parented. As a free service, I think it was valuable to the participants.” Another student wrote, “All the participants agreed that their participation in CPRT has helped them to have more insight in to the relationships with their children.”

CONCLUSION

Due to the nature of a pilot study and low participant numbers, generalization of the findings is limited. The condensed trainings were limited in effectiveness due to the short amount of time to develop the group process, teach skills, and engage in practice play sessions. In addition, compacting curriculum compromised the breadth and depth of skill training offered by the CPRT model. Separating researcher and practitioner roles of the primary investigator/facilitator was challenging. To mitigate this challenge, student research assistants were primarily responsible for gathering data by taking session notes and reviewing initial participant feedback.

Despite the limitations, this study adds to the literature by demonstrating the potential of positive benefits to military family participants in the use of filial therapy constructs and the CPRT model. Insights offered by student research assistants and participants indicate the potential effectiveness of utilizing the Child Parent Relationship Therapy (CPRT) Training Model with military families. Parents participating in the sessions noted a sense of increased efficacy in utilizing proactive parenting skills as well as decreased

emotional and behavioral concerns for their children. Parents were able to identify characteristics about their children and their strengths which they had not noticed previously which may enhance parental empathy. Building positive parenting skills and enhanced relationships through play can assist in reducing family stress throughout the deployment cycle. Parents who participated in the five-session format benefited from having the opportunity to share concerns and ideas with other parents in a group setting. The two parents who engaged in individual sessions still reported benefits of learning the skills and having the special play time with their children.

Benefits reported in this pilot study are consistent with other research demonstrating the efficacy of the CPRT model. Recent literature has supported the findings in this pilot study. Family-centered care, particularly in the form of resiliency training for families, has increasingly become a priority of the military health system (Saltzman et al., 2011). Chawla and Solinas-Saunders (2011) offer an extensive literature review which provides a rationale for the use of filial therapy with military parents and children.

The idea of offering the course for university credit as a ten-week course appears to be promising for military and veteran family members on campus. Conducting such groups on campus through Social Work Programs may contribute opportunity for student learning through involvement in research and group processes as well as be of benefit to military families within the community or on campus.

Further research on the implementation of the CPRT model with military families is warranted. Suggestions for further study include research utilizing a larger sample size, pre/post measures, fidelity to the ten-week CPRT model, longitudinal study information, and comparison of the model effectiveness for active military families and National Guard/Reserve families.

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Promoting Military Cultural Awareness in an Off-post Community of Behavioral Health and Social Support Service Providers

Christi Duette Luby

Abstract: Due to U.S. military Base Realignment and Closure (BRAC) efforts and ongoing Overseas Contingency Operations, the number of military servicemembers and veterans seeking civilian-based services has increased. As the military presence grows in previously underrepresented areas, the need for culturally competent providers will also increase both on and off military installations. The purpose of this article is to promote military cultural awareness, while suggesting ways to enhance existing community behavioral health and social support services. It builds on a review of the extant literature and findings from a community assessment to introduce civilian providers to some specific issues affecting servicemembers and their families. A framework describes ways to increase military cultural competence and build community capacity to enhance civilian-based services. In addition, two appendices list some common military terminology and multiple training resources available through military organizations and websites.

Keywords: Military cultural competence, community capacity building, resources

According to the Department of Defense (DoD), since 2001 almost 2 million military personnel have deployed in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (IOM, 2010). In addition, due to US military Base Realignment and Closure (BRAC) efforts, servicemembers and their families are relocating throughout the United States (DoD, 2005). These sustained military activities have increased the number of servicemembers, veterans, and their families seeking behavioral health and social support resources in civilian communities. The DoD believes the civilian sector will answer this call to duty and help meet this demand (US Medicine Institute (USMI), 2005).

The purpose of this paper is to promote awareness of the support necessary to improve the health of servicemembers and their families and identify resources available to providers to help meet those needs. The military represents a unique cultural group with its own language, behaviors, and beliefs (Reger et al., 2008). Issues faced by returning troops and their families may be unfamiliar to civilian providers, which may present challenges. How civilian providers respond to this increased need for services will determine their ability to offer ethical, culturally competent care (Reger, Etherage, Reger, & Gahm, 2008).

According to Defense Centers of Excellence (DCoE) (2009), to serve military communities better, qualified resource providers should be sensitive to and willing to learn about the military culture. Gaining cross-cultural competence is an ongoing process that requires the application of professional practice standards to this unique population

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(NASW, 2006). As one model suggests, providers must continuously integrate new information gathered through cultural awareness, knowledge and sensitivity to achieve cultural competence (Papadopoulos, Tilki, & Taylor, 1998).

METHOD

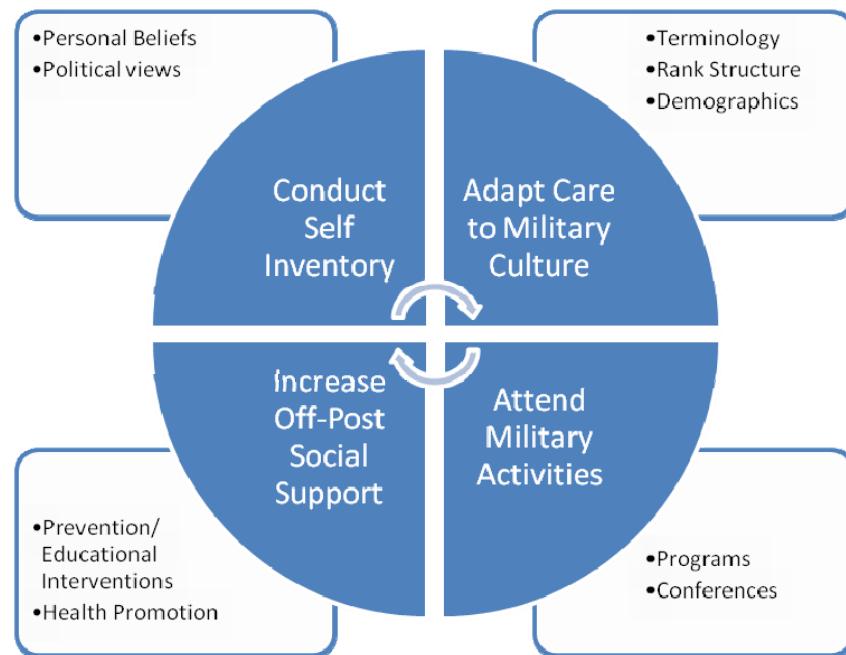
This call to action originated from ideas generated during direct practice and involvement with military installations, as well as results from an assessment of a community affected by returning troops and BRAC. A convenience sample of 184 civilian-based resource providers received an online survey to assess their services available to military personnel, veterans, and their families. The assessment established baseline data for an ongoing evaluation of this community's capacity to provide behavioral health and related support services and to determine what civilian-based services need to better support this diverse group. For example, 78% of respondents stated they would like to receive more knowledge on military culture, organizational structure, and terminology, which resulted in the creation of a resource directory (Luby, 2010).

In response to this community's needs and others like it, this manuscript promotes awareness about specific issues affecting the military and gathers various resources for civilian practitioners to fill any knowledge gaps that may exist. Building on a review of the extant research literature and practice methods used by civilians engaged in military partnerships, this manuscript develops a framework that delineates ways to increase military cultural competence and build community capacity to enhance civilian-based services (see Figure 1).

This model reinforces many of the 2007 *Standards for Cultural Competence in Social Work Practice*, and encourages an ongoing process of cultural awareness, adaptation of skills, active involvement, and providing peer-support. Next, this review identifies specific cultural issues relevant to the military population and discusses implications for practice. Lastly, a table summarizes some common military stressors and two appendices introduce a brief military lexicon and examples of resources available to improve the care of servicemembers and their families.

Conduct a Self-inventory

To increase cultural competence, first the civilian-based service provider needs to conduct a self-inventory (Hall, 2008). This includes using self-awareness and honesty to evaluate his or her position on military issues, so that political opinions and personal values do not affect the care, services, or social support provided to special populations (Hall, 2008; NASW, 2006; Slone & Friedman, 2008). This pre-assessment will help ensure professionals remain impartial and empathetic even when worldviews differ.

Figure 1: Methods to Increase Military Cultural Competence

Adapt Care to Military Culture

Mission and Values

When working with diverse groups, providers may need to adapt their services and care to be consistent with the client's culture, whatever that culture may be (NASW, 2006). Engaging in military cultural competence requires both an awareness of the client's behaviors and values, as well as a willingness to develop a multicultural perspective as providers (Hall, 2008). Each military branch has developed its own primary mission, lexicon, and set of core values. These commonalities serve to develop cultural identity and facilitate communication and cohesion among its members (Abbe, Gulick, & Herman, 2007; DCoE, 2009). As professionals learn and develop cross-cultural skills, the delivery of services becomes more population specific, and therefore, more effective (Abbe, et al., 2007; NASW, 2006).

Many cultural minorities express greater comfort in receiving treatment from healthcare professionals of the same or similar backgrounds (Chassman & Cave, 2011). In addition, some studies suggest that military members and their families respond better to help from providers that are either military affiliated or when providers attempt to understand them. For example, combat soldiers, who feel comfortable and supported by their community, heal faster and better because they are in a trusted place (Garcia, 2009). This suggests that if the civilian provider or a family member has served in the military, it

may create a stronger provider-client connection if the servicemember is aware of this common bond.

When providers acquire a basic knowledge of military values, the ability to offer culture-specific care improves. This in turn will build a stronger therapeutic alliance and lead to better clinical care. All servicemembers are trained using concepts of honor, mission first, and belief in sacrificing oneself for others and the greater good (Buck, 1981; Hall, 2008). Words such as *honor*, *integrity*, *courage*, and *strength* are at the heart of the military culture and affect every aspect of the cultural identity. These words build morale--*esprit de corps*--within the unit and often influence how, when, and whether or not a servicemember will seek help (SAMHSA, 2006). In practice, sensitivity to these values establishes a critical link from the civilian-based service provider to the military client.

Organizational Structure and Rank Hierarchy

It is advantageous for practitioners to have a basic understanding of the US military organizational structure, as well as rank hierarchy (e.g., Officers, Enlisted) and titles, which vary with each Service Branch (i.e., Army, Air Force, Navy, Marine Corps, and Coast Guard) (DCoE, 2009). Therefore, providers may wish to acquire cultural-specific knowledge to the military branches they serve. Providers that understand the differences between the classifications (e.g., active duty, inactive duty, reserve, National Guard, and veteran) will appreciate how this status may influence the stressors to which servicemembers and their families may be exposed. For example, this status determines when, how often, and for how long a servicemember will deploy.

Demographics

Another way to augment an understanding of military culture is to examine general demographics of the population (DCoE, 2009). Servicemembers' current characteristics (age, gender, marital status, race/ethnicity, rank, and occupational area) may affect their military experience and level of stressors (DoD, 2010; Rand, 2007). Having cultural sensitivity includes knowing the military member's career or occupational specialty, which helps identify the potential occupational hazards or factors that may influence his or her experiences, and therefore, behavior.

Cultural-specific Adaptation of Care

Developing cross-cultural knowledge and skills to effectively meet the needs of military client groups will enhance civilian-based care models. For example, professionals without prior experience with military personnel will become more familiar with general military terminology, as well as deployment related expressions. Being able to converse with military and civilian treatment teams is a vital part of psychological assessments and command consultations (Reger, et al., 2008). Therefore, it is also beneficial for civilian staff to be qualified to assess post-traumatic, combat stress, depression, deployment, and reintegration issues in military members and their families (Cozza, 2011; Franklin, 2009; USMI, 2005).

Combat-related treatment requires a multidisciplinary team, culturally sensitive to the diverse political, socioeconomic, and environmental factors affecting military populations (Hall, 2008). This interdisciplinary practice experience offers civilian providers an opportunity to practice intercultural competence and exhibit cross-cultural leadership skills (Abbe, et al., 2007; NASW, 2006). One study suggested that when general physicians had knowledge of military culture and the impact of war on combat veterans, this resulted in earlier diagnosis and successful psychotherapeutic treatment outcomes (Lee, Gabriel, & Bale, 2005).

Due to stigma and other related issues, barriers to seek and receive care may exist for servicemembers and their families (SAMHSA, 2006). Some soldiers have expressed concerns that seeking behavioral healthcare will harm their career or opportunity to promote (Hall, 2008; Ruzek, et al., 2004; SAMHSA, 2006). In addition, military rank determines the pay grade, which may affect the availability of resources. Providers need strategies to decrease these barriers, and be prepared to address any confidentiality concerns the servicemember may have.

Civilian providers help make decisions before and after combat about fitness for duty and mental health status. This involves privacy issues for the soldier, as well as assuring military commanders that the soldier is prepared to meet mission readiness (Kennedy & Moore, 2008). Therefore, an understanding of military medical care, principles, practice, and policies is very important when treating this population. For example, specific diagnoses can prompt a review by a military Medical Evaluation Board. Certain codes assigned for diagnoses or reimbursement of services may affect a servicemember's ability to perform certain duties, maintain certain military occupational specialties and security clearances, which in turn will affect his/her ability to deploy (US Army, 2011). Guidance on filing claims is available for both civilian and military providers to address these issues through the DoD healthcare benefits program, TRICARE.

Cultural-specific Adaptation of Care for Military Families

Culturally competent care also includes appreciating and addressing the issues and challenges that affect military families. The ability to effectively interact, understand and communicate with servicemembers and their families improves the quality of care (DCoE, 2009). Military families are similar to civilian families in many ways; just some of their challenges differ. Civilian professional interested in including this group in their client base need to understand these unique challenges.

Everyone in the family makes personal sacrifices for the mission, in support of their servicemember's call to duty. Some military issues and stressors are common and affect most military personnel and their families (see Table 1). There are other stressors experienced by some family members, which require special attention and understanding. For example, those who help care for returning wounded, ill, and injured (WII) soldiers have additional challenges (WTC, 2011). Whether servicemembers are active-duty or veterans, civilian providers can help by ensuring continuity of care, which creates smoother transitions for the entire family.

Table 1: Common Stressors Affecting Military Families

Top Three Concerns for Deployed Service Member: (Rabb, 2010)	1) Exposure to Combat 2) Home-front Concerns 3) Peer/Leaders Relationship
Military Service Member Stressors: (Rabb, 2010)	1) High Risk Occupation; 2) Mobility; 3) Authoritative Work Environment; 4) Effects on Families; 5) High degree of living with uncertainty; 6) Impact of Separation; 7) Absence of Community Support; 8) Loss of Income; 8) Minority Status (w/in civilian pop); 9) Sense of isolation or not being understood
Behavioral expectations:	Military members (and their families) are expected to conform to professional and personal behavior, both on and off-duty.
Deployment:	Service member is called to duty (without his/her family) somewhere other than the permanent duty station (ex. humanitarian effort, support of a conflict.) Time Varies by: Service Branch, Career Field, Mission
Permanent Change of Station: (PCS)	Active duty service members and their families are required to move to different duty stations (approx. every 2-4 years) to meet mission's needs, increase leadership opportunities and career development. This is a stressful time for military families (change schools; jobs; separate from family/support systems; new area)
Risk of injury or death:	Concern for a loved one's safety
Temporary Duty: (TDY)	Service member travel assignment away from duty stations (approx. few days to few months—less than yr). (Ex. trainings, conferences/meetings, temporary fill in)

Each member of the family handles military stressors differently; therefore, it may be beneficial to provide military sensitive, support services for each age group (Slone & Friedman, 2008). This previously understudied area has recently received greater attention. A growing body of literature now focuses on age-specific issues and the effects of deployments and reintegration on military spouses and children. Additionally, regional online training covers a variety of military subjects to assist military and civilian-based practice providers. These free programs deliver professional education to enhance familiarity and build community capacity.

Providers helping families of deployed servicemembers may want to learn more about Family Readiness Groups (FRG). These groups activate as a part of the rear-detachment, which includes those in the unit that stay at the home base during deployments (Operation READY, 2010). The FRG meets regularly to provide social support for the unit's military families and offer assistance to those with special needs while the servicemember deploys.

Attend Military Activities

Another way to learn about the military culture is to attend military activities, including programs and military health conferences. For example, Army Posts often open their gates to the local community by sponsoring special events and inviting the public. Social interaction and community outreach events held on military installations provide a unique opportunity for civilian providers to see the priority population in surroundings where the group works and lives. In addition, resource providers that go to where the target community gathers will have a better understanding of the issues that affect their cultural identity and environment (Minkler, 1997).

There are also online activities available that address current military care issues. For example, the military's Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) provides monthly web-based seminars on relevant topics affecting military members and their families. There are numerous opportunities to serve military servicemembers, veterans, and families both on and off military installations. In fact, the current presidential administration advertises a website to aid local communities and providers in finding ways to get involved (CNCS, 2010). When providers participate in these efforts to advocate for and empower others, the overall community capacity increases (Minkler, 1997; NASW, 2006).

Increase Civilian Organizations' Involvement and Provider Social Support

Both military and civilian professionals can help facilitate civilian social support. These community capacity-building efforts may include networking with other military and civilian providers to champion for prevention and educational interventions for health promotion within the civilian community. To increase acceptance and sustainability of these public health initiatives, it is recommended that the target participants and community members be invited to be part of the development process (Minkler, 1997). If these providers work together to share knowledge and create a directory of the local and national resources available, this will improve referral networks and overall service delivery (NASW, 2006).

As for the provider's own self-care and social support, he or she should be aware that compassion fatigue and secondary traumatic stress are very real phenomena. It is important to realize and respect that some military member's experiences will differ from that of the average citizen. When working with traumatized servicemembers, symptoms of post-traumatic stress and combat stress may be present. The stories they share with providers may contain more violent or graphic information than the traumatic experiences of the average civilian population (Bride & Figley, 2009). The experiences described may involve life or death situations, such as watching someone be harmed or killed, or the soldier may have had to kill someone.

Without proper training, those trying to help veterans may be injured psychologically due to secondary traumatic stress affects (Bride & Figley, 2009). By listening to military stories, helpers become susceptible to vicarious traumatization from these horrific experiences (Figley, 1995). Therefore, healthcare professionals may benefit from forming

a peer-to-peer support group to encourage other providers, or by attending professional continuing education that cover these specific trauma topics to develop coping skills.

DISCUSSION

The purpose of this paper is to promote awareness of the issues that affect military servicemembers and their families, to build the civilian community capacity to better serve this population, and to identify resources available to providers to help meet those needs. Military organizations do not expect civilian practitioners to completely change their mode of practice; but it seems providers who serve, treat, and care for servicemembers and their families should be sensitive to this unique culture and gain competence to provide optimal care.

This article develops a framework that depicts an ongoing process requiring time and commitment on the part of the provider. It promotes awareness of basic knowledge of policies, structure, and values to build a stronger alliance and promotes a responsive and comprehensive model of care. It addresses barriers to care, improving access to services and engaging family members, educators, and health providers in the unique needs of this population to help establish this comprehensive care model.

The military culture is unique in its core values, organizational structure, and terminology. Though made up of multiple diverse cultures, the US military cultural identity enhances uniformity amongst its members and conformity to the rules, policies and procedures that guide the overall mission. This article offers civilian-based services exposure to these distinct qualities, and promotes an awareness of the need to consider these issues during practice.

It is understood that civilian providers are busy and probably lack the necessary time to engage in every suggestion outlined in the model. Therefore, to save time for those interested in gaining familiarity with the military culture, this article provides an introduction and assembles information gathered from the research literature and used in the practice. If providers would like more information, numerous journals focus on a variety of military specific topics such as principles and practice, research, psychology, and medical ethics. In addition, multiple television dramas and movies have addressed a range of military issues to increase familiarity with this population; as well as, a military channel that reports current military news. When behavioral health and social support resource providers serving this community learn more about their issues, it will advance their level of understanding and improve their ability to help.

IMPLICATIONS FOR PRACTICE

Military installations and Veteran Centers are preparing for the influx of personnel and their families. Surrounding local communities affected by BRAC and returning veterans need to prepare as well. An assessment of the community would focus these efforts, provide a more complete picture of the community's healthcare and social support systems, and help to identify strengths, needs, and priorities. One of the ways to bridge the gap between military and civilian sectors is through empowerment and advocacy initiatives (CNCS, 2010). In addition, civilian-based providers engaged in

strategic partnerships with military installations and the veterans' administration will find many funding opportunities available to organizations and universities interested in working with military families.

The National Association of Social Workers (2006) has policy statements and a *Code of Ethics* that urge social workers to be culturally competent. Universities that offer social work and licensed professional counselor programs will need a broad approach that reaches beyond the populations they usually serve. Developing course curriculum specific to the issues affecting active-duty military and veteran populations will prepare future providers and current providers through continuing education. In addition, courses that address compassion fatigue and secondary trauma stress that include evidence-based practice to increase coping skills and build resiliency may reduce the future risks of providers suffering from work related burnout.

Primary and secondary public schools who teach military children might look for collaborative approaches within the state school systems to make military transitions less difficult. For example, parents may deploy for twelve months at a time, which is longer than an academic school year. In addition, military families move approximately every three years. When educational systems and teachers are more aware of the issues, they can become actively involved in addressing these challenges. If they help and prepare families to adjust and avoid unnecessary distress, this focus will enhance military children's overall academic success.

CONCLUSIONS

The U.S. military Base Realignment and Closure (BRAC) efforts and ongoing Overseas Contingency Operations have increased the number of service veterans seeking care in civilian communities. Professionals located in areas previously underrepresented by servicemembers and their families now have new opportunities to increase their practice to include this unique population. Since civilian providers will likely address the needs of the military population—both currently and into the near future—regional training should be a high priority.

The purpose of this article is to aid in expanding the provider's toolbox and enhance the care model to include cultural-specific awareness. It offers those providers less familiar with military customs and traditions ways to build their cultural competency and understanding of combat-related issues through several training resources. Appendix 1 provides a list of common military acronyms and terminology to facilitate familiarity with this culture's language diversity.

In addition, Appendix 2 contains links to some practical tools and military-sponsored websites for training on military specific issues. Please note this is not an exhaustive list, it is just some examples of how the Department of Defense fosters coordination between military and civilian resources. There are multiple military organizations collaborating with civilian-based services to enhance and advance the available care for military members and their families. Behavioral health and social support providers that get involved and make positive changes will not only be better prepared for the arrival and

treatment of military members and their families—but will ultimately improve the care and support for the entire civilian community.

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Appendix 1: Common Term/Acronym Definitions

http://www.dtic.mil/doctrine/dod_dictionary

AAR After Action Report: After a mission, senior enlisted noncommissioned officers go through what happened and make a report to refer problems out to the appropriate resource providers.

Active Duty full-time job as part of a military force for a specified time period (enlistment)

ACU-Army Combat Uniform, **BDU**-Battle Dress Uniform, **DCU**-Desert Combat Uniform: military issued camouflage clothes used in various environments

AMC Army Medical Center

AOR Area of responsibility

AWOL Absent without Leave

Base Air Force or Navy Installation

Battlemind Resiliency training every soldier goes through

Battlerattle Body armor

BCT Brigade Combat Team: Army's basic deployable unit of maneuver

BOG Boots on the ground--personnel deployed under military command

BRASS Breathe, Relax, Aim, Slack, Squeeze- Marksmanship Training steps for shooting a gun

Camp Marine Corps Installation

CBERN Chemical, Biological, Explosive, Radiological and Nuclear hazards may be present

Citizen Soldier Reserve and National Guard service members called up to active-duty

CO Commanding Officer

Combat Ready Service member status when eligible for deployment/capable of performing duty

Commissioned officer derives authority “commission” by sovereign power, outranks enlisted personnel

CONUS Continental United States

COSC Combat/Operational Stress Control: Deployment related stress problems

COSR Combat Operational Stress Response: a normal response to an abnormal situation

DEMOB Demobilization: disassembling troops from combat-ready status; discharge of troops

Deployment Service member called to duty away from home base, not accompanied by family

Dwell Time The amount of time a soldier spends at home between deployments

Down Range Deployed usually overseas, often in a combat zone

Enlisted personnel (rank or grade) Any rank below a commissioned or warrant officer; includes higher ranking enlisted **Non-Commissioned Officers (NCO)**, and **Petty Officers (Navy)**

EOD Explosive Ordnance Disposal: safe and technical disposal of high explosive munitions

- FAC** Family Assistance Center: National Guard family program assists families of all branches
- Fisher House** Free/low cost housing provided for family members of military patients
- FOB** Forward Operating Base: secured area used in support of tactical operations.
- Grade** Refers to “pay grade” used for personnel and pay functions
- GWOT** Global War on Terrorism
- HBC**T Heavy Brigade Combat Team
- HEMTT** Heavy Expanded Mobility Tactical Truck re-supplies combat vehicles/weapons system
- HMMWV** High Mobility Multipurpose Wheeled Vehicle – pronounce “Humvee” military 4WD
- Homefront** Back at home, where their families are while they are deployed
- IBCT** Infantry Brigade Combat Team
- IED** Improvised Explosive Device
- Inactive Duty** after active duty, soldier remains under contract, can be called back up for service
- Inside the wire** On the base (on the FOB)
- ITOs Invitational Travel Orders:** Provided by command to allow wounded warrior family visits
- Kevlar** Typically, the helmet made of the material Kevlar made for ballistic protection
- Leave Off Duty** (usually vacation)
- LSA Logistical Supply/Support Area:** Military facility, depots, R & R area, support to FOB
- MEB** Medical Evaluation Board (**MEDBOARD**) determines continued military service, referrals to **PEB**
- MEDEVAC** Medical Evacuation emergency evacuation of sick or wounded from combat area
- MHC Medical Holding Company** Facility care/support Active-duty patients not combat-ready
- MOB** Mobilization: assembling combat-ready troops and supplies for service deployment
- MOS** Military Occupational Specialty (career specialty) used by Army and USMC. USAF uses **AFSC** (Air Force Specialty Code); Navy uses **NEC** (Navy Enlistment Code).
- MRE** Meal Ready to Eat
- MST Military Sexual Trauma:** sexual assault/harassment that occurs in military setting
- MTF Military Treatment Facility**
- NTC** National Training Center
- OCONUS** Outside Continental United States
- OIF/OEF** Operation Iraqi Freedom (Iraq) / Operation Enduring Freedom (Afghanistan)
- Oorah!** Pronounced “**Who-rah**” what Marines say for “I get you/I hear you/I copy/I agree”
- Hooyah!** Pronounced “**Who-yah**” what Navy Seals say for “I get you/I hear you/I copy/I agree”
- Hooah!** Pronounced “**Who-ah**” what Army says for “I get you/I hear you/I copy/I agree”
- OPSEC** Operational Security –being careful how use, say, and share critical information

OPTEMPO Operations Tempo: pace of an operation or operations in terms of equipment usage

Outside the wire Going off the forward operating base (FOB) protected by razor wire

PERSTEMPO Personnel tempo: time an individual spends away from home station.

PCS Permanent Change of Station: move from one duty station to another (Relocating)

PEB Physical Evaluation Board determines member's fitness for duty, disability, or medical separation

Post Army installation

PX- Post Exchange Army department store; Air Force "Base Exchange" (BX); "Navy Exchange" (NEX)

Rank status and authority of personnel in relation to other military members

Rate used by Navy and Coast Guard for sailors, means same thing as rank

Redeploy to move military forces from one combat zone to another, or to return to home base

Reserve members liable for active duty recall to augment active duty in war/national emergency

RPG Rocket Propelled Grenade: hand-held, shoulder-launched rocket

R & R: Rest and Relaxation Time off for service member approx halfway through deployment

Sandbox, sandpit Iraq

SBCT Stryker Brigade Combat Team

SICK CALL Time allotted to see Doctor or other healthcare provider.

TDY Temporary Duty

"Three Hots and a Cot": Service members in theater are provided three hot meals & a bed

UMT Unit Ministry Team: chaplain (officer) and a chaplain assistant (enlisted soldier)

USA United States Army; branch of military, Personnel: "Soldier"

USAF United States Air Force; branch of military, Personnel: "Airman"

USCG United States Coast Guard; branch of military, Personnel "Sailor"

USMC United States Marine Corps; branch of military, Personnel: "Marine"

USN United States Navy; Personnel: "Sailor"

UXO Unexploded ordinance

VBED- Vehicle Borne Explosive Device

VBIED- Vehicle Borne Improvised Explosive Device

Veteran Status served in military, discharged/released with other than a dishonorable discharge

Warrant Officer officer who derives authority from a warrant, as opposed to a commission

XO Executive Officer assists Commanding Officer (CO); second in command in military unit

Appendix 2: Military Cultural Competence Resources and Fact Sheets

- 1) Center for Deployment Psychology (2009) trains military and civilian behavioral health professionals to provide high quality care necessary to address deployment-related needs of military personnel and their families. <http://www.deploymentpsych.org/>
- 2) The Combat Injured Family: Guidelines for Care for Providers
http://www.cstsonline.org/csts_items/RFR_combat_injured_family_guidelines_care_provider_sheet.pdf
- 3) The Impact of Military Duty and Military Life on Individuals and Families: Resources and Intervention
<http://www.sagepub.com/booksProdTOC.nav?prodId=Book232979>
- 4) “10 Things Military Teens Want You to Know”
http://support.militaryfamily.org/site/DocServer/TOOLKIT_8.5x11_proof6.pdf?docID=15601&JServSessionIdr002=nro0dds6
- 5) Understanding the Experience of Military Families and Their Returning War Fighters: Military Literature and Resource Review <http://www.familyhomelessness.org/>
- 6) The Combat Injured Family: Guidelines for Care
http://www.cstsonline.org/csts_items/RFR_combat_injured_families_guidelines_care_patient_sheet.pdf
- 7) Caring for America’s Children: Military Youth in Time of War
<http://pedsinreview.aappublications.org/content/vol30/issue6/index.dtl>
- 8) Military Officers Association of America
http://www.moaa.org/usergroup/usergroup_fam/usergroup_fam_spouse/default.htm
- 9) Casualty Assistance Information: Meeting the Needs of Military Families and Children
http://66.92.43.14/focus/CSTS_Casualty_Assistance_Information.pdf
- 10) Operations Security (OPSEC) Guide for Family and Friends
<http://www.armymedicine.army.mil/sfrc/OPSECTrifold.pdf>
- 11) **“REACH for Diversity”:** Respect individual differences, cultures, customs; Education of diversity adds to organization; Awareness of how people are similar, different, and unique; Collaboration with diverse providers build strong partnerships; and Honesty be honest with others, and ourselves its normal to fear people/ideas not understood. Learn to respect and appreciate differences, uniqueness. (Adapted from Dept of Veterans Affairs program)
<http://www1.va.gov/Diversity/page.cfm?pg=7>
- 12) Civilian provider web resource for PTSD and TBI
http://www.health.mil/Education_And_Training/Civilian_Provider_Education.aspx
- 13) *inTransition* (DCoE program) provides service members currently receiving mental health treatment with support as they transfer between health care systems or providers.
www.health.mil/inTransition
- 14) Wellness resources for the military community—service members, veterans, families, and providers. www.afterdeployment.org

Are the Needs of Single Parents Serving in the Air Force Being Met?

Samantha E. Blanchard

Abstract: *The military has taken extraordinary steps in establishing programs to support not only the member serving but their families as well. This article will examine military policy as it impacts single parents serving in the Air Force, highlighting existing programs, and calling for more research on this valuable population.*

Keywords: *Single parents, policy, military*

INTRODUCTION

The Air Force has the predictable aspects of a bureaucracy (i.e. fixed jurisdictional areas, firmly ordered office hierarchy, belief that holding office is a vocation, and more or less stable rules; Weber, 1978), and in particular those of a 'greedy' bureaucracy (Coser, 1974), which have implications for recruitment and retention of qualified personnel to defend our country. According to Coser (1974), "Members of greedy institutions must be so fully and totally committed to them that they become unavailable for alternative lines of action" (p. 8). These organizational attributes present stress for all, but particularly for service members who are single parents. Social support theory predicts that attention to family and other social support could mitigate some of these stressors (Boss, 2002; Karney & Crown, 2007). The military has in place program and policy steps to help increase social support, so that personnel are available for the task of protecting our country. In light of recent demographic increases in the proportion of Air Force single parents, the military should continue to build targeted family support programs and policies as a strategy to help maintain a ready workforce. This article will argue that although the Air Force's prime mission is not to provide social support for this group, it is in the organization's best interest to understand and provide for single parents.

The number of active duty members serving in the Air Force in 1990 was 525,000; by 2005 that number decreased to 325,000. Although the actual number of single parents decreased from 21,000 to 16,000, the proportion of personnel who are single parents increased from 4% to 5.1% (Air Force Personnel Center, 2010). One difference that emerges when comparing the single parents in the armed forces with those in the civilian world is that the single parents in the military are mostly male while those in the civilian world are mostly female (Bowen & Orthner, 1986).

Single parents, those without a partner sharing day-to-day parenting responsibilities for minor children, will be the focus of this article. This review will first explore the military environment, and allow the reader to more fully understand the demands and issues facing single parents serving in the United States Air Force and how those demands and obligations affect their relationship with their families. Air Force basic

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family policy, social support policy, policy enforcement, military stressors, and supporting research addressing the situation of military single parents will be discussed as well as the supports that need to be added to improve the experiences of those personnel. Finally, research recommendations will be made. This review will conclude with recommendations for possible policy changes for single parents currently serving in the Air Force.

MILITARY SOCIAL ENVIRONMENT

As an organization, the military functions similarly to civilian institutions by revealing and communicating social expectations and values to its personnel and their families. Concomitant with social expectations and family values are military work expectations. As a work organization, the military requires a range of personal and family sacrifices that dominate the lifestyles of military personnel and their families in accommodating to its work mission. Many unique and adaptive challenges are presented, because the military's environmental context requires readiness and preparedness for missions crucial to national security (Bowen, 1985; Bowen, Orthner, & Zimmerman, 1993; Chapin, 2009; Jensen, Lewis, & Xenakis, 1986; Walker, 1985; Wheeler & Kiorb, 2009). These demands of the armed forces dictate the selection of a lifestyle that pervades almost every facet of a person's life. There are few civilian occupations that require such a high level of commitment and dedication from employees (Bowen & Orthner, 1986; Hoshmand & Hoshmand, 2007). Albano (1994) and Segal (1986) used Lewis Coser's (1974) notion of the "greedy institution" to describe the great demands that the military as an organization places on the time, energy, and commitments of service members and their families, demands that are unrivaled in the civilian workplace.

A key difference between the military as a work organization compared to a civilian company is how intensely the military family is dominated by the requirements of the "greedy" organization. The military requires many sacrifices by the personnel employed by the military and their family including frequent relocations, extended separations and the subservience of the needs of the family to the requirements and objectives of the military (Bowen, et al., 1993; Chapin, 2009; Wheeler & Kiorb, 2009). In exchange the military provides many economic and social supports to compensate the family for those sacrifices, combined with a community lifestyle which allows the family members and service members an interpersonal support network (Bowen, et al., 1993; Bowling & Sherman, 2008).

MILITARY POLICY: IMPACT ON JOINING AND JOB CHOICES FOR SINGLE PARENTS

The military has policy solutions that attempt to resolve the dynamic tension between maintaining a ready workforce that is available to meet the security of the nation and ensuring support is given to members to combat the multitude of stressors that come from serving in the armed forces.

Max Weber (1978) declared a basic premise of organizational functioning as a bureaucracy: tasks are put before people. Several researchers have documented stress

arising from conflicts between the family and work lives of individuals (Bianchi, Casper, & King, 2005; Boles, 2001; Chow & Berheide, 1988). Since the foundational research of Reubin Hill (1949), there has been ongoing study of the interrelationships of family stress and military work life (Boss, 1987; Britt, 2006; Britt, Adler, & Castro, 2005; Burr, 1973; Drummet, 2003; Faber, 2008; Finkel, 2003; McCubbin, Joy, Cauble, Comeau, Patterson, & Needle, 1980; Pincus, 2001; Rothrauff, 2004).

In research that was focused on the Army, it was shown that families could contribute to readiness, and that support to families was a cost effective way to enhance readiness (Kirkland & Katz, 1989) The following policy review will show how the military, and in particular the Air Force, has screened applicants, and after their induction has created a social support system that attempts to serve all of its members and their families.

Policy on Personnel Selection

Due to the specialized needs of the nation's armed forces strict guidelines and regulations must be met by applicants seeking to join any of the military branches. These specialized needs allow the military to accept or reject applicants based on their personal characteristics such as number of dependents, financial stability, and their age. While it might be difficult for the average citizen to understand the requirements of the selection process maintained by the armed forces, these requirements have been examined and approved by the Supreme Court in the case *Kennedy v. Mendoza-Martinez* (1963):

The military is, by necessity, a specialized society (separate) from the civilian societies...The military must insist upon a respect for duty and a discipline without counterpart in civilian life,' in order to prepare for and perform its vital role ... The essence of the military service 'is the subordination of the desire and interests of the individual to the needs of the service.' The history of the courts deferring to the judgment of military leaders on matters affecting the Armed Forces is one of the most consistently upheld principles of constitutional law. Furthermore, serving in the military is a privilege and sometimes an obligation, conferring neither the right to serve nor the right to avoid service.

Policy dictates how the military controls parent status at entry. The United States Department of Defense (DoD) generally prohibits the enlistment of any individual who has responsibility for two or more dependents under the age of 18 at the time of the enlistment. The various military services have the ability to waive this requirement and many of them have even stricter requirements than the standard DoD policy. The Air Force in particular requires an examination of an applicant's financial situation if the individual has any dependents including a spouse. This is done to ensure that the individual will be able to support his or her family with a military salary (*U.S. Code, Title 10, Armed Forces* 2007. United States)

Policy on Job Assignments

The second policy area that could potentially affect single parents would be that governing job assignments. Here the fundamental value of 'equity' of tasks for all in the same job group is the rule. Policy does not limit or vary work assignments with regard to

parental status. The demands that the military places equally on all employees make it a difficult environment in which to be a single parent. There are no exceptions made in the assignment of orders, duty stations, deployments or time off for individuals who have become a single parent due to divorce or death of their spouse (*U.S. Code, Title 10, Armed Forces* 2007. United States). Social support theory would predict that individuals with strong social support would better cope with these demands (Young, 1999). The military takes this into account at the point of assignment by putting safeguards in place to assure that the service member has taken care of family obligations and will be fully available to all assignments. In these cases the single parent is required to have a local individual who is not a member of the military agree in writing that he or she will accept the responsibility of those children with no notice in the event that the parent who is in the military is deployed or otherwise called to duty. An individual who fails to comply with these regulations could receive an immediate discharge from service (*U.S. Code, Title 10, Armed Forces* 2007. United States).

Another area where policy might apply differently for single parents is the case of emergencies. When an individual serves in the military there is a limited amount of flexibility with regard to family emergencies and the needs of the military come before the needs of the family. By being a single parent and a member of the military the difficulties become more complicated because there is not another parent available to assist with the rearing of the children. The accumulation of stressors could lead to an unplanned crisis that would put the single parent into an emergency situation such as losing childcare, unstable housing, or financial difficulties. Although family emergencies sometimes occur without warning, the point is to not accumulate stressors to the point they result in emergencies. Policy changes could help prevent the accumulation of stressors that could lead to emergency situations.

Military single parents are required to fulfill the terms of the contract that was signed during the enlistment process. There is no way to renegotiate the contract unless there is a medical reason, such as a service-related injury or condition. The individual who either enlisted or accepted a commission must fulfill the terms of the contract signed or be dismissed from military service (*U.S. Code, Title 10, Armed Forces* 2007. United States).

Military Policy and Social Support for Single Parents

As well as increasing demands, policy can also establish supports for family members. In recognizing and responding to the needs of the service members and their families, Albano (1994) has stated that there have been landmark shifts in military family policy over the past two centuries. These shifts have been made from informal implicit obligations to help meet the needs of military families to formal supports that have been institutionalized through the DoD in the form of directives, public laws, policy statements,

A prime example of formal supports established by policy are the Airman and Family Readiness Centers in which parents can receive the support and services that they need in order to meet the demands created by the family. Several of these services include the Air Force Aid Society (AFAS), the Relocation Assistance Program (RAP), Family Life

Education (FLE), the Family Readiness Program (FRP), and the Transition Assistance Program (TAP). The AFAS helps with interest free loans in cases of emergencies such as traveling home for deaths, illness or accidents of immediate family members. AFAS also can help with emergency car repairs and other unexpected financial difficulties. The RAP program is designed to ease the transition to another duty station by providing information about the new assignment, tips on moving, and expectations on making the move to another base. The FLE program offers educational classes on parenting, spousal communication, and overall successful living in a military lifestyle. The FRP program offers services to the family members of those that deploy to a combat area. Services can include activities for the family members, phone calls for morale purposes, and monthly dinners with all the family members left behind. The TAP program is utilized by members of the service either retiring or leaving the service after their commitment is over. This program offers resume services, interview skills, and job hunting techniques (Air Force Instruction 36-3009, 2008).

These policy supports clearly reflect the manner in which mutual benefits are shared between the military as an organization and its constituents: service members and their families. Albano (1994) noted that “The more the military institution adapts to family needs, the more it will preserve itself as an institution. As family members become increasingly integrated into the military community, there is an increased commitment to the organization” (p.13). In essence, the military provides economic and social support to compensate families for their sacrifices in meeting the demands of the military lifestyle. Likewise, the military prides itself on facilitating an informal work and community context from which service members and their families can derive organizational and interpersonal support, and develop a sense of mutuality (Bowen, et al., 1993).

Policy Enforcement with Changing Demographics

There has been a growth in the need for family-related supports due to changes in demographics in the population from which the military recruits. Based on Defense Manpower Data Center records from 2005, almost half of the Air Force population is comprised of parents, with 10% of those being single parents without partners (Air Force Personnel Center, 2010).

Events in the world precipitated a mass deployment of the various services to the Middle East in the early 90s. During the staging of the troops for deployment it was discovered that the majority of the single parents had not made the proper arrangements for the care of their children while they were deployed. This caused the deployment to be delayed resulting in a slower reaction time for the armed forces (Albano, 1994). This also resulted in some individuals being reassigned to different units leaving at different times, creating situations in which deployed military units were not fully staffed for the mission requirements. Units going to a combat area being understaffed can result in higher casualties and increased risk (Albano, 1994). Consequently, the military had to reexamine the enforcement of policy surrounding single parents.

In order to prevent a similar situation from occurring again the instructions governing single parents were more strictly enforced to comply with the military’s primary mission

of protecting the United States. Single parents were required to create Family Care plans detailing how their children would be cared for when the parent was deployed (*Department of Defense Instruction 1342.19*).

These plans required that the individual assuming responsibility for the children be available at a moment's notice. The plan calls for short term care as well as long term care. Short term caregivers have to be co-located in the local area. Long term caregivers would step in if the parent would be gone for an extended period of time. Short and long term caregivers are given powers of attorney in order to enroll children in school and to make medical decisions during the parent's absence. Access to funds to help offset the cost of taking care of these children also had to be established. Instructions as to how these children would be transported from short term to long term caregivers are also required. Parents who were unable or unwilling to create these plans were dismissed from the Air Force so that they could care for the children without placing the primary mission of the Air Force at risk (*Department of Defense Instruction 1342.19*).

The military's shift to a more voluntary service has provided more opportunities for personnel to have family members accompany them to peace time bases all over the world. Over time, family members at bases have outnumbered military personnel (Drummet, 2003; Goldman & Segas, 1983). As the changing demographics of the military has evolved from predominantly single males to include various types of family units the military's behavioral and social science research program was expanded. The Air Force's original focus on achieving adaptation of the individual service member to military life shifted to understanding the adaptation patterns of the families of service members, specifically in adapting to the changes required by the military lifestyle (Bowen, et al., 1986; Drummet, 2003).

Military Stressors and Policy Responses

The extent to which families accept, internalize, and exhibit behaviors indicative of military expectations reflects the degree to which they are able to manage the stress and demands of the organization (McCubbin, 1979). The military requires a cadre of contextual changes which produce varying degrees of stress. Some of these changes include: frequent relocations; extended family separations; spouse/parent separation; absence and reunion; hazardous duty assignments; possibility of injury, captivity, or death in combat or in other dangerous environments; social and cultural isolation of families on bases in remote areas overseas; uncertainty of future careers; and fast-paced deployment (Albano, 1994; Bowen, 1985; Bowen, Mancini, Martin, Ware, & Nelson, 2003; Bowen, et al., 1993; Drummet, 2003; Jensen, et al., 1986; Rosen & Moghadam, 1989; Rosen & Moghadam, 1988; Wilson, 1994).

There are important differences between single parenting in the civilian world compared to single parenting in the armed forces. In sharp contrast to American society at large where females comprise the majority of single parents, single parents in the military are more likely to be males who are faced with the dual challenge of raising a child or children largely on their own while balancing their responsibilities to their respective service (Air Force Child Programs, 2011).

Importantly, military duty takes on many different forms. Some servicemen and women work for eight hours a day, five days a week, and enjoy a certain degree of stability in their schedules without the added concern of being deployed at a moment's notice. Other military occupational specialties involve long work days (in some cases 12 hours or more) and weekly schedules that frequently involve working or training on weekends and holidays. The latter category of military service may place inordinately high levels of stress on parents in general and single parents in particular as they struggle to balance their military responsibilities with their parenting. It is also important to take these issues into account when formulating support programs for single parents in the military because individual circumstances may differ greatly with military service being one of the only common denominators.

A study of Air Force women serving in the U.S. Air Force during the First Persian Gulf War deployment conducted by Pierce (1998) revealed a number of work-family conflicts that contributed to the resignation of these service personnel once their enlistments were completed. Such conflicts were identified by 25% of those leaving military service and rated as critically important by 11%. Many respondents commented that there was simply insufficient time to meet all the demands placed on them. Although some parents had successfully managed their work lives, the anticipation of having children had caused a reappraisal of their commitment to the military. The Air Force was losing highly trained personnel because of parental status.

According to Hammelman (1995), although lengthy separations of family members are a natural and expected consequence of military service, there have been some significant changes in recent years. For instance, Hammelman emphasized that, during the Persian Gulf conflict, families were separated. Although this typical for previous wars, more single parents were called to serve than previous wars. In February 1991, there were approximately 16,300 single parents serving in the theater (Hammelman, 1995). Hammelman pointed out that the "Literature on stress and the military has emphasized two-parent families in which the man was called to duty; timely and relevant studies concerning the stress experienced by single-parent military families, though, remain virtually nonexistent" (p. 143).

The following describes how the military has responded to these unique stressors by providing programs and services to address the needs of the members serving, to include family members. All the programs described below were created to serve the population as a whole. Although these programs are needed and utilized, policy changes to address the unique needs of single parents could improve the lives of single parents serving in the Air Force.

In 1994, \$2.7 billion was allocated to improve the quality of life in the armed forces (Serrano, 1994). These funds were to be used to modernize and build new military housing, enhance family-support programs, and increase military paychecks for those living in high cost areas. The armed services have come to realize that helping families become stronger can also help service members do their job more safely and efficiently. If service members do not worry about their families, their minds are clear (Heubner, Mancini, Bowen, & Orthner, 2009). The armed services are also helping families to cope

with military life through many other programs. These programs include health care, childcare, drug and alcohol abuse programs, spousal and child abuse prevention programs, child development centers, youth programs, parenting programs, family services, family support groups, legal assistance, spouse clubs, and the Red Cross (Heubner, et al., 2009).

Stress from frequent moves, base closings, and force reductions were found to be related to spousal and child abuse (Segal, 2006). In 1981, the DoD mandated cooperation among the Army, Navy, Air Force, and Marines to address prevention, evaluation, and treatment of child abuse and neglect, and spousal abuse (Moss, 1994). During the late 1980s and early 1990s, the number of spousal abuse cases rose from 12 per 1,000 to 18 per 1,000. In that same period, confirmed child abuse cases increased from 6.0 per 1,000 to 6.6 per 1,000, and on average, every year, one child or spouse died at the hands of a relative in the Army, Navy, Air Force, or Marines (Moss, 1994). In 1995, military spousal abuse rose slightly, and the rate of child abuse slightly dropped (Jowers, 1996). Over time, support programs have been developed to counteract negative trends. In 1996, lawmakers added \$30 million to the defense authorization bill for the Family Advocacy Program (Jowers, 1996). This program deals with aspects of spousal and child abuse—preventing, identifying, reporting, and treating. The New Parent Support Program was initiated to address “at risk” parents and children in early 2000. This program was developed to identify and offer resources to parents and children that met certain standards, such as age of parents, single parents, high risk pregnancy, multiple child birth, and high levels of stress (Salas & Besetsny, 2000). Programs and initiatives of this kind are considered crucial to the “readiness and retention of quality people” (Jowers, 1996).

In the last thirty years, the armed forces have risen to the challenges of spouse and child abuse, alcoholism, quality of life, and child care issues, and research has documented the need for support programs addressing these issues, and has established program effectiveness. Now is the time to document the needs of single parents in the military, and conduct intervention and evaluation research.

SUPPORTING RESEARCH ON MILITARY SINGLE PARENTS

The majority of the research on work and family issues done throughout the years has focused on two-parent family units rather than the single parent households. When single parent households were examined the researchers more typically chose single parents employed in the civilian job market.

The literature reveals little in the way of research surrounding single parents in the military. Since most of articles on military single parents are fifteen to twenty years old, I have included studies on single parents in general to help bridge this gap in the literature. Military families struggle with the same basic issues as mainstream America.

There is little doubt that stressors experienced on the job or in the family are often interrelated. The interactive nature of role overload in both the workplace and the family constitutes one of the more serious stressors for families, particularly for single women and parents of young children (Allen & Armstrong, 2006; Hall, 2007). Job-related stress and work-family conflict can be detrimental to a worker’s well-being and health,

including the over-stressed single parent (Hammer, Cullen, Neal, Sinclair, & Shafiro, 2005; Quick, Horn, & Quick, 1987).

Major causes of stress can be the characteristics of a job, demands of the job, and employment-related life events. These factors can lead to behavioral changes that cause the individual to be less responsive to the feelings and needs of his or her family members, as well as to become less productive on the job (Quick, et al., 1987). In a ten year old article describing stress among single parents serving in the Air Force Heath and Orthner (1999) concluded that when members received or perceived support from their environment their stress level decreased.

According to Bowen et al. (1993), single parents in the military face many challenges. Often, they encounter institutional discrimination and are discouraged from reenlisting if they become single parents while on active duty. Potentially, they face greater role strain and role conflict in fulfilling work and family obligations. Unlike single parents in the civilian labor force, single military parents must deal with norms of the military, such as unaccompanied family tours, deployment to foreign battlefields or extended tours with limited or no advanced notice, and frequent disruption in informal community networks and extended families. There are frequent changes in duty stations and long absences from their families; therefore, single parents may not also have access to their extended family for support while raising their children.

These demands and norms are enforced by both social and legal sanctions. In contrast to their counterparts in civilian life, single military parents are offered an important asset: reasonable job security with fringe benefits (medical, housing, and childcare subsidies; Bowen, et al., 1993). Although these benefits exist, the military should examine its policies to insure that they also meet the needs of this increasing proportion of the military population. In essence, Bowen (1987) has stated that a working knowledge of this segment of the military culture, and sensitivity to the diversity of their needs within it, provides a value-added contribution both to effective leadership by military decision makers and delivery of services by military and civilian employees.

WHAT'S MISSING FOR SINGLE PARENTS?

The following is a discussion of programs available to military family members as a whole with a focus on what could be improved to entice single parents to participate.

The military is aware of the stresses that being employed by the military places on the family structure. Many of the family life classes offered assist married couples to deal with the stress caused by deployment rather than the stress caused by being a single parent in an emotionally demanding job (Air Force Instruction 36-3009, 2008). By not designing the classes to assist single parents as well as married parents employed by the military the single parent does not have the access to the support groups that are essential for strengthening the family unit.

The military is also aware of the stresses on the family unit caused by long term deployments. In order to minimize the amount of stress on the family unit and the member, programs and initiatives have been created to help provide the necessary

support which results in minimizing the negative effects of long term deployments. While the military's main focus is in responding to situations requiring military force they understand that by providing for the dependents left at home they can create an atmosphere where the service men and women can focus on the responsibilities of their jobs with the knowledge that their family left behind at home is supported by the branch of the military that they serve (Segal, 2006). Single parents who have completed the Family Care Plan also know that their children are taken care of; however, the individual watching their children is most likely off base and not close to the services located on base. While the children have access to these services, by not being close to those services, it is less likely for them to be utilized.

Childcare is crucial due to an increase in the number of single parents and dual military career couples, along with their odd working hours, rotating shifts, deployment, and frequent moves. The Defense Department provides childcare in both child development centers and in homes. The DoD currently oversees 800 Child Development Centers (CDCs) located on military installations worldwide. These centers offer a safe child care environment and meet professional standards for early childhood education (Military.com, 2011). Child care is typically available through these centers for children ages six weeks to twelve years. Military childcare facilities are certified to meet the standards of the National Academy of Early Childhood Programs (Jowers, 1994). This accreditation is separate from the requirements set forth by the armed services and the Defense Department. Other available family childcare providers and facilities are regulated by military officials. These facilities are specifically designed to accommodate military parents who work long and/or erratic hours (Jowers, 1994). Another program designed to help parents as well as children are military youth programs. They were developed to reach pre-teens and teens. These programs provide this population with structured activities. There is also a wide variety of programs that are designed for school-age children (Jowers, 1994; Air Force Child Programs, 2011).

Mobilization deployment and relocation programs are designed to assist single and married service members cope with mobility requirements. The information and referral programs assist with answering questions regarding all aspects of military life, locating and facilitating personnel in fulfilling needs, and providing information about installations and communities, as well as about foreign customs, languages, and cultural differences. Educational programs offer workshops and classes regarding parenting, stress management, self-esteem, and strengthening family ties (Air Force Instruction, 36-3009, 2008; Jowers, 1994). Legal assistance is available for dealing with creditors, understanding rental contracts, solving personal financial problems, and other legal matters (Air Force Instruction, 36-3009, 2008; Jowers, 1994).

CONCLUSION AND CALL FOR RESEARCH

In this dynamic environment, identifying opportunities to improve the support services provided to servicemen and women is a timely and worthwhile enterprise because of its capacity to contribute both to quality of life issues as well as the primary mission of the armed forces to remain combat ready. In this regard, Wingo (2002) reported that:

The military force must increasingly rely on women, thus, comprehensive family programs that recognize changes in military families... and improving policies regarding childcare are necessary to maintain combat readiness and to continue to recruit and retain highly skilled military personnel (p. 18).

The studies done by researchers over the years have virtually ignored a substantial proportion of the population of the United States Air Force. Although there has been some recent research on single parents serving in the Armed Forces, much is conducted on the Army or the Navy (Taylor, Wall, Liebow, Sabatino, Timberlake, & Farber, 2005).

While the percentage of single parents in the armed forces should be decreasing through the recruitment policies and regulations of the armed forces, they are not. As long as the possibility of becoming a single parent still exists through a divorce or the death of a spouse, single parents will remain involved in the Air Force. As long as the proper instructions are followed and the Family Care Plan created they will be allowed to remain on active duty.

More research is needed with the population of military single parents in the areas of services addressing domestic violence, childcare needs, housing issues, and workplace challenges. However, what stands above all is the need to understand the issues facing this population because before any real policy changes can be made, one must understand the challenges and the strengths of this dynamic population.

One of the themes that quickly emerges from the review of the relevant literature is just how few studies have been devoted to how best to provide timely support services for those on active duty, especially single parents. Additionally, it has been indicated that there will likely be more single parents and more overseas deployment in the years to come rather than less (Wingo, 2002). As Wingo (2002) concluded when writing about military life:

Since it is not likely that there will be fewer global nomads among our population in the future, or around the world for that matter, there is room for even more research into the problems and advantages of this lifestyle (p. 31).

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Lessons Learned in Afghanistan: A Multi-national Military Mental Health Perspective

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Abstract: America has been at war for almost 10 years. Because of this, continuing missions in the Middle East require the support and cooperation of our allied North Atlantic Treaty Organization (NATO) forces from around the world. In this paper we provide an overview of the mission at Kandahar Air Field (KAF) and the Multi-National Role 3 hospital located at KAF. Next, we explain the mental health capabilities and unique perspectives among our teammates from Canada, Great Britain, and the United States to include a discussion of the relevant cross-cultural differences between us. Within this framework we also provide an overview of the mental health clientele seen at KAF during the period of April 2009 through September 2009. Finally, we discuss the successes, limitations, and lessons learned during our deployment to Kandahar, Afghanistan.

Keywords: Multi-national, military, mental health, deployment

INTRODUCTION

America has been at war for almost 10 years. Shortly after the attacks on the United States on September 11th, 2001, Operation Enduring Freedom (OEF) began on October 7, of that same year. This started with aerial bombings in Afghanistan by American and British forces in an attempt to end worldwide terrorism. In December 2001 the United States (US) and her allies (specifically the United Kingdom, Germany, and the Northern Alliance) had received intelligence reports that the leader of terrorist operations, Osama bin Laden, was directing operations from the rugged mountains of Tora Bora in the Nangarhar Province of Afghanistan. Efforts to capture Osama were lost despite the battle waged there.

On March 2, 2002, the US Military and other countries that comprise the North Atlantic Treaty Organization (NATO), to include the Afghan National Army, Canada, United Kingdom, Germany, France, Australia, New Zealand, Norway, and Denmark launched Operation Anaconda in an attempt to destroy al-Qaeda and Taliban forces in the Shahi-Kot Valley of the Paktia Province of Afghanistan. Operation Anaconda ended on

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March 16, 2002 with reports of over 500 Taliban forces killed. Despite this, Osama bin Laden continued to evade capture.

Soon after these initial conflicts with Afghanistan, the US presidential administration under George W. Bush, along with the United Kingdom (UK), launched Operation Iraqi Freedom (OIF) on March 20, 2003. These countries shifted their focus to Iraq based on their suspicions of that country's involvement of employing weapons of mass destruction. After capturing the president of Iraq, Saddam Hussein, and charging him with war crimes, NATO turned its attention to securing Iraq as a free democracy. Eight years later, US President Barrack Obama renamed this initiative Operation New Dawn to reflect the ongoing withdrawal of NATO's military presence in Iraq.

Despite the drawdown of OIF, OEF continues. As part of OEF, Kandahar Airfield (KAF), which was once controlled by Taliban Forces, is now a NATO base. The primary mission of the NATO forces is called International Security Assistance Force (ISAF). True to the original intent of 9/11, ISAF's goal is to help build a democratic and free Afghanistan that is devoid of oppression and terrorism. Multiple OEF operations are based out of KAF and over 45 countries are represented there. It is at Kandahar, and the surrounding Forward Operating Bases (FOBs) and Combat Outposts (COPs) near Kandahar, that represent the focus of our work for this paper.

KANDAHAR AIR FIELD

NATO has divided Afghanistan into four regional commands. Regional commands North, South, East, and West. Kandahar Airfield (KAF) is the headquarters for Regional Command – South (RC-S). Our team was deployed together at Kandahar in the summer and fall of 2009 and was responsible for nearly all mental health support in RC-S. In the summer of 2009, there were only 1-2 more military mental health providers mobilized in RC-S with their respective military units in order to provide services to those specific units. This was during the time of a massive US troop build-up in Afghanistan that started in the spring of 2009. According to ISAF statistics, the approximate RC-S troop strength in April 2009 was 22,830 (ISAF, 2011). This NATO troop strength was more than doubled in less than one year. ISAF reported a RC-S troop strength of 45,100 in February 2010. Deployment of the medical and mental health assets needed to support this burgeoning troop population originally lagged behind, leading to significant increases in workload. Productivity in terms of medical and mental health encounters was at an all-time high for OEF, leaving the medical services in place to shoulder the additional burden until reinforcements could arrive.

KANDAHAR ROLE 3 HOSPITAL

There are four levels of medical care that wounded soldiers may receive from their time in the battlefield, all the way home to their respective countries. NATO has a developed common system of identification that assigns medical treatment facilities, or 'Roles,' that correspond with the levels of medical care each provides (Department of National Defence Canada, 2010). Role 1 medical facilities provide primary health care to include services in specialized first aid, triage of casualties, resuscitation, and

stabilization. Role 2 medical facilities have the capacity to provide a higher level of treatment and care than the Role 1. Role 3 medical facilities are trauma level hospitals located in the deployed setting. They offer primary care services, surgical facilities, intensive care units, medical-surgical wards, diagnostic support and other in/outpatient services such as pharmacy, dental clinics, mental health services, and physical therapy. This was the case of the Role 3 Multinational Medical Unit at KAF (Role 3 MMU) during the time of our deployment in 2009. Role 4 medical facilities provide a broad spectrum of medical care and cannot be deployed in a combat theatre such as a local hospital found in most Western nations. If required, soldiers are evacuated to Role 4 medical facilities to their home nations.

The Role 3 MMU is organized into four components: (a) in-patient care; (b) clinical support; (c) primary care; and (d) administration. In-patient care is composed of the operating room, an intensive care unit, trauma bays, and the acute care ward. Mental health services, pharmacy, x-ray, and laboratory services falls under clinical support. Primary care was responsible for physical therapy, dental services, preventive medicine, and the unit medical services.

From 2006 to October 2009 Canada was the lead nation commanding the Role 3 MMU at the KAF. During this time period the Role 3 MMU treated over 42,000 patients, performing an estimated 4,500 surgeries and admitting more than 3,600 patients (Department of National Defence Canada, 2010). The Role 3 MMU provided care to NATO forces, Afghan security forces as well as to civilian contract employees and local nationals who had been injured as result of the conflict. The most unique aspect of the Role 3 MMU was its multinational workforce. Medical personnel, allied health professionals, and support staff from Canada, US, UK, New Zealand, Australia, Germany, Denmark, and the Netherlands ensured the highest levels of care to patients (Department of National Defence Canada, 2009).

MENTAL HEALTH CAPABILITIES AT KANDAHAR

Kandahar is the transportation hub of RC-S. Most fixed wing aircraft and rotary (helicopter) flying was done between Kandahar and the outlying FOBs or COPs. When a soldier needed the care of a mental health professional, they had the option of being flown into KAF if space was available. Otherwise, their unit leadership could call the mental health providers at the Role 3 to request that someone come to their location and provide services for their troops. This could be problematic, because it might take a soldier upwards of one week to fly from their location to Kandahar, get the short-term mental health support they needed, and return to their unit. Our team experienced similar travel challenges when we went to the FOBs as these trips averaged a minimum of 3 days or more, leaving the Role 3 mental health team back at KAF to cover the workload short staffed.

Mental health care has been an integral part of medical care provided at the Role 3 MMU KAF. The mental health department was designated as an outpatient service under primary care. Despite this, it offered 24-hour services as mandated by the Role 3 MMU KAF mission. The permanent team consisted of four Canadian mental health clinicians;

one civilian psychiatrist, one senior social work officer, one junior social work officer and one mental health nurse officer. Additionally, one Mental Health Nurse officer from the UK was assigned to the Role 3 MMU. Finally, a Combat Stress Control (CSC) team from the US Air Force was attached (lended) to the Role 3 MMU and included either a social work officer or a psychologist officer and a mental health technician. This small team was responsible for the provision of mental health care for an expanding population of over 25,000 people at KAF and to Canadian Forces located at FOBs. Together, the mental health providers were able to form a cohesive team and pool resources to provide a high quality of mental health care to service users of all nationalities who spoke English or French.

The US is unique in that it employs mental health technicians. These are enlisted members of the armed forces who are not required to have any formal training in mental health before they enlist in the military. They are sent to a mental health technical school training program after they complete basic training and receive a great deal of on-the-job training at their respective bases of assignment once they complete technical school. In essence, they are provider extenders and supporters. The US teams typically deploy mental health technicians with their mental health providers so that there are one or two technicians supporting each provider. Because this model is somewhat unique within NATO, Canadian and British providers needed to be trained as to how best to utilize the support of US mental health technicians.

CHALLENGES UNIQUE TO THE INTERNATIONAL ENVIRONMENT

Each country also has a unique approach to deployed mental health care and this created challenges for the team when treating members from another country. For example, there were vastly different standards for repatriation of military members depending on the country. This was a particular challenge for the team when, for example, a significant number of Canadian soldiers whom the team treated did not meet the Canadian standard for deployment fitness according to our psychiatrist but were denied repatriation home because they were commanded by US officers who applied a US treatment philosophy to these situations. In the Canadian Forces, a recommendation by a psychiatrist or a physician was normally accepted and substantiated by the Senior Medical Advisor who advises command. This routinely leads to final approval by the Joint Task Force Commander and the soldier was medically repatriated. This difference in policy among the various countries meant that the mental health team had to manage more clients with poor functioning and/or chronic, severe mental health issues than the team was designed and trained for. This forced a focus on symptom management rather than problem resolution when dealing with long-term clientele, further compelling the team to provide on-going care as needed rather than engage the brief therapy models that are more widely embraced by the Canadian and British military forces. This approach was selected largely because most US military members were going to remain in theatre for extended periods of time and many adjustment problems, family challenges and even some mood disorders such as depression would not completely resolve themselves unless they returned home.

Confidentiality was also a challenge in this international environment. For example, patient information is deemed confidential and is protected under federal legislation for the Canadian Forces. The only information that can be communicated to Commanding Officers are the soldier's employment limitations (e.g., cannot lift more than 15 lbs x 10 days). Any other medical or social work information requires the expressed voluntary written consent of the member and the member can refuse to sign consent. The non-US members of our mental health team were challenged by being required to comply with a US Uniformed Code of Military Justice (UCMJ) they were unfamiliar with. The disclosure of drug use, homosexual orientation, and other violations of the UCMJ had to be disclosed to their command and the member could be reprimanded as was indicated on the US consent to treatment forms that were used for all US Forces. In Canada, the disclosure of such information during the therapeutic process is protected and only discussed with the medical team that places members on employment restrictions as needed. Obliging mental health clinicians to violate patient trust by disclosing information communicated in therapeutic setting with the potential of punishment is viewed as contrary to the goals of the therapeutic process and professional standards of mental health practice. This is in no way a criticism of US military policies, rather a demonstration of the different needs of each military organization and their requirements and the challenges of working with other nations in a multinational context.

Deployment screening criteria is also different among NATO countries. This is true among the US forces (Army, Air Force, Navy, and Marines) as well, adding to the complexity of how many mental health needs a particular military member can have and still remain deployed. These differences create diverse and layered complexities in terms of expectations and diagnosis for military members in which the multinational team had to navigate. For example, US soldiers with Attention Deficit Hyperactivity Disorder taking prescribed medication for their condition is something that would likely disqualify Canadian or British forces from military service.

The stigma associated with mental health services is a problem for members of all military services, despite the country of origin. Interestingly, stigma did not appear to be as problematic for the American soldiers seen at the Role 3 and they seemed to be more willing to engage in mental health work than the Canadian or British. The British are working hard to eliminate stigma and the Trauma Risk Management program supports lowering stigma, but we speculate that, as a nation, the British have not embraced 'therapy' in the same way the Americans have and an element of 'stiff upper lip' still remains.

A further difficulty was that the British forces were only seen by their own mental health team, which caused a splitting of time between the NATO work in the Role 3 and the duties to see the British forces mainly at the British Role 1 facility for the British provider. The British deploy three mental health nurses to cover the needs of a British deployed population of between 8,000 and 10,000. British mental health nurses are expected to pay 'house calls' to the Royal Air Force Regiment who guarded KAF, and the Black Watch Regiment who were stationed at KAF. A further duty was to attend to the troops in Kabul, which was some 300 miles away, as well as briefings for all troops coming into theatre and going home. The primary mental health philosophy of the British

Forces is known as Trauma Risk Management (TRiM). TRiM is a system first used by the Royal Marines and is now well embedded into the British fighting operations (Frappell-Cooke, Gulina, Green, Hacker-Hughes, & Greenberg, 2010). TRiM is a system of peer-support that operates through trained personnel within operational units who are trained to recognize psychological issues and facilitate social support (Greenberg, Langston, Everitt, Iversen, Fear, Jones, & Wessley, 2010). This allows for mental health care to be assessed and in part delivered without the need for professional mental health practitioners to be present. If a need arises then the TRiM personnel can contact the British Field Mental Health Team for support. Further to this system, the treatment options for the British are different from the US and Canadian models. Within the NATO mental health team there was a facility for the US and Canadian troops to have access to a psychiatrist and the possibility of a number of different medications to be prescribed. This was not the case for the British forces as they cannot be in theatre with prescribed medication for mental health issues. This left the UK with limited treatment options and the use of short-term therapy, some very limited sleeping medication or just rest and 'watchful waiting' could be used before the patient would be repatriated for treatment back in the UK.

The US employs a philosophy of providing services as far forward as possible, enabling combat assets to remain in theater as long as possible and hopefully to complete their deployment and redeploy back home with their respective units. This philosophy is markedly different than other NATO countries. When we combine this with the fact that the US had roughly 50% (ISAF, 2011) of the combat troops in ISAF in 2009, this leads to an inordinate number of US troops being served in theatre as is evidenced by the figures above. This began to overwhelm NATO mental health care resources as these countries had only deployed the assets they needed for their military populations given their treatment philosophies. This had the possibility of building resentment as these NATO providers ended up having very limited time to service troops from their own countries.

Similar to the US and UK approaches, Canada uses the general principles of proximity, immediacy, and expectancy (PIE) to treat other mental health and psychosocial presentations. The PIE approach was designed to reduce the soldier's sense of having to escape fighting and return home. Thus the proximity of care was close to the battle lines. Staying close to the battle lines allowed the soldier to stay in contact with their unit and maintain a sense of belonging and cohesiveness with their unit; a vital element in mission effectiveness. Symptoms are normalized and treatment is immediate to reduce the development of, or the long-term effects of symptoms. During the time of treatment, the soldier received constant reassurance and communication from the medical providers, the chain of command, and their fellow soldiers that there was an expectancy of recovery and return to work.

Consistent with the principles of PIE, the Canadian Forces (CF) approach to mental health is the preservation of personnel and support to families through early intervention, use of chaplain and social work services, and use of family support services on bases and in the community. However, in a combat zone such as Afghanistan, the resources available to mental health clinicians and medical staff are limited. As a result, there is much less flexibility in the intensity and duration of care compared to what can be

provided at home bases. Therefore, the Canadian approach to mental health care is brief intervention. Service personnel who require more psychiatric care or psychosocial services and could not be returned to duty within a specific number of days were normally repatriated home through the medical chain of command. This was because a replacement had to be notified and deployed in a way that caused least disruption to the mission. Each deployed unit has a reserve of personnel who can replace most occupations. There were only a handful of jobs for which no replacements were available.

Due to the small size of the Canadian Forces (CF) and the integrated nature of its elements under one umbrella or force, most clinicians are able to forge relationships with the multiple command levels and their respective leaders of the deployed Battle Group. This close working relationship facilitated open communication and problem solving as an early intervention in dealing with challenging Canadian soldiers seeking mental health care. This type of intervention is highly encouraged within the CF model of patient care as it reduces the numbers of mental health and psychosocial repatriation. It also reduces an adversarial stance between medical professionals and unit commanders and instead promotes a partnership that seeks to balance the needs of the member with the operational requirements. Communication with the medical chain and unit commanders is designed to be regular and consistent. In the CF it is extremely rare that a supervisor or commander will go against a medical recommendation or a well-substantiated social work recommendation that offers a clear a supportable plan as these decisions are often made after exhausting other alternatives. Medical and psychosocial fitness for deployment are constantly evaluated at each interview with the core principle of PIE underlying each intervention.

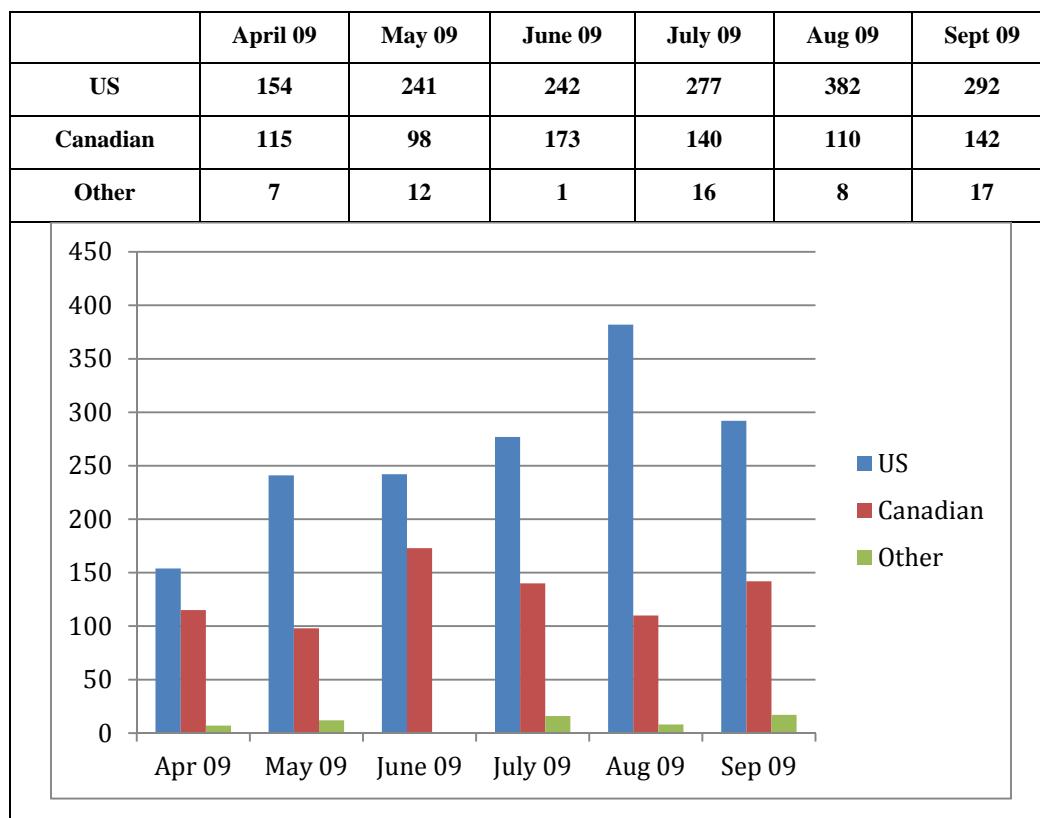
OVERVIEW OF PATIENTS – WHO DID WE SEE

Interestingly, combat stress reactions were not the predominant complaint among patients interviewed by the mental health team during the 2009 deployment. The majority of cases seen at the mental health clinic were related to depression and anxiety and adjustment issues related to military induced separations (Table 1) and the majority of cases were US soldiers as they constituted at least half of the fighting force and are deployed for the longest time (Table 2).

Table 1. Mental Health Visits by Category (April 2009 – September 2009) in the Combined Role 3 Multinational Medical Unit

Combat/Operational Stress	135 (06%)
PTSD/ASD	245 (11%)
Depression or Anxiety	623 (28%)
Mental Health Issue Not Previously Specified	111 (05%)
Stress or Adjustment Issues	401 (18%)
Partner or Family Issue	133 (06%)
Behavioral or Occupational Problem	156 (07%)
Military Acute Concussion Evaluation	131 (06%)
Brief Contact	201 (09%)
Other	89 (04%)

Table 2. Mental Health Visits by Nation (April 2009 – September 2009) in the Combined Role 3 Multinational Medical Unit



LIMITATIONS OF THE TREATMENT ENVIRONMENT

As with any deployed setting, there were natural limitations of the treatment environment. The immense heat of the summer in Southern Afghanistan makes for an oppressive setting. It also makes any kind of intervention very challenging to conduct outdoors if inside space is not available. As previously mentioned, space and a relative lack of privacy were often problematic and this was the case at the vast majority of military bases throughout Afghanistan. We also endured multiple rocket attacks. When rocket attacks occurred, the airfield was mostly shut down so that residents could shelter in bunkers to increase safety. This occurred during multiple sessions and was highly disruptive of not only that session, but of the appointment schedule overall.

Understandably, the Role 3 hospital at KAF was located directly next to the very busy flight line so that wounded troops could be transported as quickly as possible. Unfortunately, this meant that the noise level was frequently very loud and conducting interviews was challenging at those times. This location was also difficult to access for many of our patients who were stationed at Kandahar as the flight line is located near one edge of the airfield. Unlike the smaller FOBs and COPs, Kandahar is a vast base where transportation on the base is very limited. This meant that some of our patients would have to walk for more than an hour in intense heat just to be seen and served as a significant disincentive to seek care.

The final challenge/limitation of seeing patients in a combat environment has to do with carrying a weapon. US and Canadian forces are required to be armed at all times while deployed in order to support the defense of the base. Many times we would see troops who expressed significant suicidal and homicidal ideation and they would have their weapon on their person or right beside them. This occasionally led to some uncomfortable situations, especially considering the fact that a US Army soldier had been recently charged (May 2009) with killing five service people, two of which were mental health providers, after opening fire at a mental health facility in Iraq where he was being treated for combat stress. Later, concerns from patients were voiced about providers carrying weapons after the tragic Fort Hood shooting done by an army psychiatrist who was scheduled to deploy with a combat stress detachment to RC-S.

The rotating nature of deployment always is a challenge for continuity of care and team stability. Canadian military members have 6 month deployments with the exception of the contract psychiatrist who could work for as little as 3 months before returning home. British providers had 3-month deployments and the USAF deployments were 6 months. This created challenges in developing and maintaining a cohesive team, especially when you consider these deployments were staggered so the teams were normally consistent for the duration of a month or two.

STRENGTHS AND SUCCESSES

Our team was able to overcome many of the obstacles listed above and experienced several strengths and successes. We met every morning to coordinate the schedule and to discuss challenging cases. This helped to instill a common purpose of goals and mission for the team. We tried to help each other accomplish the mission, strengthening the team.

If needed, we covered for each other, shared space, and tried to put the team in front of our personal needs. This increased morale and built cohesion. We also spent some time as a team while we were off duty, celebrating or relaxing together. The team had a broad range of experience and we shared this with one another. This occurred because we expressed interest and were willing to share the different points of view we had as a result of our differences in professional training, culture, and military experiences. Good-natured teasing and competition based on these differences was evident throughout our time together. We were also fortunate enough to have a contract psychiatrist who was a retired officer in the Canadian forces so we had some common bonds in place as opposed to previous contract psychiatrists who had very limited experience with military members.

Perhaps one of the greatest successes was the productivity of the team. Productivity was arguably the highest it had ever been. In fact, it was 35% larger (2225 contacts for Apr 09 - Sep 09) than the average of the previous two 6-month rotations (Apr 08 - Sep 08 = 1426 and Oct 08 - Mar 09 = 1849). Data was not available for rotations prior to April 2008. This sharp spike in the demand for services came as a result of RC-S absorbing a significant percentage of the large US troop surge that was ordered by the Obama Administration earlier that same year.

Because the deployment of mental health support services lagged behind this surge, we had to pull together as a team in order to manage this increased demand. Good communication and coordination of services was no longer a luxury, but a rather was a necessity. This resulted in better quality of care for our patients, more useful discussion about treatment options and, most importantly, a reduced wariness of our coalition forces patients to be treated by a provider not from one's own country. This was especially helpful for US troops, since the number of NATO mental health providers at Kandahar far outnumbered the available US mental health providers. This team focus also led to the admission of the first multi-national troop to the Freedom Restoration Center located in RC-East. This was the only restoration center in Afghanistan at the time and had served only US military personnel prior to this point. This program, run by the US Combat Stress Control Detachment at Bagram Airfield, is a 3-5 day program that gives service members a break from their stressful situations and return to their units more rested and better able to cope.

One of the main tests to the joint working environment came when there was a helicopter crash on the flight line killing 16 people and traumatizing many involved in the rescue effort. The base commander requested a response from the mental health team. The team facilitated visits to the fire service, ambulance service, and various personnel (both military and civilian) who witnessed this tragedy. Despite the fact that no precedent was in place for the team to follow for such an incident, our cohesion allowed us to quickly and decisively implement an effective plan, each member providing important contributions to our approach. For example, the UK provider noted that under the UK National Institute for Health and Clinical Excellence (NICE) guidelines, single incident debriefing was not indicated for this type of disaster and had the potential to make the situation worse (NICE, 2005). This recommendation was quickly adopted by the team and was incorporated into our response.

All of these factors led to a more balanced effort on the part of the entire team and superseded insignificant issues such as who might be working harder, had better work space, or was a team player. The bonds developed in a period of two to three short months together led to lasting camaraderie post-deployment, as is evidenced by the combined authorship of this manuscript.

LESSONS LEARNED

Several lessons were learned from this experience, perhaps the most important being the value of putting aside differences in order to accomplish a larger goal of better service to our clientele. In order for coalition forces of any kind to be successful, the focus had to be on the larger team. Among the differences to be put aside are things like rank. Within the larger mental health team, rank has very little value. This is not to say that rank does not have a vital place within the context of the military, but in a setting like this one, it can create barriers. Large differences in rank can produce uneasiness and excessive formality within a military team and these barriers can take a great deal of time to overcome. In our situation, time was of the essence. Even the team leader worked to build consensus rather than be directive when this was possible.

Openness about differences proved to be vital as well. As a team, we needed to have a solid understanding of the differences in situation and philosophy for each of our members. By asking questions and honestly sharing our answers, there was an increased appreciation for the multiple roles we all had to play as well as a better understanding of the unique pressures we each faced within those roles. In social work education, we push our students to learn how to practice cultural competence and embrace the differences within the clients we serve. This situation required us to do that not just with our clients, but with our co-workers as well. Working together, we used each other's knowledge base as a pathway to cultural competence when treating service members from each other's country.

As an example of the unique pressures faced by team members, the British nurse at KAF had to juggle not only their time between duties to their own forces and the NATO command, but also toward the different treatment options of the NATO forces and two sets of paper work from the Canadian command and the British patients. Tensions could have easily existed with this 'splitting' of roles and countries philosophies towards the care of the troops. However, this was not the case for this deployment team. The unified goal for the team was focused on getting the best treatment we could to the patients rather than pursuing individual issues of power and control. The main strength of the team was found in accepting our differences and building on our strengths. An example of this was the Canadian team was highly trained in solution-focused therapy (SFT). This was a skill that was shared by the British nurse but not practiced in some time. The team shared ideas and gave peer supervision regarding using this therapy and developed a more effective joint working environment.

The higher workload appeared to help increase team cohesion. Being in a hospital environment and also being required to travel out to smaller FOBs and COPs, there was a constant workload as the number of ISAF troops increased. Quite simply put, we were

inundated with one challenging, desperate situation after another. In order to adequately manage in this kind of environment, we needed to pull together for support. This created a shared vision and an ability to provide more care to those who needed it.

As previously mentioned, there was a tension between the need to travel farther forward to meet the needs of those on the smaller FOBs and COPs and the need to maintain enough personnel at Kandahar to manage the increasing stream of patients. We sometimes received requests from forward deployed commanders that we had difficulty meeting. One tactic that worked well was to channel up requests our chains of command to have them engage directly with the forward deployed commanders and determine what the best use of the provider's time would be. They were more aware of the larger situation and helped with prioritizing and negotiating our seemingly conflicting requirements or needs. This took the conflict out of the hands of the providers at KAF, freed them up to continue seeing patients, and helped them manage potential overextension and burn out.

We need to maintain an adequate awareness of multiple theoretical frameworks. Social work students often wonder why they need to be familiar with as many different theoretical frameworks as they are exposed to throughout their undergraduate and graduate educations. This situation serves as a very good model for why we need to have at least a baseline familiarity with these theories. Working in a multi-national, multi-disciplinary team illustrates several differences in training. The Canadian and British providers tended to be more versed in solution-focused therapy whereas the US providers were primarily trained in a Cognitive-Behavioral model. Although these models can be quite compatible with one another, it is important to have a baseline understanding of these perspectives so that the providers could better appreciate and support one another while we discussed challenging cases. Clinical feedback may not be as useful if we do not understand the treatment direction and rationale being used by our colleagues.

Along these same lines, baseline knowledge of the mental health disciplines outside of social work is a very useful. In this case, our small team predominantly represented social work but also represented psychiatry, psychiatric nursing, psychology, and a non-licensed mental health technician. We were not all familiar with what unique expertise each field brought to our team so we spent a good amount of time learning from each other. This knowledge helped us more effectively strategize as a team to meet the ever-increasing demand we were facing. Urgency dictated that we focused less on appearing "competent" to one another and instead were open to differing ideas and skill sets. By remaining inquisitive and supportive, we allowed each other to assume more of a learning role without the pressure of having to appear more learned or competent than other members of the team. Because our team was so diverse, we all had questions and knowledge gaps about how to provide the best services we could in this challenging environment. It is important to note that this was the first deployment for the majority of our team and this likely contributed to a greater willingness to ask questions without the fear of appearing incompetent. Given the high turnover rates among military mental health professionals in the US military, the modal number of deployments for any mental health team is likely to be one. Although there are many who have experienced multiple

deployments, many professionals are on their first deployment while in a combat zone, so openness and a willingness to learn and cooperate are key to success.

As stated above, another lesson we learned was also that we need to understand more about the “in theatre” treatment philosophy of each nation so we could more effectively treat troops from other countries. For example, it is clear that the US highly values mental health treatment in theatre and as a general rule, US forces strive to have a soldier to mental health provider/technician ratio of 1000 to 1 or less. While our team was deployed, Canadians had a similar ratio, although it did not include mental health technicians. The British, on the other hand, had a provider to troop ratio of close to 3000 to 1. As mentioned earlier, treatment by a mental health provider in theatre is not as highly valued by the British military and the unit is charged with providing the support that is needed to troops who are struggling with mental health symptoms. Clearly, there are differing pressures, expectations, and stigmas within each country’s military forces and the providers from each of those military services feel those same pressures. This also requires more flexibility as a mental health provider. Should a US mental health provider approach a British unit in the same manner that would be used with US forces, they risk offending the unit leadership by implying they are not supporting their troops in a satisfactory manner. The ability to properly assess the situation, improvise, and be flexible with our responses proved to be an invaluable skill.

Other differences between countries are that neither Canadians nor the British employ mental health technicians like the US does. The closest equivalent position in Canada is a social service worker. They have completed a two-year college diploma, but are not authorized under health legislation to work in clinical mental health centers. Because of this, the Canadian military does not employ uniformed or civilian social service workers. Not only do the British not have mental health technicians, they do not employ social workers or psychologists as uniformed members of their military. The UK has mental health nurses and psychiatrists. Psychiatrists are generally not deployed, leaving nursing to provide all of the mental health services within theatre.

Perhaps the most important factors contributing to the success of our multi-national relationship towards mental health care work was respect of our differences and a good dose of humor. The team managed to maintain a good sense of humor within this difficult environment while also doing our job under strenuous conditions. The British provider made fun of the fact the Americans and Canadians were required to carry handguns to work while theirs were in the UK armory. The US providers enjoyed poking fun at the way the British tailored their hats to look ‘cool’. It was this kind of relationship that enabled the team to gel and work so effectively. In this situation, humor served as a great way to diffuse tensions caused by our challenging mission and helped us develop greater shared bonds.

Though a multiplicity of nations continue to serve at Kandahar, all display the same admirable resilience, dedication, and loyalty to the mission despite their country of origin, extreme conditions, an array of difficulties, and daily challenges. We came to see our clientele not as US, British, or Canadian. Instead, we were all soldiers, engaged as

one team with one mission. As a cohesive group of mental health providers we were, and continue to be, protective and proud of all who serve.

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Problem-based Learning Strategies for Teaching Military Social Work Practice Behaviors: Review and Evaluation

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Abstract: This article outlines and evaluates a military social work course as it has been taught by three social work faculty members at two universities in the southeastern US. The authors highlight why these courses are needed within social work undergraduate and graduate programs. They report how CSWE-identified military practice behaviors are addressed within the course. They also describe how practice-based learning approaches appear to be ideally suited for teaching military social work curricula. Data on student perceptions of military social work courses and the application of problem-based learning are presented along with an assessment of knowledge gains and ability to practice military social work. Findings reflect that social worker students find these courses helpful and that they believe that problem-based courses in this subject help prepare them for initial work with this population. They also highlight the need for an extensively updated military social work textbook addressing major changes within the military and social work over the last decade.

Keywords: Military social work, problem-based learning, practice behaviors, social work education, Council on Social Work Education (CSWE)

INTRODUCTION

Military and civilian social workers play a vital role in sustaining and supporting military members, veterans, and their families. Their role has grown and adapted during the last decade with the recent wars in Afghanistan and Iraq. Social workers have historically taken the lead in programs to prevent and respond to substance abuse, and family maltreatment along with providing mental health services and medical social work. They are now key players in developing and providing individual, family, and community responses to help those impacted by combat-related trauma, military deployments, and mild traumatic brain injuries.

The developing role of social workers within the military has been largely fueled by a significant increase in deployments and the expanded use of Reserve and National Guard members (Adams, Durand, Burrell, Teitelbaum, Pehrson, & Hawkins, 2005; Knox & Price, 1999). The number and frequency of deployments have led to unparalleled strains on the military, their families, communities, and caregivers. Many military members have been deployed for six to 18 months with the period of time between deployments getting shorter (Hosek, Kavanagh, & Miller, 2006). Many service members have been regularly exposed to nontraditional hostile combat conditions where they observed fellow military

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members being injured or killed (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004).

Military social workers have been described by some as mental health “first responders” to military members since they often deploy to combat zones (Savitsky, Illingworth, & DuLaney, 2009). Given the growing need for social workers, and the demands on active duty providers, social work services are increasingly being provided by civilians (Savitsky, et al., 2009). There is also an increased recognition of the military as a separate culture with unique and specific norms, challenges, strengths, and needs. These factors, among others, highlight the need to provide social work students with specialized training to prepare them for working with this population.

Leadership is now emerging within social work education to assure that social work students are appropriately trained to respond to the needs of today’s military, veterans, and their family members. The Council on Social Work Education (CSWE) stated “specialized education to prepare social workers to aid this population (military) is clearly indicated” (CSWE, 2010, p. 1). CSWE recently delineated practice behaviors for advanced practice in military social work for each of their 10 core competencies specified by the 2008 Educational Policy and Accreditation Standards (CSWE, 2010).

Although some educators have been disseminating and teaching military-focused social work publications and courses for many years, specific training programs and curriculum focused on preparing social worker students to work within the military has more broadly developed within the last five years. Courses to teach undergraduate and graduate students about military social work are now being taught in a minimum of 30 CSWE-accredited social work programs within the U.S. (CSWE, 2010). Students in these courses are learning essential information about working with military members, veterans, and their families along with being exposed to new interventions to help these groups. Social work students appear to be generally quite receptive to taking military social work courses especially at those universities in close proximity to military installations. Many of these courses intentionally address some of the inherent ethical issues and conflicts that arise for helping professionals working within a military context.

Only minimal research into the content and outcomes of military social work courses exists. The authors found one qualitative investigation that interviewed 24 graduate-trained social workers who had deployed to combat areas (Simmons & DeCoster, 2007). The social workers participating in that study had all completed CSWE-accredited graduate social work programs, and had not completed a military social work class prior to their deployments. They primarily described their social work education as helpful in preparing them to work in combat areas.

The present review and investigation outlines a military social work course using Problem-based Learning (PBL) approaches. The course was developed and taught by three social work faculty members involving nearly 100 graduate and undergraduate students at two universities in the southeastern U.S. The authors describe how CSWE-identified military practice behaviors were taught within the course. Specific examples of PBL curricula are provided. Findings from an evaluative survey of the course are also detailed.

Military Social Work

Military social work is a broad term encompassing social services provided to active duty, National Guard, or Reserve military members, veterans, their family members, and the communities in which they live (CSWE, 2010). It includes all social workers who provide these services such as uniformed and civilian social workers working within any of the branches of the Department of Defense (DoD), the Veterans Administration (VA), private and public social service agencies, and practitioners who treat or work for any of the above individuals, groups, or organizations. Military social work “involves direct practice; policy and administrative activities; and advocacy including providing prevention, treatment, and rehabilitative services to service members, veterans, their families, and their communities” (CSWE, 2010, p. 2). Daley (2003) listed six functions (See Table 1) as “international core requirements for military social work” (pp. 438-439). These six functions succinctly capture the primary focus and purpose of military and civilian social workers serving within the military services.

Table 1. International Core Requirements for Military Social Work (Daley, 2003, pp. 438-439)

Function
1. Enhance military members' capability to conduct and recover from warfare
2. Develop or consult on military policies and procedures which minimize psychosocial damage while maximizing military member and family wellness within military structural boundaries
3. Build and/or implement programs which reduce the likelihood of damage from psychosocial problems such as family violence, substance abuse, mental illness, or maladjustment to serious medical illness
4. Offer intra-military perspectives and interventions to improve service functioning
5. Ensure the highest quality of professionalism in delivery of military social work services
6. Disseminate cumulative historically effective technologies

Practice Behaviors for Advanced Practice in Military Social Work

The Council on Social Work Education (CSWE) recently delineated practice behaviors for advanced practice in military social work for each of their 10 core competencies specified by the 2008 Educational Policy and Accreditation Standards (CSWE, 2010). Although the course described in the present study was taught both before and after these practice behaviors were created, the class expressly addressed them throughout the time that it was offered. In particular, the courses address practice

behaviors related to ethical principles, application of critical thinking, research-informed practice, human behavior in the social environment, contexts that shape practice, and engagement, assessment, intervention, and evaluation at multiple levels. Table 3 identifies where these practice behaviors were taught within the course.

Problem-based Learning Approaches

PBL, also called inquiry-based learning, is a teaching method that has been used across multiple disciplines for nearly four decades within the US and many other countries (Savery, 2006). Originally and continuously used within medical education, PBL employs “real-world” problems and scenarios as a context for students to practice problem-solving skills while increasing their subject matter knowledge (Lam, 2009). Instructors who use this approach seek to provide an active-learning environment where students are challenged to use course material to assess and respond to realistic problems. PBL approaches were created out of a belief that more “traditional”, primarily didactic, lecture or instructional methods rarely give students a working content application context (Savery, 2006). Barrows (1996) described PBL as having the following core elements:

- Learning is student centered
- Learning occurs in small groups
- Teachers are facilitators or guides
- Problems are the organizing focus and stimulus for learning
- Problems are the vehicle for the development of clinical problem-solving skills
- New information is acquired through self-directed learning (p.5)

Research comparing the effectiveness of PBL to more conventional approaches for teaching multiple disciplines, is somewhat mixed and inconclusive (Kam Pun Wong & Lam, 2007). Most studies to date, especially those conducted in non-medical fields, had limited or no controls. However, a meta-analysis of 20 years of investigations into courses taught with a PBL approach concluded that students who were taught with these methods demonstrated equal knowledge acquisition when compared to those who learned with more traditional methods and they showed evidence of superior clinical problem-solving skills (Albanese & Mitchell, 1993). A second meta-analysis of 43 studies concluded that PBL consistently helped students on skills-related outcomes (Dochy, Segers, Van den Bossche, & Gijbels, 2003). Students almost universally reported high levels of satisfaction with PBL courses, and they repeatedly stated that they generally prefer this method over traditional approaches (Savery, 2006).

The use of PBL instructional approaches within social work education at the Bachelor of Social Work (BSW) and Master of Social Work (MSW) levels has consistently increased over the last twenty years. PBL has been used in schools of social work within the US, the United Kingdom, Australia, and Hong Kong (Lam, 2009). Some of these schools have employed PBL approaches across their entire curriculum (Kam Pun Wong & Lam, 2007). Schools of Social Work adopted PBL instructional methods to help students start to “think like social work professionals” and as a means of increasing the

transfer of classroom learning to the field (Williamson, Chang, Fellows, & Decker, 2007).

Rigorous evaluation into the impacts of PBL approaches on social work student outcomes is limited. Most investigations to date had difficulty employing student control groups. Two separate mixed-methods (quantitative and qualitative) single-cohort pre-and post-test studies of social work students taught with PBL methods were conducted at the University of Hong Kong (Kam Pun Wong & Lam, 2007; Lam, 2009). This university broadly adopted PBL instructional concepts across their social work program. These researchers found evidence that PBL courses taught at the BSW level stimulated student “growth in employing multiple sources of learning, directed their own learning goals and activities, and teamwork collaboration” (Lam, 2009, p. 1499). They also found that PBL-instructed students reported statistically significant increases in their social work knowledge, skills, and values compared to when they began the academic year. The generalizability of these findings is clearly limited by the lack of controls. Such student gains would arguably be anticipated with active participation in most CSWE accredited programs irrespective of teaching approach.

Beveridge and Archer (2006) compared social work student’s perceptions of a social work course taught using PBL approaches to their perceptions of a required psychology course that employed traditional didactic teaching methods. All 70 study participants took both classes. Students reported a stronger mastery of the achievement goals of the class, utilizing effective study strategies, and had a more positive perception of studying in the PBL-based social work course.

A smaller sub-sample of students in the Beveridge and Archer (2006) study reported in interviews that they liked the social work course’s “high degree of challenge, authentic tasks, self-directed learning, autonomy and choice, collaboration with peers, developing of cognitive strategies, cognitive engagement, high level of relevance of material, and developing a personal knowledge base” (p. 13). Other studies found similar social work student perceptions of PBL-focused courses to include a belief that these courses make them feel more confident to practice social work skills and better prepared for practice (Williamson, et al., 2007). Field supervisors and employers of social workers also reported that students who take multiple courses using PBL techniques appear more confident than their social work peers (Lam, 2009). Although the majority of students noted that they enjoy learning with PBL methods, some in at least two studies also stated that they struggled with a perceived lack of structure in group activities, negative group dynamics, having to trust other students to complete tasks, and inadequate collaboration skills in social work courses taught using a PBL approach (Beveridge & Archer, 2006; Hartsell & Parker, 2008).

METHOD

Course Description, Objectives, Curriculum

Six introductory military social work courses were taught by three instructors over two years at two universities in southeastern US. All six courses were taught from a basis

core syllabus, using the same textbook (Daley, 1999) with each faculty adding supplemental material as they saw fit. Table 2 details the course schedule along with required readings. Four of the courses were provided online and the other two were taught using a blended (on-line and in-person) format. Five of these courses were provided at the MSW level and one was for BSW students. One of the universities where five of the courses were taught was in a community with multiple military installations and the other university has an extended history of providing courses for military members, veterans, and their families. The course was offered at both schools as an advanced clinical practice elective for MSW students or as a general elective for BSW students.

Table 2. Course Schedule and Required Readings

Week	Topic	Required Reading
1	Course Introductions – Overview	
2	History of Military Social Work	Daley(1999) – Chapters 1,2,3 Military Facts for Non-Military Social Workers (Kadis & Walls, 2005)
3	Legal and Ethical Dilemmas in Military Social Work	Daley (1999) – Chapter 11
4	Family Advocacy in the Military Services	Daley (1999) – Chapter 4
5	Medical Social Work and the Impact of Tricare in the U. S. Armed Forces	Daley (1999) – Chapters 5,7
6	Military Social Work Practice in Substance Abuse Programs	Daley (1999) – Chapter 6
7/8	Military Social Work Practice in Mental Health Programs	Daley (1999) – Chapter 8
9	Combat-Related Post Traumatic Stress Disorder (PTSD) and Mild Traumatic Brain Injury (mTBI)	Cigrang et al. (2005) Hoge et al. (2004) Litz (2007)
10	The Impact of Combat-Related PTSD and mTBI on families	Chapin (2009), Adams et al. (2005) McFarlane (2009), Herzog & Everson (2010)
11/12	Suicide Assessment and Response within the Military	Air Force Guide to Managing Suicidal Behavior (2002), Knox et al. (2010)
13/14	Building Community Capacity in Military Communities: The Integrated Delivery Service Approach	Huebner et al. (2009)
15	Service Member and Family Wellness across the Lifespan	Daley (1999) – Chapters 16,17,18

All three instructors had a strong interest and involvement in military social work prior to teaching the course. One instructor was an active-duty Air Force social worker; another had worked as a civilian social worker within the military and is married to a retired Soldier, while the third instructor had been a private practitioner near military installations for over 15 years with a heavy military case load.

The course description is provided below:

This course provides a comprehensive and in-depth examination of the practice of military social work. SWK ### outlines the historical context of specific practice of social work within the branches of the U.S. military. The course will enable students to understand some of the unique challenges and needs of military members and their families. They will learn specific community and clinical practices to help military members and their families. The course also examines the unique culture of the military community along with specific ethical dilemmas faced by active duty and civilian social workers practicing in a military setting.

The course objectives are provided in Table 3 along with the CSWE-identified Military Practice Behaviors that they addressed. Each CSWE Education Policy (EP) or competency is also specified within the table. The first half of the course largely focused on topics that can be described as fundamental military social work curricula, which generally mirrored many of the chapters within the Daley (1999) textbook. They included: History of Military Social Work, Legal and Ethical Dilemmas in Military Social Work, Family Advocacy Programs, Substance Abuse Programs, Medical Social Work, Tricare, Mental Health Programs, and Military Member and Family Wellness across the lifespan. The second half of the class addressed topics that have arisen as essential for military social workers over the last decade such as Combat-Related Post Traumatic Stress Disorder (PTSD), Mild Traumatic Brain Injury (mTBI), Impact of PTSD and mTBI on Families, Suicide Assessment and Response, and Building Community Capacity within Military Communities.

Incorporation of Military Practice Behaviors

The course centers on many of the key elements highlighted within the CSWE-identified practice behaviors. Table 3 reviews each of the course objectives and links them to the specific practice behavior that was addressed. Each CSWE Education Policy (EP) or competency is also noted within the table. Specific emphasis was placed in the course on students learning the following topics within the military population: cultural competency, historical context, systems perspective concepts, bio/psycho/social variables, ethical dilemmas, and evidence-based practice.

The social work profession has consistently stressed the importance of cultural competency. Although there are numerous and somewhat varying ways to define cultural competency, Cross, Bazron, Dennis, and Isaacs (1989) appropriately described it “as a set of congruent behaviors, attitudes, and policies that come together in a system or agency, or among professionals, that enable the system, agency, or those professionals to work effectively in cross-cultural situations” (p. 1). Given that the US military has many

Table 3. Course Objectives, CSWE-identified Military Practice Behaviors, and Education Policies (EPs) Addressed within the Course

Course Objective	CSWE Military Practice Behavior & EP
Apply knowledge of the variables within the military structure and environment that affect social work practice	Demonstrate a professional demeanor that reflects awareness of and respect for military and veteran cultures (EP 2.1.1) Recognize boundary and integration issues between military and veteran cultures and social work values and ethics (EP 2.1.1)
Describe the historical context of social work practice within the armed services	Assess service systems' history, trends, and innovations in social work practice with service members, veterans, their families, and/or their communities (EP 2.1.9) Apply knowledge of practice within the military context to the development of evaluations, prevention plans, and treatment strategies (EP 2.1.9)
Use systems perspective concepts and framework to assess military client problems and develop interventions	Assess service systems' history, trends, and innovations in social work practice with service members, veterans, their families, and/or their communities (EP 2.1.9)
Identify, understand, and describe bio/psycho/social variables that impact human behavior in the military	Recognize and assess social support systems and socioeconomic resources specific to service members, veterans, their families, and their communities (EP 2.1.6)Recognize the impact of military transitions and stressful life events throughout the family's life course (EP 2.1.6) Identify issues related to losses, stressors, changes, and transitions over their life cycle in designing interventions (EP 2.1.6) Demonstrate the ability to critically appraise the impact of the social environment on the overall well-being of service members, veterans, their families, and their communities (EP 2.1.6)
Describe the impact of changing societal structures on human relationships in the military	Identify and analyze conflictual responses and potential consequences to conflicts between basic human rights and military life and duty experience (EP 2.1.5)
Identify and respond to ethical dilemmas involved in practicing social work with active duty military members	Employ strategies of ethical reasoning in an environment that may have policy and value conflicts with social work service delivery, personal values, and professional ethics (EP 2.1.2) Identify the military culture's emphasis on mission readiness, support of service, honor, and cohesion and how these influence social work service delivery at the micro, mezzo, and macro levels (EP 2.1.2)
Know and assess evidence-based practices for treating mental conditions common among military members and their families	Locate, evaluate, and analyze current research literature related to military social work (EP 2.1.6) Evaluate research to practice with service members, veterans, families, and their communities (EP 2.1.6) Analyze models of assessment, prevention, intervention, and evaluation within the context of military social work (EP 2.1.6) Apply different literature and evidence-informed and evidence-based practices in the provision of services across the DoD/VA continuum of care and services (EP 2.1.6)

aspects of a separate culture or subculture, it is vital that social workers who work within this population understand as much as they can about how the military functions. Students within the military social work course described here learned information about each of the military services, their unique behaviors, attitudes, and policies.

Students in the course also learned about how social workers have been working within the US military for nearly a century, and that they have helping veterans and their families for longer than that. The course provides information to understand the rich history of military social workers to include the early role of the Red Cross, accomplishments and challenges faced by pioneering military social workers, and how social work roles adapted over time with many changes within the US military and the VA systems. Students are also taught about how social workers led in the development and provision of substance abuse and family maltreatment programs across the military services.

A significant portion of the course is dedicated to understanding the unique bio/psycho/social needs of military members, veterans, and their families. Students learn about the impacts of frequent transitions, losses, and deployments among this population along with programs and interventions to lessen the impacts of these challenges. They also learn about innovative ways to foster community capacity to respond to needs and problems within military communities.

Ethical conflicts appear to be inherent for social workers who practice in or with a military population. These conflicts often result from the high priority placed on accomplishing the military mission while concurrently assuring that members, veterans and their families are acknowledged as independent humans with ongoing bio/psycho/social needs. Students in the course learn about these conflicts along ways to avoid them when possible, and they are instructed on available means to attempt to resolve them. They similarly learn about conflicts arising from the differences between civilian legal systems and those involving the military Uniformed Code of Military Justice (UCMJ).

Extensive emphasis in the course is placed on learning and “practicing” evidence-based treatments for conditions common among military members, veterans, and their families. These conditions include PTSD, substance-related problems, mTBI, and secondary trauma response. Students are required to review and critically analyze the research which supports emerging military-specific treatments for these conditions.

Use of Problem-based Learning Approaches

The course instructors employed PBL approaches by challenging students to apply each week’s lessons and material to a realistic military social work clinical or community scenario. After reviewing each scenario, students would individually formulate their analysis of the case or situation. This analysis included the student’s assessment and delineation of the military client, family, or community needs and challenges, and specific strengths. Students were also required to explicitly detail how they would intervene as a social worker within the scenario. In the online courses, students would

then post their analysis of the scenario to their small (usually 5-7 students) discussion groups. They would then provide detailed feedback assessing at least two other group members scenario reviews although they often commented on more than two reviews. The instructors provided guiding feedback and comments for each of the group discussions. They however, left the leadership of each discussion up to the students. Students were graded individually on their ability to appropriately assess the scenario and develop a viable intervention plan utilizing primarily material addressed during the course. For the blended courses, the scenario application exercises were done as formal class presentations with discussions following each.

Case scenarios represented a wide-range of clinical and community challenges and situations common within military and veteran populations. Each scenario highlighted key aspects of the course material. Some of the scenarios included a young military couple dealing with post-deployment issues, family members caring for a severely injured soldier, substance abuse by a junior military member, ethical conflicts for a civilian social worker providing services on a military installation, a community responding to several military member suicides, and a member who wants to leave the service early, along with several other relevant military scenarios. Case scenarios included veterans, family members, and members from all military branches and from locations throughout the world. Students were advised that all scenarios were not actual cases or situations, but that they were representative of clinical and community scenarios that military social workers regularly address.

The following sample scenario used by one of the instructors challenged students to respond to a family maltreatment situation:

Petty Officer Second Class (PO2) Michael Johnson is a 28 year old Sailor currently stationed at Eglin Air Force Base in Florida where he is attending Explosive Ordnance Disposal (EOD) School. He just arrived at the school last week to begin a 7-9 month program to train him as an EOD Technician. He has been in the Navy for seven years. He has worked as an Electronic Technician for his entire career up until now which required him to be at sea for long periods (5-8 months at a time). He liked the work that he did as an Electronic Technician. However, he is very motivated to succeed as an EOD Technician because of the complex type of work he will be doing and the increased status and pay that will come from this job. PO2 is married to Amanda and they have two children ages four and six. Amanda and the children are still living at his previous base (San Diego Naval Base) in California.

PO2 Johnson was brought to your office at the Eglin AFB Family Advocacy Program (FAP) office by his training supervisor, Senior Chief Petty Officer (SCPO) Barker. You are employed as a Family Advocacy Treatment Manager (FATM), which is a civilian social work position within FAP. You conduct assessments of child and spouse abuse allegations and provide treatment interventions for military members and their families who have been involved in substantiated maltreatment. SCPO Barker requests to meet with you while PO2 Johnson is completing some initial paper work. He states that he brought PO2

Johnson to your office at the request of the commander of the EOD School. The commander had been called by PO2 Johnson's previous supervisor in San Diego who states that Amanda is alleging that Michael physically abused her three days before leaving to come to his EOD program. She is also alleging that he left her with only \$100 cash and no access to any other funds to pay their bills. Before meeting with Michael you call the FAP staff at the San Diego Naval Base. They tell you that Amanda has called them also to report the abuse. They state that they evaluated and substantiated a mutual spouse abuse case with Michael and Amanda about 14 months ago. Michael attended 5 individual counseling sessions with a FAP counselor and that he completed a six-month men's domestic violence treatment course. Amanda met once with a Victim Advocate, but she declined to participate in FAP treatment or other services. The San Diego Base FAP staff hasn't met with Amanda to assess the current situation/allegations, but they have an appointment scheduled with her tomorrow morning.

You meet with PO2 Johnson for 75 minutes to assess the allegations and to evaluate his emotional status. He is initially very quiet in the interview and is clearly quite angry about the allegations. He is concerned that he will be kicked out of the EOD program. Michael denies that he harmed Amanda, but does admit that they had a significant argument three days before her left for school. He admits to pushing Amanda aside to get out of their apartment because "she was blocking the door and yelling at me in front of the kids." He tells you he thinks Amanda is "psycho" and that she needs mental health care. When you ask him for details about this statement, he states he is not able to describe any specific severe mental illness behaviors of Amanda, but that he thinks that Amanda wants to ruin his Navy career. He believes that she may be having an "internet relationship" with a guy she knew back in high school. Michael has not been sleeping well the last two nights. He states that this is because he is worried about the impact that this situation will have on his training and his career. He admits to feeling depressed, anxious, and angry. Michael denies any suicidal or homicidal thoughts, plan or intent. He also denies that he abuses alcohol or that others have been concerned about his alcohol usage.

Survey

All students who had taken the course within the two prior years were asked to complete a survey regarding the class (see Attachment). Administration of the survey was approved by both universities' Institutional Review Boards. The brief survey was conducted through Survey Monkey. Participating students responded to survey items assessing their knowledge of information reflecting Military Social Work Practice Behaviors, student attitudes regarding doing social work with military members and their families, student's anticipated social work practice with military members/families, or veterans and student perceptions of use of PBL concepts within the course. There were also several "open-ended" questions requesting students to provide feedback on their overall perceptions of the course.

RESULTS

Sample

The final sample included 19 students. Of the 110 surveys sent to students, 30 surveys were undeliverable due to incorrect email addresses. The final response rate was 23%. A small number (26%) of the respondents were either current military members or veterans while the majority (63%) reported being married to either a current military member or veteran. Thirteen respondents (68%) reported previous work experience with military members, veterans, or their family members. Almost a third (32%) of the students reported very little to no knowledge of military populations prior to taking the military social work course while a greater number (52%) reported a good to moderate knowledge and a smaller number (16%) reported extensive knowledge. The majority of students (79%) are either working or plan to work with military populations.

Military Population Beliefs

All of the students (100%) believed that concerns about confidentiality and the impact of receiving care on the career of the service member to be potential barriers for seeking social service assistance. Over half (53%) of the students believe limited coping skills to put young military families at risk while a smaller number believed the cause to be either strained finances (21%) or young age (16%) and one student (5%) none of the above were risk factors. Separation from natural resources was selected by a majority of students (84%) as a unique demand and risk for military members and their families. The majority of students (72%) correctly identified Family Advocacy Program, Substance Abuse Programs, Medical Programs, or Mental Health Programs as agencies whose primary focus is “Mission readiness.”

Problem-based Learning

The majority of students (79%) remembered the case scenarios that were presented in class. Likewise a vast majority of students (93%) of the students who answered this question believed the case scenarios to be helpful to very helpful in helping them to understand military populations (26% of respondents left this item blank).

Military Population Task Abilities

Students rated their abilities to perform specific tasks with military populations on a scale from 0 (cannot do at all) to 100 (certain can do) with a midpoint of 50 (moderately certain can do) (See Table 4). Of the 19 students who responded to the survey, 17 completed this section. The mean for specific task performances ranged from a low of 82.3 for “Review all aspects of the client’s case and history to determine benefit eligibility” to a high of 92.3 for “Provide information about substance abuse to military members or veterans.” One student rated them self less than moderately certain they could perform specific tasks with that student rating a 20 on “Review all aspects of the client’s case and history to determine benefit eligibility” and a 30 on “Establish rapport with clients from different cultural backgrounds and experiences” while another student

rated a 30 on "Network with agencies to coordinate services for military members or veterans" and a 40 on "Define military member or veterans' problems in specific terms." The remaining 15 students were at least moderately certain (50) that they could perform all of the specific tasks inquired about with military populations.

Responses to Open-ended Items

Students responded to open-ended questions regarding their experience and the settings of their work with military populations, their goals in taking the course, information they recalled from the case scenario application exercises in the course, and their overall perceptions of the course. Not surprisingly, given the close proximity of one of the universities to military installations and the close association of the other with the military, seven of the thirteen students (53.8%; n=19) who indicated they had prior experience with military populations were veterans, active-duty or family members of veterans who cited that experience. The same number of students (7; 53.8%) indicated they had experience with military populations during their social work internships, previous employment or volunteer experiences.

Table 4. Descriptive Statistics for Task Abilities Items

Item	N	Mean	SD
Review all aspects of the client's case and history to determine benefit eligibility.	17	82.35	20.77
Identify barriers to obtaining services and develop plans for overcoming barriers.	17	84.70	16.24
Establish rapport with clients from different cultural backgrounds and experiences.	17	87.64	20.77
Understand the impact of substance abuse on military members or veterans	17	90.58	10.28
Critically evaluate substance abuse issues with a military member or veteran.	17	91.17	9.27
Provide information about substance abuse to military members or veterans.	17	92.35	12.51
Work with various systems to obtain services for military members or veterans.	17	90.58	8.99
Advocate on behalf of military member or veteran	17	90.58	13.44
Network with agencies to coordinate services for military members or veterans.	17	86.47	16.93
Define military member or veterans' problems in specific terms.	17	83.53	15.78

Students had varied goals and desired outcomes from the military social work course. Nine students (50%; n=19; 1 blank) reported that they had taken the course to prepare for their internship or future employment within agencies serving military populations. Students said, "my goals for taking the social work class were directly linked to my

desire to practice SW here in Pensacola, a military town. I was also hoping to use the information learned during possible internship with the VA." Others reported wanting to be "able to work with military families as a family advocate" and "moving from base to base supporting my husband's career and I would like to be able to continue my career as a social worker on military bases." The majority of students (14; 73.7%) most commonly indicated an overall desire to become more familiar with the military community. They expressed goals to learn about the "history, roles, and impact social work has for the military," "the structure and background of the military," "the dynamics of military service," and "the issues military families face during their life as a member of the armed services," and to "gain more knowledge about the military community and how social work is integrated into that community."

Consistent with research on student learning using PBL (Lam, 2009), students were able to identify the scenario exercise and specific details about the interventions in 13 responses (68.4%; 6 blank; n=19). This is noteworthy because the six courses were taught from 2008 to 2011. The overall feedback question yielded more support for using the case scenarios. For example, "the course was good because it left room for people to do more research on the military" and "the exceptional design [which] focused on a detailed inside view of the military soldier and families. If you thought you knew what a military service member or families of service members experience during their tours of duty, before taking this course, you would be surprised to find out how much more there really is to know." And, a student who was in the blended version of the course said "it was great to discuss real life scenarios and I enjoyed the reading material and presentations". Finally, as found by Barrows (1996) several students made comments similar to the following made by one student "the information learned was broad spectrumed, but specific to caseloads. It was helpful in that the scenarios brought a certain realness to the subject at hand. Having to assess each case and interpret what was needed helped to define what the social work job was and how it should be done." One student suggested adding to the curriculum "an Advanced SW in the Military class ... to get even more in-depth information and experience."

DISCUSSION AND IMPLICATIONS

This article describes one method for teaching military social work classes to BSW and MSW students. The evaluation components of the present study were intended to explore and identify the primary benefits that students perceive from taking a PBL-centered introductory military social work course along with gauging some of their knowledge gains. Generalizability of the findings is significantly limited by a small and convenient sample size, lack of any control group, and moderately low response rate. This rate was largely impacted by the fact that many of the students had already graduated from their social work programs thereby making it difficult for the researchers to contact these individuals. The post-test only design also significantly limits drawing any conclusions based on the results. Use of a pre-test, post-test design would strengthen any assessment regarding the impact of the course content.

Despite the limitations noted above, this study provides some exploratory and qualitative evidence to suggest that PBL approaches are helpful for teaching military

social work courses. Students who responded to the survey almost universally reported that they believed the course was highly helpful in preparing them for working with military members, veterans, and their families. Many students entered this course with little or no knowledge of military populations, while many others had no work experience with military populations. Some of the students had limited life experiences with military populations and few students had any direct military experience. After taking this course, the vast majority of students reported being at least moderately certain of their ability to perform specific tasks with military populations. Most of these students could recall the PBL approaches and the scenarios. A great majority of students perceived this technique to have been helpful in understanding military populations.

Future investigations of initial military social work courses would benefit from prospective and longitudinal research methods to improve response rates, gather meaningful current and more long-term effects of the course, and PBL approached to teach social work material. The use of control groups or classes would allow for better comparison of this course to traditional or other methods.

The high level of military experience among the faculty who taught the course described in this study may be an invaluable pre-requisite for creating such a course and addressing the detailed military, veteran or family case scenarios. The present findings also suggest that this course may be better suited to in-person or interactive teaching methods.

There is a clear need for further evaluation and development of these initial military social work courses along with creating more advanced military social work courses to address military-related topics. Future courses might address such issues as helping military members and their families with deployments, assessment and treatment of PTSD and mTBI, interventions with veterans, and bereavement/loss among the military and veteran populations. They could make up the central curriculum components of a military social work concentration or certificate program. Given that the primary textbook employed in many military social work courses (Daley, 1999) is over 12 years old, there is an evident need to either substantially update that textbook to incorporate social method in response to emerging military needs and current research findings or create a comprehensive new text book to address this new material.

CONCLUSION

The military social work course described in this article appears to be meeting a need to train practitioners who are informed and sensitive to the specialized and growing needs among military members, veterans, and their family members. This course, along with the increasing number of similar courses at universities throughout the US, responds to a critical need to appropriately train social workers before they start to work with this population. Participating social work students report that these courses helped prepare them for initial military-related social work and improved their perceived ability for working with this population even though many had limited direct prior experience with the military. Many students who thought they knew military populations quite well

because of their personal experiences before taking the course commented about the knowledge that they gained after participating in the class.

The course detailed in this review was able to specifically address the essential military practice behaviors outlined by CSWE. It is also evident that Problem-based Learning approaches appear to be well-suited for teaching initial military social work courses given their focus on use of realistic problems which challenges students to integrate and apply curricula to a military or veteran client, family, or community problem. Social work educators should be able to apply the information detailed in this review along with the PBL approaches to initiate teaching their own military social work courses.

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Appendix

Survey

(For all questions below, the terms **military member and veteran** consist of any person who has served or is serving in the US Armed forces, which includes Active Duty, Retired, Separated, National Guard, and Reserve military members)

1. Have you ever been or are you currently a military member or a veteran? Yes ____ No ____
2. Have you ever been married to or had a partner relationship with a military member or veteran? Yes ____ No ____
3. Have you had any work experience with a military member, veteran, or their family members? Yes ____ No ____
(if no skip to question 4)
Briefly describe the setting/location/role of your working with military members, veterans, or their families:
4. Please rate your level of knowledge of military populations prior to completing your military social work course (circle one)?

None	Very little	Moderate	Good	Extensive
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5. Briefly describe your desired goals or outcomes for taking the military social work course:
6. Do you remember any of the military member, military family, or veteran case scenarios that were discussed in your military social work course? Yes ____ No ____ (if no skip to question 9)
7. Briefly describe one of the military member, military family, or veteran case scenarios that were discussed in your military social work course:

Please rate how helpful you believe these case scenarios were in helping you understand how to help military member, military family, or veterans?

Not Helpful	Somewhat Helpful	Helpful	Very Helpful
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8. Are you currently working with or do you plan on working with military members, military families, or veterans? Yes ____ No ____
9. For military and family members, the following are potential barriers for seeking social service assistance:
 - concerns about confidentiality
 - concerns about the impact of receiving care on the career of the service member
 - All of the above
 - None of the above
10. "Mission readiness" is the focus of which of the following military program(s)?
 - Family Advocacy Program
 - Substance Abuse Programs
 - Medical Programs
 - Mental Health Programs
 - None of the above
11. Young Military families are an at risk population because of:
 - No transportation
 - Strained finances
 - Limited coping skills
 - Young age
 - None of the above
12. Military members and their families face a number of unique demands and risks. These include:
 - Increased stress due to drawdowns
 - Mission change
 - A high number of young families with young children
 - Separation from natural support networks

Instructions for questions 14 - 23: We want to know how confident you are, in your ability to perform specific tasks with military members, their family members or veterans. After you consider each task below, please rate your confidence in your ability to perform that task successfully, by circling the number from 0 to 100 that best describes your level of confidence. What we mean here by successfully, is that you would be able to perform the specific task in a manner that a supervisor would consider excellent. The phrases above the numbers [0 = Cannot do at all; 50 = Moderately certain can do; and 100 = Certain can do] are only guides. You can use these numbers or any of the numbers in between to describe your level of confidence. We want to know how confident you are that you could successfully perform these tasks today.

How confident are you that you can...	Cannot		Moderately certain		Certain						
	Do at all	can do	can do	can do	can do	can do					
13. Review all aspects of the client's case and history to determine benefit eligibility.	0	10	20	30	40	50	60	70	80	90	100
14. Identify barriers to obtaining services and develop plans for overcoming barriers.	0	10	20	30	40	50	60	70	80	90	100
15. Establish rapport with clients from different cultural backgrounds and experiences.	0	10	20	30	40	50	60	70	80	90	100
16. Understand the impact of substance abuse on military members or veterans.	0	10	20	30	40	50	60	70	80	90	100
17. Critically evaluate substance abuse issues with a military member or veteran.	0	10	20	30	40	50	60	70	80	90	100
18. Provide information about substance abuse to military members or veterans.	0	10	20	30	40	50	60	70	80	90	100
19. Work with various systems to obtain services for military members or veterans.	0	10	20	30	40	50	60	70	80	90	100
20. Advocate on behalf of military member or veteran.	0	10	20	30	40	50	60	70	80	90	100
21. Network with agencies to coordinate services for military members or veterans.	0	10	20	30	40	50	60	70	80	90	100
22. Define military member or veterans' problems in specific terms.	0	10	20	30	40	50	60	70	80	90	100

23. Please write below your feedback on your overall perceptions of the military social work course:

Some items adapted from the *Social Work Self-Efficacy Scale*, Holden, G., Meenaghan, T., Anastas, J., & Metrey, G. (2002).

Social Work in the Department of Defense Hospital: Impact of the Work

Joan C. Beder

Abstract: Social workers in the Department of Defense Hospital system are faced with numerous challenges to best address the needs of the war wounded. Social workers serve diverse roles on the multidisciplinary team and are integral to the hospital and hospital out-patient work environment. Sometimes, however, the work extracts a toll on the social worker that may be expressed in terms of burnout and compassion fatigue. The converse is also true, that social workers may have a strong sense of compassion satisfaction about what they do. This article details the experience of social workers in Department of Defense hospitals. It describes the impact of the work on the social workers noting levels of compassion satisfaction, compassion fatigue, and burnout.

Keywords: Military social workers, compassion satisfaction, compassion fatigue, burnout

INTRODUCTION

Quantitative research is the systematic investigation of phenomena that can be analyzed numerically. Quantitative research is often done using surveys, structured questionnaires and/or multiple-choice questions. Results are often presented as 'hard numbers' using varied statistical techniques for analysis (Patten, 2004). The quantitative research reported in this article sought to inform the social service/military community about the experience of social workers working in the Department of Defense health care system, specifically evaluating levels of compassion satisfaction, compassion fatigue and burnout.

The care of our wounded service members is divided into two systems – the Department of Defense and the Veterans Administration. While there is some overlap in terms of care, the usual trajectory for service members who have been wounded is that they will return to the United States and begin their treatment in a Department of Defense hospital. Some of the less seriously injured – physically and/or emotionally - are treated and will return to active duty overseas; for the more seriously wounded, those who will not be able to return to active duty, their medical situation is stabilized and ultimately their care is transitioned to a Veterans Administration (VA) facility, ideally near their home and family.

The Department of Defense employs approximately 500 social workers placed in 26 treatment facilities (hospitals offering both in- and out-patient care), within 6 regions across the United States. The DoD social workers may be military or civilian. Within each DoD facility social workers, as part of the multidisciplinary medical team, are managing caseloads of patients with complex psychosocial, mental and physical health needs. According to Robichaux and Keesee (2008) the responsibility of the multidisciplinary team within the DoD is to ensure delivery of optimal health care while eliminating barriers, restrictions, and the stigma associated with injury, illness and

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disability. This allows the service member to focus on both physical and psychological healing and to enable a return to good health.

Despite the integral role for social workers, limited research exists detailing the impact of their work experience – specifically, levels of compassion satisfaction, compassion fatigue and burnout - for the social workers. Within the DoD system, many social workers are working with OIF/OEF service members with severe injuries, PTSD and Traumatic Brain Injury. Caseloads have increased as so many soldiers are surviving their injuries. Chivers (2011) reported "...that fewer than 7.9 percent of the Americans wounded in 2010 died, down from more than 11 percent the previous year and 14.3 percent in 2008. The reasons for the decline in death rates are mainly due to enhanced levels of care for the wounded, body armor and heavier armored vehicles. What this 'improvement' implies for the DoD and VA systems of care is a large and continuing influx of seriously wounded service members with intense and substantial physical and psychosocial needs" (p. 1).

The study described in this article sought to examine whether a caseload, dominated by OIF/OEF service members cared for in a DoD facility, had an impact on the social worker in terms of compassion fatigue, burnout and compassion satisfaction. Were there particular units within the hospital that were more stressful (measured by burnout and compassion fatigue) for the social worker, regardless of their immersion in OIF/OEF? What was the impact on CF, BO and CF of a number of variables? It was anticipated that findings on this study would be helpful for social work administrators within the DoD and by extension, the VA system.

PURPOSE

The war in Afghanistan is nearing the tenth year and the Iraq War has entered its eighth year. Yet, there remains a paucity of research on clinicians who deliver health and mental health care to the returning troops. These clinicians - physicians, social workers, nurses - are faced with the daunting challenge of providing clinical treatment to a complex cohort amidst the collective shared trauma of ongoing war (Tyson, 2007). While there has been a great deal of research on post traumatic stress disorder among trauma survivors, few researchers have examined the effects that traumatic events (such as war injury) have on people who are indirectly exposed to traumatic content, specifically, the helpers (Palm, Polusny, & Follette, 2004). More recently, as noted by Ballenger-Browning, Schmitz, Rothacker, Hammer, Webb-Murphy, and Johnson (2010), "...little is known about the burden of treating mental health disorders in the military" (p. 253).

Social workers play a vital role in the multidisciplinary team within the DoD health care system and may be involved with mental health treatment, staff consultation, offering support for caregivers and family members, and participation in utilization review (Rahia, 1999) as well as primary responsibility for direct patient interaction, support and care. In these diverse roles, the social worker is in daily contact with those severely injured and/or those who may have experienced traumatic injury to their body or mind. Family members are also part of the caseload and often require as much if not more care and attention than the injured service member. In almost all cases, the patient,

family and the social worker can anticipate difficulties with readjustment to the service member's injury, potential for redeployment and/or adjustment to civilian life. The social worker is expected to be responsive to and involved in helping make that transition while involving caretakers and family members in the care of the patient.

While engaged in their work, the social worker faces many challenges: helping the patient, engaging the family, managing increasing workloads and bureaucratic expectations. All of this is done in the context of being as supportive as possible to the needs of the service members and his/her family and within the context of a social work relationship based on empathy and caring. In the course of doing their work, social workers are exposed to the experiences of the returning service member as they recount what happened to them during the war. Figley (1995) comments that "There is a cost to caring. Professionals (social workers) who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care...The professional's work, centered on the relief of the emotional suffering of clients, automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering as well" (p. 17). This absorption can lead the helper to a variety of responses.

Compassion Satisfaction, Compassion Fatigue and Burnout

Three major constructs help describe the potential for impact on social workers that work mainly with service members: compassion satisfaction (CS), compassion fatigue (CF) and burnout (BO). Each construct addresses an aspect of the possible response of a social worker to their work. While CF, CS and BO are not limited to social workers in the military, this study details only the military cohort.

Compassion Satisfaction

Compassion satisfaction relates to the pleasure derived from being able to do your work well. It includes feelings regarding satisfaction with one's ability to be a caregiver, one's feelings toward their colleagues, and their ability to make a contribution in the lives of another (Stamm, 2005). "To flourish, social workers experience the joy of helping others and find satisfaction in their work. This joy and satisfaction can lead to compassion satisfaction, including a sense of fulfillment derived from seeing clients suffer less and watching them transform from the role of victim to survivor (Radey & Figley, 2007, p. 208). Many in the helping professions experience compassion satisfaction and have a positive feeling while doing work that is sustaining and nourishing (Bride, Radey, & Figley, 2007). Often, however, compassion satisfaction can be compromised by feelings of compassion fatigue.

Compassion Fatigue

Compassion fatigue - aka secondary traumatic stress and vicarious traumatization - refers to the negative effects on the clinician due to work with the traumatized client, effects that leave the clinician depleted to some degree and unable to adequately or more fully engage empathically with the client (Bride, 2007; Adams, Boscarino, & Figley, 2006). At some point in the life of most professionals, there will be a period of time when

compassion fatigue occurs. This is not unique to social workers. However, the likelihood of experiencing compassion fatigue is higher for those who work with the traumatized (Gentry, Baranowsky, & Dunning, 2002). Research has documented that the following groups have reported compassion fatigue: first responders (Salston, 2002), child protection workers (Bride, Radey, & Figley, 2007; Myers & Cornille, 2002; Nelson-Gardell & Harris, 2003); mental health counselors (Brady, Guy, Poelstra, & Fletcher-Brokaw, 1999; Pearlman & Mac Ian, 1995); domestic violence counselors (Bell, 2003); sexual assault counselors (Ghahramanlou & Brodbeck, 2000; Schauben & Frazier, 1995); NY City social workers who worked with clients after the 9/11 attack on the World Trade Center (Boscarino, Figley, & Adams, 2004); substance abuse counselors (Bride, 2007) and, various other healthcare services (Cunningham, 2003; Dane & Chachkes, 2001). This expanse of research supports the assertion that caregivers of the traumatized are at risk for experiencing symptoms of compassion fatigue/traumatic stress, disrupted cognitive schema, and general psychological distress as a result of their work (Bride, Robinson, Yegidis, & Figley, 2004). By extension, those who work with those traumatized by war are also at high risk for development of compassion fatigue.

For those who experience compassion fatigue, there is greater potential for disruption in the helper's experience of safety, trust, power, esteem, intimacy, independence, and control (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Additional symptoms of anxiety, disconnection, avoidance of social contact, difficulty in maintaining the therapeutic alliance, depression, somatization and disrupted beliefs about the self and others are also identified as possible outcomes of compassion fatigue (Cunningham, 2003; Pearlman & Saakvitne, 1995).

Burnout

Burnout "...is associated with feeling of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment" (Stamm, 2005, p. 8). Symptoms of burnout include feeling strained by having to work with people, issues with concentration and attention level and decreasing memory of work related details (National Center for PTSD, 2004). Burnout is often associated with bureaucratic demands that the worker feels are difficult to address or amend. Empirical studies of burnout reveal it as an especially prevalent condition among helping professionals with mental health professionals demonstrating higher levels of burnout than primary healthcare workers (Sprang, Clark, & Whitt-Woosley, 2007). Burnout differs from compassion fatigue in that compassion fatigue is the direct result of hearing emotionally shocking material from clients; burnout is a problem of the social environment in which people work. Issues such as workload, lack of control and input into the system, insufficient rewards, unfairness, etc. are all potential causes of burnout (Canfield, 2005).

Burnout is conceptualized as a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and provide inadequate support (Jenkins & Baird, 2002, p. 424.) The process of 'burning out' is described as a "...progressive state occurring cumulatively over time with contributing

factors related to both the individual, the populations served, and the organization....” (Newell & MacNeil, 2010, p. 59). Maslach, Jackson, and Leiter’s (1996) view of burnout - a widely acknowledged perspective - is that it can be conceptualized as a multidimensional construct with three distinct domains: emotional exhaustion, depersonalization, and reduced sense of accomplishment. Other attributes of burnout include physical exhaustion, dissatisfaction about oneself, cynicism towards clients (Ballenger-Browning, et al., 2011).

In a recent study (Ballenger-Browning, et al., 2011) comparing levels of burnout among mental health providers serving the military and a normative sample of mental health providers serving a civilian population, it was noted that burnout in military mental health providers was similar to that reported in similar studies of mental health workers. Of particular value in the study were the findings that patient caseload (both size and type), long working hours, amount of clinical experience, gender, occupation, and social support at work were predictors of burnout in the mental health providers working with the military.

METHODS

Instrumentation

The Professional Quality of Life Scale is a 30-item self-report measure that assesses the potential for Compassion Satisfaction (CS), the risk of Compassion Fatigue (CF) and risk of Burnout (BO). According to the creators of the scale, it is “...the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events” (Stamm, 2010, p. 12). The scale has been translated into numerous languages. The scale is available on the ProQoL website and “may be freely copied as long as (a) the author is credited, (b)no changes are made and (c) it is not sold except for in agreement specifically with the author” (Stamm, 2010, p. 5).

The scale is easily administered and takes about 7-10 minutes to complete. Respondents are instructed to indicate how frequently each item was experienced in the last 30 days. Each item is anchored in a 6-item Likert scale (0=never, 1=rarely...5=very often). Scoring requires summing the item responses for each 10-item subscale. Five scores are reversed, (1, 4, 15, 17 and 29) before computing total subscale scores (Stamm, 2010).

The alpha reliabilities of the scale are: Compassion Satisfaction =.87, Compassion Fatigue =.80 and Burnout =.72. The scale has good construct validity and is well validated with over 200 articles noted in the peer review literature (Stamm, 2005). Higher scores on the Compassion Satisfaction (CS) subscale indicate the subject is experiencing better satisfaction with his/her ability to provide care (e.g., care giving is an energy enhancing experience, increased self-efficacy). Higher scores on the Compassion Fatigue (CF) subscale indicate the subject is at higher risk for compassion fatigue. Higher scores on the Burnout (BO) subscale indicate the subject is at risk of experiencing symptoms of burnout (e.g., hopelessness, helplessness, and depression).

The average score on the compassion subscale is 37 (SD 7; alpha scale reliability .87). About 25% of people score higher than 42 and about 25% score lower than 33. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If you score lower than 33, you may be having problems with your job. The average score on the compassion fatigue scale is 13 (SD 6, alpha scale reliability .80). About 25% of people score higher than 17 and about 25% score lower than 8. If one score is above 17, you may want to take some time to understand and address your fears and work at what is frightening to you. On the burnout subscale, the average score is 22 (SD 6.0, alpha scale reliability .72) About 25% of people score higher than 27 and about 25% score lower than 18. If your score is below 18, this reflects positive feelings about your ability to be effective in your work. If your score is above 22, you may wish to think about what it is at work that makes you feel like you are not effective in your work (Stamm, 2005).

Caution in interpreting the scores is suggested in that the scale is not designed as a diagnostic tool but is more designed to 'raise flags' and be a guide to both subjects and administrators as areas of concern and attention (Stamm, 2010, p. 18).

Recruitment Procedure

This study was initiated at a large DoD hospital in the northeast United States. Institutional Review Board permission was granted to do both face-to-face and Survey Monkey interviews and an email soliciting participation in the study was sent to several DoD hospitals through the initial IRB granting institution. Survey Monkey is an Internet computer program that allows a researcher to place their survey on a site that the subject can access through a dedicated link. Responses were blinded so the researcher did not know where the responses were coming from and as no identifying information was noted on the survey, full anonymity was guaranteed. In both cases - Survey Monkey or face-to-face interviewing - the social worker guaranteed confidentiality and anonymity for both person and venue. Several face-to-face interviews were conducted to help refine the survey before sending it out system wide. The sample was considered a convenience sample comprised of those who agreed to participate; it was clearly stated that participation by the social worker was voluntary.

The survey consisted of essential demographic information (see Figure 1) and the ProQoL instrument which measures compassion satisfaction, compassion fatigue and burnout. It was anticipated that the responder would spend about fifteen minutes completing the survey. All data from the surveys was aggregated.

Figure 1. DoD Interview Questions**Basic demographics**

Age: 25-35 _____ 35-45 _____ 45-55 _____ 55-65 _____ 65+ _____

Gender: M _____ F _____

How long have you been working as a MSW? ____0-5 years ____6-10 ____11-15 ____15+

How long have you worked in the DoD system? ____0-5 years ____6-10 ____11-15 ____15+

How long have you worked with OIF/OEF Veterans? ____0-5 years 6-10_____

What service do you work on? _____Surgical _____PTSD _____TBI

_____Behavioral Health _____Other _____Case Mgmt. _____Administration

Do you work In-pt _____ or Out-pt _____

Sample

One hundred forty-one social workers from 26 treatment facility venues completed surveys. Table 1 shows the demographics of the study sample. As can be seen, the subjects were mostly female (75%), mainly working in out-patient services, with over 50% with less than 5 years within the DoD hospital system. In addition, 80% had been working with the OEF/OIF population for 5 years or less, with a majority of social workers (37%) working in Behavioral Health.

RESULTS

In general, the sample (n=141) was above the reported national norms on the ProQoL sub-scales (Stamm, 2005). While the compassion satisfaction mean score was 39.22 with a range from 23 to 50; 59% of the sample was higher than the nationally normed score of 37. The mean score for compassion fatigue was 21.5 with a range from 12 to 33; 45% of the sample was higher than the nationally normed score of 17. The burnout mean score was 28.22 with a range from 10-38 with 66.2% above the national norm of 22. To simplify this finding, this sample of social workers registered positive feelings (compassion satisfaction) about their work with over 59% feeling strongly positive. The scores on the compassion fatigue scale were high indicating the presence of compassion fatigue with 45% of the sample registering levels of compassion fatigue. In the area of burnout, the social workers were strongly above the norm with 66.2% registering high levels of burnout.

Table 1. Demographic Characteristics of Study Participants (N=141)

Characteristic		N	%
Age:			
	25-35	10	07.1
	36-45	32	22.7
	46-55	50	35.5
	56-65	42	29.8
	> 65	7	05.0
Gender:			
	Male	37	25.5
	Female	104	74.5
Years as an MSW:			
	0-5	10	07.1
	6-10	27	19.1
	11-15	34	24.1
	16-20	19	13.5
	21-25	16	11.3
	> 25	35	24.8
Years in the DOD:			
	0-5	82	58.2
	6-10	25	17.7
	11-15	17	12.1
	16-20	9	06.4
	> 20	8	05.6
Years working with OEF/OIF:			
	0-5	112	79.4
	6-10	29	20.6
Inpatient/ Outpatient:			
	Inpatient	17	12.1
	Outpatient	124	27.9
Service:			
	Surgical	10	07.1
	PTSD	39	27.7
	TBI	9	06.4
	Behavioral Health	52	36.9
	Case Mgmt.	6	04.3
	Administration	15	10.6
	Other (FAP etc.)	10	07.1

An independent samples t-test was conducted to compare the levels of CS, CF and BO for those who work 50% and those who work 75% of their time with OEF/OIF service members. For those workers who spent 50% of their time with OEF/OIF service members, the scores on the subscales were minimally different, registering statistical significance ($p>.05$) only on CS, i.e., those social workers who worked 50% of their time with OEF/OIF service members experienced higher levels of CS. For those social workers who spent 75% of their time with OEF/OIF, the difference in the scores on the subscales was not statistically significant.

Table 2. Demographic Findings on ProQoL (N=141)

Compassion Satisfaction (CS) – national norm = 37

Compassion Fatigue (CF) - national norm = 17

Burnout (BO) – national norm = 22

Characteristic		n	CS	CF	BO
Age:	25-35	10	36.90	21.40	26.00
	36-45	32	38.94	22.15	28.38
	46-55	50	39.12	22.17	28.25
	56-65	42	39.88	20.86	28.62
	> 65	7	40.57	18.00	28.00
Gender:	Male	37	38.81	21.68	28.30
	Female	104	39.37	21.45	28.19
Years as an MSW:	0-5	10	39.00	19.20	28.70
	6-10	27	37.96	23.43	27.89
	11-15	34	40.18	21.03	27.56
	16-20	19	40.21	32.21	28.89
	21-25	16	38.50	19.94	27.81
	> 25	35	39.15	20.88	28.82
Years in the DOD:	0-5	82	38.66	22.21	28.70
	6-10	25	40.16	21.44	26.12
	11-15	17	39.88	20.17	29.06
	16-20	9	39.56	19.33	28.33
	21-25	4	43.00	18.00	29.25
	> 25	4	37.50	19.50	26.75
Years working with OEF/OIF:	0-5	112	39.18	21.68	28.04
	6-10	29	39.39	20.82	28.96
Inpatient/ Outpatient:	Inpatient	17	40.94	18.88	27.24
	Outpatient	124	38.98	21.87	28.30
Service:	Surgical	10	42.40	20.80	27.40
	PTSD	39	39.85	22.59	28.69
	TBI	9	36.00	20.33	30.44
	Behavioral Health	52	38.33	21.96	28.71
	Case Mgmt.	6	40.50	16.83	24.00
	Administration	15	38.80	20.40	26.33
	Other (FAP etc.)	10	40.94	21.20	28.00

ProQoL Differences by Demographics

Multiple regression is a statistical technique used to examine the effect of multiple variables on a dependent variable. This technique allows the researcher to identify which factors, from a group of factors, predict an outcome; in this case, which factors create the findings on the ProQoL subscales.

Multiple regression was conducted to determine which variables (age, gender, years in the DoD, years as a social worker, and years working with OEF/OIF) were predictors of CS, CF and BO. Regression results for CS indicated that no variable was reliable in predicting CS. For CF, the only variable that was a reliable predictor was years working in the DoD health care system with higher CF scores for those working in the system from 0-5 years with CF decreasing over time. For BO, no variables were predictive.

ProQoL by Service

Social workers were asked to identify which service they worked on (Surgical, PTSD, TBI, Behavioral Health, Case Management, Administration). Scores on the CS, CF and BO subscales were studied to assess scores by service worked. For CS, the three highest scores for the social workers were on the Surgical service, followed by Case Management and Administration – i.e., these three services registered the highest levels of compassion satisfaction, in that order. Those social workers working with PTSD, followed by Behavioral Health and Surgical recorded the highest scores on CF. The social workers working with TBI followed by Behavioral Health and PTSD recorded the highest scores on BO. It is important to note that the differences in these scores was not dramatic, perhaps a few points, but noteworthy nonetheless.

The ProQoL subscales also evaluated the social workers to determine the impact of in-patient versus out-patient work. Survey responders were asked to indicate whether the majority of their work was with in-patients or out-patients. Scores on the subscales for CS and BO were not statistically significant based on in- or out-patient service however the score on the CF scale registered statistical significance ($p=>.05$), i, e., those social workers who had a caseload that was predominately out-patient had higher levels of compassion fatigue.

Multiple regression was conducted to determine which variables – service, years in the DoD health care system and whether the social worker worked in- or out-patient – predicted subscale scores (See Table 3). None of the three variables was a predictor for CS; for CF, each variable was predictive in the following order – whether the social worker was in- or out-patient, years in the DoD system and service worked; for BO, the only predictor was service worked with those working with traumatic brain injuries scoring the highest levels.

Table 3. Results of Multiple Regression Analysis – Predictors of Compassion Satisfaction

Factor	B	Std. Error	Beta	t	Sig.
Age	2.055	.655	.169	1.611	.109
MSW (yrs)	-.485	.559	-.126	-.868	.387
DoD (yrs)	.482	.533	.098	.903	.368
OEF/OIF (yrs)	-.496	1.581	-.031	-.314	.754
Gender	.328	1.291	.023	.254	.800
Service	-.022	.281	-.007	-.080	.937
In-pt/Out-pt	-2.302	1.738	-.119	-1.325	.187

*p<0.05 **p<0.01

Table 4. Results of Multiple Regression Analysis – Predictors of Compassion Fatigue

Factor	B	Std. Error	Beta	t	Sig.
Age	-.874	.475	-.183	-1.842	.068
MSW (yrs)	.699	.405	.237	1.727	.087
DoD (yrs)	-.895	.387	-.237	-2.313	.022*
OEF/OIF (yrs)	.594	1.146	.049	.518	.605
Gender	-.235	.936	-.021	-.252	.802
Service	-.427	.204	-.175	-2.091	.038*
In-pt/Out-pt	3.738	1.260	.252	2.967	.004**

*p<0.05 **p<0.01

Table 5. Results of Multiple Regression Analysis – Predictors of Burnout

Factor	B	Std. Error	Beta	T	Sig.
Age	.194	.470	.043	.412	.681
MSW (yrs)	.373	.401	.133	.929	.354
DoD (yrs)	-.468	.383	-.130	-1.221	.224
OEF/OIF (yrs)	1.433	1.135	.124	1.263	.209
Gender	-.033	.927	-.003	-.035	.972
Service	-.474	.202	-.204	-2.345	.021*
In-pt/Out-pt	1.552	1.248	.110	1.244	.216

*p<0.05 **p<0.01

Findings – Recap for this sample of social workers:

- CS, CF and BO all registered above the subscale normed means;
- For those social workers who worked 50% of their time with OEF/OIF, CS was high; for those who work 75% of their time no subscale scores were elevated;

- In evaluating demographic factors, BO and CS subscales were not related to demographic factors; CF was noted in those who were with the DoD system 0-5 years;
- For those who worked on the Surgical, Case Mgmt. and Administration, higher levels of CS were noted, for those who work with PTSD, Behavioral Health and Surgical, higher levels of CF were noted; for those who work with TBI, Behavioral Health and PTSD, higher levels of BO were noted;
- For those who work with out-patients, higher levels of CF were noted, not so with CS and BO;
- In evaluating the impact of service, years with the DoD and in-patient factors, none were related to CS, out-patient, years with the DoD (0-5 years in the system) and service were related to CF and only service was related to BO.

DISCUSSION

This sample of social workers represents approximately 35% of the total social work staff in the DoD (141 sample of 500 social workers in the system). As such, the findings assume a fairly strong level of credibility as reflective of the feelings of the social workers system-wide.

Generally the social workers expressed compassion satisfaction derived from their work with 59% above national norms for the subscale. Of some concern were the findings on the compassion fatigue and burnout subscales. While almost every social worker at some point will feel fatigued and burned out, over half of the responders (59%) noted levels of fatigue and two-thirds (66.2%) noted levels of burnout. This finding is not necessarily reflective of the OEF/OIF influx as scores on the subscales were not higher when social workers worked either 50% or 75% of their time with this specific cohort of returning service members. In fact, just the opposite; a surprising finding was that for those social workers who worked 50% of their time, their levels for compassion satisfaction were significantly (statistically) higher than those whose caseload was under 50%. The elevated CF and BO subscale scores suggests that attention to the burnout and compassion fatigue symptoms of the social workers might be initiated. These scores can be seen as reflecting the need for investigation of setting characteristics that might influence the development of these conditions.

To further refine the CF and BO findings, the analysis indicated that the service areas where the high CF and BO scores occurred were those working with PTSD, Behavioral Health, Surgery and TBI. These might be areas where administration could focus intervention designed to ease some of the pressure on these units.

Another area of concern, which was indicated in the analysis of the subscales, was the CF and BO scores for those social workers new to the system. Both subscale scores were statistically significant - above normed levels - for those in the system 0-5 years. As the years went on, in five-year increments, the subscale scores went down to below CF and BO normed levels. This suggests that there is a 'settling in' process, an acculturation into the system and to the work that leads to diminished levels of CF and BO. To smooth

the transition into the system, administration might consider particular attention to the new worker who may be assailed with challenges not anticipated when joining the system.

The in-patient/out-patient finding – that those working in an out-patient setting had higher scores on the CF subscale – might be reflective of the location and size of the facilities in which the social workers are placed. On in-patient services, the interdisciplinary atmosphere and larger pool of workers might buffer some of the feelings of compassion fatigue. This finding might well be further researched to determine what specific action could address these responses. Perhaps diversifying case assignments might be helpful with time spent working both in- and out-patients.

LIMITATIONS

Interpretation of the findings of this study is limited by several factors. First, the design of the study utilized and relied on one instrument for its research. As noted earlier, the instrument is not to be considered diagnostic but more trend based; as such it is possible that the participant taking the survey might be having a ‘bad day’ or a few bad days which would be reflected in the responses on the ProQoL. In addition, as a self-report device, many may have chosen not to respond to the call for participation, noting time constraints and other work obligations.

CONCLUSION

“In many ways, the health of an organization depends on the health of its staff. This is especially important for industries like health care.....These facilities are often challenged when providers are worn down by either their work environment (burnout) or the content of their work (compassion fatigue)” (Rudolph, Stamm, & Stamm, 1997, p. 88). Since social workers are an integral component of the multidisciplinary team in the DoD systems such, their care and well-being is important to the overall quality of care offered to our service members.

The research reported in this article can be seen as a snapshot, a picture in time, which reflects a certain reality. As with any snapshot, the picture can change. As the war efforts in Iraq and Afghanistan continue and our wounded service members continue to return home, the work in the Department of Defense Health Care System will not ease, if anything, it will become more intense. Work demands will increase. The social workers in the system are dedicated professionals working on behalf of our wounded. For the most part, as reflected in this study, they derive a large degree of satisfaction from their work. Due to the nature of the work and the degree of caring, there is the potential for experiencing compassion fatigue and burnout. For optimal care to be given to our wounded, attention to staff needs is warranted. The findings in this article – not to be seen as a critique - point to certain areas in the social work experience that merit attention.

On-going research on the experience of social workers is needed to help social work administrators to be sensitive to the needs of their staffs, especially as caseloads expand and the war effort continues.

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Appendix 1

PROFESSIONAL QUALITY OF LIFE SCALE

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. Consider each of the following questions about you and your current situation. Write in the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I help.
3. I get satisfaction from being able to help people.
4. I feel supported by the staff I work with.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my personal life from my life as a helper.
8. I am losing sleep over a person I helped traumatic experiences.
9. I think that I might have been infected by the traumatic stress of those I help.
10. I feel trapped by my work as a helper.
11. Because of my helping, I feel "on edge" about various things.
12. I like my work as a helper.
13. I feel depressed as a result of my work as a helper.
14. I feel as though I am experiencing the trauma of someone I have helped.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with helping techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. Because of my work as a helper, I feel exhausted.
20. I have happy thoughts and feelings about those I help and how I could help them.
21. I feel overwhelmed by the amount of work or the size of the caseload I have to deal with.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
24. I plan to be a helper for a long time.
25. As a result of my helping, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I believe that I am a "success" as a helper.
28. I can't recall important parts of my work with trauma victims.
29. I am an unduly sensitive person.
30. I am happy that I chose to do this work.

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**Build it Together and They will Come:
The Case for Community-based Participatory Research with Military
Populations**

**Ellen R. DeVoe
Abigail M. Ross
Ruth Paris**

Abstract: In this article, we describe the methodology broadly known as community-based participatory research (CBPR) and identify its relevance to social work intervention research with families serving in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF). Since the inception of OEF/OIF, much has been written about low rates of service utilization among military service members and families to address deployment and combat-related concerns. Barriers to participation include difficulty accessing programs, mistrust of clinicians/researchers, concerns about confidentiality, stigma, and career implications, and perceptions of program effectiveness. Because CBPR values the community's inherent resilience and expertise about its own needs, this method can be important for the development of feasible, culturally-relevant and evidence-based prevention and intervention models for military populations. To illustrate, we provide an overview of our implementation of CBPR to develop and test a home-based reintegration program for military families with very young children. Implications for social work practice and research are discussed.

Keywords: Military families, Community-Based Participatory Research, OEF/OIF

**INTRODUCTION TO COMMUNITY BASED PARTICIPATORY
RESEARCH**

Community-Based Participatory Research (CBPR) is an orientation to the research process rather than a specific methodology or research design. It assumes collaboration between the researcher and the community of interest in all phases of the research process (Viswanathan et al., 2004) and aims to enhance community outcomes and capacity (Minkler & Wallerstein, 2003). In practical terms, the community actively participates in defining the research questions, aims, and outcomes, rather than serving only as a context and source of data collection and/or a means to further the researcher's goals (Lantz, Israel, Schulz & Reyes, 2006). Indeed, CBPR as a method emerged from participant action and empowerment strategies developed to respond to marginalized communities that had been prey to "hit and run" research, in which researchers obtained data from a study sample for their own purposes and did not directly or immediately transfer useful or usable knowledge to benefit the community (Franco, McKay, Miranda, Paulino, & Lawrence, 2007). CBPR is also highly consistent with the current focus on translational research as a cutting-edge priority in developmental prevention and intervention science. Specifically, CBPR not only conforms to the fundamental tenet of translational research,

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to ensure that all findings derived from the research process have “end usability” (Guerra, Graham, & Tolan, 2011), but prioritizes ongoing researcher collaboration with communities that are intended to benefit from research results. We suggest that CPBR approaches in partnerships between civilian academic researchers and military collaborators can result in timely development of effective prevention and intervention strategies that have strong ecological validity, community buy-in, and relevance to the diverse needs of military families.

In the context of the military community, a CBPR approach views service members, veterans and their families as the experts on their own military-related experiences and struggles who can inform both the research world and service providers of their specific strengths and needs. In our own work as academic researchers, we approach our status as civilian-outsiders from a position of cultural humility, in which we take responsibility for and are committed to a dynamic learning process in which our education about military culture and families is open-ended. The notion of cultural humility is highly consistent with CBPR in that we assume that new knowledge about military families will influence and change the direction of our research and intervention development throughout the research process (Tervalon & Murray-Garcia, 1998). Our contributions as researchers to the CBPR enterprise include sharing information and securing resources (e.g., grant support) with the community that may not be readily available.

As part of this process, we are responsible for understanding and translating the state of the research regarding the needs of young children in military families and the availability and status of prevention and intervention initiatives targeting this population.

WHAT WE KNOW ABOUT MILITARY FAMILIES WITH VERY YOUNG CHILDREN

In January 2011, the Obama administration identified military families as an “enduring” priority for the U.S. (President’s Commission, 2011) with more than two million troops having served at least one tour in Operation Enduring Freedom and/or Operation Iraqi Freedom. An estimated 55% of the total Force is married and a substantial number of Active Duty and National Guard/Reserve (NG/R) are parents of dependent children (43.2% and 41.9% respectively) (Office of the Deputy Under Secretary of Defense, 2010). Currently, there are approximately 1.9 million children with a military parent. Of children who have experienced at least one parental deployment, those ages birth to 5 years comprise the largest age group (41.5%), followed by 6-11 year olds (31.2%), and 12-18 year olds (23.4%) (Office of the Deputy Under Secretary of Defense, 2010).

War operations in Iraq and Afghanistan have required intense and ongoing involvement by U.S. troops. In fact, the deployment demands of these conflicts are unprecedented in recent history (President’s Commission, 2011). The unique characteristics of these “fourth generation” wars (Scott, McCone, & Mastroianni, 2009), including high operational tempo, ambiguous front lines, ubiquitous enemy, and terrorist tactics have resulted in elevated combat exposure for all troops and increased rates of physical injuries and disabilities specific to contemporary combat strategies (e.g., IEDs,

roadside bombs, suicide bombs, blast impacts). While the survival rate, enabled by technological advances in medicine, communication, and transportation, is the highest of any war in history, so too are the resulting demands on all systems of care for veterans and their families. The heavy engagement of National Guard/Reserve units in war-related operations as opposed to the more traditional NG/R role in the national emergency response system also represents a significant departure from all earlier conflicts (Council on Social Work Education, 2010) and has important implications for supporting NG/R service members and their families. Specifically, because NG/R families are embedded in the civilian community, they may experience difficulty accessing supports and resources available to deploying or reintegrating families due to geographic dispersal.

Our service delivery systems, both military and civilian, are not yet equipped to respond to the volume and range of concerns within military and veteran populations. For example, although social workers constitute the largest professional discipline serving military communities, the majority of social workers do not receive specialized training through social work curricula in the classroom or field about military culture, the deployment cycle, and war trauma and its impact on families. Furthermore, because 63% of military families live in diverse communities all over the country (President's Commission, 2011), they are likely being served by community-based agencies including health and mental health clinics, hospitals, schools, and child care agencies that may not be aware of a family's military status or trained to support families who have served. Taken together, the numbers of children, parents, and communities affected, combined with the often urgent and sustained needs resulting from OEF/OIF deployment, separation and combat, necessitate a comprehensive social work response.

Social work is positioned to implement CBPR given the profession's strong foundation in ecologically-based and multi-level practice. Through collaborative research partnerships between social workers and military communities, community-based participatory approaches to prevention and intervention research can expand the profession's capacity to anticipate and offer effective and relevant services for military families. We present our experience in applying a CBPR approach to begin addressing gaps in knowledge about OEF/OIF families with very young children and developing evidence-based interventions to support them.

PARENTING VERY YOUNG CHILDREN DURING DEPLOYMENT AND REINTEGRATION

Our rationale for focusing on the birth to five year age range is multi-pronged. As noted above, children under age five are disproportionately represented among OEF/OIF families relative to older age groups and are highly vulnerable in the face of prolonged separation from a primary caregiver. While a growing body of literature also has begun to recognize resilience in military families with older children and adolescents (Chandra et al., 2010; Huebner & Mancini, 2005; MacDermid, Samper, Schwarz, Nishida, & Nyaronga, 2008), few studies have explored resilience in babies, toddlers, and preschoolers. One study of OEF/OIF children ages 1.5-5 years old during deployment indicates that preschool children of deployed parents were more likely to exhibit increased behavioral symptoms than children in non-deployed families (Chartrand,

Frank, White, & Shope, 2008). Infants and toddlers may become more irritable, demonstrate increased vulnerability in sleep disruption, and develop eating problems or separation anxiety in response to at-home caregiver depression, anxiety or parental absence (Lincoln, Swift, & Shorteno-Fraser, 2008). Discipline problems, increased need for attention, sleep difficulties, confusion, sadness, repeated questioning about the deployed parent, and fear that the deployed parent may not come home may occur in as many as 50% of children under age five with a parent currently deployed (Blount, Curry, & Lubin, 1992; Jensen, Martin, & Watanabe, 1996; Kelley et al., 2001; Rosen, Teitelbaum, & Westhuis, 1993). The possible effects of deployment on very young children may result in increased and more complicated demands on parents as they work to support their babies, toddlers and preschoolers throughout and after the separation.

We also know that for children of all ages, quality of parenting has emerged consistently as the most robust predictor of adaptive coping and resilience in adverse contexts (Luthar, 2006; Luthar, Sawyer, & Brown, 2006). The very young child's ability to cope with lengthy separation from a primary caregiver is heavily influenced by how well the at-home caregiver manages the many transitions and challenges inherent throughout the deployment cycle (Chartrand et al., 2008; Cozza, Chun, & Polo, 2005; Cozza & Lieberman, 2007; Williams & Rose, 2007). For the at-home parent with young children, maintaining child care routines and handling expanded responsibilities can be exhausting and may contribute to increased stress levels in children and parents (Kelley et al., 2001). There is also some evidence of increased risk of maltreatment, primarily neglect, during deployment (Gibbs, Martin, Kupper, & Johnson, 2007; Rentz et al., 2007). These findings suggest that non-deployed parents caring for very young children could benefit from targeted prevention and intervention services throughout the period of deployment separation and beyond.

Post-deployment adjustment presents unique challenges for military families with children under five. Babies and toddlers may not recognize the returning father or mother and often need a period of slow transition to become familiar and comfortable with their service member parent. Routines developed during deployment, such as co-sleeping, may be difficult to disrupt and may be challenged or misunderstood by the reintegrating parent. Toddlers and preschoolers may manifest more separation anxiety in response to either parent's comings and goings (Barker & Berry, 2009) and can become dysregulated when reminded of the deployment (e.g., when a parent wears his or her uniform for work). While many military families are able to anticipate and weather the strains of the post-deployment period, reintegration becomes more highly fraught when a returning parent is suffering from adverse psychological outcomes such as combat stress, depression, anxiety and/or injury or disability (Huebner, Mancini, Wilcox, Grass, & Grass, 2007). Recent findings indicating a high prevalence of sub-threshold mental health distress (range from 22-50% of returning OEF/OIF veterans), in particular partial PTSD, are especially concerning and may substantially compromise parenting in the returning service members (Jakupcak et al., 2007; Pietrzak, Goldstein, Malley, Johnson, & Southwick, 2009).

Transition to Parenthood during Deployment

When a first baby is born during a tour of duty, families grapple with the transition to parenthood in the context of the separation and uncertainty of deployment realities. A service member father's ability to support his partner is clearly constrained by the circumstances of deployment and he is unable to participate instrumentally (e.g., night feedings, etc.) in the daily routine of infant care. On balance, first-time mothers become single parents as they must manage all aspects of parenting without their partner. In our study sample we have been concerned that mothers who give birth to their first baby shortly before or during the separation period may be at greater risk of developing postpartum depression than mothers whose partners are not deployed. This was demonstrated in one study where postpartum depression (PPD) was found at a higher rate in military families as compared to those in the general civilian population (16.9% vs. 13%) (Haworth, 2010). For fathers, becoming a parent in absentia can be disorienting and distracting (MacDermid et al., 2005; MacDermid, 2006). Consequently, the returning father must simultaneously reintegrate into the couple relationship, family and community, and move immediately into fatherhood with a baby he does not yet know. Unfortunately, there is very little information about this unique and potentially at-risk subgroup of OEF/OIF parents and the specific challenges they face throughout the deployment cycle.

What is Available?

Lack of services. Until very recently the Department of Defense and Veteran's Administration (V.A.) have provided a comprehensive array of health and mental health services to the military service member or veteran with the goals of readiness and rehabilitation. Since OEF/OIF, however, there have been important changes in federal policy that focus greater attention to the health and well-being of the totality of U.S. Forces, specifically families of military service members and veterans (Department of Defense Task Force on Mental Health, 2007; Office of the Under Secretary of Defense (Comptroller) CFO, 2010; President's Commission, 2011). While these critical shifts in mandate begin to take root at the level of implementation, the current structure continues to be uneven with both redundancies and significant gaps in services. For OEF/OIF families with very young children, the most basic challenge is the relative absence of developmentally-appropriate and military-sensitive programs in communities. For active duty families and those living on or near installations, the New Parent Support Program within the Family Advocacy umbrella has long been an important resource for new parents through the baby's first year of life; however, for NG/R families living in non-military connected communities and families with babies older than 12 months, such services may not be available or accessible. Additional challenges for families with babies, toddlers and preschoolers can include geographic barriers, difficulties with accessibility (e.g., hours, locations), insurance coverage red-tape, and confusion about eligibility (Gould et al., 2010; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009).

WE BUILT IT SO WHY WON'T THEY COME?

Top-down vs. bottom-up. The command structure of the U.S. military necessarily relies heavily upon leadership dictating action and directions to lower ranking personnel in support of mission readiness and success. While a top-down strategy is highly effective in the context of war operations, the “ivory-tower” imposition of research agendas and/or mental health expertise on service members and their families has not always been well-received and may not be responsive to service members’ perceived needs. For example, although there are well-tested evidence-based models of treatment available for service members with mental health concerns, current help-seeking among OEF/OIF veterans remains much lower than documented need (Pietrzak, Johnson et al., 2009; Thomas et al., 2010) despite the fact that the suicide rate in the military reached an all-time high in 2009 (Department of Defense Task Force, 2010). Researchers have identified the specific barriers of negative beliefs about or previous experience with mental health providers (Pietrzak, Johnson et al., 2009; Thomas et al., 2010), and anecdotal evidence indicates that younger service members and veterans may be less likely to use VA-based programs. For NG/R service members, accessibility to existing programs is often a significant barrier. With these considerations in mind, we aimed to build a reintegration program for OEF/OIF families that would eliminate known barriers to participation and help-seeking, including accessibility, stigma, relevance to the military context, and developmental appropriateness. Our particular focus is the NG/R families, who represent a significant but underserved demographic in the ongoing conflicts.

Building it Together: CBPR Case Exemplar

Strong Families Strong Forces, the program we have been developing, has been working within a CBPR framework since the commencement of our project. As non-military researchers and clinicians funded to develop a program for military families with young children where one parent recently returned from a deployment in Iraq or Afghanistan, we were fully aware of the need to collaborate with military service providers and families in our region. Collectively, the leadership team had both research and clinical experience with trauma, families, and young children. We were very experienced and familiar with evidence-informed and evidence-based models to address traumatic stress and violence-exposure in children, infant mental health, and family therapy prevention and intervention strategies. One team member had substantial familiarity with the Family Advocacy Program and the New Parent Support Program specifically through involvement with an earlier program evaluation effort. Working within a CBPR frame, one of our first tasks was to begin to understand the complexities and needs of the military communities we hoped to support. We anticipated that with the community’s expertise combined with our knowledge of existing programs and resources in academia, we could achieve our ultimate goal of creating a viable and effective intervention that would be immediately useful for military families.

Phase One: Doing Our Homework

We intentionally built into our research plan adequate time and resources to develop our program with the systematic input of military families and health, mental health and

child/family program providers from both military and civilian services. Consistent with a primary tenet of community collaboration, we endeavored to do our “homework” prior to entering the military community (Franco et al., 2007). More specifically, we immersed ourselves, to the extent possible, in all available sources of information related to OEF/OIF families and context, including conferences, workshops, webinars, and the existing literature. Simultaneously, we conducted extensive outreach to professionals and researchers in diverse systems of care both locally (Veteran’s Administration, Family Support Programs, regional Vet Centers, Family Readiness Groups, regional Military Family Life Consultants and child care providers both on base and in the community) and nationally (Director of Psychological Health for the National Guard, National Center for PTSD; Operation Homefront National, Zero to Three National Center for Infants, Toddlers and Families; and the National Military Family Association). Through this intensive process, the breadth of the New England military population was clarified for us. We understood that while there were bases that continued to have smaller active duty components with a range of missions, the largest regional military populations were National Guard members and Reservists from all branches. National Guardsmen and Reservists currently represent approximately 50% of those serving in the wars in Iraq and Afghanistan and bring needs and strengths distinct from those of active duty units living on or near installations. Given these characteristics, learning the cultures of the NG/R components and the perceived needs of NG/R families with young children became and continues to be a major focus of our work.

To that end, we initiated our formal exploratory work (Phase 1) in which we engaged in countless phone conversations, email exchanges, and ultimately face-to-face meetings and interviews with key informants in our region. We began what is now our strongest collaborative relationship with the National Guard Family Program in Massachusetts (NGFP-MA). Interviews with both military and civilian providers within the NGFP-MA proved to be vital links for our contacts with families and providers in other parts of Massachusetts and other states (e.g. Rhode Island and New Hampshire). In addition, key informant interviews with V.A., mental health, social service and family support personnel deepened our sophistication regarding the needs of military families with young children from the provider perspective. Interviewees shared their perceptions of the challenges facing service members, partners, and children throughout the deployment cycle. They also shared frustration about the services they could not provide even though they could identify the needs. In general, the key informants seemed to view our funding as positive and appreciated the Department of Defense’s commitment to developing and testing innovative interventions for military families coping with the strains of deployment. However, these leaders and experts also expressed their appropriate concerns about potential for burden on military families given the explosion of research on the military and considered very carefully whether our involvement with families would be beneficial.

Earning the Trust

Throughout the process of “doing our homework,” we needed to earn the trust of the military community and to demonstrate that we had something to offer. A critical aspect

of earning the trust of the community has been showing up and spending time in and with the military community and offering full transparency about our intentions and resources (Franco et al., 2007). Specifically, after receiving invitations from our colleagues in the National Guard and Reserve in all branches of the military, we began attending Yellow Ribbon and similar pre and post-mobilization events to share our expertise with respect to young children, parenting and families. We offer briefings on our developing program, the impact of long separations on young children, and parenting guidance focused on both the at-home caregivers and service members. These presentations have been well received and we are often asked to present to a variety of groups, such as those focused on family readiness or veteran's affairs. To give a sense of the intensity of our community involvement, research staff have participated in approximately 140 formal events representing all military components over the course of 28 months. At these same events, and through informal follow-up, we began ongoing conversations with members of the military and support personnel, including chaplains and community organizations among others, who assist service members and their families. Through conversations and shared concerns we continue to build our collaborative network and to deepen our understanding of military families and the providers who support them.

Our initial contacts with service members and their families began at these same pre and post-mobilization events. Through individual exchanges with service members and their families, we described our goal to develop a program for military families with children birth to five and our interest in hearing directly from OEF/OIF service members and partners about their experiences of separation and reintegration. If interested, they were asked to sign a "consent to contact" form, granting us permission to call them, explain the process in greater detail, and ultimately visit them at home for an interview. Service members and partners were offered stipends for their time (where allowed), an essential component to demonstrate the value of their contributions.

In-depth interviews with military families focused on their stories of preparing for deployment, the actual separation, experiences of the service member in theater and of the parent at home with children, communication during the separation, reactions of children to a parent being absent, reunification when the service member returned home, and the reintegration process. We conveyed clearly that we did not have military experience and were not looking for particular answers. Families were willing to share the sometimes ingenious and myriad ways they have coped with the challenges that the deployment and separation presented. For example, we learned of service members calling for snow plows from Iraq, arranging for monthly flowers to be sent to a partner at home, and an at-home parent showing a father (via Skype) his 12 month old baby who was now walking. One mother sent regular care packages to her deployed husband that included a piece of string representing the height of each child so that he could track his children's growth while he was away. We also heard about 4- year olds who wanted to return to a mother's bed, a 2-year old who stopped talking for the duration of deployment, and a toddler who waited by the window for Daddy to come home from work every night for several months after the departure. In this exploratory phase, we listened intently to the array of family experiences and strategies, marveled at their

abilities to manage the complexities of deployments, and heeded their wishes for supports that could alleviate particular stressors during and post-deployment.

Building the Intervention

Best practices. While completing interviews with key informants, child care providers, and military families, we simultaneously began developing our intervention. As scholars experienced in research and clinical work with trauma, families, and young children, we searched the literature regarding evidence-informed and evidence-based models that addressed traumatic stress and exposure in children, infant mental health, and family therapy prevention and intervention initiatives. We knew that literature focused on work with military families with young children was not available, but we examined models that had been tested with similar populations using promising strategies. In the infant mental health literature, we looked to the works of Lieberman (Lieberman & Van Horn, 2005), McDonough (2004), Slade (2005) and Dozier (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008), all of whom described interventions for caregivers and young children addressing trauma, separations, and/or attachment concerns. Cohen (Cohen, Mannarino, Berminger, & Deblinger, 2000) and Scheeringa (Scheeringa et al., 2007) have developed cognitive-behavioral interventions that address frank trauma in children older than three years of age. Lester and her colleagues (2011) developed a family-focused resiliency building program, FOCUS, within the military using evidence-based models as their templates (Beardslee, Gladstone, Wright, & Cooper, 2003). Although several of the above programs are being adapted currently to work with military families, none except FOCUS was developed with military families in mind.

Existing best and promising practices for both infant mental health and trauma in older children and adolescents are based primarily on the child's victimization or exposure to 'frank' trauma which, in our view, does not characterize a young child's experience of deployment separation. Rather, we take the position that any family experiencing prolonged parent-child separation, including deployment, will be stressed by the experience and that traditional mental health models, typically focused on psychopathology, do not universally apply to military families. For our purposes, we envisioned our program as a universal intervention with preventive as well as therapeutic components focused on the impact of deployment separation and the legacy of war-related experiences on parenting and parent-child relationships. Our military partners also endorse this view: that a family-focused program would be well received and that access has been an important issue. Furthermore, given our understanding of the impact of separation on the parent-child relationship, we found the work of Slade and colleagues (2005) to be particularly relevant for military families due to the focus on building parental reflective capacity, in this case, about children's experiences of deployment and reintegration.

We also elected, from the beginning, to build a home-based program for OEF/OIF families in part due to the logistical challenges all families with very young children face and with the hope of reducing concerns about stigma and confidentiality. In addition, because our National Guard and Reserve families live in different communities across several states, a home-based model would allow us to serve families who would not

otherwise be able to access site-based programming. Hence, we were drawn to the home-based interventions described in the literature that tended to focus on the youngest children as viable models and we were hopeful that families in our region would be receptive to a home-based program. With these basic principles—accessibility, family-focus, building parenting capacities, and awareness of the impact of separation and combat stress—we looked to our key informants and military families to help guide and shape the focus and details of our intervention.

Applying new knowledge from the community to build Strong Families Strong Forces. Our task in building the program was to integrate the diverse contributions of knowledge from the research and practice literatures, our own expertise, and most importantly, the dominant concerns of families we interviewed. The data we collected from our interview participants were replete with details about all aspects of managing one or more deployments. OEF/OIF families' concerns spanned the entire deployment cycle including preparing children during the pre-deployment period, managing children's reactions and supporting communication during the separation, and reintegrating the service member back into family life when s/he returned from theater. Not surprisingly, interview participants shared that there were multiple perspectives on deployment from various family members. We worked to address all major interview themes with an emphasis on honoring each family member's deployment experience over the course of an eight module home-based program that involved the service member, the partner, and the child(ren) under five. Guided by our theoretical grounding in building reflective parenting capacities (Slade, 2005) we strove to focus our program on helping parents understand the emotions, perceptions, behaviors, and needs of their very young children who were too young to share their experiences in words and to encourage the couple to engage in honest discussion about the differences in their deployment narratives.

Phase Two: Piloting Strong Families Strong Forces.

Throughout the first phase of our research, we continuously vetted plans with our military collaborators through an advisory board and provided feedback about implementation and findings. With substantial support for our ideas and program from Phase 1 families and our collaborators, we moved forward with piloting the intervention with nine military families who had experienced at least one deployment and had a child under five. All nine families completed Strong Families Strong Forces and were given the opportunity to provide substantial and specific feedback about all aspects of the program. Overwhelmingly, families felt helped by the services, comfortable with the members of our team who had met with them weekly for two months, and would recommend the program to other parents in their units. In fact, several pilot families reported that they stood up during drill weekends and at Family Readiness Groups to share their stories of participation in our program and to encourage their fellow service members to consider enrolling. Phase 1 and Pilot families have consistently reported that there was no other program that they knew of, in or out of the military, which addressed the unique issues for families with young children at home.

This last piece of information presented a particular ethical quandary for us as researchers. We had designed our study as a simple clinical trial to include a treatment group and a control group that would receive “treatment as usual.” However, it became clear to us by the end of our pilot that there was no “treatment as usual” for military families with young children in our region. Because our CBPR approach demanded that we incorporate new learning about community needs into the research process, in this case the significant ethical concern of offering no services, we modified the design of our randomized trial to replace “treatment as usual” with a “waitlist control” condition with the option of receiving the program at the end of the wait period. This decision has had significant implications on budget, workload, and study scope because we have now committed to offering the program to any study family who meets eligibility criteria. The change in design was received very positively by our funders and military collaborators as we can now assure that all referred families who so desire will receive our intervention.

Phase Three: Randomized Clinical Trial and Next Steps

At the time of this writing, we are conducting the randomized clinical trial to test the *Strong Families Strong Forces* program. On the basis of our pilot and earlier community work, we began our clinical trial with some confidence that our program was feasible and that we would find families to participate. However, we did not expect the level of interest in the program among OEF/OIF families and have been overwhelmed with the volume of potential participants. Surprisingly, we also have not yet had any attrition from the study and had not anticipated that the vast majority of waitlist families would elect to ‘opt in’ at the end of the waiting period. Though we will not be able to report on the actual effectiveness of the program from a quantitative standpoint until the completion of the trial, we suspect that success in recruitment and retention with the military population stems directly from our CBPR approach. The fact that we teamed with our military collaborators to build our program from the bottom up, that concerns shared by military families became the focus of our work, and that we were willing to bring the program to the participants are a few of the CBPR methods that have contributed to the success of our study thus far. The next significant challenge for our work, if the evidence supports the effectiveness of *Strong Families Strong Forces*, will be the dissemination of the program model into existing systems of care and across diverse communities where military families live.

Reflections on CBPR Process with Military Partners

Partnering with the military, especially given our civilian status, during active war operations has presented interesting challenges and opportunities in the CBPR process. In the request for proposals, the Department of Defense discouraged investigators who did not already have existing partnerships with the military from attempting to establish potential collaborative relationships during the proposal preparation stage. This prohibition is unusual, in our experience, in that we could not develop recruitment and sampling strategies nor were we required to propose them until or unless we received funding. As a result, we could not begin our collaborative efforts with military partners

until our proposal had been recommended for funding. Although we planned specifically for time necessary to begin and consolidate community relationships, gaining approval at all relevant Institutional Review Boards for community outreach proved challenging. A second issue unique to working with the military during active war operations is the tension between the goal of maximum involvement of OEF/OIF families and community collaborators in the research and intervention development process and the realities of war-time demands on our military partners. That is, we understand and respect that military and acute systems needs are necessarily the focus of our collaborators' work. For these reasons, much of the iterative process in refining the *Strong Families Strong Forces* model has been based on feedback and observations from the families who have participated as opposed to genuine co-authoring of the program manual. Overall, however, our work with and on behalf of OEF/OIF families and their young children has been supported and well-received.

IMPLICATIONS FOR SOCIAL WORK RESEARCH WITH MILITARY COMMUNITIES

CBPR approaches, especially with military populations, require sustained commitment to community collaboration – which implies time and meaningful presence within the community. Social work researchers who undertake community-based work must expect to engage in an iterative and sustained process of engaging, incorporating and honoring community partners' perspectives and expertise into all aspects of the research enterprise. While we believe that CBPR and similar approaches to research and evaluation lead to more ecologically valid, culturally-relevant and effective interventions, there is not yet mainstream support for and recognition of this kind of work. For many academic researchers, this degree of "leg work" is disadvantageous within the narrow parameters of types of research supported because of the time required to enter a community, collect and analyze data, and publish/disseminate findings. On balance, family members and professionals who support them may feel burdened by researchers who seek knowledge and explore possible collaboration, particularly when they have experienced opportunistic or hit and run researchers in the past. Furthermore, given the protracted length of time from data collection to usable information (e.g., a viable and evidence-based intervention), researchers must be mindful of the current need for immediate services that families and community providers experience. The interests of our partners may not always be well served by participating in collaborative research endeavors. Financial remuneration may be one way to help ameliorate this tension, as providers are always accountable for their time in terms of dollars spent.

CBPR methodology also has been criticized for its lack of rigor, number of (uncontrolled) variables, involvement of "non-experts," the interpretation of qualitative data, and cost-effectiveness, among others. Given the presence of social workers in nearly all services relevant to the care of the military community, social work researchers should be on the forefront of generating new knowledge that can be applied to the development of effective and immediately usable psychosocial and community-based prevention and intervention for OEF/OIF populations. Few evidence-based approaches are available that address the intersecting layers of contemporary military life, family

systems, and community ecologies in support of OEF/OIF families. Although we are only one case, our preliminary work suggests that community-based participatory approaches may be especially promising toward achieving these goals in social work research.

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Psychosocial Effects of Trauma on Military Women Serving in the National Guard and Reserves

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Abstract: Women involved in all aspects of the United States Armed Forces face mental health needs that are unique from women in the general population. Because the most recent wars in Iraq and Afghanistan are involving more women in combat situations, social workers encounter female clients who are increasingly experiencing post-traumatic stress disorder, substance misuse, and sexual violence. Special attention must be paid particularly to women who serve in the National Guard or Reserves, as they have different concerns than enlisted active duty women. These concerns include less social support and fewer resources upon return from deployment. Thus, it is imperative for social workers in the community to be aware of these military women's experiences and unique mental health challenges in order to effectively treat their needs.

Keywords: Military women, military sexual assault, female service members, women in the military, National Guard, United States Reserve Component

INTRODUCTION

Who are “Military Women”?

The term “military women” has numerous meanings. Until recently, most descriptions of women involved in military life referred to wives of enlisted men, women in civilian posts within the military, or women in other non-combat related military service. This changed with Operation Desert Shield and Desert Storm in the early 1990s, when women began serving closer to the combat theatre. For example, women flew operational combat missions for the first time in 1998 (Martin, 2010). Regardless of what “military women” has meant throughout the years, one thing has remained the same: these women have been affected in some way by military involvement.

“Military women” have an extensive history of service in the Armed Forces. Women have been involved in U.S. military service since the Revolutionary War, but they did not enter all branches of the Armed Forces until World War II. In 1948, Congress allowed women to be permanent members of the military in non-war times (Alliance for National Defense, 2005). However, they stipulated that women could make up no more than 2% of the force and this was not repealed until 1967 (Alliance for National Defense, 2005). While there were women serving in the Vietnam War, most were registered nurses (Taft, Monson, Hebenstreit, King, & King, 2009). Women were not deployed to the combat theatre until the conflicts of the 1990s (Operation Desert Shield and Operation Desert

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Storm) and more recently, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (Cave, 2009).

Women currently represent approximately 10% of all U.S. armed forces in Iraq and Afghanistan (Martin, 2010). Recent surveys report women comprise approximately 15% of the U.S. military (Military Family Resource Center, 2009) and about 55% of women serving in the military are minorities (Haskell, Gordon, Mattocks, Duggal, Erdos, Justice, & Brandt, 2010). Women represent 17% of National Guard and Reserve Component members (Military Family Resource Center, 2009), 20% of new military recruits to active duty (Goldzweig, Balekian, Rolón, Yano, & Shekelle, 2006), and about 7% of the veteran population. Approximately 40% of women returning from service in Iraq and Afghanistan utilize VA health services (Haskell et al., 2010).

Enlisted women are now witnessing injuries and deaths whereas previous exposure was limited to their roles as medics or nurses, helping to heal the wounded men. Thus, in the past ten to fifteen years, researchers have been able to examine the toll of military life, especially combat, on the lives of women. However, there remains a gap in the research on military women, particularly active duty enlisted women and officers, including women in the National Guard and Reserve components. Because there has been limited research investigating the impact of military service among servicewomen, particularly deployment during wartime, and because social workers in the community will more often work with women in the National Guard and Reserve Component rather than active duty members, this paper focuses on women serving in the National Guard and Reserves of the United States Armed Forces.

Branches of the U.S. Military

Women's service in the branches of the U.S. military varies. There are differences between branches in the military with regard to types of service and mental health issues women may be likely to encounter. Women experience unique challenges depending upon the branch; some branches are known more for having a higher percentage of occupations and positions available to women (e.g., Coast Guard) and others the lowest (e.g., Marine Corps) (Alliance for National Defense, 2005). Though the size of both active and Reserve components of the military have significantly decreased since 1990, the number of women has increased for both components (Military Family Resource Center, 2009). Women comprise 17.8% of Reserve component members (Reservists), 10% of National Guard, and 14.3% of active duty members (Military Family Resource Center, 2009; Haskell et al., 2010).

Reservists, women who serve in the Reserves component of all branches of the Armed Forces, experience perhaps the greatest amount of challenges. Men and women serving in the National Guard and Reserve units are typically older than full-time enlisted soldiers and more likely to have civilian jobs or careers (Kehle & Polusny, 2010). They do not usually live around their military installation after they return home and thus typically have little postdeployment support (Kehle & Polusny, 2010), yet they comprise about half of the forces in OIF (Stetz, Castro, & Bliese, 2007). Studies have shown National Guard women and men tend to have a greater risk for post-traumatic stress

disorder (PTSD) and mental health issues than active duty personnel; in fact, approximately 42% of OIF National Guard troops and Reservists have mental health problems (Milliken, Auchterlonie, & Hoge, 2007). There has been little, if any, research on gender differences, other than sexual harassment and assault rates among Reservist women (e.g., Street, Stafford, Mahan, & Hendricks, 2008).

Service-related Trauma

Post-traumatic stress disorder (PTSD) is a common outcome of war-zone exposure. According to Shea et al. (2010) the current war efforts in Iraq and Afghanistan have led to the interest in studying post-deployment mental health issues. Shea et al. (2010) examined members of the National Guard and Reserve deploying in support of OEF and OIF, and found a strong association between PTSD and poorer psychosocial functioning. Further, they note that study participants who were unable to interact functionally in social situations had more symptoms of avoidance, distress, and hyperarousal.

PTSD can negatively impact the overall health status of female veterans. Ouimette and colleagues (2004), state that members who have PTSD typically possess poorer overall health functioning and an increased likelihood of a greater number of medical conditions, including mental health disorders like anxiety, depression, and substance abuse. PTSD can be devastating for any military service member, but women returning from deployment with the National Guard or Reserves may have an even more difficult time recovering from their condition for a variety of reasons including lack of resources and social support. The following sections highlight two main traumas associated with service-related PTSD and how women in the National Guard and Reserves can have more difficulty in recovery: combat trauma and military sexual trauma.

Combat Trauma

There is a very small body of research measuring female veterans' exposure to combat, however, as more women continue to deploy, interest in this topic has steadily increased (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007). Many military women will have direct exposure to combat operations, and as a result some will become injured, or even lose their life. The cost of war is insurmountable, and in addition to injury and death, members are at risk for developing serious mental health conditions such as posttraumatic stress disorder (Shea, Vujanovic, Mansfield, Sevin, & Fengjuan, 2010).

One of the strengths with the female veteran population is that they are more inclined than men to report combat exposure, and as a result, they are likely going to receive treatment they need; whereas male veterans may not report these issues, thus remain untreated (Zinzow et al., 2007). Even though women are more inclined to report exposure to trauma, there are still barriers to receiving this treatment, especially in a VA setting. For example, women are often reluctant to disclose military-related trauma experiences with clinicians from the VA because of the shame and stigma associated with these feelings (Zinzow et al., 2007). Additionally, service women have expressed a lack of continuity of care for military-related trauma (e.g. consistency).

Military Sexual Trauma

Sexual trauma is a traumatic experience for all women, however, women in the military experience more challenges with reporting the incident and obtaining legal and medical attention than their civilian counterparts. Oftentimes, they have to report back to their duty station and face the perpetrator every day; this situation is not as common in the general population (Suris, Lind, Kashner, Borman, & Petty, 2004). For military women, experiences of military sexual trauma (MST) often result in several co-morbid disorders such as substance abuse, depression, anxiety, and PTSD. Natelson (2009) reported that MST is a stronger predictor of PTSD among female service members than exposure to combat operations (Natelson, 2009). In fact, studies have shown that exposure to sexual trauma and harassment causes equal amounts of PTSD in women as combat exposure does to men (Natelson, 2009).

In the military, women are more often victims of sexual harassment and assault than are men (Murdoch, Pryor, Polusny, & Gackstetter, 2007). Recent reports show ranges of sexual assault from 4.2% to 7.3% for active duty women and 11% to 48% for female veterans; sexual harassment rates ranged from 55% to 79%, based on reported events (Goldzweig et al., 2006). More recent research on women veterans from OIF/OEF show 14% screened positive for MST (Haskell et al., 2010). Perpetrators can be residents of the overseas country where women are stationed, or more commonly colleagues or superiors of the enlisted women. Actual rates of assault and harassment are unclear, as many women are afraid to charge their fellow soldiers—or worse, their superiors—with crimes. Although the Armed Forces have recently put a great deal of effort into sexual assault reporting practices, women are still hesitant to bring charges.

Women are encouraged to report assault through the Sexual Assault Prevention and Response (SAPR) Program, established by the Department of Defense in 2004; however, many military regulations serve as barriers to reporting the incident. For example, the Department of Defense's two-tiered system of reporting may discourage a woman from reporting an incident. Under this two-tiered system, the report is either filed as restricted or unrestricted; both differ drastically when it comes to confidentiality and anonymity. Restricted reporting occurs when the victim's primary goal is to seek medical assistance and counseling (Williams & Kunsook, 2010). This type of reporting is said to be confidential and the victim's report remains anonymous. However, if the victim wishes to prosecute their assailant, they are required to file an unrestricted report, which is not anonymous. Unrestricted reporting impacts the victim's decision to proceed with prosecution, making it difficult for the perpetrator to be punished (Williams & Kunsook, 2010).

Female service members serving in the National Guard and Reserve components of the military have unique challenges to reporting and seeking help for MST. They often lack many of the resources that their active duty counterparts receive. Survivors of MST in the National Guard and Reserve are asked to report incidents to the chaplain's office, however limitations include issues with confidentiality and quality of care. Chaplains are often not licensed clinicians, therefore many are not qualified rape counselors. Moreover, unlike civilian women, victims of MST can rarely change their careers (Service Women's

Action Network [SWAN], 2010). If the unit's chain of command fails to enforce an equal opportunity policy, victims are forced to live in hostile environments and fear future incidences of harassment or assault. Reports show that approximately three-fourths of servicewomen who were raped did not report the assault (SWAN, 2010). Several factors influence the victim's ability to report the incident, including pressure from the victim's chain of command, the victim's efficacy in their ability to report the information, fear of the consequence from disclosing the information, and the unit's operation tempo (op tempo).

In military environments many times the perpetrators outrank their victims, as they may be supervisors or superiors. This allows higher-ranking perpetrators considerable control over the victims in the work environment (SWAN, 2010), which can create barriers to disclosing the information to medical and legal professionals. By seeking legal and medical help, the victim not only fears retaliation by her command, but she may also worry about harassment from colleagues (SWAN, 2010). Oftentimes, MST is under-reported because the victim fears that reports will jeopardize her military career. An estimated 33% of the 75% of women who did not report sexual assault did not know how to report the incident (SWAN, 2010). Additionally, many times anonymity is compromised in reporting cases of assault, as women must give their rank, gender, age, race and branch of service when submitting an assault report (SWAN, 2010). This makes reporting the case anonymously very difficult, which further outweighs the benefit of seeking medical or legal attention.

MENTAL HEALTH DISORDERS RELATED TO TRAUMA EXPERIENCE

Mood Disorders

Military women are at risk for developing anxiety and mood disorders, particularly those women deployed to combat areas (e.g., Fiedler, Ozakinci, Hallman, Wartenberg, Brewer, Barrett, & Kipen, 2006). Gulf War veterans who were exposed to combat reported higher rates of depression and anxiety than those not exposed to combat (Black, Carney, Peloso et al., 2004). A recent study of Iraq and Afghanistan soldiers revealed women were more likely to be diagnosed with depression than men (Haskell et al., 2010). Part of the gender differences are marked by female military members having more predisposing psychosocial risk factors for combat-related depression than military men, including greater prevalence of childhood abuse and adult sexual assault (Cox, Ghahramanlou-Holloway, Szeto, Greene, Engel, Wynn, Bradley, & Grammer, 2011). Additionally, gender differences can be attributed to military women having less social support than men (e.g., Vogt, Pless, King, & King, 2005). Women in the Reserves or National Guard may be at even greater risk as they have even less social networks and resources available than active duty service members (Cogan, 2011). Indeed, Smith and colleagues (Smith, Ryan, Wingard, Slymen, Sallis, & Kritz-Silverstein, 2008) found higher levels for PTSD for Reserve and National Guard members than active duty members, perhaps attributable to less social support. Thus, women in the Reserves or

National Guard may be at greater risk for developing mood disorders than women in other active duty branches.

Suicide rates and suicide attempts are also increasing (Yamane & Butler, 2009), particularly for younger active duty women (Wojcik, Akhtar, & Hassell, 2009). Weiner, Richmond, Conigliaro, and Wiebe (2011) found higher rates of suicide as cause of death for women in the military compared to women civilians; 25% of all female military deaths were attributed to suicide, which was the leading cause of death among military women. This is in contrast to a general female population prevalence of 1.6%. Suicide among men and women in the National Guard and Reserves has also increased between 2009 and 2010, again attributed to less access to military health care than their active duty peers, as well as reintegration issues that differ from active duty members (Goldstein, 2010). However, there is little research on suicide and related factors among branches of the military, and even less with regard to gender differences between branches.

Substance Abuse

Substance abuse, particularly of alcohol and prescription drugs, is a concern for women trying to cope with stressors and mental health disorders. Distinctive military conditions such as relocation overseas, separation from family, or a greater perceived acceptance of substance use, may foster higher rates among military personnel (Ames & Cunradi, 2004/2005). Although alcohol misuse is common during military enlistment, it seems to be more prevalent during times of pre-deployment (e.g., Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004), perhaps because substances are used as a coping mechanism. Deployment stress, and drinking to cope, may be a greater problem among members of the National Guard or Reservists, as they have less resources available for dealing with pre-deployment stress and have jobs and lives outside of the military (Ferrier-Auerbach, Kehle, Erbes, Arbisi, Thuras, & Polusny, 2009; Jacobson, Ryan, Hooper, Smith, Amoroso, Boyko, Gackstetter, Wells, & Bell, 2008). Burnett-Ziegler, Ilgen, Valenstein, Zivin, Gorman, Blow, Duffy, and Chermack (2011) found greater alcohol misuse among OIE/OIF National Guard men and women. Likewise, rates of postdeployment heavy alcohol use are higher for deployed men and women than for those who did not deploy (Federman, Bray, & Kroutil, 2000).

Gender differences exist with regard to alcohol and tobacco use. Military men drink more than their female counterparts (Ames & Cunradi, 2004/2005); however, among military women alcohol consumption is approximately 15% greater than alcohol consumption among civilian women. The difference between military men versus civilian men's consumption is approximately 7%. Bray and Marsden (2000) found that 5% of women in the military were heavy drinkers. A study of National Guard OIE/OIF men and women examining alcohol misuse found 23% of National Guard women reported harmful drinking (Burnett-Ziegler et al., 2011). Though gender differences were not reported, Jacobson et al. (2008) found Reserve and National Guard members who reported combat exposure to have significantly higher odds of new-onset heavy weekly drinking and binge drinking. Additionally, whereas only heavy drinking men were likely to use illegal drugs, even moderately heavy drinking women in the military are likely to

use them (Kao, Schneider, & Hoffman 2000). Thus, the difference between military and civilian women's drinking is higher than the difference between military and civilian men.

Military women serve in a male-dominated work environment, which itself is a risk factor for heavy drinking (Wallace, Sheehan, & Young-Xu, 2009). While working in a male-dominated environment is a risk factor for civilian women as well, women in the military experience additional stressors that civilian women may not (e.g., combat and related traumatic events) (Wallace et al., 2009). Military women are also less likely to use traditional coping mechanisms that civilian women are more apt to utilize to cope with stressors (Norwood, Ursano, & Gabbay, 1997). Additionally, after returning from being deployed, women who deployed were almost three times as likely to report alcohol misuse than women who were not deployed (Federman et al., 2000). Military women also have a higher prevalence of using tobacco (45%) than men or than civilian women, and the same rate as military men of heavy smoking (30%) (Bray, Fairbank & Marsden, 1999). Substance abuse programs such as TRICARE's smoking cessation program (ucanquit2.org) and a changing culture in the military that discourages heavy drinking and alcohol abuse as well as underage drinking (Wallace et al., 2009) are helping to lower rates of misuse and increase treatment options. Still, rates remain high.

Eating Disorders

Eating disorders are highly comorbid with substance use disorders, PTSD, and mood disorders (Streigel-Moore, Garvin, Dohm, & Rosenheck, 1999). Studies of service members suggest males and females participate in bulimic behaviors more than civilians (Peterson, Talcott, Kelleher, & Smith, 1995). Additionally, McNulty (1997) found a higher prevalence of anorexia, bulimia and eating disorder NOS among active duty Navy nurses than among civilians. A more recent study reported higher disordered eating patterns in enlisted women than enlisted men, and more so for soldiers who had had previous psychiatric treatment for other disorders (Warner, Warner, Matuszak, Rachal, Flynn, & Grieger, 2007).

A high percentage of enlisted women develop abnormal eating patterns or eating disorders, at a rate higher than the general population (Lauder, Williams, Campbell, Davis, & Sherman, 1999). A survey of active duty military women found 33.6% of women met criteria for being "at risk" of an eating disorder, and 27% of those at risk had a diagnosable eating disorder. Overall, there was an 8% prevalence rate of eating disorders (anorexia nervosa, bulimia nervosa and binge eating disorder) in the military, higher than the general population at about 6% (Hudson, Hiripi, Pope, & Kessler, 2007; Lauder et al., 1999).

More recent research on disordered eating among deployed military women reported no significant correlation between deployment and disordered eating (Jacobson, Smith, Smith, Keel, Amoroso, & Wells, 2009). However, women who were exposed to combat were almost twice as likely to develop disordered eating patterns and more than two times as likely to lose an extreme amount of weight, compared to men and women who were not exposed to combat (Jacobson et al., 2009). One explanation may be that women

serving in the military feel similar pressures as women athletes, to maintain certain body size and be physically active; likewise, women serving in active duty may feel similar societal pressures to be “thin” as women not serving in the military (Lauder et al., 1999). Furthermore, enlisted soldiers have fitness testing and weigh-ins periodically, and studies have shown disordered eating patterns increase around these times, including binging and purging, laxative use, and fasting (Garber, Boyer, Pollack, Chang, & Shafer, 2008). Carlton, Manos, and Van Slyke (2005) reported high rates of disordered eating among enlisted Navy women and men, with behaviors increasing before weigh-ins (“making weight”) and fitness tests. Another reason for higher prevalence among women serving in the military is using disordered eating patterns and exercise as a way to gain control over their lives and cope with stressors (Jacobson et al., 2009).

There is limited research related to eating disorders among military men and women in active duty. Moreover, few studies have been conducted specifically examining differences among branches of the military, including National Guard and Reserve components. Lauder and Campbell (2001) found that 20% of women in the Reserve officer training corps (ROTC) cadet examined had reported abnormal eating behaviors, putting them at risk for developing an eating disorder. Thus, eating disorders among women in different branches of the military remains an important area to investigate.

SOCIAL ISSUES FOR NATIONAL GUARD AND RESERVE COMPONENT MILITARY WOMEN

Reintegration into civilian life is a difficult challenge for most veterans and PTSD may increase the likelihood of readjustment problems (Sayer, Noorbaloochi, Frazier, Carlson, Gravely, & Murdoch, 2010). The Department of Defense has recognized the need for reintegration plans for active duty service members by having an established system to assist members in their transition to civilian life. However, National Guard and Reserve components had minimal plans in place for reintegration (U.S. Government Accounting Office [GAO], 2005). In 2008, congress recognized that reintegration and access to services can be particularly challenging for reserve components and so they funded the Yellow Ribbon Reintegration Program (YRRP) through the National Defense Authorization Act. Despite the growing numbers of female service members in both active duty and reserve components, many of these reintegration plans fail to incorporate services that meet distinct needs of female service members (Business Professional Women Foundation [BPW], 2007). Furthermore, the differences between components result in different reintegration needs for each.

Work

Popular media has reported on the condition of female veterans’ unemployment and career reintegration challenges (e.g., Thiruvengadam, 2011). According to the U.S. Department of Labor (2011) Gulf War II veterans, those who have served since September 2001, have an unemployment rate of 11.5%; however female Gulf War II veterans have a slightly higher unemployment rate of 12%. The U.S. Department of Defense provides the Transition Assistance Program (TAP) for reintegration back into civilian life, including some services for reserve component service members (U.S. GAO,

2005). However, these services are limited for reserve component members due to the shorter demobilization period they have and the distance from TAP services, which tend to be near major military installations (BPW, 2007). Active duty female veterans report that the TAP services are helpful acquiring a job, but long-term support is lacking where it is needed (BPW, 2007). YRRPs do provide some employment and career assistance, however neither TAP or YRRPs are mandated to provide specific programs for female service members.

Other federal programs have also been implemented to address employment issues for veterans. For example, the Department of Labor established America's Heroes at Work, a website dedicated to educating and preparing employers for hiring veterans with traumatic brain injuries or PTSD (U.S. Department of Labor, 2011). A PTSD diagnosis can greatly impact one's employability and ability to work. PTSD symptom severity tends to impact female veterans' ability to work and satisfaction with work; that is, as symptom severity increases, so do impairment and dissatisfaction (Schnurr & Lunney, 2011). Unemployment and PTSD symptoms are risk factors for homelessness in female veterans (Washington, Kleimann, Michelini, Kleimann, & Canning, 2010), which is a serious issue considering that one in four female veterans are homeless (Gamache, Rosenheck, & Tessler, 2003).

Social Network

Social support is an important aspect affecting the risk of developing PTSD among veterans. Vogt et al. (2011) report that social support is a greater mediator of PTSD symptoms for female veterans than for male. Related to post-deployment social support, veterans who reported more concern for relationships during deployment were also strongly related to PTSD symptoms and this is, again, stronger for female veterans (Vogt, Smith, Elwy, Martin, Schultz, Drainoni, & Eisen, 2011). Relationship concerns may be valid for some female service members; the rate of divorce is higher for female service members than it is for male service members (Karney & Crown, 2007). This increased rate is stable across service component and rank (Karney & Crown, 2007). Overall, the divorce rate is higher among military service members (Karney & Crown, 2007), but marriage in the armed forces differs compared to civilian marriage patterns (Hogan & Furst-Seifert, 2009). Military personnel with active-duty experience are three times more likely to marry between the ages of 23 and 25 compared to civilians, and military personnel who have served more than two years in active duty are significantly more likely to be divorced (Hogan & Furst-Seifert, 2009).

Members of the National Guard and Reserve often *volunteer* for deployments, as opposed to being called for duty, which further increases partners' stress. They typically do not associate themselves as being a "military family" which alienates them from the military culture and also their access to support (Huebner et al., 2010). Faber, Willerton, Clymer, MacDermid, and Weiss (2008) suggested Reserve component families experienced role confusion during the member's deployment and military family support groups provided assistance to families while adjusting to deployment and reunification. Resources that help families adjust and cope with deployment are often not available because Guardsmen and Reservists are "geographically dispersed" throughout their states

and are typically not close to their duty stations (Huebner, Mancini, Wade, McElhaney, Wiles, Butler, & Ford, 2010). This could potentially reduce the amount of resources available to the family because they are less likely to have access to services and programs and may not be able to associate with a network of people who are experiencing the same deployment frustrations (Huebner et al., 2010).

Access to Care

Women have repeatedly reported that the VA system lacks appropriate services for women's health (Kelly, Vogt, Scheiderer, Ouimette, Daley, Wolfe, et al., 2008). Throughout the last four decades, reforms have been introduced in order to meet the rising demand for female-centered care. The number of female service members is at an all-time high, which has resulted in an even greater demand for appropriate care. Despite reforms, gender disparities still exist at the expense of women's health.

As noted, the impact of MST has resounding effects on female veterans' access to health care and general health. Repeated violence against female veterans was linked to an increased use in health care (Booth, Falk, Segal, & Segal, 2004). Women who experience MST also report a greater difficulty in readjustment, compared to female members without a history of military sexual trauma (Katz, Bloor, Cojucar, & Draper, 2007). Despite the detrimental impact of sexual trauma, female veterans reported a greater perceived difficulty in accessing VA health care and they cited impediments to receiving quality care, such as problems with VA staff and a lack of services fit for addressing the needs of female veterans (Kelly et al., 2008).

Military members of both genders reported a perceived lack of competence of military health care services, though female members specifically emphasized a lack of female centered knowledge (Jennings, Loan, Heiner, Hemman, & Swanson, 2005). Washington, et al. (2007) reported that female veterans lack an awareness of VA health care entitlements and access and they also reported they felt the VA health care system lacked gender specific sensitivity and competence. Female veterans' perceptions of gender-specific care has been reported in VA mental health care as well; that is, female veterans with PTSD have reported that women-centered treatment was the most important factor contributing to their comfort with VA services (Fontana & Rosenheck, 2006).

Gender differences exist in issues related to VA mental health care services in addition to those reported for the health care system at large. Proportionately, women have slightly more mental health concerns than men (Hoge et al., 2006) and women veterans' mental health diagnoses differ in type (Fontana, Rosenheck, & Desai, 2010). Congruent with reports that women experience more MST during service, women attributed their PTSD most often to MST, whereas men reported combat related exposure as the most prevalent cause for PTSD (Fontana et al., 2010). Service access differs between genders, in that women tend to seek services on an outpatient basis especially women who have comorbid physical and mental health problems (Frayne, Yu, Yano, et al., 2007). Though a body of literature is beginning to accumulate regarding female veterans' experiences with the VA health care system, fewer studies have specifically

focused on women in reserve components or reserve members' families. Reserve component members reported more health concerns, referrals to mental health care, interpersonal conflicts, PTSD, depression, and other mental health risks than active duty members (Milliken et al., 2007).

Among existing resources and programs provided to reserve members and their families is the YRRP. The program was created to support service members and their families through each phase of deployment: Pre-deployment, during deployment and Post-deployment. Additionally, programs for communities and service members' employers upon re-deployment or release from active duty are offered to help with successful reintegration (National Guard Bureau Joint Support Services, 2010). Services include education and assistance with TRICARE, the military's insurance plan, and Veterans Affairs Benefits such as health services, classes in anger management and substance abuse prevention, personal safety education including domestic violence awareness and services, along with more specialized issues which are unique to married and single service members (National Guard Bureau Joint Support Services, 2010). Additionally, the National Guard Bureau offers a Psychological Health Program, developed to focus on the challenges unique to National Guard service members. Because National Guard armories and wings are typically more community-based and not located near military treatment facilities (e.g., Veterans Administration hospitals and services), programs such as the Psychological Health Program provide these necessary services. The uniqueness of the National Guard members' lives as civilians prior to and after deployment necessitates reliance on community resources to help them reintegrate and adjust from military life to civilian life (National Guard Bureau Joint Support Services, 2010).

WHERE DO WE GO FROM HERE? A RESEARCH AND SERVICE AGENDA

This paper has highlighted issues that women serving in the Reserve Component and National Guard experience that are unique to other women in the military. Though these women encounter some similar issues as their male counterparts, they are at risk for additional problems including sexual assault, interpersonal violence, higher rates of eating disorders and substance use disorders. Similarly, women in these two military branches experience more difficulties than active duty women with regard to social supports, access to healthcare, and higher rates of suicide and other mental health issues.

Military women, particularly those in the National Guard and Reserves, also have fewer services available to them than men. The need exists for more specialized services to women, more research on women's substance misuse, mental health and sexual assault issues. There needs to be a more gendered approach to services, as the number of women who will use VA services is projected to double within five years (Maze, 2010). Additionally, there needs to be an increase in the awareness focused on the unique needs of military women, particularly those serving in branches like the National Guard and Reserves where many military health and support services are not available or easily accessible.

Social workers are important to improving service availability and utilization. Social workers who work within the VA system, as well as those in the general population who are not specifically oriented to veterans or military members' issues, need to be educated on the unique mental health concerns of all military women, while serving in the military and after deployment. Social workers need to provide services or referral mechanisms for women to reintegrate to their lives after deployment. These services can include helping women cope with PTSD and combat-related anxiety, MST-related PTSD and depression, family issues, financial concerns, substance misuse, eating disorders, traumatic brain injuries, and other physical injuries. Social workers are particularly well suited to conduct community-based group therapy sessions, family therapy sessions, psychoeducation programs, and workshops that can help military women heal.

Federal funding agencies are beginning to understand the need for more research into military health and mental health, but more focus needs to be placed on gender differences and women-specific issues. Women's issues have not been researched well or extensively; while there is quite a substantial body of literature on military men's mental and physical health issues and the effects of combat and deployment on men, there is a paucity of research with regard to women. As more data exists from women's more extensive military service in the past two decades, we need to examine the effects of military life on women. Similarly, as the OEF/OIF wars marked the first time National Guard and Reservists were deployed for active service during combat, much research is needed that will focus on the unique challenges these women face predeployment and upon returning home.

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**Assessment of PTSD in Older Veterans:
The Posttraumatic Stress Disorder Checklist: Military Version (PCL-M)**

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Abstract: The Posttraumatic Stress Disorder (PTSD) Checklist: Military Version (PCL-M) is a 17-item, self-report measure of PTSD symptomatology in military veterans and provides one total score and four subscale scores for older veterans' PTSD (re-experiencing, avoiding, numbing, and hyperarousal symptoms). Study subjects are 456 male veterans over 55-years old with deployed experiences selected from a larger survey data by Veterans' Affairs Canada (VAC). This study found that overall scale reliability was excellent with alpha of .93 and subscale alphas ranging from .81 to .90. Confirmatory Factor Analysis (CFA) confirmed the best fit of four first-order factor model. Criterion validity was confirmed through significant associations of the PCL-M scores with well-established measures of depression, substance abuse, and general health indices. The PCL-M is recommended as a reliable and valid tool for the clinical and empirical assessment of screening PTSD symptomatology, specifically related to older veterans' military experiences.

Keywords: Military Veterans; PTSD; Retrospective study; PCL-M; Canadian

INTRODUCTION

Since the 1970s, there has been a vital demographic trend in the Veterans Administration (VA). Although the total number of veterans is declining, the proportion of older veterans is increasing dramatically (Richardson & Waldrop, 2003). Additionally, the proportion of older persons in the veteran population far exceeds the proportion of older persons in the U.S. population. Much of the VA's efforts are rightly focused on the emerging needs of recent veterans from the wars in Afghanistan and Iraq. However, there is a paucity of research on the psychological and physical needs of aging veterans.

In 2000, the median age of veterans was fifty-seven years, fifty-four in Canada (Veterans Affairs Canada, 1999), compared to only thirty-six years for the general U. S. population and 39 years for Canadians (Administration on Aging, 1999). Over 37 percent of the veteran population (9.5 million of the total 25.5 million veterans) was age sixty-five or older, compared to 13 percent of the general population. By 2020, nearly half of the entire veteran population (7.6 million, or 45 percent, of the total 16.9 million

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veterans) will be age sixty-five or older. Although most are male, the number of female veterans is growing. In 2000, over 5 percent (1.4 million) of all veterans and 3 percent (325,000) of veterans age sixty-five or older were female. By 2020, over 9 percent (1.6 million) of all veterans and 4 percent (316,000) of veterans age sixty-five or older will be female. Among female veterans, the proportion age sixty-five or older was 23 percent in 2000 and is projected to be 20 percent in 2020. As in the general U.S. population, the "old-old" are the fastest-growing segment of the veteran population. By 2020, 6 percent of all veterans and 13 percent of veterans age sixty-five or older will be age eighty-five or older (1.1 million). Thus, VA and VAC will continue to encounter a very large group of potentially frail, older veterans in the next twenty years (Fitretoglu, Liu, Pedlar, & Brunet, 2007).

One of the significant psychiatric conditions resulting from exposure to traumatic events such as conflict and war zone exposure is PTSD. The *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* 2000 (American Psychiatric Association, 2000) criteria for PTSD requires exposure to a traumatic event involving actual or threatened death or serious injury. Multiple categories of traumatic events have been considered for PTSD that includes cancer, sexual harassment, hurricanes, and military peacekeeping operations (Asmundson, Stein, & McCreary, 2002; Dirkzwager, Bramsen, & Van Der Ploeg, 2005; DuHamel, et al., 2004; Forbes, Creamer, Hawthorne, Allen, & McHugh, 2003; Gray, Bolton, & Litz, 2004; Palmieri & Fitzgerald, 2005; Richardson, Naifeh, & Elhai, 2007). Categories, notwithstanding, the event must produce a response of intense fear, helplessness, or horror (Criteria A), and the experience of as many as 17 symptoms that are categorized in three symptom clusters: re-experiencing (Criteria B), avoidance or numbing (Criteria C), and arousal (Criteria D). The formal diagnosis of PTSD requires that an individual experience at least one of five re-experiencing symptoms, three of the seven avoidance or numbing symptoms, and two of five arousal symptoms and that the symptoms experienced have a duration of greater than one month (Criteria E). Additionally, the psychological disturbance causes significant distress or impairment in important areas of functioning such as social and occupational (Criteria F).

PTSD is associated with other psychological and emotional problems (Asmundson, Frombach, McQuaid, Pedrelli, Lenox, & Stein, 2000; Asmundson, Wright, McCreary, & Pedlar, 2003; Mehlum & Weisaeth, 2002). Frequently co-morbidity with depression, anxiety, and alcohol and substance use has been studied (Asmundson, et al., 2002; Forbes, et al., 2003; Yarvis, Bordnick, Spivey, & Pedlar, 2005; Yarvis & Schiess, 2008). Major depression was the most common co-morbid diagnosis, occurring in just under half of men and women with PTSD in the National Co-morbidity Survey (Kessler, Sonnega, Bromet, Huges, & Nelson, 1995). Additionally, PTSD was the primary diagnosis associated with the majority of cases in the development of affective disorders and substance use disorders (Kessler, et al. 1995). Persons with preexisting major depression had an increased and twofold risk for subsequent exposure to traumatic events and pre-existing depression increased the risk of PTSD among exposed persons more than threefold (Breslau, Davis, Peterson, & Schultz, 2000). Further, the wars in Afghanistan and Iraq have resulted in higher mental health utilization by U.S. Veterans (Hoge, Auchterlonie, & Milliken, 2006).

As wars and conflicts continue, there is increasing concern for soldiers in combat zones, many of whom are at high-risk for PTSD (e.g., Gray, Bolton, & Litz, 2004; Helmer, Rossignol, Agarwal, Teichman, & Lange, 2007). Given rising deployments of military forces on asymmetric missions to various conflict zones, it is important to better understand the risk factors for PTSD of these veterans. Research on the prevalence of traumatic exposure has tended to focus on younger populations. Specifically, there is a need for research regarding PTSD identification in older veterans (Cook, Elhai, Cassidy, Ruzek, Ram, & Sheikh, 2005). The goal of this study about trauma and its effect in older adults, especially veterans and recent war veterans is to contribute to a knowledge gap. The specific purpose of the present study is to evaluate the overall psychometric properties of the PCL-M using the sample of old Canadian peacekeepers.

MATERIALS

The PTSD Checklist (PCL) was developed by Frank W. Weathers and colleagues at the National Center for PTSD (Weathers, Litz, Herman, Huska, & Keane,) and has three adult versions, the military (PCL-M), civilian, unspecified event (PCL-C), and the civilian, specified event (PCL-S). The PCL-M is an adult 17-item self-report instrument that assesses PTSD symptoms in relation to stressful military experiences. Respondents rate each item from 1 ("not at all") to 5 ("extremely") to indicate the degree to which they have been bothered by that particular symptom over the past month. Thus, total possible scores range from 17 to 85. PTSD symptom severity scores are determined by summing the participants' answers to all 17 items. The standard procedure for determining PTSD is to compute the questionnaire's three subscales: re-experiencing, avoidance/numbing, and hyper-arousal. When the PCL-M is used as a continuous measure, a cut-off score of 3 or more for each item is the most appropriate (Forbes, Creamer, & Biddle, 2001; 1993Weathers et al., 1993). A cutoff score of 50 on the PCL-M yielded a sensitivity of .82, specificity of .83, and a $K = .64$ in the original sample of U.S. Vietnam and Gulf War veterans (Weathers, et al. 1993). However, other subsequent studies with different populations have suggested that lower cutoff scores, 30, 31, 37, and 38 more accurately identify individuals with PTSD respectively (Andrykowski, Cordova, Studts, & Miller, 1998; Cook, Elhai, & Arean, 2005; Dobie, et al., 2002; Yeager, Magruder, Knapp, Nicholas, & Frueh, 2007).

The PCL has proven to be a psychometrically sound instrument for screening PTSD (Weathers, et. al, 1993). The test retest reliability was $.96$, $\alpha = .93$ for Criteria B symptoms, $\alpha = .92$ for Criteria C symptoms, $\alpha = .92$ for Criteria D symptoms, with an overall $\alpha = .97$ for all items (Weathers, et al., 1993). Another study reported similar internal consistency values (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). It is noted that there has been no normative data published. According to Asmundson's study (Asmundson, et al., 2000), the PCL-M has good contrasted-groups validity and sound convergent validity. Strong correlations have been shown between the overall PCL-M and other scales designated to measure PTSD (i.e., $r = .93$ with the Mississippi Scale for Combat-related PTSD (Keane, Caddell, & Taylor, 1988); $r = .90$ with the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979)).

There are constant debates on the construct validity. The *DSM-IV*'s factor structure of PTSD is a higher-order 3-factor model with three first-order symptom factors and a second order PTSD factor. Some researchers using Confirmatory Factor Analysis (CFA) find that PTSD data fits 4-factor models better (Asmundson, et al., 2002; Asmundson, et al., 2003; Simms, Watson, & Doebbeling, 2002). Elkut and Shevlin (2007) tested a four-factor PTSD model that was re-structured using the *DSM-IV*'s 3-factor structure. These factors include re-experience, avoidance, dysphoria, and arousal. There is also evidence that two-factor solutions may have utility as well. Two studies reported that a 2-factor model consisting of one overarching (second-order) latent factor (posttraumatic stress) and two first-order factors of re-experiencing and avoidance (items B1-B5 and items C1-C2) and numbing and arousal (items D1- D5 and C3- C7) was a better fit (Buckley, Blanchard, and Hickling, 1998; Taylor, Kuch, Koch, Crockett, & Passey, 1998). Simms and colleagues (2002) predicted that factors representing non-specific components of PTSD would have the highest associations with variables representing depressive symptomatology. Asmundson and colleagues (2003) suggest that PTSD symptoms in military veterans can be adequately conceptualized using hierarchical two-factor or four-factor inter-correlated models.

Several recent studies have focused on measuring PTSD symptomatology in older adults as an indicator of the impact of trauma using the PCL (Cook, Elhai, & Arean 2005; Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Cook, Elhai, Cassidy, et.al., 2005; Schinka, Brown, Borenstein, & Mortimer, 2007; Schnurr, Spiro, Vielhauer, Findler, & Hamblen, 2002). A CFA of the PCL conducted with a sample of elderly hurricane survivors (Schinka, et al., 2007) revealed the strongest model support for an intercorrelated 4-factor model comprised of re-experiencing, avoidance, numbing, and arousal factors. Similarly, this array of factors, supported by Keen (Keen, Kutter, Niles, & Krinsley, 2008) in their study of male veterans suggested the avoidance and numbing symptoms of Cluster C are more distinct than they are similar. However, there have been limited studies, which have specifically investigated PTSD in veterans of peacekeeping missions and from the conflicts in Iraq and Afghanistan (Richardson, et al., 2007). Few have studied the PCL-M with older veterans. Additional research is needed to further the understanding and knowledge base regarding the PTSD symptom structure in the context of chronic, repeated, and varied trauma exposures in peacekeeper populations.

The purposes of this study are to (1) investigate the prevalence and severity of PTSD among older Canadian peacekeepers with deployed experiences, (2) evaluate the overall psychometric properties of the PCL-M with older male veterans, and (3) confirm factor structure of the PCL-M with testing alternative CFA models drawn from previous studies.

Source of Data

The present study used the secondary data as part of a health status assessment conducted by VAC. With permission from the Department of National Defense Canada and the Research Director of VAC, Prince Edward Island, VAC provided data to the first author in 2004. The data used was based on a mail-out survey conducted September through December, 1999 by the Review of Veterans' Care Needs Project, VAC. The

dataset received from the VAC contained 1968 observations (1856 male, 112 female) consisting of 411 variables from a questionnaire given to Canadian military personnel in the fall, 1999. This survey was restricted to VAC pensioners living in Canada and was originally conceptualized to address gaps in support and services. Creactic+, a Montreal based research firm, reported a 72 percent response rate, and 96 percent of the respondents filled out the questionnaire on their own. Thus, the current sample of respondents is considered to be representative of the VAC Canadian Force (CF) population (Asmundson, et al., 2000). For the present research, study subjects included 456 male United Nations peacekeepers over the age of 55 years. This sample was selected from a larger sample of 1968 regular and reserve force Canadian military personnel with three criteria: being male, having been deployed overseas to a conflict more than one time, and being 55 years or older.

Measurement

The original survey was comprised of 411 variables with seven domains. For the purposes of this study, in addition to the PCL-M, only major selected variables were described as below.

Center for Epidemiologic Studies-Depression (CES-D) Scale (Radloff, 1977): Canadian veteran's depression was assessed with the CES-D, a 20 item self-report scale of depressive symptoms according to frequency of occurrence from less than 1 day per week to 5-7 days per week. The CES-D has been reported to have good reliability in studies with the elderly (Radloff & Terri 1986) and provided good agreement with other measures of depression. Total scores range from 0 to 60, with higher scores indicating more depressive symptoms. The mean score for both younger and older adult subjects in the general population respectively is 9, with 16, a useful cut-off for screening subjects who likely experience a significant level of depression (Radloff & Terri, 1986). In this study, the Cronbach alpha is .905 and the mean CES-D score for older male veterans with deployed experience is 13.84 (SD =7.53, range = 0 - 60), indicating that overall older veterans were more depressed than that of the general population. Accordingly, with the 16 cut-off score, approximately 27.8 % of the total sample can be diagnosed as seriously depressed.

Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organization for multinational use in primary care settings and evaluated over a period of two decades (World Health Organization, 2001). As a core screening assessment tool, the original AUDIT consists of 10 questions about recent alcohol use, alcohol dependence symptoms, and alcohol-related problems. The AUDIT was validated on primary health care patients in six countries. In comparison to other screening tests, the AUDIT has been found to perform equally well or at a higher degree of accuracy across a wide variety of criterion measures such as MAST ($r=.88$) and CAGE ($r=.78$) (WHO, 2001). A test-retest reliability study indicated higher reliability ($r=.86$) in a sample consisting of non-hazardous drinkers. In this study, two domains were created to separately assess frequency of use and dependency. Alcohol use and problems via the AUDIT are summarized in the 1999 Regular Forces Dataset by the variables QFINDEX and ALCPROB. The QFINDEX included questions pertaining to how frequently alcohol

is consumed during a specific time period and how many drinks are consumed on a typical drinking occasion. The ALCPROB focused on “alcohol-related” problems with questions related to problems with alcohol and negative consequences linked from alcohol consumption (i.e. going to work intoxicated). The overall alpha level is .802.

General Health Indices consisted of three components. A single question was used to measure self-rated *health status*. For example, the question (“Compared to other people your age, would you say that in general your health is?”) had four possible answers from 1 (excellent) to 4 (poor). In a previous study, a one-item measure of perceived health was found to be correlated positively and significantly with the overall score of a 20-item health-related quality of life measure with established validity and reliability (Musick, 1996). The second component included queries of older veterans on the possibility of them having any long-term conditions diagnosed by a health professional among 21 specific conditions on a list. This list included common physical problems among older adults, such as Arthritis and Rheumatism, Depression, Diabetes, High Blood Pressure, vision and hearing problems. Consistent with the other outcome variables, a higher score on the scale indicates a worse overall perceived health status. Lastly, the respondents were asked to answer how many medications, both prescribed and non-prescribed they are currently taking.

Data Analysis

Data analysis consisted of a CFA of the two, three, and four factor, latent variable models. CFA involved a structural equation model (SEM) using the PRELIS 2.8 and LISREL 8.8. By default, the LISREL uses the maximum likelihood (ML) method of parameter estimation. Several researchers supported the argument that ML is found to perform well under less than optimal analytical conditions (for example, small sample sizes and modest departures from multivariate normality) (Kline, 2011). Thus, considering a moderate abnormal distribution of the data, ML is adopted to be a reasonable estimation method for this study. Several measurement models were tested using LISREL Version 8.80 with a covariance matrix generated by PRELIS Version 2.8.

The goodness of fit statistics used in the present study to assess model fit are as follows: (1) Chi-square (χ^2) and degree of freedom (df), (2) the Goodness-of-Fit Index (GFI), (3) the Comparative Fit Index (CFI), (4) the Non-Normed Fit Index (NNFI), (5) the Root Mean Square Error of Approximation (RMSEA) which all fit measures that are well explained in most cited textbooks (Kline, 2011). Chi-square (χ^2) as the traditional absolute fit measure is used to test the closeness of fit between the hypothesized model and the perfect fit (Kline, 2011). A smaller χ^2 value is indicative of good fit, whereas a large value reflects poor fit (Hu & Bentler, 1999). As with the GFI, values of CFI range from zero to 1.00, with values closer to 1.00 and are indicative of good fit, and .90 is the ‘critical value’ that indicates acceptable fit (Mueller & Hancock, 2007). Similar to the CFI, the NNFI compares how much better the model fits compared to a baseline model (Hu & Bentler, 1999; Kline, 2011). Finally, by taking into account the error of approximation in the population, the RMSEA’s values of less than .05 indicates a good fit, values as high as .08 represent reasonable errors of approximation in the population, and values above .10 indicate mediocre fit (Hu & Bentler, 1999). Because different

indices reflect different aspects of model fit, researchers typically report the values of multiple indices as mentioned above.

RESULTS

Table 1 presents sample characteristics. The majority of the selected sample is Anglo (88.2%). In the highest level of education and training, persons not completing secondary schooling are 34.7% (n=150), completed high school (n=98, 22.7%), some post-secondary education (n=85, 18.6%), completed diploma and post secondary (n=74, 16.2%). Around 90% of participants are married under common law. Regarding present rank or rank on their release, non-commissioned officers are the majority (n=308, 67.5%) and both senior and junior officers are 25% (n=103). The average number of unique deployment is 1.37 ($SD = .647$) with the average number of years served being 20 years ($SD = 12$ yrs). Forty-two percent have a total individual income of less than \$20,000 in the previous year, 24.3% have an income between \$20,001 and \$30,000, 18.2% between \$30,001 and \$40,000, and 13.2% between \$40,001 and \$50,000.

Table 1 also consists of descriptive statistics of selected variables. In the single-item reporting self-rated health condition, the majority of respondents assessed their general health condition as either good (37.5%) or fair (37.9%), while 71 persons (15.6%) rate ‘poor’. Out of a total of 21 physical health conditions, the mean number is 3.63 ($SD = 2.17$) with a score range between 0 and 14. Forty-one percent of respondents report having unspecified other long-term conditions (n=175), the top three of which are Arthritis or Rheumatism (62.9%), back problems excluding Arthritis (60%), and High Blood Pressure (30.8%). Concerning more critical chronic conditions, 14.4% of respondents are suffering with Diabetes, while with Heart Disease (20.3%), even Cancer (7.1%), and Stroke (6.6%).

Table 2 summarizes descriptive results of individual items for each factor, the mean and standard deviations with score range and distribution. As stated earlier, instruction starts with how each problem may or may not have affected you and following questions like “Had repeated disturbing dreams of your military experiences?” and score ranges from 1 to 5, with 1 indicating *no* and 5 indicating *extremely*. The mean score for the severity ratings on the total score is 23.73 ($SD = 8.72$, range = 17~83). The descriptive statistics on the subscales are as follows: Re-experiencing ($M = 6.80$, $SD = 3.78$), Avoiding ($M = 2.60$, $SD = 1.58$), Numbing ($M = 7.03$, $SD = 3.5$), and Hyper-arousal ($M = 8.39$, $SD = 4.40$). Among individual items, the rating of two items – sleep difficulties and diminished interests – are relatively higher than others.

Table1: Descriptive Statistics of Selected Variables (N=456)

Variables	Number	(%)	Range	Mean	(SD)
<i>Demographics</i>					
Age			55-76 years old	60.53	(3.116)
Education:					
Secondary Not completed	150	(32.9)			
Completed Secondary	98	(21.5)			
Some Post-Secondary	85	(18.6)			
Completed Diploma	74	(16.2)			
Complete Bachelor +	25	(05.5)			
Individual Income					
Less than \$19,999	78	(17.1)			
\$20,000 and \$29,999	111	(24.3)			
\$30,000 and \$39,000	83	(18.2)			
\$40,000 and 49,000	60	(13.2)			
\$50,000 over	55	(09.3)			
Marital Status					
Married/Common Law	407	(89.3)			
Not Married	48	(10.5)			
<i>Military-Related</i>					
Number of Years Served			1-45	19.89	(11.86)
Number of Deployments			1-4	1.74	(0.942)
<i>Health-Related</i>					
General Health Index					
Excellent	37	(08.1)			
Good	171	(37.5)			
Fair	173	(37.9)			
Poor	71	(15.6)			
Number of Health Problems					
Arthritis or rheumatism	275	(62.9)			
Back problem	263	(60.0)			
High blood pressure	135	(30.8)			
Cancer	31	(07.1)			
Number of Medications					
			0-25	3.02	(3.171)
Alcohol Problems (AUDIT)					
QFINDEX			9-35	11.61	(2.65)
ALCPROB			2-10	3.60	(1.61)
Depression (CES-D)					
			7-35	7.57	(1.54)
			0-60	13.84	(7.53)

Table 2: Prevalence of the PTSD (N = 456)

Items (PCLM1-17)	Range	Mean	SD	Skewness	Kurtosis
Re-experiencing (Factor 1)	20	6.80	3.77		
1: Intrusive memories	4	1.49	1.01	1.928	2.406
2: Nightmares	4	1.39	.91	2.299	4.200
3: Flashbacks	4	1.25	.73	3.095	9.064
4: Psycho. Distress	4	1.48	1.04	2.069	3.097
5: Psycho. Reactivity	4	1.32	.84	2.609	5.885
Avoiding (Factor 2)	8	2.60	1.57		
6. Thoughts/Feelings	4	1.31	.85	2.749	6.512
7: Activities/Places/People	4	1.31	.87	2.844	6.997
Numbing (Factor 3)	19	7.03	3.52		
8: Trauma-Related Amnesia	4	1.33	.84	2.648	6.058
9: Diminished Interest	4	1.69	1.14	1.354	0.360
10: Detachment	4	1.38	.90	2.392	4.828
11: Restricted Affect	4	1.27	.78	3.050	8.565
12: Foreshortened Future	4	1.46	1.05	2.149	3.266
Hyper-arousal (Factor 4)	20	8.39	4.39		
13: Sleep difficulty	4	2.23	1.46	0.610	-1.218
14: Irritability/Anger	4	1.63	1.06	1.585	1.436
15: Difficulty Concentrating	4	1.63	1.009	1.549	1.134
16: Hypervigilance	4	1.41	.98	2.259	3.787
17: Exaggerated Startle	4	1.52	1.06	1.880	2.236
PCLM Total	66	23.73	10.25	2.260	5.780

Table 3 lists internal consistency established by means of Cronbach's alpha coefficients for frequency total and subscale scores, which were very good (.810) and excellent (.926). The alphas represent the shared variance of the items within each factor. In contrast, the squares of intercorrelations of the subscales represent the shared variances across scales. This suggests that the subscales measured independent and distinct phenomena (Mueller & Hancock, 2007). Similarly, intercorrelations among subscales are lower than internal consistency alphas.

Table 3: Correlation Matrix among Subscales with Reliability

Factor Names	1	2	3	4	Total
Reexperiencing (F1)	1.00				
Avoiding (F2)	.676**	1.00			
Numbing (F3)	.702**	.622**	1.00		
Hyper-arousal (F4)	.654**	.540**	.795**	1.00	
PCLM Total Reliability (Cronbach's Alpha)	.902	.838	.810	.835	.926

** Correlation is significant at $p < .01$ (1-tailed)

Table 4 presents structural elements of the model such as factor loadings with t-values, and squared multiple correlations. Each PTSD item loads on its latent factor with factors ranging from .38 to .87, which are all statistically significant with t-values ranging from 10.71 to 17.34. The R^2 values range from .32 to .68, indicating between 32% and 68% of the variance on individual items can be accounted for by the latent factor to which they are consigned. Considering results that the selected fit indices reflect a good-fitting model and the factor loadings are statistically significant, the result confirms the factor structure of the PCL-M.

Table 5 summarizes the fit statistics comparing the results of different models. As most experts in SEM (Kline, 2011) have addressed that good model fit should not be interpreted as having 'truly proven' the hypothetical model, we tested several equivalent models which were published in previous studies with different samples. Considering theoretical and practical provision among five competing models, the four-factor inter-correlated model (4-factor 1st order model) is the best fitted model ($\chi^2 / df = 3.663$, RMSEA = .080, CFI = .97, IFI = .97) based on the cut-off mentioned above. The 3-factor model and 4-factor second-order model are also found to have a satisfactory fit with a cut-off of CFI, NFI, & IFI $> .95$.

To establish convergent validity, a further Pearson correlation matrix (Table 6) shows statistically significant relationships between the four sub scales and related psychological and physical health conditions. As expected, the relationship between PTSD and depression are strongly and significantly correlated ($r = .726$). With one insignificant relation between alcohol problems and avoiding symptoms, the total PTSD score is also statistically significantly associated with Alcohol problems ($r = .219$), General Health ($r = .359$), and total number of Medications ($r = .435$) at the significance level of .001. To test concurrent validity, a t-test and f-test were used to clarify the relationship between the mean score on the PCL-M and the selected demographic variables.

Table 4: Factor Loadings (Path Coefficient (β), T-values (t), and R^2)

Items (PCLM 1-17)	Re-Experiencing	Avoiding	Numbing	Hyper-Arousal	R^2
1: Intrusive memories	.70 (17.42)				.66
2: Nightmares	.59 (16.94)				.64
3: Flashbacks	.48 (15.52)				.56
4: Psychological Distress	.76 (17.34)				.66
5: Psychological Reactivity	.54 (16.09)				.59
6: Thoughts/Feelings		.58 (15.64)			.63
7: Activities/Places/People		.56 (16.04)			.66
8: Trauma-Related Amnesia			.44 (10.71)		.32
9: Diminished Interest			.75 (13.89)		.48
10: Detachment			.59 (14.82)		.53
11: Restricted Affect			.38 (11.78)		.37
12: Foreshortened Future			.71 (15.35)		.56
13: Sleep difficulty				.87 (11.82)	.38
14: Irritability/Anger				.64 (13.35)	.46
15: Difficulty Concentrating				.85 (17.59)	.68
16: Hypervigilance				.60 (14.45)	.51
17: Exaggerated Startle				.75 (15.34)	.56

Note: All path coefficients are significant

Table 5: Summary of Fit Statistics with ML Estimation Method from Different Models

Models	χ^2	df	$\chi^2/\text{df ratio}$	SRMR	GFI	AGFI	AIC	RMSEA	CFI	NFI	IFI
2-Factor A	607.02	118	5.161	.070	.81	.75	727.23	.118	.95	.93	.95
2-Factor B	663.07	118	5.619	.074	.79	.72	825.09	.128	.94	.93	.94
3-Factor	486.09	116	4.190	.059	.86	.81	540.28	.096	.96	.95	.96
4-Factor A	374.57	113	3.315	.047	.89	.85	433.22	.080	.97	.96	.97
4-Factor B	421.29	115	3.663	.057	.88	.84	471.52	.086	.97	.95	.97

Table 6: Convergent and Discriminant Analyses

Variables Name	Full PCLM	Re-experience	Avoiding	Numbing	Hyper-arousal
Convergent					
Depression	.726**	.570**	.464**	.715**	.721**
Alcohol Problem	.219**	.165**	.063 ns	.210**	.342**
General Health	.359**	.245**	.189**	.396**	.413**
Total # of Medication	.435**	.277**	.182***	.373***	.437***
Discriminant					
Education	.003 ns	.008 ns	.054 ns	-.025 ns	-.055 ns
Income	-.195**	-.170**	-.059 ns	-.214**	-.203**
Marital Status	.114*	.024	-.027 ns	.210**	.103**
# of Household	.058 ns	.050 ns	.033 ns	.293 ns	.084 ns

Notes: **Correlation is Significant 0.01 level (1-tailed)

* Correlation is significant at the 0.05 level (1-tailed)

ns = not significant

DISCUSSION

The present study provides additional support for the PCL-M as a highly reliable and valid measure of PTSD symptomatology. Further, the CFA result supports other research suggesting that avoidance and numbing symptoms of cluster C are more distinct than they are similar. The use of valid and reliable self-report PTSD instruments such as the PCL-M can improve the recognition, identification and diagnosis of PTSD. Consequently, the PCL-M may aid in the design of subsequent treatments for trauma survivors. An alternative model of PTSD indicating the separation of the DSM-IV symptoms of avoidance and numbing may be useful in structuring and developing treatment plans. The interrelationships between PTSD symptoms in designing and implementing treatment interventions may be important to consider given the support for factor solutions that link re-experiencing and avoidance or hyper-arousal and numbing as second order.

Consideration of alternative models of the structure of PTSD has important implications for clinical practice. Recently, researchers have suggested that treatment for persons diagnosed with PTSD may need to be customized to particular types of symptom presentations (Palmieri & Fitzgerald, 2005). For example, there is some evidence to suggest that cognitive-behavioral treatment for PTSD may be less effective for individuals with higher levels of pre-treatment emotional numbing (Taylor, Federoff, Koch, Thordarson, Ecteau, & Nicki, 2001). In subsequent research, Taylor and his colleagues found that using exposure therapy may show greater utility in symptom reduction for effortful avoidance than with symptoms of emotional numbing (Taylor, Thordarson, Maxfield, Federoff, Lovell, & Ogrodniczuk, 2003).

Because the conflicts in Iraq and Afghanistan are ongoing, the full impact on the mental health of service members is not yet accurately known. According to the U.S.

Department of Veterans Affairs, PTSD affects 6.8 percent of the general population. However, Iraq and Afghanistan veterans are returning with PTSD rates as high as 50 percent (Helmer, et al., 2007). Affected veterans can have multiple difficulties in daily functioning both at home and in their jobs. Many veterans may also face self-medication risks with alcohol and drug abuse (Yarvis, 2008). At a time of increasing PTSD among returning veterans from Iraq and Afghanistan, clinical social workers must pay special attention to the growing problem of untreated and undertreated war-related trauma as we know from the abundance of literature on Vietnam veterans that untreated PTSD contributes to significant health problems in older veterans (Kulka, et al., 1990).

The military has worked hard to inform returning veterans about what they might experience emotionally and how it may affect their families (Yarvis, Franklin, & Dungee -Anderson, 2009). However, most veterans do not ask for help with PTSD symptoms out of shame or fear that it will negatively affect their career advancement. Even when taking into account the effect of combat exposure, it is critical to consider that a negative homecoming reception may prevent veterans from talking about their experiences or expressing their feelings about what happened while deployed. Further, veterans may also have a difficult time adjusting to their pre-deployment roles in the family as much as the family feels the pressure to adjust to a soldier's homecoming. Accordingly, family members can be instrumental in seeking out needed help if veterans are experiencing symptoms of PTSD, depression, or substance abuse (Cabrerra, Yarvis, & Cox, in press; Jordan, et al., 1992).

While the present study has much strength, several limitations should be addressed. First, the study was a relatively small and purposeful sample restricted to older male veterans. Second, the missing cases were quite large even though we purposely selected, and we are curious whether it may be due to possible systematic or random errors. Additional research is required to further our understanding of the PTSD symptom structure in the context of varied, multiple, and chronic trauma exposure in peacekeeper populations. A population based longitudinal study should be conducted to assess returning troops' emotional experiences. Because the "post" in PTSD means that symptoms begin months or years later, some veterans as they age are experiencing late onset PTSD symptoms – memories, flashbacks, and nightmares – triggered by watching television news about the war or exposures to stimuli not previously experienced as aversive by the veteran. Future study direction should target more extensive diagnostic evaluation of the veteran's co-morbidity of psychological and social stressors including poorer health, unhealthy coping behaviors, and conflicts in family relationships, which may be led from unresolved past traumatic experiences.

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War-related Trauma: Increasing the American GI's Resilience through Marriage

**Warren N. Ponder
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Abstract: *Studies have shown PTSD has a negative impact on close relationships among Vietnam War veterans. Recently, studies have replicated these findings in the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) cohort. Currently, over half of the military is married and veterans are returning from combat with elevated rates of PTSD. Thus, investigating which symptom clusters influence marital satisfaction of the veteran the most is important for assisting social workers and other mental health professionals in identifying and prioritizing treatment goals. The current study identifies which of the four PTSD symptom clusters impacts marital satisfaction the most in returning combat veterans using regression analysis. The emotional numbing cluster negatively impacted marital satisfaction whereas the hyper-arousal cluster positively impacted it. Using all 17 Post-traumatic Disorder Checklist-Military (PCL-M) questions as possible predictors of veterans' marital satisfaction, regression analysis revealed five of the questions account for 26 percent of the variance in marital satisfaction. Clinical implications and recommendations are explored.*

Keywords: Veterans, marital satisfaction, PTSD, PCL-M, marriage

INTRODUCTION

When veterans return from Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF), they may come back with experiences of war that often lead to the development of post-traumatic stress disorder (PTSD) (Seal, et al., 2008). For purposes of this article, veteran(s) is an all inclusive term that refers to Active Duty personnel and those who have separated from their respective military component who have been deployed in support of Operation Iraqi Freedom (OIF) and/or Operation Enduring Freedom (OEF). To be diagnosed with PTSD, according to the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV TR) (American Psychiatric Association [APA], 2000), a person must meet several requirements. The first criterion is that:

The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness or horror (p. 467).

The person must also have symptoms from three clusters present for longer than one month: (B) re-experiencing, (C) avoidance/emotional numbing, and (D) hyper-arousal. Re-experiencing symptoms are intrusive memories about the trauma; nightmares; feeling as though the trauma is reoccurring; intense psychological distress; and physiological reactivity. Avoidance/emotional numbing symptoms are efforts to avoid thoughts,

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activities, and memories of the trauma; decreased interest in activities; emotional detachment; restricted affect; and a sense of a foreshortened future. Hyper-arousal symptoms are characterized as difficulty falling asleep; irritability; difficulty concentrating; hyper-vigilance; and an exaggerated startle response. The last criterion for PTSD is “the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (p. 468).

Seal et al. (2008) report that about 21.8% of returning OIF and OEF veterans have PTSD. When a veteran is married—over half of the US military Active Duty population is (Defense Manpower Data Center [DMDC], 2008)—PTSD not only affects the veteran but also the marital dyad and the entire family system (Monson, Taft, & Fredman, 2009). Research shows secondary/vicarious traumatization, caregiver burden, ambiguous loss, and intergenerational transmission can develop in close relationships when an individual exhibits PTSD symptoms (Monson, Fredman, & Dekel, 2010). Maintaining and strengthening military marriages is integral in protecting veterans and their families from negative outcomes additional to PTSD including intimate partner violence, divorce, and suicide. The primary purpose of this study was to identify which post-traumatic stress symptom clusters impact marital satisfaction the most among returning OIF/OEF veterans to assist social workers and other mental health professionals in prioritizing treatment goals.

LITERATURE REVIEW

Researchers have been studying adaptation in close relationships after trauma for some time (e.g., Hill, 1949; Lavee, McCubbin, & Patterson, 1985; McCubbin, & McCubbin, 1991; McCubbin & Patterson, 1982; Segal, 1986). Whisman and Beach (2010) assert “studies have suggested that marital satisfaction is lower among people with psychiatric disorders, including anxiety disorders” (p.17). The majority of what is known about PTSD and close relationships is derived from research conducted on Vietnam veterans and their partners (Monson, et al., 2010). For example, Jordan et al. (1992) examined data from the National Vietnam Veterans Readjustment Survey (NVVRS) and concluded approximately 60% who met PTSD criteria reported medium-high to high levels of marital issues and poor family adjustment. Additionally, significant others of Vietnam veterans reported less satisfaction in their life (Jordan, et al., 1992). Finally, researchers (Jordan, et al., 1992; Kulka, et al., 1990) report male Vietnam veterans diagnosed with PTSD were more likely to experience divorce than those not diagnosed with PTSD. However, McLeland, Sutton, and Schumm (2008) caution divorce rates may not be the best way to determine if deployments cause marital dissolution and suggest “using marital or relationship-satisfaction scores may be a more sensitive way to assess the immediate effect of predeployment or deployment stress on close relationships” (p. 842).

Literature has shown the more severe the PTSD experienced by the male veteran, the lower the marital satisfaction (Allen, Rhoades, Stanley, & Markman, 2010; Renshaw, Rodrigues, & Jones, 2008). PTSD can have a deleterious impact on a close relationship with an ultimate culmination being physical aggression as Stith, Green, Smith, and Ward (2008) concluded in a meta-analysis investigating marital satisfaction and marital discord

as precursors to intimate partner violence. Their results indicate “that decreased marital satisfaction and increased marital conflict are positively associated with physical aggression in intimate relationships” (p. 158).

Theoretical Framework Explaining the Role of PTSD in Marital Satisfaction

There are two main theories of PTSD in an interpersonal context: the Couple’s Adaptation to Traumatic Stress Model (CATS Model) (Nelson Goff & Smith, 2005) and cognitive behavioral interpersonal theory (Monson, et al., 2010). The CATS Model shows how individuals and/or couples function and cope after a traumatic event; for this study, the traumatic event is combat exposure of the veteran and the long-term effects that exposure has on the veteran and the veteran’s marriage. The CATS Model posits that how the couple copes with the trauma is contingent on three variables: predisposing factors/resources, level of functioning in each partner, and the couple’s functioning (Monson, et al., 2010; Nelson Goff & Smith, 2005). Monson and colleagues (2010) have also illustrated that cognitive behavioral theory explains relationship issues where PTSD is present. Monson et al. (2010) assert domains like safety, trust, power, esteem, and intimacy can be impacted by a trauma, thereby affecting close interpersonal relationships. Essentially, as the veteran manifests PTSD symptoms at the individual level in the cognitive, behavioral, or affective realm, the same symptoms can be seen at the dyadic level. Both theories highlight the interpersonal exchange of PTSD in close relationships, yet leave the question: are certain symptoms more deleterious to the couple than others?

The Role of Individual PTSD Clusters in Close Relationships

Prior to 1998, there were few studies examining the role individual PTSD clusters play in close relationships (Riggs, Byrne, Weathers, & Litz, 1998). Riggs et al. (1998) were able to conclude each PTSD cluster can uniquely impact the interpersonal dyad. For example, if a veteran is re-experiencing trauma via nightmares, the spouse might not be inclined to sleep in the same room, possibly resulting in further isolation and emotional separation which could lead to the marriage deteriorating. Similarly, if a veteran is avoiding situations or becoming emotionally numb, this could lead the veteran to become less intimate with the spouse as has been confirmed in current research (Nunnink, Goldwaserf, Afari, Nievergeltf, & Baker, 2010; Solomon, Dekel, & Zerach, 2008). Riggs et al. (1998) concluded that the emotional numbing was the only significant predictor of relationship distress among Vietnam veterans diagnosed with PTSD. However, in their limitations, they caution their results may not be generalizable to other traumatized populations, which can include different war cohorts such as OIF/OEF.

PURPOSE OF THE STUDY

From an interpersonal therapeutic context, identifying which clusters are creating the most impairment for OIF and OEF veterans in relation to their marriages—a key source of support for them—is of paramount concern to assist mental health professionals in prioritizing treatment goals such as strengthening military marriages. The primary purpose of this study was to fill the gap in previous research by identifying which PTSD

clusters impact marital satisfaction among returning OIF/OEF veterans. The hypotheses that guided this study included:

- H1) Veterans who score above 50 on the Post Traumatic Stress Disorder Checklist-Military (PCL-M) will have lower marital satisfaction than veterans who score 49 or below on the PCL-M.
- H2) Emotional numbing as measured by the PCL-M will be the strongest predictor of OIF/OEF veterans' marital satisfaction among the four different clusters.
- H3) A model exists to predict RAS scores based on individual PCL-M questions.

METHOD

Procedure for Data Collection and Analysis

This exploratory study used an anonymous survey to investigate variables that influence marital satisfaction among OIF and OEF veterans. All procedures were approved by the University of Texas at Arlington Institutional Review Board. These authors contacted veteran service organizations to inquire if they would allow us to collect data from their members. After written permission was obtained from the organizations, these authors posted the survey to their private discussion boards, chat rooms, and via email. Only organizations that verified OIF or OEF service via Department of Defense Form 214 were allowed to participate in this study. Data were collected for approximately forty days and included demographic questions, the Relationship Assessment Scale, the Combat Exposure Scale and the Post-traumatic Stress Disorder Checklist-Military version. All data were analyzed using the Statistical Package for Social Sciences (SPSS) version 18.0; statistical significance was assessed at the .05 level.

Measures

Relationship Assessment Scale (RAS)

The Relationship Assessment Scale (RAS) is a seven-item measure that assesses satisfaction in close relationships (Hendrick, 1988). The cumulative scores range from one to five. Hendrick, Dicke, and Hendrick (1998) report "Scores over 4.0 would likely indicate non-distressed partners, whereas scores closer to 3.5 for men and between 3.5 and 3.0 for women would indicate greater relationship distress and possibly substantial relationship dissatisfaction" (p. 141). The RAS has good discriminant validity and has been found to have good convergent validity with both the Dyadic Adjustment Scale (DAS) (.80 and .88) and the Kansas Marital Satisfaction Scale (KMSS) (.64 for men and .74 for women) (Hendrick, et al., 1998).

Combat Exposure Scale (CES)

The Combat Exposure Scale (CES) was developed by Keane et al. (1989) and is a seven-item self-report instrument designed to measure level of combat exposure. The items are rated from one to five and measure extent and severity of active combat experiences using a score weighted for the severity of each item. Scores can range from 0 to 41 with a higher score indicating heavier exposure. The test-retest reliability of the CES is .97 (Keane, et al., 1989) showing excellent stability. For internal consistency, Cronbach's Alpha was calculated for the CES to be .85 (Keane, et al., 1989). Additionally, Keane et al. (1989) concluded that the CES has good discriminant validity.

Post-traumatic Stress Disorder Checklist Military (PCL-M)

There are several versions of the PTSD Checklist (PCL) that can be modified to different populations including civilians, spouses, and military personnel. The PTSD Checklist- Military (PCL-M) is a Likert scale standardized assessment instrument with 17 items assessing PTSD symptomology derived from the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (APA, 1994). Each item relates to criteria for the PTSD diagnosis. Pratt, Brief, and Keane (2006) examined the PCL-M and concluded that it has good convergent and discriminant validity along with high internal consistency and test-retest reliability. The PCL-M is used to identify persons within the military population who might have a diagnosis of PTSD, requiring further clinical assessment for confirmation of the diagnosis (Weathers, Litz, Herman, Huska, & Keane, 1993).

The DSM first recognized PTSD as a mental disorder in 1980 (APA, 1980) and currently has three symptom clusters (re-experiencing, avoidance/emotional numbing, and hyper-arousal) (APA, 2000). For some time researchers have recognized the avoidance and emotional numbing features of PTSD as separate and distinct (Asmundson, Stapleton, & Taylor, 2004; Foa, Riggs, & Gershuny, 1995; Riggs, et al. 1998). For the purposes of this study, the avoidance/ emotional numbing traits are separated into two groups by generating means for each PCL-M question and coding them into the following clusters: questions 1-5 (re-experiencing), 6-7 (avoidance), 9-11 (emotional numbing), and 13-17 (hyper-arousal), thereby creating cluster means. The decision to code PCL-M questions into these clusters is in replication of Riggs et al.'s (1998) coding strategy and is recommended by staff from the National Center for PTSD (B. Litz, personal communication, February 16, 2011).

Participants

The sample consisted of 119 participants. All were married and had been deployed to OIF or OEF at least once. One hundred and one were males (84.9%) and eighteen were females (15.1%). The majority of respondents were White ($n = 107$, 89.9%). Four other categories accounted for the remaining 10.1% (Hispanic, $n = 4$; Other, $n = 4$; More than one race, $n = 3$; and African American, $n = 1$). Because the majority of the participants were White males, separate analyses based on race and sex would have lacked statistical power so no sub-group analyses were conducted. Length of marriage ranged from 1 to 37 years with a mean of 9.18 years ($SD = 7.96$). Of the respondents, 56 (47.1%) had been

deployed once; 38 (31.9%) twice; 14 (11.8%) three times; and 11 (9.2%) four or more times to OIF/OEF. Length of deployment was collapsed into total months deployed. The minimum was two months and the maximum was 39 months. The mean was 16.58 months ($SD=8.52$). Five respondents did not complete this question. Ninety-five (79.8%) of the respondents had been stateside more than one year, the rest had been home one year or less and two did not complete this question.

RESULTS

Assessment Instruments

All 119 participants completed the RAS, CES and PCL-M. The distributions of these scales all approached normality. For the RAS, the minimum score was one and the maximum was five; the mean RAS score was 3.65 ($SD = 1.02$). The data suggest that eighty-one participants (68.1%) are likely not maritally distressed (3.5 or higher) and thirty-eight participants (31.9%) are likely distressed in their marital relationships (3.49 or lower). The mean CES score was 16.46 ($SD= 9.9$) indicating light to moderate combat exposure (Keane et al., 1989) with scores ranging from 0 to 41; 48% of the respondents reported moderate or high combat exposure. The minimum score for the PCL-M was 17 and the maximum was 85, the mean PCL-M score was 43 ($SD= 17.61$). Forty-five participants (37.8%) had a PCL-M score of 50 or greater suggesting a PTSD diagnosis, requiring further clinical assessment for confirmation of a PTSD diagnosis.

Hypothesis 1

The first hypothesis was veterans who score above 50 on the PCL-M will have lower marital satisfaction than veterans who score 49 or below; this was tested using t-tests. The mean PCL-M score for those 50 and above was 61.46 ($SD = 10.13$) and the 49 and below group's mean PCL-M score was 31.81 ($SD = 9.56$). The mean marital satisfaction score for the 50 and above cohort was 3.45 ($SD= 1.14$), suggesting greater marital distress than the 49 and lower group whose mean RAS score was 3.78 ($SD= .92$). Homogeneity of variance was assessed using Levene's Test. Equal variances were not assumed ($F_{(78,6)}= 4.41$, $p< .05$). The t-test indicated a rejection of hypothesis 1 since there was no statistically significant difference in marital satisfaction between veterans who had a clinical cutoff on the PCL-M of a score above 50 versus those who scored 49 or below ($t_{(78,6)}= -1.64$, $p=.11$).

Hypothesis 2

The second hypothesis was that the emotional numbing cluster as measured by the PCL-M will be the strongest predictor of OIF/OEF veterans' marital satisfaction among the four different clusters. A regression model using the enter method with RAS scores as the dependent variable and each PTSD symptom cluster mean as the four independent variables was conducted. The regression model was statistically significant ($F_{(4)}=5.75$, $p<.001$) and had an Adjusted R squared value of .14, which accounts for 14% of the RAS variability. The emotional numbing and hyper-arousal clusters were both statistically significant predictors of marital satisfaction. The beta weight of the emotional numbing

cluster was larger ($\beta = -.73$) than the hyper-arousal cluster ($\beta = .49$), thus supporting hypothesis two. The emotional numbing beta weight suggests that as emotional numbing increases, marital satisfaction decreases. The hyper-arousal beta weight can be interpreted that as hyper-arousal increases, so too does marital satisfaction. Please refer to Table 1.

Table 1. Prediction of Marital Satisfaction by PTSD Symptoms Clusters

PTSD Clusters	β	t	p
Re-experiencing	.09	.50	.62
Avoidance	-.06	-.37	.71
Emotionally numb	-.73	-4.61	<.01
Hyper-arousal	.49	2.73	<.01

Hypothesis 3

The third hypothesis is a model exists to predict RAS scores based on individual PCL-M questions. Due to the results of hypothesis 1, all participants were included in the testing of this hypothesis as opposed to the original plan of only including participants who scored 50 or higher on the PCL-M.

A backward stepwise regression model with all 17 PCL-M questions as predictors of marital satisfaction was conducted. The statistically significant model ($F_{(5)}=9.07$, $p<.001$) had an Adjusted R squared value of .26, which accounts for 26% of the RAS variability. Five PCL-M questions (10, 11, 14, 15, and 16) were statistically significant: two relating to emotional numbing and three to hyper-arousal. The beta weights for feeling distant from others ($\beta = -.29$), emotionally numb ($\beta = -.44$), and irritable or angry ($\beta = -.27$), suggest inverse relationships with marital satisfaction—as each increases, marital satisfaction decreases. The beta weights for difficulty concentrating ($\beta = .35$) and being alert or watchful ($\beta = .44$) can be interpreted that as these increase, so too does marital satisfaction. Please refer to Table 2 for a complete listing.

Limitations

Data were not gathered from the spouse's point of view; this was done to ensure anonymity to the veteran. If data had been gathered from the spouse, anonymity could not have been ensured. Future studies should aim to collect data from the spouse and service member. Another limitation is that data for this article were gathered at one point in time (post deployment). Data should optimally be gathered pre, during, and post deployment in an attempt to establish a baseline level of marital satisfaction and assess change over time, especially given the CATS model of PTSD in an interpersonal context where the couples' predisposing factors/resources, level of functioning in each partner, and the couple's functioning impact the dyad (Monson, et al., 2010; Nelson Goff & Smith, 2005).

Table 2. Prediction of Marital Satisfaction by Post Traumatic Stress Disorder Military (PCL-M) Items

PCL-M Question	<i>B</i>	t	p
10. Feeling <i>distant</i> or <i>cutoff</i> from other people? ^a	-.29	-2.12	.04
11. Feeling <i>emotionally numb</i> or being unable to have loving feeling for those close to you? ^a	-.44	-3.25	<.01
14. Feeling <i>irritable</i> or having <i>angry outbursts</i> ? ^b	-.27	-2.05	.04
15. Having <i>difficulty</i> concentrating? ^b	.35	2.42	.02
16. Being “ <i>super-alert</i> ” or watchful or on guard? ^b	.44	3.91	<.01

^aRelates to the emotional numbing cluster.

^bRelates to the hyper-arousal cluster.

CONCLUSIONS AND IMPLICATIONS FOR SOCIAL WORK PRACTICE

This study is a significant contribution to the growing body of literature on how PTSD among returning OIF/OEF combat veterans affects interpersonal functioning. Almost thirty-eight percent of veterans in the current study had a score of 50 or higher on the PCL-M suggesting a PTSD diagnosis requiring further clinical assessment for confirmation of the diagnosis; this is considerably higher than previous research (e.g. Hoge, et al., 2004; Seal et al., 2008). Research investigating PTSD has generally analyzed PTSD symptoms using the three clusters set forth by the DSM-IV (TR). However, recent research has concluded that the avoidance/emotional numbing cluster is in fact two distinct clusters (Asmundson, et al., 2004; Foa, et al., 1995; Riggs, et al. 1998). This study assesses the impact of PTSD, conceptualized using the four cluster organization of symptoms, on veterans' marital satisfaction. The goal of this study is to assist social workers and other mental health professionals in prioritizing treatment goals related to the four clusters so as to increase veterans' marital satisfaction quickly, equipping the veteran with an important resource—the marital relationship—for support and healing while decreasing the likelihood of intimate partner violence, divorce, and suicide.

Conclusions

Our first conclusion is that, though it has been supported in the literature, veterans with PTSD have more problems in their marriages than their fellow, trauma-exposed veterans without PTSD (Monson, et al., 2009), the results of this study do not support this finding. In our sample 37.8% scored a 50 or above on the PCL-M, suggesting that a PTSD diagnosis and marital satisfaction scores among those with PTSD were not

statistically different than those for the veterans who scored 49 or below on the PCL-M. One possible reason for this is the moderate combat exposure reported by this sample. Those participants with a score of 50 or greater on the PCL-M on average endorse moderate combat exposure. Their mean score on the CES was 20.51 ($SD= 9.86$) whereas those with a score of 49 or below on the PCL-M reported light to moderate combat exposure ($M=14$; $SD= 9.15$). Renshaw et al. (2009) showed combat exposure was directly related to PTSD, which was related to lower marital satisfaction. Thus, since the combat exposure on average was moderate, it could account for the results not being significant.

Our second conclusion is that emotional numbing and hyper-arousal are the two clusters with the most impact on veterans' marital satisfaction. This differs from previous research (Riggs, et al., 1998) where the avoidance/emotional numbing cluster was the only significant predictor of relationship distress among Vietnam veterans. The data of the present study shows that as the veterans' emotional numbing increases, the veterans' marital satisfaction decreases; for the hyper-arousal cluster, as hyper-arousal increases, so too does the veterans' marital satisfaction.

Finally, our third conclusion is that certain aspects of the emotional numbing and hyper-arousal clusters are more influential on marital satisfaction than others as indicated in the regression analysis of individual questions on the PCL-M. Specifically, the emotional numbing cluster components of feeling "distant or cut off" from others and emotionally numb or "being unable to have loving feeling for those close to you," and feeling "irritable" or having "angry outbursts" all had inverse relationships with marital satisfaction meaning the less severe these components, the higher the marital satisfaction. For the "difficulty concentrating," and being "watchful" components of the hyper-arousal cluster, the more severe these are, the higher the marital satisfaction. Together, these five components explained a little more than a quarter of the variance in marital satisfaction with the remaining items in emotional numbing and two questions regarding hyper-arousal not being significant to marital satisfaction.

Implications for Practice and Future Research

The findings of this article are important to social workers and other front line mental health providers who treat OIF/OEF combat veterans and their family members. Even if a veteran does not meet full diagnostic criteria for PTSD, it is important for a clinician to assess for sub-clinical symptoms. The PCL-M is widely used and could easily be adapted for clinical practice with couples. It is recommended that the clinician administer the PCL-M to the veteran and a modified version to the spouse upon intake. The PCL-M can easily be modified to obtain the spouse's perceptions of the veteran's post-traumatic stress symptoms; this has been done previously in a research setting (Renshaw, et al., 2008) and could easily be adapted for a clinical setting. This would allow for a more holistic picture of PTSD in the couple's interpersonal relationship. Using the results of our PCL-M regression model, the clinician could look at the individual PCL-M questions, especially the 5 that were significant in this study, and be provided with a quick overview of the couple's presenting issues.

A clinician can use these findings to quickly hone in on and prioritize areas for intervention; this is especially important for veterans seeking couple's therapy because of the extensive impact that the emotional numbing and hyper-arousal clusters have on marital satisfaction. In work with veterans prior to OIF/OEF, behavioral/cognitive-behavioral therapy has been the most effective approach to working through couple-related issues (Monson, et al., 2009). However, current research shows that effectiveness can be achieved using a generic approach or by using a more PTSD-focused approach (Monson, et al., 2009) leaving the clinician in a quandary as to which modality to embrace. Thus, one example of how the findings of this study assist in prioritizing treatment goals relates to using behavioral/cognitive-behavioral therapy while enhancing communication when the veteran is exhibiting emotional numbing. When emotional numbing is present, communication or quality of communication between spouses decreases leading to stress, in turn resulting in lower marital satisfaction. Thus, a primary social work implication is that when emotional numbing is present, a couple's counseling treatment goal should be increasing quality of communication to maintain or increase marital satisfaction. This has been found to be an effective strategy with Vietnam veterans (Cahoon, 1984; Sweany, 1987).

Two additional social work implications from our research relate to the effects of hyper-arousal. Hyper-arousal includes irritability and angry outbursts, difficulty concentrating, and increased watchfulness; this study supports that two of these aspects—irritability and angry outbursts—have an inverse relationship with marital satisfaction. The authors posit that the irritability and angry outbursts may be perceived as a threat by the spouse who shuts down and withdraws. Thus, social work interventions with couples should focus on anger management. Contrastingly, our findings support that the other aspects of hyper-arousal—decreased concentration and increased watchfulness (items 15 and 16 on the PCL-M)—increase marital satisfaction, perhaps eliciting more empathy from the spouse. Specifically decreased concentration by the veteran might not be viewed as a threat thereby allowing the spouse to assist without threat of harm. Being watchful or on guard has the same possibilities for eliciting empathy from the spouse without the spouse feeling threatened. Clinically, social workers may be wise to prioritize emotional numbing, anger and irritability over increasing concentration and decreasing watchfulness given the results of this study.

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Internet-based Spousal Communication during Deployment: Does it Increase Post-deployment Marital Satisfaction?

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Abstract: *The purpose of this study was to explore the question: Is a service member's post-deployment marital satisfaction correlated with frequency and mode of communication during deployment? This study used an anonymous exploratory design with a sample of 119 Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) married veterans. Service members who communicated daily during deployment with their spouses had higher marital satisfaction scores than those who communicated less than once per week. Additionally, participants who used US mail had the highest marital satisfaction scores compared to telephone and internet-based communication. This study expands the overwhelmingly qualitative current literature to include quantitative analysis of this topic. This study also depicts the veterans' experiences since many of the previous studies of this topic used samples of spouses.*

Keywords: *Communication, marital satisfaction, Veteran, Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF)*

INTRODUCTION

Being able to stay connected to loved ones has been a top priority for military personnel for generations with both military and non-profit organizations allocating resources to aid soldiers in using all modes of communication available. During World War I (WWI) and World War II (WWII), soldiers' primary mode of communication was the US mail (Schumm, Bell, Ender, & Rice, 2004). During WWII soldiers were frustrated with the long wait times associated with receiving mail (Applewhite, & Segal, 1990; Bell, Schumm, Knott, & Ender, 1999; Stouffer, Suchman, DeVinney, Star, & Williams, 1949). The Military Auxiliary Radio System (MARS) was used during the Korean and Vietnam wars allowing service members faster communication time with their loved ones (Schumm, et al., 2004). During Operation Desert Storm (ODS) fax, e-mail, videotapes, US mail, audiotapes, and teleconferences where available to some of the deployed personnel (Ender & Segal, 1990; Schumm, et al., 2004). During Operation Joint Endeavor (Bosnia), Operation Restore Hope (Somalia), and Operation Uphold Democracy (Haiti), email, telephone and sometimes teleconferencing were available (Schumm et al., 2004).

In the present wars, Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), military personnel have the most modern forms of communication at their fingertips. Whereas in previous wars US mail was the only mode of communication, service members now can communicate with their loved ones over such media as telephone, email, instant messenger/message board, video, and webcam (Merolla, 2010), increasing frequency and immediacy of communication. Access to much of the modes of

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communication is provided by the military with non-profits assisting with items such as telephone calling cards and cell phones. Little is known about the impact that these additional communication modes have on the marital relationship after deployment. The purpose of the current study is to determine if a service member's post-deployment marital satisfaction is correlated with the frequency and mode of communication during deployment.

Theoretical Framework

Many theories exist about marital satisfaction covering a broad spectrum of aspects that impact satisfaction including employment, communication, adoption, and stress. For the purposes of this study, the two theories discussed are related to stressful events and are focused on the uniqueness of the military couples' experiences. A long-standing theory of marital satisfaction in the face of life-stressors is Hill's (1958) ABC-X Model in which he attempted to address how (A) an event or stressor and (B) the family's resources or strengths led to (C) how the family attached meaning to the event and whether they enter or avert (X) crisis. This theory has been thoroughly tested and revised (e.g., Boss, 2002; Lavee, McCubbin, & Patterson, 1985; McCubbin & McCubbin, 1991) with more recent work focusing on the theory's application to the military marriage. Most recently, Boss (2002) expanded on the ABC-X Model by proposing internal and external contexts. The internal context includes things the family has control over and can change such as the structural, psychological, and philosophical domains. The external context includes things the family has no control over: culture, history, economy, development, and heredity. This contextual focus adds a much needed arena for focus on marital communication as integral in the process of surviving and thriving in the face of crisis.

Boss and others have continued to apply the ABC-X model with its varied revisions and expansions to the military marriage. In Boss' proposed expansion of the theory to include internal and external contexts, the examples are focused in the military domain related to post-traumatic stress disorder (PTSD). Rosen and Durand (2000) have also further tested the ABC-X model with Persian Gulf War veterans. A two-phased study was commissioned, the first data collection was done while the service member was deployed and the second after the personnel had been stateside for one year. They conducted factor analysis and identified five factors that explained marital adjustment post-deployment: feeling distanced from each other; feeling closer to each other; increased role-sharing; increased independence of spouse; and increased dependence. They concluded that a large portion of the marriages that dissolved upon returning home had pre-deployment issues and that deployment actually strengthened the marriage for those who did not dissolve their marriages.

Despite the vast body of literature on marital satisfaction, available theories such as the ABC-X model continue to be weak in certain aspects. One area lacking, especially in relation to military marriages and deployment stress, is the impact of communication (Karney & Crown, 2007) with the few studies on communication during deployment focusing heavily on the spouses, (i.e. Lapp, Taff, Tollefson, Hoepner, Moore, & Divyak, 2010; Merolla, 2010; Sahlstein, Maguire, & Timmerman, 2009) and only one from the veterans perspective (Durham, 2010).

Partially in response to this, another theory of marital satisfaction was developed by Karney and Crown (2007) in their significant work *Families under stress: An assessment of data, theory and research on marriage and divorce in the military*. Karney and Crown (2007) drew upon literature studying civilian marriages to expand the stress hypothesis to fit within the context of a military marriage. Their theory has four components: (1) the conceptualization acknowledges the military spouses' enduring (i.e., items that are stable and each spouse brings to the marriage such as demographic, psychological, and personal history variables) and emergent traits (i.e., things that can change over the course of a marriage such as maturity or financial stability); (2) the consideration of the environmental factors within and outside the military community (e.g., family, employment, and housing); (3) the impact spousal communication has on the marriage; and (4) "that spouses' satisfaction with their marriage is but one predictor of whether or not a marriage will remain intact; barriers and a lack of alternatives can keep spouses in a marriage whether or not they find the marriage satisfying" (Karney & Crown, 2007, p. xxvi-xxvii). How spouses communicate during deployment will impact the post-deployment marital outcome.

The Karney and Crown (2007) theory has been used to assist and guide other empirical investigations of military marital satisfaction (e.g., Allen, Rhoades, Stanley, & Markman, 2010; Merolla, 2010). Allen et al. (2010) used the Karney and Crown (2007) framework to explain how adaptive processes such as communication contribute to the link between PTSD and marital satisfaction. They concluded that the adaptive processes such as communication outlined in Karney and Crown's model do partially account for the association between PTSD and marital satisfaction for both husbands and wives and note that focusing on communication is an important approach to intervention with couples struggling during post-deployment. Similarly, Merolla (2010) used Karney and Crown's model (2007) to guide their qualitative research on marital maintenance during deployment. Their study focused on spouses rather than service members and communication emerged as one of three main marriage maintenance mechanisms being not only important in terms of frequency but also in terms of mode of communication and the need for communication to be routinized.

LITERATURE REVIEW

Applewhite and Segal (1990) were among the first researchers to study modern modes of communication of military personnel during deployment. They surveyed 133 military personnel who were deployed on a peacekeeping mission to Sinai in the 1980s. The study concluded the majority of personnel thought optimistically about the use of the telephone as a medium to stay connected to family, but also found it to be extremely expensive. Interestingly, in their study of communication during Operation Restore Hope, Bell et al. (1999, p. 515) noted, "In general, communication had a positive effect on several outcome variables, with the notable exception of marital satisfaction, possibly operating through an intervening variable of perceived stressfulness of peacekeeping operations that was predicted by having had communication problems."

Sahlstein and colleagues (2009) conducted a qualitative investigation with a sample of 50 female spouses through the lens of relational dialectics. They found that through the

different stages of deployment, several themes emerged: pre deployment (uncertainty vs. certainty), deployment (autonomy vs. connection), and post deployment (openness vs. closedness). They found military culture influences how spouses communicate in two ways. First, the soldier could not disclose information because of the operational security of the mission and secondly the variability in mode of communication. One participant specifically noted high-ranking officer's limited phone privileges as a consequence for unfavorable behavior in theatre.

Merolla (2010) conducted a qualitative investigation about marriage maintenance with 33 wives of currently deployed service members. His findings acknowledge geographic separation can help and hurt a relationship. The following modes of communication were the most frequently referenced in regards to communication with their spouse: phone (61%), letters/care packages (55%), email (including digital photos) (52%), instant messenger/message board (15%), video messages (9%), and webcam (6%). Participants had concerns about the military's operational security, meaning it limited the conversation on the phone and over the internet. Fifty-five percent of participants reported creating and maintaining a communication routine with family was important (Merolla, 2010).

Lapp et al. (2010) used a phenomenological perspective to guide their study. They interviewed 18 spouses (two were male) of National Guard and Reserve service members who lived in a rural or semi-rural setting of less than 70,000 people. The study found that some spouses felt captive to the instant forms of communication available—always waiting by the phone for their partner to call. Spouses intended to stay connected via telephone, instant messenger, email, and webcam. Lapp et al. (2010, p. 60) note “All of the participants were reassured by frequent contact with their spouse.”

Most qualitative research has focused on the spouses of veterans who were deployed. Recently, Durham (2010) studied the service member's point of view by conducting a qualitative investigation of six OIF male combat veterans discharged from the military. She concluded that all respondents chose to limit their communication with family back home. Respondents report limiting their communication was done because of regulations, control, and the distraction it could cause from the mission. If a service member is distracted from the mission, it could lead to less concentration resulting in death of self or a fellow service member.

Currently, little quantitative empirical investigation has been conducted on the impact of frequency and mode of communication during a combat deployment on marital satisfaction. These new modes of communication may act as potential confounding variables affecting marital satisfaction. With the ever-evolving modes of instant communication, these authors were interested in which mode would have the highest marital satisfaction. We suspect that internet-based communication will have the highest because it is immediate and allows for a more frequent routine whereas mail can take weeks to arrive at its destination and/or get misplaced. Additionally, these authors suspect that face-to-face communication via webcam will have higher marital satisfaction because it might provide a sense of comfort for the stateside spouse because they can visually see the service member.

To date almost all the studies investigating communication within the marital dyad among OIF and OEF service members have been qualitative in nature. Previous researchers have laid a solid foundation for this quantitative investigation. A great deal of the current research pertaining to deployment and separation within a marital dyad is outcome driven (i.e., divorce or the marriage continues). Researchers (Drummet, Coleman, & Cable, 2003; Merolla, 2010) assert relationship maintenance during deployment within the military community is an area that still needs further exploration. Karney and Crown (2007) posit current research is lacking in depth analysis about "all the ways that spouses interact, communicate, resolve problems, provide support, and understand each other" (p. 24). With only one empirical investigation primarily focusing on the service member (Durham, 2010), more studies are needed to understand things from their perspective.

The purpose of the current study was to explore the question: Is a service member's post-deployment marital satisfaction correlated with frequency and mode of communication during deployment? Three hypotheses guided the study, largely grounded in Merolla's study of marital maintenance from the spouses' perspective. Considering Merolla's (2010) work indicating that routine communication was an important factor in marital maintenance, the first hypothesis was that the higher the frequency of communication during deployment, the higher the marital satisfaction post-deployment. Since internet-based communication is more immediate than US mail and can be more frequent than the telephone, the second hypothesis was that participants who used internet-based communication during deployment will have higher post-deployment marital satisfaction scores than participants who used telephone and US mail. Finally, because communication and partner interaction emerged for the spouses in Merolla's study as major factors in marital maintenance, the third hypothesis was that participants who used face-to-face communication via webcam would have higher post-deployment marital satisfaction than participants who used other forms of internet-based communication.

METHOD

Data Collection

This exploratory study used an anonymous survey to investigate the relationship between spousal communication during deployment and marital satisfaction post-deployment. All procedures were approved by the University of Texas at Arlington Institutional Review Board. We contacted national veteran service and advocacy organizations through email to see if they would allow us to post a link to their private discussion boards, chat rooms, and send to their members. National service and advocacy organizations were selected based on how rigorously they vetted prospective members. Only organizations that verified eligibility through DD214s were allowed to participate in the survey. This was done to make sure the respondents were truly OIF/OEF veterans. After permission was obtained from the group leaders, they sent an email to their constituents or allowed us to post links on their websites, chat rooms, and discussion boards. Data was collected for approximately six weeks.

Instrumentation

A researcher-developed survey was administered along with the Relationship Assessment Scale (RAS). The researcher-developed survey was designed to gather demographic information and inquire about frequency and mode of communication during deployment. The first question was "how often per week did you communicate with your spouse?" The possible answers were: less than once a week, 1-2 times a week, 3-4 times a week, 5-6 times a week, or every day. The second question was "what was the main mode of communication with your spouse while you were deployed?" The possible answers were: computer (email, instant messenger, and webcam), US mail, or telephone. If the respondent selected computer, a follow up question was administered, "what was the primary method of communication on the computer?" The possible answers were email, instant messenger/chat room, or webcam. For the questions about mode of communication, the respondents were allowed to only select one answer so as to ensure that we knew the main mode and primary method respectively.

The Relationship Assessment Scale (RAS) is a seven-item measure that assesses satisfaction in close relationships (Hendrick, 1988). The cumulative scores range from one to five. Hendrick, Dicke, and Hendrick (1998) report "Scores over 4.0 would likely indicate non-distressed partners, whereas scores closer to 3.5 for men and between 3.5 and 3.0 for women would indicate greater relationship distress and possibly substantial relationship dissatisfaction" (p. 141). The RAS has good discriminant validity (Hendrick, et al., 1998) and has been found to have good convergent validity with both the Dyadic Adjustment Scale (DAS) (.80 and .88) and the Kansas Marital Satisfaction Scale (KMSS) (.64 for men and .74 for women) (Hendrick, et al., 1998). Test-retest reliability of the RAS was .85 and it was found to be consistent across several samples (Hendrick, et al., 1998).

Participants

The sample consisted of 119 married participants. One hundred and one were males (84.9%) and eighteen were females (15.1%). Because there were only 18 females who responded, analyses were not conducted on the role of sex in terms of the research question. The majority were White (89.9%). Four other categories accounted for the remaining 10.1% (Hispanic, n = 4; Other, n = 4; More than one race, n = 3; and African American, n = 1). Because there were only 12 non-Whites who responded, analyses were not conducted on the role of race and ethnicity in terms of the research question.

Data Analysis

The survey data were collected in categorical and continuous forms. The ordinal data were analyzed using nonparametric statistics—Spearman's Rank Correlation Coefficient, and the ratio data were analyzed using Analysis of Variance (ANOVA) using the Statistical Package for Social Sciences (SPSS) version 18.0. Statistical significance was assessed at both the .05 and .10 levels; the liberal .10 level is deemed acceptable for exploratory studies (Black, 1999).

RESULTS

All 119 participants completed the Relationship Assessment Scale (RAS). The range of scores was from 1 to 5 with a mean of 3.65 ($SD = 1.02$); the distribution approached normality. Higher scores indicate a non-distressed relationship. The primary mode of spousal communication was computer (email, instant messenger, webcam) (55.5%) with telephone (24.4%) and US mail (20.2%) following. Please see Table 1 for a complete listing.

Table 1. Frequency of Communication with Spouse while Deployed

Mode of Communication	Frequency of Communication	Frequency	Percent	Cumulative Percent
Computer (email, instant messenger, webcam)	Less than once per week	10	15.2	
	1-2 times per week	16	24.2	
	3-4 times per week	12	18.2	
	5-6 times per week	7	10.6	
	Everyday	21	31.8	
	Total	66	100.0	55.5
US mail	Less than once per week	9	37.5	
	1-2 times per week	3	12.5	
	Everyday	12	50.0	
	Total	24	100.0	20.2
Telephone	Less than once per week	5	17.2	
	1-2 times per week	8	27.6	
	3-4 times per week	2	6.9	
	5-6 times per week	3	10.3	
	Everyday	11	37.9	
	Total	29	100.0	24.4
Grand Total		119		100.0

Hypothesis 1

Hypothesis one is the higher the frequency of communication during deployment, the higher the marital satisfaction post-deployment. Since the frequency of communication was measured ordinally, Spearman's Rank Correlation Coefficient was calculated ($\rho = .238$, $p < .01$) and indicates a weak but statistically significant direct relationship. The average RAS score increased with frequency of communication. Those service members who communicated less than once per week while deployed had an average RAS score of

3.34 whereas those who communicated everyday averaged 3.97. To assess whether the differences among means for the ordinal levels of frequency of communication were statistically significant, an Analysis of Variance (ANOVA) was conducted. It was statistically significant ($F_{(118)} = 2.18$, $p = .08$) at the .10 level of significance. Please see Table 2 for frequency of communication and mean RAS scores.

Table 2. Mean Frequency of Communication with Spouse when Service Member was Deployed and Average RAS Score

Frequency of Communication	N	Mean	Std. Dev.
Less than once per week	24	3.34	1.19
1-2 times per week	27	3.46	1.14
3-4 times per week	14	3.45	1.09
5-6 times per week	10	3.84	.59
Everyday	44	3.97	.82
Total	119	3.65	1.02

Hypothesis 2

Hypothesis two is that participants who used internet-based communication during deployment will have higher post-deployment marital satisfaction scores than participants who used telephone and US mail. The average RAS score differed with mode of communication. Those service members who preferred internet-based communication (email, instant messenger, webcam) had an average RAS score of 3.50 (SD = 1.08), US mail 4.10 (SD = .63), and telephone 3.64 (SD = 1.06). The Analysis of Variance (ANOVA) was statistically significant ($F_{(116)} = 3.20$, $p < .05$) at the .05 level of significance.

Hypothesis 3

Participants who used face-to-face communication via webcam would have higher post-deployment marital satisfaction than other forms of internet-based communication. The Analysis of Variance (ANOVA) was not statistically significant ($F_{(63)} = 1.73$, $p = .19$). Please see Table 3 for means and standard deviations.

Table 3. Type of Computer Communication and Average RAS Score

Method of Computer Communication	N	Mean	Std. Dev.
Email	55	3.59	1.03
Instant messenger or chat room	7	2.80	1.03
Webcam	4	3.43	1.67
Total	66	3.50	1.08

DISCUSSION

The purpose of this study was to explore the question: Is a service member's post-deployment marital satisfaction correlated with frequency and mode of communication during deployment? This study expands the current literature to include quantitative analysis of the topic since the previous research on communication during a combat deployment has been overwhelmingly qualitative (e.g. Durham, 2010; Lapp, et al., 2010; Merolla, 2010; Sahlstein, et al., 2009). This study also depicts the veterans' experiences since three of the previous studies used samples of spouses (i.e. Lapp, et al., 2010; Merolla, 2010; Sahlstein, et al., 2009), and only Durham's (2010) used a small sample of veterans.

Findings include that the higher the frequency of communication during deployment, the higher the marital satisfaction post-deployment for the veteran. This supports the theory of military marriage presented by Karney and Crown (2007) where communication is one of four aspects contributing to whether a marriage survives stressors such as combat deployment. This is in contrast to a previous empirical investigation that found communication during Operation Restore Hope did not impact marital satisfaction (Bell et al., 1999). However, it should be noted that Operation Restore Hope did not have the years of infrastructure that a deployed service member now enjoys in OIF or OEF. It is reasonable to consider that since the infrastructure is more comprehensive in OIF and OEF soldiers have access to more reliable communication, which Bell et al. (1999) listed as a possible reason communication did not have a positive impact on marital satisfaction.

Additionally, researchers found that despite the wider availability of new technologies (e.g. webcam, email, synchronous chat) for communicating during deployment, US mail was still the most highly correlated with level of marital satisfaction post-deployment. Of the internet-based forms of communication, email produced the highest RAS scores ($M = 3.59$) over synchronous forms of communication (i.e. chat and webcam).

There are a plethora of possible reasons why US mail was related to higher RAS scores than internet-based communication and the telephone, all likely connected to another component of Karney and Crown's (2007) theory of stress as it relates to military marriage: the consideration of the environmental factors within and outside the military community (i.e., family, employment, and housing). In general the instant nature of these types of communication has its drawbacks. Lapp et al. (2010) noted that some spouses stateside felt bound to their mode of communication always waiting by the phone for their partner to call. Spouses may also be more apt to vent frustrations in an unfettered way whereas letter writing allows time for the spouse to reflect on the most important things to focus on in communication. Instant communication also presents issues for the service member. Deployed service members try to limit their communication with loved ones stateside because they believe it could take away from the mission (Durham, 2010), interfering with concentration and focus which could end up in them not doing their job to their best ability resulting in a person's death, possibly their own.

Another reason for US mail's continuing preferential status among service members may be related to cost, time and location constraints when using telephones and the internet. Though there are many veteran friendly organizations that provide free calling cards to deployed service members, the cost of sending a letter via US mail or email or chatting online is far less than using the telephone while deployed. Time constraints are another issue for the telephone as well as the internet. While letters can be written anywhere and anytime, the internet and telephones require equipment often shared with many fellow-service members requiring scheduling. With shared equipment, scheduling usage is not the only issue. Location is perhaps the most important since telephones and internet are usually accessed in community settings. There is likely an element of closeness that can be delivered in a hand written letter that cannot be in an email or a phone conversation. Spouses may feel at liberty to write more personal information in a letter that they think no one else could look at since letters can be written in fairly private settings.

Related to privacy are deployed service members' concerns about operational security (Merolla, 2010) which can be easily compromised if the enemy is monitoring internet-based correspondence. Service members might feel at greater liberty to say things in a letter than through internet-based communication or over the telephone because of operational security. A letter that is sealed in an envelope will not face the security scrutiny internet-based or telephone communication would.

Limitations

This study did have limitations with regard to sampling, questions asked, and choice of method. In terms of sampling, limitations were: 1) we only collected data from the service member and not the spouse; 2) we limited the study to service members who were still married at the time of the survey possibly creating a bias toward higher marital satisfaction; 3) the sample was mostly White. We recommend that future researchers include the spouses as participants and aim for a more diverse sample on relationship status (i.e., include divorced and separated), race, and ethnicity. Though the sample seems heavily biased toward Whites, our sample is very closely representative of the military dispersion of race as indicated in Table 4 which notes how our sample compares to the target population. For the questions asked, our two main limitations were: 1) we did not focus on the content of the correspondence, only the frequency; and 2) we did not ask the participants about availability of modes of communication during deployment nor command restrictions on frequency of communication. Future studies should attempt to incorporate a mixed methods approach. The quantitative element should be structured to capture the method and frequency of communication and the limitations to these in terms of availability and command limitations to frequency. The qualitative piece should be designed to incorporate the content of the communication especially to determine if there is closeness that is delivered in a letter that is not in internet or telephone communication due to operational security concerns.

Table 4. Study Sample Demographics Compared to US Military Active Duty 2008 Demographics

	Study Sample	Target Population (Active Duty US Military as of 2008)
Sex ^a	Male = 85% Female = 15%	Male (Officers) = 85% Male (Enlisted) = 86% Female (Officers) = 15% Female (Enlisted) = 14%
Age ^a	36.35 years old	28 years old
Race ^{a, b}	White = 90% All others = 10%	White = 75% All others = 25%
Married ^a	100%	55%

^a Defense Manpower Data Center (DMDC) (2008). Active Duty Demographic Profile. Retrieved from www.deomi.org/home/saveCountFiles.cfm?fileid=280.

^b The total number of participants selecting a race other than White was 12 (10% of the sample). These were grouped together as “All others” and include African American, Asian, Hispanic, and Other.

Implications for Social Work Practice

Concerns for the safety of the service member and his or her fellow-service members, privacy, and security of the mission must be considered in tandem with the study results that frequent communication correlates with happier marriages post-deployment. Specific implications for social work practice relate to actions to be taken both with the soldier and the spouse. Prior to deployment, it is recommended that soldiers and their spouses be encouraged to use hand-written letters as their primary form of communication with each other, limiting internet and phone usage to quick messages of love and greeting, explaining the body of literature supporting that hand-written letters strengthen the marriage. Perhaps the couple could agree to write a few sentences to each other every day and mail the result every few days. Both soldiers and spouses should be encouraged to consider the impact of words on the others’ well-being, knowing that news of the others sadness or other difficulties could compromise the soldier’s safety or the spouse’s coping with the soldier’s absence, respectively. If both soldier and spouse are able to focus on the positive—especially positive emotions—in their communication (regardless of mode), outcomes will include increased positive emotions, resilience and improved quality of life (Frederickson, 2001). During deployment, it is recommended for nonprofits that typically have assisted with telephone access through calling cards and cell phones focus their efforts more on care packages, stationary, postage, and the like. Not only will this encourage use of US mail but will also allow their limited funds to stretch further, helping more soldiers and spouses than previous phone-focused endeavors.

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Helping Veterans and Their Families Fight On!

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Abstract: This new generation of veterans is coming home to families, friends, employers, and communities that likely do not understand military culture, nor the effects that military service and reintegration have on a veteran's life, leading to the next war – the Reintegration War. Military servicemembers, veterans, and their families face challenges within the Reintegration War that are different from their civilian counterparts and are complicated by military-specific circumstances. In order to more effectively and efficiently address the challenges servicemembers, veterans, and their families face, we need to work together in a comprehensive effort. Strategies are presented to help win the Reintegration War and ease the transition for servicemembers, veterans, and their families.

Keywords: Family members, military, reintegration, servicemembers, Veterans

THE NEXT WAR

The current wars in Afghanistan and Iraq have collectively proved to be the longest-running conflicts in the history of the United States. According to U.S. Census data, approximately 2.3 million men and women have served in the U.S. military during this period (i.e., post-9/11)—a significant number that nonetheless only represents about 1% of the country's population (U.S. Census Bureau, 2010). It is even more alarming that an estimated 2 million deployments have occurred during these wars (Belasco, July 2, 2009), nearly enough for all military personnel to have been deployed at least once, although multiple deployments are more common. With the drawdown of U.S. military involvement in Afghanistan and Iraq, a large influx of military personnel will soon return home, separate from military service, and will need to adjust to life outside the wire. This new generation of veterans is coming home to families, friends, employers, and communities that likely do not understand military culture, nor the effects that military service and reintegration have on a veteran's life, leading to the next war – the Reintegration War.

In the Reintegration War, some of the challenges confronting veterans and their families are significant and indisputable, but not always visible (Institute of Medicine, 2010; Tanielian et al., 2008). Popular media typically focus on the highs and lows of military and veteran life, such as troop homecomings and military family reunions, war casualties, or suicides, and overlook the everyday struggles of reintegration that veterans and their families face. Although many veterans grapple with physical or psychological wounds, the scope of challenges is broader and deeper than most realize. Whatever their reasons for entering military service, or the politics behind the conflicts, this is a high-risk population in need and we all have a moral duty to support and care for them. A

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community-wide front is required to combat the many problems that they face, and in order to win this war we must fight our battles in coordination and with dedication.

MILITARY FAMILIES: WHO THEY ARE AND HOW THEY SERVE

No man is an island. That is, we cannot discuss the issues and challenges affecting servicemembers or veterans without considering their families. The military family can include parents, spouses, partners, siblings, children, grandparents, and other loved ones, who may serve as caregivers to wounded warriors (Calhoun, Beckham, & Bosworth, 2002). These individuals form an important part of the veteran's support network (Wilcox, 2010) and their health and well-being are directly connected to those of their veteran. That is, a family member's health and wellbeing is also affected by the stressors and challenges in the veteran's life (Bride & Figley, 2009; Chandra et al., 2010; Lester et al., 2012; Sheppard, Malatras, & Israel, 2010).

The dynamic relationship continues throughout the servicemember's career and can last beyond separation from the military. Military families also have the unique challenge of "serving with their servicemember." For example, while a servicemember is deployed to a combat zone, their family often worries about the health and safety of the servicemember, in addition to the added task of redistributing household roles to make up for the absence. Once the servicemember returns home, the military family will need to readjust their mentality and household structure to their pre-deployment status, which can often be difficult, particularly for the non-military spouse. Finally, after separation from the military, and throughout the servicemember's career, military families will often relocate and re-adjust to their new home, and develop a civilian family pattern (Pincus, House, Christensen, & Adler, 2001).

BEYOND THE HOMECOMING: THE REINTEGRATION WAR

Many of the Reintegration War challenges that veterans and their families experience are similar to those in the civilian world. However, military populations have added unique challenges that may be affecting both veterans and their families, including military-related psychological trauma, military-related physical injuries, unique rules and regulations within the military, social stigma, lack of understanding in the community, lack of access to resources in the community, single parenthood, divorce, unemployment, lack of support for children, and other factors that make life less predictable and controllable. These circumstances, challenges, and problems affect veterans and their families, and hinder their reintegration into the civilian community. This section will describe some of the challenges veterans and their families face in the Reintegration War.

Frequent Relocation

In a typical military career, servicemembers and their families will relocate every 3-4 years, often across the country and sometimes internationally. These frequent relocations impose additional stressors for the entire family and force them to transition into a new life at a new military installation. Quite often, military installations are not located in the most desirable locations, and it is often difficult to find good schools for children and

employment for the spouse. In addition to the typical family disruptions, relocations can lead to feelings of alienation and lack of community identification (Burrell, Adams, Durand, & Castro, 2006; Burrell, Castro, Adler, & Britt, 2006; McKain, 1973), particularly among those who live off-base. Military families who are able and choose to live on base have the opportunity to live within a supportive community that understands the unique needs of military families.

When they are connected to the military, servicemembers and their families usually maintain close ties to the base and its support services and schools. Once they separate from the service and reintegrate into the civilian world, however, veterans and their families can feel adrift and unsure about where they could seek support or help, especially if they move to an unfamiliar town or another state.

Lack of Access to and Utilization of Resources for Veterans and Military Families

It can be difficult to navigate through the maze of resources available for military populations (Weinick et al., 2011). Despite the many support services available for veterans and their families, it can be frustrating to go through the process of filing for government services or discouraging to search for help or support in their community. Sometimes, especially in rural areas, veterans do not have access to a Veterans Affairs (VA) office and civilian services are not available. In urban areas, an overabundance of service choices can be overwhelming and confusing, and as more servicemembers separate from the military and move to these areas, both government and community service organizations can also become overwhelmed by veteran needs (Weinick et al., 2011).

Although veterans or families who persist in searching for help or support may find an available service, they are often confronted by well-meaning but uninformed providers who do not understand the scope of the challenges they face as military-impacted individuals. This is a significant barrier to care when we consider that many servicemembers and veterans harbor a stigma against seeking help, especially mental healthcare, and might become so frustrated by a provider's ignorance of military culture and understanding of reintegration challenges that they discontinue treatment (Bryan & Morrow, 2011; Kim, Britt, Klocko, Riviere, & Adler, 2011; McFarling, D'Angelo, Drain, Gibbs, & Rae Olmsted, 2011; Vogt, 2011; Weinick et al., 2011).

Single Parenthood and Divorce among Servicemembers

The levels of stress present in military marriages often lead to separation and divorce. Research indicates that those who serve in the military often marry earlier and divorce earlier (Hogan & Seifert, 2010; Karney & Crown, 2007). The divorce rate among military-connected couples has risen steadily since 2001, and once separated from the military both veteran men and women have a higher divorce rate than comparable civilians (Karney & Crown, 2007).

The divorce rate for female servicemembers is 2-3 times higher than that of their male counterparts (Karney & Crown, 2007). Female servicemembers may deal with issues related to family role reversal, separation from their children, and instability in

their marriages. In American culture, women are typically responsible for household management, are primary caregivers for children and aging parents, and are more likely to face overwhelming expectations upon their return home and reintegration into the community and their family life (Coltrane, 2000). Single parents, many of them mothers in the military, have the added stress of finding caregivers for their children while they deploy, another family transition that adds to the difficulties of reintegration and redeployment (Kelley, Herzog-Simmer, & Harris, 1994).

Interestingly, research indicates that it does not matter whether the deployed parent is the father or the mother, as both have equal effects on child behavior (Kelley et al., 1994). Thus, deployments and the military life, in general, are stressful and challenging for both male and female servicemembers, although the challenges to the female servicemember can be even more difficult.

Unemployment among Veterans

In the coming years, as the wars in Iraq and Afghanistan come to an end and the military budget declines, up to a million servicemembers in their prime working years are expected to separate from the military. This large group of separating servicemembers will need to find employment in the civilian job market. The rate of unemployment among veterans is on the rise and is expected to increase as more veterans enter the civilian workforce. The 2011 unemployment rate among post-9/11 veterans who served active duty was 12.1% (Bureau of Labor Statistics, March 20, 2012), which was higher than the average national unemployment rate for 2011 of 8.95% (Bureau of Labor Statistics, 2012).

Many veterans will have difficulty finding employment with companies that likely do not understand how their skills translate into the civilian work environment. On top of this, veterans also face the common misperception that all veterans suffer from PTSD or have some mental health problem that will not make good or reliable employees. In fact, over 80% of recent servicemembers have *no reported mental health conditions* (Hosek, 2011). Honorably discharged veterans often possess excellent leadership skills that translate well into the civilian work environment, in addition to experience working in diverse work environments. It will be important to ensure employees are aware of the benefits of hiring veterans and that veterans are aware of ways to translate their military skills into a civilian context.

Lack of Support for Military Children

Military children face many challenges and destabilizing events unique from their civilian peers. They typically cope with the stress of their active duty parent's absence due to training or deployment, in addition to the fear of loss and worry for their active duty parent's safety. Furthermore, military children often face challenges of reintegrating into a new military installation and school system every 3-4 years, which can disrupts their social ties, academic career, and daily routine. Military children who have had one parent deploy to either Iraq or Afghanistan are more likely to be diagnosed with mental health problems, which increases with increased length of deployments (Mansfield,

Kaufman, Engel, & Gaynes, 2011). Those whose parents return with mental health problems or injury face even more stress at home and are more likely to experience problems of their own at home or at school. Military family members, including military children, are also susceptible to secondary traumatic stress (Galovski & Lyons, 2004; Herzog, 2008).

When their home life is disrupted due to a parent deploying or returning home, a military child's most stable environment is usually his/her school. However, most teachers and school administrators have never been trained in how to respond to or handle students with parents who are serving in the military. Without support from the school, military-connected children are at increased risk of school violence, substance use, suicide, and dropping out of school (Chandra et al., 2010; Gorman, Eide, & Hisle-Gorman, 2010; Lester, Leskin, et al., 2011; Lester, Mogil, et al., 2011).

These findings highlight the need to ensure school teachers and administrators identify military children and know how to help them. Additionally, it is important to ensure that children are receiving appropriate services to help prevent mental and behavioral problems related to a deployed parent.

Challenges among Reserve and National Guard Members

Reserve and National Guard members are generally similar to active duty forces, but are slightly older and more educated (Department of Defense, 2010). Reserve and National Guard members typically have a part-time commitment to the military. However, in recent years, more Reserve and National Guard members are being called to active duty, often to complete a deployment in a combat location.

Reserve and National Guard members are disproportionately at risk for mental health problems, with reservists more likely to need mental healthcare services following deployment (Schell & Marshall, 2008; Werber et al., 2008). Reserve and National Guard members face the added challenges of the frequent civilian-military-civilian transition and are often a long distance from a military installation, thus resulting in more difficulty accessing services and having a supportive environment (Werber et al., 2008). Thus, it is important to help ease the civilian-military-civilian transition for Reserve and National Guard members and their families to help ensure more positive adjustment.

Physical and Psychological Injuries

Due to advances in combat medicine, more servicemembers with disabling injuries are returning home than ever before. Physical wounds suffered in combat include loss of limbs, facial wounds, burns, hearing damage, and traumatic brain injury (TBI), principally from explosions of roadside bombs or improvised explosive devices (IEDs). Wounds such as these are debilitating, at least to some degree, and can require long periods of reconstructive surgeries, rehabilitation, clinical therapy, as well as long-term care by the spouse or a family member, such as a parent. Injuries such as TBI are additionally challenging because they can be difficult to diagnose and treat, especially if a veteran has trouble establishing the injury with the VA and receiving disability benefits

or health coverage for treatment (Weinick et al., 2011). Any of these injuries, however, is a significant stressor on a veteran's life and that of his/her family.

The invisible wounds of war, psychological responses to stress, typically posttraumatic stress, depression, and anxiety, have at long last been acknowledged by the U.S. Government and general public as legitimate and serious injuries. Symptoms of posttraumatic stress disorder (PTSD) involve three clusters: a) intrusion symptoms, b) avoidance symptoms, and c) arousal symptoms (American Psychiatric Association, 2000). These symptoms not only affect the veteran's quality of life, but that of his/her family members. However, diagnosis and treatment are difficult because servicemembers have little incentive to report symptoms, due to fear of delaying their return home, fear of discharge, or fear of the stigma of mental illness (Kim et al., 2011; Kim, Thomas, Wilk, Castro, & Hoge, 2010; McFarling et al., 2011; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009).

Although PTSD garners much attention in the realm of combat-related injuries, it is not the only mental health problem that servicemembers and veterans experience. Research estimates that approximately 30% of servicemembers who deployed to Iraq or Afghanistan suffer from PTSD, depression, or TBI (Tanielian et al., 2008). Depression can impede personal relationships and career advancement, and cause emotional and financial stress in the family, while suicide attempts in particular produce complicated grief and guilt among surviving family members and unit members, and may result in life-long impairment requiring long-term care by a spouse or other family member (Institute of Medicine, 2010).

Substance use disorder has been increasing in recent years among military servicemembers and recent veterans (Department of Defense, 2011). Returning servicemembers are at increased risk for self-inflicted and other-directed harms, including tobacco use, hazardous drinking, drug use, and accidental overdose. Veterans and their family members who do not utilize treatment for mental health problems are at risk for self-medicating symptoms with alcohol or substances, which can further impair their reintegration and damage their personal relationships and financial security. Unfortunately, like other psychological problems, treatment for substance use disorder also carries the burden of stigma associated with treatment (Rae Olmsted et al., 2011).

Military Sexual Trauma (MST)

Female servicemembers, who make up approximately 15% of military forces (Department of Defense, 2010), have high exposure (20-40%) to sexual assault during their service, known as military sexual trauma (MST) (Kelly, Skelton, Patel, & Bradley, 2011). MST also occurs in male servicemembers, but at a lower rate. However, the impact of MST is significant for both male and female servicemembers. Sexual harassment and assault under deployment conditions are associated with a five times greater risk of developing PTSD among female servicemembers and six times greater risk of developing PTSD among male servicemembers, a higher risk than combat itself confers (Kang, Dalager, Mahan, & Ishii, 2005). These traumas are unique to the military experience, as the resulting diagnoses can include an element of "moral injury," a

violation of values and/or a betrayal of trust, which is caused by the assailant's betrayal of the victim's trust and expectation of protection from fellow servicemembers.

SUMMARY

The challenges described above are not a comprehensive list of the Reintegration War challenges that servicemembers, veterans, and their families are facing. However, this list of challenges illustrates the broad scope of issues that we must consider when we seek to support or advance reintegrating veterans and their families. It is imperative that we, as family members, service providers, educators, employers, and community members, not only be fully cognizant of this scope of reintegration issues, but also be aware of how these issues reverberate through the veteran's support network. In order to advance a comprehensive effort to strengthen the reintegration of veterans and their families into the community, we must communicate and cultivate a broader and deeper understanding of these issues within all levels of our society and government—on neighborhood, local, state, and national levels.

Our Challenge

The lack of quality care and support for reintegrating veterans and their families is a significant issue because the strength and viability of our all-volunteer force is undermined when the health and well-being of its members and veterans is so precarious. Hundreds of thousands of servicemembers returning from Iraq and Afghanistan are projected to develop both visible and invisible wounds of war (Institute of Medicine, 2010; Tanielian et al., 2008). Additionally, all of these veterans and their family members are currently reintegrating into their communities or will be over the next several years. These are daunting numbers, which are complicated by the low access to and utilization of services, and even the low levels of military cultural competency among providers. Recent research indicates that veterans were often unaware of available services, were unsure of whether the service would be helpful for their specific problems, lacked information about service locations, were uncertain of eligibility requirements, and did not know how to apply (Schell & Tanielian, 2011).

Despite recent efforts to increase access to appropriate care for veterans, veterans often encounter a civilian environment ill-prepared to accommodate them and their families due to a lack of understanding about the many challenges and issues that military-impacted individuals face. This shortcoming can be detrimental to the health and well-being of veterans and their families, especially if it discourages them from seeking the care or help they require.

Let us pause here for a moment to acknowledge that there is no silver bullet. The challenges of reintegration encompass such a multitude of factors and actors that *no* organization is or can be a one-stop shop for the needs of veterans and their families. Each organization, be it a government department, non-profit organization, or local agency, has unique strengths and skills, and all of us must coordinate in order to accomplish the mission: to help veterans and their families reintegrate into the community.

HOW TO WIN

Let us examine how we can accomplish this mission. Given the daunting reintegration challenges and associated issues facing our servicemembers, veterans, their families, and our communities, it is essential that government agencies, nongovernmental organizations, and professionals work together to create a model of public-private partnership that will enhance the care and services provided to veterans and their families.

To begin, we must first fill the fundamental gap in our knowledge about the needs of reintegrating veterans and families and the experiences of those who use these systems to access help and resources, as well as research and learn about the best treatment practices that we can apply to these individuals. Then, we need to identify our service capabilities. Since none of us can fill every need of military-impacted populations, we must each identify the specific needs or issues that we are best equipped to handle. Next, we must coordinate our response to the needs of veterans and their families by creating an integrated cooperation and referral system, which will facilitate timely access to competent and capable treatment and services.

Identify Needs

In the United States, where there is no universal conscription, the gap between civilian and military culture is significant. The U.S. military has its own distinct culture, and as in all cultures, it has developed its own language, symbols, norms, systems for rewards and punishment, and internal institutions to reinforce expectations. The insularity of military culture promotes unity and resilience for the rigors of war, but it can also leave servicemembers and their families less equipped and less comfortable in a civilian environment. At the same time, the widespread lack of understanding of military culture means that community behavioral health providers and other professionals are less effective in communicating with servicemembers, veterans, and their families, less prepared to recognize the constraints they face, and less able to choose interventions or approaches that are helpful.

This shortcoming is significant because, for example, while military ethical standards and traditions are respected in principle by the civilian community, they carry added meaning not always recognized in a therapeutic encounter and can alter the success or failure of a therapeutic alliance. A veteran or family member who seeks out help can be dissuaded from pursuing treatment or assistance if the provider is not familiar with their most basic values and the constraints of their lifestyle. The general lack of understanding regarding military culture and its significance is the first gap in knowledge that every individual and organization that serves military-impacted populations must bridge. In addition, more research is needed on the effect of military culture on the lives of servicemembers, veterans, and their families across all demographics and military service requirements, especially regarding the effect that these factors have on reintegration.

In 2009, to address this gap in knowledge, the School of Social Work at the University of Southern California established the first-ever graduate Military Social Work specialization in a major civilian research university and created the USC Center

for Innovation and Research on Veterans & Military Families (CIR), which strengthens the transition of veterans and their families into the community. CIR's creation was driven by our recognition of the critical and emergent need for qualified community providers to treat community-dwelling veterans and their families and rigorous applied research highlighting the challenges faced by, and unique strengths of, military-impacted populations.

At CIR, we leverage the unique educational and research resources of the University of Southern California to optimally serve the nation's veterans and their families by conducting practical research that informs policymakers and deepens the understanding of the obstacles faced by returning veterans and their families. This research informs the Military Social Work specialization in the Master of Social Work program at the School, as well as the continuing education courses that CIR has developed for behavioral healthcare providers and other professionals who serve or work with military-impacted populations.

Specify Service Capabilities

The needs and issues relating to reintegration span the entire life spectrum of servicemembers, veterans, and their families, employment, relationships, education, marriage, children, mental and physical health, legal issues, which no single organization can meet alone. If we are to successfully strengthen this population's reintegration into the community, then we must each focus on the functions that we can best perform and cooperate to accomplish the tasks we cannot complete alone.

As an example, CIR is located in Los Angeles and is perfectly positioned to conduct research on the needs and reintegration experiences of military-impacted populations due to the large number of veterans—approximately 1,000,000—living in Southern California. In addition, the U.S. Department of Veterans Affairs estimates that an additional 27,000 veterans migrate to California each year. Finally, Orange County and Los Angeles County combined have the largest concentration of National Guard and Reserve forces anywhere in the country. California, and particularly Los Angeles County, therefore represents a highly significant testing-ground for evaluating and developing new community-based interventions that support positive functioning of veterans in a civilian environment and are socio-culturally adapted for ethnic diversity. For these reasons, one of CIR's strongest contributions to the effort of strengthening the reintegration of military-impacted populations is conducting research that will inform best practices for all service providers.

Furthermore, CIR also contributes on the education and training front, by developing and providing innovative, research-informed instruction to social work students, behavioral healthcare providers, and other professionals that work with military-impacted populations. These providers and professionals are employed by other organizations or agencies whose focus and talent is in competently and efficiently deploying direct services to these populations.

Coordinate Response

Finally, it is unlikely that the needs of veterans and their families, as well as the quality and access to care and qualified providers, will be adequately addressed unless local, state and federal agencies join forces. Therefore, we need to create a coordinated approach to supporting and engaging veterans and their families by bringing together our diverse sets of resources and identifying new opportunities across the public and private sectors.

To begin with, we must achieve greater coordination between the Department of Defense, the Veteran's Health Administration, and civilian health agencies in transferring patient records, sharing knowledge of efficacious and effective interventions, developing a competent workforce, and building community collaborations to serve veterans and their families. In the past, military and civilian services for veterans existed on parallel tracks, but today they are intertwined as never before, driven together out of necessity to address the widespread phenomenon of homelessness, drug abuse, and mental illness among Vietnam veterans. Local mental health clinics, school mental health programs, hospital emergency rooms, and other mental health-affiliated agencies are vital to providing care and support to veterans and their families. Therefore, these civilian providers will require an understanding of the needs in military-impacted populations as well as facilitated access to their medical records, held by military or government agencies.

Next, a coordination effort is required to bring diverse resources together in order to identify new opportunities to cooperate across public and private sectors and develop approaches to providing care and support to veterans and their families. This coordination effort must be based in and informed by the needs of the local community, but also supported at the state level. As a Southern California institution, CIR maintains connections with hundreds of community care and healthcare organizations in the region, and connects them with its local, regional, and national partners in order to advance solutions in research and care for military-impacted populations. Similarly, each region of the country needs an entity that can facilitate the connections, organization, and dissemination of information necessary to coordinate community response to the needs of local military-impacted populations and promote these needs and the needs of the service providers on both a state and national level.

CONCLUSION

No one comes home from war unchanged. For some, leaving the combat zone marks the beginning of a new battle – to reconcile the emotional changes that have resulted from their experiences, to smoothly reunite with their families, to put the stresses of combat behind them, and to find employment that fulfills them and utilizes the skills they have gained. Many veterans and their family members need expert assistance in rebuilding their lives, and it is our responsibility to support them. In order to adequately respond to the needs of veterans and their families and strengthen their reintegration into the community, we must all join together and operate as a single unit—a collection of

capable organizations and individuals, each with specific focus areas and tasks. Only together, and with each other's help, will we accomplish this important mission.

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