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Letter From the Editor

Welcome to the third issue of the *Journal of Military and Government Counseling* (*JMGC*). *JMGC* is the official journal of the Association for Counselors and Educators in Government (ACEG). This journal is designed to present current research on military, veteran, the military family, and government topics. ACEG was established to encourage and deliver meaningful guidance, counseling, and educational programs to all members of the Armed Services, to include veterans, their dependents, and Armed Services civilian employees – this mission was later expanded to include all governmental counselors and educators.

This issue is an eclectic collection of articles in practice, theory, and research. The lead article investigated anger in recent combat veterans. The second article focuses on vacation counseling and education for veterans. The next article is research into the lives experiences of Army social workers in combat. The final article gets creative in working with military families through the deployment cycle. I did not receive a graduate student article for this issue – so, I welcome grad students to submit an article. To the counselor educators – encourage your students (especially veteran students) to submit and article or co-author with them.

I need more submissions for the JMCG – as of today, I do not have enough articles in the queue for another issue. So, ask around where you work – or try writing yourself. I'm advertising for submissions through ACA channels. Now that I have three issues to present, I will be focusing on getting the *JMGC* listed in a database (such as ERIC, SocINDEX, or PsychARTICLES) and assigning Digital Object Identifiers. Once *JMGC* is established, I'll work to have us listed in databases such as PubMed.

Benjamin V. Noah, PhD
JMGC Founding Editor

Correlates of Anger Among Operation Enduring Freedom and Operation Iraqi Freedom Veterans

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Abstract

The relationship between anger and selected variables among combat veterans from Afghanistan and Iraq was examined. The variables included posttraumatic stress disorder, combat experience, social support, and alcohol use. The participants were drawn from an email registry kept at a Veterans Affairs Medical Center. Participants completed an anonymous survey online, which included demographic information and questionnaires related to each of the variables. The data were analyzed using linear, standard, and stepwise multiple regression models. Results indicate that while all independent variables were significantly correlated with anger in the linear regressions, all except for combat experiences were significant in the multiple regression models. Posttraumatic stress disorder had the largest correlation followed by alcohol use and social support. Limitations and implications of the study are also included.

KEYWORDS: military, veterans, anger, combat, PTSD, social support

The aim of this study was to exam the relationship between anger and selected variables among veterans of the present military conflicts in Iraq and Afghanistan. These variables were: posttraumatic stress disorder, combat experiences, alcohol use, and social support.

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As of 2008, over 1.5 million men and women had served in Operation Enduring Freedom (Afghanistan) or Operation Iraqi Freedom (Iraq) (Erbes, Curry, & Leskela, 2009). According to the "Iraq and Afghanistan Veterans of American," close to 2.5 million had served through 2011 (IAVA, 2011). Anger is one of the concerns among war veterans. Anger is a common adaptive response to combat, particularly during the fight or flight moments that arise in instances where one is preparing to fight an enemy or retreat from an enemy (Ovrebo, 2009; Thomas, 2003; Reyes & Hicklin, 2005). However, anger persistence after deployment has been described as a "salient symptom of postwar adjustment" (Chemtob, Novaco, Hamada, Gross, & Smith, 1997, p. 17). Although soldiers deployed to Iraq and Afghanistan are able to communicate with their loved ones at home with significantly more ease than military personnel could during any previous war or conflict, this does not always prevent the stress experienced, and can, in fact, increase stress (Erbes, Polusny, MacDermid, & Compton, 2008). Some additional risk factors that were determined to be associated with increased anger among veterans that have served in Afghanistan include financial problems, housing conditions, occupational difficulty, loss of relationships, and legal problems (Reyes & Hicklin, 2005). These researchers reported that out of 634 soldiers seen for individual therapy between June and December of 2002, anger, depression, and loss were all common in the majority of those soldiers that were diagnosed (Reyes & Hicklin, 2005, p. 485).

Veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have reported other differences in their deployment experiences from previous generations of combat veterans (Erbes, Curry, & Leskela, 2009). Some of the differences include the fact that men and women serving in Iraq are older upon deployment to combat zones, more likely to be married, and more likely to have children; moreover, they are involved in multiple, lengthy deployments (Monson, Fredman, & Adair, 2008). These multiple deployments increase the risk of PTSD and other health concerns (Kline et al., 2010). Additionally, a relatively high number of those who have served in Iraq or Afghanistan are National Guard and Reserve members, and are not in a military training environment on a regular basis (Schnurr, Lunney, Bovin, & Marx, 2009). These, and other, differences highlight the need for further studies utilizing the OEF/OIF population.

It is important to define anger. Dr. Charles Speilberger, a psychologist, defined anger as "an emotional state that varies in intensity from mild irritation to intense fury and rage" (APA, 2010, The Nature of Anger section, para. 1). Dr. Spielberger also stated that anger "can be accompanied by both physiological and biological changes. When one gets angry, his or her heart rate and blood pressure increase, as do fight/fight energy hormones of adrenaline and nonadrenaline" (as cited in Reyes & Hicklin, 2005, p. 483). Anger is not in itself a diagnosable disorder, but can be a part of other diagnoses including chronic alcohol abuse and PTSD (Castillo, Fallon, Baca, Conforti, & Qualls, 2002). The DSM-IV-TR lists "irritability or outbursts of anger" as one of the increased arousal symptoms that may affect those with PTSD (APA, 2000). And, anger has been associated with combat PTSD even after controlling for combat experience and excessive alcohol use (Jakupcak et al., 2007).

Although PTSD among veterans has been heavily researched, research is ongoing, and is expanding to include OEF and OIF veterans. It has been stated that "the assessment and treatment of anger may form a critical component of interventions for PTSD and other mental

health sequelae of trauma exposure" (Forbes et al., 2004, p. 250). Additionally, research indicates that veterans do not always have the awareness about the need to change problematic behavior, such as anger (Murphy, 2004). Among the PTSD research is information on the connection between PTSD, anger, and combat veterans (Deffenbacher & DiGiuseppe, 2002; Hawthorne, Mouthann, Forbes, & Novavo, 2006; Reyes & Hicklin, 2005; Rosen et al., 2001). In addition, variables such as *alcohol* (Deffenbacher & DiGiuseppe, 2002; Eckhardt & Crane, 2008; Forbes et al. 2008; Rosen et al., 2001; Steindl, Young, Creamer, & Crompton, 2003) and *social support* (Card, 1987; Erbes, Polusny, MacDermid, & Compton, 2008; Guay, Billette, & Marchand, 2006; Koenen, Stellman, Stellman, & Sommer, 2003; Strazdins & Broom, 2007) and their association with anger, in particular among combat veterans with PTSD, have been explored.

Despite this research, information on how these variables interact as an explanation for or predictor of anger among OEF/OIF veterans is lacking. There has been research on a variety of combinations of the research variables on several veteran populations to include Vietnam, Gulf War, and OEF/OIEF. However, to the researchers' knowledge, no research has been conducted utilizing an OEF/OIF population and this specific set of variables. Research has shown that veterans who completed an anger management program "reported an increased capacity to control anger" that was maintained for at least 18 months post-treatment (Chemtob, Novaco, Hamada, & Gross, 1997, para. 32). Having this knowledge along with what factors most significantly affect levels of anger among combat veterans may help to enhance the much needed treatment for OEF/OIF veterans.

Research Questions

Based on the gap in literature, the following research question and hypotheses were explored using Linear and Multiple Regressions:

Research Questions
RQ 1: What is the relationship of PTSD with anger among OEF/OIF veterans?
RQ 2: What is the relationship of level of combat exposure with anger among OEF/OIF veterans?
RQ 3: What is the relationship of level of post-deployment social support with anger among OEF/OIF veterans?
RQ 4: What is the relationship of alcohol use with anger among OEF/OIF veterans?
RQ 5: What is the relationship of PTSD, combat exposure, post deployment social support, and alcohol use with anger among OEF/OIF veterans?

Hypotheses
HY 1: Level of PTSD will be significantly correlated with level of anger among OEF/OIF veterans.
HY 2: Level of combat exposure will be significantly correlated with level of anger among OEF/OIF veterans.
HY 3: Level of social support post-deployment will be significantly inversely correlated with level of anger among OEF/OIF veterans.
HY 4: Alcohol use will be significantly correlated with anger among OEF/OIF veterans.

HY 5: PTSD, level of combat exposure, post-deployment social support, and alcohol use will be associated with a significant proportion of the variation in anger among OEF/OIF veterans.

Study Population

The study population consisted of veterans who have served in Afghanistan and/or Iraq during the OEF/OIF wars. These veterans must have served in at least one branch of service (Army, Navy, Air Force, or Marines). The sample for this study was drawn from the OEF/OIF Registry at the Bryan Jennings Dorn Veterans Affairs Medical Center (Dorn VA) in Columbia, South Carolina. Although registered at this hospital, they may be treated at any community based outpatient clinic affiliated with the hospital.

Method of Data Collection

After approval by the Institutional Review Boards, including the Department of Veterans Affairs, Veterans on the OEF/OIF registry (described above) who have provided the Department of Veterans Affairs (VA) with an email address for communication were contacted. These solicitation attempts included information about the study and instructed interested veterans to go to an encrypted link on the internet. Veterans who navigated to the website consented to participate in this study by reading and agreeing to an informed consent. Participants in this study completed demographic information and a number of questionnaires: The Clinical Anger Scale, the Posttraumatic Stress Disorder Checklist, and Combat Exposure Scale, the Duke-UNC Functional Social Support Questionnaire, and the Alcohol Use Disorder Identification Test. (More information on these can be found in the following section.) Participants were able to skip any question(s) they chose and were able to stop the survey at any time. They were reminded many times how to reach out for assistance, should they need it during the survey or afterwards. For example, after certain responses were given. Participants were only allowed to take the survey Monday-Friday, during the hours of 9:00-5:00 EST. The researchers had no knowledge of which veterans received information about the study nor did the researchers have any knowledge of which veterans participated. However, included in the informed consent was contact information regarding how to reach out for mental health treatment including telephone numbers for the Telephone Advice Program Line (TAP Line) that is open and available to veterans 365 days a year, 24 hours a day at (1-888-651-2683); the telephone number of the Suicide Prevention Lifeline (at 1-800-273-TALK); and contact information for the researchers. Participants were notified that although contacting the researchers would disclose that they have participated in the survey, it would not disclose which survey they completed.

Data Collection Instruments

The Clinical Anger Scale (CAS) was copyrighted in 1995 and is used to assess clinical anger. Permission was granted by William E. Snell, Jr., to use this assessment tool for the purpose of this research study. The CAS is a 21-item, Likert scale questionnaire that was "designed to measure the syndrome of clinical anger" (Snell, Gum, Shuck, Mosley, & Hite, 2007, p. 4). Format and scoring are similar to assessment tools previously created by Aaron Beck

wherein 0-13 indicates *minimal clinical anger*, 14-19 indicates *mild clinical anger*, 20-28 indicates *moderate clinical anger*, and 29-73 indicates *severe clinical anger*.

The internal consistency of this scale was analyzed using Cronbach's alpha, which resulted in a reliability coefficient of .94. This and additional information gathered "indicates that the CAS was largely unifactorial in nature, highly reliable, and essentially uncontaminated by social desirable and lying tendencies" (Snell, Gum, Shuck, Mosley, & Hite, 1995, p. 221). Convergent validity for the CAS is supported due to the correlation between CAS with two subscales on the State-Trait Anger Scale (STAS) and the Anger Expression Scale (AES). A factor analysis conducted using the CAS demonstrated internal consistency and test–retest stability (Snell et al., 1995). Data for this analysis were collected from 1986 to 1991 using over 1,100 college students who completed multiple testing instruments in addition to the CAS, including the STAS and the AES. Findings support the convergent validity of the CAS as the scores on the CAS were strongly and positive correlated with both the substances on the STAS and the AES.

The PTSD Check List-Military (PCL-M) contains 17 items, based on the diagnostic criteria outlined in the *DSM-IV-TR* (APA, 2000) that are scored on a 5-point scale with responses that range from *not at all* to *extremely*. This tool was originally developed in 1993 at the National Center for PTSD by Frank Weathers and colleagues (Norris & Hamblen, 2004). According to this same author, in a sample of combat veterans, those with a diagnosis of PTSD obtained a mean of 63.58 *(SD* = 14.14) and those without a diagnosis of PTSD obtained a mean of 34.40 *(SD* = 14.09). Internal consistency has been described as *excellent* and *very high* and test–retest reliability was .96 for Vietnam veterans (Norris & Hamblen, 2004; Orsillo, 2001). Orsillo (2001) also reported that the PCL-M has been significantly correlated with other measures of PTSD among samples of Vietnam and Persian Gulf War veterans. A cut-off score of 50 or above out of 85 possible points is recommended as optimal for indicating PTSD (International Society for Traumatic Stress Studies, 2011). This self-report measure of PTSD takes approximately 5-10 minutes to complete (Orsillo, 2001).

The Combat Exposure Scale (CES) is a 7-item self-report measure that assesses wartime stressors wherein items are rated on a 5-point frequency (United States Department of Veterans Affairs National Center for PTSD, 2010). The score is calculated by using the sum of weight scores with the highest score on this measure being 41 points. *Light combat* is indicated by a score of 0-8, *mild-moderate combat* is indicated by a score of 9-16, *moderate combat* is indicated by a score of 17-24, *moderate-heavy combat* is indicated by a score of 25-32, and *heavy combat* is indicated by a score of 33-41 (U.S. Department of Veterans Affairs for PTSD, 2010).

Three studies were conducted to assess the psychometric properties of this scale which investigated the internal consistency, factor structure, test–retest reliability, and "a comparison of scores of combat veterans who did and not reach DSM criteria for PTSD" (Keane et al., 1989, p. 53). These researchers found a high degree of reliability, .85, using a sample of 362 Vietnam veterans. In addition, an internal consistency level of .75 was determined using item-reminder total score correlations. Participants completed this scale twice, with one week in between, and the results indicated that $r(29) = .97$, $p < .0001$. This indicates "excellent stability over this time period" (Keane et al., 1989, p. 54). In the third research study using 30 Vietnam veterans who

held a PTSD diagnosis and 32 Vietnam veterans without a psychiatric history, there was a statistically significant difference in the scores (29.37, *SD* = 10.42 versus 22.84, *SD* = 10.42, respectively).

The participants also completed the Duke-UNC Functional Social Support Questionnaire (FSSQ). This eight-item instrument is designed "to measure an individual's perception of the amount and type of personal social support" and was designed to reflect the multidimension content (Broadhead, Gehlback, DeGruy, & Kaplan, 1988, p. 246). Participants completed items that fell under subgroups of quantity of support, confidant support, affective support, and instrumental support that will be scored on a 5-point Likert-type scale. The creators of the instrument explain that "higher scores reflect higher perceived social support" (Broadhead et al., 1988, p. 247). According to these researchers, the FSSQ was tested on 401 randomly selected participants attending a family medical clinic; the population consisted primarily of Caucasian females. A correlation coefficient of .66 was found for test–retest reliability; to improve instrument reliability, the original scale was reduced from 14 items to eight items. Construct and concurrent validity were also supported.

The AUDIT, Alcohol Use Disorders Identification Test, is used readily by the World Health Organization to "identify persons with hazardous and harmful patterns of alcohol consumption" (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001, p. 2). According to these authors, the 10-question AUDIT was developed and evaluated over a period of two decades and has been found to be accurate across gender, age, and cultures. There is increasing evidence that this test is valid and reliable (Babor et al., 2001). According to these authors, a score of 8 or more indicates harmful alcohol use.

Demographical Profile of Participants

One hundred and fourteen individuals agreed to the informed consent and began the survey. All participants who completed 75% or more of the survey (or answered at least 47 out of the 63 questions not including demographics) were included in this research as participants. This criterion reduced the total number of participants to 97. Answers that were not submitted were coded by taking the average score from the other participants for that question.

The age range was 24-62 years (42 ± years). There were 10 participants who reported their gender as female and 87 participants who reported their gender as male. Sixty participants reported having served in the Army, 21 reported having served in the Air Force, 8 reported having served in the Marines, and 7 reported having served in the Navy. Of these, 55 were serving on active duty prior to being sent to Afghanistan or Iraq, 32 were serving in the National Guard, and 16 were in the Reserves. There was some overlap as several participants reported having been on active duty and the National Guard prior to deployment. Total length of military service ranged from 2 years to 37 (± 17 years). Twenty-three participants were currently serving.

Twenty-five participants served in Afghanistan (22 served one tour, two served two tours, and one served three tours). The average length of time spent in Afghanistan was approximately 8 months. Seventy-six of the participants served in Iraq (63 served one tour, nine served two tours, two served three tours, one served four tours, and one served 5+ tours). The average length

of time spent in Iraq was approximately 10.5 months. There was some overlap as several participants reported having served in both Afghanistan and Iraq. Several participants indicated that they served in Middle Eastern countries other than Afghanistan or Iraq. These veterans are considered OEF/OIF according to the Department of Veterans Affairs.

Fifty-eight participants worked full-time while six participants worked part-time. Of the 33 participants who reported being unemployed, 16 were seeking employment. Twenty-two of the subjects reported being full-time students and 5 reported being part-time students. The majority of participants (60) were married at the time of the survey; 7 were separated, 11 were divorced, 1 was widowed, and 18 never married. Of those that were married, 34 were married to a first spouse, 17 married to a second spouse, 7 married to a third spouse, 1 married to a fourth spouse, and 1 married to a fifth spouse.

Thirty-eight participants reported having been diagnosed with posttraumatic stress disorder (PTSD), but 39 reported having been treated for PTSD. Thirty-three reported having been treated for PTSD with a combination of mental health medication and counseling, two with medication alone, and four with counseling alone. Twenty-six participants reported being service connected for PTSD; 60 reported never having applied, five reported applying and awaiting a reply, and six reported applying and having their claim denied. Service connected participants reported their rating on a scale of 10% (2), 30% (11), 50% (9), 70% (3), and 100% (4). Twenty participants reported having been previously involved in treatment for anger. Despite 22 participants reporting that they would like to speak with someone regarding PTSD treatment or anger management treatment, no participant made contact requesting assistance.

Testing Assumptions

The average score was input for missing data. There was only one outlier, in the Functional Social Support Questionnaire (FSSQ). This was determined based on Mahalanobis distance and chi-square value. After the data was analyzed with the outlier and without the outlier, statistical significance was determined either way; therefore, the outlier did not hurt the data and remained in the data set. Normality, multivariate normality, and linearity were slightly positively skewed, but not enough to require data transformations. The assumptions of homoscedasticity and homogeneity of variance-covariance were met. Additional testing assumptions will be explained along with the results of the regressions below.

Descriptive Statistics

Table 1 describes the descriptive statistics for each variable. The mean for the Clinical Anger Scale (CAS) was 34.04±12.64. This mean is in the severe range on the clinical anger scale. The mean for the Functional Social Support Questionnaire (FSSQ) was 1.86±1.0. This mean indicates low perceived social support. The mean for the PTSD Check List-Military (PCL-M) was 35.47±18.13. This mean is below the cut-off score of 50 that indicates PTSD. The mean for the Combat Exposure Scale (CES) was 14.73±5.85. This mean is in the mild-moderate range for combat exposure. The mean for the Alcohol Use Disorder Identification Test (AUDIT) was 15.70 ±5.54. A score of 8 or higher indicates problematic drinking.

Results of Regressions

Anger and posttraumatic stress disorder. A linear regression analysis was conducted to evaluate the association of posttraumatic stress disorder (PCL-M) with anger (CAS). The scatterplot for the two variables indicated that the two variables are linearly related. The regression equation for predicting clinical anger is *Posttraumatic Stress Disorder* = .630 *Anger* + 11.701. PTSD scores account for 81.6% of the variance in the anger scores. The correlation between PTSD and anger is .903 and $p<.001$. As this is statistically significant, Hypothesis 1 (level of PTSD will be significantly correlated with level of anger among OEF/OIF veterans) can be accepted.

Anger and combat exposure. A linear regression analysis was conducted to evaluate the association of combat experiences (CES) with anger (CAS). The scatterplot for the two variables indicates that the two variables are linearly related. The regression equation for predicting clinical anger is *Combat Experiences* = .814 *Anger* + 22.403. Combat scores accounts for 14.2% of the variance in the anger scores in the linear regression. The correlation between combat experiences and anger is .377 and $p<.001$. As this is significant, Hypothesis 2 (level of combat exposure will be significantly correlated with level of anger among OEF/OIF veterans) can be accepted.

Anger and social support. This is an inverse correlation because the lower the score on the Functional Social Support Questionnaire (FSSQ), the less amount of perceived social support. The Clinical Anger Scale (CAS) works in the opposite direction. A linear regression analysis was conducted to evaluate the association of social support with anger. The scatterplot for the two variables indicate that the two variables are linearly related. The regression equation for predicting clinical anger is *Social Support* = 5.595 *Anger* + 22.520. FSSQ scores accounted for 25.1% of the variance in the anger (CAS) scores. The correlation between social support and anger is .501 and $p<.001$. As this is significant, Hypothesis 3 (level of social support post-deployment will be significantly inversely correlated with level of anger among OEF/OIF veterans) can be accepted.

Anger and alcohol use. A linear regression analysis was conducted to evaluate the association of alcohol use (AUDIT) with anger (CAS). The scatterplot for the two variables indicates that the two variables are linearly related. The regression equation for predicting clinical anger is *Alcohol Use*= .799 *Anger* + 21.503. Alcohol scores accounts for 12.2% of the variance in the anger scores. The correlation between alcohol use and anger is .35 and $p<.001$. As this is significant, Hypothesis 4 (alcohol use will be significantly correlated with anger among OEF/OIF veterans) can be accepted.

Anger and integration of variables. Standard and stepwise multiple regressions were conducted to predict the effect of PTSD, combat exposure, alcohol use, and social support on the anger among OEF/OIF combat veterans. There is no multicollinearity in this data. This assumption is demonstrated to be met as there is a relationship above .3 between each of the independent variables and the dependent variable. None of the correlations are above .7; therefore, all variables will be retained. Additionally, tolerance values are higher than .10 and the variance inflation factor is less than 10 (see Tables 1 and 2).

Table 1
Correlations

		CAS	FSSQ	PCL-M	CES	AUDIT
(Pearson *r*)	CAS	1.000	.453	.903	.377	.350
	FSSQ	.453	1.000	.569	.155	.241
	PCL-M	.903	.569	1.000	.422	.283
	CES	.377	.155	.422	1.000	.199
	AUDIT	.350	.241	.283	.199	1.000
Sig. (1-tailed *t*)	CAST	.	.000	.000	.000	.000
	FSSQT	.000	.	.000	.065	.009
	PTSDT	.000	.000	.	.000	.002
	CEST	.000	.065	.000	.	.026
	AUDIT	.000	.009	.002	.026	.

Table 2
Coefficients

	Correlations			Collinearity Statistics	
	Zero-order	Partial	Part	Tolerance	VIF
(Constant)					
FSSQ	.453	-.210	-.088	.659	1.518
PCL-M	.903	.864	.702	.553	1.809
CES	.377	-.060	-.024	.802	1.246
AUDIT	.350	.256	.108	.900	1.111

The normal probability plot of the regression standardized residual and the scatterplots do not indicate any major deviations from normality. As indicated previously, the only outlier was in the FSSQ and it was determined that this outlier did not affect the results. As shown in Table 3, the standard multiple regression indicates that the overall model of the four independent variables significantly predict anger, R^2=.833, R^2_{adj}=.826, $F(4,97)$=114.93, $p<.001$. Review of the beta weights indicate that PCL-M, β=.944, $t(97)$=16.485, $p=<.001$, FSSQ, β= -.108, $t(97)$= -2.057, p=.043 and AUDIT, β=.144, $t(97)$=2.538, p=.013, significantly contributed to the model (see Table 4). The three variables accounted for 83.3% variance in anger among OEF/OIF combat veterans. Combat (CES) was not significant (β= -.027, $t(97)$= -.572, p= .569). These results indicate that Hypothesis 5 (PTSD, level of combat exposure, post-deployment social support, and alcohol use will be associated with a significant proportion of the variation in anger among OEF/OIF veterans) can be partially supported.

Table 3
Anger and Integration of Variables (Standard)

Model	R Square	Adjusted R Square	df	Sig.
1 Regression	.833	.826	4	.000
Residual			92	
Total			96	

Table 4
Anger and Integration of Variables (Standard)

Model	Beta	*t*	Sig.
FSSQ	-.108	-2.057	.043
PCL-M	.944	16.485	.000
CES	-.027	-.572	.569
AUDIT	.114	2.538	.013

  A stepwise multiple regression was then completed wherein the predictor for Model 1 was PCL-M, the predictors for Model 2 were PCL-M and AUDIT, and the predictors for Model 3 were PCL-M, AUDIT, and FSSQ. CES was entered into the stepwise multiple regression but deleted as it was not significantly correlated with CAS. As indicated in Table 5, PCL-M accounted for 81.6% of the variance, PCL-M and AUDIT together accounted for 82.5%, and PCL-M, AUDIT, and FSSQ accounted for 83.3%. The ANOVA indicates that all models are statistically significant wherein $p<.001$.

Table 5
Anger and Integration of Variables (Stepwise)

Model	R Square	Sig.
1	.816	.000
2	.825	.000
3	.833	.000

Discussion and Implications for Practice

  Based on the results of this research study, OEF/OIF combat veteran diagnosed with PTSD would benefit from a course in anger management that is specifically tailored to meet the unique needs of this population. As a result of reducing their problematic anger, this population

might be more successful at managing other troublesome symptoms including their PTSD symptoms. Anger needs to regularly be assessed.

Forbes et al. (2008) stated that in order to improve the efficacy of treatment, alcohol use among veterans needs to be more readily assessed. Based on the numbers of OEF/OIF veterans who report hazardous alcohol use, this is very much warranted. However, not only does assessment need to increase and improve, but this population needs broader and quicker access to substance abuse treatment.

Additionally, this population needs to be evaluated for low social support. Those that are without sufficient social support should be educated on ways to find and maintain social support and follow-up should be provided to ensure this is taking place. Peer support trainings should be more widely available and support groups should be readily offered.

Limitations of the Study

As with any research study, this study has a number of limitations. While the largest group of OEF/OIF veterans nationally is under the age of twenty-nine, the average age of those who participated in this research study was forty-two years old. This may limit the generalizability of the results as the difference in age might have an impact in every area (Brown, 2009). For example, older veterans may manage anger in a different way than younger veterans; they may perceive social support differently, and so forth. Additionally, the lack of association between anger and combat exposure in the multiple regression is a limitation to this study. It would be helpful to further explore this in particular the possibility of a mediating variable having an impact on this relationship.

As the participants completed the survey anonymously online, the validity and reliability of the data might be questioned. The veterans were sent a link to their email addresses, but there was no way to ensure that the intended recipient completed the survey. Additionally, although the participants were asked to only take the survey one time, there was no way of ensuring this. This could be remedied by having participants come to a VA facility where a research assistant could monitor in order to prevent duplication.

Finally, the issue of service connection must be addressed. Despite the fact that it was clearly noted in the request letter and informed consent that service connection would not be affected, it is possible that some veterans may have chosen not to participate in the survey for fear it would affect their service connection claim or rating. Additionally, there is a possibility that those who did participate were concerned about their service connection rating and may have answered questions accordingly. In other words, they may have exaggerated their symptoms out of worry that lower scores would lead to a reduction in service connection rating or prevent them from getting an increase in service connection rating. That being stated, it is important to note that less than a quarter of the participants scored in the PTSD range on the PCL-M, no participant reported heavy combat, and all participants scored above the cut-off on the AUDIT which indicates the possibility of problematic drinking behavior

.

Recommendations for Future Research

If a replication study were conducted, the study might be strengthened by having participants complete the survey online at a VA medical center to ensure participants are OEF/OIF veterans and to ensure they only take the survey one time. However, this also has the possibility of reducing participation due to time involved. This same study could be conducted using veterans from other eras (such as Vietnam or Gulf War) in order to determine if there are any differences in the results based on specific combat experiences.

Future research could specifically include veterans who have served in Middle Eastern countries other than Iraq or Afghanistan during this time period in order to obtain a clearer picture of effects that serving in various combat zones has had on American service men and women. A similar study could be conducted without PTSD as a variable. This might help to obtain a clearer picture as to the role of combat exposure, alcohol use, and social support on anger among OEF/OIF veterans. As "research on processes by which social support has its effects on PTSD remains in its infancy," more research on the relationship between PTSD, social support, and anger could also be conducted (Guary, Billette, & Marchand, 2006, p. 329). Additionally, other instruments could be used to help determine if the results of this study are reliable.

Finally, it might be helpful to replicate this study with a veteran group and a non-veteran group in order to look at differences. In particular, it would be helpful to assess level of anger among non-veterans with PTSD. One option would be for the study could seek applicants that have been diagnosed with PTSD by a mental health professional.

Conclusion

The purpose of this research study was to explore who among veterans that have served in Operation Enduring Freedom or Operation Iraqi Freedom may experience higher levels of problematic anger. The hypotheses stated that anger and each of the four independent variables (PTSD, combat experiences, alcohol use, and social support) would all be statistically significantly correlated and that all four of the independent variables combined would be significantly correlated with anger. Four of the five hypotheses were met. The exception was that combat experiences was not significantly correlated with anger in the standard multiple regression, and, as a result, was left out of the stepwise multiple regression. The stepwise multiple regression revealed that PTSD was the most significantly correlated with anger followed by alcohol use and social support. The results indicate that it would be beneficial for all OEF/OIF veterans with PTSD to complete a course in anger management designed specifically for this population. Additionally, it is necessary for this particular population to be carefully screened for alcohol abuse/dependence and provided appropriate treatment. It is also important for members of this population to be educated on how to obtain and maintain necessary social support. This study could be replicated or modified in a number of ways in order to further the knowledge related to anger among OEF/OIF veterans.

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Impact of Vocational Counseling and Education on Work Attitudes and Job Placement of Recovering Substance Abusers: Implications for Veterans

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Abstract

Substance abuse impacts the vocational success of veterans and non-veterans. Recent findings suggest that job placement of recovering substance abusers is positively correlated with level of education and work attitudes (Kidorf, Neufeld, & Brooner, 2004). This study used a quasi-experimental design to examine the role of vocational counseling in improving job placement outcomes. It also examined the relationship between duration of counseling and level of education on ensuing work attitudes and the subsequent relationship between work attitudes and job placement rates. Results revealed that work attitudes improved as a function of education and duration of counseling, and the correlation between employment rates and work attitudes was marginal. Implications of how these findings will impact vocational rehabilitation service provision will be discussed.

KEYWORDS: vocational counseling, vocational outcomes, work attitudes, veterans

Individuals with a history of substance abuse face several barriers to employment, some of which include intermittent work history, few transferrable skills, reliance on government benefits, stigma, and presence of forensic history (Joyakody, Danziger, & Pollack, 2000). Lichter and Joyakody (2002) assert that many times, these barriers pose a greater challenge than the actual addiction. Therefore, vocational counseling guides a person in reconnecting natural and social supports which can help rebuild a network that can encourage work readiness, employment acquisition, and retention (Magura, Staines, Blankertz, & Madison, 2004).

According to the National Institute on Drug Abuse (2008), substance abuse hinders individuals from optimally performing in vocational settings. Several studies have found that job

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placement success amongst individuals with disabilities is impacted by variables such as work attitude, vocational counseling, and level of skill or education (Kidorf, Neufeld, & Brooner, 2004; Magura & Staines, 2004; Roessler, 2003). Due to fiscally conservative programmatic practices that are in use today, greater stress is placed upon short-term counseling techniques that prepare individuals for vocational readiness (Atherton, 2011; Leukefeld et al., 2003). In order to determine whether duration of vocational counseling and level of education can contribute to successful job placement outcomes, it will be important to understand the effect of vocational counseling and level of education on ensuing work attitudes of recovering substance abusers.

Landmark rehabilitation acts serve as the backbone of the service delivery process for veterans and civilians. The Smith-Hughes Act served to restore vocational independence to veterans from the Spanish-American War, while the Smith-Sears Act provided aid to veterans of World War I, and the Smith-Fess Act expanded the scope of service by addressing the social, education, and vocational needs of civilians and veterans with disabilities (Roessler & Rubin, 2006). These laws have guided the ultimate goal of rehabilitation, which is to assist individuals in maximizing their postmorbid work potential via education and training, so that they can be matched with vocations that can lead to employment (Cottone & Tarvydas, 2001).

In response to economic changes that have impacted the rehabilitation services community in the past decade, great stress is being placed on state, federal, and local (public and private) programs that promote job placement for persons with disabilities. According to Erickson, Lee, and von Schrader (2012), only 33.9% of individuals with disabilities were employed in 2010, indicating that nearly 66% of the population of individuals with disabilities is unemployed. This statistics is not significantly different for veterans with disabilities, who comprise 18.9% of the total veteran population (Erickson et al., 2012). Accordingly, the last fifteen years have witnessed rehabilitation agencies develop multitudes of programs that aim to improve vocational skill building, match interest with abilities, and promote subsequent job placement and retention (Chandler, Meisel, Jordan, Rienzi, & Goodin, 2004). Although skill acquisition is still integral to vocational success, greater focus is being placed on the development of programs which enhance job acquisition and retention (Rogers, Anthony, Lyass, & Penk, 2006).

Shepard and Reif (2004) indicate that evaluation of counseling methods and placement strategies that contribute to job placement is not a well-explored area in the field of rehabilitation literature. Furthermore, there are distinct gaps in the literature pertaining to the work attitudes of persons recovering from substance abuse. Gaps in literature exist because work attitudes were originally studied amongst persons with physical conditions, not those in remission for substance abuse (Gilbride, Mitus, Coughlin, & Scott, 2007). Additionally, much of the literature has not focused on the role of level of education on the ensuing work attitudes and employment success rate of persons with disabling conditions (Blustein, Kenna, Gill, & DeVoy, 2008). So, the vocational and educational needs of recovering substance abusers and their ensuing work attitudes need to be examined further. Furthermore, little is known about the role of counseling and the level of education in the job placement success of this population (Magura et al., 2004; Chan, Chieng, Chan, Rosenthal, & Chronister, 2006). Accordingly, the need to study the duration of counseling and level of education on the work attitudes and vocational placement of recovering drug abusers exists.

This study used a quasi-experimental design to investigate how employment-focused vocational counseling and level of education impact work attitudes and successful vocational outcomes. The independent variables were duration of counseling (brief or baseline) and level of education and the dependent variables were work attitude scores and job placement. The Job Search Attitude Inventory (JSAI) was used to measure work attitudes, while actual employment acquisition measured vocational outcomes. Vocational counseling was defined as either brief (fast-track) or baseline (traditional) in duration. Brief vocational counseling (control measure) offered 10 hours of counseling in 12 weeks and provided essential preparation of employment strategies (i.e., job readiness and job hunting skills). In contrast, baseline vocational counseling (treatment measure) offered 20 hours of counseling in 12 weeks and provided comprehensive preparation of employment strategies (i.e., job readiness and job hunting skills). A rehabilitation services department from a northeastern state (RSD) uses both brief and baseline techniques, but fiscal drawbacks are encouraging the use of fast-track services, thus the efficacy of brief vocational counseling is of great interest (Blustein, Kenna, Gill, & DeVoy, 2008).

Three research questions, along with three null (Ho) and three alternate (H) hypotheses guided this study. All research questions and hypotheses were addressed based on scores obtained after three months of counseling. The research questions and hypotheses are listed below.

Research question #1: Was there a significant difference between work attitudes in the baseline group compared to the brief group?

H1: There was a significant difference between work attitudes generated by participants in the baseline group, compared to those of their cohort in the brief group.

Ho1: There was no significant difference between work attitudes generated by participants in the baseline group, compared to those of their cohort in the brief group.

Research question #2: Was there was a significant difference between work attitudes as a function of level of education (no high school diploma, high school diploma, and some college)?

H2: There was a significant difference between work attitudes as a function of level of education (no high school diploma, high school diploma, and some college).

Ho2: There was no significant difference between work attitudes as a function of level of education (no high school diploma, high school diploma, and some college).

Research question #3: Was there a significant relationship between posttest work attitudes and job placement?

H3: There was a significant relationship between posttest work attitudes and job placement.

Ho3: There was no significant relationship between posttest work attitudes and job placement.

We attempted to extend current trends in research. It was expected that baseline vocational counseling would be associated with higher work attitudes, which would be associated with higher employment rates. We also expected that people with higher education

levels would possess higher work attitudes that would be associated with greater placement outcomes.

Method

Due to recent changes in the economic climate, rehabilitation agencies are forced to save time and money and produce greater results in fewer counseling hours. Thus, the new wave of vocational counseling is referred to as brief or fast-track counseling. At present, the state education department of a large northeastern state utilizes both measures (baseline and fast-track) and asserts that both versions of counseling are equally effective. As a result, this study compared the two approaches to assess if one was more effective than the other in producing positive placement outcomes (employment).

A review of demographic trends from the local area revealed that recovering substance abusers from outpatient TCs could naturally be divided into three groups of educational achievement. As a result, level of education became an organic variable that could not be controlled. In an effort to add randomness to the design, clients were randomly assigned to either the treatment or control counseling group and both groups received the pretest and posttest, prior to and after receiving the counseling intervention. Nevertheless, due to the organic variable, the groups were inherently nonequivalent and, therefore, we chose a nonequivalent quasi-experimental design.

Participants

Substance Abuse and Mental Health Services Administration (SAMSHA) indicates that cocaine is often abused in conjunction with alcohol (2006). Therefore, this study defined a recovering substance abuser as an individual whose primary drug of choice (DOC) was cocaine and secondary DOC was alcohol, with an overall history of one or more years of drug abuse, and at least six months of sobriety via a state-approved treatment center (TC). Given that all participants were affiliated with TCs under the supervision of the Office of Drug and Alcoholism located in a large northeastern metropolitan city, it was assumed that participants were affiliated with AA (Alcoholics Anonymous) or CAA (Cocaine Abusers Anonymous) and were in receipt of similar out-patient substance abuse prevention services.

Recovering drug abusers receiving treatment from OSD supervised TCs in a metropolitan city in a northeastern state comprised the overall population. Participants were between 20 to 45 years of age, the population size was approximately N=9,000 and the sample size was *n*=900. Since this study only presents data pertaining to veterans recovering from substance abuse, the subpopulation was approximately N=820 and the subsample was *n*=81.

Of the 81 individuals who were sent the engagement letter, 75 responded to the letter, 71 started the study, and 63 completed the study. Participants were organically divided into three relatively equivalent stratified groups: no HS diploma or GED (n=20), HS diploma or GED (n=24), and some college (n=27). Half of the participants from each stratified group were randomly assigned to the control group and the other half were assigned to the experimental

group. Of the total 71 participants, half (35) were randomly assigned to baseline counseling, while the other half (36) were assigned to brief counseling.

Research Methods

A 3X2 pretest-posttest comparison group design was used because level of education, an organic variable, could not be randomly assigned. The study explored the effect of the first independent variable (duration of counseling: brief or baseline) and the second independent variable (level of education: no high school diploma, high school diploma or GED, or some college - up to an Associate's degree) on the ensuing dependent variables of work attitudes (scores on the JSAI scale) and job placement outcomes (employed or unemployed). Duration of counseling was divided into two groups: 20 hours in three months (the baseline or control group) and 10 hours in three months (the treatment or experimental group). It is important to note that while the control group was comprised of greater counseling hours, it was deemed as the baseline group because traditional vocational counseling offers approximately 20 hours of service per three-month period. In contrast, the treatment group was comprised of 10 hours of vocational counseling per three months and was known as the fast-track counseling group.

Measures

Work attitude scores. The Job Search Attitude Inventory (JSAI) is an interval measure that calculates work attitudes related to job placement and possesses excellent content and construct validity, as well as strong reliability (reliability coefficient of .76), with an internal consistency of α=.91 (Lock, 2005). It presented 32 multiple choice questions with responses on a four-point Likert scale. Scores on the JSAI range from 132 to 28 (Liptak, 2001). Several items from the JSAI are similar in content to the Assertive Job Hunting Survey (internal consistency of α=.82), and the Job Seeking Self Efficacy Scale (internal consistency of α=.90), both of which are valid and reliable measures of job seeking abilities and efficacy related to job placement success (Strauser & Berven, 2006).

Job placement. Job placement, also known as employment, was a naturally dichotomous demographic variable that was measured at the end of the study. Employment was a nominal measure and was either measured as placement (1 point = job acquisition) or no placement (0 point = no job acquisition). A point bi-serial correlation was used to explore the relationship between job placement and work attitude scores in order to explore the relationship between the two variables. The RSD measures employment on an annual basis, as it is directly linked with program success and funding.

Statistical evaluation. Data were analyzed via the use of a one-way repeated measures 2X3 factorial ANOVA, with pretest-posttest comparison groups, on SPSS. The independent variables were level of education and counseling duration and the dependent variables were work attitudes and employment.

Procedure

The target population was narrowed to outpatients from two state-accredited TCs. Individuals from these TCs were distributed across 15 counseling caseloads in the RSD and resulted in a roughly even distribution (270) when divided across three educational levels. In order to obtain a stratified sample, about 10% of the individuals (27) were randomly selected from each group, comprising a sample of *n*=81. A computerized randomization method using the probability proportionate to size method was used for selection of participants by RSD administration. We received a list of 81 clients, with corresponding contact information and names of the respective out-patient substance abuse counselors.

The RSD provided the sampling frame, as it maintains a list of screened clients who meet the definition of recovering drug abuser. As per agency management, the study maintained ethical guidelines espoused by the American Counseling Association (ACA) and the Commission on Rehabilitation Counselor Certification (CRCC). At all times, participant privacy, confidentiality, anonymity, and beneficence were endorsed.

An engagement letter was used to recruit participants and obtain informed consent. To ensure that at least 20% of the clients would respond to the letter, ten days after mailing the first engagement letter, a second letter identical to the first, was mailed to clients who didn't respond to the initial attempt. A final engagement letter, sent one week after the second letter, was sent to clients who had failed to respond. Lastly, a scripted phone call, made seven days after the final letter, was used to attempt to recruit potential participants and reaffirm informed consent. Most participants responded to the first and second engagement letters, so the phone call was only used for a total of 9 participants. Those who chose to not pursue the study were thanked for their time and the phone call was terminated. Additionally, in order to assure that potential participants understood the engagement letter, a copy of the letter and informed consent form were forwarded to each individual's respective substance abuse counselor and vocational counselor.

Once executed, informed consent was received from each participant; the participant was mailed a post-engagement letter scheduling the pretest within the following two weeks and was reminded that counseling services would begin after seven days. The letter also advised participants that they would take a 15 to 20 minute survey (JSAI pretest) one week before starting the counseling intervention. Participants were advised that the JSAI would be administered in group format in a state-run facility conference room (operated by the RSD). Date, time, and location of the survey were specified in the same letter and participants were informed that all procedures were standardized. The post engagement letter also clarified that the survey would be administered a second time, via group format, one week after the counseling sessions completed. On the day of the survey, participants were informed that they would be allowed 30 minutes to take the survey.

Counseling took place over a span of three months, was preceded by the pretest, and followed by the posttest. Directions for completing the survey were read aloud to participants, but participants were also provided time to read the directions and ask questions. Directions and

content of the JSAI were presented at the 7th grade reading level, with the assumption that the material would be understood by all participants.

Job placement was measured if a participant actually obtained employment. One month after counseling was completed, participants were contacted a final time via a scripted phone call written at the 5th grade readability level. They were asked if they were already employed or were scheduled to start a job in the coming weeks. The information was used to link the relationship between vocational counseling, work attitudes, and job placement. It was expected that individuals who received brief counseling (10 hours) would indicate a lower work attitude, while those who received baseline counseling (20 hours) would indicate a higher work attitude score. The JSAI was used to measure job-seeking efficacy and successful job placement (vocational success) and was administered as a pretest and posttest survey. The pretest was administered a week before the start of the intervention, and the posttest was administered a week after the end of the intervention. Meanwhile, job placement rates were obtained one month after the completion of the intervention. Posttest JSAI scores and job placement rates were correlated to examine the relationship between job placement and vocational counseling.

Data Entry

All surveys were checked for completeness. In an effort to protect privacy, the database was stored on a secure computer in a locked room, which was only accessible to the primary researcher (Neuman, 2006). Data entry was checked during the pretest and posttest phases, and discrepancies in data were checked and corrected.

Analysis

Central tendency measures and measures of variability were used to analyze the results (Mertens, 2005). As well, an independent samples *t-test* and one-way 2X3 repeated measures factorial ANOVA were calculated to determine significant differences between pretest and posttest results. Grouped nominal data were also produced from job placement results for those who were employed in comparison to those who were not (Neuman, 2006). Since the job placement data were naturally dichotomous and nominal, and the work attitude scores were interval, a point bi-serial correlation was used to examine the relationship between work attitude scores and job placement results (Heiman, 2000). Furthermore, work attitude scores were analyzed via a 2X3 repeated measures factorial ANOVA, using the factors of level of education and hours of counseling (Mertens, 2005).

Validity

Internal Validity

The extraneous variable of counseling method was controlled by offering all clients standardized vocational counseling services by the RSD. Additionally, an effect of researcher inference was not identified, since counseling services and continuing education were provided by RSD staff. As well, a therapeutic referral system was offered to participants who experienced traumatic life events while participating in the study and data from these persons was removed

from the study. Lastly, both the pretest and posttest presented the same questions in order to address the impact of test content on validity (Neuman, 2006).

External Validity

The researchers were interested in learning if the findings possessed transferability to other situations, times, and disability populations beyond the nature of this study (Neuman, 2006). The transferability of findings to recovering substance abusers in other states and nations was of primary import. Use of a large sample enhanced the generalizability of results across systematic replications with different age groups, ethnicities, and drug cultures (Leedy & Ormrod, 2005).

Ethical Issues

According to the American Counseling Association (2005) and the Commission on Rehabilitation Counselor Certification (2010), the welfare of human participants must be of primary concern in a research study. As a result, this study addressed participant rights, confidentiality, informed consent, protection of privileged information, anonymity, protection from harm, data storage, and honesty with professional colleagues in the informed consent form and the Institutional Review Board (IRB) application. As well, these issues were explained to the participants, so that they were aware of their rights and understood how their data would be used during in the study (Corey, G., Corey, & Callanan, 2011).

The potential for risk in this investigation was quite minimal, as vocational counseling and the use of a work attitudes measure are not emotionally invasive procedures (Reardon & Bullock, 2004). However, participants were free to not respond to any of the survey items that made them feel uncomfortable and had the right to stop participating in counseling services at any time. Also, a 24-hour referral service to a free local counseling center was arranged for participants who needed counseling during the course of the intervention. As well, these clients were removed from the study and their data were not used for statistical analysis.

Results

Education and counseling played a direct role in the work attitudes and subsequent job placement success of participants. The results pointed to the relevance of vocational counseling and the need to provide services to improve the vocational potential of recovering substance abusers. Though 81 clients agreed to participate in the study, only 63 completed the study.

Description of Participants

The study was comprised of out-patient recovering substance abusers who received vocational counseling via the RSD. At the start of intervention, 81 participants expressed interest in participating in the study, but 6 refused to sign the consent form, 75 consented to participate, 71 started the study, while only 63 completed the intervention in its entirety. Attrition of eight individuals took place, such that six dropped out due to drug relapse, one dropped out due to homelessness, and another dropped out due drug sale and possession. The research sample was comprised of n = 63 (males = 57). Table 1 presents a distribution of study participants in the

pretest-posttest groups. The research sample was uniformly distributed across the education and counseling categories: 35 (49.30%) received baseline counseling, while 36 (50.70%) received brief counseling. Each counseling by education cell contained between 6 and 16 participants, such that clients were organically divided into relatively equivalent stratified groups: no HS diploma or GED (n=11), HS diploma or GED (n=28), and some college (n=32). Half of the participants from each stratified group were randomly assigned to baseline treatment and the other half were in to experimental treatment.

Table 1. *Descriptive Statistics for the Dependent Variable (JSAI Scores) Across the Independent Variables (Counseling and Education) for Pretest-Posttest Difference Scores*

	Mean Difference Score	Difference Score *SD*	N (pre)	N(post)	%
Baseline Counseling					
No HS Diploma	19.80	3.70	5	5	14.29
HS Diploma/GED	25.62	3.75	14	13	40.00
Some College	33.79	7.27	16	14	45.71
Total	26.40	7.59	35	32	100.00
Brief Counseling					
No HS Diploma	11.40	4.10	6	5	16.67
HS Diploma/GED	20.42	5.60	14	12	38.89
Some College	18.93	5.01	16	14	44.44
Total	16.20	5.88	36	31	100.00
Total (Baseline + Brief)					
No HS Diploma	15.60	3.90	11	10	15.49
HS Diploma/GED	23.02	4.68	28	25	39.44
Some College	26.36	7.14	32	28	45.07
Total	21.60	5.24	71	63	100.00

Note. N = number of subjects; *SD* = standard deviation of difference scores between JSAI pretest and post*; Mean* = mean difference score between JSAI pretest and posttest

Age, ethnicity, education, and gender. Age ranged from 23 to 45 years and mean age was 33.31 years (*SD* = 6). Most participants were in their 20s (n = 30), several were in their 30's (n = 25), and a few were in their 40s (n = 8). Males outnumbered females by approximately a 10-to-1 ratio. Overall, participants were ethnically diverse and included Caucasians (n = 17), African Americans (n = 25), Hispanics (n = 20), and Interracial Americans (n = 1). Approximately one sixth (15.87%) of the participants had no high school diploma, greater than one third (39.68%) had a high school diploma, and nearly half (44.44%) had some college education (see Table 1).

Summary of Results

Overall, the results supported the first and second hypotheses, suggesting a main effect of counseling and a partial main effect of education. The third hypothesis was not supported as it related a marginal relationship between posttest JSAI scores and job placement. Although the

role of education and counseling was associated in the increase of work attitude scores amongst recovering substance abusers, they were not associated with marked job placement success. Only 11.11% (n = 7) of the participants were employed after the end of the intervention. In keeping with routine agency services, all unemployed participants were offered additional counseling, skill development, and job developer services to assist with employment.

Detail of Analysis and Results

Mean JSAI scores of the No High School pretest and posttest groups were 64.8 (*SD* = 2.9) and 81 (*SD* = 5.9), respectively. Similarly, mean scores of the High School pretest and posttest groups were 73.2 (*SD* = 3.4) and 96.4 (*SD* = 3.7), respectively. As well, mean scores of the Some College pretest and posttest groups were 86.7 (*SD* = 4.4) and 112.8 (*SD* = 6.8), respectively (see Table 1). Lastly, the mean posttest scores of participants who received baseline counseling was 101 (*SD* = 13.2), while the mean posttest scores of participants who received brief counseling was 92 (*SD* = 11.4), indicating an increase in work attitude scores was associated with longer counseling hours. Pretest and posttest JSAI scores were correlated via a Pearson Moment Correlation at $r = .79$ ($p < .05$), suggesting that pretest performance were a strong indicator of posttest performance.

Three hypotheses were tested and a 2X3 one-way factorial ANOVA on pretest and posttest scores revealed main effects of counseling and education, but no significant interaction between education and counseling. A Pearson point-biserial correlation on posttest scores and job placement rates revealed a significant bivariate relationship.

Difference scores between the pretest and posttest were computed by subtracting each pretest score from each posttest score. The ANOVA provided data on the two independent factors and their interaction. Hypothesis 1 compared baseline counseling to brief counseling as they relate to subsequent work attitude scores. The mean pretest-posttest difference score for the baseline group was 26.40 (*SD* = 7.59), while the mean pretest-posttest difference score for the brief group was 16.20 (*SD* = 5.88). The ANOVA revealed that higher work attitude scores were associated with greater hours of counseling, ($F_{[1, 57]} = 20.80, p < .05$), supporting the first hypothesis and suggesting that after three months of counseling, there was a significant difference between work attitude scores of recovering substance abusers in the baseline group in comparison to their counterparts in the brief/fast-track group.

Hypothesis 2 compared the different levels of education and how they relate to ensuing work attitude scores. Table 1 presents mean pretest-posttest difference scores across the three levels of education. Participants with no high school diploma obtained a mean pretest-posttest difference score of 15.60 (*SD* = 3.90), while participants with a high school or GED diploma obtained a mean pretest-posttest difference score of 23.02 (*SD* = 4.68). Compared to the other two levels of education, participants with some college education scored the highest on the posttest, with a mean difference score of 26.36 (*SD* = 7.14). The ANOVA revealed that higher work attitude scores were associated with greater levels of education ($F_{[1, 57]} = 5.38, p < .05$). Results were in the hypothesized direction, indicating that after three months of counseling, there was a significant difference between work attitude scores across the different levels of education. The trend favored higher education, but post hoc analyses revealed that the increase in posttest

work attitude scores was not uniformly dispersed across the three levels of education. So, the second hypothesis was only partially supported.

Post hoc analysis via the Hayter Fisher harmonic means pairwise test compared the differences between pretest and posttest scores across the three levels of education and revealed mixed results. The pairwise test showed that improvement in work attitude scores was significantly greater in the high school cluster ($M = 23.02$) than in the no high school cluster ($M = 15.60$), while improvement in work attitude scores was not significantly different between the some college cluster ($M = 26.36$) and the high school cluster ($M = 23.02$). These data suggest that those who had a high school diploma had significantly improved work attitude scores than those with no high school diploma ($p < .05$), while those who had a high school diploma did not have significantly improved work attitude scores than those who had some college training ($p > .05$).

The ANOVA did not reveal a significant interaction between counseling and education ($F_{[2, 57]} = 2.19, p > .05$). Descriptive data revealed that while there was a direct linear relationship between education and counseling for the baseline group, there was a departure from linearity; indicating a nonlinear relationship between education and counseling for the brief group. In the baseline group, participants with no high school diploma scored the lowest ($M = 19.80, SD = 3.70$), followed by those with a high school diploma ($M = 25.62, SD = 3.75$), while participants with some college scored the highest ($M = 33.79, SD = 7.27$). However, in the brief group, participants with no high school diploma ($M = 11.40, SD = 4.10$), were followed by those with some college ($M = 18.93, SD = 5.01$), while participants with a high school diploma scored the highest ($M = 20.42, SD = 5.60$; see Figure 1). Thus, participants with some college demonstrated the greatest amount of change in work attitudes in the baseline group, while those with a HS diploma confirmed the greatest amount of change in work attitudes in the brief group.
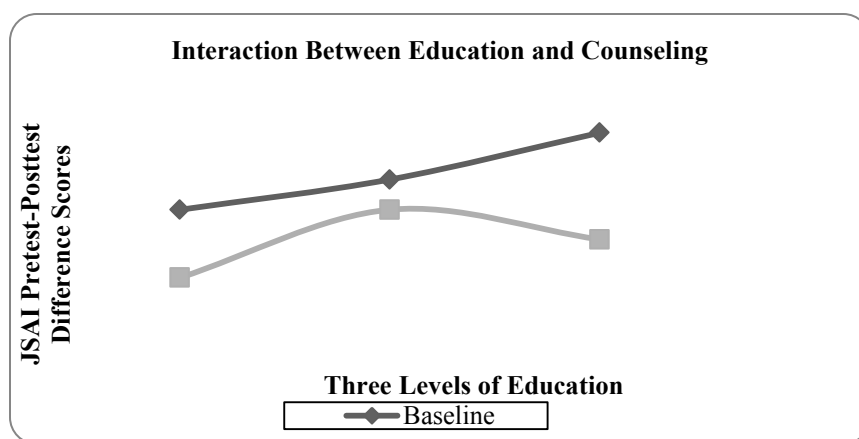
Figure 1. JSAI pretest-posttest difference scores across Baseline and Brief counseling groups reveal that there is a departure from linearity going from the High School to the Some College level of education. The departure from linearity indicates the presence of an interaction effect between the variables of duration of counseling and level of education.

There is a significant relationship between posttest work attitude scores, as measured by the JSAI and job placement success, at three-months post-counseling. A Pearson point-biserial

correlation between JSAI pretest, posttest scores, and job placement rates was computed. The correlation coefficient revealed no relationship ($r = 0.0$, $p > .05$) between job placement and pretest scores, and a significant relationship ($r = +.90$, $p < .05$) between posttest work attitude scores and job placement. Though the correlation was based upon a very small sample size (n = 7 job placements), the data indicated a positive relationship between high posttest work attitude scores and subsequent job placement success. The third hypothesis was marginally supported, as data presented a significant relationship between work attitude scores and job placement success, although a small sample size suggested that several other variables must be involved in the successful vocational outcomes of recovering substance abusers.

Conclusion

Statistical analysis supported the first hypothesis, partially supported the second hypothesis, and marginally supported the third hypothesis, which was based on a very small sample. The results suggested a linear relationship between hours of counseling and work attitude scores, as participants from the baseline cluster had higher work attitude scores than those from the brief cluster. The results also suggested a direct relationship between level of education and work attitude scores, as participants with a high school diploma or some college scored higher than those with no high school diploma. However, the results did not reveal an interaction effect between counseling and education, suggesting that the increase in work attitudes was not identical and equally impacted by intervention across the three levels of education in the baseline and brief clusters. Lastly, the results revealed a significant relationship between posttest work attitude scores and job placement rates, suggesting that the link between work attitudes and employment is present, but unclear and needs further examination.

Recent changes in public benefits and limits on spending have reduced the number of readily available resources for the rehabilitation of recovering substance abusers (Iglehart, 2009; Kopel & Burrus, 2012). As a result, greater demands are being made of public social service agencies to integrate recovering addicts into the workforce. However, reduced resources have led to the increased use of brief counseling services and while this service commonly used in public rehabilitation facilities, its functional efficacy relative to job placement needs further examining (Beveridge & Fabian, 2007; Corey, M. & Corey, 2011; Shepard & Reif, 2004). Thus, the role of vocational counseling and education in impacting work attitudes has become integral to studying job placement success amongst recovering substance abusers (Shepard & Reif, 2004).

Discussion of the Results

The results did not fully support all hypotheses. Although there are multifarious reasons as to why the study was unable to support its hypotheses, certain design flaws and limitations played an integral role in the study and its ensuing results. For example, level of education could not be actively controlled, and it led to the use of a quasi-experimental design which limited the use of causal statements. Also, the researchers had minimal contact with the participants during the course of the study, which later posed as a limitation when following-up for job placement information. Moreover, the researchers did not collect additional data, such as behavioral responses and brief interviews, which may have added greater depth to the current results.

Additionally, the one-month time lag between the completion of the intervention and job placement follow-up did not allow enough time for job-seeking in the current economic climate.

Other limitations include the lack of information the researcher had about the participants' legal histories and its impact on their ability to secure employment. Recovering substance abusers who are veterans seeking to re-enter the work force tend to face greater difficulty securing employment, as they are often accompanied by a rap sheet that can encumber job placement (Sung, 2001). An external variable that may have impacted results is the current job market in the Northeastern US. Burkhauser, Daly, Houtenville, and Nigar (2002) studied the job placement rates of workers with disabilities and reported that in comparison to other workers, individuals with disabilities were under-represented in the work force, and faced significantly fewer employment opportunities during a slow economy. Thus, low job placement rates found by this study have supported the findings of Burkhauser et al. (2002) and Chernick (2005), indicating that economic trends may be linked with the employment of workers with disabilities.

Results partially supported the first hypothesis, which suggested a serial relationship between increased levels of education and higher work attitude scores. This finding supports the results of Magura et al. (2004) and Sung (2001), who found that clients with higher levels of education were associated with higher rates of vocational success. As well, this finding indicated that higher levels of education were associated with better work attitudes, which may have been indirectly associated with higher work motivation, thereby supporting the findings of (Staines et al., 2004). Overall, the results revealed that the greatest work attitude scores were earned by participants with the highest level of education (some college). While education alone cannot be accountable for vocational success, these findings suggest that education plays a central role in the vocational development of recovering drug addicts.

Leukenfeld et al. (2005) reported that higher levels of education were associated with other successful life experiences, while lower levels of education are associated with other life failures. Thus, Leukenfeld et al. postulated that individuals with lower levels of education had lower self-esteem and poorer employment opportunities than their counterparts, who had higher levels of education. In view of these findings, it is plausible to consider that self-esteem may be associated with work attitudes and vocational success, and individuals with lower education levels may experience lower vocational success.

A post hoc test revealed that while the improvement in work attitude scores was significantly greater in participants with a HS diploma compared to those with no diploma, there was no significant difference in work attitude improvement between participants with a HS diploma and those with some college education. One plausible explanation as to the lack of a difference between these two groups may be due to the fact that participants with some college education may not be significantly more educated than those with a HS education. Based on these findings, it is reasonable to postulate that participants with significantly higher levels of education compared to a HS diploma, such as a BA or MA degree, may score significantly higher work attitude scores than those with a high school diploma. It is recommended that future studies should compare significantly different educational levels, such as no HS diploma (drop-out at 8th grade), HS diploma, and college graduates (BA degree).

The results also revealed a main effect of counseling and highlighted a serial relationship between duration of counseling and ensuing work attitudes. Work attitudes were significantly higher for participants who received baseline counseling, compared to those who received brief counseling, thereby supporting the second hypothesis. But, the results did not reveal an interaction effect between counseling and education. Overall, there was an unequal amount of change in work attitudes experienced by participants in the baseline group compared to their counterparts in the brief group. Thus, participants with some college demonstrated the greatest amount of change in work attitudes in the baseline group, while participants with a HS diploma demonstrated the greatest amount of change in work attitudes in the brief group. This incongruity in work attitude improvement indicates that baseline and brief counseling methods are inherently different and lead to somewhat dissimilar results.

Lastly, the results revealed a significant relationship between work attitudes and job placement outcomes, suggesting that work attitudes are involved in predicting employment outcomes of recovering substance abusers. However, other possible variables may have influenced the employment of recovering drug addicts *include*: changes in the local and national economy, child care demands, lack of stable housing, difficulties with securing and retaining public benefits, lack of work ready attire, and weak social support network. This study did not control for any of the aforementioned variables and their role in the employment success of recovering drug abusers was not explored.

It is important to note that although a valid and reliable tool was chosen to measure work attitudes and job placement data, no single test measures the direct effect of vocational counseling on work attitudes related to job placement. As a result, the lack of such a testing measure posed a threat to the overall internal validity of the study. However, it is expected that over time, research regarding job placement of individuals will increase, thereby promoting the need to devise a better instrument.

Recommendations for Further Research

Several steps can be taken to improve the overall design and validity of this study. Future studies can build upon the current findings by enhancing the research design to include qualitative methods. Some recommendations that can improve the overall design and provide deeper understanding of the rehabilitation needs of recovering drug addicts include increased contact with and monitoring of study participants, use of interviews to support survey findings via providing thick data, and an assessment of the variables that influence vocational success, such as the role of vocational needs, work attitudes, criminal histories, and the child care and health insurance needs of the study participants.

Regular monitoring of study participants at two week intervals can allow the researcher to build rapport with the individuals, thereby enabling the collection of more detailed follow-up job placement information towards the end of the study. As well, routine contact with vocational counselors who provide counseling and job placement services can enrich the researcher's examination and control of external variables that may influence job placement and work attitudes. Lastly, by maintaining regular contact with substance abuse prevention counselors, the

researcher can gain additional information about the participants' drug treatment services and their influence on vocational progress.

Use of interviews can add a mixed methods slant to a study, which in turn can enhance the overall versatility of the design (Creswell, 2002). By developing rapport with participants, researchers can obtain thick data regarding the experiences of participants before, during, and after vocational counseling, which can influence their ability to secure and retain employment. As well, the use of interviews can allow the researcher to obtain more detailed information about job placement, while the triangulation of this information from vocational and substance abuse counselors can increase the accuracy of the data (Mertens, 2005).

The use of an assessment tool to determine the influence of additional variables, such as the role of the local economy, criminal histories, child and health care needs, as well as welfare and housing concerns, can offer further insight regarding the vocational needs of recovering substance abusers (Sung, 2001). By learning more about the variables that influence job acquisition, future studies can expand upon the current findings may be able to develop more realistic measures of vocational success. In addition to measuring whether a participant has obtained employment, future studies can aim to explore the milestones that take place between completing vocational counseling and obtaining employment.

Results from the present study revealed that duration of vocational counseling positively influenced the work attitudes of recovering substance abusers, as participants who received longer hours of counseling earned higher work attitude scores than their counterparts, who received fewer hours of counseling. Furthermore, the results buttressed the findings of previous studies and supported the assertion that vocational and substance abuse counseling are integral parts of saves the rehabilitation process, as they save the federal government hundreds of millions annually in health care costs (Brucker, 2007; Magura et al., 2004; Staines et al., 2004).

Overall, results from this study can be generalized to the rehabilitation counseling needs of recovering drug abusers in large metropolitan cities. While all large cities have unique drug populations, the counseling and education needs of recovering drug abusers are similar in scope (Brucker, 2007). Thus, it is expected that the vocational and substance abuser counseling needs of recovering cocaine and alcohol abusers from other large metropolitan cities will relate to those of recovering substance abusers from this study's research site. However, in order to extend external validity, future studies should attempt to explore the relationship between vocational counseling and work attitudes of recovering substance abusers in other large cities.

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The Lived Combat Experiences of U.S. Army Social Work Officers Who Endure Combat Stress, Trauma, and Psychic Burn-Out

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Abstract

This research was a qualitative study, exploring the lived combat experiences of U.S. Army social work officers who deployed in support of Operation Iraqi Freedom during 2007–2009. A semi-structured interview was used to facilitate in-depth exploration of the lived combat experiences of U.S. Army social work officers who deployed in support of Operation Iraqi Freedom during 2007– 2009 and to understand how U.S. Army social work officers defined those lived combat experiences from their perspective. The findings of the research study revealed that for each U.S. Army social work officer, the deployment process was a rewarding, difficult, complex, and nonlinear journey. Although the actual lived combat experience was unique for each U.S. Army social work officer, all participants were motivated to find freedom from the stress, anxiety, unwanted thoughts, and unwanted feelings caused by deployment, and all participants experienced rewarding job satisfaction as they navigated a path fraught with obstacles in the combat environment. The impact of education is also noted. The lack of empirical research investigating the lived combat experiences of U.S. Army social work officers inhibited a more comprehensive understanding of the effects of deployment on U.S. Army social work officers in the combat environment.

Keywords: Combat stress, burn-out, U.S. Army Social Work officer, lived combat experience

This study of U.S. Army Social Work Officers in Support of Operation Iraqi Freedom during 2007-2009 was insightful, revolutionary, and very informative specific to U.S. Army

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mental health, U.S. Army mental health officers, and the implementation of mental health skills during combat operations in "real time." The research question simply asked what are the lived combat experiences of U.S. Army social work officers who deployed in support of Operation Iraqi Freedom during 2007–2009? The study explicitly covered research and practice within the mental health arena for the U.S. Army.

Introduction

The wars in Afghanistan and Iraq began as conventional operations intended to overthrow brutal regimes that were deemed hostile, barbaric, and uncivilized toward the United States in a post 9/11 world. Subsequently in 2007, coinciding with the rapid increase in troop deployments, the Army implemented 15 month deployments in support of Operation Iraqi Freedom (OIF). Mental health officers in the U.S. Army began deploying two or three times over the next two years. Military combat is marked by vicious human aggression as individuals are asked to injure, kill, and inflict suffering on fellow human beings (Dekel, Solomon, Elklit, & Ginzburg, 2004; Grossman, 1995). Soldiers are subjected to a malevolent and chaotic world dominated by the imminent threat of injury or death (Dekel et al., 2004) as well as global and civil uncertainty (Bollinger, Riggs, Blake, & Ruzek, 2000). The act of killing and resultant guilt is a known factor in the development of posttraumatic stress disorder (PTSD) in veteran populations (Fontana & Rosenheck, 1999; MacNair, 2002), as many soldiers are unable to reconcile the act of killing with their own sense of morality (Kilner, 2002). More importantly, the act of killing another human being violates a basic law that governs civilized societies (Fabrega, 2004; Fontana & Rosenheck, 1999; Grossman, 1995). This resistance to killing creates a traumatic quandary for the soldier. In the event the soldiers choose to overcome this innate resistance to killing in order to save their own life, or the life of a fellow soldier, they must live with the guilt of their actions. This represents what U.S. Army social work officers must contend with in terms of providing treatment and patient care to soldiers who kill, witness death, and live with it as result of intense combat. U.S. Army social work officers routinely provide mental health treatment to service members who kill their enemies during battle, which in turn impacts the lived combat experiences of U.S. Army social work officers as mental health providers to those service members. The impact on U.S. Army social work officers lived combat experience occurred in one of three ways: vicarious trauma, compassion fatigue, or burnout due to the nature of the work during combat operations. The authors conclude with a discussion of the implications for U.S. Army social work practice and planning of mental health support for future deployments.

Methodology

A basic interpretive qualitative study (Merriam, 2002) was utilized to investigate the lived combat experiences of U.S. Army social work officers who deployed during 2007–2009 in support of Operation Iraqi Freedom. Purposive sampling was used to identify 10 U.S. Army social work officer participants. U.S. Army social work officers between the ages of 25 and 57 who deployed in support of Operation Iraqi Freedom were recruited utilizing the U.S. Army social worker directory. A recruitment letter was emailed to each potential participant and follow-up via email and telephone was conducted. It was intended to use a semi-structured interview that contained a mix of predetermined questions and opportunistic probing; however,

the nature of the meetings with the participants dictated that unstructured interviews were actually more appropriate. During the interview, each participant was encouraged to share his or her story, illuminating the experiences of deployment in Operation Iraqi Freedom during 2007–2009. Questions were prepared to guide the direction of the interview, but the sessions diverged as the participants' shared valuable insight that fell outside the realm of the prepared research questions. Immediately following each interview, a constant comparative data analysis method was used to analyze the data, and prepared it for further analysis upon completion of all the interviews. Interviews lasted between 45 and 90 minutes.

The U.S. Army social work officers who deployed served as mental health providers during OIF 2007-2009 during the most critical time of the war in Iraq, namely during the *combat surge*. The gender of the 10 active duty U.S. Army social work officers was five females (50%) and five males (50%). The average age was 37 years with a range of 25 to 57 years. All participants were commissioned officers: Captains (3), Majors (2), Lieutenant Colonels (4), and Colonel (1). Ethnicity was not recorded. Six were serving their first combat tour in Iraq, whereas four had previous deployment experience having deployed two or more times in support of Operation Iraqi Freedom.

ATLAS.ti was used to analyze the transcripts. There were seven families of codes that represented the data, along with one hermeneutic unit defined as U.S. Army social work officers. In order to demonstrate internal validity, accuracy, and credibility, multiple sources (e.g., notes, journals), when available, were used to confirm the emerging findings. In addition, the transcribed data that were collected during the interviews were sent back to the participants who were asked to check for accuracy and clarity. Furthermore, the interviews were described in thick, rich detail that sufficiently illuminated the lived combat experiences of U.S. Army social work. Despite the internal validity, accuracy, and credibility of this study, it was not intended to portray deployment of U.S. Army social work officers as representative of all deployments in support of Operation Iraqi Freedom or generalize the findings to all U.S. Army social work officers who deployed before 2007 and after 2009.

RESULTS

The common themes that emerged from the research questions were coping strategies, education, job (task or type of work), lived combat experience, mental health issues, self-care, and support system. Two themes were relevant to the research and will be discussed further. In brief, this study revealed that despite various obstacles and means of coping with the rigors of deployment in a combat environment the deployment process took varied paths for each participant and resulted in different outcomes for each participant. The two primary themes that will be discussed and delineated are education and mental health issues from the perspective of the research participants.

Education

Education is a primary theme that is related to several subthemes that were revealed in the research data. These subthemes include the following concepts: courses and education, inadequate preparation and training, and Master of Social Work (MSW) limited or no impact on

managing the stress of combat. Courses and education denote the type of education and training a U.S. Army social work officer has received: for instance, taking the combat stress course or some other specialized course designed to enhance a U.S. Army social work officer's skill set during combat operations. Inadequate preparation and training and lack of preparation described the level of preparation and training of each participant. The MSW had limited or no impact on managing the stress of combat and specifically denotes the impact, if any, an MSW degree and training had on each participant's ability to manage the stress of combat. Education was a preeminent theme because it illustrated the providers' skill set, experience, and training prior to deployment which highlighted how each provider managed patients, conflicts, peer review, and sensitive issues concerning limited experience and lack of training not limited to conflicts of interest and or suicide or burn-out during combat operations.

Courses and education. Courses offered by the U.S. Army provide specific training for U.S. Army social work officers to prepare for combat and, more importantly, to prepare for deployment to a war zone/combat environment. The courses and education specifically refer to U.S. Army training (field training exercises, combat stress course, weapon qualification, and Joint Readiness Training at Fort Polk, LA), and civilian training (ethics, social work conference, psychotherapeutic workshops). One of the primary courses offered to mental health providers (psychiatrists, psychologists, mental health technicians), to include U.S. Army social work officers, prior to deployment is the two-week combat stress course. The course is a prerequisite to deployment provided at CONUS Replacement Centers (CRC) in the continental United States prior to deployment. The course is designed to provide U.S. Army social work officers with some additional training to manage stress, alleviate stress, and to recognize the warning signs and symptoms of combat stress.

Inadequate preparation and training. Inadequate preparation and training are related to each U.S. Army social work officer's preparation and training leading up to the respective deployment in support of Operation Iraqi Freedom 2007–2009. Of the participants (n=10) in the study, 50% of the participants (n=5) indicated they felt inadequately trained and prepared for being deployed to a war zone (Odom, 2011).

Mental Health Issues

Mental health issues presented as several subthemes in the data. These subthemes include the following concepts: anger and anxiety, and stressful work conditions and work exhaustion.

Anger and anxiety. Anger and anxiety are two emotions that impact everyone. Anger and anxiety are both woven into the fabric of humanity. This is to say that individuals become upset and subsequently experience anger and anxiety in all phases of life. Military combat is known to create anger and anxiety within the soldier. Operation Iraqi Freedom 2007–2009 was witness to an enormous amount of anger and anxiety, which was experienced by U.S. Army social work officers due to the nature of their work as clinicians. Anger and anxiety refers to the emotions and feelings that U.S. Army social work officers experienced as a result of the exposure of a combat environment marred by death, destruction, and danger in support of Operation Iraqi Freedom 2007–2009. Of the participants (n=10), 100% experienced issues related to anger and anxiety as a result of deployment (Odom, 2011).

Stressful work conditions and work exhaustion. U.S. Army social work officers were deployed under very stressful work conditions and each labored exhausting hours during Operation Iraqi Freedom 2007–2009. Stressful work conditions refer to working in an environment that exposed U.S. Army social work officers to mortars, rockets, and enemy small arms fire, which subsequently subjected U.S. Army social work officers as key medical staff to death constantly. Work exhaustion refers to the state of feeling very tired, weary, or sleepy resulting from insufficient sleep, prolonged mental or physical work, or extended periods of stress or symptoms of anxiety. Boring or repetitive tasks can intensify feelings of work exhaustion, and work exhaustion can be described as either acute or chronic. Of the participants (n=10), 100% reported experiences of stressful working conditions and work exhaustion demonstrating how stressful the work environment was and just how exhausting the work (clinical and otherwise) became over time during their respective 2007–2009 deployments in support of Operation Iraqi Freedom (Odom, 2011).

DISCUSSION

It was concluded that the deployment process was a multifaceted, nonlinear, and complex journey. While the participants revealed the common themes of coping strategies, education, job (task or type of work), lived combat experience, mental health issues, self-care, and support system, the deployment process was not the same for any of the U.S. Army social work officers who deployed in support of Operation Iraqi Freedom. Some subthemes, such as trustworthiness among providers and spending time with battle buddies, was significant in terms of managing the stress of combat and serving as effective coping strategies. The data analysis revealed that the deployment experience was a profound individual process that may or may not result in the culmination of a successful deployment experience. The study findings suggested that U.S. Army social work officers must be aware of many different nuances, dynamics, and environmental conditions, previously noted, that may influence and impede their ability to function, cope, and thrive in a combat environment under austere conditions, such as Operation Iraqi Freedom or any future U.S.-led combat operation.

Both primary and secondary themes emerged from the data that illustrated and characterized the lived combat experiences of U.S. Army social work officers. The lived combat experiences of U.S. Army social work officers who deployed in support of Operation Iraqi Freedom during 2007–2009 were shaped by both the combat surge and the anniversary (2006- 5 year anniversary/ 2011- 10 year anniversary) of the war in Iraq. It was during the 2007–2009 time frames that the highest number of casualties and fatalities from the war in Iraq were recorded for U.S. forces in support of Operation Iraqi Freedom.

Numerous U.S. Army social work officers in the study experienced intrapsychic conflicts and mental health issues, to include symptoms of depression, anxiety, burnout, vicarious trauma, insomnia, change in personality, PTSD, stuffing, unresolved anger, and combat stress (Odom, 2011). All ten participants reported varying degrees of burnout as a result of working 24-hour operations early on during their respective deployments, to include on-call after-hour responsibility (which meant each participant experienced and suffered from both sleep disruption and sleep deprivation as a result of being awakened in the middle of the night in order to respond

to both emergencies and mental health crises) and their normal 7:00 a.m.–7:00 p.m. work rotation (Odom, 2011).

IMPLICATIONS AND CONCLUSIONS

The participants indicated that the military, specifically the U.S. Army, needs to ensure that U.S. Army social work officers who deploy are driven from a motivation perspective. The U.S. Army needs to do three things: (a) ensure that a U.S. Army social work officer's ability to do things such as a Command Mental Health Evaluation and other administrative tasks are not hampered, (b) take U.S. Army social work officers who have deployed and send them on recruiting tours of schools, and (c) pay U.S. Army social work officers equitably for what they do. All U.S. Army social worker officers receive a graduate education at a school of social work accredited by the Council of Social Work Education and each program at a given graduate social work program is structured and outlined with a specific emphasis. The emphasis may be clinical, humanistic, cognitive, Gestalt, psychoanalytic/psychodynamic or behaviorism. Therefore, U.S. Army social work officers learn how to manage through understanding health and wellness, prevention and intervention to subdue anger, anxiety and stress in various MSW degree programs throughout the Continental United States. Ninety percent of the participants (n=9) think it is unreasonable still that a psychiatrist and psychologist has a twenty thousand dollar per year bonus while that bonus for professional social workers is only six thousand dollars.

Some of the findings of the study suggested that a U.S. Army social work officer should not be promoted to senior leadership unless he or she has deployed in a combat environment. The research findings supported the notion that the U.S. Army seems to value U.S. Army social work officers who have comprehensive experience in a hospital (clinical) setting more than U.S. Army social work officers with operational (combat) experience. The military needs to establish a separate track for U.S. Army social work officers who want to specialize in operational (combat) experience or force U.S. Army social work officers to spend time in both areas.

It is imperative that all U.S. Army social work officers in a deployed environment understand and specifically work to ensure that they do not unwillingly subject themselves to any one of the combat stress factors because combat stress factors may compromise a U.S. Army social work officer's capacity to function or excel in a combat environment. It is worth noting that any of the six factors may contribute to depression or ultimately lead to a fatality. The primary job of a U.S. Army social work officer is to return to duty as many soldiers as possible, as quickly as possible. Combat stress is the number-one issue facing all mental health providers who experienced combat in Iraq (Department of the Army, 2006). This is to say, one of the major concerns is for U.S. Army social work officers to seek psychotherapy before and after deployment as a mandate. It is explicit from the present study that the deployment experience for U.S. Army social work officers during Operation Iraqi Freedom during 2007–2009 was a complex, nonlinear, and multifaceted journey. The conflicts in both Iraq and Afghanistan have lasted longer than American involvement in World War II, and the wars in Iraq and Afghanistan have challenged the U.S. Armed Forces in unprecedented ways (Hoge, 2010). When U.S. Army social work officers return from battle, many struggle to return to their normal lives and this too is specifically attributable to endured stress, trauma, and psychic burn-out experienced within the combat operations, namely that of Operation Iraqi Freedom and Operation New Dawn. One very basic intervention for mental health providers who work with the service members of the U.S. Armed Forces is to simply start where the service member is, this is unequivocally 'where the rubber meets the road' in terms of helping service members to heal and regain their lives post deployment.

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Conquering Ambiguity with Creativity: Using Creative Family Counseling Interventions with Military Families

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Abstract

Military families experience numerous transitions and changes as they progress through the deployment cycle. Family counseling is one resource for this population to receive support and assistance during periods of ambiguity, confusion, and redefining roles, as such, creative interventions provide a useful tool for therapist to engage this population. This article provides a brief overview of the military deployment cycle, salient features of military families, and the importance of a systemic framework for treating this population. Furthermore, this article provides clinicians with three specific creative interventions based on the deployment cycle for implementation with families.

KEYWORDS: military families, creative interventions, family counseling

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Employment in the military offers a unique experience for personnel and their families. Often this framework includes a social network of individuals with similar interests and understanding. In addition to camaraderie and culture, individuals and their families often display increased resiliencies and strong family relationships (Wiens & Boss, 2006), yet many military families seek counseling for support during times of transition (Hall, 2011).

According to recent statistics from the Department of Defense (DoD, 2012), the U.S. Armed Forces are comprised of 1.4 million active duty personnel. Of these enlisted individuals, 56.5% are married, 44.2% have children, and 38.9% are married with children. In addition, 6.5% of active duty personnel are married to another service member while 5.3% are single parents. Furthermore, the number of women in the military has increased in recent years (Martin & McClure, 2000) and data estimates 1.9 million military dependents, the majority of which are children.

The growing number of military families and dependents (DoD, 2012) can be attributed to changes in the structure of the military during the last forty years. A major shift in the composition of the U.S. Armed Forces started in 1973, with a transition from draft enlistment to the initiation of an all-volunteer Armed Forces. Unique challenges emerged for active duty military families as a byproduct of these structural transitions. Specifically, due to the volunteer nature of the Armed Forces, many service members experienced, and continue to experience, second and subsequent enlistments. With these expanded employment periods, the probability increases that personnel will be married or have children over the course of their service (Blaisure, Saathoff-Wells, Pereira, Wadsworth, & Dombro, 2012; Martin & McClure, 2000; Ridenour, 1984). In short, military families exist in greater numbers and represent more diverse family systems than in the past. As such, counselors will benefit from being aware of the unique aspects of military culture, deployment cycle, usefulness of a systemic perspective, and benefits of integrating creative interventions into therapy.

Salient Aspects of Military Culture

Military culture includes several unique aspects, which differentiate military families from civilian clients. Several particularly important cultural considerations include frequent relocations and a structured, hierarchical philosophy. These characteristics permeate the family unit as each member is affected by the larger military culture.

One of the primary features of military culture is the necessity for geographic relocation (Orthner & Rose, 2005), which can result in additional family stressors. Children experience the challenge of leaving a familiar environment and integrating into a new school system and social circles (Bradshaw, Sudhinaraset, Mmari, & Blum, 2010). During these times, "[t]he most prevalent stressors on the students [result] from tension at home, strains on their relationships with peers, adapting to a new school environment, academic challenges, student/teachers relationships, and becoming involved in extracurricular activities" (Bradshaw et al., 2010, p. 90). Due to multiple geographic relocations, some military families may experience detachment from the civilian lifestyle, which can be isolating and alienating (Hall, 2011; Ridenour, 1984).

Many family members experience a need to adapt to the structured standards and expectations inherent within military culture. The hierarchical and authoritarian structure under which the military operates also poses unique challenges for families, including a lack of control over promotions and salary increases, strict class systems, and family members' behaviors serving as a direct reflection on the military member's rank (Hall, 2011; Ridenour, 1984). The overall structure and hierarchical nature of the military helps to organize both the service member's day-to-day experiences as well as the experiences of the service member's family. When considering salient aspects of military culture, it is important to discuss the deployment cycle, as it has a large impact on the experiences of military personnel and their families.

Deployment Cycle

Active duty personnel and dependents are immersed in military culture, which includes a variety of characteristics that differ from civilian life. The deployment cycle, one unique aspect of military lifestyle, is a term used to describe the experiences that occur when a military service member is called to deploy (Peebles-Kleiger & Kleiger, 1994; Pincus, House, Christenson, & Adler, 2001; Virginia Joint Military Family Services Board, 2003). This process involves a series of stages, described below, in which the service member and their family experience and prepare for departure, separation, and reintegration.

Before Deployment

The first stage of the deployment cycle, pre-deployment, describes the period when the service member has been notified that he or she will deploy and is preparing to leave on assignment (Pincus, et al., 2001). The duration of this phase can vary from a few weeks to over a year. During this period, family members often alternate between feelings of denial and anticipation of their loved one leaving, which can be a very painful time for families (Peebles-Kleiger & Kleiger, 1994; Pincus, et al., 2001). Families experience an emotional cycle, alternating between feelings of numbness, fear, upset, and protest (Pincus et al., 2001). Some families cope with these feelings by focusing on the tasks that need to be accomplished before the service member deploys, such as planning for childcare, budgeting, and creating or finalizing wills. During this time, many children and adolescents are confused and anxious regarding the details about their parent's departure and how they can remain connected while their parent is deployed (Virginia Joint Military Family Services Board, 2003). Unique considerations during this stage of the deployment cycle include how the family is coping with the uncertainty and readjustments related to new roles, responsibilities, and routines at home and at the deployed individual's base.

During Deployment

The second stage, deployment, describes the period when the service member has relocated to a location away from his/her family (Pincus et al., 2001). During this time, separation challenges many military families. Frequent concerns include managing relationships with limited communication, a shift in roles and boundaries for the stay-at-home parent and children, and feelings of loss and helplessness for the military service member (Chandra et al., 2010; Drummet, Coleman, & Cable, 2003). These frequent separations can impact the

psychological and physical wellbeing of the stay-at-home spouse, as well as overall marital satisfaction (Burrell, Adams, Durand, & Castro, 2006) as the stay-at-home spouse faces myriad stressors including loneliness, depression, anxiety, feelings of loneliness, and increased responsibility (Pincus et al., 2001; Rosen & Durand, 2000). Family members also experience uncertainty and tension related to changing family member's roles, responsibilities, and routines (Huebner, Mancini, Wilcox, Grass, & Grass, 2007; Pincus et al., 2001).

Separations, particularly during combat deployments, are marked by emotional volatility where military family members experience fear, upset, numbing, concern, emptiness, loneliness, insecurity, and other emotions associated with the fear of loss and uncertainty (Di Nola, 2008; Peebles-Kleiger & Kleiger, 1994). During deployment, children commonly struggle with academic engagement and peer functioning (Chandra et al., 2010).

After Deployment

When the deployed service member returns to their home-base, the post-deployment phase occurs (Pincus et al., 2001). The family experiences a period of reintegration as each member re-adjusts to the service member's presence in the home. Families may believe that reuniting with the service member is the cure for their difficult experiences; however, reunion is a time of great stress, and may last anywhere from three to six months (Pincus et al., 2001).

During this phase, children may struggle with reconnecting with their reintegrated parent (Pincus et al., 2001). Younger children may not remember their parent or understand why their parent has been gone. School-aged children typically respond by wanting a lot of attention; whereas, teenagers may appear moody and act as if they do not care their parent has returned home. Children and adolescents may fear the return of their deployed parent because the stay-at-home parent has threatened them with the service members' return as a means of discipline or because they know that rules, roles, and responsibilities in the family will shift as their parents' return. Children often display loyalty to the stay-at-home parent when the service member returns (Pincus et al., 2001; Virginia Joint Military Services Board, 2003). The entire family may face anxiety and concern surrounding the possibility of another deployment (Chandra et al., 2010).

Some families are able to reach a state of stabilization, when family dynamics have been renegotiated to include the returning parent (Peebles-Kleiger & Kleiger, 1994). However, for some families, redeployment does not allow adequate time to reintegrate the deployed family member into the family system. This truncated time period can result in family members having unresolved worries and expectations from the previous deployments (National Military Family Association, 2005). During the reintegration stage, children often witness negative changes in parents' relationship, and all family members report difficulty in reconnecting with the returning service member (Virginia Joint Military Family Services Board, 2003). Overall, the process of deployment can be tumultuous for family members, but given the unique strengths of military families, this process can be successfully navigated to improve communication and foster the development of a cohesive family system.

Military Family Resilience and Protective Factors

While a discussion of the challenges experienced by service members and their families is important, an exploration of resilience is equally necessary. Resilience within the military setting has been defined as the ability for a family system to endure substantial disruptions while maintaining a level of effective family functioning (Masten, 2011). In addition, resilience is characterized by protective factors that help serve as buffers against stress and risk (Weber & Weber, 2005). Family resilience is comprised of many elements, including, but not limited to, individual characteristics, family support systems, cultural and contextual factors, and community services (Paley, Lester, & Mogil, 2013).

One particular resiliency experienced by military families is a sense of flexibility and tolerance for ambiguity (Lemmon & Chartrand, 2009). Military families endure geographical relocations, family separations, and a lack of control over many aspects of what is considered normal to civilians (e.g., communication with spouse; Ridenour, 1984). As such, military families develop an ability to tolerate change and adjust to meet the transitioning needs of the individual family members, family system, and military system (Lemmon & Chartrand, 2009). Although stressors have the potential to become severe without adequate support for the family, these stressors are considered to be normative stressors to which the military family typically adapts well. For instance, military families can build strong family relationships built around the notion that families support each other through challenging times. A profound sense of kinship, support, and family unity can be the result of this bonding through adversity (Wiens & Boss, 2006). In addition, military families are likely to have an added support network of other military personnel and families. Finally, research indicates that children are less likely than civilian children to participate in risk taking behaviors (Hutchinson, 2006). In sum, military families encounter many unique challenges but also display characteristics that indicate resiliency and toughness.

Need for a Systemic Perspective

The importance of a systemic perspective into therapeutic work with military service members and their families cannot be overemphasized. Because these individuals must balance multilayered and intersecting roles as family members, unit or squadron members, and community members, they experience the particular challenges of serving multiple and contradictory purposes (Everson & Camp, 2011). Emotional triangles between service members, family, and the military as a system are not uncommon (Everson & Camp, 2011). Boundaries within and among these systems can serve as a buffer in times of stress, providing a sense of safety and integrity, or they can limit access to resources and support.

Each family's experience within the larger military system is individual and unique to their family's situation. Differences can be attributed to the member's branch, rank, deployment status, length of time in service, family history of military connection, and other important factors. Nevertheless, military families share a common relationship with the ecosystem of the military. To support the notion of an ecosystemic perspective, the military "wields a tremendous pressure on families to conform to its prevailing social norms" (Everson & Camp, 2011, p. 21). A systemic counseling orientation matches this multilayered and complex perspective.

Benefits of Experiential Activities with Military Families

Given the multilayered, systemic nature of military families, experiential activities have the potential to engage clients and facilitate the therapeutic process. For instance, literature describes in-session activities as a method for counselors to stimulate the joining process (Gladding, 2011; Pascoe, 1999) and overcome impasses (Carson & Becker, 2004; Pascoe, 1999). Creative interventions can be useful tools during the initial joining stages as well as throughout the counseling process.

As described in literature on education, not all clients learn in a similar manner. For instance, some individuals learn through kinesthetic movement, others favor language or logic, others are inclined to auditory information, while some learn from interpersonal or intrapersonal interactions (Gardner, 2011; Schimmel & Jacobs, 2011). Therefore, when counseling a family, the incorporation of experiential activities has the potential to meet multiple learning styles, improve the chances of engaging more family members in the session (Jacobs, Masson, Harvill & Schimmel, 2012), and foster holistic involvement in the counseling process (Carson & Becker, 2004). In addition, experiential activities can transcend the superficial acquisition of knowledge to encourage client's physical, emotional, and creative expression through imagination and mind-body connection (Malchiodi, 2005).

While the integration of experiential activities has been proven to be effective with multiple populations (Carson, Becker, Vance, & Forth, 2003; Gladding, 2011; Murray & Rotter, 2002; Pascoe, 1999; Schimmel & Jacobs, 2011), limitations are present. Because of individual personality, interest, or aptitude, not all clients may be an appropriate match for a specific expressive modality (Gladding, 2011). In addition, published literature on the incorporation of expressive activities into family therapy is limited to suggestions for adapting play therapy exercises to engage children. Nevertheless, Carson (1999) states that "creative approaches to therapy allow family members to communicate their thoughts and feelings spontaneously in a caring and nonthreatening environment" (p. 328). While some limitations exist, overall, one can conclude the introduction of experiential activities infuses energy (Gladding, 2011), creates an opportunity to match a family's interests (Malchiodi, 2005), and cultivates memorable experiences (Carson et al., 2003). The active tasks presented in this article can be used to successfully engage a family, nurture the therapeutic relationship, empower clients as they take control of prescribed tasks, and foster a sense of accomplishment (Malchiodi, 2005).

Experiential Activities

The authors of this article have designed the proceeding activities to provide counselors with specific intervention tools tailored to each phase of the deployment cycle. When using these techniques, counselors can benefit from integrating high levels of flexibility and adaptablity to anticipate meeting the dynamic needs of families. While these activities provide specific guidelines for implementation, they can be adjusted to meet specific family goals.

Activity One – Symbol Creation Activity: Pre-Deployment

The underlying objective of the symbol creation activity is to help families begin to explore their identity as it relates to their values and beliefs. Value clarification and symbol creation may serve as a source of support as family members anticipate deployment. While creative counseling interventions encourage clients to explore challenges from different angles and generate a new, shared meaning in the context of therapy (Gladding, 2008); the use of symbols and metaphors further encourages clients to examine struggles in new ways (Alvarado & Cavazos, 2008). The creation of a symbol that represents the mission statement or ethos of the family can thus serve as a foundation to explore the uncertainty that often coincides with family transitions.

This activity is especially useful during the pre-deployment phase as it helps to anchor a sense of shared purpose among family members, creating continuity amidst uncertainty. During the pre-deployment phase many families experience feelings ranging from anxiety to denial. The counselor needs to be aware of the length of time prior to the impending family separation. Clarification of family expectations can decrease some of the anxiety associated with family separations, and creating a family symbol can facilitate meaningful discussions around those expectations.

Materials and preparation. Various materials can be used to create family symbols. To simplify the process, counselors can provide basic art supplies such as pencils, crayons, markers, and paper for the family members to sketch initial ideas for the family symbol. Once a sketch or idea is formed, the counselor can plan to bring additional materials to subsequent sessions. Materials might include paints, clay, magazines, or other items for making collages. Family members can also be asked to bring meaningful items or supplies to contribute to the creation of their family symbol.

Activity. Family members are asked to reflect on the most important aspects of their family identity. This process can be guided by a discussion of experiences, hobbies, key values, beliefs, or other family characteristics that differentiate them as a unit. Once members describe important elements of their family's culture, they are then instructed to visualize symbols that may be representative of this culture. Symbols could include a family coat of arms, a sculpture, family painting, collage, or other created object. The symbol serves as a reminder of the uniqueness, importance, and integrity of the family system. Once the symbol is created, the counselor should process the meaning of the symbol with the family. A closing discussion can include the development of a plan for displaying the symbol or finding alternative ways that each family member can carry the symbol during the period of separation.

Discussion questions. The following list of questions can be used to explore issues related to separation, deployment, and family transitions as they relate to family identity and values.

1. How does this symbol represent your family?
2. What was it like creating a family symbol together?
3. How does this symbol reflect your family's values?
4. How is your family symbol unique?

5. What feelings emerged for you as you created this family symbol?
6. How does this symbol reflect each of you individually?
7. How does the symbol merge each of your individual identities?
8. How might you use this family symbol as a way to connect with your family in times of separation or transition?
9. Would this symbol have looked different a year ago? Five years ago?
10. What elements of this symbol are most important for you?

Family members are encouraged to continue to reflect upon these questions and others related to the creation of their family symbol. Additional processing might include exploration of how family members can connect to this tangible representation of their family in times of separation or stress.

Activity Two – Family Bridges: Active Deployment

The use of metaphors and metaphorical thinking in family counseling has been shown to have multiple benefits for clients (Lyddon, Clay, & Sparks, 2001), which may be particularly relevant for military families experiencing frequent change and transition. The incorporation of metaphors can support the establishment of a safe and secure therapeutic alliance, as well as create a shared, nonthreatening language to process difficult experiences and emotions (Lyddon et al., 2001). Further, metaphorical language provides a valuable window into important aspects of a client's perceptions, which can assist clinicians with or without experience counseling a military population.

"Family Bridges" are designed for implementation with families when one or more family members are deployed and living in a different geographical location. A bridge is suggested as a particularly powerful metaphor as these structures bring together two parts of land that are physically separated. The intervention is designed to: (a) foster a safe space to explore expectations, fears, and hopes; (b) highlight areas of family strength, skill, and interdependence that can provide continuity during deployment; (c) build insight and empathy for different family members' perspectives; and (d) facilitate collaborative problem solving across family subsystems (i.e., spousal, parental, etc.) despite the geographic separation. Overall, establishing and modeling a safe, nonjudgmental environment that provides room for divergent perspectives is critical.

Material and preparation. For this activity, counselors need materials to assist family members in constructing a bridge within the session. Options may include Lego blocks, string, foam "noodles," paper and art supplies for drawing, and/or photographs of bridges. In choosing and implementing a metaphorical intervention, the clinician should consider family members' abilities to comprehend the abstract nature of metaphors.

Activity. The counselor begins this activity by introducing a bridge as a possible metaphor to represent aspects of the family's experience during the deployment. After this introduction, the counselor asks the family to reflect on the function of a bridge as well as structural components (i.e., towers, suspension cables, deck, anchors) essential to the foundation.

Family members are then guided through an exercise of constructing a bridge representative of their family during this phase of both the family and deployment life cycles.

In constructing the bridge, the counselor directs the family members to first envision and then discuss the separate geographic spaces residing on either side of the bridge. For example, family members may discuss their perspectives of the family home and of the deployment base. The counselor may facilitate a conversation on different roles or characteristics within these spaces. Metaphorical language can be extended into the description of these spaces (i.e., is the land isolated? scary? easy to navigate?).

Next, the counselor facilitates the construction of the actual bridge. The family members may wish to assign individuals to represent structural components of the bridge. An exploration of family assets may be facilitated through the addition of supportive suspension cables to the bridge, representative of family strengths and skills. The counselor may also facilitate a discussion of potential threats to the bridge. In sum, the goal of this activity is to support the family in building a metaphorical bridge, which captures the perspective of their family. While members of the family are geographically separated, the counselor can support the family in reconstructing a metaphor that describes strength, resiliency, and perceived connectivity.

Discussion questions. The following questions may be employed by the counselor during both the actual building process, as well as after the bridge has been constructed. These questions can assist family members in examining changes and continuities to the family system during the deployment stage.

1. What did you learn about your family members during this activity?
2. How is your role in the family (or bridge) unique?
3. How is your role in the family (or bridge) connected to the role of other family members?
4. Describe your perspective based on your position on the bridge. What could you see or not see?
5. What structures of the bridge feel more "shaky" to your family at the present time?
6. How might your family reinforce elements of the bridge so that it may feel more solid?
7. What external threats (i.e., wind, traffic, storms) may exist? How will your family approach these challenges?
8. What maintenance may be necessary to retain the integrity of the bridge?
9. What is unique about this bridge? How does this relate to the unique aspects of your family?

While a bridge is suggested as a relevant metaphor to assist a family to process changing perspectives and vantage points during deployment, a variety of other metaphors may be suitable. In applying metaphorical language, counselors may be particularly attentive to the terms spoken by families to describe their experience and substitute these phrases during the intervention. Additionally, based on the family's connection with the metaphor, the language developed during this activity can be applied in subsequent sessions. If all family members are not able to be present in session, the counselor may assign homework, which includes sharing this material with the deployed service member by phone, videoconference, or letter.

Activity Three – Tipping the Scale: Returning from Deployment

"Tipping the Scale" is designed to be implemented with families returning from deployment. This activity facilitates the discussion of family experiences during deployment in order to capitalize on the family's resilience. Specific goals include reconnecting and reacquainting family members, rebalancing power within the family hierarchy, fostering adjustment to reentry from deployment for both the family and the deployed individual, and accepting new family roles (i.e., just because the family contains the same members, it may not necessarily be the *same* family). A multitude of stressors exist for families in this stage of the deployment cycle (Pincus et al., 2001). As such, a counselor must be attentive to creating a safe space for vulnerability and emotional exploration.

Materials and preparations. For this activity, counselors need rocks large enough to write on, permanent markers, and a balance scale. If a counselor does not have a balance scale, one can be constructed easily using a coat hanger, plastic cups, and string. The creation of this scale can also be a task assigned to the children at the start of the session while "adult" concerns are discussed, or the family can build the scale if time permits.

Activity. The counselor begins the activity by asking family members to think of events and milestones that occurred during the service member's deployment. Each individual determines milestones, which he or she considers important and writes these events on the rocks. Younger children can be invited to use images or symbols to denote events.

After the events have been listed on the rocks, family members are directed to share and discuss the important events that occurred during the separation. This discussion is an integral part of the process as it helps the family members recognize the events the other family members found important. In addition, this process can helps individuals feel understood as experiences are shared. The opportunity to reminisce, explore the feeling of separation, and discuss changes within the safety of an activity can begin to facilitate the family's re-integration process.

After family members discuss recent events, the counselor instructs them to think of strengths as a family and write these strengths on a new set of rocks. The goal of this portion of the activity is for the family to uncover enough resiliencies to offset the separation, hardships, and differences. Questions such as "What are things that your family previously did well together? What is going well in your family now? How do you support one another?" may facilitate the activity and help the family recognize their strengths.

Once the two sets of rocks have been created, families "balance the scale" by adding life events, which took place during the deployment, to one side of the scale and placing family strengths on the other side. This balancing activity is an opportunity for families to reflect upon their recent differences as a source of strength. By going through this process of finding balance, families can recognize systemic strengths, build confidence in problem solving capabilities, and discuss current roles.

Discussion questions. In addition to the questions posed above, after completing the activity, the counselor can choose from the following list of questions to assist the family in processing the experience.

1. What did you learn about your family members during this activity?
2. How does sharing your experiences help you feel understood?
3. What thoughts and feelings did you experience during this exercise?
4. What similarities and differences did you observe with regard to what you perceived as important or valuable to your family?
5. What did you learn about yourself?
6. How can you find balance within this *new* structure?
7. What thoughts and feelings emerged when you discussed your family's strengths?
8. How does this activity serve as a metaphor for finding balance in your home life?
9. How have your values as an individual and as a family changed?

While this activity is designed to reintegrate family members after separation, counselors can introduce the concepts at various stages of the deployment cycle. The focus on reacquainting family members, cultivating communication, and perspective taking can be valuable to any family. The process of engaging family members in thoughtful reflection while performing this task can serve to stimulate both individual growth and family cohesion (Carson, 1999).

General Suggestions for Implementation

While this article presents three activities, a counselor can also modify other techniques for use with military families. In so doing, several suggestions can be made. First, creative interventions should be based on the age of the youngest child, or lowest developmental level, within the family. This ensures the developmental appropriateness for all members of the family and promotes inclusivity and participation. Additionally, the counselor should develop interventions considering family-specific culture. Bernal and Saez-Santiago (2006) suggest several culturally sensitive aspects on which to focus when modifying techniques to fit client needs including: appropriate and culturally-relevant language, concepts, values, metaphors, symbols, and sayings.

Several other suggestions include knowing and understanding the background and therapeutic goals of the original technique, in order to ensure appropriate execution. As such, creative techniques should only be integrated into family counseling when they fit within the larger treatment context and goals for therapy. Techniques should be used with intentionality to address the larger therapeutic goals and further the counseling process.

Carson et al. (2003) note that flexibility, risk-taking or willingness to take risks, and humor or a sense of humor are the most frequently cited practitioner characteristics when implementing creativity into family counseling. Family counselors should reflect on these characteristics when implementing creative interventions so as to maintain a light-hearted perspective of themselves, clients, and the implementation of interventions throughout the counseling process. Conversely, one of the biggest barriers found to using creative interventions

was time constraints (Carson et al., 2003), which is an important limitation when evaluating the realistic barriers to using creative interventions in family counseling.

Conclusion

In sum, as with any other multicultural and diverse clientele, counselors should approach counseling from an educated yet curious perspective. To be effective, counselors should perform background research and inquiry into general and branch-specific military culture. However, family counselors should also approach every family with curiosity, as each will have their own family culture and experiences within the larger military context. The importance of systemic perspectives, in the context of counseling military service members and their families, cannot be overstated, and counselors should be cognizant of a multi-layered and complex systemic interaction and interplay when working with military families.

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