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**January, 2017**

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## **Letter from the Editor**

The *Journal of Military and Government Counseling (JMGC)* enters its fourth year of publication! *JMGC* is the official journal of the Military and Government Counseling (MGCA). This journal is designed to present current research on military, Veteran, and government topics.

This issue is an eclectic collection of articles in practice, theory, and research. Counselor competencies are a trend in the profession and this issue has two articles (a bit of serendipity) on the topic of counselor competence with military-related clients. The second article presents an evaluation of a program that joins military and faith-based organizations and supported by the Department of Veterans Affairs Quality Enhancement Research Initiative (QUERI) Rapid Response Project (RRP 12-460) and the VISN 2 Center of Excellence for Suicide Prevention (the introductory article is in Volume 4, Issue 1). The fourth article presents a creative approach to building parent-child attachment prior to deployment. The final article is an interesting (and rare) look at the marital satisfaction of male Army spouses.

I am still seeing an increase in submissions and gladly welcome more submissions for the *JMGC*. I do hope that we sustain the submission – if we can, I may feel comfortable moving to four issues next year. So, ask around where you work – or try writing yourself. I'm advertising for submissions through ACA channels.

Benjamin V. Noah, PhD  
*JMGC Founding Editor*

## **Mental Health and the U.S. Military: The Need for Counselor Competencies**

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### **Abstract**

*The U.S. military community is composed of active duty, reserve, and Veteran service members and their families. The individuals within this population embody a distinct culture and lifestyle, characterized by service-related identity and experiences. The military community faces critical clinical and systemic mental health challenges. Recently, professional counselors were included in military settings, requiring special considerations of professional and ethical standards of practice. These issues support the need for the creation of counselor competencies that address the knowledge, awareness, and skills required to meet the mental health needs of the military population.*

*KEYWORDS: Veterans, counselor competency, ethics, treatment*

The U.S. is home to more than 23.4 million Veterans, 2.3 million active duty, Reserve, and National Guard personnel, and 3.1 million immediate family members (SAMHSA, 2014). Recent conflicts such as Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn, Operation Inherent Resolve, Operation Resolute Support, and Operation Freedom's Sentinel, have mobilized U.S. Armed Forces at their highest levels since World War II (U.S. Department of Defense [DoD], 2011). The unique circumstances service members and their families contend with can have consequences that impact physical and mental health, as well as relationships, finances, and careers (Carrola & Corbin-Burdick, 2015). SAMHSA (2014) cited critical concerns facing the military population, such as suicide, trauma, substance abuse, homelessness, and involvement with the criminal justice system. After the past fifteen years of

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war, service members and their families need mental health professionals who can empathically understand their distinctive identity and clinical concerns to provide competent care.

The military population is unique in their clinical need and thus deserves counselors who demonstrate proficient understanding and skill aligned with the experiences of the military community. Given the prevalence of the military members in the U.S. population, researchers in counseling have suggested the importance of defining them as a cultural group in diversity course work (Price, Stickley, & Prosek, 2015; Wix, 2015) and called for counseling-specific ethical models to implement when counseling service members (Prosek & Holm, 2014). Numerous ethical considerations outlined in the *American Counseling Association Code of Ethics* (American Counseling Association [ACA], 2014), including diversity, professional competence, and appropriate treatment must be uniquely addressed within the context of the military community. Moreover, counselors deserve a document that addresses the knowledge, awareness, and skills required of them to best serve military affiliated clientele. We believe there is substantial support in the literature to develop a thorough, concise, and relevant counselor competencies document. In this paper, we outline the unique dynamics of military lifestyle and culture, highlight significant clinical and systemic features of this population, and summarize the professional and ethical standards of practice that support the need for counselor competencies regarding the military population.

### **Military Lifestyle and Culture**

The community of soldiers, sailors, airmen, marines, coastguardsmen, and their loved ones represent diverse service-related experiences. Service members vary by rank and grade, service roles, time in service, training and readiness requirements, number of relocations, overseas assignments, number and length of combat deployments, and exposure to life-threatening or traumatic events. In particular, unique features of the lifestyle and culture of the military community are important for counselors to consider.

### **Lifestyle Considerations**

Military life is marked by many transitions, which are often qualitatively characteristic to this population. On average, military families move ten times more often than their civilian counterparts (Joining Forces, 2016). Relocation impacts proximity to natural support systems such as family and friends; disrupts daily routines due to changes in community resources such as childcare, school, and school programs; and impacts financial stability and spousal employment (Collins & Kennedy, 2008). The U.S. Department of Defense (DoD; 2012) concluded that emotional and behavioral health consequences are associated with the stress related to relocation and deployment. In light of the transitions experienced in the military community with several relocations and deployment cycles, there is potential for the need of additional emotional support from mental health services (Chandra et al., 2011). Counselors who are attuned to the relocation and deployment cycles can utilize that information in their approach to advocating for and providing services to the military community.

Training and deployment necessitate frequent, prolonged, and unpredictable separations (Clever & Segal, 2013). The deployment cycle, which is characterized by pre-deployment,

deployment, and re-deployment were associated with stressors and emotional responses during each stage (Gerwitz, Erbes, Polusny, Forgatch, & DeGarmo, 2011). Pre-deployment may elicit feelings of shock and worry about impending life changes as service members participate in increasingly intensive training and prepare to leave (Esposito-Smythers et al., 2011). The deployment phase may be characterized by feelings of loss, grief, fear, or loneliness (Esposito-Smythers et al., 2011). Because of the threat of injury, absences due to military training and deployment are qualitatively different than other occupational absences (Clever & Segal, 2013). Deployment may be stressful for family members creating new routines and accepting new duties in the absence of service members, while service members face physical and emotional challenges of the tour. Re-deployment may be characterized as a joyful time for reunification, but may be quickly complicated by the rebalancing of household roles, manifestation of symptoms of stress or trauma related to military duties, and renegotiation of family relationships after extended time apart (Esposito-Smythers et al., 2011). Counselors need to understand additional challenges faced by reservists or guard members. When reserve or guard units are selected to deploy, members are required to leave their civilian jobs and must quickly transition from civilian routines to the demands of military life. Although relocations and deployment cycles represent environmental and emotional stressors, there are also unique considerations for values and identity within the military population of which counselors need to be aware.

### **Cultural Considerations**

Core values espoused across the branches of the military, specifically selfless service, mental and moral strength, and high excellence factor significantly in the development of the warrior identity (Fenell, 2008). Reger, Etherage, Reger, and Graham (2008, p. 22) explained, “[given] the extent that a culture includes a language, a code of manners, norms of behavior, belief systems, dress, and rituals, it is clear that the Army represents a unique cultural group.” Counselors have an ethical responsibility to consider the implications of military culture and to provide culturally informed services to military members and their families. Prosek and Holm (2014) suggested that counselors may navigate the dynamics of the military population by increasing their knowledge of military culture in general, possibly utilizing a collectivist framework to cultivate trust with members of this community. Currently, the U.S. military functions as a professional, all-volunteer force, meaning members of the military community make a choice to acculturate to the structure and demands of the military (Fenell, 2008). Because a client’s worldview is influenced by his/her culture, it behooves counselors to be versed in the norms and values that are distinct to military life. Serving the military population may be enhanced by the awareness that stigma associated with counseling might serve as a barrier to treatment.

Individuals within the military community may be reluctant to seek mental health services if they internalize stigma due to a perceived conflict between their military cultural values and their mental health concerns. The purpose and meaning derived from the service member identity contributes to expectations that military personnel fight proudly and honorably without being deterred by pain or danger (Hall, 2016). Military culture encourages the assumption of absolute responsibility, and Hall postulated that this mindset can create a paradox, wherein service members are accountable for their own stress management, but simultaneously accept blame for their stress-induced reactions to the factors inherent to their service

commitments. Correlating negative outcomes (emotional or behavioral) to military service may appear to pathologize the military lifestyle. Research psychiatrist Maj. Gary H. Wynn, of the Walter Reed Army Institute of Research, estimated that less than half of the service members who report mental health symptoms related to combat-stress receive the care they need, and that of those who are in care, 20-50% will terminate treatment before it is complete (Robson, 2012). Executive Director of the Center for Advanced Defense Studies, retired U.S. Army Lt. Col David Johnson, attributed this low engagement in mental healthcare to fear that psychological testing will prevent service members from being selected for combat missions, a concern particular to an all-volunteer force (Robson, 2012). Marine Lt. Col. Gabrielle M. Hermes, a Pentagon spokeswoman, advocated for "creating a climate that encourages service members to seek help...and broadening communication and awareness to service members and their families" (Clark, 2016, para. 8). Military members might be reluctant to obtain counseling services; thus, it is imperative for counselors to demonstrate effective competencies to bridge the gap between stigma and culturally responsive treatment. It is the professional counselor's responsibility to keep clients engaged when they do participate in clinical services.

### **Clinical Features of the Military Population**

There are several clinical areas in which service members may present distinctly compared to the civilian population, including suicide risk, presenting problem/diagnosis, substance misuse, and military sexual trauma. Alongside service members, military spouses and children (referred to within the military system as *dependents*) also experience notable social, behavioral, and emotional challenges. Several clinical features of the military population are discussed to highlight the uniqueness of this group.

#### **Suicide**

Suicide represents an increasing problem in the military (Cato, 2013). Service members experience unique stressors, such as (multiple) combat deployments, frequent mobility, and large amounts of time away from their families. These stressors were assumed to underlie the increasing incidence of suicide attempts and completed suicides among military personnel (LeardMann et al., 2013). Suicide rates across the population of active-duty military have increased drastically (Bryan, Jennings, Jobes, & Bradley, 2013). In 2010, 295 service members died by suicide, and almost half of those who "died by suicide had visited military treatment facilities within 3 months of the suicide death" (Cato, 2013, p. 225). Also unprecedented is the number of military suicide attempts. Walker (2011) reported the number of suicide attempts by U.S. Marines is at an all-time high, with the number of reported attempts during the first 11 months of 2011 more than doubling the number since data was recorded. Additionally, the suicide rate in the Army increased every year between 2004 and 2009 (Ritchie et al., 2011). The rise in military suicides and attempted suicides was attributed to the stress of long and frequent deployments (Walker, 2011). The U.S. Department of Veterans Affairs (U.S. Department of Veterans Affairs [VA], 2016) found that in 2014, an average of 20 Veterans died by suicide each day, and that six of those 20 were consumers of VA services. The burden of suicide is disproportionately high among Veterans. While Veterans account for 8.5% of the U.S. population, 18% of deaths by suicide among U.S. adults were accounted for among Veterans (VA, 2016).

Counselors working with military service members need to be attuned to the higher-risk of suicidality. Furthermore, awareness of resources within and outside of the VA system are important adjunct services to be considered in treatment planning. It is not surprising that a population with higher rates of suicide presents to counseling with complex mental health needs.

### **Presenting Problem/Diagnosis**

Posttraumatic stress disorder (PTSD) was officially recognized as a diagnosis in 1980 (Lasiuk & Hegadoren, 2006). Although military trauma stress reactions were known, it was not until Veterans advocated for mental health care that their stress was viewed as an injury from combat. The new utilization of a PTSD diagnosis led to an increased need for mental health practitioners in the military system (Daley, 2000). For example, between 2004 and 2009, 26% of Veterans treated by the Veterans Health Administration (VHA) were diagnosed with PTSD (Bass & Golding, 2012). Recently, Veterans have returned from combat experiencing physical injury, which was associated with a higher prevalence of PTSD (Yarvis, 2013). Moreover, traumatic brain injury (TBI) also garnered attention with 19.5% experiencing TBI during deployment (SAMHSA, 2014). Boyd and Asmussen (2013) reported presenting symptoms can vary for persons with TBI because symptomology can also be influenced by factors such as the effects of medication or psychiatric illness. For many, mental health disorders co-occur with a substance misuse concern.

### **Substance Misuse**

Substance misuse is an established problem in U.S. military settings given that prevention efforts were enacted by Congress in 1794 (Kennedy, Jones, & Grayson, 2006). Weiss et al. (2012) identified special challenges associated substance abuse treatment due to military training and deployment schedules, and acknowledged the high prevalence of comorbidity of substance use disorders with other disorders among Veterans. From 2003 to 2009, there was a 56% increase in the number of Veterans seeking treatment for alcohol use disorder (Addiction Center, 2015). A 2008 survey of roughly 28,500 active duty military personnel found that 12% reported illicit drug use (Burda-Chmielewski & Nowlin, 2013), which was an increase from the 5% reported in 2005 (Bray et al., 2006). Similarly, SAMHSA (2014) found that 7% of Veterans met the criteria for a substance use disorder (in a review of cases between 2004 and 2006). The National Institute on Drug Abuse (NIDA; 2011) reported an increase in prescription drug abuse and heavy alcohol use, and stated that alcohol abuse is the most prevalent problem in this population. Additionally, prescription drug abuse tripled from 2005 to 2008 (NIDA, 2011).

The military population presents with complex symptomology given that 22% of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans with PTSD also were diagnosed with a co-occurring substance use disorder (SUD; Brancu, Straits-Tröster, & Kudler, 2011). Among Vietnam Veterans the percentage of co-occurring PTSD and SUD triples to 74% (Kulka et al., 1990). Therefore, addressing presenting problems of mental health and substance use disorders must be a holistic, simultaneous effort.

## **Military Sexual Trauma**

The VA (2015, para. 1) defined military sexual trauma (MST) as “experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service.” In the annual sexual assault report, the DoD (2016) cited 6,083 reports of sexual assault, a significant increase from 2,846 reports in 2007. The DoD (2016, p. 9) endorsed six program efforts to eliminate occurrences of sexual assault, specifically by “advancing sexual assault prevention, encouraging greater reporting, reporting sexual harassment complaints, improving response to male victims, combating retaliation associated with sexual assault reporting, and tracking accountability in the military justice system.” Katz (2016) reported various behavioral symptoms associated with MST (e.g., feeling betrayed, general distrust, anger, and resentment towards a unit, superiors, or the military in general), which may account for the increase in reports of sexual assault. Rates increased by nearly 25% in just one year, and female Veterans were more likely than male Veterans to experience sexual assault (Katz, 2016; Mathewson, 2011; Zinzow, Grubaugh, Frueh, & Magruder, 2008). Within the military population, researchers estimated that the prevalence of rape among women is 11% and 1.2% among men (Mathewson, 2011). Additionally, combat trauma and MST tend to co-occur for people in the military (Katz, 2016); and Kelly, Vogt, Scheiderer, Ouimette, Daley, and Wolfe (2008) found that female Veterans with MST were more likely to experience co-occurring symptoms of depression and PTSD.

Wilson (2008, p. 22) reported that the military is different from other institutions in that it has the “mission first” mentality, and Veterans are trained to “take life and destroy property,” hinting at reasons for the structure and culture of the military to be linked to increased rates of sexual violence (Katz, 2016). Recovery may be delayed because military personnel have little control over the environments in which they live and work (Maltz & Katz, 2016). Receiving treatment for MST may occur within or outside the VA system. Kelly et al. (2008) reported female Veterans were more likely to use VA health centers for treatment of MST, rather than community settings. However, the participants of the study also reported they were dissatisfied with services because the VA health centers were more focused on care for male Veterans (Kelly et al., 2008); indicating a potential need for appropriate treatment geared towards women in the community setting.

## **Military Dependents**

Active duty service members coupled with spouses, children, Veterans, and families represent one-third of the U.S. population (Hall, 2016). As previously discussed, military families experience frequent separations, reunions, and relocations. These transitions are guided by life under the *mission first* mentality and compounded by strict regimentation, threat of injury or loss, lack of security to meet family’s needs, social effects of rank on family dynamics, and lack of personal control over promotion (Hall, 2016).

Each of these significant factors can affect the military family in a multitude of ways, which may become of clinical concern. Parents deal with the repercussions of multiple deployments on the family unit. Service members struggle to fully reintegrate back into the

family before deploying again (Figley, 2012). Furthermore, military family systems are constantly threatened by illness, incapacitation, separations, and death. Service members may struggle with reintegration, and similar experiences may be observed in other family members (Herzog & Everson, 2007; Herzog, Everson, & Whitworth, 2011).

Over half of today's active duty military is married, and nearly half of active duty members have children (DoD, 2012), and there are over one million school-age children and adolescents who are military-connected (Russo & Fallon, 2015). The National Healthy Marriage Resource Center (2011) suggested that military couples are at much higher risk of marital dissolution than couples in the general population due to the military system which includes, but is not limited to, lengthy separations, relocations, and increased incidents of combat stress (Daley, 1999; Herzog et al., 2011; Figley, 1998; Dekel, Goldblatt, Keidar, Solomon, & Polliak, 2005). Given the stress of the military culture, family members may present to counseling with unique clinical needs.

**Children.** Frequent transition is a common theme experienced by military children. Not only do children confront the threat inherent to deployment, but they are also acutely aware of their lack of control over relocation (Everson, Herzog, & Haigler, 2011; Finkel, Kelly, & Ashby, 2003; Weber & Weber, 2005). SAMHSA (2014) reported that children with a deployed parent are more likely than their civilian counterparts to experience emotional difficulties at school, at home, and with peers. Additionally, mental health diagnoses and emotional difficulties are positively correlated with cumulative lengths of deployments (SAMHSA, 2014). As children move into adolescence and adulthood, researchers reported instances of school failure and developmental delays due to separation, loss, and deployments disrupting the normal life (Acion et al., 2013; Everson et al., 2011; Keim, 2009).

Adolescents may cope with frequent transition and mobility by engaging in substance misuse; and may suffer from anxiety and/or mood disorders and emotional behavioral disorders (Barrios & Hartmann, 1997). Rates of alcohol use, binge drinking, marijuana use, and other illegal drug use (including prescription drug misuse) are greater for children of currently or recently deployed parents than for children of parents who are not in the military (Acion et al., 2013). Researchers also indicated that military-connected children suffer from secondary trauma symptomatology that is similar but less intense than PTSD symptoms (e.g., avoidance; Herzog et al., 2011; Motta, Joseph, Rose, Suozzi, & Leiderman, 1997).

**Spouses.** Military spouses learn to conform to the change and uncertainty of the military lifestyle (DeCarvalho & Whealin, 2012; Orthner & Rose, 2006), and are called upon to hold families together during times of mobility and transfers. Spouses contend with military cultural rules and regulations, as well as frequent separations (Eaton et al., 2008; Hall, 2016). Reintegration after separation or deployment requires role re-negotiation and adaptation at each phase of the deployment cycle (Orthner & Rose, 2006). Spouses were instrumental in advocating for policy change garnering more support from the government; however, researchers indicated that due to repeat deployments Veterans and spouses are at high risk for developing mental health problems (DeCarvalho & Whealin, 2012; Lyons & Elkovitch, 2011) and secondary trauma (Herzog et al., 2011). Spousal secondary trauma refers to spouses who struggle with somatic psychiatric symptoms and emotional distress (Dekel, Solomon, & Bleich, 2005).

Secondary trauma may be overlooked in the clinical setting if counselors are not aware of the military family experience and culture.

Military members are at higher risk of suicide, experience complex combat-related traumas, and misuse substances. Additionally, the family members' experience of transitions and deployments may lead to presenting problems of academic and relationship distress, as well as secondary trauma. Beyond clinical presentation, there are additional environmental risk factors for the military population.

### **Systemic Risk Factors for the Military Population**

Military personnel may leave active duty assignments, but that does not necessarily mean their challenges dissolve or dissipate. According to the Bureau of Labor Statistics (2012), the unemployment rate of Iraq and Afghanistan Veterans is 10.3%, which is double the U.S. civilian unemployment rate. It is not surprising that given the high rates of mental health distress, substance misuse, and unemployment that military service members are at additional risk for incarceration and homelessness.

#### **Incarceration**

The VA (2016) reported some military service members are at an increased risk for incarceration compared to non-veteran peers. For example, White Veterans ages 35-54 were at higher risk for incarceration than White non-veterans (VA, 2016). Conversely, Black and Hispanic Veterans from the All-Volunteer Force (AVF) and Vietnam eras were generally at lower risk of incarceration than age-and race-matched non-veterans (Greenberg, Rosenheck, & Desai, 2007; VA, 2016).

In the *New York Times*, Sontag and Alvarez (2008) reported that over 100 homicides were committed by returning combat Veterans, and that more than one-third of the victims were spouses, girlfriends, children, and other relatives of the combat Veterans. In 2011-12, 8% of inmates at state and federal prisons were Veterans (Bronson, Carson, Noonan, & Berzokfsky, 2015). However, Kuhn and Nakashima (2011) reported that reentry services were one of the highest unmet needs of incarcerated Veterans.

The VA has two programs for incarcerated and justice-involved Veterans: (a) The Health Care for Reentry Veterans (HCRV); and (b) the Veterans Justice Outreach (VJO) programs (Carrillo, Costello, & Yoon Ra, 2013). The HCRV program targets Veterans leaving prison, and was designed to prevent homelessness and decrease the re-incarceration. Additionally, VJO programs were created to help justice-involved Veterans avoid homelessness and gain access to VA benefit and medical services.

Justice-involved Veterans may receive mental health services while incarcerated, or be connected to community services upon release; thus, counselors need to be competently prepared to address the complex needs of clients who are grappling with their criminal behavior within the schema of their military identity. And, although programming to support justice-involved

Veterans exists to address physical needs such as homelessness, all Veterans are at-risk for housing problems.

### **Homelessness**

The Housing and Urban Development (HUD) and Department of Veterans Affairs Supported Housing (VASH) Program (2011) reported that 144,842 people who self-identified as Veterans spent at least one night in a shelter or transitional housing program in 2010. Veterans comprise approximately 11% of the U.S. homeless population, which equates to 31 homeless Veterans for every 10,000 Veterans and can be compared to 21 homeless persons per every 10,000 civilians (Witte, 2012). Additionally, researchers found that mental health problems contributed to homelessness among Veterans returning from Iraq and Afghanistan (Cunningham, Henry, & Lyons, 2007).

In terms of gender, Katz (2016) reported that female Veterans are three to four times more likely to become homeless than non-veteran women due to incidents of MST, as well as increased rates of unemployment, disability, poor health, and post-traumatic stress. Furthermore, financial stress led to increased numbers of homeless female Veterans (Katz, 2016). According to the VA (2016), Veterans represent 8.5% of the U.S. population; however, they represent 12% of the homeless adult population (Peterson et al., 2015). Overall, the number of homeless Veterans is declining (Hamilton, Washington, & Zuchowski, 2013), but the number of homeless women Veterans is increasing (Katz, 2016).

The military population may experience daily life fundamentally different than civilians. We described the constant uncertainty of relocation and deployment; the unique clinical features such as risk of suicide, co-occurring disorders, and MST; the stressors for children and spouses; and the additional risk-factors faced including unemployment, incarceration, and homelessness. Counselors are ill-prepared to address the complex symptomology of military clients without appropriate knowledge, awareness, and skills.

### **Ethical and Professional Considerations**

Historically, counseling the military population in military settings (e.g., DoD or VA) was a privilege not afforded to professional counselors, but provided by other helping professionals such as psychologists and social workers. However, in recent years, licensed professional counselors became approved mental health providers in both the VA healthcare system and TRICARE insurance program (Barstow & Terrazas, 2012). The Military and Family Life Counseling (MFLC) Program was started in 2004 as a pilot to provide behavior health on DoD installations (MHN Government Services [MHN], 2017). The MFLC program has grown significantly since its inception and now provides licensed professional counselors on most DoD installations and Guard and Reserve service members (MHN, 2017). The Army Substance Abuse Program (ASAP) was authorized in 2011 to provide professional counseling services to military personnel (Department of the Army, 2016). Given counselors' increased employability within the military community, it is important to prepare counselors to competently provide services. Creating counselor competencies is a significant proactive movement to appropriately train and support counselors in the provision of ethical and proficient mental health care.

## **Counselor Competence**

The ACA (2014) *Code of Ethics* suggested counselors must honor “diversity and [embrace] a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” (p. 3). Working with the military population may also warrant counselors to be aware of personal perceptions of military members and their experiences. Counselors are instructed to be aware of personal values and not impose them on their clients (ACA, 2014, A.4.b.). For example, researchers have noted that one’s own political views of the current wars may impede the ability to accept a service member’s mission to serve (Prosek & Holm, 2014; Stone, 2008; Wix, 2015). Therefore, understanding the client’s worldview in the context of the *mission first* mentality is essential to build therapeutic rapport (Stone, 2008).

Additionally, there are three ACA (2014) ethical sections specifically related to professional competence that counselors may consider upon starting clinical work with the military community (§C.2.a., §C.2.b., and §C.2.c.). In §C.2.a., counselors are directed to practice within the scope of their training (ACA, 2014). Similarly, in §C.2.b., counselors are instructed to receive appropriate training when exploring a new specialty area (ACA, 2014). And finally, in §C.2.c., counselors are cautioned to apply for positions only if they are qualified (ACA, 2014). In light of counselors’ growing opportunity to serve the military population, it is important for professional counselors to approach new roles with appropriate knowledge and skills, especially with how to treat the unique clinical features of the military community.

## **Appropriate Treatment**

Counselors are directed to use clinical modalities based on empirical or theoretical literature (ACA, 2014, §C.7.a.). In collaboration with the DoD, the VA (2010) published *Clinical Practice Guidelines* that endorsed specific evidence-based treatments for use in military settings: prolonged exposure therapy (PET), cognitive behavioral therapy (CBT), problem solving therapy (PST), behavioral therapy/behavioral activation (BT/BA), acceptance and commitment therapy (ACT), interpersonal therapy (IPT), mindfulness-based cognitive therapy (MBCT), eye movement desensitization reprocessing (EMDR), and stress inoculation therapy (SIT).

Additionally, there are numerous therapeutic modalities with empirical or theoretical support, although they do not have the SAMHSA evidence-based practice approval. For example, Strom et al. (2012) suggested the therapeutic power of unit cohesion. This model was made popular with several peer-to-peer programs across the U.S., providing counseling services in the group setting to reinforce the military mentality of the unit. Furthermore, holistic approaches with recreational therapies (Duvall & Kaplan, 2014) and yoga (Staples, Hamilton, & Uddo, 2013) were found effective for combat Veterans. Therefore, counselor competencies need to address the research on appropriate treatment modalities for the military population.

## **Conclusion**

The dearth of literature regarding the unique features, clinical needs, and culture of the military population, coupled with the counseling profession’s recent inclusion in more mental

health settings with the military, warrants a counselor competency document. Currently, the Military and Government Counseling Association (MGCA) is leading an effort to write and publish counselor competencies to better serve the military population seeking mental health treatment. In line with the MGCA mission to “develop and promote the highest standards of professional conduct among counselors and educators working with armed services personnel and veterans” (www.mgcaonline.org, n.d., para. 1), competencies must support counselors’ ability to provide ethical, inclusive, and effective mental health services to the military community.

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## **Engaging Faith Based Organizations to Assist Service Members and Veterans: An Evaluation of Partners in Care**

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### **Abstract**

*Proactively addressing the mental health needs of service members, Veterans, and their families is a national priority. The Partners in Care program was developed to educate and motivate faith-based leaders to identify community resources to meet these needs. We used qualitative methods to evaluate program implementation. National Guard Chaplains (n=5) and individuals representing faith based organizations (n=205) participated. Chaplains' utilization of existing networks facilitated implementation, but lack of adequate staffing was a barrier to sustainment. Participants valued the program and potential to provide linkages to resources. Barriers hampered program implementation despite enthusiasm for this partnership and provided lessons learned.*

*KEYWORDS: faith, chaplain, community partnerships, mental health, suicide prevention*

Proactively addressing the mental health needs of service members, Veterans, and their families is a national priority (White House Press Release, 2012). One way to address these needs is to help individuals increase their resiliency. Resilient individuals draw upon internal resources and environmental supports to endure hardship (Bowen & Martin, 2011; Weiss, Coll, Gerbauer, Smiley, & Carillo, 2010). Developing resiliency is of particular importance to National Guard service members and their families because they have only limited access to supportive services within their local communities and lack the resources typically provided at military bases (Bowen & Martin, 2011; Weiss et al., 2010).

Community faith-based organizations are strategically placed and mission-driven to support local Veterans, service members, and their families. Rural residents are more likely to seek supportive assistance from religious leaders than from formal sources of mental health care (Wang, Berglund, & Kessler, 2003). Clergy, as trusted community leaders, frequently find themselves providing “first responder” spiritual and emotional support to returning soldiers and their families (Openshaw & Harr, 2009; Sullivan, 2007). However, barriers such as the cultural divide between traditional mental health services and some faith traditions, or the lack of confidence or expertise of some faith leaders about mental health issues, may impede their ability to serve their congregants (Openshaw & Harr, 2009; Sullivan, 2007). Clergy often report a lack of adequate knowledge and training necessary to detect, support, and refer persons with mental health problems, particularly individuals who are depressed or at a heightened risk for suicide (Kramer et al., 2007).

The Partners in Care program was developed to educate community faith leaders about mental health services and establish a network that could facilitate cooperation and referrals among local faith communities and National Guard chaplains to provide linkages to community mental health education, outreach, and support for Veterans, service members, and their families (Partners in Care, n.d.). The Partners in Care pilot program included a mixed-methods evaluation of its implementation. This manuscript describes the Partners in Care program evaluation and highlights the barriers and facilitators to program implementation.

**Background and rationale of the Partners in Care Program.** In an effort to coordinate support for National Guard members and their families by building partnerships with local faith leaders, the Maryland National Guard Joint Force Headquarters Chaplain's Office began a state-wide educational and outreach program called Partners in Care (Lee, 2012). The resulting Partners in Care network allowed National Guard Chaplains to refer Soldiers, Airmen, and their families to "local congregations, free of charge and without regard to any religious affiliation" (Partners in Care, n.d., para. 2). National Guard Chaplains' specific expertise positioned them to lead the effort to establish the state-wide referral network. The Maryland program gained recognition within the National Guard Bureau as a best-practice (Lee, 2012). For a faith-based organization to participate in the Maryland National Guard's Partners in Care program, it had to agree to these components:

- All religious organizations were welcomed to participate as "Partners in Care" congregations.
- Participation was voluntary.
- Complete a Memorandum of Understanding (MOU). This formalized the partnership, and defined the purpose, scope, and expectations of the parties involved.
- Provide support free of charge, with no future obligation or expectation (such as attending religious services) on the part of the faith community or the recipient.
- Provide support from each congregation or organization according to their available resources.
- Offer assistance equally to all service members, Veterans, and family members who were referred, regardless of religious affiliation.

These components assured that no faith-based group would be favored or endorsed, and that no recipients would be favored or given preferential treatment based on their beliefs or religious affiliations. This ensured that the relationship between the participating congregation and the recipient would be based strictly upon the needed services and had nothing to do with religious beliefs. Partners in Care recipients were not subjected to well-meaning attempts to educate them about the religious beliefs of the congregation, convert them, or have any ongoing relationship with the congregation aside from receiving the service.

Due to the high suicide rate of military service members and Veterans, the National Action Alliance for Suicide Prevention's Military/Veterans Task Force collaborated with the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Guard Bureau, and the Department of Veterans Affairs (VA), to pilot-test the Partners in Care program more widely to determine if it could be a useful strategy in reducing suicide in other locales. The pilot test included five states, Arizona, Missouri, Minnesota, Oregon, and Virginia, chosen by SAMHSA based on National Guard administrative commitment to the project. A National Guard Chaplain from each state was chosen by the Adjutant General to lead that state's implementation. National Guard Chaplains were introduced to the Maryland model of the Partners in Care program and encouraged to develop a version of the Maryland Partners in Care program that best reflected the culture and accommodated the needs of their respective local communities. National Guard Chaplains were responsible for developing a local team to conduct a one-day training on the Partners in Care program, referred to as a "Summit," to engage faith-based organizations to enroll in the Partners in Care program.

National Guard Chaplains invited leaders of faith-based organizations in each of the five states to attend their state Summit and learn about the Partners in Care program. While each state’s Summit agenda purposefully varied based on the identified need(s) of that state, the overarching goals were to educate attendees concerning military life, deployment, and the VA’s Operation S.A.V.E. suicide prevention program (Department of Veterans' Services, 2013; King et al., 2012); and to offer attendees the opportunity to enroll their faith organizations as “Partners in Care.” This manuscript describes the lessons learned from the project evaluation.

## Program Evaluation

### Program Evaluation

The evaluation of the PIC program was informed by the *Promoting Action on Research Implementation in Health Services (PARIHS)* framework (see Figure 1). The PARIHS framework considers successful implementation to be a function of the relationships between evidence, context, and facilitation (Rycroft-Malone, 2004). The role of evidence is broadly conceptualized and focuses on the quality of the scientific research, the match of that research with clinical experience, and the perceived value of the evidence to patients. Context includes dimensions such as work culture, clarity of policies and procedures, leadership practices, resources, and performance evaluation practices. Finally, facilitation involves supportive techniques that help implement a program or practice change. For this study, we view the NG Chaplains as facilitators of the implementation of the PIC programs. More specifically, the NG Chaplains serve as external facilitators supporting PIC implementation. PIC utilizes the expertise of these NG Chaplains to organize and provide training to members of their respective state’s faith based community, develop an action plan for the development of community support networks that link military families with needed services, as well as monitor program attendees progress in applying PIC in their community. In addition, they provide referrals of National Guard service members who are in need of supportive services in their home community.

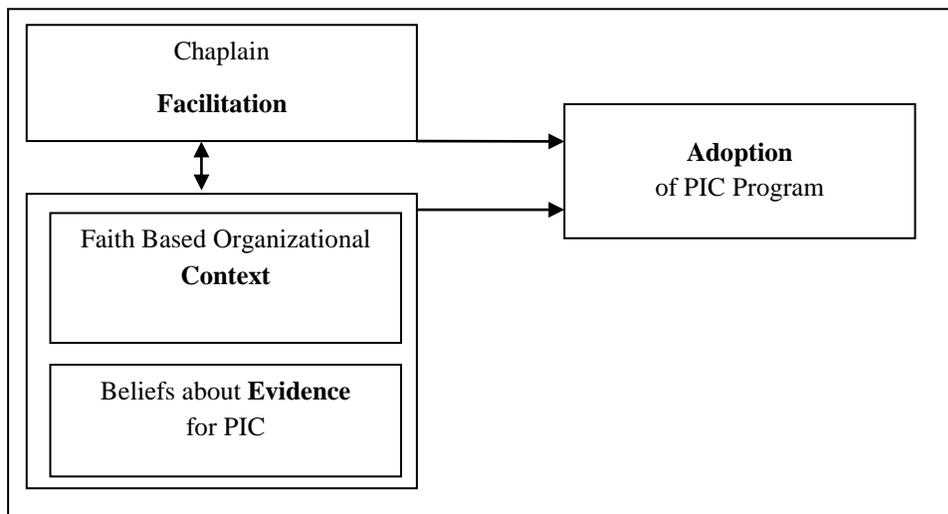


Figure 1. PARIHS Framework for PIC

Key informant interviews were conducted with multiple stakeholders to gain an understanding of the Partners in Care program implementation. Implementation varied according to local needs, but all sites held a one-day Summit training and enrolled representatives from local faith communities as “Partners in Care” to support local service members, Veterans, and their families. The mixed-methods evaluation included pre- and post-Summit training surveys and semi-structured interviews of National Guard chaplains (Summit training organizers) and faith-based leaders (Summit training attendees). This study was approved by the Central Arkansas Veterans Healthcare System (CAVHS) Institutional Review Board. Results from pre- and post-training surveys (Waliski, Matthieu, Townsend, Castro, & Kirchner, 2016) and our evaluation of the SAVE training are reported elsewhere. In this paper we report the results of the qualitative, semi-structured interviews.

**Participants and recruitment.** Participants included five National Guard Chaplains (one from each state) who completed three key informant interviews each, 205 individuals representing faith-based organizations who completed pre- and/or post-training surveys, and 127 participants willing to be contacted for follow-up telephone interviews.

**Semi-structured Chaplain interviews.** A VA research scientist experienced in qualitative interviewing conducted semi-structured telephone interviews with the chaplains at two-weeks, three-months, and six-months following the Summit training. Interviews were audio recorded and transcribed verbatim except to omit any identifying information. In order to elicit chaplains’ views on the barriers and facilitators to Partners in Care implementation and sustainability, implementation strategies, and perceived impact of the Partners in Care program, the interviews covered the following topics:

*Baseline interview.*

- National Guard Team Development (Partners in Care program initiation at the National Guard level, approvals required, institutional support available, internal communications and planning, and lessons learned)
- Community Stakeholder Engagement (stakeholder involvement in planning, communication to engage community stakeholders, level of support from community stakeholders, and lessons learned regarding community stakeholder engagement)
- Partners in Care Training Program (program description, agenda/other documents, perception of how training program was received, things that went well, things that needed improvement, lessons learned, adequacy of support, and need for additional support)
- Post-training activities and experiences (description of contact with Summit attendees, any increased service delivery for Veterans, service members, or family member with suicidal tendencies)

*Three- and six-month follow-up interviews*

- Partners in Care Implementation (experiences, opinions, barriers, successes, plans for improvement, lessons learned, and number of organizations enrolled)
- Operation S.A.V.E. training (opinions, lessons learned, any increase in service delivery for suicidal tendencies)

- People served (number of National Guard members, number of National Guard family members, other Veterans, and family members of other Veterans served by Partners in Care)

*Six-month follow-up interview additional topics:*

- Recommendations for the future of the Partners in Care program
- The number of National Guard members or Reservists in the state

**Semi-structured Summit attendee interviews.** We also interviewed a sample of Summit attendees who indicated on a post-Summit training survey their willingness to participate in follow-up interviews. Respondents attended Summit trainings in Missouri, Minnesota, Oregon, or Virginia (Arizona Summit trainings were held prior to the completion of the evaluation design and therefore Arizona Summit trainees were not included in our post-Summit surveys or follow-up interviews). The attendee telephone interviews were conducted at three, six, and 18 months after the Summit trainings. Interviewers sought information on attendees' perceived understanding and impact of the Partners in Care program, their intent to implement the program, barriers and facilitators to implementing the program, number of individuals or families assisted through the program, suggestions for improvements, and additional topics that should be addressed in future trainings.

### **Qualitative Data Analysis**

The evaluation team used qualitative methods to analyze key informant interviews. Interview transcripts were entered into ATLAS.ti software Version 7.0 (ATLAS.ti, 2012) for coding and analysis by a team of three coders. Two coders read and analyzed each interview and the third reviewed for agreement and identified any inconsistencies or need for clarification.

Using grounded theory, researchers initially reviewed three of the two-week and three-month Chaplain interviews to identify prominent themes and patterns and develop top-level codes. Top level codes consisted of the main topics that emerged from the majority of stakeholders. These codes were defined, and then all Chaplain interviews were analyzed. Coding results for the two researchers were compared, and discrepancies were resolved. Once agreed upon and approved by all three researchers, all data was analyzed, sub-coded and reported. The same method was used for the Summit attendee data.

### **Results**

Findings represent the perceptions and opinions of the National Guard Chaplains responsible for engaging and enrolling Partners in Care organizations. Perceptions and common themes reported by National Guard Chaplains and the Summit attendees are provided for both the implementation and sustainment of Partners in Care as well as their general opinions of the program.

## Implementation

### **National Guard Chaplains' perspectives.**

**Partner enrollment.** When asked how many partners were enrolled, National Guard Chaplains provided estimations that ranged from “very few” to “hundreds.” Chaplains indicated that keeping documentation was a challenge due to the extra work load, the lack of time to build an accurate list of partners, and the fact that Chaplains are generally not expected to keep records of their contacts.

**Existing collaborators and potential partners.** National Guard Chaplains' prior connections and professional networks with faith-based organizations and coalitions provided the infrastructure and additional personnel needed to successfully implement the program. National Guard Chaplains reported that they called upon their colleagues from their own churches and faith networks to attend the Summit and then encouraged the Summit Attendees to inform other faith-based organizations in the community who had not been represented. Additionally, National Guard Chaplains reported involving existing National Guard and VA support programs, local public servants (e.g., law enforcement, fire department), and community agencies (e.g., United Way, Salvation Army) in the ongoing implementation of the Partners in Care program.

**Suggested strategies to improve communication.** Every National Guard Chaplain identified ongoing communication and relationship building as important. One National Guard Chaplain indicated that communication should occur “early and often.” When prompted to further explain how additional funding would have helped them maintain a more useable database of contacts for themselves and their partners, one chaplain suggested a SharePoint site on the internet where each state's Chaplain could post potentially useful comments, information, and documents. Such a site could also serve as a useful time-saving strategy for Partners in Care partner engagement maintenance. Another suggested strategy was to build a computerized database with resources by zip code that would become a long-term, sustainable resource for use by all Partners in Care partners.

**Increased contact among participants.** Additionally, National Guard Chaplains reported needs to personalize and expand publicity efforts in the implementation of Partners in Care programs, which included holding community outreach by in-person visits to Partners in Care organizations, holding topic-related work groups, attending community and faith events, and hosting annual/quarterly breakfasts.

**Flexibility.** Flexibility was a strategy used by National Guard Chaplains in planning and providing the training and implementing the program. National Guard Chaplains allowed each faith-based organization to identify what, when, and how resources or services were to be provided. This strategy allowed for both large and small groups to provide assistance based on their available resources. National Guard Chaplains sought assistance on behalf of the service member or Veteran based on the service member's need and the resources available.

**Barriers to Implementation.** The Memorandum of Understanding (MOU) requirement for Partners in Care program partnership was reported as a barrier. To address this barrier, some

National Guard Chaplains considered organizations as being Partners in Care affiliated if they aligned with the Partners in Care program mission and goals and verbally acknowledged Partners in Care partnership, but did not formally execute or sign a MOU. Of the five National Guard Chaplains reporting, four indicated that flexibility regarding signing an MOU was an important strategy. One state used an existing process for community engaged partnerships and two states indicated there were legal concerns with using the MOU so it was disregarded. Two used the MOU inconsistently.

### **Summit attendees' perspectives.**

***Faith organization strengths.*** Summit attendees were asked about the strengths their faith organization possessed that would make the Partners in Care program easy to implement in their organizations and communities. Many Summit attendees mentioned their organization's willingness to help others, one describing "a small congregation with caring people," and another stating "we hand out plenty of brochures, buttons, pins and magnets. So our people know the help is here." Overall, attendees noted that the strength of the faith based organization was related to their enthusiasm to offer mutual aid and support to Veterans, military service members, and their families. The range of services offered by faith-based organizations was broad and contingent on the resources and strengths of the individual organizations.

***Barriers to implementation.*** Those Summit attendees not indicating that they had implemented the Partners in Care program reported challenges due to lack of resources, the limited size of their congregation, and not feeling supported by their leadership (Table 1).

## **Sustainment Strategies**

### **National Guard Chaplains' perspectives.**

***Use of established programs.*** National Guard Chaplains reported that they involved existing National Guard and VA support programs, locally established public servants (e.g., law enforcement, fire department), and community agencies (e.g., United Way, Salvation Army) in the sustainment of the Partners in Care program. Law enforcement officers are likely the first responders to encounter a Veteran in suicidal crisis, or a suicidal Veteran may qualify for a benefit for temporary housing or financial assistance provided by the United Way or Salvation Army. National Guard Chaplains noted that once a formal partnership was developed, negotiating other issues like relationships, cooperation, and organizational boundaries was paramount. Chaplains in the majority of the states found it beneficial to broaden their community of support agencies beyond the faith arena. One state included law enforcement, fire departments, health departments, and other state and local governmental agencies as resources.

Finally, National Guard Chaplains identified the need for open communication and collaboration with multiple institutions when providing support and services for service members and Veterans who were experiencing crisis or may have been at heightened risk for suicide.

Table 1. *Barriers or Challenges to PIC Program Implementation- Attendee Responses*

<b>Communication</b>	“Would like to implement but Chaplain will not return phone call.” “Need more communication and connection to community.” “Need more communication and follow-up.” “We have been waiting around for phone calls and have received none at this point. Our congregation actually had a meeting about PIC to discuss who would contact the National Guard Chaplain and let them know that we are still on the list as participants.” “Trying to get started has been a challenge. Nobody really knows what direction to go in. There is not enough information available to move forward or design ideas.”
<b>Contact with National Guard</b>	“The only interaction with the National Guard Chaplain was receiving a thank you for your participation letter.” “... we have an as needed-hands off approach” “We are willing but they [National Guard Chaplains] have not done anything.” “...limited because the MOU has not been signed yet but we have let the Chaplain know that we are here to help.”
<b>Lack of Resources</b>	“...location was small and away from resources.” “There are also budget restraints.” “We are a really small church and we are trying to build up our resources enough to implement the program in the future.”
<b>Congregation Characteristics</b>	“Lack of active duty, guard and/or reserve service members in the community due to it being in a rural area.”
<b>Lack of Support by Faith Organization</b>	“It was presented to the Elders and there's just not enough information out there...The program seems a little premature and there doesn't seem to be a need in the community at this time.” “The MOU has not been signed yet.”

**Heavy workload challenging.** They further reported that the need for more staffing due to the heavy workload of engaging and communicating with partners remained a challenge in order to sustain the program efforts.

**Training, social contacts, and recognition.** National Guard Chaplains reported that public relations coupled with continuous training were used as strategies for Partners in Care sustainment. In terms of education, National Guard Chaplains perceived that Partners in Care partners needed refresher training to better understand service needs and types of referrals frequently used with military and Veteran populations following the initial training received at the Summit (Table 2). Additionally, National Guard Chaplains reported personalizing and expanding publicity efforts in the implementation of Partners in Care programs, which included holding community outreach by in-person visits to Partners in Care organizations, holding topic-related work groups, attending community and faith events, and hosting annual or quarterly breakfasts. Recognition of Partners in Care organizations with certificates, public acknowledgement, or a collaborative introduction between key stake holders were noted as being useful for highlighting the Partners in Care program. Lastly, engaging existing state (e.g., State Office of Veterans Affairs) and national (e.g., VHA, Vet Centers, tribal governments) partners and creating a National Guard Chaplains Corps that would consist of a group of chaplain assistants to help with community outreach and events, were mentioned as innovative strategies used for sustainment.

Table 2. *NG Chaplain: Facilitators or Barriers to PIC Implementation*

<b>Publicity</b>	<p>When I've spoken in public they may not sign up, I have to have that memorandum of understanding. They may not sign up but they're very supportive of it and every time I go speak I get two or three other speaking events that roll out of that." "It would have been beneficial if I just made it a lifestyle to talk about PIC. So, I believe in time I'm going to be able to do good things."</p> <p>"I really want to have like a newsletter or I hate to say a Facebook page but you know that's just something else you have to maintain and that's just it I don't have anybody to maintain it. So I don't want to do too much at the same time I'm doing what I can to keep what I've got and not let it grow so fast that I lose people. So I'm kind of in that zone; it's a good problem to have."</p>
<b>Training Content</b>	<p>"We're offering those pastors and counselors training on how to relate to us and if I could just keep going on the path I'm on, man I'd be really happy. I'm just running out of energy and people and at the end of the fiscal year nobody had any annual training days left."</p>
<b>Funding Staff</b>	<p>"There needs to be a person dedicated; you can develop this thing to where all states funding could be completely dried up to zero and these faith based groups would be more than happy to provide a lot of the assistance our soldiers and families need. It is a lot of work and I'm the only fulltime support Chaplain in the State, which handicaps me quite a bit."</p>
<b>Collaborations Existing Partners</b>	<p>"I don't think you would have a successful PIC program [without experience and credibility in the community]. Because it's not just the leadership within the Military, but also the leadership within the community. For instance, because I am the senior chaplain for the state, if I go to a clergy meeting I'm already, if you will, recognized."</p> <p>"I see that part of our success is because we were willing to work together and we got along with each other, you know, in terms of our personalities....Although, [name] is a counselor we got along together professionally. In other words, I wasn't trying to compete with them because I am the chaplain and because of spiritual or religious issues."</p>
<b>Collaborations: New Partnerships</b>	<p>"I think the way I would say it would be that...The Coalition, we are...our mission is capacity building. So the way we do that is through cross-sector collaboration. So you can think of us as sort of the facilitators of helping the Military, government, and community organizations work better together."</p>

**Summit Attendees' perspectives.**

**Barriers to implementation.** Summit attendees most often mentioned challenges with limited communication with National Guard Chaplains. None of the follow-up participants had received additional contact with the National Guard Chaplains. These respondents indicated this as a barrier to implementation for the program within their community. Although some wanted to get their organizations involved they indicated a lack of understanding and guidance to do so. These individuals' participation in the pilot project follow up evaluations decreased over time, and no Summit attendees participating in the follow-up interviews reported that their faith organizations had implemented and sustained the program.

## **General Opinions**

### **National Guard Chaplains.**

*Staffing needs.* The National Guard Chaplains noted that their Partners in Care were always willing to distribute tangible goods and services, such as clothing or provide assistance with child care. One National Guard Chaplain indicated economic benefit through ongoing efforts of faith-based organizations to help distribute material goods and resources directly to military service members and their families, explaining that faith based organizations can assist in ways that the National Guard cannot (See Table 2). For the four states that did not have a funded state-wide or regional coalition, all National Guard Chaplains suggested those states would need at least a full time Chaplain with experience and credibility in the broader community in order to effectively establish the Partners in Care program.

### **Summit attendees.**

*Varying services and perspectives.* The Summit attendees reported that multi-faceted support and services ranging from counseling to providing financial resources were available through their organizations. Counseling included spiritual and grief counseling along with mental health and addiction counseling, with referrals to mental health providers when appropriate. Churches also offered emergency funds, job re-training, food baskets or food pantries, clothing, temporary housing, and assistance with transportation and child care. Thus, the range of services offered by faith-based organizations was broad and contingent on the resources and strengths of the individual organizations. Although National Guard Chaplains indicated they had enrolled partners they did not provide a count of how many partners were involved and there is limited data from Summit attendees to support that these resources were partnered with military service members or Veterans in need. Some Summit attendees reported they had not been contacted for support, were no longer motivated to engage their organization, or assumed there was no need to partner.

## **Discussion**

Community-based participatory research (CBPR) has been used to improve community health and reduce health disparities and is intended to promote change in public health efforts (Young, Patterson, Wolff, Greer, & Wynne, 2015). Successful community program, project, or research implementation and sustainment includes several key characteristics including: a clear, identified and equitable goal with clear processes and procedures that include skilled, knowledgeable, and diverse stakeholders representing the community involved (Andrews et al., 2013; D'Alonzo, 2010; Belone et al., 2016; Bodison et al., 2015; Braithwaite et al., 2013; Sadler et al., 2012; Young et al., 2015). Additionally, leadership should be multilevel and represent the best interests of those impacted, and there should be a balance among process, activities, and outcomes that is continually evaluated and improved to maximize sustainability. Therefore, our discussion of study results is framed around these characteristics.

## **Comprehensive Representation**

Diverse, skilled, and knowledgeable representation of all stakeholders involved in development, implementation, and sustainment of a project are identified as a key characteristic for successful community change (Sadler et al., 2012; Shalowitz et al., 2009). Engaging stakeholders who are knowledgeable about the communities in which the project will be implemented could increase the resources available to the planning team. Although building trusting relationships is more difficult in larger groups of leadership representing multiple interests, it may assist in identifying concerns or barriers in the early stages of development so that time may be saved during implementation. Trusting relationships are an essential characteristic so that all members feel comfortable enough to provide valuable and sometimes sensitive information to stakeholders outside of the community. Trusting relationships are established when all stakeholders have a clear understanding of the goal to embed a project into the community, have a feeling that their interests are valued and protected, and believe that the project outcomes are tangibly beneficial to those they represent. Community based research suggests the use of Community Advisory Boards to direct project efforts (D'Alonzo, 2010; Newman et al., 2011).

The idea to conduct a pilot study of the Partners in Care program in five states began at the national level with key stakeholders represented with VA, SAMHSA, and National Guard Bureau representatives. The National Guard Bureau enlisted the support of State Adjutant Generals and senior Chaplains to facilitate the training and implementation in the communities, SAMHSA provided supportive staff services, and the VA provided the program evaluation. However, as we review the results it appears that the project implementation lacked adequate engagement of stakeholders at the community level. By establishing multiple collaborations early in the process of Partners in Care implementation, faith-based organizations were more likely to be engaged in ensuring its success, and aiding in sustaining the program over the long term. One state utilized the partnership of an existing state-wide civilian military/Veteran support organization and another identified the use of a steering committee when planning for implementation. These two states reported fewer barriers to facilitation.

Therefore, consistent with CBPR principles, engaging multiple stakeholders that represent the targeted population proves to be worthwhile. Community based participatory research in public health is a collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers who work collaboratively for maximum effectiveness and quality to reach clearly identified implementation and dissemination goals (Bodison et al., 2015; Israel, Schulz, Parker, & Becker, 1998; Shalowitz et al., 2009). Therefore, one strategy for improvement in the future would be to empower National Guard Chaplains with an overview of lessons learned in this study to assist in the facilitation of further efforts.

**Skilled leadership and staff.** CBPR findings indicate that developing a project to be implemented within a community should include members who are knowledgeable about the culture of the community or about the research or evaluation of the project, or skilled in the project to be implemented (Andrews et al., 2013; Braithwaite et al., 2013; Shalowitz et al., 2009). Project leaders should be able to be flexible in expectations, and maintain a balance

between processes, activities, and outcomes, while ensuring that all members are aware of barriers and triumphs of the group's efforts (Andrews et al., 2013; Braithwaite et al., 2013; Shalowitz et al., 2009). These findings should be clearly communicated to stakeholders in a timely manner.

Continued communication and public relations coupled with follow-up training were often reported by National Guard Chaplains and Summit attendees as essential factors for Partners in Care implementation that were present in states having greater implementation success. Communication challenges arose when National Guard Chaplains were not approached by service members in need and the faith-based partner organizations were not contacted. This limited contact strained the relationships with Partners in Care partners because the partnership was viewed as unneeded or the National Guard Chaplain as unresponsive. The major challenge for National Guard Chaplains was the time and man-power needed to successfully devote to Partners in Care implementation. Coordinating the one-day training, enrolling partners, and maintaining ongoing collaborative relationships were all expectations placed on the National Guard Chaplains in addition to their daily job responsibilities. Results from all National Guard Chaplains call for additional staff and resources for the program to reach its full potential.

**Goals and policies.** For programs to be successfully integrated into a community, stakeholders leading implementation and sustainment efforts must have a clear understanding of the goals and the internal and external policies that will govern the process. The Partners in Care program had a clear goal in that National Guard Chaplains were to engage community faith organizations to assist in supporting military service members, Veterans and their families, but there was limited guidance in the actual implementation of the program.

The National Guard Chaplains were primarily briefed on the Partners in Care program and how it ran in Maryland. There was a guide provided by the Maryland National Guard Chaplain that contained an overview of how the program worked and example documents. National Guard Chaplains were told to modify it to best fit the needs of each community.

The flexibility that allowed Chaplains to implement their state's Partners in Care program based on need also made it difficult to describe, explain to others, compare, and measure outcomes. For example, without MOU's stating the responsibilities and expectations and without follow-up contact, Partners in Care partners involved in key informant interviews were unclear if they were still considered a partner. Understanding the goals that are jointly developed and having everyone agree on the policies and procedures to reach those goals would be one strategy to keeping stakeholders engaged and therefore sustaining the program.

**On-going project evaluation.** Evaluations should be conducted throughout the implementation and sustainment process to assess the needs, determine if goals are being met, and to identify needed improvements and celebrate successes (Andrews et al., 2013; Shalowitz et al., 2009). Evaluations can be used to build support when working to identify the overall outcome and prove a need for sustainability efforts. Consistent communication revealing the evaluation results keeps stakeholders involved, informed, and engaged in the project.

Although the piloting of Partners in Care was evaluated to identify barriers and

facilitators to implementation and sustainment, the evaluation design did not include opportunities to communicate these findings to stakeholders throughout implementation efforts. Without communication and evaluation, Summit attendees reported assuming there was no need to assist military service members or Veterans or that there was a lack of interest from the Chaplain.

**Limitations.** Design and methods proved to be a limitation in evaluating the PIC program. The evaluation component of the project was added after the implementation plan was decided; therefore, the methods were determined based on what would be gained from the identified implementation plan. Ideally the evaluation plan should evolve with the plan for implementation so that goals, objectives, and outcomes are identified and the evaluation design and methods inform these outcomes. Although the authors acknowledge the limitations of design and methods, found value in the lessons learned through the process of working with three government agencies to pilot a national community engagement project. Secondly, approximately 50% (n=127) of those attending the Summits (introduction to Partners in Care program) indicated that they were willing to be contacted in the future for additional interviews, but after three months only 22% were actually willing to do so. This decreased similarly at six and 18 months. There are several potential causes for these low response rates. First, the evaluations focused heavily on questions related to faith-based organizations and their resources. Summit attendees included people from other organizations and individuals that provide support and services in the community. Individuals not involved in a faith organization may have felt they had nothing to add and thus did not participate in follow-up interviews. Also, the lack of post-Summit communication between National Guard Chaplains and partners may have had an impact on those who did not choose to participate in the follow-up interviews. Thus, the evaluation of Partners in Care implementation rates rests solely on those organizations that chose to participate in the follow-up interviews.

Another study limitation was that many of the state National Guards had existing programs that involved faith-based organizations. This made it difficult to identify new relationships established during the evaluation period, previous relationships, and the impact that these new and existing relationships had on the Partners in Care program. For some states, implementation of the Partners in Care program did not change support because existing programs were already successfully assisting service members, Veterans, and their families.

One unexpected limitation of the study was that most National Guard Chaplains did not keep records of the number of faith-based organizations that had agreed to partner, or the number of service members or Veterans they had referred to participating organizations. Therefore, evaluation of the Partners in Care program's success depended on the National Guard Chaplains' subjective opinions on the program and data obtained from the declining key informant participation in follow-up interviews. Reasons for not participating in the follow-up interviews were not ascertained. This could indicate a potential selection bias where those who saw greater value in the Partners in Care program were more likely to respond; other important factors in understanding the Partners in Care implementation outcomes by those choosing not to participate in key informant interviews would thus be lost in the evaluation process. Thus, it is critically important to build evaluation metrics into implementation and sustainment phases of pilot community partnership programs. This would help ensure that the data collected adequately

capture key factors that facilitate or impede new program implementation. Utilization of on-line surveys could capture input from those faith-based organizations choosing not to participate in follow-up telephone interviews.

### **Conclusions**

This study aimed to provide insight from key informant interviews regarding the factors that facilitated or impeded implementation of the Partners in Care program in the five pilot states. Findings identified the challenges to implementation and ongoing sustainability of a community engagement program and strategies to aid in the program's evolution. Key issues and strengths related to the implementation of the Partners in Care program included versatile staffing and collaboration models, which ensured that National Guard Chaplains were able to take into consideration the uniqueness of each state, the faith-based organizations, and local communities.

Specific to the challenges of implementation and sustainability, results indicate that while setting up new partnerships with the faith communities was the initial goal for the Partners in Care program, the need to sustain these partnerships was equally important and became a second ongoing goal with its own separate set of requirements and challenges. The decrease in impact over time parallels the decrease in the number of attendees participating in the interviews. This loss to follow-up (as indicated by a decrease in willingness to participate at 18 months) may signify those organizations were no longer participating in Partners in Care; and conversely, those that were willing to participate in follow-up interviews at 18 months may represent those that had become invested in the Partners in Care program.

While National Guard Chaplains indicated partnerships were continuously improving, attendees most often reported a lack of contact or follow-up from the National Guard Chaplains and expressed the need for more frequent contact following Summit training. Attendee responses also indicate the need for guidance and structure following the Summit; a clear understanding that the National Guard will only contact partners as needed; and that partners are encouraged to build community support and programs to assist military service members, Veterans, and their families without the oversight of the National Guard.

Findings indicate that faith-based organizations were interested in building supportive communities for service members, Veterans, and their families and had resources to assist. But, for this approach to reach its potential for success, mutual collaboration between government agencies, strong communication systems, financial backing, and clearly defined goals must be firmly established. The need for individuality and flexibility of each local Partners in Care program was supported by the data, which highlighted that basic tenets and goals must be determined and adhered to by each state so that the impact of the program can be identified and evaluated. National Guard Chaplains and Summit Attendee reports indicate a potential benefit in engaging other community support and service organizations as partners to assist this population. Further research is needed to explore the power and effect of combining resources, empowering individuals through knowledge of mental health and suicide prevention, and encouraging volunteerism, in an effort to increase personal resiliency and help seeking for mental health concerns for Veterans and their families.

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## **Counselor Competency in Divorce and Disputes in Military Families**

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### **Abstract**

*Over 2.7 million troops have deployed to the wars in Iraq and Afghanistan since 2001 (U.S. Department of Veteran's Affairs, 2014). Researchers found that within the first three years following deployment, 75% of service members experienced relationship problems and 35% either separated or divorced (Sautter, Armelie, Glynn, & Wielt, 2011). The counseling field lacks an understanding of divorce and disputes specific to military families; yet skills and knowledge in this clinical role are necessary. The absence of knowledge and skill can lead to various forms of ethical misconduct with numerous possible negative consequences. This article provides an overview of the relevant literature, cultural considerations, competencies, and effective treatments related to these issues within military families. An illustrative case study is provided.*

*Keywords: divorce, military families, military*

Military families experience stressors and challenges that are unique to military service including repeated lengthy separations between spouses and children and combat deployments (Schepard & Emery, 2014). Other challenges include posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), other mental health problems, physical injuries incurred during

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combat, substance abuse, and domestic violence (Schepard & Emery, 2014). Although the legal system has made progress in addressing the needs of military families, the court system must consider the uniqueness of military families and collaborate with counselors and other specialists to provide supportive resources, strategies, and treatments that consider the effects of war upon these clients (Schepard & Emery, 2014).

Counselors have the opportunity to provide post-combat Veterans and their families with supportive care and effective treatments that address disputes and divorce (Zeber, Noel, Pugh, Copeland, & Parchman, 2010). There is inadequate research on the effects of military combat on prevalence of divorce and prevention strategies addressing relationship problems in military couples (Foran, Wright, & Wood, 2013). Further, more research is required for counselors to provide competent care to military families, specifically addressing the underlying factors that lead military couples to divorce court. When a divorce takes place within a military court there are additional concerns to consider, which include federal military pension divisions (Sullivan, 2016). The following article provides an overview of the relevant literature addressing the factors that contribute to divorce among military couples, considerations for treatment related to military culture, professional competencies, and effective treatments related to divorce and disputes within military families.

### **Military Culture Considerations Regarding Divorce**

Military families undergo tremendous change and are expected to adapt to the military value system. According to Park (2011), “when one person joins, the whole family serves” (p. 65). Military families experience many stressors when their service member serves their country, including concerns for safety as well as a sense of powerlessness, as decisions related to deployment are in the hands of the U.S. Military (Negrusa, Negrusa, & Hosek, 2014). Divorce is also stressful for couples since many decisions regarding the family lie ultimately in the hands of the court system (Coyne, Myers, & Witting, 2009).

The military is an authoritarian system with a culture of secrecy, which can be isolating for military families (Gerlock, Grimsey, & Sayre, 2014). Military service members ascribe to the values of honor and duty and are willing to risk their lives to protect others’ freedoms (Simmons & Yoder, 2013). The military mission is a service members’ priority and requires a sacrifice from the entire family (Mouristen & Rastogi, 2013), which can be a positive experience when it provides the family with a sense of meaning and purpose (Mouristen & Rastogi, 2013). Military families value strength; therefore, there is a stigma associated with seeking help (National Child Traumatic Stress Network, 2016; Simmons & Yoder, 2013). Military culture affects a couple’s functioning; therefore, mental health care providers should seek to understand military culture when they engage these families (Mouristen & Raastogi, 2013). Systemic influences include the warrior mentality; which is resistant to help, frequent relocations; which can lead to a sense of instability, the significance of the military mission within the family; which includes obedience and dedication, the military’s authoritarian system of rank, and a constant readiness for disaster; which affects couples and families (Mouristen & Rastogi, 2013).

Women serving in the military appear to be at a higher risk for divorce than men (Kanzler, McCorkindage, & Kanzler, 2011). Karney and Crown (2011) found the risk of divorce

was lower for female Army officers than for other female service members. According to Karney and Crown's (2011), research with over 500,000 married service members, longer deployments appeared to increase marriage stability, and the longer the deployment, the lower the risk of divorce in service members from most branches and statuses in the military; however, for female service members, they are "always more likely to divorce" as a result of a deployment (Negrusa et al., 2014, p. 475).

According to Rosa (2014), there is a lack of literature covering military court cases processed in civil courts. For example, Simon (2014) found that attention to military status and military culture is important when conducting child custody evaluations. Attention must be paid to potential biases both for and against military service held by the evaluator, the impact of deployment cycles on the family, any potential PTSD diagnoses of either parent, the possibility of the family relocating, supportive individuals and systems available to the family, and the child's attachment to each parent.

Divorce among military families is further complicated by the effects of war, long separations, and subversion by the military system and the mission (Simon, 2014). Mental health care providers must be careful to avoid making unwarranted assumptions when determining what is best for a child in a divorce case, such as attributing all dysfunction to military service, PTSD, or parent/child separations (Simon, 2014). Additionally, providers have a responsibility to understand the laws that address military separations in their respective states, as there are military rights included in the Service Member's Civil Relief Act (SCRA, 2010 as cited in Simon, 2014) that protect the military parent from engaging in the legal process while deployed.

### **Contributors to Divorce among Military Families**

Marital disputes and discord have a deleterious impact upon military service members and their families. A review of the literature suggested divorce is detrimental to health, creating vulnerability for developing PTSD, and depression in military populations (Wang et al., 2015). Within the first three years of returning home from deployment, 75% of service members reported experiencing relationship problems, with 35% reporting separation or divorce (Sautter et al., 2011). Although military couples have lower divorce rates than the general population, these rates increased with exposure to combat (Frey, Blackburn, Werner-Wilson, Parker, & Wood, 2011) and deployments to a hostile zone contributed to a higher risk of divorce (Lemmon & Stafford, 2014). Satcher, Tepper, Thrasher, and Rachel (2012) found that divorce rates increased by 50% among military couples following a deployment to Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF). Although deployment has contributed to divorce in some couples, there is little information on the effect of high levels of military combat exposure and marital dissolution. Psychological distress and difficulties readjusting following deployment to OEF and OIF have negatively affected families; however, the full effect of deployment on marital relationships and families is not known (Collinge, Kahn, & Soltysik, 2012).

A review of the literature revealed that the following factors contributed to marital problems for military families: deployment and reintegration challenges (Lowe, Adams, Browne, & Hinkle, 2012), psychological distress due to traumas of combat (Bello-Utu & DeSocio, 2015),

lack of support for mental health problems (Valenstein et al., 2014), family stress (Bello-Utu et al., 2015), intimate partner violence (IPV; Schmalings, Blume, & Russell, 2011), infidelity (Snyder, Balderrama-Durbin, & Fissette, 2012), role conflict between work and family (Kgosana & Van Dyk, 2011), and reorganization of life priorities leading to the breakup of the family (Foran et al., 2013). Negrusa et al. (2014) reported that divorce appeared to become more likely as the length of deployment time increased; however, research by Karney and Crown (2011) was conflicting and found that longer deployments lowered the risk of divorce except for active duty Air Force deployments in military husbands married to civilian wives. Further, when there were children in a marriage relationship, the likelihood of divorce decreased, and those who had a greater number of children were even less likely to divorce (Negrusa et al., 2014).

### **Deployment and Reintegration**

The processes and stages of deployment and reintegration present various challenges that are unique to military members in their families. In pre-deployment, preparations are made for a service member's departure and include legal preparations: setting up a will, granting power of attorney, putting one's financial house in order, and arranging for childcare when necessary (Lowe et al., 2012). Goodbyes are also said to friends and family (Lowe et al., 2012). The actual deployment includes emotional ups and downs as the spouse who remains at home assumes responsibility for the household and any children, while at times experiencing fear for a loved one's safety (Lowe et al., 2012). This stage can be lonely and can lead to depression (Lowe et al., 2012). Reintegration is a transition stage when the service members return home and experiences the effects of a long absence from home (Lowe et al., 2012). Stressors experienced by a military family member's deployment and reintegration struggles also expose families to secondary trauma from war (Bello-Utu & DeSocio, 2015). Since nearly half of service members who have children have experienced repeated deployments, this contributes to increases in the incidences of trauma exposure in children (Bello-Utu & DeSocio, 2015).

Branch of service affects the types of stress service members and their families' experience. Those in the Army are most likely to experience ground combat and those who are members of Special Forces groups in the armed services receive little notice of their departure with little time available for families to prepare for a deployment (Wadsworth, 2013). The combat levels found in the OIF and OEF wars, which included terrorist tactics with suicide bombers, improvised explosive devices (IEDs), and lengthy deployments, have led to increases in mental health problems for service members (Baptist et al., 2011). Further, these experiences have an unknown future effect on their marriages (Baptist et al., 2011).

Lengthy and repeated deployments contribute to decreases in children's resilience with the stress associated from a parent's repeated departures, subsequent unavailability, and re-entry home after war (Bello-Utu & DeSocio, 2015). Service members' stressors include experiencing re-entry into a changed family system, which includes redefined family roles and responsibilities (Bello-Utu & DeSocio, 2015).

Deployments to military operations have led to increases in loss of life, injury, and complex trauma in service members, which are challenging for families, and repeated deployments and lengthy tours have exposed children and families to secondary trauma from war

upon reintegration (Bello-Utu & DeSocio, 2015). Further, the inability of society to participate successfully in the reintegration of service members into families and communities has contributed to moral injury, which includes shame and guilt for service members and their families (Glynn, 2013, p. 412).

Deployment was not found to create lasting marital strain for all couples, with some military couples experiencing benefits that strengthened their marriage relationships (Allen, Rhoades, Stanley, & Markman, 2010). Benefits included the sense of purpose and meaning in sacrificing for the military mission (Mouristan & Roustigi, 2013) and utilizing available supports to improve coping and communication, strengthening the marriage relationship (Allen, Rhoades, Stanley, & Markman, 2011). Additionally, couples that were able to communicate well and adapt to the demands of a deployment found that they grew closer and had a greater appreciation for one another, which strengthened their marriages (Baptist et al., 2011).

More specifically, married U.S. active-duty Soldiers with civilian wives reported high levels of stress attributed to deployment and reintegration, including concerns regarding loneliness, combat, life and death, physical and psychological injuries, and potential negative effects on children (Allen et al., 2011). Additional stressful experiences during deployment include concerns over communication with the deployed service member (Allen et al., 2011). Marital communications during deployment to stay connected were beneficial; however, service members' sharing was selective due to safety concerns, confidentiality of military information, personal privacy, and protection of the non-deployed spouse (Baptist et al., 2011). In addition, the non-deployed partner may filter information shared to protect the feelings of the deployed partner who is absent from family life (Rossetto, 2013). Communication during deployment is important for maintaining connections between couples; however, withholding information has a negative effect on military wives' physical and mental health and marital satisfaction (Carter & Renshaw, 2015).

### **Psychological Distress and Mental Health Problems**

Military service members and their families experience various mental health concerns that may contribute to disruptions in family functioning. Veterans and active duty Soldiers are reluctant to seek out professional help for mental health care problems due to stigma, problems getting an appointment scheduled, transportation problems to attend an appointment, and the high cost of treatment (Valenstein et al., 2014). Further, many military service members who do seek out treatment do not complete treatment (Valenstein et al., 2014).

A study conducted by the U.S. Department of Defense compared military divorce rates before and during OEF and OIF, and found that rates were not higher during these operations, suggesting that other factors, such as mental health issues that arise from military service, may be more likely to cause divorce than the actual deployment experience (Monson, Fredman, & Taft, 2011). The "*signature injury*" from OIF and OEF is traumatic brain injury (TBI), which affects about 20% of Veterans (Satcher et al., 2011). Approximately 11% of Veterans of these wars experience symptoms associated with PTSD (Satcher et al., 2011).

According to Hyatt, Davis, and Barroso (2015), 40% of service members who experience mild traumatic brain injury (mTBI) also have a diagnosis of PTSD. Symptoms of mTBI include headaches, exhaustion, cognitive deficits, and difficulty regulating emotions that lead to strong outbursts (Hyatt et al., 2105). Since TBI is an invisible wound, familial relations are also strained due to conflicts that erupt due to a service member's labile mood and irritability resulting from the brain injury (Hyatt et al., 2015). Families struggle to adjust to their "new normal," which includes renegotiating roles and responsibilities within the family system (Hyatt et al., 2015, p. 305).

PTSD symptoms can damage a couple's communication and marital satisfaction in various ways. Hyperarousal symptoms (e.g., hypervigilance, exaggerated startle response, irritability) can lead to intimate partner violence and problematic expressions of anger, while avoidance symptoms may present a demand/withdraw communication pattern (Foran et al., 2013) and lead to substance abuse as a way to distance oneself from trauma-related thoughts or emotions. Further, symptoms categorized as negative alterations in cognition and mood (e.g., anhedonia, feeling detached and isolated from others, shame and guilt) can also impact relational functioning.

In addition to PTSD, military members experience higher rates of suicide when compared to the general population (Clever & Segal, 2013). According to Mouristen and Rastogi (2013), 60% of Army suicides were attributed to marital failure, highlighting the potential severity of the consequences of a failed marriage and the need for effective ways to address these issues. Strengthening a couple's marriage before a deployment may prepare non-military spouses to be a greater source of support for their military partners during deployment (Carter et al., 2011), decreasing the risk of divorce.

Less attention has been given to the impacts of military service on the mental health of spouses and family members, who similarly to military service members, are also more likely to experience mental health challenges. Negrusa and Negrusa (2014) reported a relationship between PTSD and divorce, with military wives experiencing more mental health problems than those married to civilians. According to Paley, Lester, and Mogil (2013), anxiety disorders, problems with sleep, and symptoms of depression, especially when deployments are lengthy, are characteristics of service members' spouses. Military spouses who seek out counseling may present with sadness, anger, and anxiety (Paley et al., 2013). Further, military spouses may also experience difficulties related to secondary trauma and develop PTSD from exposure to their partner's PTSD symptoms. Children, who experience their parents' repeated departures when deployed, may find it hard to trust in their deployed parent's availability, which leads to anxiety and hypervigilance, interfering with a child's mastery of present developmental tasks (Paley et al., 2013). Additionally, when a parent experiences hyperarousal from trauma, the ability to parent effectively leads to chronic activation of a child's attachment system. When a parent is deployed, children are more likely to experience suicidal ideations (Bello-Utu & DeSocio, 2015). In addition, mental health outcomes for children and their non-military parents were negatively affected by repeated deployments (Bello-Utu & DeSocio, 2015). Thus, it appears that trauma permeates the entire family (Negrusa & Negrusa, 2014).

While the prevalence of mental health concerns among military members is well-documented, active-duty service members and Veterans continue to face various barriers to seeking help for these issues. Stigma surrounding a mental health diagnosis and fear of differential treatment by superiors and peers often prevents active-duty military personnel and Veterans from receiving professional help (Greenberg, Anderson, & Robinson, 2012). Service members who believed there was less stigma associated with receiving mental health care reported a more positive reintegration experience, perhaps because of their belief they could receive help if it was needed (Fink, Gallaway, & Millikan, 2014). Early intervention is important when service members are exposed to combat, and unaddressed problems contribute to a greater risk of divorce (Foran et al., 2013).

### **Family Stress**

Military families experience stress that is compounded by frequent, lengthy deployments (Frey et al., 2011). Approximately 70% of those deployed reported being deployed for a year, which created hardships for families (Zeber et al., 2010). Spouses who experienced deployments reported the following stressors: loneliness, worrying, waiting, and pulling double duty (Lapp et al., 2010). Military deployments can also negatively affect children who experience relational attachment disruptions, problems with motivation, and underlying anxiety as expectations of deployment are always on the horizon (Lowe et al., 2012). Over 16% of school-age children of active-duty personnel have been diagnosed with anxiety, depression, or another mental health disorder (Mansfield, Kaufman, Engel, & Gaynes, 2011).

### **Intimate Partner Violence**

Intimate partner violence (IPV) is a prevalent problem among U.S. military couples (Schmaling et al., 2011), with incidence rates as much as three times higher than those of civilians (Taft et al., 2013). Additionally service members diagnosed with PTSD are at a higher risk of inflicting violence on an intimate partner (Kar & O'Leary, 2013). Close to 20% of IPV victims never disclose abuse due to shame and embarrassment (Spangaro, Zwi, & Poulos, 2011), and this is particularly true of victims in military families who are often reluctant to report IPV to military authorities due to fears it will affect their partner's military career (LaMotte, Taft, Reardon, & Miller, 2014) or that the information will not be kept confidential (Foran, Slep, Heyman, Linkh, & Whitworth, 2011). Following a combat deployment, service members may also express more hostility and aggressive communication, which complicates reintegration (Theiss & Knobloch, 2013).

### **Infidelity**

Infidelity is the most frequently cited reason for divorce across both military and civilian populations. Military couples are at greater risk of infidelity due to the vulnerabilities associated with military life, including multiple lengthy deployments and separations (Snyder et al., 2012). Marital infidelities among military couples increased during the wars in Afghanistan and Iraq (Wang et al., 2015); however, it is not known if the increase in divorce rates for military couples was due to infidelity or was a result of mental health problems related to the traumas of war (Foran et al., 2013).

## **Role Conflict and Reorganization of Life Priorities**

Role conflict has contributed to marital and family stress as military service members experience pressure to meet expectations both at home and at work (Kgosana & Van Dyk, 2011). The rates of divorce and separation among those who experienced a deployment have doubled, but exposure to combat alone did not raise the risk of divorce or separation (Foran et al., 2013). Risk of divorce was found to be higher when exposure to combat was coupled with a troubled marriage (Foran et al., 2013).

Some service members whose relationships were highly conflictual before deployment found that the life threatening risk of combat contributed to marital dissolution and provided motivation to leave a dysfunctional relationship (Foran et al., 2013). Others came to feel an increased connection with those they served with and consequently limited their reliance upon marital partners for support. This shift in reliance upon their spouses for support has contributed to a breakdown in the marriage relationship (Foran et al., 2013).

## **Protection of Children**

Family courts across the United States have been receiving an increased number of military divorce cases that involve child custody disputes because approximately 51.4% of all service members are married, and 42.1% have children (Department of Defense, 2014). Child custody battles in high conflict divorces require counselor competency for ethical conduct. According to Grossman and Koocher (2010), there are many ethical complaints brought to licensing boards that involve child custody cases. These child custody disputes are highly conflictual, especially when they include claims or reports of IPV (Nichols, 2014). The risk of child maltreatment by caregivers appeared to increase when one parent was deployed to OIF and OEF, as compared to the risk when the family was unified (Boberiene & Hornback, 2014). This risk was four times greater for child neglect, and it doubled for child abuse (Boberiene & Hornback, 2014). Additionally, divorce alone can be traumatizing to children, leaving lasting negative effects and causing “long term psychological damage” (Nichols, 2014, p. 664).

## **Counselor Competencies to Effectively Treat Military Families Divorcing**

### **Professional Competence**

Achieving and maintaining professional competencies is essential when working with military families involved in divorce and custody issues. Professional competence is generally described as the underlying professional attributes of individuals in relation to the diverse knowledge, skills or abilities they possess (Boyatzis, 1982). Miller (1990) viewed competence as a pyramid with four levels. Level 1 is *knows*, referring to a person’s ability to learn a particular skill. Level 2 is *knows how*, referring to a person’s ability to understand a task conceptually. Level 3 is *shows how*, where a person demonstrates the ability to perform under supervision or practice. Level 4 is simply *does*, where a person clearly demonstrates an autonomous ability to perform a given task. Professional competence in court testimony and child custody matters refers to professionals possessing the education, training, and experience to adequately meet the demands of these roles in an ethical manner (Rust, Raskin, & Hill, 2013).

Competent legal and ethical training is critical to the development of skilled clinical practice (Hill, 2004). The absence of knowledge and skill can lead to various forms of ethical misconduct with numerous possible negative consequences (Even & Robinson, 2013). Ethical misconduct can give rise to a variety of deviations from the established professional code of ethics as well as from state laws and regulations, which may result in ethical complaints and censure, lower job satisfaction, and a variety of professional deficiencies (Fu, 2014; Neukrug & Milliken, 2011; Wurgler et al., 2014). Additionally, the American Counseling Association's *Code of Ethics* (American Counseling Association [ACA], 2014) specifically demands competency as a vital element in multiple sections of the code, most prominently in Section C: Professional Responsibility.

### **Competency in Child Custody**

Each year, 1.2 million marriages end in divorce in the United States (U.S. Census Bureau, 2009), with first marriages lasting an average of eight years (Henry, Fieldstone, Thompson, & Treeharne, 2011). Sixty-five percent of divorces in the United States involved families with minor children (Cohen, 2002) and 10% included disagreements over the custody of dependents (Luftman, Veltkamp, Clark, Lannacone, & Snooks, 2005). In comparison, studying the effects of divorce on military families, Wang et al. (2015) found 5.3% of respondents divorced while in service, while the Department of Defense (2014) found the military divorce rate to be 3.1%. The clinical area of child custody disputes, highly conflictual divorce, and parental alienation involves a particularly complicated set of legal and ethical issues for mental health professionals to navigate (Lebow & Rikart, 2007; Moore, Ordway, & Francis, 2013; Patel & Choate, 2014; Patel & Jones, 2008; Pickar, 2007). Lacking competence in this clinical domain can increase a mental health professional's risk of ethical or licensure censure. For example, professional counselors have been receiving ethical complaints in matters of child custody and civil litigation at an increased rate compared to other common forms of ethical misconduct (Patel & Choate, 2014; State of Ohio CSWMFTB, 2012). In addition, child custody matters have the highest percentage of deposition and record requests of all clinical issues and client types in the counseling profession (HPSO, 2014).

### **Effective Treatments**

Mental health care providers should provide effective treatments to meet the needs of post-combat Veterans and their families, which may include preventative work, assistance in reintegration, healing from trauma, and divorce care (Zeber et al., 2010). Deployments to the OIF and OEF have negatively affected military families with 15 to 30% of service members experiencing symptoms of PTSD, depression, and anxiety (Waliski, Kirchner, Shue, & Bokony, 2012). Further, out of 300,000 children whose parents were deployed, over 50,000 were diagnosed with a mental health disorder (Waliski et al., 2012).

According to Bello-Utu and DeSocio, (2015), repeated deployments had a negative effect on children's resilience and coping. War creates "attachment rupture[s]" (Mouristan & Rastogi, 2013, p. 75), and addressing these, whether between partners in reconciliation or through a divorce procedure, is important. Counselors treating military families locked in disputes need to consider these factors that affect marriages and contribute to a high risk of divorce (Wang et al.,

2015). In addition, screening for PTSD is necessary to provide competent care to military families (Zeber et al., 2010).

The Department of Veterans Affairs (VA) healthcare system utilizes evidence-based treatment models for families and couples to provide efficacious services for Veterans and their families (Sherman, Fischer, Owen, Lu, & Han, 2015). Structured approach therapy for PTSD (Sautter et al., 2009), cognitive-behavioral conjoint therapy for PTSD (Monson, Macdonald, & Brown-Bowers, 2012), and behavioral couples therapy for alcoholism and drug abuse (O'Farrell & Fals-Stewart, 2006) are therapeutic approaches for military couples that have yielded reductions in problematic symptoms (Sherman et al., 2015). The following sections will explore supported approaches for treating military members and their families.

### **Couple and Family Therapy**

**Couples therapy.** Cognitive-behavioral conjoint therapy (CBCT) is an approach designed to simultaneously reduce PTSD symptoms and increase relationship satisfaction, and has demonstrated significant improvements in Veterans' PTSD symptomology and intimate partner relationships (Monson et al., 2011). Couples attend 15 sessions, 75 minutes in length, that include education about PTSD and relationships, communication skills training through in vivo exposure, and cognitive interventions targeted at beliefs that have a negative effect on relationships: safety, trust, closeness, power and control (Schumm, Fredman, Monson, & Chard, 2012 as cited in Monson et al., 2012).

Carr (2014) reported that emotion-focused therapy was also beneficial in treating military couples to reduce symptoms of PTSD resulting from combat. Emotion focused therapy focuses on processing the deeper emotions from traumatic experiences facilitating greater attachment security through identifying and understanding negative patterns of interacting, development of relationship skills, and facilitating plans for future coping (Schumm et al., 2012 as cited in Monson, Macdonald et al., 2012). Researchers indicated this intervention led to PTSD symptom improvement and couple satisfaction in the relationship (Schumm et al., 2012; as cited in Monson, Macdonald et al., 2012). Military couples who participate in either CBT-CT or emotion-focused therapy experience improvements in PTSD symptoms, and greater satisfaction in their marriages, which may prevent divorce.

**Family focused therapy.** Family focused therapy contributed to reductions in stressors, improvements in mental and physical health in Soldiers, and improvements in family functioning (Zeber et al., 2010). Monson et al. (2011) reported that the primary focus of most research on OIF and OEF Veterans has been studying intimate partnerships using the family therapy model, which is the most researched family treatment model. When including children in the family therapy model, considering the child's stage of development is critical, and Schepard and Emery (2014) provided support for the inclusion of children's developmental stage in therapy, mediation, and custody evaluations. Family therapy includes children in treatment when developmentally appropriate. When the entire family is in therapy, outcomes include improvements in family functioning, reductions in stress, and improvements in mental and physical health in military families.

School counselors can also provide safety and support for children experiencing a parent's deployment through engaging in creative expressive activities and teaching coping skills (Waliski et al., 2012). Preventative work and improved communication between children and parents protects children from developing behavioral problems and subsequent mental health disorders related to a parent's deployment (Waliski et al., 2012). More research is required to understand the effects of parental deployment and family stress on a child's mental health and inclusion in family treatment (Monson et al., 2011).

**Multifamily group model.** According to Sherman et al. (2015), mood disorders are linked with relationship functioning, a connection that supports the relational treatment model. The REACH (Reaching out to Educate and Assist Caring Healthy Families) model is a family intervention that takes place over a 9-month period with three phases (Sherman et al., 2015). In the first phase, Veterans with mental illness and a supportive family member attend therapy for four sessions designed to build rapport, to assess the client's functioning, coping abilities, and supports (Sherman et al., 2015). The second phase takes place over six weeks, educating families on mental illness and providing opportunities for discussion (Sherman et al., 2015). The third phase lasts six months and provides support to maintain the skills and knowledge obtained in therapy (Sherman et al., 2015). Researchers reported that the REACH model, a multifamily group intervention, increased support-seeking behaviors in veterans with mood disorders, but Veterans' perceptions of social support and symptomology did not change (Sherman et al., 2015). Families engaged in the REACH model also reported improvements in understanding and the ability to cope with veterans' mood disorders (Sherman et al., 2015).

Multifamily group therapy (MFGT) is an evidence-based treatment model initially designed for use with clients diagnosed with schizophrenia and their families (Perlick et al., 2011). The model has since been adapted for use in treating OEF and OIF Veterans with TBI and their families (Perlick et al., 2011). Families who have a family member diagnosed with a mental illness participate as a group to receive multi-family group treatment, psychoeducation, and behavioral interventions (Stuart & Schlosser, 2009). Perlick et al. (2011) reported that MFGT provided beneficial education for families about PTSD and TBI symptomology, and assisted them in learning to reframe problems and acquire skills to cope with the relational threats experienced when living with someone with a mental disorder. Additionally, MFGT moved couples towards greater understanding of their strengths, weaknesses, and functioning as a couple (Perlick et al., 2011). Multifamily group therapy provides support for military families faced with a family member diagnosed with mental illness. When the family is a part of the education and treatment process, skills gained to cope with the relationship challenges of living with a mentally ill family member, may deter divorce. The military family can either support or worsen a Veteran's mental health following a deployment (Monson et al., 2011). Future research on the role of the family in Veterans' treatment is necessary to make changes in military policy toward including partners in the therapeutic process (Monson et al., 2011).

### **Case Illustration**

Upon graduation from high school, Marco enrolled in college, but quickly discovered it wasn't for him. By the following January, he decided to enlist in the military, specifically the Army. At his graduation from boot camp, he proposed to his high school girlfriend, Evangelina,

known as *Lina*; and the couple subsequently eloped. Marco married quickly, largely because he anticipated being deployed to the Middle East and was fearful that Lina would move on to another relationship. Lina married quickly because she was anxious to move from her parents' home, where her strict, Italian immigrant father offered her little freedom and imposed traditional notions of male and female gender roles.

Lina became pregnant on their weekend honeymoon. Early in the pregnancy, Marco was deployed to Afghanistan for his first tour. Accordingly, Lina never moved out of her parents' home. Their first son was born while Marco was away. Vincent, named for Lina's father, was almost a year old when Marco returned home. Lina relied heavily on her mother for support and assistance with a new baby. Marco did not appreciate his in-laws' level of involvement in his life and with his son. It seemed that Lina would solicit and accept advice from her parents to the exclusion of input from Marco. Not unlike Lina's father, Marco liked to be the head of his household. He realized quickly that they could not remain in Lina's parents' home or their marriage would be in jeopardy.

The couple obtained on-base housing, and Marco was initially very attentive and romantic, but Lina's expectations regarding their life as a couple fell short. Marco was active on the base and never home. He would socialize after work with other soldiers because of the bond he shared – and because the moment he would walk in the door, Lina would have things for him to do.

It was not long before Lina became pregnant again. Marco was not particularly involved in the pregnancy, but was present for the birth of their second son – this one named Marco, after him. Marco was more attentive to baby Marco, while Lina spent most of her time with Vincent. By the time the baby was a year old, Marco was deployed for a second time. Marco's second experience was far more intense than his first. He was in the midst of active combat, and the loss of life was significant. Lina had limited information about Marco's whereabouts. She was worried, distraught, and lonely. Caring for two small children took an emotional and physical toll, and she once again turned to her parents for support. Sometimes, Lina would leave the children with her mother so she could go out. Lina was barely 19 years old when she and Marco married – and before she knew it, she was 24, married, with two little boys and no life. Lina turned to Jeff, the husband of a female soldier on base who had also been deployed and was on active duty overseas. It was not long before friendship and long talks turned romantic.

When Marco returned home, he was not the same. He seemed preoccupied, highly agitated and very anxious. Marco had difficulty sleeping during the night and was drinking a lot. He interacted well with little Marco, but had virtually no relationship or interaction with Vincent. Conversation between husband and wife quickly erupted into argument. Lina was often unkind and would hurl insults at Marco. She would also throw things and threaten to take the children and return to her parents' home. Sometimes Marco became physical, pushing Lina, grabbing her, or shoving her out of the way. After one incident when Lina threatened to call the military police, Marco pleaded with her not to, explaining that there would be severe repercussions for his military career if he was accused of domestic violence. He begged Lina to go to counseling with him off-base and with a lay counselor. Marco did not want to seek counseling through anyone associated with the military due to a fear that the information would be reported to his

commanding officer and any suggestion that he was not stable or had marital problems would interfere with his long-term career plans.

The couple began marital counseling with a licensed professional counselor in a nearby town. In the meantime, Lina continued the relationship with Jeff, unbeknownst to Marco. She learned that even if she and Marco divorced, the military would ensure the payment of child and spousal support, as well as guarantee the continuation of certain other benefits. Several weeks into counseling, Lina met with the counselor alone. She expressed concern about Marco's demeanor and described incidents of domestic violence. She stated that she was afraid and was taking the children to her parents' home. Lina was conflicted because she felt that she needed a restraining order, but did not want to hurt Marco's military career. She also confided about her relationship with Jeff. Weeks later, Marco also met with the counselor alone. The counselor explored with him his feelings of depression and the possible diagnosis of posttraumatic stress disorder. Marco also confided his suspicion that Lina was involved in an extramarital affair, but expressed a belief that he was just "paranoid." He explained that he confronted another soldier on base and accused him of sleeping with Lina while Marco was deployed. The man denied being involved with Lina and Marco was embarrassed. Marco professes his love for Lina and a commitment to the marriage.

Shortly thereafter, while Marco was at work, Lina moved out with the children and most of the couples' belongings to her parents' home. Marco reacted with anger and concern. He plans to fight for custody since he believes that it is Lina's mother, and not Lina, who is caring for the children. Lina filed for divorce, and Marco continues to see their marriage counselor in individual counseling.

### **Case Discussion**

There are obvious threshold implications associated with the counselor agreeing to see Marco individually after having served as the couple's marriage counselor. The counselor became privy to information when Lina disclosed that she was having an affair during the individual session Lina had with the counselor. While Marco doesn't know the truth, he suspects Lina's infidelity, but is also questioning his own judgment and stability. The counselor could be perpetuating Marco's self-blame and feelings of "paranoia" by withholding the information that would validate his concerns. However, does the counselor owe a duty of confidentiality to Lina, who shared intimate information in the context of a counseling session? Moreover, Lina also shared with the counselor that Marco has an explosive temper, is jealous, and had been physically violent on several occasions. The counselor may not have an obligation to report Marco's past behavior to the authorities, but should recognize that any disclosure of Lina's admission to Marco could trigger another violent episode. If the counselor does validate Marco's concerns about the infidelity, does she then have a duty to warn Lina of the possible danger? If Marco harms Lina as a result of learning the truth, is the counselor liable for any injury to Lina? If the counselor reports Marco to the authorities for Lina's safety, is the counselor potentially liable for harm to Marco if he loses his job and career? Can the counselor support either parent in a custody claim against the other?

When the case involves complex issues such as this one, it becomes particularly important for a counselor who treated individuals as a couple to help each member of the couple successfully transition to referrals for a separate individual counselor. In this case, it is not advisable for the counselor to continue seeing Marco individually due to the many potential complications. However, if the counselor is going to see Marco, it is critical for the counselor to provide Marco with a new informed consent document that details the evolution of the relationship. According to Section B.4.b in the *ACA Code of Ethics* (ACA, 2014), “in couples and family counseling, counselors clearly define who is considered the client and discuss expectations and limitations of confidentiality.” In some jurisdictions, the counselor would be well-advised to also obtain a consent or waiver from Lina to morph from a joint counselor into the therapist for just the husband. As stated in Section A.2 of the *ACA Code of Ethics*, “clients have the freedom to choose whether to enter into or remain in the counseling relationship...Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.” In individual counseling, Marco’s therapy would likely explore his experiences related to military deployment, depression, and possible PTSD, as well as the impact of his marital troubles and the divorce. While there is a benefit for a counselor to know all involved parties and have direct access to input and information from other than the specific client, the source of the additional information can create a significant conflict of interest and set the stage for boundary violations and breaches of trust.

### **Conclusion**

Increased military action and deployment over the past two decades has resulted in millions of personnel returning home, often significantly changed by their military experience. The return to civilian life likely includes the return to marriage, family, and children also affected by the deployment. This phenomenon has coincided with significant changes in domestic law, and family, marital, and custodial trends, all of which may impact mental health. Military families embroiled in divorce and custody disputes offer unique clinical dynamics and create multiple challenges to counselors and mental health professionals whose task is the treatment and care of these clients. Significant societal, legal, and professional challenges add to the complexity of these issues, prioritizing the need for competent practitioners aware of the relevant professional literature, cultural considerations, and evidence-based treatment models.

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## **Creatively Fostering Pre-Deployment Parent-Child Attachment**

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### **Abstract**

*Military families face challenges that other families do not typically even consider. Frequent relocations, temporary duty separations, and deployments are some of the greatest obstacles for families as a whole. Young children are especially susceptible to stressors and developmental challenges during these separations from parents. However, despite the known developmental and attachment implications, very young children are often not prepared for a separation before a parent leaves (Louie & Cromer, 2014). This activity provides a creative way for parents and children to nurture their attachment to one another and appropriately discuss and prepare for the deployment cycle – resulting in alleviated stress and an easier family reintegration upon return.*

**KEYWORDS:** *creativity, military, children, attachment theory*

Military families are culturally ingrained with resilience (Hall, 2016). These families are faced with hardships that many other families do not have to consider – frequent relocations, combat deployments, and severe injury or death of a spouse or parent (Hall, 2016). With the more recent conflicts in Iraq and Afghanistan, these challenges are augmented. Deployments are more frequent and last longer (Hall, 2016; Hosek, Kavanagh, & Miller, 2006). Cultural shifts within the military and combat have changed the experience of injury and risk of death (Hall, 2016). For example, the most recent combat deployments have often included non-traditional combat zones such as civilian-inhabited urban areas. Additionally, the enemy has recruited or terrorized their local civilians into participating in combat related activities, creating ambiguity around who is or is not a threat. The heightened risk for service members has resulted in increased challenges and stress for military families. Particularly, young children may struggle with various phases of the deployment cycle, in part because they are often thought to be too young to understand what is happening and are therefore not informed (Louie & Cromer, 2014). However, children as young as preschool-age have the cognitive capacity to understand deployment, and to grieve the absence of a deployed parent (Paris, DeVoe, Ross, & Acker, 2010). If these children are not prepared appropriately, they may feel upset or confused, and may mistakenly blame themselves for the separation. Thus, it is integral to family functioning to

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engage in processes that (a) explain, in developmentally appropriate ways, what the deployment cycle looks like; and (b) facilitate strong and secure attachment to the parent or caregiver who is leaving.

### **The Deployment Cycle**

An understanding of the deployment cycle is important for any counselor working with military families. The cycle can be conceptualized in various ways, but is often cited as being split into five distinct phases: pre-deployment, deployment, sustainment, re-deployment, and post-deployment (Pincus, House, Christenson, & Adler, 2001). *Pre-deployment* is the time during which a service member is notified of an upcoming deployment, is training for the deployment, and the family is preparing for that service member's departure. This is often a very busy time for everyone involved, because of the various issues that need attention (Pincus et al., 2001). The time that is typically referred to as a deployment actually encompasses three distinct phases of time. *Deployment* is characterized as the first month of physical departure, in which the family and the service member adjusts to their new roles and routines. *Sustainment* is the period of time during which family and the service member have adjusted to their new roles and routines. Sustainment lasts until the final month of the deployment, termed *re-deployment*, during which service members and families prepare for the service members' return home (Pincus et al., 2001). Once the service member is home, the *post-deployment* stage begins. During post-deployment, said to last 3 to 6 months, the service member reintegrates into the family and the routines, roles, and responsibilities established during sustainment are often renegotiated (Pincus et al., 2001).

It is important to consider that deployments occur for different purposes (e.g., combat, peacekeeping, training), and therefore may have varying levels of risk associated with them. This will likely influence the family's distress levels and the service member's comfort with the deployment (Sheppard, Malatras, & Israel, 2010). Additionally, deployments vary in their duration depending on military branch, purpose, and ongoing conflicts. During the most recent conflicts in Iraq and Afghanistan, the deployments (i.e., deployment, sustainment, and re-deployment) have tended to range from 6 to 18 months, which are some of the longest deployments the U.S. military has seen since World War II (Sheppard, Malatras, & Israel, 2010; Hall, 2016). Unfortunately, frequent and longer deployments have been associated with greater levels of parent stress and depressive symptoms (Gerwitz, McMorris, Hanson, & Davis, 2014), poorer family functioning (Allen, Rhoades, Stanley, & Markman, 2011), and poorer general well-being (Everson, Darling, & Herzog, 2013). Challenges with mental health were particularly high among spouses raising young children alone during periods of deployment (Barker & Berry, 2009). Additionally, longer and more frequent deployments are also more strongly associated with emotional and behavioral problems in young children.

### **Families and Deployment**

As of 2014, military service members who are also parents made up almost half of the active duty ranks, and they reported having 1,076,046 children age birth to 18 years (U.S. Department of Defense [DoD], 2014). Research findings have demonstrated the potential for adverse effects of combat deployment on the family system. Several studies have found "higher

rates of depression, anxiety, overall stress, and decreased family cohesion when a parent is deployed in a combat zone” (Nguyen, Ee, Berry-Cabán, & Hoedebeck, 2014, p. 81). For a family already experiencing the basic stressors of the deployment cycle, these increased mental health issues and challenges to family bonds can be extremely taxing.

### **Developmental Considerations**

The RAND Deployment Life Study (2016) reported findings that teenagers and young children demonstrated the most difficulty with parental deployment separation and reintegration. Parents of children under 11 years of age reported emotional conduct problems and problems in peer relationships (RAND, 2016). Teenagers and their parents reported feeling less family cohesion and a decline in quality of relationship with the non-deployed parent (RAND, 2016). Similarly, the Military Family Lifestyle Survey (Blue Star Families, 2014) showed that younger children, particularly ages 0 to 5 years, are most vulnerable to the effects of parental separation caused by deployment (Jensen, Martin, & Watanabe, 1996; Watanabe & Jensen, 2000). As children ages 0 to 5 years of age are the largest age group for active duty families (42%), with ages 6 to 11 years comprising another 32% (U.S. DoD, 2014), it is imperative to have appropriate preparation and support throughout parental deployment. Parents who were asked about their child’s adjustment to a parental deployment shared that they most commonly saw separation anxiety, worry, irritability, aggression, depression, difficulty concentrating, and difficulty sleeping (Blue Star Families, 2014).

**Attachment styles.** One of the core tenets of attachment theory is that “variation in security and thus the [internal working model] are a direct function of lived experiences, especially experiences in the earliest portion of the life span (i.e., first 3-5 years of life)” (Belsky, 2002, p. 166). Given the large numbers of these young children within the military system, it would be negligent to overlook the impact of deployment and other challenges to parental attachment. Attachment styles are the ways in which individuals relate to intimate caregiving and receiving relationships with attachment figures – typically parents, children, and romantic partners (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988; Levy, Ellison, Scott, Bernecker, 2011). Healthy parent-child attachment predicts healthy child development, while insecure attachment is predictive of various mental health and interpersonal challenges (Zeanah, Berlin, & Boris, 2011). The developed attachment style is determined by the individual’s confidence in the ability of the attachment figure to act as a *secure base*, from which the individual can stray and freely explore their physical, interpersonal, and emotional environment when not under stress. Additionally, the attachment figure also must act as a *safe haven*, from which the individual can seek comfort and safety when in distress (Bowlby, 1988; Levy et al., 2011). Ainsworth, Blehar, Waters, and Wall (1978) identified three strategies of attachment: secure, avoidant, and ambivalent. A fourth strategy, disorganized, was later identified (Main & Solomon, 1986).

**Secure attachment.** Children with secure attachment styles are often open to exploring their environment and relationships. They often utilize their caregiver as a safe base for exploration, able to independently investigate their environment as long as the caregiver is within a reasonable distance (Ainsworth et al., 1978). When upset, securely attached children can be soothed by their caregiver due to the sense of trust and safety between them. This confidence in

the relationship allows for the attachment figure to temporarily leave the child's presence and for the child, although initially upset, to be confident that they will return (Ainsworth et al., 1978).

***Avoidant attachment.*** Children who use an avoidant attachment style often do not orient to their caregiver while exploring their environment (Ainsworth et al., 1978). Instead, they are both physically and emotionally independent – to the extent that they do not seek comfort or contact from their caregiver when experiencing distress. The caregiver in this dyad is likely to be insensitive and unresponsive to the child's needs (Ainsworth et al., 1978). Therefore, the child has learned he/she cannot depend on the caregiver as a source of safety or comfort and instead choose to avoid them and attempt to self-soothe or seek comfort elsewhere.

***Ambivalent attachment.*** Children who are ambivalently attached often exhibit dependent and clingy behavior, having trouble moving away from the caregiver to explore new situations, and becoming extremely distressed when the caregiver leaves them in an unfamiliar situation; but upon the caregiver's return the child may reject attempts at interaction (Ainsworth et al., 1978). The caregiver may find it difficult to soothe an ambivalently attached child, because the child is not comforted by the interaction. Often, this type of attachment style reflects inconsistent responses to the child's needs (Ainsworth et al., 1978). The child may desire connection and comfort from the caregiver, but has experienced that the caregiver does not consistently provide such an environment, thereby creating a confusing paradox for the child.

***Disorganized attachment.*** Children who exhibit disorganized attachment often have histories of abuse or neglect, and may demonstrate fear responses toward the caregiver. These individuals typically show disorganized behaviors through aimless wandering, freezing, confused facial expressions, and undirected movement (Main & Solomon, 1986). There is no identifiable pattern for coping, as there is with the other three identified attachment styles. Most often, interpersonal interactions are erratic, resulting in a disorganized and incoherent template for relationship.

Clearly, if children do not feel secure in their attachment, they are more likely to develop negative self- and other-perceptions, creating obstacles for any close relationships. Additionally, because emotional regulation is closely linked with the behaviors and patterns within close relationships, it may be that some of these children begin to have problems with appropriate regulation of their emotions (Belsky, 2002). While these challenges to attachment may not be permanent, they certainly add additional stress to the family that is already facing adversity. Finding a way to foster secure attachment throughout the deployment process is integral to a successful deployment for the entire family.

## **Deployment Preparation**

Environment and context make important contributions to attachment (Posada, Longoria, Cocker, & Lu, 2011). Literature is limited on the effects of parental deployment on adolescents and children; however, it is clear that the deployment process can place a great deal of stress on parent-child relationships and attachments (Hall, 2016). The Deployment Life Study (RAND, 2016) results indicated that communication and preparation are critical factors that determine functioning of the family members once the deployed parent returns. Similarly, Louie and

Cromer (2014) found that parents who prepared their young children for deployment, and who nurtured attachments before and during deployment, experienced less parenting stress during deployment and less reintegration stress post-deployment. Their research also indicated that communication (immediate or delayed) during deployment did not predict parenting stress beyond the effects of pre-deployment preparations (Louie & Cromer, 2014). Therefore, it makes sense that age-appropriate pre-deployment preparations for children should be a major focus to aid in minimizing parenting stress and nurturing secure attachments. In fact, Louie and Cromer (2014) call for a developmentally appropriate intervention “specifically for families with young children . . . Such an intervention will have the potential to minimize the negative effects of deployment on the parent-child relationship and on children’s emotional, behavioral, and social development” (p. 502). These interventions could also promote resilience throughout the entire family during the deployment cycle.

It seems important to note that while such interventions may be done outside of the counseling office, it is unlikely for this to happen. Specific cultural norms within the military emphasize emotional compartmentalization in order for the service member to be successful in combat and reduce outside distractions (Burk, 2008; Hall, 2011). Particularly during preparation for a combat deployment, service members may choose to focus on the tasks needed to be ready to leave (i.e., having bills transferred into their spouses name, creating a power of attorney document, making sure they have all of their gear, etc.) rather than spending too much time on emotionally charged issues that could distract them from their mission (Hall, 2016). Therefore, to facilitate meaningful dialogue and gain the most positive outcome, it may be best to conduct such activities with a clinician to facilitate. Mental health clinicians can structure the session to stay focused on processing difficult emotions and addressing issues important to the service member and the child and family, as well as helping the child-parent dyad identify strengths and positive elements of the situation. The following activity is therefore introduced within the context of a counselor-client relationship.

### **Activity Objectives and Assumptions**

The objectives for this activity are largely drawn from the rationale for this intervention and existing knowledge about children of military families. The objectives are as follows:

1. To foster secure attachment and connection between parent and child.
2. To facilitate healthy adjustment to the deployment phase.
3. To open lines of communication about deployment and what it means for the family.
4. To decrease parenting stress during deployment and reintegration stress after deployment.

Additionally, this activity and its effectiveness is based on several assumptions about the existing family structure, including:

- The child and parent have at least moderately secure attachment upon coming in to session.
- There is no abuse or neglect present between the child and parent. If a history is present, the family must be actively working toward creating a safe and secure environment. However, the counselor must take into account contextual considerations and determine levels of safety on a case-by-case basis to determine if this activity will be beneficial.
- The child is able to understand verbal communication, and possibly utilize his/her own verbal skills (this is largely dependent on age and development of the child).

### **Activity Process**

The counselor prepares for the session by having the appropriate supplies available. This includes at least two pillowcases (but could include as many as people in attendance to the session), fabric paint, fabric markers, photo sleeves, pins, craft jewels, and other creative materials the counselor believes will be appropriate to the session. The counselor can encourage the family to bring in personal items that they would like to use as well, such as copies of photos, fabric scraps, and other items they may want to affix to the pillowcase. The activity can be done with the parent-child dyad, parent and multiple children, or the entire family, depending on the needs and desire of the family. If there are multiple children in the family and they each want their own time, the counselor can arrange for several separate sessions with the parent and each child. This session can occur any time before the deployment process, but is likely best held 4 to 6 weeks prior to leaving. This gives the family time to prepare, hold multiple sessions if they feel the need to explore additional subjects, and will be far enough out from the leaving point that the service member is not likely to be too overwhelmed with other variables. When the family arrives, the counselor introduces the activity through the following prompt:

You and Mom/Dad are getting ready for a deployment. Deployments can be hard on everybody in the family because you have to be away from each other for a long time, and that can make you feel sad, or scared, or angry. One of the hardest parts about being separated is not getting to see or talk to each other all the time. We are going to do an activity today that will help you feel closer to each other when you cannot be with or talk to each other.

The counselor hands a pillowcase to both the child and the deploying parent (or multiple children and parents, if the whole family is participating in the activity), introduces all of the art materials in the room, and asks if they brought any of their own materials to add to the pillowcase. The counselor encourages the child and parent to think of favorite memories, inside jokes, song lyrics, special nicknames or phrases, or any important messages, and to begin writing or painting these on to the pillowcase. If the child is unable to write, they can draw pictures that represent their message, or ask their parent to help them. Additional special items can be adhered with hot glue or sewn onto the case. Specifically, photos can be placed in plastic photo sleeves and glued or sewn on (it is recommended to use copies of photos so as not to accidentally ruin the original). Once both child and parent have completed their pillowcase the counselor facilitates dialogue about what was included. Prompts and questions may include, but not limited to:

- Tell me about this memory. What makes it your favorite?
- How does this [song lyrics/joke/memory] make you feel closer to your child/parent?
- What is your favorite part about this picture?
- Is there anything your parent can add to this that will help you feel safe or calm when they are away?

Be sure to address any additions that both parent and child included (e.g., the same memory, joke, or phrase). This is also a good opening for the parent to provide the child with information about the deployment (e.g., where they are going [if they can share], an estimate of how long, if they will be able to communicate during this time) and to answer any questions the child might have. This may also be a time to discuss how roles might change within the family system, and if the child would like the remaining parent to take over any special rituals or specific roles of the service member, or if they'd rather have them put on hold until the service member returns. As the session closes, the counselor has the parent and child exchange pillowcases. When the parent

deploys, the child will keep the parent's pillowcase, and the parent will keep their child's (if they are not restricted on what they can take with them). Having the pillowcase that the other created, with sentimental pictures, mementos, and words, can help both parent and child feel closer to each other during this long separation. If the parent is unable to take his/her pillowcase with him/her, he/she may ask the child who should keep it safe while the parent is gone. As children may be disappointed or upset that their parent cannot take the special creation with them, it is important to give them the decision-making power to either appoint a "caretaker" for the pillowcase or to keep both in their possession.

## **Adaptations**

Pillowcases are useful because they are large and easy to decorate, travel easily, and their place on the bed means the individual is likely to see it every day. Additionally, pillows are often used as comfort objects and convey a sense of safety, as individuals are typically most vulnerable when sleeping. However, this activity can be adapted using t-shirts or blankets instead of pillowcases, or even decorating a box and placing certain special objects inside; use whatever the child and family find to be easiest and most appealing to them. The activity can take place using virtually any material that the parent and child can exchange, and that the parent can take with him/her on the deployment. This activity may also be useful for temporary trainings where a parent must leave, or the child may want to use this activity with good friends they will have to leave behind when the family must relocate. Additionally, pillowcases can be updated or modified with each subsequent separation, if desired, or new ones can be created. Further adaptations include the fostering of adult attachment through use with a partner or spouse before deployment or other separation.

Adaptations with couples may use different prompts than child-parent variations of this activity. For example, a prompt may be as simple as "You are very scared of what the next few months might look like as your partner prepares to leave for deployment. This activity may help you to feel connected and secure within the relationship, even when you cannot control external events," or "It's been really difficult for you two to talk about being apart for so long, particularly under these circumstances. This activity is designed to help open that communication, and to help you feel more connected to each other." This conversation is likely to be very different from a parent-child dialogue and may include topics such as maintaining sexual intimacy during the deployment, how to cope with communication restrictions, and what (if any) topics are "off-limits" during deployment or during certain phases of deployment.

## **Conclusion**

Existing research points to the importance of pre-deployment preparation as a strong predictor of maintaining secure attachment throughout deployment, alleviating parenting and family challenges that can accompany the already stressful separation and reintegration (Louie & Cromer, 2014). Engaging in activities such as the one described here can help to nurture attachment and provide education and information for children, circumvent future developmental attachment challenges, and maintain family cohesion, healthy functioning, and overall resilience for both parent, child, and the family as a whole.

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## **Deployments and Marital Satisfaction of Civilian Male Spouses**

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### **Abstract**

*Deployments can be unpredictable causing stress on the marital relationship. Research has shown that the strength of the marriage prior to deployment and the at-home spouses' ability to work or gain new skills are factors that affect the marital relationship. The life of an Army spouse is very difficult and the job of a Soldier affects the level of marital satisfaction from beginning to end. The marital satisfaction within those marriages offers a wide range of indicators that Army spouses, male or female, encounter on a day-to-day basis. These indicators may stem from the number of deployments (including Temporary Duty assignment or military trainings), the length of deployments, years married, amount of time between deployments, and the level of marital satisfaction. Therefore, the following quantitative correlational study using the Marital Adjustment Test (MAT) seeks to find the relationship between the number of deployments and the effect on the marital satisfaction of civilian male Army spouses to determine if those variables increase the risk of divorce among female Soldiers.*

**KEYWORDS:** *military families, deployment Marital Adjustment Test, male Army spouse*

Over a million Soldiers have deployed since 9/11 (Tan, 2009). Deployment of the Army is longer than all other branch of the military causing a wider range of emotional distress as compared to temporary duty assignments, schools or other trainings which do not involve long

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separation periods (Primeau & Christiansen, 2011). Since 2001, millions of Soldiers have deployed in support of overseas conflicts as well as school and military trainings.

The overwhelming burden of wars and military deployment leaves little time for Soldiers to spend with their spouse and families. While the Soldier manages deployment responsibilities, the at-home spouse is also challenged with deployment changes that disrupt the normal dynamics of romantic relationships and family life. Deployment can cause stress on the relationship as separation poses a great risk to marital satisfaction due to loneliness, depression, poor finances, unemployment, emotional issues, and infidelity when the spouse is deployed (Allen, Rhodes, Stanley, & Markman, 2010; Ashbury & Martin, 2012).

Since the wars in Iraq and Afghanistan, the divorce rate continues to rise according to statistics from the US Department of Health and Human Services (DHHS, 2012). The Department of Defense (DoD; 2012) reports a 3.6% rise in military divorce rates compared to 3.3% in 2007 in comparison to the 2009 national average of 3.5% (Centers for Disease Control and Prevention [CDC], 2012; U. S. Department of Health and Human Services [DHHS], 2012). Statistics show the number of divorces ranged from an estimated 27,312 to 765,000 in 2009 from those married service members of active-duty Army, Air Force, Navy, and Marine Corps.

Marital satisfaction fluctuates. Military culture encompasses unique factors that tend to increase stressors and disrupt family dynamics as compared with the civilian lifestyle (Burrell, Adams, Durand, & Castro, 2006). Burrell et al. noted military culture experiences unique factors when compared to civilians. These experiences range from training exercises, constant moving or Permanent Change of Station (PCS), loneliness, and long periods of separation due to deployments. Military norms, culture, and demands can impact the entire family, even beyond the enrolled service time, such as the transition into civilian life as a Veteran (Rausch, 2013); therefore, the family will encounter challenges throughout the life of military service. Marital bonds are no exception to these stressors. Living on a military base and moving into a life of structure and protocol requires adjustment even for the first-time Soldier. This is also daunting for the spouse. Military wives implied that sustaining the long-distance relationships was a stressful experience causing marital satisfaction to be challenged (Cynar, 2008; Dimiceli, Steinhardt, & Smith, 2010; Karney & Crown, 2007).

Multiple deployments and marital satisfaction has been in the research spotlight, but literature reveals inconsistencies in whether deployments and marital satisfaction are connected (Dimiceli et al., 2010; Easterling & Knox, 2010; Karney & Crown, 2007; Moelker & Kloet, 2006; Wheeler & Stone, 2010). Determining the relationship between deployment and marital satisfaction is critical, due to the effect that family has on mental emotions of Soldiers deployed, overseas, Temporary Duty (TDY), or in military training. As Soldiers are faced with additional deployments, many spouses are left alone and become dissatisfied with their marriages. A variety of indicators are encountered daily and now, with more male spouses staying home, it is becoming evident that support for them is limited (U.S. Army Community and Family Support Center [ACS], n.d.). Burrell et al. (2006) proposed that the life of the civilian male Army spouse is as difficult as the job of a Soldier; both affect the state and level of marital satisfaction from the time the Soldier is first given orders to deploy until the Soldier returns.

With the increase of long deployments, the Army is now beginning to see damage to families and marriages (Gimbel & Booth, 1994). Until recently, support services have been geared toward civilian wives of Soldiers rather than husbands (Karney & Crown, 2007). The male spouse may feel guarded about the relationships in which his spouse engages during her duty day while deployed, TDY, or during military training (Crooks & Henderson, 2008). Activities within military spouse clubs may appear to be sexist with focus on the female spouse. Civilian male Army spouses feel overlooked, ignored, abandoned, and forgotten in the military community (Time, 2012). Family Readiness activities are not designed with men in mind, but cater to wives of Soldiers (Crooks & Henderson, 2008). Designing activities that identify the needs of civilian male spouses during support group participation is important to establish communication. Therefore, the following quantitative correlational study examined the relationship between the number and length of deployments (including Temporary Duty (TDY) and military training), years married and amount of time between deployments, and marital satisfaction of civilian male Army spouses. The Marital Adjustment Test (Locke & Wallace, 1959) and a binary logistic regression assessed the relationship between these variables.

### **Literature Review**

The existing research determines that even during peacetime military families' exhibit undue stress from frequent relocations that can separate them from family, friends, employment, and their spouses (Ruger, Wilson, & Waddoups, 2002). Karney and Crown (2007) suggest that research seems to continue to argue that deployments are not contributing factors of the high rise of divorce in the military. However, the underestimation of those in mental distress after multiple deployments has caused a lapse in counseling due to availability of counselors in the military community (Ruger et al., 2002). This study investigated whether multiple deployments are related to the loss of marital satisfaction and consequently divorce.

Karney and Crown (2007) argue that deployments do not contribute to the high rate of divorce in the military. Rather, it is the unique nature of deployments that place couples in situations without maintenance and social support to assist the marital relationship that leads to higher chances of divorce (Carter, 2014; Porter, 2014). Despite Karney and Crown's assertions, some studies show that deployment was an extenuating factor in divorce for military couples (Call & Teachman, 1991; McLeland, Sutton, & Schumm, 2008; Nice, McDonald, & McMillian, 1981).

This implies the significance of how stressors associated with deployments weakens the marital relationships as identified by using the Schlossberg Transitional Theory as a theoretical model for this study. Schlossberg defines transition as any event or non-event experienced by the individual which changes the relationship, routines, trust, and the roles in that relationship (Schlossberg, Waters, & Goodman, 1995). The civilian male spouse experiences all of these things during the first onset of deployment, TDY orders, or military training (Easterling & Knox, 2010; Newby, McCarroll, Ursano, Fan, Shigemura, & Tucker-Harris, 2005). There is an immediate change in routine within the house and marriage when a Soldier is deployed. The relationship as a whole is interrupted due to the absence of one spouse, leaving the role of the other changed (Evans, Forney, & Guido-DiBrito, 1998).

Through education, the Army is now attempting to ensure that spouses and Soldiers begin to recognize and work on the many stressors of deployment that are placed on marriages (U.S. Department of Defense [DoD], 2012). It is recognized that support from the deployed soldier's family impacts their ability to successfully cope with combat related deployment stressors (Sterner & Jackson-Cherry, 2015). Because the military is mainly male oriented, there are limited support programs designed with the civilian male spouse in mind. Traditionally, men are seen as the spouse to deploy instead of women. Although this no longer applies, it remains a stigma within the ranks of the military (Crooks & Henderson, 2008). Civilian males account for 7% of all military spouses. Often males are not equipped to deal with psychological and emotional strains that come with the lifestyle of living within the military community (Crooks & Henderson, 2008). Porter (2014) examined the relationship of civilian males during deployment and highlighted the ineffectiveness of current supports for civilian male spouses. Porter suggests the military does not perceive the stay-at-home civilian male spouse to be a contributing force in his wife's career.

Literature implies that whenever the term military spouse is used the immediate thought is military wives. The U.S. Department of Defense (2012) identifies females as 14.5 % of active-duty married Soldiers and this number is up by 1.4% as compared to the numbers in 1970. Even though the data shows that 46 % of those 207,000 women are married, 48 % of their partners are also described as being active duty members of the military. However, along with these numbers the number of female Soldiers married to civilian spouses was listed at approximately 51,000.

In 2011, the number of female Soldiers reached eight percent even though that number is decreasing it continues to be at 7.2% which is higher than the 2.9% divorce rate of male Soldiers (Military.com, 2014). Karney and Crown (2007) suggested that the longer the deployment among the military branches the risk of divorce was less, these statistics suggest that divorce rates are not affected by deployments. However, studies (Call & Teachman, 1991; McLeland, Sutton, & Schumm, 2008; Nice, McDonald, & McMillian, 1981) show that deployment was an extenuating factor in divorce for military couples through their use of correlation and regression approaches. Statistics show that the Army deploys more than 200 days at a time (Primeau & Christiansen, 2011). This shows why more than 8,000 Soldiers have divorced since the Iraq and Afghanistan wars, illustrating the high divorce rate in the Army (Defense Manpower Data Center [DMDC], 2008). Data also show that at least 30% of female Soldiers are married to civilian males (DMDC, 2008); furthermore, the divorce rate is higher for those female Soldiers (Karney & Crown, 2007).

It is not known why female Soldiers have the highest divorce rate in the military; however, it is speculated that the stress on civilian husbands is more than they can stand, which causes the marriage to weaken and eventually ends in divorce (Karney & Crown, 2007). Research on the effect that deployment has on marital satisfaction suggests that there is no connection between the two. However, there are studies that indicate just the opposite and can justify how deployments influence marital satisfaction (Ashbury & Martin, 2012; Bell & Schumm, 2000; Gimbel & Booth, 1994). Henry (2011) conducted a qualitative study which used family systems in the treatment of trauma associated from deployment by Soldiers. This study shows the significance of those deployment stressors on the marriage as one of the reactions associated by a decrease in the marital relationship; thus, showing the relationship between

marital satisfaction and multiple deployments for civilian male spouses.

### **Role of the Civilian Male Spouse**

The challenge for the civilian male spouse is to be prepared for the role reversal and biased attitudes within the atmosphere of military support groups, which are geared toward women. This may cause the civilian male spouse to feel ostracized within the environment of women meetings and functions (Time, 2012). They may be the only male attending in many instances. However, just as women need the support of each other, men also need that social interaction (Campbell & Wright, 2010; Sanchez, 2011).

Through networking, social media or face-to-face contact, women meet, share, and connect which is comparatively less inhibited than male bonding. The civilian male spouse does not fit in this military social network. Although he, too, requires someone to listen and relate to how he feels and network with during deployments. On many military installations, there are not many male spouses involved in the Family Readiness Groups, and in some cases, they are not connected with the military installation at all (Sanchez, 2011). The role of stay-at-home spouse has changed with a 20% increase of females entering the military (DOD, 2012).

Schlossberg's Transitional Theory (1989) suggests that strategies for coping with changed events are needed, in order to modify and take control of feelings the civilian male spouse experiences (Schlossberg et al., 1995). Schlossberg uses the 4 S's (situation, support, self, and strategies) to identify those factors, which influence the ability a person has to cope during the transition (Schlossberg et al., 1995).

Stress occurs even before the Soldier is deployed (Burrell et al., 2006). Allen et.al (2010) found that combat, loneliness, sexual frustration, loss of communication with spouse, death, effects on children, and safety were the factors that caused much of the stress among spouses. Situations with finances and the possibility of becoming a single parent, along with the emotional stress of being separated are multiplied during deployments to a combat zone. This brings cause to those coping mechanisms, which need to be in place before and during the deployment (Padden, Connors, & Agazio, 2011).

### **Research Design**

This quantitative study used the Marital Adjustment Test (MAT) to measure marital satisfaction utilizing an online survey (Locke & Wallace, 1959). The assessment results were scored and plotted to determine if there is a relationship to the variables. The hypothesis was tested using a binary logistic regression model to assess the relationship between the number and lengths of deployments (including TDY or military trainings), years married, and amount of time between deployments and marital satisfaction of the civilian male spouse (Leedy & Ormrod, 2010; Locke & Wallace, 1959).

### **Target Population and Participant Selection**

The target population for this study was civilian male Army spouses, ages 18 or older

who are married to female Soldiers in the Army, have been married for two or more years and have experienced at least two deployments (including TDY or military trainings). The population consisted of all races with different ethnic backgrounds. There were 4,674 soldiers assigned to the study site who were married at the time of the study (AmericanTowns.com, 2013; DoD, 2006) and approximately 339 participants were needed. However, only 139 participants were obtained.

This study was open to all Army civilian male spouses living on or off post. Participants were recruited from married civilian male Army spouses using flyers posted off post at local businesses and areas that military families conduct business or shop. The information was also posted on non-government military websites and post cards/flyers were mailed or posted via website using a mailing list from the American Legion. In order to use those civilian male spouses who live on post, the researcher provided flyers to all civilian male Army spouses who shop or conduct business outside of the military installation.

### **Instrument/Measures**

The Marital Adjustment Test (MAT) is a 15-item measure of marital satisfaction that will assess the scores of the marital satisfaction of civilian male Army spouses. One question provides a global adjustment to the instrument. There are eight questions which measure if there are possible disagreements in the relationship and finally, six questions measure how conflict is resolved, cohesion and communication skills. The amount of satisfaction experienced provides the measurement of biased responses (Locke & Wallace, 1959). Some items are slanted to provide discriminant power to them as Hunt's (1978) study found that although slanted it had little effect on the relationship between the adjustment scores and the other variables (Freeston & Pléchaty, 1997; Locke & Wallace, 1959). The MAT produces unremitting scores (2 to 158) and can generate nominal categories of the marital distress if the score is below 100 or if the score for marital satisfaction is 100 or greater. The total scores were used for analysis and the mean score for marital satisfaction (Locke & Wallace, 1959).

Internal consistency for the MAT resulted with a correlation of .90. Instrument is internally consistent and discriminates reliably for satisfied and unsatisfied marital satisfaction. Therefore, measuring the variables (number and length of deployments, years married, amount of time between deployments) and marital satisfaction provided data, which identified if the civilian male Army spouse is satisfied or dissatisfied in the marriage. The reliability of the MAT was found to be remarkable and have positive validation (Gottman, Markman & Notarius, 1977; Locke & Wallace, 1959). Literature has determined that the MAT is widely used to measure the level of marital satisfaction.

### **Data Collection and Analysis**

The purpose of this study was to examine the relationship of multiple deployments and the effect it has on the marital satisfaction of civilian male Army spouses. Participants (N = 134) were identified as civilian male Army spouses married to female Soldiers for at least two years, living on or off post, having experienced at least two deployment separations, and who are at least 18 years old were used to determine results.

Many of the participants have been married for 2–5 years (63, 48%). Most of the participants have experienced four or more deployments (89, 69 %). The length of the deployment was one year to 18 months for most of the participants (87, 66%). The amount of time between deployments was three to six months or less (65, 49%) or one year to 18 months (60, 45 %). Most participants rated their degree of happiness as “happy” (94, 71%). A total of 78% of participants expressed low marital satisfaction.

### **Research Question**

The following research question was examined: *What is the relationship between multiple deployments (to include TDY and military trainings) and the marital satisfaction scores of civilian male Army spouses?* A binary logistic regression was conducted to assess if the number of times a spouse has deployed, length of deployment, or time between deployments had a significant effect on marriage satisfaction. The results of the binary logistic regression model showed significance ( $\chi^2(3) = 9.10, p = .028$ ), suggesting that number of times a spouse has been deployed, length of deployment, and time between deployments accounted for 12% (Nagelkerke  $R^2$ ) of the variance in marriage satisfaction. The individual predictors were examined further and found that length of deployment ( $B = -1.97, p = .016$ ) was a significant predictor, suggesting that as length of deployment increased marriage satisfaction decreased. There is a significant relationship between marital satisfaction of civilian male Army spouses and multiple deployments with length of deployment showing a greater significance. This conclusion supports past research, which indicates that multiple deployments has a significant relationship on the marital satisfaction among female spouses. Nevertheless, this study only used the perceptions of the civilian male Army spouse. Still, studies completed by previous researchers (Call & Teachman, 1991; McLeland, Sutton, & Schumm, 2008; Nice, McDonald & McMillian, 1981) show that deployment is an extenuating factor in divorce for military couples through their use of correlation and regression approaches.

### **Discussion of the Results**

This study showed there is a significant relationship between the marital satisfaction of civilian male Army spouses and the number and length of deployments (TDY's, or military training), years married, and the amount of time between deployments of the service member. These factors are consistent with research found on civilian male Army spouses (Drummet et al., 2003; Kelley, 1994; Levai et al., 1994; Wexler & McGrath, 1991). Marital satisfaction scores of those civilian male Army spouses surveyed were placed in two categories: low marital satisfaction (78%) and high marital satisfaction (22%). Individual predictors were examined and results found that the length of deployment was a significant predictor, suggesting that as the length of deployment increased the marriage satisfaction decreased. However, the times deployed and time between deployments did not have significant results (Drummet et al., 2003; Kelley, 1994; Levai et al., 1994; Wexler & McGrath, 1991).

### **Implications for Research and Practice**

Because of longer deployments there is an interruption in the roles and routines of the Soldier wife and civilian male Army spouse. Marital discord can only add to the stress

experienced by the spouse and Soldier before, during, and after deployment. Deployment relocates the marital relationship, mental stability and communication factors away from the relationship. This prevents military couples from developing healthy and successful marriages in many instances (Primeau & Christiansen, 2011). Allen et al. (2010) also suggest that when combat exposure is defined as a variable more anxiety is experienced on the marital relationship, correlating a high stress level.

The need for more programs geared toward male spouses within the military is necessary to help those male spouses with no military exposure, such as prior military service fit in this non-traditional role. Continued research on deployment is needed to clarify what types of deployments may be more harmful to marital relationships. A lengthy deployment to a combat zone with the potential of death, injury or emotional trauma may be perceived differently from a shorter training deployment.

This study highlighted a concern for marriages of Army Soldier female spouses. To combat the concern, continued refinement and development is needed for quality intervention practices for military couples experiencing low marital satisfaction. Rudow (2013) reminds us that new research and the expansion of research in the field of counseling is essential to benefit the Soldier, spouse, and military family as a whole. He recommends that research warrants that mental health programs be broadened to identify concerns of the relationship between the Soldier and military spouse before, during and after deployment in order to establish quality supportive therapeutic plans (Rudow, 2013). Porter's (2014) study of how the relationship of civilian males was maintained during deployment shows how ineffective current programs and support for civilian male spouses are. Porter suggests that even in 2014, there are implications which found that the military still does not perceive the stay-at-home civilian male spouse as a contributing force in his wife's career. Research has determined that there are limited support programs designed with the civilian male spouse in mind due to the continued stigma identified with the military has continued the traditional role where men are seen as the spouse to deploy instead of women (Crooks & Henderson, 2008).

### **Limitations**

The limitations in this study include ethical considerations with confidentiality, issues which may be associated with possible trauma to the participant, the sampling population, potential bias from participants, and limitations with the internet.

### **Sampling**

The sample population excluded all military services other than active Army. This limited the data that could be collected from those civilian male spouses in the Navy, Marine Corps, Air Force, and National Guard. As well as the limitation of having the ability to survey the Soldier spouse due to IRB and U.S. Department of Defense (DoD) restrictions (Capella, 2012; DoD, 2012). The exclusion of other than active duty civilian male Army spouses eliminated all the reserve components, thus limiting the sample size.

### **Potential Sample Bias**

The drawback of excluding the Soldier wife of the civilian male Army spouse confines the collection of data to only one set of views on the relationship. Since the study is subjective, and based on the perception of the civilian male Army spouse, honest and truthful answers to questions concerning deployment were expected. The pre-disposed bias of respondents relating to the sensitivity of being able to express their true feelings was a concern. Although a non-disclosure statement was attached to the survey and no names were used for identification, military spouses are often very subtle in answering questions that may affect them or the career of their spouse (Segal, & Harris, 1993).

According to articles in the *Military Spouse* magazine (2014) there are guidelines for spouses or command spouses (spouses of officers). They are trained through conferences and workshops that encourage spouses to “get involved” in the military community and unit where the Soldier works. This benefits the Soldier when the spouse is active within the unit or military community. Therefore, as the command spouses interact with noncommissioned officer spouses’ male or female, the sentiment of assignment with pride is passed down. Rank was not identified in the study through the use of an online survey; however, bias may still have existed among the participants.

### **Internet Limitations**

The online survey may have omitted those participants who had no access to a computer, thereby limiting the sample and inclusion of more data. Future research should include both online and paper surveys. The limitation of the possibility of technical problems with timeouts online may cause errors to the data. The solution to this may be to have participants survey online in one specific place which has the computers needed for the online survey and can be controlled by the researcher.

### **Ethical**

The ethical issues that this study presumed includes the limitations that may produce issues such as data privacy and confidentiality, integrity of data, and the use of professional standards according to the Belmont Report (DHHS, 1979), the American Counseling Association (ACA) ethical standards as well as the IRB’s guidelines (ACA, 2014; Capella [internal policy document], 2012). The use of an online survey provides a confidential and reliable source to obtain information according to (Leedy & Ormod, 2010). However, the researcher cannot gauge the emotional reactions of a participant while online. Therefore, information was provided for call-in mental support.

### **Recommendations for Future Research or Interventions**

The military deploys more Soldiers now than ever across all the branches. The Army alone deploys more than 200 days at a time, this is the longest deployment time amongst the branches (Primeau & Christiansen, 2011). Much of the current research is based on single deployments; however, this idea is changing with more than a million soldiers deploying since

9/11 (Tan, 2009). The length of deployment needs more research evidenced by (Jensen, Martin & Watanabe, 1996) study which found that longer deployments caused poor adjustment within the family especially for children. Additionally, more research is needed to clarify what type of deployments has more harm to the marital relationship. For example, a lengthy deployment to a combat zone with the potential of death, injury, or emotional trauma may be perceived different from a shorter training deployment.

While this study examined the Army specifically, inclusion of other branches of the service is a needed step for future research. The study could be broadened by studying the perceptions of the male spouse in all military branches. It would encompass a well-rounded group with different experiences and stressors relating to all branches of military life. In addition, the inclusion of the Soldier wife would benefit the research by providing input of both military male spouse and female Soldier. While it was not possible in the scope of this study to measure those stressors concerning marriage, in-laws, finances and disagreements identified by the civilian male spouse future research using the data collected would be beneficial to understanding the different needs of the military male spouse.

Last, more research is needed to explore military support programs that address the needs of the civilian male Army spouse. The military has programs designed to help spouses during deployment which are continual; however, they have not been effective in the fight to bring the numbers down past the national divorce rates. In addition, the civilian male spouse is still trying to find where they fit in the programs (Karney & Crown, 2007). This becomes more of a crucial support to help those male spouses with no military exposure such as prior military service fit in this non-traditional role. In order for soldiers to function in the workplace especially on the battlefield, family situations must be in order (Ashbury & Martin, 2012). Therefore, quality relationships must be capitalized on prior to, during and after deployment. This is needed to maintain positive marital satisfaction and will require continued education, more counseling, and better opportunities for spouse employment (Bell & Schumann, 2000).

### **Conclusion**

The U.S. Department of Defense (2012) statistics show that the number of female Soldiers married to civilian spouses was listed at approximately 51,000. Although the number decreased to 7.2% in 2011 the number of female Soldiers divorced reached 8%, which is higher than the 2.9% divorce rate of male Soldiers (Military.com, 2014). This causes marriages in the military to be at a higher risk for divorce especially among female Soldiers (CDC, 2012, DHHS, 2012; Karney & Crown, 2007; Rudow, 2013). Past research indicates that males are not equipped to deal with the psychological and the emotional strain that is placed on relationships during deployments (Crooks & Henderson, 2008). These findings further present the argument that the length of separation of any kind erodes the marital satisfaction of civilian male spouses either through deployment, temporary duty assignment or military trainings.

In order to help maintain relationships, families, and the lives of soldiers on the battlefield, it is imperative that researchers study stressors to develop plans that build effective communication skills between the Soldier and spouse before, during and after deployment. Setting this plan into action will allow a better quality of life for Soldiers and their families.

Although the military does tell families and soldiers that “families first” is how they operate, knowledge of the military life style will illustrate that “the mission always comes first” (Hightower & Scherer, 2007).

This study benefits researchers to better comprehend how repeated separations have an effect on the marital satisfaction of civilian male spouse and how the male spouse copes with the stress of separation. The hypothesis certainly offers a glimpse into the mindset of the civilian male spouse. Understanding the psychological stress experienced by these civilian male spouses allows for future development of new programs and updating current programs to include the military male spouse.

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