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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. The lead article presents a "first look" at 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 second article examines military couples' communication within the lens of communication privacy management theory. The next article reviews the needs of LGBTQ+ youth during a parental deployment. The fourth article counseling issues concerning female service members and deployment. The final article suggests using solution-focused brief therapy and sand tray when working with military dependent teens. I welcome grad students to submit an article. To the counselor educators – encourage your students (especially Veteran students) to submit and article or co-author with them.

I am seeing an increase in submissions and gladly welcome more submissions for the JMCG. I do have enough articles in the queue for another issue and the start toward a third. 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

Training as a Recruitment Strategy for Building Military and Community Partnerships with Faith-Based Organizations: The Partners in Care Program

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Abstract

As Operations Enduring Freedom, Iraqi Freedom and New Dawn called upon extensive numbers of National Guard service members to serve multiple, and often lengthy deployments, the stress of separation and combat began to show a personal, professional, and social impact on National Guard members and their families. The Partners in Care program was developed to connect National Guard Chaplains with local faith-based organizations to provide service members, Veterans, and their families with needed community resources and support. To initiate the Partners in Care program, community faith leaders attend a-one day Summit training about military life, deployment, mental health issues reported by military personnel, suicide prevention, and how faith-based organizations can support service members and Veterans in their local communities. Once they have completed Summit training, interested faith-based organizations enlist to become a "Partner in Care." This manuscript describes the evaluation outcomes of the one-day Summit training in five states. Evaluations were based upon pre- and post-training surveys of attendees (N=217, 205 respectively). Faith-based community attendees highly rated the Summit training (95% favorable rating), and the suicide prevention training (91% favorable rating). A majority of respondents (63%) indicated interest in becoming a Partners in Care-affiliated congregation. Attendees' familiarity with signs of suicide increased from 69% to 84% following the workshop (p<0.001).

Keywords: community partnerships, military, clergy, suicide prevention

As Operations Enduring Freedom, Iraqi Freedom, and New Dawn called upon extensive numbers of National Guard service members to serve multiple and often lengthy deployments, the stress of separation and combat began to have a personal, professional, and social impact on National Guard service members and their families (Chandra, et al., 2010; Chartrand, Frank, White, & Shope, 2008). Given that many faith-based organizations and their leaders have goals, expertise, and knowledge to serve in times of crisis; these organizations are poised to partner with the military to support the health and wellness of military personnel, Veterans, and their families. Local clergy frequently provide frontline spiritual and emotional support for returning soldiers and their families. A study of healthcare providers and clergy found that both groups reported the perception that they are not prepared to deal with mental health issues of returning Veterans due to insufficient training to address these needs (Chevalier et al., 2015). In the same study, education concerning these issues was identified as being helpful to rectify this inadequacy. Another study also reported the difficulties reported by clergy in recognizing mental health problems and knowing local resources to assist returning Veterans (Fromson et al., 2014). In that study after an education intervention, a post survey indicated significant improvement in clergy knowledge and preparedness to assist Veterans. Leaders of faith-based organizations need to be able to identify mental health problems and have knowledge of community resources and links to individuals who have skills to assist people in need.

Partners in Care (Lee, n.d.) links National Guard Chaplains to faith-based organizations with the goal to support military personnel and Veterans in their communities. To initiate the Partners in Care program, faith-based leaders participate in a one-day training program about military life, deployment, mental health issues reported by military personnel, suicide prevention, and how faith-based organizations can play a supportive role for service members and Veterans in their local communities. Then interested faith-based organizations enlist to become a "Partner in Care." Designated partners share contact information with their state's National Guard Chaplain(s) so that the chaplains can direct service members and Veterans to local resources for financial assistance, childcare, vehicle repair, lawn care, and any other services that may be available through volunteers in the faith-based organization.

The Partners in Care program was conceived when the National Action Alliance for Suicide Prevention's Military/Veterans Task Force identified a need to not only find methods to support individuals not only through the Departments of Defense and Veterans Affairs, but also to engage support from the local communities in which they reside. Task members from the Department of Defense, Substance Abuse and Mental Health Services Administration (SAMHSA), the National Guard Bureau, and the Department of Veterans Affairs (VA) collaborated on a plan to pilot the Partners in Care program in five states. Arizona, Missouri, Minnesota, Oregon, and Virginia were chosen based on their interest and support from the National Guard Adjutant General and Chaplains. The goal of the project was for National Guard Chaplains to engage and educate leaders of faith-based organizations in an effort to bridge the gap of understanding for civilians about military culture and deployment. Our intent was to institute a systematic evaluation of the pilot implementation to inform a national rollout of the project within the Department of Defense. This manuscript describes that evaluation and reports its findings.

Methods

The National Guard Adjutant General designated a National Guard Chaplain in each of the five pilot states to implement the program. These National Guard Chaplains were responsible for developing a local team to conduct a one-day training, "Summit," and for recruiting faith-based organizations to enlist in the Partners in Care program.

National Action Alliance for Suicide Prevention's Military/Veterans Task Force members from SAMHSA assisted the National Guard Chaplains in the pilot program states in identifying faith-based organizations in their state to invite. Chaplains invited local leaders of faith-based organizations via email, social media, standard mail, or word of mouth to attend the one-day training Summit, which lasted 6-8 hours. While each state's Summit agenda purposefully varied based on the identified needs of that state, the overarching goals were to provide education about military life, deployment, and the VA's Operation S.A.V.E suicide prevention program (Knox, Kemp, King, & Wood, 2010; Suicide Prevention Resource Center [SPRC], 2014); and to offer attendees a chance to become a Partners in Care-affiliated congregation. Suicide prevention coordinators from VA Veterans Integrated Service Network (VISN) 2 Center of Excellence for Suicide Prevention provided training in Operation S.A.V.E (Knox et al., 2010; SPRC, 2014). Clinician researchers with expertise in suicide prevention

research from VA's Mental Health Quality Enhancement Research Initiative and (VISN) 2 Center of Excellence for Suicide Prevention developed and conducted the project evaluation.

Four of the states (MO, MN, VA, OR) used a large group educational format while Arizona used a smaller group break out approach. National Guard Chaplains recruited military personnel, military family members, Veterans, and mental health care professionals experienced in treating deployment stressors to provide educational sessions at the Summit. National Guard Chaplains secured these presenters based on their knowledge and experience with the life experiences and mental health of people who experience deployment. The training format included opportunities for Summit attendees to ask questions of and interact with the presenters to better understand military culture.

A total of 222 community faith leaders participated in the trainings in the five pilot states (see Table 1). Pre- and post-surveys were distributed to attendees before and immediately following the training. The pre/post-Summit surveys queried the attendees' knowledge of military culture, suicide prevention, and comfort with talking to someone who is suicidal. In addition, surveys asked attendees to rate the overall Summit, the individual training components (e.g., Operation S.A.V.E., Orientation to Partners in Care, presentations, and printed or video material), and how well the Summit met their expectations, on a scale from 1 to 5 (1 = poor and 5 = excellent). Surveys also asked about the likelihood that the attendee's congregation would sign up to participate in the Partners in Care program within the next six months, and if they would recommend the Summit training to other colleagues. Pre- and post-surveys also asked attendees to rate a set of statements on a scale from 1 to 5 (1 =strongly disagree and 5=strongly agree) related to their attitudes and familiarity with military culture, how well their congregations could be helpful to National Guard members in their community, and their familiarity with suicide prevention strategies. A total of 217 pre-Summit and 205 post-Summit surveys were returned from four states (pre-Summit: MN=27, MO=47, OR=86, VA=57; post-Summit: MN=47, MO=38, OR=63, VA=57). The Arizona Summit trainings preceded the implementation of the evaluation, so Arizona attendees did not complete Summit pre- and post-evaluations.

Survey results were analyzed using SAS software, Version 9.3 (SAS, 2011). Responses were calculated as a percentage of the total (N=217 and N=205 respectively). Differences in the frequency of positive responses (e.g., response of 4 or 5) between the pre- and post-surveys were analyzed by Fisher's exact test with significance set at the 0.05 level. Fisher's exact test was chosen because it is more accurate than the chi-squared test or G-test of independence when the expected numbers are small (McDonald, 2014).

Results

Table 1 shows pre- and post-Summit survey results. A total of 217 attendees returned pre-Summit surveys and 205 attendees (94%) returned post-Summit surveys. The majority (58%) identified themselves as a leader in a faith-based organization, with the remaining attendants identifying as clergy members (44%), or as involved in their organization in a non-clergy role (45%). Of the individuals completing pre-Summit surveys, 89 (41%) stated that they had served in the military, and 43 (19%) indicated that they had a National Guard member in their family. Of the 205 attendees who completed the post-Summit survey, 127 (62%) indicated their interest

in a follow-up contact. Thus approximately two thirds of the attendees were open to the idea of exploring Partners in Care implementation within their congregations, and to participating in follow-up interviews at the time of their Summits.

Table 1. *Survey Results*

Participant Characteristics

	N	(%)
Role in Faith-based Organization		
Leader	125	58
Clergy	95	44
Involved non-clergy	97	45
Served in military	89	41
National Guard family member	43	19

	Pre Survey N=217		Post Survey N=205		
Participant Responses	N	%	N	%	p-value
Familiar with military life	169	78	153	75	
Congregation could assist military personnel in need	179	82	162	79	
Relatively comfortable talking to someone contemplating suicide	168	77	169	83	
Can recognize signs someone is considering suicide	150	69	172	84	$p<0.001$
Know what to say to someone who may be considering suicide	122	56	169	83	$p<0.0001$
Know how to find professional help for someone considering suicide	173	80	190	93	$p<0.001$
Know what to do and whom to contact if someone is in suicidal crisis.	153	71	190	93	$p<0.0001$
How likely is congregation to implement Partners in Care?					
Highly likely			77	38	
Somewhat likely			63	31	
No response			51	25	
Desire follow-up contact			127	62	
Training Components ratings:					
Overall excellent or very good			195	95	
Summit met expectations			184	90	
Would recommend Summit training to others			184	90	
Partners in Care Program Orientation excellent or very good			183	89	
VA Operation S.A.V.E. training excellent or very good			186	91	

Attendees rated the Summit training highly; 95% of responses rated the Summit as either excellent or very good, and 90% felt that the Summit training did an excellent or very good job at meeting their expectations. The orientation to the Partners in Care Program as well as the training for the VA Operation S.A.V.E. training both received favorable ratings of very good or excellent (89% and 91%, respectively). Over 90% of attendees responded that they would recommend the Summit training workshops to others.

Most participants entered the Summit trainings feeling that they were familiar with military life (78%), that their congregations could assist military personnel in need (82%), and that they were relatively comfortable talking to someone contemplating suicide (77%). About the same percentages of people answered affirmatively to these questions post-survey, but attitudes did not change following Summit training. However, pre- and post-workshop positive responses to four questions (I can recognize the signs that someone is considering suicide? I know what to say to someone who I think may be considering suicide? I know how to find a professional or a service that can help someone who is considering suicide? and I know what to do and whom to contact if someone is in suicidal crisis?) increased from 69% to 84% ($p<0.001$), 56% to 83% ($p<0.0001$), 80% to 93% ($p<0.001$), and 71% to 93% ($p<0.0001$), respectively. When queried about the likelihood of their congregations participating in the Partners in Care program, 38% of respondents were highly likely to implement Partners in Care, 31% were somewhat likely to implement Partners in Care, and 25% did not respond. Although not indicating that they would implement Partners in Care or become a Partners in Care congregation, the majority indicated that they would implement efforts that aligned with Partners in Care program goals as a result of the Summit training. While 90% of respondents would recommend the Summit training to other churches, the attendees also suggested that other groups (i.e., first responders, healthcare and social service organizations, or civic groups) should be included in future training Summits.

Surveys also included an open ended-response format for Summit attendees to list or describe the strengths and weaknesses of the Summit and make suggestions for improving community collaborations to assist this population. Results indicated a desire for greater education to understand a mental health diagnosis and reduce the stigma of seeking help.

Discussion

Given that the goal of the Summit was for National Guard Chaplains to engage and educate leaders of faith-based organizations in an effort to bridge the gap of understanding for civilians about military culture and deployment, the demographic make-up of attendees was unexpected. Forty-one percent stated that they had served in the military, and 19% indicated that they had a National Guard member in their family. Although service members, Veterans, and their family members commonly express an interest in volunteering to assist other military service members, that was not the target audience originally envisioned for this program. Since only 58% of attendees identified themselves as a leader in a faith-based organization, and many attendees would identify as feeling that they were familiar with military life (78%), there may have been a mismatch between the training agenda and evaluation instrument as originally designed (anticipating an audience who needed an orientation to military culture and who were leaders of religious congregations) and the actual training attendees. This may explain why only 62% indicated interest in a follow-up contact, 38% were highly likely to implement and 25% did not respond. Survey respondents may have lacked the authority within their organization to make that decision or to act as a contact person.

Many summit attendees expressed that they planned to become better informed in order to be attentive to the needs of military and Veterans in their community; that they planned to share the information gained at the Summit with members of their organizations, and that they

planned to increase networking and collaborations in order to meet these goals. If the motivation indicated in the evaluations leads to the actions described and faith-based organizations enroll into the Partners in Care program, military personnel, Veterans, and their families could find support in communities where mental health has been underserved. Attendees valued the knowledge gained from the Summit, and engaging faith-based organizations in supporting these families could potentially assist the VA and DoD in addressing the overwhelming stressors that could lead to suicidal ideations.

Respondents suggested the inclusion of non-faith community service organizations and members of first-response teams and health care services in future Summit trainings. This response indicates a willingness to work collaboratively with other community groups and service providers. Additionally, it indicates that faith-based leaders may have past experience collaborating with other health professionals and service providers in their communities.

Building Community Support

Overall, attendees gave superior or good ratings to the Summit training and Partners in Care program introduction, which indicates they valued learning about the unique cultures and experiences of military communities. Gaining an understanding about populations other than one's own often allows one to become more understanding and accepting diverse cultures and beliefs (Barden, 2013). Additionally, civilians have indicated a willingness to volunteer to assist military personnel, Veterans, and their families (Waliski, Ray & Kirchner 2013; Waliski, et al. 2014). This linking of community service organizations, professionals, and resources could have benefits for the Departments of Defense and Veterans Affairs and for other government agencies challenged with addressing public health concerns.

Community Approach to Suicide Prevention

Although pre-training survey results indicated that participants entered the Summit trainings feeling that they were able to assist those in suicidal risk, their confidence in identifying signs of suicide and directing individuals to care improved. These results suggest a potential benefit of providing suicide education as a strategy for suicide prevention. Post-Summit evaluation comments indicated attendees had a better understanding of community resources for Veterans and military, suicide prevention, and the needs for family support after receiving Summit training. The 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, a report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention (2012) highlights suicide as a primary cause of death in the U.S. and recommends that suicide prevention efforts use a multi-directional public health approach that includes creating awareness and providing education on the identification and prevention of suicide and that promotes collaborations between private and public sector professionals. These strategies were endorsed by Summit participants, whose evaluations indicated a need for additional education on issues other than suicide, such as responding to families regarding loss of loved one, PTSD, traumatic brain injury, and issues with re-integration into civilian life.

Community Support for Government Action

Greater awareness and understanding of the military culture, the experiences of Veterans and their families that have experienced war time deployment, and the challenges often experienced by these individuals may encourage more community support and collaboration among health and welfare service organizations. President Obama has signed Executive Orders for departments under his command, which are being encouraged to collaborate (White house press release, August, 31, 2012), and has encouraged individuals and service organizations to join forces in supporting Veterans (e.g., https://www.whitehouse.gov/joiningforces). Uniting the public with a common goal of serving Veterans could be a method to decreasing the stigma of mental health help seeking among Veterans and, therefore, could help in reducing suicide. Additionally, more collaboration and awareness of government programs may help to increase the transparency of government efforts and increase the public's support, while at the same time building sustainable community networks to improve public health.

Implications for Counselors

Licensed counselors are available in even our most rural communities and are located in schools, universities, community mental health clinics, non-profit agencies, and faith based organizations. They are able to promote greater awareness of the military family life and mental wellbeing. Therefore, counselors interested in serving military personnel, Veterans, and their families should reach out to government agencies and other organizations with similar missions. These collaborative efforts could lead not only to improved support but also begin to establish networks of professionals that can be called upon to address other public health issues.

Limitations

While allowing each state National Guard Chaplain to develop training Summits according to their own needs served to promote introduction of Partners in Care and adapt it to the needs of individual communities, the varying approaches and the differences in attendees at the Summits (e.g., faith-based volunteers, clergy, or members of non-faith based civic groups) made it difficult to evaluate the overall impact of the strategies taken. Selection bias is another potential limitation as there were no criteria for selection of Summit attendees. Comments from the National Guard Chaplains and survey results indicate that those attending may have been recruited because they had a preexisting connection to the National Guard or Summit organizers. Thus, the post-summit surveys and willingness to be contacted for future follow-up may reflect individual attitudes and not the reality of a congregation's leadership as a whole. If the program continues in the future, it is advised that standard implementation procedures be determined and followed, with the attendant revisions to evaluation design and data collection measures.

Conclusion

National Guard Chaplains relied on existing networks and formed collaborations to provide Summit training workshops in which the Partners in Care, a collaborative National Guard and community initiative aimed decreasing stress and increasing resilience to improve the health and wellbeing of Veterans, military, and their families was introduced. Although relying

on existing partnerships may have helped to successfully provide a Summit, it may have hindered the establishment of relationships with organizations that are not familiar with military life and the stressors of deployment. Further outreach to those organizations not frequently partnering with the NG or VA may be a benefit for the program's success.

Attendees at the Summit trainings highly rated information about suicide prevention, military needs, and ways that communities could help. The Summit training workshop format seems to be an adequate vehicle for introducing this community partnership program. Addressing areas of needed improvement in the program and its evaluation will improve the collaboration between national agencies and local partners.

References

Barden, S. M. & Cashwell, C. S. (2013). Critical factors in cultural immersion: A synthesis of relevant literature. *International Journal for the Advancement of Counseling, 35*, 286-297.

Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Han, B. (2010). Children on the homefront: The experience of children from military families. *Pediatrics, 125*(1), 16-25.

Chartrand, M. M., Frank, D. A., White, L. F., & Shope, T. R. (2008). Effect of parents' wartime deployment on the behavior of young children in military families. *Archives of Pediatrics and Adolescent Medicine, 162*(11), 1009-1014. doi:10.1001/archpedi.162.11.1009

Chevalier, L., Goldfarb, E., Miller, J., Hoeppner, B., Gorrindo, T., & Birnbaum, J. (2015). Gaps in preparedness of clergy and healthcare providers to address mental health needs of returning service members. *Journal of Religion and Health, 54,* 327-338, doi:10.1007/s10943-014-9917-0

Fromson, J.A., Ioodice, K. E., Donelan, K. & Birnbaum, J. (2014). Supporting the returning veteran: Building linkages between clergy and health professionals. *Journal of Psychiatric Practice, 20*(6), 479-483, doi:10.1097/01.pra.0000456598.89234.76

Knox, K. L., Kemp, J., King, D. A., & Wood, J. (2010). *Operation S.A.V.E. - Instructor's Guide and Tool-kit.* 1-34. VISN 2 Center of Excellence at Canandaigua. Canandaigua, NY.

Lee, W. S. (n.d.). Information Paper "Partners in Care" & Sample Memorandum of Understanding. Maryland National Guard Joint Force Headquarters (MDNG-JFHQ). Retrieved from http://aosresourcecenter.com/file_depot/0-10000000/390000-400000/398422/folder/1126372/PARTNERSINCAREOUTLINE$26MOU.pdf

McDonald, J. H. (2014). *Handbook of Biological Statistics* (3rd ed.). Baltimore, MD: Sparky House.

SAS Version 9.3 [computer program]. Cary, NC: SAS Institute Inc.; 2011

Suicide Prevention Resource Center (SPRC). (2014). *Operation S.A.V.E.: VA Suicide Prevention Gatekeeper Training.* Retrieved from http://www.sprc.org/bpr/section-III/operation-save-va-suicide-prevention-gatekeeper-training

Waliski, A., Ray, D., Kirchner, J. E. (2013). School counselors' observations of OEF/OIF children and families: Identifying opportunities for assistance. *Journal of Military and Government Counseling*, *1*(2), 101-110. Retrieved from http://acegonline.org/wp-content/uploads/2013/02/JMGC-Vol-1-Is-2.pdf

Waliski, A., Townsend, J., Cheney, A. M., Sullivan, S., Hunt, J., & Curran, G. M. (2014). Establishing community partnerships for the prevention of mental distress and suicide in military personnel and veterans. *Journal of Military and Government Counseling, 2*(1), 2-15. Retrieved from http://acegonline.org/wp-content/uploads/2013/02/JMGC-Vol-2-Is-1.pdf

White house press release. (August, 31, 2012). Factsheet: President Obama Signs Executive Order to Improve Access to Mental Health Services for Veterans, Service Members, and Military Families. Retrieved from https://www.whitehouse.gov/the-press-office/2012/08/31/fact-sheet-president-obama-signs-executive-order-improve-access-mental-h

Can You Keep a Secret? Examining Military Couples' Disclosure through the Lens of Communication Privacy Management Theory

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Abstract

Since 2001, relational communication within the military has generated interest due to wartime deployments and service members returning physically injured or suffering from mental illnesses such as post-traumatic stress disorder (PTSD). As a result, interdisciplinary research has ensued, combining both research and practice in an effort to assist service members and their partners in tackling problems in romantic relationships due to these changes. This paper explores military couples' disclosure tactics through the scope of communication privacy management theory (CPM) and Erving Goffman's face theory. Suggestions for therapists who assess military couples, as well as directions for future research, are mentioned.

KEYWORDS: communication privacy management theory, military couples, disclosure, counseling

Since 1954, the United States military has created programs in hopes of assisting military couples and families in adjusting to military culture (Cline, 2003). In most western civilian cultures, women are seen as staples in their households, however, and often times, military couples are learning to manage their lives independent of one another, although they are still living as one unit (Moore, 2012). As a result, many military couples may find their relationships strained and negatively impacted.

Disclosure is a way couples communicate and create intimacy (Yoder & Nichols, 1980). It is through disclosure that bonds are made and information is shared (Fivush, Bohanek, Robertson, & Duke, 2004). For military couples, disclosure seems to play many roles in the relationship, including roles of intimacy and protection (Coyne & Smith, 1994; Joseph & Afifi, 2010; Suls, Green, Rose, Loundsbury, & Dordon, 1997). Based on their motivations to disclose

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(e.g., comradery, connectedness to a unit, the need to vent about maintain the home in a partner's absence, etc.), military couples may find some information easier to share with others than with their partners (Hoyt, et al., 2010; Joseph & Afifi, 2010). Dindia and Allen (1992) posit that events happening in life are usually revealed to friends before spouses and family members. Additionally, service members who disclose about combat events are more likely to discuss them with those who have experienced similar situations than someone like a civilian spouse or partner (Hoyt et al., 2010).

Recently within the discipline of communication, studies have investigated how and why individuals choose to disclose information (Petronio, Reeder, Hecht, & Ros-Mendoza 1996; Petronio, 2002). Communication Privacy Management (CPM) discusses in great detail one's motivation for disclosure, the possible need for privacy, and how this information is managed through various interactions with others (Caughlin, Petronio, Middleton, & Ashley, 2013; Petronio, 2002; 2004). Goffman's (1990) original work on face theory and self-presentation also lends itself well to this context as the pressure (spoken through protocol and implied) to maintain a particular image is impressed on both the military service member and his or her partner.

This paper explores the complexities and differences of military couples in their communicative processes. Through the theoretical frameworks of CPM and face theory, advances can be made to extend these theories in the clinical setting and add to the disciplines of counseling and psychology, offering another dimension of investigation to assess how romantic relationships within the military are maintained and function.

Importance of Disclosure in Relationships

Openness is seen as a positive predictor of mental health and relationship satisfaction (Finkenaur & Hazam, 2000; Smyth & Pennebaker, 2001). It is known to be both therapeutic and health promoting (Stiles, 1987). According to social penetration theory, psychologists Altman and Taylor posit that self-disclosure, a primary form of openness, is a running theme and requirement in making relationships work (as cited in Yoder & Nichols, 1980). When looking at these factors through the eyes of civilian populations, this information may prove to be groundbreaking and monumental; however, with this literature stating the importance of openness and disclosure, it should not be assumed that the lack of disclosure is always negative, particularly amongst those in romantic relationships within the military. According to Merolla (2010), romantic relationships in the military have been noted to be different from several other types of relationships such as, prolonged amounts of time away from one another, and limited access to technology for communication during untypical civilian relationship events like war time deployments. Issues such as these are important to consider when assessing military romantic relationships for two reasons. First, since these relationships do contain issues not common to the average civilian romantic relationship, they should be treated and examined differently. Second, although programs in the past have sought to address romantic relationships of those in the military, these programs were originally designed for civilian couples (Stanley et. al, 2005). As a result, some important information useful to military couples could have been omitted or overlooked. In addition to this, since military couples are understudied, there is not a wealth of knowledge derived from this population of individuals (Merolla, 2010). In knowing

this, researchers and practitioners should keep an open mind while addressing romantic relationships within the military.

Disclosure among Military Couples

When investigating how disclosure relates to military couples, it is important to note that secrecy is sometimes required from service members to ensure efficient work practices. Moore (2012) states secrecy is a rule in the military used to keep personal issues separate from those related to work. As a result, service members may not have the liberty of sharing information with their partner about the details of their employment or what is happening on military bases (Moore, 2012). Consequently, this may leave a partner feeling excluded and unable to relate to their service member on an array of issues, resulting in relational strains due to the tension in their communicative processes. These strains are known as relational dialectic tensions (Baxter, 2004). As service members are attempting to maintain their romantic relationships, they are also attempting to maintain their allegiance to the government and protocol, resulting in a "tug-of-war" mentally and conversationally as to how and what they choose to disclose. In this setting, military couples may also be attempting to shelter their partner by withholding information for the sake of protection and to buffer stress (Joseph & Afifi, 2010). Joseph and Afifi reported that wives were less likely to express themselves in the event their stress would affect their spouse. Also, spouses are encouraged by the military to withhold information to avoid distracting their service member from the "mission" (Joseph & Afifi, 2010).

Surprisingly, there has been mixed results of the effects of protective buffering between military couples. Joseph and Afifi (2010) found that protective buffering was not associated with marital satisfaction among military couples. However, 20 years prior, protective buffering was seen as a possible relationship inhibiter, causing higher levels of stress and lower levels of marital satisfaction (Coyne & Smith, 1994; Suls et al., 1997).

Why might this be? Although there is no empirical research to support this assumption, it is possible that war-time deployments over the past 12 years have acclimated couples to knowing only limited information surrounding their partners' employment, and thus protective buffering is not seen as a dysfunction. One could also consider that non-deployed loved ones have more access to information pertaining to their deployed service members through the media and Internet access than those of 20 years ago, resulting in a reduced need to have direct disclosure from their service member. Cline (2003) reports due to military personnel cutbacks, service members are being deployed more frequently for longer stays. This factor may also aid in the normative functioning of military couples operating without a wealth of disclosure between one another since frequent and prolonged times of separation is causing them to live lives of increased independence (Moore, 2012).

Still, not all military couples are content with adjusting to ambiguity. Disconnect in disclosure preferences can have negative health implications due to the lack of communication (Joseph & Afifi, 2010). Issues may also become unresolved and uncontended, causing additional conflict in the future. Roloff and Wright (2009) report that couples who are invested in their relationships are less likely to allow negative issues to ensue without addressing them; however, in the military this is not always the case. Frisby, Byrnes, Mansson, Booth-Butterfield, and

Birmingham (2011) found that in contrast to confronting one another, military couples sometimes participate in imaginary interactions, practicing conversations alone, in the event they choose to address their partner in the future. This can be problematic because the partner may never know his/her partner's problem. Research also suggests that communication problems can be a precursor to divorce, and couples who talk more are more satisfied in their relationships (Dunleavy, Banfield, Booth-Butterfield, Goodboy, & Sidelinger, 2009; Bodenmann et al., 2007).

According to the Defense Manpower Data Center (2009) for the years 2001-2007, the divorce rate doubled for those in the Army. The divorce rate for the military is also currently higher than the civilian divorce rate at 53% (U.S. DOD, 2010). As service members continue to be deployed and return home, understanding how military couples manage their privacy within their relationships will be important for practitioners as they assist service members in making proper readjustments stateside.

Communication Privacy Management Theory (CPM) and Face Theory

Secrecy can be a tactic used to help manage romantic relationships in the military, but it potentially causes more harm than good. Acts of non-disclosure are ubiquitous to both civilian and military couples (Frisby et al., 2011); however, given the special circumstances of military couples, the focus should be shifted from eliminating the avoidance of disclosure to creating a better formula by which military couples can manage their privacy.

As stated previously, CPM posits that information is property and individuals have the privilege of owning it (Petronio, 2002). As owners of information, individuals have the right to share or withhold their information based on their own discretion. For example, a service member could receive bad news about work performance on his or her job. CPM would argue this news is owned by the service member, and based on his or her discretion, he or she may choose to share this news, but is not required to. Likewise, the partner of a service member may find out information about his/her health. The partner has the liberty to keep this information or share it with others.

When considering this, one could say that military couples see their information as an object or something to be owned. They value it and seek to preserve or share it only with those they trust. Petronio (2002; 2004) would suggest that when disclosure happens, individuals become co-owners of the information shared. This rule could give those who co-own information the liberty to share with others, possibly without the approval of one another. This can also be important when examining military couples because this can be a reason why information may not be shared. According to Hall (2011), secrecy is a component of military success. If too much information is disclosed or shared with others, security could be breached.

For military couples, protection of one's privacy is not only limited to one's job. Emotional and psychological security in romantic relationships within the military can also be a reason for an insistence of privacy. Caughlin and Afifi (2004) argue that disclosure between military couples often places individuals in a state of vulnerability, at the mercy of the listener. Additionally, though disclosure is seen as a way to bring couples together (Altman & Taylor, 1973), the result is not always a stronger bond. Disclosure can cause couples to grow apart based

on the information shared (i.e., the news of infidelity). Service members may not disclose information about their personal experiences relating to deployments to their partners because they may feel that their partners will see them differently (Hall, 2011). They may also be reluctant to seek counseling because of the fear of being stigmatized and others finding out their information (Straits-Troster et al., 2011).

Goffman (1990) would suggest that in instances such as these, individuals feel a need to maintain an image that is standard with their social norms. Since the military prides itself on heroism and honor, it could be detrimental to a service member to know his or her partner (or others of his or her community) sees him or her differently. There is also the issue of partners "teaming up" with their service member to help maintain a stoic image, despite the reality of present conditions.

Hall (2011) would add to this argument by stating that stoicism, secrecy, and denial are all components utilized within military culture. This means there might be a great possibility that service members and their partners willingly withhold information, do not show vulnerability, and refuse to admit truths to others because this is considered the "norm" in military culture. Goffman (1990) also suggests that individuals who share in the truth of one's image and how it is displayed before others are given a role to play to help maintain that image. In the case of military couples, this may be evident as both the service member and his or her partner work together through certain tactics to ultimately protect one another and the corresponding images they display to others.

There are also rules for disclosure, which include knowing the right time to disclose (Petronio et al., 1996). Adding to the general studies of romantic relationships in the military, CPM could also prove to be beneficial when looking at the disclosure processes of military couples during war-time deployments. In the book, *Wheels Down: Adjusting to Life after Deployment*, Moore and Kennedy (2011) give examples of instances when disclosure was not provided to the service member while they were deployed. As a result, relationships were terminated and finances were spent without the service member's knowledge (Moore & Kennedy, 2011). Additionally, CPM takes into account cultural differences, noting that culture will help drive when and how individuals disclose information (Caughlin & Afifi, 2004; Petronio, 2002). This component can be crucial for military couples as they are aware that the military culture endorses privacy and, therefore, this may also be a reason why they decide whether or not to disclose information.

Clinical Implications for Mental Health Providers

For the Service Member

Mental health providers should have a good understanding of military culture, the individual services being required of military personnel, and how both might affect help-seeking and therapeutic relationships. Providers can improve their education on military culture by seeking additional information from a variety of sources, including the Department of Veterans Affairs (e.g., the Community Provider Toolkit), accredited professional schools offering courses on military culture and topics related to military-connected populations, and by reading and

listening to the narratives of veterans and their families. It is imperative for providers to understand that there is a high level of variation in the experiences of individual service members, Veterans, and their families. As Moore (2012) states, all service members are not the same, and the lives they lead vary greatly based on rank, hierarchy, and their assignments. Through the process to understand why and how service members think, practitioners can begin to address the problems service members face with a different perspective. It will also be helpful for the practitioner to evaluate his or her own feelings towards the military and associated topics, making sure he or she is not offering biased information or failing to understand the service member due to preconceived judgments (Freeman, Moore & Freeman, 2009).

When assessing service members through the scope of CPM and face theory, it is important for mental health providers to remember that the information service members possess could be seen to them as valuable objects or possessions. The service member may also be utilizing the components of stoicism and image control as a type of protection, making disclosure during sessions difficult. Noting this, it is important to remember that the information to be disclosed by the service member has a value he or she has placed on its ownership. As a result, there may be some reluctance for service members to share information initially, as those who have the privilege of receiving this information need to be qualified according to service member's standards. It may be best for practitioners to spend time building a good rapport with service members through situations and examples that lead back to military culture and allow the service member to open up and disclose at will, irrespective of the level (individual, couple, or family) of counseling.

For the Romantic Partner

Just as a practitioner should have a good understanding of military culture, he/she should also understand that the majority of romantic partners involved in military relationships are civilians. Gambardella (2008) reported that 90% of military spouses are women and civilians. It is important to know that these individuals have not had the training their service members have had on adjustment and are more likely the individuals who will be changing employment, schools, and seeking new friendships. Though the military has implemented support services where spouses can join support groups, receive information about deployments, as well as meet new friends (Cline, 2003; Hall, 2008), the need to discuss issues with a practitioner may still arise.

Some of the reasons resulting in this need may include the lack of social support that spouses encounter when relocating (Blaisure, Saathoff-Wells, Pereira, Wadsworth, & Dombro, 2012). The stress of making sure their children adjust properly to schools and are in the best of care are just some of the additional stressors some military partners will encounter (Hall, 2011). Practitioners may find that military spouses use the opposite approach when utilizing CPM and face theory than their spouses as they may disclose more information about themselves in hopes of attaining a more normalized state of living. Spouses may also find practitioners to be qualified individuals to share information with (as clinicians are often considered trustworthy in civilian sectors) and may not feel the need to uphold an image as the military service member. Collectively, these issues are important as the practitioner should understand the attitudes of both the service member and his or her partner and how they vary from one another.

For Couples

When addressing couple's therapy using CPM and face theory, the practitioner should be mindful of the team concept spoken of by Goffman (1990). Though the service member and partner may conduct themselves differently in individual sessions, it is important to note that they may come into therapy on a united front. They may have previously discussed with one another what can and cannot be disclosed. There may also be situations when one spouse feels the need to protect the other by utilizing face-saving strategies. It may also be possible, based on the topic of discussion, that couples may be more open and willing to disclose about some things (e.g., children, employment, in-laws) than others (e.g., PTSD, deployment, infidelity). Additionally, there is always the possibility that situations are viewed differently by the service member and partner, leading to disagreements as to what and how situations should be discussed, which can be further complicated during times of transition and uncertainty in the relationship (Cox & Albright, 2014). Practitioners should investigate and assess the couple's worldview and incorporate exercises that the couple can relate to utilizing the service member's experience and the spouse's relation to situations that happen in the civilian sector.

Conclusion

Research supports that military couples differ from their civilian counterparts. There are also differences in how military couples manage disclosure in their romantic relationships. By understanding this, researchers and practitioners have an opportunity to assess these relationships through a different scope, possibly creating a better understanding for those who will follow in research and practice. The War on Terror has created multiple challenges for loved ones and service members who are returning from deployment overseas. As service members grapple with their experiences and their partners seek to have their lives back, assistance from researchers and practitioners will prove imperative to finding answers and utilizing techniques to help create a sense of normalcy for those affected.

For practitioners, when assessing military couples through the lens of CPM and face theory, be mindful that both the service member and his or her partner may value the information they possess, creating rules about who should have access to it. This may create disclosure boundaries between the service member and his or her partner, as well as the couple in therapy. Additionally, as Goffman (1990) would suggest, sometimes couples can create teams where they work together to maintain an image. This can be the image of the service member, partner, or relationship. As practitioners meet with service members, their romantic partners and military couples in therapy, it is important to assess these ideals, being aware that some service members, partners, and military couples may be concerned with the damage that disclosure may do to their image.

Since stoicism, secrecy, and denial are all considered norms of military culture, practitioners should be aware those involved in therapy may not want to disclose for fear of being seen as the opposite of what the military promotes. This information can be useful in creating exercises or techniques to help military couples manage their concerns of damaging their image, along with building rapport with individuals in hopes that they will decide to be open and disclose.

Future directions for research in this area may include studies that address the norms of military culture and how practitioners can create interventions to help service members balance these characteristics while on base and in the home. There is also substantial room for this area of research to grow as not much is known about the daily lives of those in romantic relationships in the military. By understanding how the service member and his or her partner function day to day may provide great insight for practitioners to understand how romantic relationships in the military are managed, and thus create a platform for future works by assessing problematic issues and remedying them when things go wrong.

References

Altman, I., & Taylor, D. (1973). *Social Penetration: The Development of Interpersonal Relationships.* New York, NY: Holt, Rinehart, & Winston.

Baxter, L. A. (2004). Relationships as dialogues. *Personal Relationships, 11,* 1-22. doi:10.1111=j.1475-6811.2004.00068.x

Blaisure, K. R., Saathoff-Wells, T., Pereira, A., Wadsworth, S. M., & Dombro, A. L. (2012). *Serving Military Families in the 21st Century.* New York: Routledge.

Bodenmann, G., Charvoz, L., Bradbury, T. N., Bertoni, A., Lafrate, R., Giuliani, C., … Behling, J. (2007). The role of stress in divorce: A three-nation retrospective study. *Journal of Social & Personal Relationships, 24,* 707-728. doi: 10.1177/0265407507081456

Caughlin, P. J., Petronio, S., Middleton, V., & Ashley. (2013). When families manage private information. In Anita L. Vangelisti (Ed.), *The Routledge Handbook of Family Communication* (pp. 321-337). New York, NY: Routledge,.

Caughlin, J. P., & Afifi, T. D. (2004). When is topic avoidance unsatisfying? Examining moderators of the association between avoidance and satisfaction. *Human Communication Research, 30,* 479-513. doi:10.1111/j.1468-2958.2004.tb00742.x

Cline, L. S. (2003). *Today's Military Wife: Meeting the Challenges of Service life* (5th ed.). Mechanicsburg, PA: Stackpole Books.

Cox, J., & Albright, D. L. (2014). The road to recovery: Addressing the challenges and resilience of military couples in the scope of veterans' mental health. *Social Work in Mental Health, 12*, 560-574.

Coyne, J. C., & Smith, D. A. F. (1994). Couples coping with a myocardial infarction: Contextual perspective on patient self-efficacy. *Journal of Family Psychology, 8*, 43-54. doi:10.1037/0893-3200.8.1.43

Defense Manpower Data Center (2009). *Selected Manpower Statistics.* Arlington, VA: Department of Defense.

Dindia, K., & Allen, M. (1992). Sex differences in self-disclosure: A meta-analysis. *Psychological Bulletin, 112,* 106-124. doi:10.1037/0033-2909.112.1.106

Dunleavy, K., Banfield, S., Booth-Butterfield, M., Goodboy, A., & Sidelinger, R. J. (2009). Repairing hurtful messages in marital relationships. *Communication Quarterly, 57,* 67-84. doi:10.1080/01463370802664701

Finkenauer, C., & Hazam, H. (2000). Disclosure and secrecy in marriage: Do both contribute to marital satisfaction*? Journal of Social and Personal Relationships, 17,* 245-263. doi:10.1177/0265407500172005

Fivush, R., Bohanek, J., Robertson, R., & Duke, M. (2004). Family narratives and the development of children's emotional well-being. In M. Pratt & B. Fiese (Eds.), *Family Stories and the Life Course: Across Time and Generations* (pp. 55-76). Mahwah, NJ: Erlbaum.

Freeman, M. S., Moore, B., Freeman, A. (2009). *Living and Surviving in Harm's Way.* New York, NY: Routledge.

Frisby, B. N., Byrnes, K., Mansson, D. H., Booth-Butterfield, M., & Birmingham, M. (2011). Topic avoidance, everyday talk, and stress in romantic military and non-military couples. *Communication Studies, 62,* 241-257. doi:10.1080/10510974.2011.553982

Gambardella, C. L. (2008). Role-exit theory and marital discord follow extended military deployment. *Perspectives in Psychiatric Care, 44*(3), 169-174. doi:10.1111/j.1744-6163.2008.00171.x

Goffman, E. (1990). *The Presentation of Self in Everyday Life.* New York, NY: Doubleday.

Hall, L. K. (2011). The importance of understanding military culture. *Social Work in Health Care, 50*(1)*,* 4-18. doi:10.1080/00981389.2010.513914

Hoyt, T., Pasupathi, M., Smith, W. B., Yeater, A. E., Kay, S. V., & Tooley, E. (2010). Disclosure of emotional events in groups at risk for posttraumatic disorder. *International Journal of Stress Management*, *17*(1), 78-95. doi: 10.1037/a0017453

Joseph, A. L., & Afifi, T. D. (2010). Military wives' stressful disclosures to their deployed husbands: The role of protective buffering. *Journal of Applied Communication Research, 38*(4), 412-434. doi:10.1080/00909882.2010.513997

Merolla, A. J. (2010). Relational maintenance during military deployment: Perspectives of wives of deployed soldiers. *Journal of Applied Communication Research, 38*(1), 4-26. doi:10.1080/00909880903483557

Moore, B. A. (2012). *Counseling Military Couples.* New York, NY: Routledge.

Moore, B.A., & Kennedy, C. H. (2011). *Wheels Down: Adjusting to Life After Deployment.* Washington, DC: APA Lifetools.

Petronio, S. (2004). Road to developing communication privacy management theory: Narrative in progress; please stand by. *The Journal of Family Communication, 4*(3&4), 193-207. doi:10.1207/s15327698jfc0403&4_6

Petronio, S. (2002). *Boundaries of Privacy: Dialectics of Disclosure.* Albany, NY: State University of New York Press.

Petronio, S., Reeder, H. M., Hecht, H. M., & Ros-Mendoza, T. (1996). Disclosure of sexual abuse by children and adolescents. *Journal of Applied Communication Research, 24,* 181-199. doi**:**10.1080/00909889609365450

Roloff, M. E., & Wright, C. N. (2009). Relational commitment and the silent treatment. *Communication Research Reports, 26,* 12-21. doi:10.1080/08824090802636967

Smyth, J. M., & Pennebaker, J. W. (2001). What are the health effects of disclosure? In A. Baum, T. A. Revenson, & J. E. Singer (Eds.), *Handbook of Health Psychology* (pp. 339-348). Mahwah, NJ: Lawrence Erlbaum Associates.

Stanley, S. M., Allen, E. S., Markman, H. J., Saiz, C. C., Bloomstrom, G., Thomas, R., … Bailey, A. E. (2005). Dissemination and evaluation of marriage education in the Army. *Family Processes, 44,* 187-201. doi:10.1111=j.1545-5300.2005.00053.x

Stiles, W. B. (1987). "I have to talk to somebody:" A fever model of disclosure. In V. J. Derelega & J. H. Berg (Eds.), *Self-disclosure: Theory, Research, and Therapy* (pp. 257-282). New York, NY: Plenum Press.

Straits-Troster, K. A., Branchu, M., Goodale, B., Pacelli, S., Wilmer. C., Simmons, E. M., & Kudler, E. (2011). Developing community capacity to treat post-deployment mental health problems: A public health initiative. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(3), 283-291. doi:10.1037/a0024645

Suls, J., Green, P., Rose, G., Loundsbury, P., & Gordon, E. (1997). Hiding worries from one's spouse: Associations between coping via protective buffering and distress in male post-myocardial infarction patients and their wives. *Journal of Behavioral Medicine*, *20*, 333-349. doi:10.1023/A:1025513029605

U.S. Department of Defense, Statistical Information Analysis Division (2010). Armed Forces Strength Figures for November 30, 2010. Retrieved from http://siadapp.dmdc.osd.mil

Yoder, J. A., & Nichols, R. C. (1980). A life perspective comparison of married and divorced person. *Journal of Marriage and Family*, *42*(2), 413-419. doi:10.2307/351238

Adversities of Parental Deployment: Meeting the Needs of LGBTQ+ Youth

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Abstract

The body of literature surrounding the distinctive impacts of parental deployment on youth is growing. However, little attention has been given to the unique identities children begin to develop, namely one's sexual orientation. At present, no literature examines the unique impact that deployment may have on LGBTQ+ identified youth. Present interventions to address the problems faced by youth dealing with parental deployment are inadequate to meet the unique needs of this population. This article then examines the areas of familial relationships, psychological well-being, and socialization of LGBTQ+ identified youth. Incorporating community training, mentorship programs, and differentiated theoretical approaches in clinical settings may address many of the unique needs faced by this population.

Keywords: LGBTQ+, youth, deployment

Introduction

Numerous studies purport children of deployed soldiers experience difficulties stemming from parental deployment (Chandra et al., 2009; Chartrand, Frank, White, & Shope, 2008). Current literature supports the notion that differentiated experiences exist based on various aspects of a child's identity, such as gender, age, and socioeconomic status (RAND Corporation, 2011; Pagano, 2014).

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Impact of Parental Deployment on Youth

Prior to the initiation of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), little research pertaining to the impact of deployment on soldiers and their families could be found (Chandra et al., 2009; Flake et al., 2009). However, the body of literature regarding this population is growing. Present research supports the notion that children of deployed soldiers face difficulties in the areas of familial change (Chandra et al., 2009), psychological well-being (RAND Corporation, 2008), and social interactions (Chandra et al., 2010).

One of the central impacts on a child during a parent's deployment is the relational shift that takes place with family members (Chandra et al., 2009; Flake et al., 2009; Huebner et al., 2007). While military families already face a number of unique stressors not encountered by families comprised entirely of civilians, deployment adds additional stress and potential negative impacts on children (Drummet, Coleman, & Cable, 2003). Such changes go beyond simply missing the deployed parent, to include financial stressors as well as changes in roles and responsibilities due to deployment (Richardson et al., 2011).

One study addressed the difficulties relating to one's family, including adjusting to new roles and expectations. "Boundary ambiguity" may define this adjustment in roles, responsibilities, and family mores (Huebner et al., 2007). What Huebner et al. defines as "boundary ambiguity" provides support for the notion that dissonance develops regarding family relationships and roles. This may be due to the need for children and adolescents to assume a dual role such as sibling and caregiver.

Flake et al. (2009), Richardson et al. (2011), and Lester et al. (2010) found a significant predictor of adjustment during deployment was the well-being of the at-home caregiver. These studies purport that the at-home caregiver experiences increased stress and anxiety and such shifts negatively influence their relationships with their children and service member. School officials report that students tended to reflect the increased stress and anxiety of the at-home caregiver (Richardson, 2011). One study found conflicts with family members and emotional ties with them shifted during deployment. As a result, instances of "lashing out" became commonplace (Huebner et al., 2007). Current literature posits that support within the family is crucial to a child's overall well-being during deployment (Lester et al., 2010).

A possible area of impact for children of deployed soldiers is psychological well-being (Chartrand et al., 2009; Flake et al., 2009; RAND Corporation 2008). The construct of psychological well-being incorporates numerous facets and affects a variety of conditions and settings (Reed et al., 2011; Richardson et al., 2011). Aspects of psychological well-being include anxiety, depressive symptoms, emotional health, and the need to seek out mental health services (Chandra et al., 2009; Gorman et al., 2011; Reed et al., 2011). Such aspects of psychological well-being suggest interrelated impacts on family relationships, academic performance, and externalized behavior.

Changes in anxiety, depression, and emotional stability are psychological effects of

deployment facing this population (Chandra et al., 2009; Gorman et al., 2011; RAND Corporation 2011). Studies indicate that approximately one-third of children of deployed soldiers experience significant problems with anxiety, which is nearly twice the rate of children with civilian caregivers (Lester et al., 2010; RAND Corporation, 2011). Chartrand et al. (2008) found children older than three experience clinically significant scores on the Child Behavioral Checklist (CBCL) or the CBCL-Teacher Report form (CBCL-TRF).

Compared to children with civilian parents, Gorman et al. (2011) found an additional 26.7 hospital visits per 1,000 persons per year for children of deployed parents. This study noted pediatric behavioral and stress disorders rose approximately 18% during deployment. This is striking when compared with an 11% decrease in all forms of health care visits for this population when a parent was not deployed (Gorman et al, 2011). Such results serve as indicators of the physical symptoms that may manifest when confronting children with increased depression, anxiety, and stress due to parental deployment.

An increased presence of suicidal ideation is pertinent to the mental health community and a key issue faced by this population (Reed et al., 2011). Among sample sizes of students including 9,565 assessing quality of life, 9,964 assessing suicidal ideation, and 9,986 assessing depression, parental deployment lead to a significant increase of suicidal thoughts for males and females in the 8th grade and continued for males into the 12th grade (Reed et al., 2011). Increases in suicidal ideation may stem from the fact that children of deployed soldiers are significantly less likely to feel connected to their school due to isolation attributing to lack of knowledge regarding deployment within the community and general school difficulties, in addition to stress related to an increase in daily household responsibilities (RAND Corporation, 2011).

Current Interventions

There are numerous interventions utilized to address experiences faced by children of deployed soldiers. Interventions include play therapy, resilience training, and clinical approaches. The interventions discussed vary in modalities when addressing the unique problems commonly encountered by members of this population.

Family-based Interventions

Play therapy and military influenced programs are family-based interventions used with military youth. Filial therapy is a specific type of play therapy for military youth. Chawla and Solinas-Saunders (2011) state filial therapy is useful for military families experiencing various changes in the home. These changes include new roles for family members, such as one caregiver assuming dual roles, dealing with stressful situations, and coping with various types of separation in the home between parent and parent or parent and child (Chawla & Solinas-Saunders, 2011). Filial therapy teaches caregivers skills to help children cope with deployment and creates a stronger interpersonal relationship with the at-home caregiver. Caregivers learn to listen empathically, utilize imaginary play, create more structure in the home, and set limits with children. These skills foster routine and stability for caregivers and children, while considering the feelings of caregivers and children during play. These skills allow more self-expression, facilitate adjustment, and introduce a manner of interacting other than verbal communication

(Chawla & Solinas-Saunders, 2011). The authors deduced these findings from multiple studies based on research samples ranging from one case study to 36 participants, which indicate there were increases on behalf of the caregiver in empathy, positive relationships between caregiver and child, acceptance, and understanding play behaviors with a decrease in unproductive or delinquent behaviors on behalf of the child (Solis et al., 2004; Jang, 2000; Yuen et al., 2002; Chau et al., 1997; Lee et al., 2003).

An additional family based approach is Families Over Coming Under Stress (FOCUS), a resilience training to help children of military families adjust psychologically. The impact of the program on children's adjustment and using a path model to comprehend the interpersonal relationships between the family members are the main goals of the FOCUS program. The author assessed FOCUS using a sample including families containing at least one child and parent in the military, which resulted in 280 families and 505 children. After conducting a confirmatory factor analysis assessing family areas of strengths and challenges before using the program, upon completing the program, one month and six months after completing the program, the results indicate all factors with statistical significance of p is less than or equal to .001 (Lester et al., 2013). The program will elicit positive levels of adjustment in children, which could increase the level of functioning for the family, and ultimately diminish the amount of stress for the children. Parents and children learn cognitive behavioral skills and receive family education skills to help increase family functioning and child adjustment. The skills learned by parents include setting goals, problem-solving, regulating emotions, stress management, loss, and handling separation. The family education skills taught involve recognizing stress induced reactions and how these reactions affect the family system. Other skills include understanding communication styles within the family, taking advantage of strengths, and learning about common reactions to stress and child development (Lester et al., 2013). In addition to receiving interventions at home, military youth could benefit from school-based interventions.

School Based Interventions

School-based interventions help military youth cope with deployment. Interventions include group and individual counseling. Group counseling can provide military youth with an outlet to normalize experiences and share various methods of coping. The purpose of these groups is to help students understand the process of deployment, create a safe place to discuss experiences, and learn coping skills. The focus of the group is the emotional experience of deployment, defined as the pattern of how a family experiencing deployment responds emotionally (Rush & Akos, 2007). In order to provide students with services, it is necessary for counselors, educators, and leaders to understand how deployment influences students. Catholic Charities, a faith-based nonprofit, provides counseling support groups in private Catholic schools for military youth to assist with academic performance and negative psychosocial symptoms (Carpenter-Aeby, Aeby, & Raynor, 2012).

Individual Clinical Interventions

Esposito-Smythers, Lemmon, Wolff, Bodzy, Swenson, and Spirito (2011) suggest using an evidence-based approach to help decrease stress for children and families during deployment.

Clinical interventions focus on several different approaches to helping military youth. These interventions include theoretical perspectives and set curricula.

These interventions include cognitive-behavioral therapy (CBT). One program is the Penn Resiliency Program (PRP), which uses positive psychology along with CBT to prevent depression, reduce feelings of hopelessness and anxiety, and address different behavioral issues. Another approach is modular CBT, which uses psychoeducation and teaches self-monitoring and behavioral techniques, among other strategies. Psychoeducation helps teach coping skills to children and families. Self-monitoring helps teach children and families to understand and keep track of emotional, cognitive, and behavioral responses. Behavioral techniques such as, cognitive rational analysis, help children and families understand the deployment process and change any dysfunctional thinking (Friedberg & Brelsford, 2011).

Inadequacies of Current Interventions

Current approaches utilized to assist children of deployed soldiers are valuable in mitigating negative experiences. However, none of the current interventions differentiate among the population served, based on their sexual orientation. Rather, current approaches treat children of deployed soldiers as a homogenous population. Such undifferentiated approaches are concerning given that present literature strongly posits different internal and external manifestations of distress resulting from parental deployment based on a host of factors including age, gender of the child, and gender of the deployed parent (Chandra et al., 2009; Pagano, 2014; Reed et al., 2011). Given that research indicates numerous differences in development for LGBTQ+ youth when compared to heterosexual peers (Garofalo & Katz, 2001; Meyer, 2003), it is important to develop interventions suited to meet the unique needs of this population.

The Unique Experiences of LGBTQ+ Youth

On Familial Relationships

Family stands as a powerful influence on the trajectory of LGBTQ+ youth's identity formation, relationships, and engagement in risky behaviors. Throughout the coming out process, the fear of familial rejection or victimization, isolation from the family, and denial of financial support may lead LGBTQ+ youth to hide their sexual orientation (Higa et al., 2014). Such fear may lead LGBTQ+ youth to believe their home is not a safe place to talk openly about their sexual orientation. Following their coming out, some LGBTQ+ youth experience family members pushing them to be straight or view their sexual orientation as a phase (Higa et al., 2014). Those who experience a supportive family have a smoother coming out process. If LGBTQ+ youth do not perceive support at home, they are likely to feel isolated (Mishna et al., 2009).

In addition to discomfort amongst family members, familial troubles can lead to LGBTQ+ youth becoming homeless. LGBTQ+ youth often run away to escape families who disapprove of their sexual orientation. LGBTQ+ youth may become homeless due to families forcing them out of the home (Durso & Gates, 2012). Family victimization, which leads to

homelessness, has long-term mental, emotional, and safety ramifications such as feelings of neglect, financial trouble, criminal behavior, and abandonment of education goals (Garofalo & Katz, 2001).

LGBTQ+ youth experiencing negative reactions from their families report added side effects. Williams and Chapman (2011) found fear of parental knowledge to be a primary barrier in obtaining needed medical attention. In their national sample, 25.1% of LGBTQ+ youth compared to 17.9% of heterosexual peers reported not seeking warranted medical care. Additionally, familial acceptance is an important factor for the mental health of LGBTQ+ youth (Ryan & Gruskin, 2006).

Family support, identity formation, and social issues can be instrumental in the development of appropriate behaviors for this population. Walls, Laser, Nickels, and Wisneski (2010) noted talking with families was a helpful coping technique for 12.8% of LGBTQ+ youth who engaged in cutting behaviors. In a meta-analysis gathered by Goldbach, Tanner-Smith, Bagwell, and Dunlap (2013), the data supported the claim that LGBTQ+ youth who reported higher levels of substance abuse also perceived less familial support from their peers, demonstrating the important role family plays. Overall, much research suggests that familial support and acceptance are important factors as LGBTQ+ youth navigate their identity exploration (Higa et al., 2014).

On Psychological Well-Being

For LGBTQ+ youth, the effects of high school victimization often coincide with mental health issues such as internalized homophobia, substance abuse, suicide attempts, low self-esteem, anxiety, depression and posttraumatic stress symptoms (D'Augelli et al., 2002; Mishna et al., 2009). Issues such as internalized homophobia may stem from bullying and negative comments that LGBTQ+ youth receive, while issues such as suicide, anxiety, or depression are due to the isolation of LGBTQ+ youth (Mishna et al., 2009). Research shows LGBTQ+ youth are less likely than their heterosexual peers to seek mental health services (Williams & Chapman, 2011). Additionally, societal messages outside of the school environment could lead to the internalization of negative thoughts and higher levels of stress due to stigma, marginalization, and oppression (Williams & Chapman, 2011).

Research shows that feeling the need to hide ones sexual identity is associated with depression, anxiety, and stress, and that depression or thoughts of suicide is linked to the development of internalized homophobia (D'Augelli et al., 2002; Meyer, 2003; Savin-Williams, 1994). Research also shows disclosing sexual orientation improved self-esteem, academic performance, and fostered resilience (Kosciw, Palmer, & Kull, 2014). Repetitive negative comments directed at LGBTQ+ youth and threats of violence have the greatest impact on mental health for this population, as victimization is the key factor that suppresses the positive effects of coming out on future adjustment (Russell et al., 2014).

LGBTQ+ youth are at an increased risk for suicide compared to their heterosexual peers. Research examining suicide rates of youth over 12 months found compared to 11% of non-LGBTQ+ youth, 9% of gay youth, 13% of bisexual male youth, 38% of lesbian youth, and 30%

of bisexual female youth have attempted suicide (Saewyc et al., 2007). Suicide is the leading cause of death among LGBTQ+ youth, and many LGBTQ+ youth who attempt suicide will do so without discussing their sexuality (Garofalo & Katz, 2001; Lewinsohn et al., 1996; Remafedi et al., 1991). More concerning is studies indicate an increase in the reporting of suicide attempts among LGBTQ+ youth, which seems to imply an increase in the suffering of LGBTQ+ youth (Remafedi et al., 1998). Suffering, such as bullying, can have a lasting effect on the suicide risk and mental health of LGBTQ+ youth, and the relationship between bullying and suicide is greater for LGBTQ+ youth compared to non-LBG youth (Kim & Leventhal, 2008).

On Socialization

No singular social group victimizes LGBTQ+ youth. Additionally, for LGBTQ+ youth there is no social setting that is risk free (Mishna et al., 2009; Pilkington & D'Augelli, 1995). Each setting poses different risks (Pilkington & D'Augelli, 1995), even settings that are presumably safe (Mishna et al., 2009). School is a social setting plagued with significant risk and victimization of LGBTQ+ youth (D'Augello et al., 2002). Examples of victimization in school include bullying, feeling alienated or silenced, feeling isolated, feeling afraid, risk of internalized homophobia, abandonment of school or educational goals, and having difficulty finding a supportive adult (D'Augelli et al., 2002; Higa, 2014; Mishna et al., 2009; Walls, 2010). Research shows that LGBTQ+ youth who feel the presence of supportive role models, like teachers, coaches, counselors, or LGBTQ+ adults, have positive outcomes and reduced negative experiences (Seil, Desai, & Smith, 2014).

Victimization of LGBTQ+ youth in school settings can be verbal or physical attacks, blatant or subtle, brief or long lasting, and often influence the mental health of LBG youth (D'Augelli et al., 2002). The severity of bullying in school differs from person to person (Mishna et al., 2009). Research by D'Augello et al. has found that incidents of victimization at school were greater the earlier an LGBTQ+ youth came to terms with their sexual orientation, self-identified, and came out to others. Meaning, openness about one's sexual orientation in high school correlates to victimization. Though coming out in adolescents is linked to peer victimization, Russell et al. (2014) found the earlier the coming out process, the higher correlation with positive social and emotional well-being over time. Disclosure is important in helping LGBTQ+ youth gain support, while also being a risk factor (Kosciw, Palmer, & Kull, 2014; Newman, 2002).

Pilkington and D'Augelli (1995) found that 43% of males and 54% of females lost the friendship of at least one peer as a result of coming out, and nearly 30% of males and 35% of females were harassed or verbally abused in school, limiting their openness regarding their sexual identity. Male youth tend to be victimized more frequently than female youth; females tend to report abuse more (D'Augelli et al., 2002). In addition to direct victimization, over a third of LGBTQ+ youth knew other LGBTQ+ youth who had been verbally harassed or assaulted, serving to increase fear and inhibit LGBTQ+ youth from expressing themselves (D'Augelli et al., 2002). D'Augelli et al. also suggested that in order to evade victimization, LGBTQ+ youth resort to school avoidance or dropping out to protect themselves. Twenty-five percent of LGBTQ+ youth, compared to only 5% of heterosexual youth have missed school due to fear (Garofalo et al., 1998).

While it may be the case that identifying LGBTQ+ is not equally stigmatized in all social contexts, 42% of LGBTQ+ youth report not feeling comfortable disclosing their sexual orientation to people in the community (Pilkington & D'Augelli, 1995), are victimized by the media, bullied in many religious institutions, and lack a safe space or people to turn to for support (Mishna et al., 2009). Having a safe adult with whom LGBTQ+ youth can openly and safely discuss their sexual orientation was significantly associated with a decrease in cutting behaviors (Walls et al., 2010). Victimization of LGBTQ+ youth is often unreported (Mishna et al., 2009; Pilkington & D'Augello, 1995), due to fear, feelings of helplessness, punishment for defending themselves, and knowledge that teachers are less likely to intervene on their behalf (Snapp et al., 2015).

New Interventions Addressing LGBTQ+ Youth in Military Settings

LGBTQ+ youth face numerous problems compared to their heterosexual peers. Subsequently, there is a need for concrete ways to ensure their psychological, mental, and emotional well-being. Research indicates that LGBTQ+ youth have difficulty establishing a positive identity, as they have a hard time identifying supportive role models (Dempsey, 1994) in their lives, and lack safe people to turn to in times of need (D'Augelli et al., 2002; Higa, 2014; Mishna et al., 2009; Walls, 2010). Research also suggested LGBTQ+ youth who have supportive role models, such as successful LGBTQ+ adults, experience reduce negative incidents and have more positive outcomes (Seil, Desai, & Smith, 2014).

Safe Zone Training

The Safe Zone program has two primary components, ally training and the Safe Zone icon. Ally training consists of education about LGBTQ+ issues, skills to become an advocate, and how to create a supportive environment (Bolger & Killermann, 2015). While the specific origins of this program are unclear and different variations are evident, educational settings nationwide implement the overarching philosophy of Safe Zone. The Safe Zone icon is a token received upon completion of the training. The icon is placed in offices to convey acceptance of the LGBTQ+ community. The presence of the Safe Zone icon is also used to identify safe places to discuss LGBTQ+ issues (Finkel et. al., 2003). Research evaluating the effectiveness of the Safe Zone program is limited; however, one study examined the effects of providing Safe Zone training to 66 psychology graduate students and two administrative staff members.

The Safe Zone training results indicated there was positive attitude change for 40% of participants regarding their ability to be affirmative of LGBTQ+ issues. It is noted the scale used with participants may not have appropriately captured all changes, in addition to, a possible ceiling effect in the study, which could lead to a smaller percentage change. Nevertheless, prior to the Safe Zone training, more participants indicated a positive attitude when affirming LGBTQ+ issues, than participants who did not. Based on these results, Safe Zone helped create an affirming and open environment for LGBTQ+ individuals, provided education about LGBTQ+ issues, and informed participants about the struggles surrounding sexual identity (Finkel et. al., 2003). In one case study, a university viewed evidence of property damage, physical abuse, and harassment of LGBTQ+ students. In response, the university saw positive

results after implementing the Safe Zone program to eliminate the discriminatory atmosphere and commit to creating a healthy and open-minded environment (Alveraz & Schneider, 2008).

When considering the military environment and issues faced by LGBTQ+ military youth, a program such as Safe Zone could bridge the gap between military culture and the LGBTQ+ community. Training military personal to provide a safe environment for LGBTQ+ military youth could help them discuss familial issues, prevent psychological trauma, and cope with social hardships. Training military personnel in Safe Zone protocol would equip them with the skills needed to interact with and understand the presenting concerns of LGBTQ+ youth. Overall, the Safe Zone training program has the potential to create a healthier environment for LGBTQ+ military youth.

Mentoring Programs

Mentoring is a relationship between two or more people where an older, more experienced individual provides help, support and guidance to a younger individual. Mentoring programs work in two ways, they screen and match older mentors with at risk youths and the pair meet regularly to engage in a wide variety of activities designed to support and benefit the youth. The goal of mentoring programs is to help at risk youth succeed in school, form better relationships, abstain from risky behaviors, and build self-esteem (Rhodes & DuBois, 2006).

A 2014 survey reported that youth, who identify as LGBTQ+, are more likely than non-LGBTQ+ youth to be at risk, and are in greater need of the benefits a mentoring program can provide (Mallory, Sears, Hasenbush, & Susman, 2014). Since many LGBTQ+ youth receive messages from family and friends that they are 'sick' or 'bad' for being who they are (Garofalo & Katz, 2001), being paired with a successful and supportive LGBTQ+ adult can debunk this belief. Mentoring programs could give LGBTQ+ youth the opportunity to meet others like themselves, help them build a community in which they may explore social roles, and provide a safe and supportive environment (Garofalo & Katz, 2001).

Research documenting the effectiveness of mentoring programs finds that mentoring programs are beneficial in reducing risky behaviors in at risk youth (Mallory et al., 2014). A meta-analysis of over 73 mentoring programs found that mentoring has positive effects on youth's social, behavioral, emotional, and academic development (Bruce & Bridgeland, 2014). Another study posits positive effects between mentoring programs and the psychological well-being of at risk youth (DuBois, Holloway, Valentine, & Cooper, 2002). Herrera, DuBois, and Grossman (2013) found that youth in mentoring programs show reduced depression symptoms, achieve greater peer acceptance, and have a more positive belief about their ability to succeed in school than youth not in mentoring programs.

When considering the issues faced by LGBTQ+ military youth, mentoring programs could help reduce psychological disturbance such as depression and anxiety, as well as provide them with the support needed to help handle social hurdles. Overall, mentoring programs can be effective helping at risk youth. As it would be essential for mentors to identify as LGBTQ+, mentoring programs for LGBTQ+ military youth have the potential to help create a healthy

environment by providing LGBTQ+ youth with individuals who understand. These mentors can help LGBTQ+ youth navigate the trials and tribulations of their lives.

A Relational-Cultural Perspective

The military maintains a culture different from that of mainstream America. One hallmark of such a culture is the value placed on the overtly masculine ideal (e.g., physical strength, restricted affect, and violence), traditional values, and the funneling of varied emotions into a singular acceptable emotion; anger (Brown, 2012). It is widely understood that not fitting into traditional gender roles and mores is an aspect of identifying as LGBTQ+ (Kilmartin, 2009; Whilchins, 2014). Distress for LGBTQ+ youth is a common aspect of growing up in a culture that places value on heteronormative ideals (Wilchins, 2014). Given such a stark contrast between LGBTQ+ identity and military culture, it is imperative for clinicians to appropriately address such a difference.

Relational-cultural theory (RCT) emphasizes how cultural paradigms play an integral role in human development, and cultural differences with others may inhibit mature identity development. Additionally, those who are isolated experience dissatisfaction with life (Jordan, 2000). Given how literature strongly posits that LGBTQ+ youth are likely to feel alienated, RCT stands as a critical intervention to utilize with this population. Through RCT, this population may be able to be authentic or, "represent her/himself in relationships more fully" (Miller et al., 2004, p. 72). Through representing themselves more fully in a cultural context that devalues nonconformity, LGBTQ+ youth may be able to foster healthier relationships with others within the military community.

Future Research

Providing appropriate services for LGBTQ+ identified youth during parental deployment is critical. In order to accomplish this goal, further research is warranted. It is recommended that the impact of military culture on LGBTQ+ identified youth be further examined. Suggested areas for research include the age a child "comes out," the gender of the child, the length of deployment, and how long the child's parent have been in the military. Additionally, more information regarding the impact of the child's at-home caregiver along a child's status as LGBTQ+ is necessary as a child's relationship with the at-home caregiver is continually found to be the predictor of well-being during parental deployment (Lester et al., 2010; Richardson et al., 20111). Through addressing these and other aspects of this population's experience during deployment, researchers may improve the services offered to LGBTQ+ youth during deployment.

<div align="center">

Conclusion

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The deployment of a parent takes a serious toll on children. Providing appropriate care for all children is a crucial aspect of ensuring healthy development and mitigating the various problems stemming from parental deployment. It is critical that researchers and clinicians not treat children of deployed military members as a singular entity, but based on the unique characteristics that define these children. The problems faced by LGBTQ+ identified youth in

America are widely known and necessitates attention when examining the areas of familial relationships, psychological well-being, and socialization. In order to care effectively for this population, it is imperative to use differentiated clinical and non-clinical approaches.

References

Alvarez, S. D., & Schneider, J. (2008). One college campus's need for a safe zone: a case study. *Journal of Gender Studies*, *17*, 71-74. doi:10.1080/09589230701838461

Bolger, M. & Killerman, S. (2015). *The safe zone project*. Retrieved September 21, 2015, from http://thesafezoneproject.com/

Brown, M.T. (2012). *Enlisting masculinity: The construction of gender in U.S. military recruiting advertising during the all-volunteer force*. New York, NY: Oxford.

Bruce, M., & Bridgeland, J. (2014). *The mentoring effect: Young people's perspectives on the outcomes and availability of mentoring.* Civic Enterprises with Hart Research Associates for MENTOR: The National Mentoring Partnership, Washington, DC.

Carpenter-Aeby, T., Aeby, V. G., & Raynor, M. (2012). The catholic school community as a protective factor for students whose military parents have been deployed. *Journal of Instructional Psychology, 39,* 201-213.

Chandra, A., Lara-Cinisomo, S., Jaycox, L., Tanielian, T., Burns, R., Ruder, T., & Han, B. (2009). Children on the homefront: The experience of children from military families. *PEDIATRICS*, *125*, 16-25. doi:10.1542/peds.2009-1180

Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Han, B. (2010). Children on the Homefront: The Experience of Children From Military Families. *Pediatrics*, 125, 16-25. doi:10.1542/peds. 2009-1180

Chartrand, M., Frank, D., White, L., & Shope, T. (2008). Effect of parents' wartime deployment on the behavior of young children in military families. *Archives of Pediatrics & Adolescent Medicine*, *162*, 1009. doi:10.1001/archpedi.162.11.1009

Chau, I., & Landreth, G. (1997). Filial therapy with Chinese parents: Effects on parental empathic interactions, parental acceptance of child and parental stress. *International Journal of Play Therapy, 6,* 75-92. doi:10.1037/h0089409

Chawla, N., & Solinas-Saunders, M. (2011). Supporting military parent and child adjustment to deployments and separations with filial therapy. *The American Journal of Family Therapy, 39,* 179-192. doi:10.1080/01926187.2010.531647

Dempsey, C. L. (1994). Health and social issues of gay, lesbian, and bisexual adolescents. *Families in Society: The Journal of Contemporary Social Services, 75*, 160-168.

Drummet, A., Coleman, M., & Cable, S. (2003). Military families under stress: Implications for family life education. *Family Relations*, *52*, 279-287. doi:10.1111/j.174-3729.2003.00279.x

DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002). Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology, 30,* 157-197. doi:10.1023/A:1014628810714

Durso, L.E., & Gates, G.J. (2012). *Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless*. Los Angeles, CA: The Williams Institute with True Colors Fund and The Palette Fund.

Esposito-Smythers, C., Wolff, J., Lemmon, K. M., Bodzy, M., Swenson, R. R., & Spirito, A. (2011). Military youth and the deployment cycle: Emotional health consequences and recommendations for intervention. *Journal of Family Psychology, 25,* 497-507. doi:10.1037/a0024534

Flake, E., Davis, B., Johnson, P., & Middleton, L. (2009). The psychosocial effects of deployment on military children. *Journal Of Developmental & Behavioral Pediatrics*, *30*, 271-278. doi:10.1097/dbp.0b013e3181aac6e4

Finkel, M. J., Storaasli, R. D., Bandele, A., & Schaefer, V. (2003). Diversity training in graduate school: An exploratory evaluation of the safe zone project. *Professional Psychology: Research & Practice*, *34*, 555.

Friedberg, R. D., & Brelsford, G. M. (2011). Using cognitive behavioral interventions to help children cope with parental military deployments. *Journal of Contemporary Psychotherapy, 41,* 229-236. doi:10.1007/s10879-011-9175-3

Garofalo, R., & Katz, E. (2001). Health care issues of gay and lesbian youth. *Current Opinion in Pediatrics, 13,* 298-302.

Garofalo, R., Wolf, R. C., Kessel, S., Palfrey, J., & DuRant, R. H. (1998). The association between health risk behaviour and sexual orientation among a school-based sample of adolescents. *Pediatrics, 101,* 895-902.

Goldbach, J. T., Tanner-Smith, E. E., Bagwell, M., & Dunlap, S. (2013). Minority stress and substance use in sexual minority adolescents: A meta-analysis. *Prevention Science, 15,* 350-363. doi:10.1007/s11121-013-0393-7

Gorman, G., Eide, M., & Hisle-Gorman, E. (2011). Wartime military deployment and increased pediatric mental and behavioral health complaints. *Pediatrics*, *127*, peds.2009-2856d-peds.2009-2856d. doi:10.1542/peds.2009-2856d

Heatherington, L., & Lavner, J. A. (2008). Coming to terms with coming out: Review and recommendations for family systems-focused research. *Journal of Family Psychology, 22,* 329-343. doi:10.1037/0893-3200.22.3.329

Herrera, C., DuBois, D. L., & Grossman, J. B. (2013). *The Role of Risk: Mentoring Experiences and Outcomes for Youth with Varying Risk Profiles.* New York, NY: A Public/Private Ventures project distributed by MDRC.

Higa, D., Hoppe, M. J., Lindhorst, T., Mincer, S., Beadnell, B., Morrison, D. M.,…Mountz, S. (2014). Negative and positive factors associated with the well-being of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth. *Youth & Society, 46,* 663-687. doi: 10.1177/0044118X12449630

Huebner, A., Mancini, J., Wilcox, R., Grass, S., & Grass, G. (2007). Parental deployment and youth in military families: Exploring uncertainty and ambiguous loss. *Family Relations*, *56*, 112-122. doi:10.1111/j.1741-3729.2007.00445.x

Jang, M. (2000). Effectiveness of filial therapy for Korean parents. *International Journal of Play Therapy, 9,* 39-56. doi:10.1037/h0089435

Jordan, J., & Dooley, C. (2000). *Relational practice in action: A group manual.* Wellesley, MA: Wellesley Centers for Women Publications.

Keuroghlian, A. S., Shtasel, D., & Bassuk, E. L. (2014). Out on the street: A public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless. *American Journal of Orthopsychiatry, 84,* 66-72. doi:10.1037/h0098852

Kilmartin, C. T. (2010). *The masculine self* (*4th ed.).* Cornwall-on-Hudson, NY: Sloan.

Kim, Y., & Leventhal, B. (2008). Bullying and suicide: A review. *International Journal of Adolescent Medicine and Health*, *20*, 133–154.

Kosciw, J. G., Palmer, N. A., & Kull, R. M., (2014). Reflecting resiliency: Openness about sexual orientation and/or gender identity and its relationship to well-being and educational outcomes for LGBT students. *American Journal of Community Psychology, 55,* 167-178. doi:10.1007/s10464-014-9642-6

Lee, M., & Landreth, G. (2003). Filial therapy with immigrant Korean parents in the United States. *International Journal of Play Therapy, 12,* 67-85. doi:10.1037/h0088879

Lester, P., Peterson, K., Reeves, J., Knauss, L., Glover, D., Mogil, C., . . . Beardslee, W. (2010). The long war and parental combat deployment: Effects on military children and at-home spouses. *Journal of The American Academy Of Child & Adolescent Psychiatry*, *49*, 310-320. doi:10.1016/j.jaac.2010.01.003

Lester, P., Stein, J. A., Saltzman, W., Woodward, K., MacDermid, S. W., Milburn, N., . . . Beardslee, W. (2013). Psychological health of military children: Longitudinal evaluation of a family-centered prevention program to enhance family resilience. *Military Medicine, 8,* 838-845.

Lewinsohn, P. M., Rhode, P., & Seeley, J. R. (1996). Adolescent suicidal ideation and attempts: Prevalence, risk factors, and clinical implications. *Clinical Psychology: Science and Practice, 3,* 25-46. doi:10.1111/j.1468-2850.1996.tb00056.x

Mallory, C., Sears, B., Hasenbush, A., & Susman, A. (2014). *Ensuring Access to Mentoring Programs for LGBTQ Youth.* Los Angeles, CA: The Williams Institute.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129,* 674-697. doi:10.1037/0033-2909.129.5.674

Miller, J. B., Jordan, J. V., Stiver, I. P., Walker, M., Surrey, J. L., & Eldridge, N. S. (2004). Therapists' authenticity. In J. Jordan, M. Walker & L. Hartling (Eds.), *The complexity of connection: Writings from the Stone Center's Jean Baker Miller Training Institute* (pp. 64–89). New York, NY: Guilford Press.

Mishna, F., Newman, P. A., Daley, A., & Solomon, S. (2009). Bullying of lesbian and gay youth: A qualitative investigation. *The British Journal of Social Work, 39,* 1598-1614. doi:10.1093/bjsw/bcm148

Newman, P. (2002). Coming out in a hostile social environment: Challenges for HIV prevention among young gay men. *Journal of HIV/AIDS and social services, 1,* 81-94.

Noell, J. W., & Ochs, L. M. (2001). Relationship of sexual orientation to substance use, suicide ideation, suicide attempts, and other factors in a population of homeless adolescents. *Journal of Adolescent Health, 29,* 31-36.

Pachankis, J. E., & Goldfried, M. R. (2013). Clinical issues in working with lesbian, gay, and bisexual clients. *Psychology of Sexual Orientation and Gender Diversity, 1,* 45-58. doi:10.1037/2329-0382.1.S.45

Pagano, T. (2014). Gone but not forgotten: The impact of fathers' military deployment on their sons. *Journal of Military & Government Counseling*, 2, 76-87.

Perrin, E. C. (1996). Pediatricians and gay and lesbian youth. *Pediatrics in Review, 17,* 311-318. doi:10.1542/pir.17-9-311.

Pilkington, N. W., & D'Augelli, A. R. (1995). Victimization of lesbian, gay, and bisexual youth in community settings. *Journal of Community Psychology, 23,* 34-56.

RAND Corporation,. (2008). *Deployment experiences of guard and reserve families:*

Implications for support and retention. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/pubs/monographs/MG645.html

RAND Corporation. (2011). *Views from the Homefront: The Experiences of youth and spouses from military families*. Santa Monica, CA: RAND Corporation. Retrieved from http://www.rand.org/pubs/technical_reports/TR913.html

Reed, S., Bell, J., & Edwards, T. (2011). Adolescent well-being in Washington state military families. *American Journal of Public Health*, *101*, 1676-1682. doi:10.2105/ajph.test.2011.300165

Remafedi, G., & Carol, H. (2004) Preventing tobacco use among lesbian, gay, bisexual and transgender youths. *Nicotine & Tobacco Research, 7,* 249-256. doi:10.1080/14622200500055517

Remafedi, G., Farrow, J., & Deisher, R. (1991). Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics, 87,* 869-875.

Remafedi, G., French, S., Story, M., Resnick, M. D., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: results of a population-based study. *American Journal of Public Health*, *88*, 57–60.

Rhodes, J. E., & DuBois, D. L. (2006). Understanding and facilitating the youth mentoring movement. *Social Policy Report*, *20*, 1-19.

Richardson, A., Chandra, A., Martin, L. T., Setodji, C. M., Hallmark, B. W., Campbell, N. F., . . . Grady, P. (2011). *Effects of Soldiers' Deployment on Children's Academic Performance and Behavioral Health*. Santa Monica, CA: RAND Corporation.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2004). Ethnic/Racial differences in the coming-out process of lesbian, gay, and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology, 10,* 215-228. doi:10.1037/1099-9809.10.3.215

Russell, S. T., Toomey, R. B., Ryan, C., & Diaz, R. M. (2014). Being out at school: The implications for school victimization and young adult adjustment. *American Journal of Orthopsychiatry, 84,* 635-643. doi:10.1037/ort0000037

Rush, C. M., & Akos, P. (2007). Supporting children and adolescents with deployed caregivers: A structured group approach for school counselors. *The Journal for Specialists in Group Work, 32,* 113-125. doi:10.1080/01933920701227034

Ryan, C, & Gruskin, E. (2006). Health concerns for lesbians, gay men, and bisexuals. In D. F. Morrow & L. Messinger (Eds.), *Sexual orientation and gender expression in social work practice: Working with gay, lesbian, bisexual, and transgender people* (pp. 307—342). New York, NY: Columbia University Press.

Saewyc, E., Poon, C., Wang, N., Homma, Y., Smith, A., and the McCreary Centre
    Society (2007). *Not yet equal: The health of lesbian, gay, and bisexual youth in
    BC.* Vancouver, BC: McCreary Centre Society.

Savin-Williams, R. C. (1994). Verbal and physical abuse as stressors in the lives of lesbian, gay
    male and bisexual youths: Associations with school problems, running away, substance
    abuse, prostitution and suicide. *Journal of Consulting and Clinical Psychology, 62,* 261-
    269.

Seil, K. S., Desai, M. M., & Smith, M. V. (2014). Sexual orientation, adult connectedness,
    substance use, and mental health outcomes among adolescents: Findings from the 2009
    New York City youth risk behavior survey. *American Journal of Public Health*, *104*,
    1950-1956. doi:10.2105/AJPH.2014.302050

Snapp, S. D., Hoenig, J. M., Fields, A., & Russell, S T. (2015). Messy, butch, and queer:
    LGBTQ youth and the school-to-prison pipeline. *Journal of Adolescent Research, 30,* 57-
    82. doi:10.1177/0743558414557625

Solis, C., Meyers, J., & Varjas, K. (2004). A qualitative case study of the process and impact of
    filial therapy with an African American parent. *International Journal of Play Therapy,
    13,* 99-118. doi:10.1037/h0088892

Walls, N. E., Laser, J., Nickels, S. J., & Wisneski, H. (2010). Correlates of cutting behavior
    among sexual minority youths and young adults. *Social Work Research, 34,* 213-226.

Wilchins, R. (2014). *Queer theory, gender theory: An instant primer.* Los Angeles, CA: Alyson
    Books.

Williams, K. A., & Chapman, M. V. (2011). Comparing health and mental health needs, service
    use, and barriers to service among sexual minority youths and their peers. *Health &
    Social Work, 36,* 197-206.

Yuen, T., Landreth, G., & Baggerly, J. (2002). Filial therapy with immigrant Chinese families.
    International Journal of Play Therapy, 11, 63-90. doi:10.1037/h0088865

Female Service Members and the Deployment Cycle: Implications for Gender Sensitive Counseling

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Abstract

The Global War on Terror reflects increased deployment lengths, frequencies, and utilization of female service members. The deployment cycle conceptualizes family transitions before, during, and after deployments. Most applications of the deployment cycle take the perspective of a deployed male service member, with the implicit assumption the deployment cycle model may be seamlessly translated across diverse family configurations. This article forwards a more gender sensitive understanding of the experiences of female service members across the deployment cycle. Brief overviews of the deployment cycle and gender sensitive counseling perspectives are provided, followed by gender sensitive considerations for female service members relevant to each stage of the deployment cycle. Finally, gender sensitive counseling techniques and recommendations for civilian counselors are provided.

KEYWORDS: women, deployment cycle, gender sensitive counseling

In the nearly 15 years following the events of September 11, 2001, more than 2.6 million service members have been deployed in support of the Global War on Terror (Department of Defense, 2014). Deployments have increased in length and frequency, as well as in the utilization of female service members (Agazio, et al., 2013; Gewirtz, McMorris, Hanson, & Davis, 2014). Women comprise 14.9% of the active duty force and 42.7% of service members are parents (Department of Defense, 2014). Military mothers tend to occupy lower socioeconomic statuses and are three times as likely to be single parents and five times as likely to be married to another service member (Schumer & Maloney, 2007).

Deployments impact the lives of those leaving and those left behind. Recent deployment literature reflects increased recognition that military-connected spouses, partners, and children "serve too" (Chan, 2014; DeVoe & Ross, 2012; Hall, 2010). Researchers have examined the

impact of deployments on family role distributions, marital satisfaction, divorce rates, short- and long-term implications for children, and family readjustment following the return of a deployed service member (Chandra et al., 2010; Faber, Willerton, Clymer, MacDermid, & Weiss, 2008; Flake, Davis & Johnson, 2009; Knobloch & Theiss, 2012; Louie & Cromer, 2014), among other areas. A majority of research assumes a deployed male service member, with little to no consideration of the experiences of deployed female service members (Agazio et al., 2013; Gewirtz et al., 2014; Street, Vogt, & Dutra, 2009). Consequent knowledge and service gaps are detrimental as preoccupation with family wellbeing is a serious and dangerous challenge for service members in war theaters (Ghahramanlou-Holloway, Cox, Fritz, & George, 2011). Additionally, concerns about balancing a military career with family responsibilities are positively associated with intentions to leave the military prematurely (Kelley et al., 2001).

"Just as the roles of women in the military have changed throughout the years, it is important to recognize the impact of war on these women has likely changed as well" (Hernandez, 2013, p. 2). The deployment cycle (DeVoe & Ross, 2012; Peebles-Kleiger & Kleiger, 1994; Pincus, House, Christensen, & Adler, 2001) is a well-established framework for conceptualizing logistical and emotional transitions service members and families encounter before, during, and after deployments. To date, most applications of the deployment cycle model have been from the perspective of a deployed male service member and a non-military female wife and/or mother, with the implicit assumption the deployment cycle model may be seamlessly translated across diverse family configurations (Agazio et al., 2013; Crompvoets, 2011; Gerwitz et al., 2014; Street et al., 2009). The purpose of this article is to forward more gender sensitive understandings of the experiences of female service members across the deployment cycle. Toward this, a brief overview of gender sensitive counseling perspectives is provided, followed by a description of major phases of the deployment cycle. Next, gender sensitive considerations for female service members relevant to each stage of the deployment cycle are discussed. Finally, implications for professional practice are provided, including gender sensitive techniques and recommendations for civilian counselors.

Gender Sensitive Counseling Perspectives

Gender sensitive counseling highlights gender as a socially constructed and central organizing feature of social life (Foster & Lloyd-Hazlett, 2015; Haddock, Zimmerman, & MacPhee, 2000). Consideration is given to the ways in which all members of society are subjected to some form of gender socialization, which shapes the beliefs and expectations individuals hold around acceptable and non-acceptable gender roles (O'Neil, 2008). Gender sensitive counseling approaches are also concerned with intersections between gender and other socially constructed organizing principles of social identity including race, class, culture, and sexual orientations; power inequities across identities are of particularly importance (Haddock et al., 2000; Weinrach & Thomas, 1996).

Principles of gender sensitive counseling overlap with feminist critique and theory, particularly the notion that the "personal is political" (Hare-Mustin, 1978). This means personal experiences are inextricability embedded in political situations, contexts, and realities. As discussed by Bryan and colleagues (2012), "the failure to understand the impact of an individual's social context and worldview on their behavior limits effective consultation and

treatment" (p. 98). Thus, the application of a gender sensitive lens is necessary to ethical and culturally competent understandings of the unique, and gendered, experiences and challenges of female service members (Danforth & Wester, 2014).

Analysis of stressors inherent to gender conformity is central to gender sensitive counseling approaches. *Gender role conflict* is defined as a "psychological state in which socialized gender roles have negative consequences for the person or others" (O'Neil, 2008, p. 362). Internal conflicts occur when societal expectations restrict the expression of the person one desires and/or believes herself to be. Gender role conflicts may be exacerbated during periods of role transition if new gender role expectations conflict with the demands of previously held roles. Specific to female service members, gender role tensions may emerge during socialization into military culture. For some women, strategies that have contributed to success in the past (i.e., nurturance, sensitivity, open communication, emotional attunement, leadership) may come into conflict with emerging identities (Brooks, 2001). Gender role conflicts across intersections of the identities of soldier, leader, woman, mother, spouse, warrior, and caretaker seem particularly poignant. Further, the personal, social, and professional implications of such intersections may be facilitative or inhibitive of wellness during and after service (Agazio et al., 2013; Crompvoets, 2011; Mattocks et al., 2012).

Gender and Military Culture

Grounded by extensive research with children in military families, Wertsch (2011) delineated several aspects of military culture relevant to understanding potential gendered expectations and gender role conflicts encountered by female service members. Military culture may be considered a warrior society as opposed to the democratic society occupied by most United States citizens. Military culture is theoretically conceptualized as a Fortress, encompassing the ways of life, physical communities, and mental and psychological worlds of service members.

Wertsch (2011) described three interrelated Masks of the Fortress – secrecy, stoicism, and denial – that help shape the behaviors and actions of those within the structure. Relative to *secrecy*, priority may be given in military-connected families to avoid doing or revealing actions or beliefs that reflect badly on the service member. Otherwise stated, "what happens in the family, stays in the family" (Hall, 2010, p. 55). Fear and stigma of exposing "family business" or vulnerability further confounds help seeking behaviors. The second mask, *stoicism*, speaks to an expectation carried for oneself, fellow soldiers, and family members. "Warriors believe in the mask of stoicism… They expect stoic behavior from one another… [and] expect it of their children" (Wertsh, 1991, p. 1). Across many military families, stoicism is rewarded and emotional expressions discouraged and/or punished. The final mask, *denial*, is described paradoxically; a certain degree of denial is necessary to cope with the risks, uncertainties, and dangers of military service, but such denial can contribute to more global repression of feelings. As captured by Lyons (2007):

> Losses are often inevitable… The warrior must build a wall around tender emotions to be able to function in a calculated, all-about-business manner to stay alive and not jeopardize other comrades…. It becomes second nature. The pattern does not shut off even after the person is home and safe. (p. 312)

Other distinctive components of military culture include authoritarian structures, isolation, alienation, class [rank] systems, parental absence, and ever-present preparations for potential disaster (Hall, 2010; Heyward, Benoit, Herman, Holmes, & Lloyd-Hazlett, 2013). Deployed service members hold that one's life is subordinate to the greater good (Bryan, Jennings, Jobes, & Bradley, 2012). The "importance of maintaining the group's identity and security [is stressed]" and requires that each service member puts the goals of the group ahead of any personal goals they might have (Danforth & Wester, 2014, p. 99). Application of a gender sensitive framework to key components of military culture, such as the Masks of the Fortress, enhances understanding of the social context and worldviews female service members are embedded within, including tensions created by gendered roles and expectations.

Gender, Psychological Stressors, and Support Services

In addition to illuminating gender conflicts across socialized expectations of female and military identities, gender sensitive counseling approaches inform contextualized delivery of assessment and support services. Ghahramanlou-Holloway and colleagues (2011) outlined eight unique psychological stressors and associated mental health issues common to female service members: (a) exposure to traumatic events, including sexual assault; (b) suicide ideation and behaviors; (c) body dissatisfaction and eating disorders; (d) menstruation and pregnancy; (e) relationship and martial functioning; (f) parenthood; (g) barriers to care and stigma; and (h) social support. Gender differences in post-traumatic stress disorder (PTSD) have been reported, but with some mixed results (Luxton, Skopp, & Maguen, 2010). Feczer and Bjorklund (2009) found male Veterans received a much higher rate of PTSD diagnosis than women; additionally, female service members reporting military sexual trauma (i.e., sexual assault or severe and threatening sexual harassment during military service) were far less likely to receive a PTSD diagnosis. Researchers have suggested a history of trauma prior to military service may increase a woman's risk for cumulative trauma exposure (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007) and that female service members are more likely to develop PTSD following exposure to military-related traumatic events than their male counterparts (Tolin & Foa, 2006). Continued underrepresentation of female service members in military scholarship, as well as the execution of studies not sensitive to relevant gender differences, renders accurate understanding of the prevalence rates, causes, and mediating factors of psychiatric problems among this vulnerable population difficult.

A dearth of evidence-based psychosocial treatments for female service members exists (Ghahramanlou-Holloway et al., 2011). While female service members are more likely to utilize mental health service (Carbone, Cigrang, Todd, & Fiedler, 1999), nearly half of service members report needing psychological services but not getting them (Owens, Herrera, & Whitesell, 2009). Veterans Affairs (VA) services are frequently perceived as "for men" (Bergman, Frankel, & Yano, 2015) and non-VA facilities are viewed as not having appropriate knowledge or skills to deal with women Veterans (Street et al., 2009). Female service members report feeling a lack of identity within existing Veteran communities, which leads to holding back in community interactions, being forgotten, and feeling silenced (Davis, Ward, & Storm, 2011).

Overview of the Deployment Cycle

Gender sensitive approaches are needed to "address the unique needs of military women veterans [spanning] from their acculturation to military life upon service entry, to basic training, technical training, and finally to the entire course of their professional military service… and reintegration into civilian life" (Ghahramanlou-Holloway et al., 2011, p. 6). A substantial portion of professional military service may surround deployment(s). The deployment cycle (DeVoe & Ross, 2012; Peebles-Kleiger & Kleiger, 1994; Pincus et al., 2001) describes experiences that may occur when a military service member is called to deploy. The deployment cycle consists of three broad phases that may be further divided into sub-stages. Normative stressors and transitions transpiring at each stage of the deployment cycle on both the war- and home-front are described within the model.

Pre-deployment

The first stage of the deployment cycle, pre-deployment, describes the time period leading up to the actual deployment. The duration of this phase can span a couple of weeks to more than a year. The presence of a range, and at times conflicting, emotions including tension, protest, and anger is a key feature of the pre-deployment stage (Pincus et al., 2001). Service members may waiver between desires to devote additional time to preparatory training versus spending time with one's family prior to leaving. The pre-deployment stage is also comprised of a variety of logistical tasks, including planning for childcare, preparing legal documents and wills, adjusting school and work schedules, and soliciting additional support systems (DeVoe & Ross, 2012).

Deployment

The second stage of the deployment cycle, deployment, represents the time period where service members have relocated away from their families. As adjustments are made to changes in the family configuration, symptoms of depression, sadness, hopelessness, and even relief, may emerge for the service member and their family (Pincus et al, 2010). A primary logistical task for the deployment stage includes establishing and/or modifying lines of communication, which may be complicated by security and technological constraints of the service member's deployment. Extant research highlights emotional disorganization, volatility, and ambiguous loss as affective hallmarks of the first six weeks of a deployment (Di Nola, 2008). Often, the non-deployed parent is charged with responding to children's questions, concerns, and distress after the deployment. Following the initial period of emotional chaos, a sub-phase of sustainment emerges as new routines and "normals" become familiar (Di Nola, 2008). However, research to date has not sufficiently explored if these trends hold when mothers versus fathers are deployed.

Post-Deployment

The final stage is post-deployment or the reintegration phase. Though formally marked with the return of the deployed service member, the length of the post-deployment stage varies from six weeks to up to three years (Gewirtz, Erbes, Polusny, Forgatch, & DeGarmo, 2011). While many military-connected families believe reuniting with the deployed service member

will "fix" deployment related challenges, reunion is a time of great stress for many families. Key tasks during reintegration include becoming a family again, reacquainting and building relationships, negotiating changes in roles, reestablishing intimacy, and responding to perceived or actualized changes in family members (DeVoe & Ross, 2012). Reintegration may be further complicated by wartime deployments, wherein family members may have been exposed to greater danger, threat of death or injury, greater limitations to communication, and more limits to information that could be shared during the deployment.

Gender Sensitive Considerations of the Deployment Cycle

The following sections explore gender sensitive considerations of each stage of the deployment cycle, with specific attention to the experiences of deployed mothers. Relevant emotional and logistical processes for the deployment cycle stages are discussed, as well as recommendations for mental health professionals partnering with female service members. Recognizing the infeasibility of capturing the potential and unique experiences of each deployed female service member, the examples provided are intended to initiate neglected conversations about these diverse military family configurations.

Pre-Deployment

Planning for changes to the home front is a significant task of the pre-deployment phase, particularly for deploying mothers. Prior to the actual deployment, time may be spent training at duty locations or deployment stations. Deploying service members may vacillate between "ramping up" training and pulling back to spend time with family before leaving (Maguen et al., 2008). Deploying female service members may also be charged with securing supplemental childcare, enrolling children in day care centers, and asking family members for assistance. As described by one deploying female service member, the pre-deployment process was akin to "summoning the village" (Agazio et al., 2013, p. 255).

Though literature on deployed mothers is limited, changes to childcare routines may be more dramatic when a female service member is deploying versus a male service member. Greater changes to the non-deployed parent's daily routine may be necessitated to accommodate increased day-to-day parenting responsibilities. Deploying single parents will likely need to solicit the help of extended family members to care for children, which may require children to relocate to different cities and to be separated from siblings. Relocation of children may transpire prior to the deployment date based on extended family member's availabilities, school schedules, and other factors (Agazio et al., 2013). Additionally, children may move away from military-based schools and other military-based resources they are accustomed to.

Balancing the emotional and logistical tasks associated with pre-deployment can be difficult. In a study conducted by Hernandez (2013), one female Veteran stated:
> I saw myself going into business mode instead of like mom mode. I was like logistically this has been done, this has to be done, and I don't think I spent enough time explaining to them why this is happening. (p. 78)

Though deploying mothers may never feel fully prepared to leave, counselors may be of great service to families during this "holding pattern" for which the family understands adaptations

will happen but cannot yet begin to make changes (Lapp et al., 2010). Counselors may be cognizant of marital or family conflict and detachment, understanding a certain degree of distance may be reflective of healthy coping strategies versus symptoms of depression and anxiety (Agazio, et al., 2013). Relinquishing (or the perception of relinquishing) a primary childcare role may be especially difficult. Counselors can assist deploying mothers in venting these feelings, as well as in exploring areas of convergence and divergence across multiple identities carried (i.e., mother, wife, soldier).

Familiarity with pre-deployment logistical tasks, as well as community and military-resources to accomplish these tasks may free up already limited time and energy and allow for greater emotional processing of the upcoming separation. Counselors may help deploying mothers create checklists delineating necessary preparatory tasks, as well as to delegate tasks to others when appropriate. Assistance may be provided to establish communication plans, support networks, and comfortable childcare arrangements. Counselors may support deploying mothers in identifying documents (i.e., powers of attorney, identification and insurance cards, care plans) needed to maintain dependents' access to health care, particularly if the caregiver will be using non-military healthcare facilities.

Military-connected families that have prepared children for deployment report significantly lower scores on both short- and long-term parenting stress measures (Gewirtz et al., 2014). Strategies for healthy communication with partners and children may be modeled and practiced for a variety of topics, including detachment, anticipatory grief, conflict, communication challenges, childcare, and managing worries (Agazio et al., 2013; DeVoe & Ross, 2012). Counselors working with families can assist members in conducting developmentally appropriate conversations with children, including engaging children in planning for the separation. A number of excellent online (i.e., Military OneSource, Deployment Kids, Operation Military Kids, National Military Families Association) and bibliotherapy (i.e., *I miss you! A military kid's book about deployment, My mommy wears combat boots, Love Lizzie: Letters to a military mom)* tools exist for counselors and families in preparing for deployment (Agazio et al., 2013).

Finally, the actual act of saying "good bye" is an important family ritual closing the pre-deployment stage of the deployment cycle (DeVoe & Ross, 2012). Though parents may wish to save children (and themselves) from the anguish of a difficult goodbye, not having this moment may be problematic, especially for younger children not able to developmentally process a parent's absence. Out of sight is not out of mind. Families should discuss the departure, as well as ways to stay connected during the physical separation (Heyward, et al., 2013).

Deployment

During the actual deployment, consideration should be given to experiences on both the war- and home-front. Logistical constraints may limit direct service options; thus, shifting mental health support to children, partners, and caregivers may be appropriate during this phase of the deployment cycle. An estimated 20-46% of non-deployed female spouses meet screening criteria for moderate to severe depression and generalized anxiety disorders during a deployment (Eaton et al., 2008; Warner, Appenzeller, Warner, & Grieger, 2009). Emotional expressions from non-

deployed spouses and partners of envy, anger, resentment, anxiety, depression, guilt, marital conflict, and communication difficulties may be important to note (Agazio et al., 2013). Deployment often challenges parents' abilities to regulate emotions, which can impact parenting quality (Gewirtz et al., 2011). Additionally, increased parenting roles and responsibilities can affect the non-deployed parent's professional career (Lara-Cinisomo et al., 2012).

"Although children 'serve too,' they usually have little to say in this decision because they are usually born after the parent has already joined" (MacDermid Wadsworth, Hughes-Kirchubel, & Riggs, 2014, p. 6). While many military-connected children display tremendous resiliency, maladjustment and problematic behaviors may emerge during a parent's deployment (Chandra & London, 2013; Huebner, Mancini, Wilcox, Grass, & Grass, 2007). Attention should be given to the influence of children's age, developmental levels, and gender on symptom expression. Difficulties may emerge in a variety of settings including home, school, and with peers. Children may sense changes in behavior or affect from both deployed and non-deployed parents (Chandra et al., 2010). However, as the majority of research about the implications of parental deployment on children has drawn from samples of deploying fathers/non-deployed mothers, generalizations from extent research should be made with caution.

Deployment may be particularly demanding for some military mothers due to dual stress associated with both the war- and home-front (Feldman, Herron, & Hanlon, 2007). Research highlights the priority deployed mothers give to "trying to keep life normal for their children" during a deployment (Agazio et al., 2013, p. 258). Emphasis is also given to preserving the maternal bond (Agazio et al., 2013). Counselors working with deployed mothers may affirm and explore mixed feelings that can surround the deployment. For example, deployed mothers may simultaneously express pride in doing service for one's country and in one's career, while also expressing sadness or guilt around missing important milestones or events in their children's lives while deployed (Agazio et al., 2013).

Extant research suggests proactive preparation for sustaining parent-child attachments during the deployment can help mitigate parental reintegration stress (Louie & Cromer, 2014); however, again this research is more limited to deployed fathers. Counselors may assist military-connected families in developing strategies and symbolic rituals for building the deployed parent into daily routines (Heyward et al., 2013). Psychoeducation about developmental needs and appropriate communication techniques, such as more frequent reminders to younger children about why a parent is away, is also recommended (DeVoe & Ross, 2012). Counselors may also assist families in adapting to changes in family care plans established prior to the deployment.

Female service members encounter unique stressors and dangers during deployments. Safety is the primary concern for deployed women, specifically concerns of sexual assault by another military member or locals (Hernandez, 2013). Deployed mothers utilize a number of coping strategies during deployment, which may include excessive exercise, working extra hours, talking with other military women, starting romantic/intimate relationships, and spirituality and faith (Agazio et al., 2013). For some deployed mothers, a sense of helplessness may emerge as attempts are made to address problems at home but without the feeling of appropriate support of their families or from the military. Gender biases may exist should a commanding officer have personal views precluding of sending women in to combat or that

women are best utilized when they stay home and are able to enact their roles as mothers (Hernandez, 2013). Qualitative interviews support a shift in command's perception of deployed mothers from the stellar "go-to" women to perceptions of being annoying, emotional, or needy if presented with real family concerns or issues (Hernandez, 2013). Counselors should be aware of the varied sources of marginalization female service members may encounter, including biases from commands, fellow service members, and family members themselves.

Post-Deployment

While a certain level of fantasy surrounds the post-deployment phase, the reintegration of a service member represents a time of significant stress for many military families. Transitions home may be best conceptualized as a "decompression" process, wherein service members are leaving "high pressure" deployment situations and returning back to their "low pressure" lives (Currie, Day, & Kelloway, 2011). Counselors may assist families in developing more toned-down approaches to family reunions and to temper expectations about the experience. It is possible young children may not be able to recognize their returning parent (Barker & Berry, 2009). Counselors may provide anticipatory guidance to returning female service members about normative challenges many families experience during reintegration. Such challenges include difficulties with connection and communication in both partner and parent-child dyads, heightened conflict, financial and employment changes, changes in sexual contact, and tensions around reestablishing daily routines (Knobloch & Theiss, 2012).

Concurrent to normalizing post-deployment reactions and adjustments, mental health professions should also be attentive to signs and symptoms indicative of more serious adjustment difficulties, including posttraumatic stress symptoms. Female service members are more likely to have been victims of in-service sexual assaults and sexual harassment, which are positively related to increased suicide risk, substance use and abuse, PTSD, employment difficulties, and sexual dysfunction, among other complications (Street et al., 2009). As PTSD and traumatic brain injuries (TBI) can further complicate the reestablishment of partner and parent-child relationships (Berz, Taft, Watkins, & Monson, 2008), it is important for mental health professionals to screen for psychiatric disorders after deployment (Felker, Hawkins, Dobie, Gutirrez, & McFall, 2008). Withdraw from, overreaction to, or dismissal of intense family interactions involving discipline or conflict may signal both emotional suppression and/or flooding (Gewirtz et al., 2014).

A gender sensitive lens sheds important light on potential challenges experienced by deployed female service members during reintegration. Family relationship disruptions are more strongly associated with post-deployment mental health for female service members (Street et al., 2009). However, female service members may lack relevant supports from the military, including access to appropriate post-deployment health care services. Most military-sponsored reintegration programs have implicitly assumed roles of a returning male service member and non-deployed female spouse (Hernandez, 2013); far fewer resources exist for female service members, non-deployed male partners, and single parents. While sharing and making meaning of deployment experiences is a demonstrated beneficial coping mechanism for women veterans, this exercise may be incongruent with traditional male-dominated military culture (Feldman,

Herron, & Halon, 2007). Further, mental health services provided are generally individual over family-based.

Reintegrating mothers may also experience adjustment difficulties surrounding public and personal perceptions of the "Veteran woman" identity (Street et al., 2009). Conflicts may also emerge around gendered expectations that women prioritize caring for the family over their own individual needs (Hernandez, 2013). As illustrated by a female Veteran's experience:

> Men have this role that they perceive of having to take care of everything, but I think the real burden and details of everyday life really fall on the women…I didn't have any extra energy to deal with my PTSD and it, it caused a lot more damage because of it. (Hernandez, 2013, p. 89).

Deployed mothers may experience guilt over wanting space or isolation when their children or partners yearn to be close to them (Hernandez, 2013). Counselors may prioritize assisting deployed mothers in managing reintegration, residual combat experiences, and expectations for an almost immediate return to household and parenting responsibilities (Gewirtz et al., 2014).

Implications for Professional Practice

In addition to the considerations for each deployment cycle stage outlined above, a number of more general gender sensitive counseling strategies may be utilized by mental health professionals assisting deployed female service members and their families (Foster & Lloyd-Hazlett, 2015; Haddock et al., 2010). First, it is recommended that counselors consider the role of values in the therapeutic process. In contrast to viewing the aims of counseling as "value free," gender sensitive perspectives encourage reflection on the values counselors and clients alike bring to the therapeutic process. Values are acknowledged, discussed, and reflected on so to not interfere with the counseling process. Additionally, values may be integrated as strengths where appropriate. For example, a value of counselors may be to prioritize the experience of the client, seeking to enhance the client's life within this subjective understanding rather than in according to predetermined treatment goals. Second, counselors may conduct integrated analyses of gender roles, power, and oppression (Haddock et al., 2010). Consciousness raising is sought, wherein female service members and their families are able to connect personal experiences to broader implications of gendered society. Female service members and their families work toward re-socialization within newly acquired perspectives that emphasize understanding challenges and pathology as residing within larger social constructions over individuals themselves. Finally, gender sensitive approaches emphasize social advocacy to change oppressive systems. Gender sensitive advocacy could include personal client advocacy, as well as advocating for larger efforts within military culture and available support services (Foster & Lloyd-Hazlett, 2015).

More than a discrete theoretical perspective, gender sensitivity is a dimension of cultural competence (Danforth & Wester, 2014). To be culturally competent, counselors working with deployed female service members should also have a firm understanding of military culture. Without this, understanding of clients' social contexts and worldviews, including consequent gender role and identity conflicts, is stifled. Pryce and colleagues (2000) summarized key competencies for civilian counselors. First, civilian mental health professionals should gain understanding of military hierarchical culture and its requirements. Specific attention should be

given to rank as an organizing feature of military life. For many military families, rank is reflective of education, income, access to resources, and level of responsibility. Second, civilian counselors should understand salient aspects of military culture and how these may impact service delivery and client beliefs. Counselors are encouraged to understand and respect limits of confidentiality, while also establishing a safe environment for communication. Framing prevention and intervention services as forms of self-reliance and self-sufficiency may function to combat stigma around helping seeking behavior. Third, civilian counselors are encouraged to understand general developmental issues for families, as well as unique transitions associated with the deployment cycle (Hall, 2010; Pryce, Ogilvy-Lee, & Pryce, 2010). Finally, civilian counselors should know and use available military resources. Counselors may also utilize a gender sensitive lens to help advocate for more appropriate supports and services for female service members and their families.

Conclusion

The purpose of this article was to forward more gender sensitive understandings of the experiences of female service members across the deployment cycle**.** To date, the experiences of deployed female service member have largely been silent in military literature, with an expectation of transferability of the more researched perspectives of deployed male service members. Increased and tailored attention to the experiences of deployed female service members is critical given the significant impact of work-family concerns on service members' wellbeing and safety, as well as the increased number of female service members being deployed.

Gender sensitive perspectives underscore gender as a central organizing feature of social life, and thus, an essential component to understanding clients' experiences and worldviews. A goal of gender sensitive approaches is to shed light to power inequities that covertly shape individual behavior; and through the recognition of imbalance, greater individual and collective conscious emerges. Counselors have tremendous opportunity, and responsibility, to further dialogue about the silenced perspective of deployed female service members; gender sensitive counseling approaches not only helps start this conversation, but give voice to enhanced care and understanding.

References

Agazio, J., Hillier, S., L., Throop, M., Goodman, P., Padden, D., Greiner, S., & Turner, A. (2013). Mothers going to war: The role of nurse practitioners in the care of military mothers and families during deployment. *Journal of the American Association of Nurse Practitioners, 25*, 253-262.

Barker, L. H., & Berry, K. D. (2009). Developmental issues impacting military families with young children during single and multiple deployments. *Military Medicine, 174*(10), 1033–1040.

Bergman, A. A., Frankel, R. M., Hamilton, A. B., & Yano, E. M. (2015). Challenges with

delivering gender-specific and comprehensive primary care to women veterans. *Women's Health Issues, 25*(1), 28-34.

Berz, J. B., Taft, C. T., Watkins, L. E., & Monson, C. M. (2008). Associations between PTSD symptoms and parenting satisfaction in a female veteran sample. *Journal of Psychological Trauma*, *7*(1), 37-45.

Brooks, G. R. (2001). Counseling and psychotherapy with male military veterans. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (Vol. 1, pp. 206–226). San Francisco, CA: Jossey-Bass.

Bryan, C. J., Jennings, K. W., Jobes, D. A., & Bradley, J. C. (2012). Understanding and preventing military suicide. *Archives of Suicide Research, 16*, 95–110.

Carbone, E. G., Cigrang, J. A., Todd, S. L., & Fiedler, E. R. (1999). Predicting outcomes of military basic training for individuals referred for psychological evaluation. *Journal of Personality Assessment*, *72*(2), 256-265.

Chan, C. S. (2014). Introduction to the special section: Research on psychological issues and interventions for military personnel, veterans, and their families. *Professional Psychology: Research and Practice, 45*(6), 395-397.

Chandra, A., Lara-Cinisomo, S., Jaycox, L. T., Tanielian, T., Burns, R., Ruder, T., & Han, B. (2010). Children on the homefront: The experience of children from military families. *Pediatrics, 125*, 16–25.

Chandra, A., & London, A. S. (2013). Unlocking insights about military children and families. *Future of Children, 23*(2), 187–198.

Crompvoets, S. (2011). The health and wellbeing of female veterans: A review of the literature. *Journal of Military and Veterans' Health, 19*(2), 25-31.

Currie, S. L., Day, A., & Kelloway, E. K. (2011). Bringing the troops back home: Modeling the postdeployment reintegration experience. *Journal of Occupational Health Psychology*, *16*(1), 38-47.

Danforth, L., & Wester, S. R. (2014). Gender-sensitive therapy with male servicemen: An integration of recent research and theory. *Professional Psychology: Research and Practice, 45*(6), 443-451.

Davis, J., Ward, D. B., & Storm, C. (2011). The unsilencing of military wives: Wartime deployment experiences and citizen responsibility. *Journal of Marital and Family Therapy, 37*(1), 51-63.

Department of Defense. (2014). *2013 demographic report*. Washington, DC: Office of the

Deputy Under Secretary of Defense.

DeVoe, E. R., & Ross, A. (2012). The parenting cycle of deployment. *Military Medicine, 177*(2), 184-190.

Di Nola, G. M. (2008). Stressors afflicting families during military deployment. *Military Medicine*, *173*(5), v-vii.

Eaton, K. M., Hoge, C. W., Messer, S. C., Whitt, A. A., Cabrera, O. A., McGurk, D., ... & Castro, C. A. (2008). Prevalence of mental health problems, treatment need, and barriers to care among primary care-seeking spouses of military service members involved in Iraq and Afghanistan deployments. *Military Medicine*, *173*(11), 1051-1056.

Faber, A., Willerton, E., Clymer, S. R., MacDermid, S. M., & Weiss, H. M. (2008). Ambiguous absence, ambiguous presence: A qualitative study of military reserve families in wartime. *Journal of Family Psychology, 22*, 222–230.

Feczer, D., & Bjorklund, P. (2009). Forever changed: Posttraumatic stress disorder in female military veterans: A case report. *Perspectives in Psychiatric Care*, *45*(4), 278-291.

Feldman, S., Herron, A., & Hanlon, C. (2007). "Because women cope differently": A qualitative investigation of the experiences of female war, peacemaking and peacekeeping veterans-implications for reintegration and rehabilitation into the community. *Department of Veterans Affairs. Victoria University*, 1-153.

Felker, B., Hawkins, E., Dobie, D., Gutierrez, J., & McFall, M. (2008). Characteristics of deployed Operation Iraqi Freedom military personnel who seek mental health care. *Military Medicine*, *173*(2), 155-158.

Flake, E. M., Davis, B., Johnson, P., & Middleton, L. (2009). The psychosocial effects of deployment on military children. *Journal of Developmental & Behavioral Pediatrics, 30*, 271–278.

Foster, V. A., & Lloyd-Hazlett, J. (2015). Feminist family therapy. In E. Neukrug (Ed.) *Encyclopedia of Theory in Counseling and Psychotherapy,* Thousand Oaks, CA: Sage.

Gewirtz, A. H., Erbes, C., Polusny, M. A., Forgatch, M. S., & DeGarmo, D. (2011). Supporting military families during and after deployment: The need for parenting interventions. *Professional Psychology: Research and Practice, 42*, 56–62.

Gewirtz, A. H., McMorris, B. J., Hanson, S., & Davis, L. (2014). Family adjustment of deployed and nondeployed mothers in families with a parent deployed to Iraq or Afghanistan. *Professional Psychology: Research and Practice*, *45*(6), 465-467.

Ghahramanlou-Holloway, M., Cox, D. W., Fritz, E. C., & George, B. J. (2011). An evidence-informed guide for working with military women and veterans. *Professional Psychology: Research and Practice, 42*(1), 1-7.

Haddock, S. A., Zimmerman, T. S., & MacPhee, D. (2000). The power equity guide: Attending to gender in family therapy. *Journal of Marital and Family Therapy*, *26*(2), 153-170.

Hall, L. K. (2010). *Counseling military families: What mental health professionals need to know*. New York, NY: Routledge.

Hare-Mustin, R. T. (1978). A feminist approach to family therapy. *Family process, 17*(2), 181-194.

Hernandez, R. Z. (2013). *The impact of deployment of U.S. military women: A grounded theory* (Unpublished doctoral dissertation). St. Mary's University, San Antonio, TX.

Heyward, K., Benoit, E., Hermann, K. M., Holmes, C. M., & Lloyd-Hazlett, J. (2013). Conquering ambiguity with creativity: Using creative family counseling interventions with military families. *Journal of Military and Government Counseling, 1*(3), 177-191.

Huebner, A. J., Mancini, J. A., Wilcox, R. M., Grass, S. R., & Grass, G. A. (2007). Parental deployment and youth in military families: Exploring uncertainty and ambiguous loss. *Family Relations, 56*, 112–122.

Kelley, M. L., Hock. E., Bonney, J. F., Jarvis, M. S., Smith, K. M., & Gaffney, M. A. (2001). *Military Psychology, 13*(1), 55-71.

Knobloch, L. K., & Theiss, J. A. (2012). Experiences of U.S. military couples during the post-deployment transition: Applying the relational turbulence model. *Journal of Social and Personal Relationships, 29*, 423–450.

Lapp, C. A., Taft, L. B., Tollefson, T., Hoepner, A., Moore, K., & Divyak, K. (2010). Stress and coping on the home front: Guard and reserve spouses searching for a new normal. *Journal of Family Nursing*, *16*(1), 45-67.

Lara-Cinisomo, S., Chandra, A., Burns, R. M., Jaycox, L. H., Tanielian, T., Ruder, T., & Han, B. (2012). A mixed-method approach to understanding the experiences of non-deployed military caregivers. *Maternal and child health journal*, *16*(2), 374-384.

Louie, A. D., & Cromer, L. D. (2014). Parent–child attachment during the deployment cycle: Impact on reintegration parenting stress. *Professional Psychology: Research and Practice*, *45*(6), 496.

Luxton, D. D., Skopp, N. A., & Maguen, S. (2010). Gender differences in depression and PTSD symptoms following combat exposure. *Depression and Anxiety, 27*(11), 1027-1033.

Lyons, J. A. (2007). The returning warrior: Advice for families and friends. In C. R. Figley & W. P. Nash (Eds.), *Combat stress injury: Theory, research, and management* (pp. 311-324). New York, NY: Routledge: Taylor and Francis Group.

MacDermid Wadsworth, S., Hughes-Kirchubel, L., & Riggs, D. S. (2014). Research and training about military families: Where are we? In S MacDermid Wadsworth & D. S. Riggs (Eds.), *Military deployment and its consequences for families: Risk and resilience in military and veteran families* (pp. 1-17). New York, NY: Springer Science & Business Media.

Maguen, S., Turcotte, D. M., Peterson, A. L., Dremsa, T. L., Garb, H. N., McNally, R. J., & Litz, B. T. (2008). Description of risk and resilience factors among military medical personnel before deployment to Iraq. *Military Medicine*, *173*(1), 1-9.

Mattocks. K. M., Haskell, S. G., Krebs, E. E., Justice, A. C., Yano, E. M., & Brandt, C. (2012). *Social Science & Medicine, 74*, 537-545.

O'Neil, J. M. (2008). Summarizing twenty-five years of research on men's gender-role conflict using the gender role conflict scale: New research paradigms and clinical implications. *The Counseling Psychologist, 36*, 358–445.

Owens, G. P., Herrera, C. J., & Whitesell, A. A. (2009). A preliminary investigation of mental health needs and barriers to mental health care for female veterans of Iraq and Afghanistan. *Traumatology*, *15*(2), 31.

Peebles-Kleiger M. J., & Kleiger J. H. (1994). Re-integration stress for Desert Storm families: Wartime deployments and family trauma. *Journal of Traumatic Stress, 7*(2), 173-194.

Pincus, S. H., House, R., Christensen J, & Adler, L. E. (2001). The emotional cycle of deployment: A military family perspective. *U.S. Army Medical Department Journal, 4/5/6*, 15-23.

Pryce, J. G., Ogilvy-Lee, D., & Pryce, D. H. (2000). The "citizen solider" and reserve components. In J. A. Martin, L. N. Rosen, & L. R. Sparacino (Eds.), *The military family: A practice guide for human service providers* (pp. 25-42). Westport, CT: Praeger.

Schumer C. E., & Maloney, C. B. (2007). *War at any price: The total economic costs of the war beyond the federal budget*. Retrieved from: http://www.fas.org/irp/congress/2(X)8_hr/ warcost.pdf

Street, A. E., Vogt, D., & Dutra, L. (2009). A new generation of women veterans. Stressors faced by women deployed to Iraq and Afghanistan. *Clinical Psychology Review, 29*, 685-694.

Tolin, D. F., & Foa, E. B. (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin*, *132*(6), 959-992.

Warner, C. H., Appenzeller, G. N., Warner, C. M., & Grieger, T. (2009). Psychological effects of deployments on military families. *Psychiatric Annals, 39*(2), 56-63

Weinrach, S. G., & Thomas, K. R. (1996). The counseling profession's commitment to diversity-sensitive counseling: A critical reassessment. *Journal of Counseling & Development*, 74(5), 472-477.

Wertsch, M. E. (2011). *Military brats: Legacies of childhood inside the fortress.* St. Lois, MO: Brightwell.

Zinzow, H. M., Grubaugh, A. L., Monnier, J., Suffoletta-Maierle, S., & Frueh, B. C. (2007). Trauma among female veterans: A critical review. *Trauma, Violence, & Abuse*, 8(4), 384-400.

Guiding Through Life Stressors: Utilizing Solution-Focused Brief Therapy and Sand Tray as a Counseling Approach with Military Teens

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Abstract

Adolescence is one of the most difficult development periods in life. Stressors such as social pressure, physical change, academics, and even bullying encompass the adolescent period. Moreover, teens within the military family unit have added strain on this critical stage of development. Counselors must be aware of the strain that the military lifestyle adds to the adolescent client. This article will give guidance to counselors on how solution focused brief therapy and sand tray can be combined to work with teens in a military lifestyle.

KEYWORDS: adolescence, stressors, development, military, families, counselors, solution-focused brief therapy, sand tray

Introduction

Adolescence is a vital stage of development. It is characterized as a period of physical, psychological, and emotional development that can affect the individual later in life (Wiley & Berman, 2013). According to Erik Erikson (1968), adolescence is the period of identity formation for each person. His developmental stage for adolescents includes the extremes of identity versus role confusion (Erikson, 1968). This theory postulates that psychological crises must be resolved in order for the individual to become successful in identity development (as cited in Carroll & Wolpe, 1996).

Erikson believed that the adolescent developmental period was filled with struggles pertaining to roles within relationships, goals, and values that give the adolescent purpose and direction (as cited in Wiley & Berman, 2013). However, there are several issues that Erikson does not address. These include physical, social, academic, family, and internal struggles that become overwhelming at times. Many of these issues are enhanced with the complexities of the military family.

Erikson believed that the adolescent developmental period was filled with struggles pertaining to roles within relationships, goals, and values that give the adolescent purpose and direction (as cited in Wiley & Berman, 2013). However, there are several issues that Erikson does not address. These include physical, social, academic, family, and internal struggles that become overwhelming at times. Many of these issues are enhanced with the complexities of the military family.

According to Roaten (2011), there is no other period of development, other than the first three years of life, which embodies drastic brain changes that of an adolescent. These physical brain changes only attribute to a small amount of transitions related to a teen's life. Many adolescents are transitioning into high school where social pressures increase. Others are finishing their high school years and getting ready to begin their young adult life.

Often times, adolescents must learn to adapt to the new changes in roles, expectation, and environment that they are in (Skudrzyk et al., 2009). Adolescents deal with academic pressures, self-doubt, peer pressure, teachers, parents, and complex relationships (Skudrzyk et al., 2009). Many students report dealing with pressures derived from school relationships such as bullying and even dating violence (Skudrzyk et al., 2009). Social media has greatly increased the amount that teens are exposed to different social pressures. For example, many cannot escape the harassment of a bully because of the internet and social media.

Adolescents are faced with multiple stressors. Senior level high school students experience stress from making adequate grades to enter college. Young teens experience stress from taking standardized exams that are required to move on in their education. Support from parents is essential during this period, in order to persevere through the layers of stress that this period of development holds. Counselors must be aware that adolescents in a military family may not have the necessary support to overcome the stress associated with this developmental period.

Military Culture and Resilience

For counselors to be successful in building a therapeutic relationship with clients who are in a military family, it is important to have a basic understanding of military culture, and the identity of the service branch that you are working with. The key component for success when working with service members and family members is to learn what military culture means to them personally. Families who are in the Armed Forces have unique stressors that they live with every day. Operational tempos or the training schedules for military members that require them to leave their home for significant times, include: deployments, that are directed by world events, permanent change of duty stations that are mandated by the Department of Defense, and routine, short term training assignments are only a few examples of what can bring instability into the homes of military families.

Adolescents are more likely to be resilient in the face of these scenarios than younger children in military families. Another factor that increases positive coping strategies for adolescents is the response of the caretaker that is left in the home, to the disruption in the family routine. It is more likely for children in the home to remain resilient if the caretaker maintains a

consistent schedule and takes care of his/herself and remains emotionally stable. However, research outlines specific issues that occur in adolescents when resilience is low.

Stressors for Adolescents in Military Families

Deployment Status of Military Parent

Cederbaum et al. (2014) studied the influence of parental military connectedness and parental deployment on adolescent mental health. Results indicated that adolescents in military families have a much higher rate of feeling sad or hopeless than established clinical norms. Results from this particular study indicated higher rates of suicidal ideation than in other studies. Deployment status was indicated as a prominent stressor.

Mmari, Roche, Sudhinaraset, and Blum (2009) studied the consequences of parental deployment for adolescents and their families and identify potential strategies that may help adolescents cope with parent's deployment. The results from eleven focus groups discussed adjusting and readjusting from deployment as the biggest stressor. Adolescents may feel more of a conflict, due to accessibility and constant coverage of combat situations, than younger military family members. Cognitive ability for adolescents to understand the dangerous consequences, such as injury or death, for a deployed parent can increase stress. Changes in responsibilities and the routine of the home are indicated as stressors. Reuniting with parent and relinquishing and reestablishing roles and household routines when a service person comes home from deployment can be difficult and stressful. The important events that are missed during deployment is another stressor that was identified by focus group members.

Academic Struggles and Behavior Issues

Engel, Gallagher, and Lyle (2010) outlined child outcomes in the Post 9/11 environment. This environment has seen a significant increase in troop deployments. The study provides a more geographically diverse data set which increases validity and relevance. Engel et al. defined academic achievement as including five separate academic subjects. Engel et al. also redefined deployment dimensions to include length and timing of deployment. The study used 56,000 school age children between 2002 and 2005 who were enrolled into Department of Defense (DoD) schools. Military parents' service record was paired with students' test scores. Findings suggest that deployment lowers total test score by 0.42 points. This associates lower academic achievement for children with military parents. The study reflected that effects of parental deployment tend to dissipate after the return of the parent. DoD schools are also more likely to have support mechanisms in place to buffer deployment issues that emerge with students that non DOD schools.

Morris and Age (2009) examined youths in military families ability to cope, present effortful control, and adjustment practices. Morris and Age studied 65 youth (ages 9-15) who had one parent in the military. Results indicated that youths in military families reported higher numbers of conduct problems than established clinical norms. Results also indicated that avoidant coping showed a higher rate of emotional symptoms where effortful control and

maternal support act as protective factors. There were no significant differences in deployed versus non-deployed parents.

Multiple Relocations

Lemmon and Stafford (2014) outlined common issues for stress in children due to deployment cycles as school failure, behavior problems, acting out, regression in developmental milestones, and physical symptoms of pain or dysfunction. Specific stressors include moving into diverse geographical areas of the world, living on an installation and having the tools of war present in their everyday life, learning early on that the needs of military service come before their own, and with older adolescents having to answer the question "Where are you from?" without having a permanent residence to identify as a home. Other stressors include guilt/shame as a result of internal conflict at the idea of their parents serving others when navigating normal egocentric stages of childhood, that shouldn't rationally exist.

Milburn and Lightfoot (2013) outlined research related to adolescent development in U.S. military families during wartime including behavioral, emotional, and academic risk status. Adolescents who are in military families have the added stressors of multiple moves, relocation, and deployment of parent to a combat setting. Physical development can be stressful for most adolescents. Adolescents, who have a deployed parent, can have an increased stress factor, due to limited communication or infrequent ability to communicate with deployed parent. Adolescents, who are in military families, have a unique cognitive development due to the realization of dangerous consequences of their parent's job and the change in life because of deployments. This results in higher rates of stress, worry, fear, and anxiety during deployment cycles. A constant exposure to everyday combat situations through the media can disrupt ability to cope and adapt to deployment of parents. Emotional issues can be difficult due to deployment which often times leaves adult responsibilities with older siblings and expectations to be an adult and respond to situations like an adult. A shift in orientation to peers can be difficult for adolescents in a military family as a result of the multiple relocations.

Role Reversals

Baptist, Barros, Cafferky, and Johannes (2015) discuss the development of resilience in 30 adolescents from National Guard families that had been deployed. Adolescents who were not offered comfort from familiar social and school networks, were left with their families to meet that need. The extent of comfort from a parent was dependent on the quality of the parental relationship. Adolescents were inclined to uphold military values of personal courage and withdraw to self-soothe. Stressors that were indicated include: emotional and behavioral difficulties, and influence of caretaker parents emotional response to deployment of military parent (Baptist et al., 2015). Self-reliance, family life, friends and school, community connection, and society and media are all indicated as themes to help build resilience in adolescents in military families.

Maholmes (2012) used attachment and family stress theories to frame the effects of deployment on immediate and long term child adjustment. Adolescents are more likely to be aware of changes in family dynamics related to deployment cycles, including dangers to the

deployed parent. Responses to these changes may depend on the type of attachment bond, length of deployment, the number of years that the parent has served, and the ability of parents to create a sense of normalcy even in the midst of deployment.

Maholmes (2012) suggested that a role reversal may occur, leaving the adolescent with more responsibility during deployment. This can lead to an acceptance of adult responsibilities or a refusal to take them on, leaving the adolescent with feelings of anger, frustration, or apathy toward family, school, and extracurricular activities. Attitudes can hamper coping abilities leading to negative thinking patterns. When the deployed parent returns home, adolescents can become resentful if acceptance of responsibility isn't acknowledged or relinquished. Unlimited access to information related to day to day life in deployment situations can lead to significant stress and lead to maladaptive coping mechanisms, such as binge drinking.

Solution-Focused Brief Therapy with Adolescents

Counseling offers support that is essential to adolescents in military families. It allows teens to process their current situation and give them necessary coping skills for the future. Solution-focused brief therapy has been effective in the adolescent population over time. For example, solution-focused brief therapy (SFBT) has been the basis for some school-based counseling programs (Froeschle, Smith, & Ricard, 2007).

Solution-focused brief therapy (SFBT) is unlike many other therapeutic techniques, in that it does not focus on the problem at hand, but creates an environment that moves toward solution building (Gostautas, Cepukiene, & Pakrosnis, 2005). Goals in SFBT are derived from strengths in an individual rather than weaknesses (Enea & Dafinoiu, 2009). The positive approach of solution-focused brief therapy may facilitate positive change in the long term (Enea & Dafinoiu, 2009). Positivity is essential when counselors work with families in the military.

Many believe that SFBT can be an effective approach to a wide range of problems. Researchers have found that using SFBT for resolving issues such as sleep disorders, eating disorders, parent-child relationships, marital problems, family violence, sexual abuse, suicidal ideation, and depression may have up to a 70% success rate (DeJong & Berg, 1998). Many of these issues are ones that effect adolescents and may be enhanced by the military lifestyle. Military families are often plagued by relationship strain and added responsibility when one parent leaves for training or deployment. As a result, counselors must consider methods of treatment that have proven to be effective in resolving multiple issues.

Froeschle et al. (2007) examined the efficacy of a prevention program based on SFBT. The program evaluated was the "SAM" (solution, action, mentorship) program, which is based on three main components used to combat drug use in adolescent females (Froeschle et al., 2007). The three main components include; group solution-focused brief therapy, action learning techniques, and mentorship. The SAM program utilized solution-focused brief therapy techniques such as the miracle question, scaling, and finding exceptions (Froeschle et al., 2007). Data from the study indicated that SFBT techniques were effective in cultivating less favorable attitudes toward drug use, an increase in positive social behaviors, and an increased knowledge

of consequences due to choices of drug use (Froeschle et al., 2007). This study is an example of the positive effect that SFBT has on the adolescent population.

Solution-Focused Brief Therapy and Sand Tray

Sand tray is a therapeutic technique grounded in play therapy (Swank &, Lenes, 2013). It can be effective with all ages, ethnicities, and genders (Taylor, 2009). Sand tray therapy uses sand, figurines, and the imagination of the individual to describe and confront difficulties that one cannot verbalize (Taylor, 2009). It gives the client a way to speak through their problems in a non-threatening manner (Taylor, 2009). Combined with solution-focused brief therapy, it may give the military adolescent a more effective way to share his/her life and its struggles.

Adolescents have a difficult time verbalizing their problems at times. This is especially true for adolescents in a military family, who may feel as though their peers cannot understand the complexities of their life. Counselors may use sand tray as an expressive technique to form a bond between their outer and inner worlds (Swank & Lenes, 2013). In turn, this gives teens the tools for self-expression by bridging the gap between verbal and nonverbal communication (Swank & Lenes, 2013).

Sand tray allows the individual to deal with interpersonal concerns, learn new skills, problem solve, and develop coping skills (Draper, Ritter, & Willingham, 2003). Sand tray and solution-focused brief therapy offer a positive outlook on therapy that is different than other techniques. Research has clearly shown that solution-focused brief therapy is effective when working with youth. In addition, researchers indicate that sand tray is an effective treatment for children and adolescents (Swank & Lenes, 2013).

Most of the current research pertaining to sand tray has focused on children and adolescents within the school system (Swank & Lenes, 2013). Recently, Swank and Lenes conducted a study using sand tray to work with adolescent females that were attending an alternative school. They utilized sand tray within a group counseling setting. The researchers identified several common themes within the group. These included self-expression, development of insight, growth, hope, and positive group dynamics (Swank & Lenes, 2013). Researchers concluded that sand tray used in a group setting allowed students to have supportive interactions with their peers (Swank & Lenes, 2013).

According to Flahive and Ray (2007), sand tray utilized in schools may give students an opportunity to experience positive peer interactions. Positive peer interactions are important for the development of youth. Erikson (1968) postulated that peer relationships are most important during the phase of development known as identity vs role confusion. Identity vs role confusion is Erikson's stage of development that transitions an individual from childhood to adulthood (Erikson, 1968). Promoting positive peer interactions can be a strength of techniques used by sand tray. Developing genuine peer relationships may add needed support for the military adolescent.

Sand tray employs techniques that may be non-threatening to an individual. Sand and figurines are familiar to all individuals during childhood and seems less threatening than

traditional verbal therapy (Taylor, 2009). Solution-focused brief therapy focuses on problem solving and the strengths of the individual, making it easy to use with sand tray. Placing a positive, strength-based view on the three-dimensional creativity of an individual can have an outcome that has no boundaries (Taylor, 2009).

Both SFBT and sand tray allow individuals to take ownership and empowers them for change in their own lives (Taylor, 2009). Solution-focused brief therapists typically focus on keywords in the verbal interaction with clients. While sand tray therapists will focus on specific items or where items are placed in the tray, both sand tray and solution-focused brief therapists attempt to empower the client by allowing them to take charge of their positive traits and utilize them for change. Counselors could use this technique with a military teen to create positive change. Shining a light on the strength and resiliency military teens possess because of their lifestyle, may enable them to thrive during other difficulties in life. Both of the techniques discussed also focus on the interpersonal aspects of the healing process (Taylor, 2009).

Therapists may use compliments, a technique specific to SFBT, in combination with sand tray to create positive change. For example, the therapist may use a compliment to demonstrate good decision making skills from an observation they have of a client's sand tray (Taylor, 2009). Relationship questions are also used in SFBT. These questions seek to learn how clients view themselves based on how they are viewed by others (Taylor, 2009).

Exploring relationships may be useful when working with an adolescent who has a parent that is deployed. At times, these teens have added responsibility that can blur the lines between parent and child. In sand tray, clients typically use figurines to show relationships. A therapist could combine the two by asking specific questions related to how their client is viewed by individuals represented in the sand tray. Therapists can also use the SFBT technique of exploring exceptions to learn more about the sand tray creation of their client. The therapist may do this by asking exception questions related to events portrayed in the sand tray.

Implications for Practice

School Counselors and community counselors that work with youth must be aware of techniques that are effective with this particular population. Studies have shown that both solution focused brief therapy and sand tray are effective when working with children and adolescents. In fact, solution focused brief therapy stands alongside reality therapy and rational emotive behavior therapy as proven methods used in schools (American School Counseling Association [ASCA], 2010). According to the *ASCA Ethical Standards* (2010), school counselors must have knowledge of theories and techniques that work in schools.

Sand tray is a form of play therapy that requires special training and instruction (Swank & Lenes, 2013). Some counselor education programs provide courses in play therapy. However, that is not standard among all of them. Counselors can receive training through specialized play therapy programs, workshops, and conferences (Swank & Lenes, 2013). It is essential that counselors have specific training before implementing any therapeutic technique. The American Counseling Association (ACA; 2014) has clearly outlined requirements for professional responsibility. According to the *ACA Code of Ethics* C.2.b, counselors may only practice in

specialty areas after appropriate education, training, and supervision have taken place (ACA, 2014).

Advocating for the Military Teen

In addition to providing therapy, counselors must advocate for their clients. The *ACA Code of Ethics* discusses the role of advocacy in professional practice (ACA, 2014). Counselors must advocate for their clients to improve services, access, growth, and development (ACA, 2014). This is true for all clients, but may be necessary for the military client. Military families need services to get through deployments, the return of their family member, or loss of a parent. Counselors should be knowledgeable of programs that are specifically available to military members.

For example, the exceptional family member program (EFMP) is designed to meet the needs of US military families during the transition process (Marine Corps Community Services, 2015; United States Army Family Morale, Welfare, and Recreation, 2016; Military OneSource, 2016). These needs include emotional, physical, medical, and educational needs (Marine Corps Community Services, 2015; United States Army Family Morale, Welfare, and Recreation, 2016; Military OneSource, 2016). This is just one of the many programs offered by the US Armed Forces. They also serve to assist members by providing education, counseling, childcare, after school programs, and employment aid services (MCCS, 2015; Military OneSource, 2016). Each Armed Forces installation also provides a 24 hour hotline to report domestic and child abuse for those living on the installation (MCCS, 2015; Military OneSource, 2016). They provide two additional hotlines to report assault and sexual abuse (MCCS, 2015; Military OneSource, 2016). Family members may not be aware of the services available. Therefore, counselors must find ways to refer clients to services that meet their needs.

Implications for Research

This article outlined four themes in the literature about adolescents in military families. Future research should investigate the effect of sand tray and SFBT on the following: the perceptions of what deployment means to military family members left at home; the academic struggles and behavior issues of military children in school settings; resiliency of adolescents who have had multiple relocations due to the military; and the understanding of role reversals in the home during deployment cycles. Military families can be classified as a closed group, making it incredibly difficult to gain connections for research. Individuals who have connections to this closed group will add different perceptions to the literature than researchers who have no military affiliation.

Conclusion

Adolescents in military families may have more life issues to overcome than the traditional adolescent. Their family is unlike any other and causes strain to an already developing child. Specific issues for an adolescent in a military family may include but are not limited to: deployment status of military parents, academic struggles and behavior issues, multiple relocations, and role reversals. Counselors must be aware of the military teens' struggles and

offer support that differs from traditional therapeutic techniques. Combining solution focused brief therapy and sand tray may offer a positive and creative outlet for these teens. Giving them a way to express their family struggles without feeling pressure is beneficial for their development. Sand tray gives teens that outlet. Constructing interventions based on both sand tray and solution-focused brief therapy techniques may be beneficial for adolescents in the military. It can give them the empowerment needed to live life as an adolescent in a military family. Counselors that combine effective therapeutic techniques and advocacy will give the military adolescent tools for success.

References

American Counseling Association. (2014). Code of ethics and standards of practice. Alexandria, VA: Author.

American School Counselor Association. (2010). ASCA ethical standards. Alexandria, VA: Author.

Baptist, J., Barros, P., Cafferky, B. & Johannes, E. (2015). Resilience building among adolescents from National Guard families: Applying a developmental contextual model. *Journal of Adolescent Research, 30,* 306-334. doi:10.1177/0743558414558592

Carroll, J. L., & Wolpe, P. R. (1996). *Sexuality and gender in society.* New York, NY: Harper Collins College Publishers.

Cederbaum, J.A., Gilreath, T.D., Benbenishty, R., Astor, R.A., Pineda, D., DePedro, K.T., . . . Atuel, H. (2014). Well-being and suicidal ideation of secondary school students from military families. *Journal of Adolescent Health, 54,* 627-677. doi:10.01016/j.jadohealth.2013.09.006

DeJong, P., & Berg, I.K. (1998). *Interviewing for solutions,* Pacific Grove, CA: Books/Cole.

Draper, K., Ritter, K., & Willington, E. (2003). Sand tray group counseling with adolescents. *Journal for Specialists in Group Work, 28,* 244-260. doi:10.1177/0193392203252030

Enea, V., & Dafinoiu, I. (2009). Motivational/solution-focused intervention for reducing school truancy among adolescents. *Journal of Cognitive and Behavioral Psychotherapies, 9,* 185-198.

Engel, R.C., Gallagher, L.B., & Lyle, D.S. (2010). Military deployments and children's academic achievement: Evidence from Department of Defense Education Activity Schools. *Economics of Education Review, 29,* 73-82.

Erikson, E.H. (1968). *Identity youth and crises.* New York, NY: W.W. Norton.

Flahive, M.W., & Ray, D. (2007). Effect of group sandtray therapy with preadolescents. *The Journal for Specialists in Group work, 28,* 362-382. doi:10.1016/S1054-139X(01)00304-4

Froeschle, J., Smith, R., & Ricard, R. (2007). The efficacy of a systematic substance abuse program for adolescent females. *Professional School Counseling, 10*, 498-505.

Gostautas, A., Cepukiene, V., Pakrosnis, R. (2005). The outcome of solution-focused brief therapy for adolescents in foster care and health care institutions. *Journal of Psychology, 6,* 5-15.

Lemmon, K., & Stafford, E. (2014). Advocating for America's military children: Considering the impact of parental combat deployment to Iraq and Afghanistan. *Family Court Review, 52,* 343-354.

Marine Corps Community Services. (2015). *MCCS forward.* Retrieved from http://www.usmc-mccs.org/

Maholmes, V. (2012). Adjustment of children and youth in military families: Toward developmental understandings. *Child Development Perspectives, 6,* 430-435.

Milburn, N.G. & Lightfoot, M. (2013). Adolescents in wartime US military families: A developmental perspective on challenges and resources. *Clinical Child Family Psychology Review, 16,* 266-277. doi:10.1007/s10567-013-0144-0

Military OneSource. (2016). *Special Needs.* Retrieved from http://www.militaryonesource.mil/efmp

Mmari, K., Roche, K.M., Sudhinaraset, M., & Blum, R. (2009). When a parent goes off to war: Exploring the issues faced by adolescents and their families. *Youth and Society, 40,* 455-475. doi:10.1177/0044118X08327873

Morris, A. S., & Age, T. R. (2009). Adjustment among youth in military families: The protective roles of effortful control and maternal social support. *Journal of Applied Developmental Psychology, 30,* 695-707. doi:10.1016/j.appdev.2009.01.002

Roaten, G. (2011). Innovative and brain-friendly strategies for building a therapeutic alliance with adolescents. *Journal of Creativity in Mental Health, 6,* 298-314. doi:10.1080/15401383.2011.630306

Skudrzyk, B., Zera, D., McMahon, G., Schmidt, R., Boyne, J., & Spannaus, R. (2009). Learning to relate: Interweaving creative approaches in group counseling with adolescents. *Journal of Creativity in Mental Health, 4,* 249-261.

Swank, J.M., & Lenes. E.A. (2013). An exploratory inquiry of sandtray group experiences with adolescent females in an alternative school. *The Journal for Specialists in Group Work, 38,* 330-348. doi:10.1080/01933922.2013.835013

Taylor, E. R. (2009). Sandtray and solution-focused therapy. *International Journal of Play Therapy, 18,* 56-68. doi:10.1037/a0014441

U.S. Army Installation Command. (2016). *Child and Youth School Services.* Retrieved from http://www.armymwr.com/Family/childandyouth/default.aspx

Wiley, R., & Berman, S. (2013). Adolescent identity development and distress in a clinical sample. *Journal of Clinical Psychology, 69*, 1299-1304.