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Military Families' Reintegration and Resiliency:
An Examination of Programs and Civilian Counselor Training.

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JAMES MADISON UNIVERSITY

In

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Abstract

Military members and their families have many potential issues to face, both during deployment and reintegration. Some of these issues include mental health problems, relationships with family members, employment, etc... This paper will include a review of the literature regarding current concerns of military members and their families, an overview of some of the existing programs aimed to help this population, interviews with three counselors working with the military population, and conclusions and recommendations for future programs. Findings included differences between programs in the research and what techniques counselors may be using and strategies for developing effective programs.

Military Families: Reintegration and Resiliency

Introduction

Issues surrounding the military and their mental health and well-being are at the forefront of much conversation due to complex reintegration issues. Service members who are deployed face a number of stressors and potentially traumatic events, and their families at home can also be affected by distress while their service member is away (Lester et al., 2012). Since 2001, about 2.4 million service members have been deployed for Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) (Ross & DeVoe, 2014). As of 2012, there were approximately 1.4 million active duty and 856,000 reserve members in the military. There are over 3.1 million family members that will be supporting these military members while they are deployed and upon return home (Clark, Jordan, & Clark, 2013). The current conflict contains stressors that service members in the past have not always had to face. Suicide bombers and roadside improvised explosive devices (IEDs) are not unusual challenges for them to face (Barker & Berry, 2009). Once soldiers return, there are many challenges they and their families may face. There could be physical injuries such as amputations, musculoskeletal injuries, shrapnel injuries, auditory damage, or burns. In addition to these visible injuries, they may have invisible injuries, including traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), depression, or substance use disorders. Thirty-three percent of members who come back from combat are reported to suffer from TBI, PTSD, and depression, with 5% meeting the criteria for all three of these diagnoses (Cozza, Holmes, & Van Ost, 2013).

The purpose of this paper is to explore current issues regarding reintegration for military members and their families. The paper will also look at current programs available to military members and their families in order to help with reintegration issues. Interviews with counselors currently working with this population will also be included in order to provide a real world perspective on these issues. To conclude the paper, there will be future considerations for effective programs and strategies for counselors to learn about the military population.

Literature Review

As many military members leave active duty, the responsibility for caring for them will range from the Department of Defense (DoD) and into the Veterans Administration (VA) and civilian agencies (Glynn, 2013). There needs to be educational opportunities and resources to make sure civilian therapists can work effectively with this population. Another reason that civilian counselors need to be trained on how to work with this population is the issue of meeting the needs of service members once they are no longer part of the military. While they are on active duty, the health services are available through the DoD and members are provided with counselors who are familiar with the military and relevant treatment approaches. With the ending of the OEF/OIF/OND conflicts and budgetary constraints in the DoD, there will be hundreds of thousands of military members returning or have already returned to a civilian community when they might have been planning for a longer military career (Glynn, 2013).

It is important that the civilian communities they are returning to are able to meet the needs of this unique population, whether these needs are socioeconomic in nature or

deal with mental health well-being (Glynn, 2013). Therapists in the private-sector may need to consider several factors when working with military personnel and their families. Some military members may choose to go to a therapist in the private-sector over a therapist in the military because of the fear of discrimination or damage to their career. Civilian therapists should be familiar with the unique culture and language of the military because it can be the difference in someone staying for treatment or not coming back after the first session. One example is Operation Immersion (OI) (Goodman, 2011). OI allows therapists in the private-sector the opportunity to be immersed into the military experience in order to understand their potential clients better. It is a two-day experience where counselors sleep in bunk beds in open bays, share showers, eat Meals Ready-to-Eat (MRE), and do high cardio workouts. Several therapists could see noticeable differences in their work with military clients after having participated in this program. For some, it gave them credibility with their clients and allowed the clients to speak more freely about their personal stories. The clients seemed to appreciate the counselors' attempt to learn about military culture. Counselors who have participated in this reported a greater ability to understand their military clients' struggles and experiences (Goodman, 2011).

In addition to gaining comfort with the military lifestyle, counselors need to become aware of some basic systemic differences (Goodman, 2011). For example, there are differences between branches of the military related to healthcare and culture. Those who are in the National Guard or Reserves have health care benefits that are different from other military personnel, which can make finding adequate services more difficult (Goodman, 2011). The therapeutic approach used in counseling can also vary

depending on the branch of service. What may work for a member of the U.S. Army may not have the same effect for someone who is in the U.S. Navy (Everson & Herzog, 2010).

In a study done by the National Guard in California in 2010, 14,000 members were tracked from 2006-2010 to see what mental health issues they experienced. This study includes four categories for mental health treatment: self-initiated, provider-initiated, requested by a commander, or suggested by a peer. This study suggested that as many as 60% of issues for these Guard members had to do with the reintegration process itself (such as concerns with marriages/families and jobs/finances) rather than effects of combat. Coming back to civilian life and figuring out their new roles can be a major transition (Danish & Antonides, 2013). Divorce and separation is a common occurrence in military couples. Three years after coming home from deployment, one-third of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans who were receiving Veterans Affairs (VA) care had been through a separation or divorce. The length and amount of deployments are also related to higher rates of divorce, particularly among sailors and marines (Link & Palinkas, 2013). Military training may have served them well in a warzone, but it may not prepare them to transition back to civilian life. Service members may also struggle with trying to find meaning and purpose in their new lives at home (Danish & Antonides, 2013).

Despite experiencing a difficult transition, service members still may not seek help. Stigma is a major impediment to treatment. To some, “stigma can be more devastating, life limiting, and longer lasting than the primary illness itself” (Danish & Antonides, 2013, p. 551). In 2004, 6,000 marines and soldiers were surveyed for major depression, generalized anxiety, or PTSD. For those who met criteria for these

diagnoses, only 38-45% said they would be interested in receiving help and 23-40% actually did receive mental health care. Military culture negatively affects the willingness of a soldier to get help. Some fear it would hurt their career, especially when they do not want to jeopardize being able to return to war (Danish & Antonides, 2013). Some service members do not fully trust mental health professionals. The roots of this distrust are the stigma surrounding seeking help, and fears of being perceived as weak and of being treated differently by fellow service members (Jarrett, 2013).

One in five OEF and OIF veterans lives in a rural area. There are mental health problems in about 40% of these veterans and suicide rates are higher among rural residents. Research shows that rural veterans might not access needed mental healthcare, even when it is available through the VHA (Waliski, Townsend, Cheney, Sullivan, Hunt, & Curran, 2014).

Members of the National Guard/Reserves (NG/R) have some unique challenges when compared to members of other branches (Scherrer et al., 2014). They tend to be more geographically scattered than other branches of the military. They also might get less training before active duty and usually are not surrounded by their military unit after they finish their deployment. Financial struggles and relationship difficulties are also more common among members in this military branch. NG/R members have higher rates of PTSD and depression than active-component military members. NG/R members were also more often referred to receive behavioral healthcare after deployment. The family members and spouses of NG/R members are usually disconnected from military family support networks because of their geographical distribution, and it may be harder for them to learn about support systems for the military and veterans (Scherrer et al., 2014).

All of these issues can have a significant impact on a service member's family as well. Visible and invisible injuries, the stress of medical care, and possible rehabilitation services can put a strain on the uninjured parent (Cozza, Holmes, & Van Ost, 2013). Physical and psychological injuries also may affect parenting styles and interactions with kids. Because of those injuries, a parent may no longer be able to play outside with their kids or their personality and behavior may have changed (Cozza, Holmes, & Van Ost, 2013). In a 2009 study of active duty spouses by Defense Manpower Data Center, slightly less than one-third of those surveyed reported their service member having problems reconnecting with children after deployment (Link & Palinkas, 2013). Kids aged five and under are the largest group of minor dependents of active duty service members (more than 470,000 children, 40.3% of minor dependents). This age group has a set of unique stressors in addition to having an active duty parent, some of which include developing language and memory skills and emerging attachment to others. A commonly reported issue with the return of the service member is the young child not recognizing him or her, which may be a result of disrupted attachment formation (Barker & Berry, 2009). Children can have varying reactions, depending on their age and development, to the changes that accompany their parent returning home with an injury. Some might have emotional or behavior problems, be saddened or confused, or disengage from the family (Cozza, Holmes, & Van Ost, 2013).

For children under the age of five with a deployed parent, 25-50% show home discipline problems, sadness, and more demands for attention (Barker & Berry, 2009). There can also be changes in appetite and sleep, including nightmares. Behavior issues seem to be more prominent in younger children rather than older, especially for boys

(Barker & Berry, 2009). The length of deployment and the psychological health of parents were seen as risk factors for more distress in children. Link and Palinkas (2013) studied persons with active duty spouses to investigate the impact of having a parent who was deployed. One-third of these spouses said there were decreases in academic performances, more than half claimed problems at home, and two thirds said their child's level of anxiety or fear increased (Link & Palinkas, 2013). In Barker and Berry's 2009 study of parents and children who had been involved in single or multiple deployments, there were interesting findings. The children in these groups had parents who had been gone, on average, half of their lifetime. As the number of deployments increased, the children had a matching increase in behavior problems from predeployment to deployment. Parent and child comments from these studies included questions kids had about when the deployed parent would be coming home, if they still lived there or not, taking a while to warm up to the deployed parent once they returned, and advice about keeping kids socialized with play groups, understanding that they feel the stress in the household too, keeping pictures of the deployed parents around the house, and letting the child speak to them as often as possible (Barker & Berry, 2009).

Deployment is seen as the biggest stressor for military spouses (Link & Palinkas, 2013). Secondary victimization can occur with these spouses, which is when PTSD symptoms can be passed on to the spouse from the service member through disturbing descriptions of war experiences (Link & Palinkas, 2013). These spouses are just as vulnerable, if not more, to the stresses that their active duty spouses are facing. Potential contributors are the lack of support and lack of information on the status of their spouse (Lester et al., 2012).

Given the stressors that military members and their families face, there are many programs that aim to help this population. The following section will go over some of these programs and their effectiveness with military members and their families.

Current Programs

Currently, there are many programs and theories available to service members and their families aimed to help them face these challenges, many of which are based on family systems theories (Cozza, Holmes, & Van Ost, 2013). Several programs adopt Walsh's Family Resilience Theory and are rooted in the belief that families have a need for shared beliefs, constructive communication, and healthy patterns of organization. These principles were expanded to create intervention strategies for families, which include:

Educating adults and children about the impact of injury and the expected recovery process;

Reducing family distress and disorganization through family care management and provision of practical support;

Developing emotion regulation skills necessary for ongoing dialogue and collaboration;

Developing a shared understanding using injury communication; and

Developing optimism and future hopefulness (Cozza, Holmes, & Van Ost, 2013, p. 315-318).

Lester et al. (2012) investigated the effectiveness of the *FOCUS (Families OverComing Under Stress)* program. The program is based on family-centered preventive interventions and was originally used with the US Marine Corps as a

demonstration for the US Marine Corps and the US Navy. It is a strength-based, practical program that is applicable to military families. It incorporates a structured narrative approach where family members can share their unique stories and experiences while learning coping skills. FOCUS also uses the stress continuum model of the US Navy and US Marine Corps, which divides up deployment stress into four color zones (green, yellow, orange, and red), which represent an escalating stage of risk of psychological distress or injury (Lester et al., 2012).

FOCUS training is given to individual families in eight sessions. Parent/family sessions (90 minutes) usually last longer than child sessions (30-60 minutes). There were 488 families (742 parents) who were enrolled in FOCUS training from July of 2008-February of 2010 (Lester et al., 2012). Of the 488 families, 51.2% were self-referred, 42.6% were referred by a provider, and 6.2% were referred by other sources like friends or volunteers. The families were assessed before and after the FOCUS intervention (Lester et al., 2012). Self-reported family functioning was measured by the McMaster Family Assessment Device (Ryan, Epstein, Keitner, Miller, & Bishop, 2005) and distress levels were measured by the Brief Symptom Inventory (Derogatis, 2001). There were no differences between active and non-active duty parents, but both groups were significantly more distressed than community norms. After the interventions, parents were asked to rate their perceptions of change and satisfaction with the program on a 0-7 scale. Improvements in emotional regulation were rated at a mean of 5.52 and improvements in understanding combat stress/family stress reactions were 6.05. Overall, parents were satisfied with the program. They rated overall helpfulness at a mean of 6.51, satisfaction with the program at 6.58, and willingness to recommend it at 6.7.

Scores for unhealthy family functioning and distress had been reduced by the end of the program (Lester et al., 2012). Children in the program had decreases in overall difficulties and improvements in prosocial behavior, as measured by the Strengths and Difficulties Questionnaire-Parent Report (Goodman, Ford, Simmons, Gatward, & Meltzer, 2000). Of the original 488 families enrolled in FOCUS, there were 331 who completed the intervention. Some families could not complete it because of deployment-related geographical moves, and one of the considerations the authors suggested was finding programs well-suited for other branches of the military that are geographically spread out, like the National Guard or Reservists (Lester et al., 2012).

Scherrer et al. (2014) conducted an assessment of the *Yellow Ribbon Reintegration Program (YRRP)* for National Guard members and their supporters. This aim of this study was to see the effectiveness of this program for NG members and their spouses or supporters and to see if it was able to open the door for future referrals and outreach for this population. The YRRP consists of weekend trainings that are held 30 days and 60 days after deployment. Slightly more than half of the NG members that attended the trainings had supporters with them. The NG members and supporters completed a questionnaire at the beginning and end of the YRRP. There were 683 NG members and 411 supporters that were included in this study (Scherrer et al., 2014).

During the YRRP, the members and their supporters received information about services that are available to them, including educational, employment, family/relationship, legal, and healthcare services. This program also informs members about frequent issues that occur during reintegration, like relationship issues, substance use, anger, and post-traumatic stress (Scherrer et al., 2014).

The data in the Scherrer et al. (2014) study show that 82.7% of NG members and supporters said YRRP gave information or ways to help in at least one of the five categories (educational, employment, family/relationship, legal, and healthcare service). When compared to NG service members, there were more supporters who learned about the information at YRRP for the first time. NG members had more concerns about education, employment, and health compared to their supporters. NG supporters had more concerns with family/relationship issues than the NG members. With all five categories of reintegration assistance, 83% of participants thought that YRRP was helpful. Participants felt that YRRP was most helpful in giving information about education and healthcare, but less helpful with information about employment, family/relationship issues, and legal issues. Authors speculated that including supporters in YRRP may have been an advantage for improving reintegration for NG members (Scherrer et al., 2014).

There are predeployment YRRPs where supporters can learn information similar to what they learn at postdeployment YRRP (Scherrer et al., 2014). Given the differences between NG members and supporters in those saying it was the first time they learned the information, the authors wondered whether supporters might have been concerned about the immediate changes about to take place in their family at the predeployment YRRP and may not have been able to take in all the information at the predeployment YRRP. More research is currently being done on the short and long term relationship, economic, and health outcomes related to deployment to observe the effectiveness of YRRP (Scherrer et al., 2014).

The *Wounded Warriors* program is dedicated to the rehabilitation and care for military members of all branches who have been injured in their service on or after September 11, 2001 and their families (Wounded Warrior Project, 2014). These injuries can be physical and/or mental. In recent conflicts, there are many more service members surviving severe injuries. For every soldier who was killed in World War I and World War II, there were 1.7 soldiers wounded. In contrast, for every U.S. soldier killed in OIF or OEF, seven are wounded. Over 48,000 service members have been injured in these recent conflicts. In addition to these physical injuries, about 400,000 service members have psychological injuries from these conflicts and 320,000 are believed to have suffered a traumatic brain injury while deployed. Wounded Warriors incorporates many aspects of the reintegration process into their work with veterans. Their programs are divided into four areas: mind, body, economic empowerment, and engagement. There are many similarities between these areas, especially mind and body (Wounded Warrior Project, 2014).

One program that falls under the **mind** category is the *Combat Stress Recovery Program* (Wounded Warrior Project, 2014). The first part of this is Project Odyssey, an outdoor retreat that focuses on rehabilitation and connecting with nature and peers. Activities include horseback riding, skiing, hockey, fishing, kayaking, and among others. The purpose of these activities is for veterans to gain experience working through challenges they may face related to combat stress. There are opportunities for Project Odyssey in the service member's area, a specific Project Odyssey retreat for couples to rebuild their relationship, and an international Project Odyssey to begin while they are still on active duty at Landstuhl Regional Medical Center (LRMC) in Germany. Between

October 2012 and September 2013, 86% of warriors felt that the PTSD coping skills they learned during Project Odyssey were useful or very useful. Another resource for the warrior's mind is the Restore Warriors online program to teach them about PTSD symptoms, combat stress, and TBIs. There are self-assessment tools, videos of fellow warriors sharing their stories, and exercises to teach them about readjustment (Wounded Warrior Project, 2014).

The *Independence Program* is a long term program that helps warriors who rely on their families or caregivers because of brain injury, spinal cord injury, or other neurological conditions (Wounded Warrior Project, 2014). A unique plan is designed for each warrior, bringing him/her and the entire support team together to give the warrior purpose through participating in social activities, wellness, volunteer work, education, and living skills. There is also a long term support trust in the event that a warrior's caregiver dies and they are at risk of institutionalization. Resources like life-skills training, home care, and transportation are available for all warriors that are enrolled for these services and benefits. The goal is for those warriors to still be able to live as independently as possible (Wounded Warrior Project, 2014).

Wounded Warriors has programs aimed to help the **body** as well (Wounded Warrior Project, 2014). In these *Physical Health and Wellness (PH&W)* programs, the goal is to help deal with depression, reduce stress, and encourage a healthy and active lifestyle for the warriors. There are activities for the warrior to participate in no matter what stage in the recovery process they are experiencing. There are inclusive sports for warriors with cognitive, emotional, or physical injuries to help them with leadership skills and thriving. Some of these include adaptive horseback riding, wheelchair baseball, and

accessible fishing and hunting. Fitness is also emphasized in the PH&W programs, including various types of aquatic exercise to relieve pain or strengthen muscles that are weak. This program also teaches nutrition information about the food groups and how to make healthy food. There is also an emphasis on mind and body wellness working together and this program suggests participating in activities like yoga, meditation, stress management, scuba, and smoking cessation education (Wounded Warrior Project, 2014).

Also under the body category is *Soldier Ride*, a four-day cycling program to wounded service members that covers either a 25-mile or 50-mile course (Wounded Warrior Project, 2014). This event can be for various ability levels through adaptive hand cycles, trikes, and bicycles. Soldier Ride helps create bonds between the warriors and helps with their confidence. Soldier Ride is offered in nearly twenty locations in the U.S. and Germany. Between October 2012 and September 2013, 91% of warriors said that they were able to seek out other recreation events in their community because of being in a PH&W event (Wounded Warrior Project, 2014).

The Wounded Warriors program has **economic empowerment** programs to make sure veterans can find careers after they return (Wounded Warrior Project, 2014). The *TRACK* program is a free 12-month education program specifically for Wounded Warriors located in Jacksonville, Florida and San Antonio, Texas. This program allows warriors to support one another as they begin or continue their education, make goals for physical health, and learn how their combat injuries might affect their work. Another free program is the *Transition Training Academy (TTA)* for warriors who are interested in the information technology (IT) field. This is an experiential program and is especially useful for those living with TBI or PTSD. TTA is available in several locations across the

United States and also online. Between October 2012 and September 2013, 96% of warriors reported that they could use what they learned in TTA to lead their future career choices if they left the military (Wounded Warrior Project, 2014).

The Warriors to Work program gives career guidance to veterans who want to reenter the civilian workforce (Wounded Warrior Project, 2014). This program helps the veteran decide a career, make a resume, prepare for an interview, and network. In addition to helping the warriors themselves, this program also connects with employers to provide them with information about combat-related injuries like PTSD and TBI. Between October 2012 and September 2013, 1,000 warriors were placed into employment through Warriors to Work, which is almost double the amount that were placed to work between October 2011 and September 2012. Seventy-four percent of warriors remain in employment 1 year after being placed, according to data collected between October 2012 and September 2013 (Wounded Warrior Project, 2014).

The **engagement** section of Wounded Warrior programs is a peer mentoring program and an alumni program (Wounded Warrior Project, 2014). There are different alumni events throughout the year and an online community where alumni can keep in contact for long-term support. There are also opportunities for alumni to support activities for newly injured members. Between October 2012 and September 2013, there were 38,954 warriors actively engaged with Wounded Warrior Project. The Benefits Service portion of this program ensures that warriors and their families have access to government benefits through the DoD and VA. This program also allows for access to resources available to wounded military service personnel through Wounded Warrior and in their community and helps provide the tools they need to become financially secure.

Between October 2012 and September 2013, \$16.38 million was obtained for individual warriors through the Benefits Service (Wounded Warrior Project, 2014).

There are currently Wounded Warrior programs to support military members who are overseas, in Landstuhl Regional Medical Center (LRMC) and Ramstein Air Base in Germany (Wounded Warrior Project, 2014). They provide jackets, sweatpants, and other comfortable clothes for injured service members to wear while traveling home because their belongings may not get transferred to LRMC with them. The programs also provide support to the doctors and nurses that care for the military members. Wounded Warrior Project (WWP) backpacks are provided with comfort items (toiletries, clothes, cards, etc...) for wounded military members while they are at military trauma units around the United States. For those members who are overseas, there are smaller versions of these backpacks, known as *Transitional Care Packs (TCPs)*. There are also *Family Support Totes (FSTs)* that are given to the family or spouse of a wounded service member in the hospital. These FSTs include a neck pillow, toiletry kit, and many more comfort items (Wounded Warrior Project, 2014).

The peer mentor program is a way for warriors who might be farther along in their recovery to help out a fellow warrior (Wounded Warrior Project, 2014). These mentors are specifically trained to help support their peers. They are available to listen and motivate the other warriors, be a resource for them and their family, help with readjustment issues that they have experienced firsthand, and help set goals for the warrior and their family. Between October 2012 and September 2013, 90% of warriors felt that the peer mentor programs contributed to changes in their ability to help other wounded warriors. As of September 1, 2014, there were 7,920 family members that

Wounded Warrior Project has served. Between October 2012 and September 2013, 94% of warriors said that they were able to network with other family members. As of October 1, 2014, there were 58,034 WWP alumni, 18,020 WWP backpacks and 43,175 Transitional Care Packs given to wounded warriors (Wounded Warrior Project, 2014).

The *Strong Families Program* is a grant-funded program through the DoD (Ross & DeVoe, 2014). It is an eight-module program that is home-based and aims to help with parenting-related stressors of deployment and was developed centered around engagement strategies and potential barriers to participation. Because there is a lack of research on effective engagement strategies for military families, the developers of the Strong Families Program took into consideration effective interventions for dealing with practical and psychological difficulties in family engagement for non-military populations. Despite the knowledge about barriers for military members and families being involved in mental health services, there is still difficulty in getting military members and their families involved in treatment. There is little research on military families with young children and how often they seek mental health treatment. The participants in Ross and DeVoe's 2014 research on the Strong Families program were asked to give their perceptions about the program, how helpful it was for their family, and ways to improve (Ross & DeVoe, 2014).

In their study of the *Strong Families* program, Ross and DeVoe (2014) reported 124 National Guard/Reserve (NG/R) families were enrolled in the study, and 119 continued beyond the initial home visit. Of these participants, 93% completed seven out of eight sessions and posttest assessments. This program uses a strengths-based approach to help with deployment stressors that can affect parent-child relationships. Strong

Families had the well-being of the child and parent as the focus, rather than the psychopathology of the child or parent. The clinicians wanted to honor and respect each family member's perspective and story. The developers of this program also took time to consider what strategies help with treatment initiation and retention in difficult populations. Some of these strategies took place before the program is developed, such as ease of access to the target group, building trust with the group, and consulting the group about their perceived needs. This shift from emphasizing the service member/his or her disorder to emphasizing the impact of parental mental functioning on the parent-child relationship seemed to reduce some of the stigma about mental health treatment that can be a barrier. By having this program at home, it can take away some of the barriers that might exist for NG/R families, such as distance from a clinic and finding child care coverage. The home-based nature of the program most likely contributed to the high initiation and retention rates (Ross & DeVoe, 2014).

For the first few modules of *Strong Families*, clinicians focus on parenting within the military and building in engagement strategies throughout each module. They developed their principles based on Grote, Zuckoff, Swartz, Bledsoe, and Geibel (2007), who developed an engagement interview for financially disadvantaged women who were depressed. This interview was a combination of ethnographic and motivational interviewing. This interview happens before treatment and identifies barriers to treatment. In the first two modules, the family's hopes and reasons for participating are discussed and the clinician finds out the psychosocial history from a military perspective (Ross & DeVoe, 2014).

The third and fourth modules focus on the family's experience with parenting during a deployment cycle and what the child's experience of deployment and reintegration has been (Ross & DeVoe, 2014). These first four modules allow for Modules 5-8 to be individually tailored to each family's needs. There is a lot of flexibility within this program to account daily stressors like financial issues or family conflicts that may get in the way of treatment goals. The clinicians working with these families can work with them on these issues in session and also help with referrals or other helpful resources for the family to use in between sessions. Modules 5-8 are also flexible, with the clinician and family working collaboratively on the treatment goals. This type of program speaks to the importance of and need for deployment-specific parenting support (Ross & DeVoe, 2014).

Waliski et al. (2014) describes programs where community members and community-based organizations partner together to support veterans. One of these programs is a faith-based program called *Partners in Care* (PIC) (Waliski et al., 2014). The goals of this program are connecting a state's National Guard chaplain office and faith-based communities and create more access to supportive services for veterans and their families. Promoting resiliency and reducing the risk for behavioral health problems like suicide are other key goals of this program. The PIC program also trains faith-based leaders in *Operation Statewide Advocacy for Veterans' Empowerment* (SAVE). The goals of Operation SAVE, an evidence-based gatekeeper training intervention, are to prevent suicide and mental health issues by becoming a link between agencies in the federal and state governments. This allows access to services that can help with this issue and help make the transition to civilian life a positive one. *Operation SAVE* has been used

a lot with the Veteran's Health Administration (VHA). Research has shown that this program increases knowledge of suicidal warning signs and referrals for veterans showing these signs (Mann et al., 2005). This program was the first gatekeeper training program that was specifically for veterans, and allowed VHA staff to feel more confident in responding to veterans who are suicidal (Waliski et al., 2014).

Another program that is connecting faith-based communities and mental health providers in rural areas is the *Mental Illness Research Education and Clinical Center* (MIRECC) VA/clergy program (Waliski et al., 2014). There was a need recognized for this kind of programs based on the difficulties that veterans can face with access to mental health care, and the added difficulties for veterans in rural areas (Waliski et al., 2014). About one-third of OEF/OIF veterans will come back from active duty to rural areas, and about one in five of these veterans will have mental health issues (Waliski et al., 2014). The goals of MIRECC are to train pastors as first responders to returning veterans in the area and create connections in rural communities between churches, community mental health providers, military support services, and the VA. This program is community-based and looks different at each site depending on what the unique needs of that community are. The community knows the local resources, who would be the best referral for someone, and community members usually know the veteran well and have a shared history with him or her. This "community based participatory model" proposes that if you join equally with the community members, the program will be more likely to continue over time because each program will be individualized based on the needs of the community (Waliski et al., 2014).

The MIRECC VA/Clergy program has been effective in several different ways (Waliski et al., 2014). There has been more awareness of the needs and struggles of veterans in rural areas and their families and more collaboration between military programs, VA mental health providers, and faith communities. Because of the uniqueness of the program, it is designed to fit the needs many different communities (Waliski et al., 2014).

The *Transition Assistance Program (TAP)* and the *Disabled Transition Assistant Program (DTAP)* were developed by the DoD, VA, Department of Transportation, and the Labor Department's *Veterans Employment and Training Service (VETS)* to meet needs of service members before and during separation (Coll & Weiss, 2013). These programs offer job assistance and training information for service members within 180 days of separation from military service. TAP is a three-day workshop at certain military locations that offers family support services, Department of Labor contractors, state employment services, and Veteran's Employment and Training Services. Service members learn how to search for jobs and write resumes and cover letters. They also are taught about current labor conditions and the veteran benefits that can be available to them if they are honorably discharged. The VA healthcare system offers a lot of services to veterans, such as PTSD treatment services, sexual trauma counseling, and readjustment counseling. This healthcare is free for veterans who had served in combat after November 11, 1998. They have five years from when they served to receive service for free for injuries or illnesses related to combat (Coll & Weiss, 2013).

DTAP programs give disabled veterans direction about VA services and Vocational Rehabilitation and Employment (Coll & Weiss, 2013). The goal is to help

veterans who have a disability from duty adjust back to civilian life. The DTAP sessions are similar to the TAP sessions, covering topics such as VA Vocational Rehabilitation and Employment Programs, VA healthcare information, and the VA Caregiver Support program. There are also Adult Day Health Centers (ADHC) where veterans can go and socialize with peers. There is home-based care available through the VA that can provide nursing, medication management, mental health, and other needs for veterans (Coll & Weiss, 2013).

In order to bring to life various dimensions of the research, informal interviews were conducted with three therapists who have experience with counseling military families. Priscilla Ragsdale, Lisa Southworth, and Lisa Mustard are counselors with unique backgrounds and ways of working with this population.

Interviews

Priscilla Ragsdale: Veterans

Priscilla Ragsdale, MA.Ed., LPC, NCC, works at the Alexandria Vet Center. She was an active member of the Army from 1980-1988. In addition to her active military duty, she has about six years experience counseling in a military setting. She attended The Virginia Polytechnic Institute and State University (Virginia Tech). She did internships in a military setting, one of which was the Fort Belvoir chaplain Family Life Ministry and Training Center (P. Ragsdale, personal communication, October 24, 2014).

Ragsdale's internships allowed her to learn more about and use different theories working with her clients. These experiences also helped her to learn more about the military and about different branches with which she was not familiar. She was able to learn about the different ranks and the roles of each of these for different branches of the

military. She has done many online courses and training about PTSD through the National Center for PTSD website and the Massachusetts Institute. These additional trainings have allowed her to learn more information about the trauma perspective and how clients might be coping in addition to the information she had because of her military background (P. Ragsdale, personal communication, October 24, 2014).

Ragsdale loves learning new techniques to use with clients and described the PTSD manual that she gives to clients when she first meets them. This manual is specific to military veterans and uses the language of military service members. She goes over the manual with them one step at a time, talking about the symptoms and triggers of traumatic memories. She discusses what the experience is like for them individually and what these symptoms mean for them in their life. Relaxation techniques are also discussed, and she talks to them about what relaxation looks like for them (P. Ragsdale, personal communication, October 24, 2014).

When asked what information is important for counselors (civilian in particular) to know about the military population and culture, Ragsdale said to “be comfortable asking questions.” She reviews information about different branches and ranks online, but if a client uses terminology she does not understand, she will ask them to clarify and help her understand it. In her experience, most people are comfortable with her clarifying terms if she is unfamiliar. She has asked clients how their rank in another branch of the military compares to the Army so that she has a better understanding of it. She relies on her clients to educate her on some areas. She also helps clients explore issues in their culture that are important to them in order to understand them better. She has heard of other clients who are sometimes offended if the counselor was not familiar with the

particular war or conflict during which they served, so she realizes that how clients react to being asked to explain something is very individualized. Sometimes she will disclose to a client that she too has served, but only if she feels there is clear purpose for disclosing this information (P. Ragsdale, personal communication, October 24, 2014).

The main techniques and theories that Ragsdale uses in her work with clients are cognitive therapy, eye movement desensitization and reprocessing (EMDR), solution-focused, and relaxation techniques. Some of these relaxation techniques might be grounding or imagining a calm safe place. She sees a lot of people with a PTSD diagnosis, but in her work she focuses on the specific symptoms with which each individual client may be struggling. Whether the client experiences bad dreams of combat, anger, depression, or marital issues, she works to find out what the person is struggling with in life. Sometimes clients come to her because they are combat veterans and their significant others would like them to come in, but they might not feel as if anything is wrong. An example she gave of triggers of memories that could be affecting a veteran was always needing things to be tidy and others not understanding. Ragsdale talked about finding out what war this individual served in and what kinds of experiences this person might have had. She would find out what kinds of things have to be kept neatly. This person might not want things on the floor or in the corner of the room because it reminds them of an IED. In this case, she would work on grounding and making sure that person was living in the present and stepping back having them be aware of where they are (P. Ragsdale, personal communication, October 24, 2014).

Ragsdale facilitates two groups a week in addition to seeing clients individually. These groups are closed and she prefers veterans to be in therapy before attending the

groups. The topics can vary in these groups, and recently they had discussed emotional flashback management and depression and what these things can look like for each person. These groups are educational as well as skill-building, and sometimes there are referrals for psychiatrists if medication might be another helpful way for individuals to deal with symptoms (P. Ragsdale, personal communication, October 24, 2014).

Ragsdale also discussed some of the items she has in her office and on the walls. She has a shelf with many dolls and Barbie's in different military uniforms. She realized that sometimes clients look around when they get into her office and she started this collection. As she realized she was missing some branches of the military, or as clients would point it out to her, she would add more dolls to be representative of the clients she was seeing. She also has several butterflies on one wall of her office and she put them there as a metaphor of the change process and might explain this as a kind of icebreaker to a new client. She says that when it is a caterpillar, it might not understand it has the potential to fly, and that it has to work in order to get to that point. She uses this a way to help clients understand that sometimes we start at one point and do not know where we will end and that there is a process of working in order to move forward (P. Ragsdale, personal communication, October 24, 2014).

Ragsdale discussed the importance of the site where you are working and whether you might be working with individuals who have been veterans for a long time or with active duty military members might change the skills you learn and use with each of those populations. She does not enter the relationship assuming she knows everything and realizes that we might not always say the right thing every time with a client. She talked about times when she apologized for maybe getting ahead of herself if she realized

she was not going in the right direction for a client, and asking them where they would like to start (P. Ragsdale, personal communication, October 24, 2014).

Ragsdale stressed the importance of each client's individual experience in relation to qualities of good programs aimed to help military populations. Whether a client gets something out of a program can depend on that individual, and what may work for one person may not be effective for another. She also said that the fact that you are doing something as a counselor is better than nothing at all. She could only speculate about what might need to be changed about current programs in order to help the military population more effectively. She said that we normally get better as we understand more about the military and their needs. She said that if the client is returning for services, chances are you are doing something that is working (P. Ragsdale, personal communication, October 24, 2014).

Lisa Southworth: Children and Families

Lisa Southworth, M.Ed., LPC, works at Post Trauma Resources, LLC. She is a civilian counselor whose husband is in the Army National Guard. She has been working at Post Trauma Resources for 14½ years. Southworth has gone through a lot of training in order to work with the military population, including online trauma training through Medical University of South Carolina, training through TRICARE, conferences and workshops, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training online (L. Southworth, personal communication, November 24, 2014).

She uses TF-CBT in her work with clients and she talked about its usefulness in managing symptoms and expressing experiences. She works mostly with children and families on issues like deployment, coming home, how to manage stressors during these

times, and developing a sense of safety. She talked about the importance of civilian counselors understanding the culture and the makeup of the military. She discussed an assumption that is sometimes made about the military not being family-friendly and that a client could pick up on that from a counselor. Counselors showing respect and regard for what these military members have volunteered to do is also important for Southworth. She also was able to differentiate how military members themselves might react to a counselor not knowing much about the military culture. Family members might be happy to explain things to a counselor if they are not aware of some aspect of the military or do not know what a particular acronym means. With service members themselves, if they can see that a counselor is interested and trying to learn, they will most likely explain things, so trying to gain as much information as you can would be beneficial (L. Southworth, personal communication, November 24, 2014).

Southworth also discussed how during times a military member might not be as stable, like right before or after deployment, they want to be told concrete things to do because of their military mentality and might not respond as well to process-oriented work. She also shared something that she did with her own family when her husband returned. For 90 days after returning home from deployment, she suggests not changing the routine that the family has been used to since the service member has been deployed. This lets the service member ease back into things in the family, even though there might be a desire to jump back into the old routine before they deployed. She uses this idea with her clients as well (L. Southworth, personal communication, November 24, 2014).

Southworth discussed her own experiences with support groups when her husband was deployed and what about them did not work for her and her family, like differences

in ways of coping. She described some of the support groups near her for active duty members and their families who might be used to more deployments. Support groups, especially those for single parents, can be helpful. She discussed how single parents is a particular population in the military that needs support because they might have joined the military for a better life for their child and might not have a lot of family support nearby. There are also family activities that she finds can be helpful since kids will show behavior problems at school and kids respond to parental anxieties (L. Southworth, personal communication, November 24, 2014).

In her work, Southworth always asks clients what their supports are. She normally works with parents on parenting skills, then works separately with the children, and will bring them together in a session if doing so is necessary. In her work with children, she helps them learn things they can do on their own in order to feel better (deep breathing or squeezing a pillow) and when they might have to go to a safe adult. She also has an activity where she asks the kids if they know how to give a hug, and explains to them how when they are sad, mad, or frustrated, a hug can make them feel better. She will have them practice with their parent in the session, which allows for bonding between the parent and child, lets the kids know they are loved and supported and that what they are going through is manageable, helps parents feel more connected to their kids, and helps the parent feel like they are doing something. She also described the importance of keeping in contact with the child's school counselor to make sure they know about the parent being deployed or returning home. She discussed her experiences with her own kids and the importance of letting them choose if they want to go to the school counselor or not. One activity that one of her children found helpful was making a book with the

school counselor about how he missed his dad. Her husband spoke at her children's school and youth group when he came back home about what his experience of being in Afghanistan was like, which Lisa described as validating to her kids because it showed what their dad was doing was important (L. Southworth, personal communication, November 24, 2014).

Lisa Mustard: National Guard

Lisa Mustard, Ed.S., MPH, LMFT, is a Psychological Health Coordinator with the National Guard (NG). She has worked with NG troops and their family members for five years. She has worked with persons on deployment and with reintegration issues the most, and while seeing persons with these particular presenting concerns, she has seen changes over the last few years with soldiers' presenting concerns overall. Because they are not currently being deployed anymore and there are budget losses which can mean letting some persons go or some leaving the NG, some military personnel are at a crossroads and she is curious to see how things change in the future. Mustard described how the NG is different from other branches of the military. Even though persons in the NG live a civilian life most of the time; they wear a military uniform once a month. Because they will no longer be deployed, these clients may wonder what their lives will entail, especially those that had been in the NG for a long period of time (L. Mustard, personal communication, December 1, 2014).

Mustard has had counseling jobs in other settings before beginning her work with the NG, but she described a family friend who was a Marine pilot and was killed in Afghanistan. Seeing his wife go through this struggle sparked her interest in working

with this community. She wanted to be able to give back and support soldiers and their family members (L. Mustard, personal communication, December 1, 2014).

Mustard received a lot of training about the military from colleagues and from experience. She has also completed online training about the military culture and continues to earn continuing education credits (CEUs). She described how her job is more clinical and involves a lot of assessing symptoms. The period of time from nine months to two years post-deployment is the time when she has seen the most mental health issues, such as depression, PTSD, alcohol misuse, and suicidal ideation. She identifies their symptoms and determines whether cause is a situational stressor or a more serious mental health concern that might require a referral to more acute care like the VA or Vet Center if they have been deployed before. She can refer them to the Employee Assistance Program (EAP) of the NG, the Department of Mental Health, and Military One Source if the soldier has not deployed before. She works mostly with soldiers, but will occasionally get a request from a spouse or family member about a soldier (L. Mustard, personal communication, December 1, 2014).

When asked what is important for civilian counselors to know about working with this population, Mustard talked about loyalty and trust; they want to know they can trust you. She also discussed the importance of meeting them where they are and asking questions is okay when the counselor does not know something. She also brought up the fact that underneath the suit is a unique individual with their own worldviews and perspectives. Some of them might not want to be in the military, and they might not all have the same perspective on war, the military, and family; so counselors would benefit from realizing this fact (L. Mustard, personal communication, December 1, 2014).

Mustard sees clients for about 3-8 sessions. So, she uses a lot of short term, brief, and solution-focused techniques in her work. She also uses CBT and systems theory because of her training as a LMFT. She stressed the importance of staying objective with regard to what might be going on with a soldier and avoiding the “he said, she said” that may arise because you are hearing different things from a spouse or commander. She also stressed the importance of remaining clinical and getting to root of the client’s presenting concerns. She does not want to be seen as a punitive person and tries to always inform soldiers that coming into see her is voluntary and different from going to Behavioral Health, which is more medical and can put restrictions on what they can do (L. Mustard, personal communication, December 1, 2014).

When talking about programs for military members and their families, Mustard believes that these programs are great, but the hard part is getting them to go. Sometimes they will not go to support groups or other programs out there until they hit rock bottom, or they may not have the time to go. She talked about going into the communities that military members and their families are already involved in, like churches, in order to get them involved. The NG chaplains are able to get military personnel engaged and she described a program called Strong Bonds that chaplains put together for these persons. She described some other ways to get military personnel involved and engaged in programs: showing them the benefit and how these programs can make them feel better, have a better relationship with their child and/or spouse, and inviting them to think about things differently (L. Mustard, personal communication, December 1, 2014).

There are some common themes that emerged during these interviews. Although these counselors each have unique experiences and careers, they all discussed utilizing

online training, workshops, or collaborating with colleagues in order to learn about the military population and effective interventions. Each of these counselors also discussed the importance of a civilian counselor being knowledgeable about the military, but also being willing to ask questions and get to know the military member as an individual.

Discussion and Future Considerations

Based on the above research, many conclusions can be drawn. One significant conclusion rested with the experience of NG members and their supporters during the period prior to deployment. Since they are typically full-time members of the civilian community, rather than part of a military community, information on supportive care tends to be disseminated differently. The Scherrer et al. (2014) study showed that there were discrepancies in the information that NG members received prior to deployment compared to their supporters. Having information sessions before deployment or halfway through the deployment in order to make sure the supporters are able to get the same information as NG members is a future consideration. There were also differences in what NG members thought was the most important information compared to their supporters. Relationship issues seemed to be more important to supporters, while NG members were more concerned with employment and education issues. This information could be used in order to meet the needs of both NG members and their supporters. Counselors are likely to be working with individuals and family members related to the NG. Understanding the discrepancies in information dissemination could help counselors develop their own interventions for supporting these individuals and families.

There are several common themes from the different programs that have been discussed in this paper. Many of the programs recognize the fact that the issues these

service members may be dealing with can be psychological as well as physical.

Resiliency and strength-based approaches appear in many of the programs. Whether it is involving reintegration individually, within the family, or within the community as a whole, these programs aim to anticipate the struggles military members and their families might face and help them cope.

Another conclusion from this research involved the differences between the techniques and strategies known and used by the counselors who were interviewed and those that were discussed in the research. These differences may cause some to question the relevance/efficacy of these programs. While some of these programs may have proven effective, much of the work conducted by the counselors who were interviewed seemed to deviate somewhat from the processes outlined in these other programs. Much of their counseling practice was developed through the relationships with service members and their families and intentionally seeking relevant continuing education. While there are certainly important aspects to the more formal programs and significant overlaps in the approaches of the three counselors interviewed, one conclusion of this research is that counselors interested in working with military families need to make evidence-based and intentional selection of continuing education to strengthen their work. Spending time with military members and their families and studying their experiences also strengthens one's practice.

Based on the interview with Lisa Mustard and the Waliski, Townsend, Cheney, Sullivan, Hunt, & Curran (2014) article, future programs and research might focus on how to implement programs into service personnel's communities order to ensure more participation in the program. Lisa Mustard described several important issues in her

work with National Guard members. Because of budget restraints and soldiers currently not being deployed anymore, she is seeing more clients than usual presenting with concerns regarding what is next for their lives. Programs and interventions can be geared toward helping these veterans figure out what their next step might be, especially those who have been in the National Guard for a long time. Mustard also described the time period of nine months to two years post deployment as the time frame when she has seen the most mental health concerns. So programs aimed for this time period might be effective for military members and their families.

Final Remarks

There are many different stressors that military members and their families each face depending on the length of time deployed, branch of service, support once they return, and any presenting mental health concerns. More civilian counselors may be getting clients with a military background as many of them are leaving active duty. There need to be educational opportunities and resources to make sure civilian therapists can work with this population in order to meet the needs of service members once they are no longer part of the military (Glynn, 2013).

These military members risk their lives and their families deal with their absence and potential issues upon return. Mental health professionals may benefit from giving back and in order to do so, they may need to learn what strategies best serve and support military personnel and their families. Researching existing reintegration programs is one step mental health professionals can take in order to begin developing awareness and competency working with this population. Mental health professionals may also benefit

from actively seeking discussions with professionals who have significant experience to understand their education, training, and competency building process.

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