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**December, 2015**

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## **Letter from the Editor**

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

This issue is an eclectic collection of articles in practice, theory, and research. The lead is our first non-military related article and focuses on mental health stigma among first responders. The second article presents best practices in relation to healthcare in the LGB segment of the military population. The third article examines resilience and sports in rehabilitation counseling with Veterans with spinal cord injuries. The fourth article presents a program for the children of seriously wounded service members. I personally like to publish articles that focus on children. I call the children the “forgotten population” in military mental health. My youngest daughter still calls my 15 month deployment in the Gulf War her “dark time” and reflects the isolation she felt at that time. The final article presents a pilot program for the wellness of military women.

I need more submissions for the JMCG – as of today, I have enough articles on-hand for one more issue. I want to always have at least five articles for each issue. So, ask around where you work – or try writing yourself. I’m advertising for submissions through ACA channels.

Benjamin V. Noah, PhD  
*JMGC Founding Editor*

## **Mental Illness Stigma among First Responders and the General Population**

ALLISON CROWE  
East Carolina University

J. SCOTT GLASS  
East Carolina University

MANDEE F. LANCASTER  
East Carolina University

JUSTIN M. RAINES  
East Carolina University

MEGAN R. WAGGY  
East Carolina University

### **Abstract**

*Researchers examined mental illness stigma in first responders and the general population using focus group interviews. Categories of stigma were coded a priori using Stemler's (2001) content analysis. Frequently occurring categories of stigma for first responders were discrimination, disbelief, loss of status, and shame. The general population endorsed stigma categories such as disbelief, discrimination, shame, and dangerousness. Loss of status was of particular concern for first responders, suggesting that stigma might impact first responders differently from the general population, due in part to the unique characteristics of their profession. Blame was a category unique to the general population while discrimination, disbelief, and shame were coded in both groups. Implications for mental health professionals and future directions for research are offered.*

*Keywords: stigma, mental illness, attitudes, first responders*

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Allison Crowe is Assistant Professor of Counselor Education in the Department of Interdisciplinary Professions at East Carolina University. J. Scott Glass is a Professor of Counselor Education in the Department of Interdisciplinary Professions at East Carolina University. Mande F. Lancaster, Justin M. Raines, and Megan R. Waggy are affiliated with the Center for Survey Research at East Carolina University. *Address correspondence to Allison Crowe, ECU, 225, Mailstop 121, Ragsdale Hall, Greenville, NC 27858 (crowea@ecu.edu; phone: 252-328-4218; fax 252-328-5114).*

## **Introduction**

In 2012, 43.7 million adults in the United States were living with mental illness (MI; SAMHSA, 2013); however, only a portion of these (approximately one-third) seek help from a mental health professional (Bathje & Pryor, 2011). Although mental health treatment decreases symptoms and improves quality of life, the stigma associated with MI prevents many from revealing that they have a diagnosable concern (Corrigan, 2004; Feldman & Crandall, 2007; NAMI, 2012). It is well documented that first responders (police officers, fire fighters, and emergency medical technicians [EMTs]) who deal with emergencies, natural disasters, and other traumatic events struggle with mental health issues. Examples include depression (Benedek, Fullerton, & Ursano, 2007), posttraumatic stress disorder (PTSD; Benedek et al., 2007; Houge et al., 2004; North et al., 2002), and alcoholism (Jacobson et al., 2008; Kohan & O'Connor, 2002; Taft et al., 2007) as well as physical health injuries that can lead to stress (Szubert & Sobala, 2002).

Despite a clear demand, first responders often do not seek the help of mental health services for fear of being stigmatized as weak, breaches in confidentiality, or potential negative impacts on their careers (Kronenberg et al., 2008; Kupersanin, 2002). Additionally, seeking psychological support and all that it entails (e.g., vulnerability, admitting a struggle, surrendering control) is counter to what first responders are trained to embody on the job, such as emotional and physical toughness, as well as control (Royle, Keenan, & Farrell, 2009). In addition to the traumatic experiences that are inherent to the work, other unique job traits such as long work shifts that are oftentimes irregular, overnight hours, unpredictable and dangerous environments, as well as physical demands contribute additional stressors (Meadows, Shreffler, & Mullins-Sweatt, 2011).

Regehr, Hill, and Glancy (2000) examined individual characteristics as they related to social support and traumatic stress reactions in firefighters who experienced traumatic events on the job. Firefighters with feelings of insecurity, lack of personal control, and isolation from others were more likely to report high levels of depression and PTSD symptoms after exposure to a traumatic event. Koch (2010) looked at the emotional and psychological impact on police officers after encountering the traumatic experience of responding to completed suicides. The study results identified common coping strategies that the officers used to mediate the traumatic incident (e.g., blocking feelings, humor, anger, faith, and telling stories). However, officers also reported feeling aware of the discomfort they experienced long after the traumatic incident had occurred. Moreover, some reported a heightened awareness of their own mortality as well as suicidal ideation (Koch, 2010).

## **The Current Study**

It is well documented that first responders struggle with mental health concerns and are not getting the professional help they need due to the stigma associated with seeking help (Kronenberg et al., 2008; Kupersanin, 2002; Royle et al., 2009). In order to explore perceptions regarding mental illness and help seeking in a variety of first responders, this research study examined attitudes toward mental illness in police, fire fighters, and EMTs. Understanding negative attitudes or mental illness stigma from both a personal and professional standpoint may

uncover important information about first responders' perceptions. Although mental illness stigma has been studied (Bathje & Pryor, 2011; Brown & Bradley, 2002; Crowe & Averett, 2015; Glass, Crowe, Raines, & Lancaster, 2014; Smith & Cashwell, 2010; 2011), this research will add to the literature by exploring mental illness stigma in first responders and the general population. This study was qualitative in nature and allowed the opportunity for in-depth responses from participants and a deeper understanding of attitudes towards mental illness and help seeking. The following questions guided the research:

- 1 What are some of the negative views our culture, in general, has about mental illness that might cause stigma?
- 2 Do first responders and the general population believe that stigma might prevent people from seeking help?
- 3 How do first responders and the general population think mental illness stigma applies (or doesn't apply) to people they know, or people in general? In other words, have they known people who have feared seeking mental health treatment because of stigma?
- 4 If yes, then what were the fears, hesitations, or possible negative consequences of seeking help for mental health treatment?

### **Method**

The authors conducted a total of four focus groups with members of two populations of interest, first responders and the general population. Two group meetings were held with participants from law enforcement, emergency, and fire departments. General population participants included staff members from a university located in the southeastern United States. The focus groups were primarily qualitative in nature, with the exception of a few questions regarding demographics and mental health history of each participant. Prior to participant recruitment and data collection, the Institutional Review Board of the authors' university approved the study. Participants were recruited via email from two different Listservs – a county-wide Listserv for all first responders and a university-wide Listserv for all current university staff members. Participation was voluntary and there were no incentives provided. To address participant qualifications and consent, the authors conducted initial phone screenings to verify that all participants met the required criteria for inclusion. Participants were asked if they were at least 18 years old, were comfortable discussing attitudes towards mental health in a focus group, and if they were comfortable providing demographic information about personal mental health experiences. Participants who answered yes to all three questions were eligible to participate. Participants in the first responder sub-sample also were screened to ensure employment as law enforcement, emergency, or fire department officials.

All participants were asked to complete a short demographic form and a mental health history questionnaire prior to the start of discussion. Focus groups lasted anywhere from 60 to 90 minutes and all were directed by use of a pre-designed question script. Discussions were audio-recorded and later transcribed for ease of analysis. Demographic information included age, gender, ethnic background, relationship status, level of education, and current occupation. For mental health history, sample questions included: Have you ever sought treatment for a mental health concern? Was the treatment you received helpful? What did you seek treatment for? Do you have someone in your family with a mental illness? Both first responder and general population subgroups were asked the same general questions; however, first responders also

answered such as: Can you describe the types of stressors that you face on the job? What types of emergency situations have you dealt with in your job?

## **Participants**

**First responders.** A total of seven people participated in the first responder focus groups. There were four men and three women. Participant ages ranged from 34 to 58, with an average age of 40 ( $SD = 8.72$ ). Six participants reported being Caucasian and one reported being African-American. The majority of participants reported being married ( $n = 6$ ) with the one participant reporting being single, never married. Participants had received either a four-year ( $n = 4$ ) or a two-year ( $n = 3$ ) college degree. Occupations included fire and rescue ( $n = 2$ ), paramedic/firefighter ( $n = 2$ ), and police officer ( $n = 3$ ). The majority of participants indicated that they had previously sought treatment for a mental health concern ( $n = 4$ ), and all of those same participants indicated that the treatment they received was helpful. Reasons for seeking treatment included alcohol addiction, anxiety, life coaching, and postpartum depression. Three participants reported that a family member had a mental illness. These family mental illnesses included addiction, anxiety, and depression. The majority of participants ( $n = 5$ ) also indicated that they would seek mental health treatment in the future should they begin to suffer from any symptoms.

**General population.** A total of ten full-time employees at a university located within the southeastern states participated in the general population focus groups. There were four men and six women. Participant ages ranged from 27 to 65, with an average age of 49.6 ( $SD = 11.03$ ). Nine participants were Caucasian and one reported as being African-American. Exactly half ( $n = 5$ ) were single, never married, with the other half ( $n = 5$ ) were married. Half of the participants ( $n = 5$ ) indicated that they had received a master's degree, with the remaining participants indicating that they had received either a four-year ( $n = 2$ ) or a 2-year ( $n = 3$ ) college degree. Occupations included administrative assistant, archivist, lab compliance coordinator, library technician, student affairs administration, and maintenance technician.

The majority of participants indicated that they had previously sought treatment for a mental health concern ( $n = 7$ ), and all of those same participants indicated that the treatment they received was helpful. Reasons for seeking treatment included anxiety, bipolar disorder, past trauma experience, depression, family concerns, and relationship issues. The majority of the group also indicated that they had a family member with a mental illness ( $n = 7$ ). These family mental illnesses included alcoholism, depression, anxiety, bipolar disorder, dementia, and schizophrenia. The majority of participants also indicated that they would seek mental health treatment in the future should they begin to suffer from any symptoms ( $n = 7$ ).

## **Data Analysis**

Transcribed versions of the focus group discussions were used to analyze the data. All statements made by participants during the discussions were used as unique quotes. The authors followed Stemler's (2001) content analysis procedures using an *a priori* coding strategy. Through this approach, the authors began with a pre-established set of 12 coding categories that were based on both research and theoretical descriptions of stigma that had previously been



published. These included: blame, discrimination, loss of status, isolation, shame, social exclusion, disbelief, authoritarianism, benevolence, dangerousness, rarity, and origin. The initial set of codes was revised following the preliminary rounds of data analysis (Stemler, 2001). Three members of the research team coded each statement as representative of one factor of stigma. These potential factors, or codes, were based on an *a priori* review of the literature regarding known factors of stigma. This list was finalized following a pilot test round where all members of the research team coded a subset of data from both populations.

Table 1 lists the description, source, example quote, and frequency of each of the 12 terms in the total sample. When all three coders agreed on a factor, the agreed-upon code became the final code. When only two coders agreed on a factor, the final code was the one on which both agreed. Statements that resulted in disagreement between all three reviewers resulted in the statement being coded into the “Other/no code” category. A total of 141 statements were coded by each coder, resulting in a total of 423 codings. The authors calculated the inter-rater reliability for these codings, and this resulted in an overall percentage of agreement of 85.8% and a Fleiss’ kappa statistic of 0.600, indicating moderate agreement (Landis & Koch, 1977).

Table 1. *Stigma Terms*

Term	Description	Source	Sample Quote	First Responders (n)	General Population (n)	Total (n)
Blame	to find fault with (imposed by others or self); to hold responsible; to place responsibility for; can be towards the mental illness or consequences of the mental illness	Byrne, 2000	“...we’re causing it”	0	5	5
Discrimination	prejudiced or prejudicial outlook, action, or treatment; based on labeling (e.g., weak, lazy) and stereotyping that is oversimplified, prejudiced, or uncritical judgment. “Black sheep of the family” role – a worthless or disgraced member of the family/system; an outcast	Byrne, 2000; Link & Phelan, 2001	“...it can hamper your ability to move on or upwards in the agency because now you have this label”	17	10	27

Table 1. *Stigma Terms* (continued)

<b>Term</b>	<b>Description</b>	<b>Source</b>	<b>Sample Quote</b>	<b>First Responders (n)</b>	<b>General Population (n)</b>	<b>Total (n)</b>
Loss of Status	losing standing as a result of their experiences, such as in their communities, workplaces, and other social systems. Loss of power.	Link & Phelan, 2001	“you can use it against somebody to keep them down if you wanted to.”	8	0	8
Isolation	the act of isolating or the condition of being isolated. Separation – “us and them.” Self-imposed; internal.	Byrne, 2000	“I couldn’t go everywhere I used to go, couldn’t hang out with anybody I used to hang out with...”	2	0	2
Shame	a painful emotion caused by consciousness of guilt, shortcoming, embarrassment, or impropriety. Can result in secrecy – hiding or concealing, keeping secret, or maintaining privacy or concealment.	Byrne, 2000	“...could this hurt my job in the future, so I was hiding it [therapy appointment] on my outlook calendar.”	4	8	12
Social Exclusion	processes in which individuals and entire communities of people are systematically blocked from societal rights, opportunities and resources that are normally available to members of society. Restricting activities such as marriage, children, voting.	Byrne, 2000	“you got to fill out this form, they won’t help them with the form...it’s hard sometimes to actually get the help.”	1	1	2

Table 1. *Stigma Terms* (continued)

<b>Term</b>	<b>Description</b>	<b>Source</b>	<b>Sample Quote</b>	<b>First Responders (n)</b>	<b>General Population (n)</b>	<b>Total (n)</b>
Disbelief	disbelief about the mental illness, abusing the system, or taking advantage of support, suspiciousness about mental illness existing	Merriam-Webster, 2013	"...sometimes it's used as an excuse."	8	12	20
Authoritarianism	the belief that obedience to authority is necessary and people with mental illness are inferior and demand coercive handling by others	Cohen & Struening, 1962	"...they are unproductive members of society."	0	1	1
Benevolence	being kind and sympathetic, kindness to unfortunates, leading to behavior akin to how parents treat children	Cohen & Struening, 1962	"people are feeling like we aren't being a nice to the poor guy."	2	2	4
Dangerousness	the extent to which people believe that a person with mental illness poses a threat to them	Feldman & Crandall, 2007	"...if you let him loose in the population he will hurt people and kill people."	3	6	9
Rarity	the degree to which people believe that a mental disorder is uncommon. People might think that rarer conditions are more severe	Feldman & Crandall, 2007	"Anytime somebody is diagnosed with something and you say it, there is an automatic assumption that it's extreme"	0	2	2
Origin	the cause of mental illness as genetic/biological, or psychosocial	Feldman & Crandall, 2007		0	0	0

## Results

### Stigma and First Responder Population

A total of forty-five statements were coded according to stigma categories. The most frequently occurring category of stigma that participants expressed was *discrimination*. Seventeen statements were coded in this category. Typically, these statements reflected the perception that people with mental illness would be treated differently from people who do not claim a mental illness or exhibit recognizable symptoms of a mental illness. Several statements were reflective of the discrimination towards persons with a mental illness in their professional setting. One first responder stated, "In our line of work, people get frustrated...that 15th, 16th call that happens at 3 o'clock in the morning and it's somebody with mental illness. They might not get all the compassion that they deserve." One participant suggested that those with mental illness go to great lengths to hide mental illnesses to avoid the stigma, "I think that the secrecy, because people with mental illness are obviously aware that people don't accept it or understand it. They probably live a lot of their life in secrecy hiding that aspect." From a personal perspective, the following first responder had this to say about how a mental illness might result in discrimination,

And then just going back to the labeling...it can hamper your ability to move on or upwards in the agency because now you have this label, whether or not you've actually sought any help, whether or not you've gotten any help, whether or not any has been offered, now you have this label and you are stuck. So there is that fear that if I listen and I go, you know what I actually need is some serious help here. It's not laziness, it's not a cover up, it's not this, and then well, crap, now you're really stuck because it's out in the open and it just verified everything...so there's a big fear there.

The next two frequently occurring stigma categories for first responders were *disbelief* and *loss of status*, with a total of eight statements coded for each category. Participants commented from a personal perspective, as found in this statement,

You can't see a mental illness like you can a broken arm or a burning house. We are used to reacting to tangible things usually. Even with a heart attack, that you can't see someone having a heart attack, but we can put a piece of equipment on you that can say yay or nay or give us some clues into what's going on with you to help us diagnose. If your sugar drops, we have a tool that can tell us on a scale is it 0 or 200. But mental illness is transparent, you can't see it, so there is a lot of trust involved that someone is not faking it.

Another first responder spoke about disbelief from a professional standpoint in the following statement:

...being scared, us being nervous, not knowing what you are going to get. Not knowing if they are faking so they can get out of trouble or not knowing if they are truly mentally ill and not being able to recognize which type of mental illness it is, because I've been in all

the trainings to tell you everything, but in 2 seconds I ain't got time to diagnose somebody before the fight's on.

Disbelief was also mentioned regarding the potential for persons to fake symptoms to gain certain benefits as found in the following statement: "Whether it be abusing the system or abuser of medication, an abuser of services because they are faking it. I don't think that's the large majority, just to make that clear, but I think it happens."

*Loss of status* was also the second most frequently occurring category of stigma, with eight statements coded in this area. One first responder stated the following:

For me, if somebody had a mental illness and they ran for mayor, the opposing person would use that against them. That's kind of how I look at it. For some people, you can use it against somebody to keep them down if you wanted to.

Another aspect of loss of status was the speed in which a status could be lost. One first responder felt fearful about this:

It scared me to death because I thought about that day when you wake up and you have an imbalance, a true chemical switch in your brain changed you over night. That's really scary for me. So I'm looking at loss of status and maybe it would be bad enough that you didn't even know what was going on. But being labeled and being isolated, and going from being mainstream to being on the other side of the fence overnight.

Another aspect of loss of status was the potential negative impact, specifically having ones' gun taken away, on a first responder's career,

We were talking about some of the labeling, it's a weakness, it's laziness, it's all of these different things and it puts a fear in somebody of going to get that help because they are afraid that they are going to see that and go oh boy, we got to put the brakes on, what's going on with this person, and take away the gun, so then you're like, oh all of the sudden my livelihood is on the line simply because I might need to seek some help.

Professionally, first responders also spoke about the shame related to a mental illness in their line of work. An example of this is the following,

Like our supervisors, they might be keeping a finger on the pulse of what's going on, but I think, in my mind, there needs to be a little bit more intervention earlier on before it even gets to that point. But unfortunately, instead of just being able to have an open conversation about it whether it be with peers or with supervisors or them, you know, hey chief, hey, this is what's going on, there is that fear of reprisal and those kind of things.

Another first responder spoke of shame in this way:

I'll just be honest. I actually went to alcohol treatment and everything like that. I'm a confirmed recovered alcoholic and everything. The biggest thing that kept me from

wanting to go when I realized I had a problem was the fact that oh god, I have to call myself an alcoholic now. I was just, this is not who I am, I can't be this, I'm a normal person.

An additional dimension of shame acknowledged the difficult process of recognizing and admitting the need for help and the potential long-lasting consequences of this as a first responder.

It takes a very, very deep level of surrendering for someone to admit that there is something wrong with the head or the way that things work in their body and it's going to be that way the rest of their life. They just don't want to face that reality. Can you fix it? No, we can treat it. I think that scares a lot of people, is that this is with them for their whole life.

Three statements were coded as *dangerousness*. One participant commented on how this relates to dealing with a mental health emergency.

For me as the first responder, no matter what I do, if I taze him 10 times, because it took me 10 times to get this naked man with the knife in his hand in custody, then I did that too much. If I shoot him, because that was my first reaction, he's got the knife and he's right there and I shoot him, that's going to be wrong. If I let him go and he runs off into the woods because I didn't want to have to hurt him, then I let him get away. It's a tough quandary to be in.

Two statements were coded for both *isolation* and *benevolence*. *Social exclusion* had only one item coded as such.

### **Stigma and General Population**

A total of forty-seven statements were coded according to stigma categories from the general population. The most frequently occurring category of stigma that participants expressed was *disbelief*. Twelve statements were coded in this category. Generally, these statements reflected the perception that a person with mental illness was using it as an excuse or abusing the mental health system in order to secure benefits, or that the person with the mental illness was not as sick as he or she claimed to be. An illustrative statement that describes the notion of using mental illness as an excuse was as follows:

I think there's an idea that it's sometimes it's used as an excuse. You can't cope so you're going to go see somebody. You're going to use that as an excuse. You're not really depressed, you're just really down and you could have had better coping skills, you're more resilient and can deal with it...

One participant expressed the notion that those with mental illness abuse the system with the following statement:

I know people who are supposed to have mental issues and they do it to get the drugs and my word, because you look at it every day when you look at the news and everything. The billions of dollars that are spent in this country on mental health and my, it's going to sound bad, but abuse, I think it's abused.

A similar quote that captures this dimension of disbelief is illustrated in the following, "Schizophrenia, or being bipolar, or manic depressive, or OCD, we kind of casually bat these around in conversation and ascribe certain characteristics to people who we say have these issues, which may or may not *actually* be the case."

The next most frequently occurring category of stigma was *discrimination*. A total of ten statements were coded as such. Participants commented on personal experiences of discrimination from their own lives including, "From people outside, my mom was mentally ill so it goes back to my younger years where even the neighbor kids couldn't play with us. They would see my mom get taken to the hospital and different things." Another participant shared how she felt discriminated against for having a mental illness:

I've been diagnosed Bipolar II. I am on medication. It is very hard to admit to people because...anytime I get upset about something. Oh hey, calm down. It's automatically assumed that if I get passionate about anything, it's oh, she's just crazy. You get dismissed so easily because oh, well she does that or says that, oh she's just crazy.

Discrimination related to career was also mentioned in statements such as the following: "I grew up in a military culture, married to a career military, is weakness. That's considered weakness." This participant seemed to believe that military culture, in particular, discriminates against having a mental health concern.

*Shame* was the next most frequently occurring category of stigma, with eight statements coded as such. One dimension of shame seemed to be concealment of a mental illness, or seeking treatment for a mental illness. This can be found in the following statement,

...there was a time I was dealing with some family issues and I was seeking therapy and... I hid it. You know we all have outlook calendars where everybody can see them so I hid what the appointment was. I... had code words for it. I had a lot of weight on my own thoughts of what the stigma might be, or could this hurt my job in the future, so I was hiding it on my outlook calendar.

Another aspect of shame was the idea that having a mental illness is not as shameful as it was in the past, in particular for students on a college campus. The following quote speaks to this, "I think it's less than it used to be. I remember the counseling centers used to worry about oh, is there a front door and a back door that you can get through. I think that's changed a little bit for students." Another aspect of shame seemed to be others covering up someone's mental illness. A participant stated the following, "all of the sudden he tells us he is bipolar and his twin is a clinical social worker who works with battered families and stuff like that so she had covered up for him for years."

Six statements were coded as *dangerousness*. An example of this is the following, “Unpredictable. I have a family member who is severely mentally ill and if he doesn’t take his meds he is a danger to himself and others and he has to be locked up.” One participant differentiated between mental illness and other illnesses in that dangerousness is not necessarily associated with other illnesses as it is with mental illness. The following illustrates this:

I think there is still a stigma attached to genuine mental illness, going back to my nephew. That I could be disabled but I’m not going to go out and kill people, whereas if you let him loose in the population he will hurt people and kill people. There is a big difference there. So there is that unpredictability.

An additional dimension of dangerousness seemed to be that mental illness cannot always be “fixed.” One participant commented, “Scary. If somebody is behaving, sometimes it can be very scary and you don’t know how to react to it. I’m a fixer, and you can’t fix everything.”

Five statements were coded as *blame*. One participant commented on how this was present for her in her personal life, and as a child growing up with a mother with a mental illness.

Well there’s also an element of we’re causing it too. My mother has dealt with depression in her life, and oh we could just make mom happy as children, we could just make mom happy and this won’t be a problem. And it’s not, it’s ignoring the fact that it’s not an external factor.

Blame was also discussed as something that is ascribed to the person with the mental illness: “there’s a lot of blame for the person who is experiencing the illness.” Blame was also described as manifesting because the illness itself is not understood. The following quote illustrates this:

It’s not seeing the illness... my aunt [has] this expectation for my mom to be different than she is, and there’s some self-blame in there from my aunt...And so my aunt will comment if they go out to eat ... or she might not pick up after herself as well. I have housekeeping that comes in and she has a case manager and all that kind of stuff. But she’s ridiculed instead of someone being able to see that she’s never going to be any different. It is just the way she is.

Two statements were coded as *benevolence*. *Authoritarianism* and *social exclusion* had one statement each.

## Discussion

Of the various terms from the literature (Byrne, 2000; Cohen & Struening, 1962; Feldman & Crandall, 2007; Link & Phelan, 2001; Taylor & Dear, 1981) that have been used to describe stigma, the following dimensions of stigma were found in this study: discrimination, disbelief, loss of status, shame, dangerousness, isolation, benevolence, social exclusion, blame, and authoritarianism. Origin, a term not found in this research, has been used to describe stigma in previous studies (Feldman & Crandall, 2007). Origin speaks to the cause of mental illness as



biological or psychosocial, and therefore stigmatized. In this research, however, this term did not surface.

The most frequently occurring categories for first responders were discrimination, disbelief, loss of status, and shame. Also identified were dangerousness, isolation, benevolence, and social exclusion. For the general population group, the most frequently occurring stigma categories were disbelief, discrimination, shame, dangerousness, and blame. Infrequent, but coded dimensions in the general population were benevolence, authoritarianism, and social exclusion. Loss of status was of particular concern for first responders, which seems to relate to the literature suggesting that first responders are fearful of the professional consequences that might come from the struggle with a mental illness (Kronenberg et al., 2008; Kupersanin, 2002). Blame was a category that arose only in the general population focus group, suggesting another variation in perceptions of stigma. Discrimination, disbelief, and shame were coded in both groups.

First responders described discrimination as it impacted the person with the mental illness, for example, one first responder explained that persons with mental illness might not get the care they deserve after first responders have received a number of calls for mental health emergencies on a particular shift. Previous literature (Watson et al., 2005) on first responders and mental health emergencies discussed the notion that first responders should become aware of their attitudes towards mental illness, since these attitudes will inform behaviors and decision-making. First responders might feel frustrated after a number of mental health emergencies, which could impact how they respond to these types of calls. Discrimination from having a mental illness was also described on a personal level since a number of quotes from the first responders described personal views on how it might be perceived if they were to reveal a mental health concern to a supervisor or colleague. This notion of being discriminated against for having a mental illness as a first responder is consistent with the literature (Kronenberg et al., 2008; Kupersanin, 2002) that has highlighted that the culture does not allow showing signs of “weakness,” such as a mental illness.

Disbelief was a dimension of stigma that was found in both first responders and the general population. This aspect of stigma is the notion that a mental illness might be exaggerated or completely fabricated in order to get services, abuse the system, or avoid responsibilities. Disbelief was found in both groups and seems particularly important as future researchers continue to try and understand mental illness stigma and all of its dimensions. There is still a notion that if we cannot see the illness (e.g., a heart attack, as a first responder in our study mentioned), then we discount, or discredit the person who is struggling. On a personal level, first responders might feel as though others will see them as avoiding responsibilities, or making excuses for themselves by struggling with a mental health concern. Professionally for first responders, having a tangible issue to resolve is “easier” than responding to mental health emergencies.

First responders, particularly police officers, feel as though they are gatekeepers for the mental health community as well as criminal justice system, since often they respond to mental health emergencies and decide the course of action for the person (Barillas, 2012). If first responders doubt the authenticity of a mental health emergency, since they are more difficult to

respond to than tangible emergencies, they might be more prone to stigmatize the person in need of mental health or other treatment.

Shame, or concealing the mental illness for fear of stigma, was another aspect found in both groups. There is much literature on mental illness still being a mark of disgrace, often resulting in avoidance of professional help due to the label of mental illness (Kronenberg et al., 2008; Kupersanin, 2002), and this seemed to be present in our sample. First responders in our study mentioned feeling shame related to having a mental illness. As authors (Royle et al., 2009) had posited, there might be an added shame for first responders since the first responder work culture values strength, courage, and performance under pressure, which are traits that are often not associated with seeking help, expression of struggles, and vulnerability. Mental health professionals who work with first responders, or a member of the general population might seek to normalize the notion of seeking help for a mental health concern so that feelings of shame are decreased.

Of particular importance is loss of status, a dimension of stigma that was found in the first responder group. Many discussed some of the implications of revealing a mental illness to a supervisor, for example fear of losing job responsibilities, being labeled by colleagues, having your gun taken away, or not being promoted. Previous authors (Kupersanin, 2002) had noted this aspect of mental illness stigma as particularly important for first responders, and our participants voiced similar concerns. Certainly, it is beyond the scope of mental health professionals to change the “cultures” that exist that might penalize first responders who struggle with mental health concerns, but advocating on behalf of clients, educating others about the mental illness not being a sign of weakness or resulting in negative consequences might assist in slowly changing the systems that perpetuate such stigmas.

### **Limitations and Future Directions**

As with all research, the current study is not without limitations. Both first responders and general population participants had some experience with mental illness themselves, or in their families. As well, many had sought mental health treatment and felt positively about the treatment. This information was captured in a demographic form in order to consider how this may or may not have impacted participants’ attitudes. Future research on mental illness stigma might want to include those who have not personally experienced a mental illness or had mental illness in their families, in order to examine whether stigma towards mental illness varies according to familiarity and help seeking experiences. Since many participants noted that they had sought mental health treatment before, this might have impacted their attitudes. In addition, the participants who made up the general population sub-group were employed as staff members at a university, so that generalizability cannot be assumed. Additionally, the researchers of the study inherently hold biases and assumptions since they are knowledgeable about the topic of stigma. Efforts to minimize this included the decision to have three coders during data analysis, two of whom were not content experts on stigma but rather experts on survey research.

This research answered the call in the professional literature to examine first responders’ attitudes about mental illness. In addition, it is known that first responders are experiencing mental health issues due to the traumatic experiences they witness, yet struggle with seeking

professional mental health services (Kronenberg et al., 2008; Kupersanin, 2002; Royle et al., 2009), and this research helped to uncover first responder attitudes about mental health concerns. With this understanding, mental health professionals might be able to develop services and programs for first responders that might not be as stigmatizing or perhaps not carry a stigma at all. Although research exists on the topic of stigma and mental illness (Bathje & Pryor, 2011; Brown & Bradley, 2002; Crowe & Averett, 2015; Glass et al., 2014; Smith & Cashwell, 2010; 2011), this study added to the literature by exploring mental illness stigma in both first responders and the general population in a qualitative design, allowing the opportunity for in depth responses from participants and a deeper understanding of attitudes towards mental illness and help seeking. Future research on similar topics might include more large-scale quantitative designs to explore whether attitudes are consistent with larger samples of first responders.

A few final clinical implications from the research are as follows: counselors working with first responders should be aware that there is still stigma attached to seeking help for a mental health concern for many in this profession. Loss of status, in particular, might be a fairly large concern for a first responder who begins counseling, so that assurance of confidentiality and privacy are of paramount importance. Reframing the notion that seeking assistance as a sign of weakness would also be helpful for a first responder who is seeking help. Counselors might also assist with taking steps towards changing the culture of the first responder profession in regards to mental health by holding trainings or seminars that teach about mental health statistics, destigmatize mental health concerns, and offer information and community resources. Additionally, counselors might also consider contacting those in managerial positions in law enforcement, fire and rescue, and EMT to assist with destigmatizing mental health treatment as a way to advocate for clients with mental illness.

### **Conclusion**

Mental illness is still stigmatized in both the general population and in first responders. Particular dimensions of stigma in this study suggest the importance of further investigation of how we might continue efforts to normalize mental health treatment, as well as begin to change the professional cultures that exist that do not support mental health concerns when they do arise. Literature has supported that first responders, specifically, are struggling with mental health concerns. In order to meet the needs of this particular group, the stigma of mental illness must be addressed so that these professionals can receive the support necessary to help them continue to be effective dealing with the stressors unique to their professions.

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## **Best Practices in the Healthcare of LGBT Military Service Members, Partners, and Families**

MARK A. STEBNICKI  
East Carolina University

PERSKO J. GRIER, JR.  
University of Maryland, Baltimore

JEFFREY F. THOMAS  
East Carolina University

### **Abstract**

*The stress of deployment, post-deployment, and reintegration has multiple mental and physical healthcare challenges to all service members, partners, spouses, and family members. In particular, lesbian, gay, bisexual, and transgender (LGBT) active duty service personnel and Veterans experience poorer physical and mental health outcomes when compared to heterosexual service members and Veterans. The concerns in terms of the LGBT military service personnel are that this group participates in healthcare prevention, screening, and treatment at significantly lower levels than non-LGBT service members. In part, many healthcare providers do not have the awareness, knowledge, and skills to provide services to the unique cultural characteristics of LGBT military and Veterans. This article examines the mental and physical health disparities among LGBT military personnel, Veterans, partners, spouses, and families and offers recommendations for best practices for providers that advocate optimal mental and physical wellness.*

*Keywords: lesbian, gay, bisexual, transgender, military, Veteran, healthcare prevention*

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Mark A. Stebnicki is a Professor, Coordinator of Military and Trauma Counseling Certificate Program in the Department of Addictions and Rehabilitation at East Carolina University. Persko J. Grier, Jr. is the Outreach and Access Coordinator, National Network of Libraries of Medicine, Southeastern Atlantic Region at the University of Maryland, Baltimore. Jeffrey F. Thomas is a Doctoral Student in the Department of Addictions and Rehabilitation Services and a Behavioral Health Service Coordinator and Clinical Counselor in the Division of Infectious Diseases, Department of Internal Medicine at East Carolina University. *Correspondence concerning this article should be addressed to Mark A. Stebnicki. Email: Stebnickim@ecu.edu.*

## **Introduction**

This article discusses the mental and physical health disparities among lesbian, gay, bisexual, and transgender (LGBT) military personnel, Veterans, partners, spouses, and families and offers recommendations for best practices for mental and medical healthcare providers. Despite the repeal of “Don’t Ask, Don’t Tell” (DADT Repeal Act, 2010) which took effect September of 2011, persons that identify openly as transgender, transsexual, or queer are not afforded protection under this Act. Active duty personnel that are transgender (T) typically decline not to openly disclose their sexual orientation to their healthcare providers while serving in the military. This is primarily because the fear of retribution, professional and social isolation, denial of promotions, and other reasons that will be discussed at length later in this article. Accordingly, the military-related literature reflects primarily the medical and mental health services received within the LGB military community and not individuals who identify as transgender. Research related to persons who identify as transgender is somewhat more obtainable in Veteran and civilian LGBT populations because the repercussions of “coming out” to peer enlisted and/or officer ranks are not as severe. Thus, as a point of clarity, this article discusses LGB and the transgender community interchangeably based on the active duty personnel or Veteran status and as reflected by the qualitative and quantitative medical and mental health literature.

Much of the research related to LGBT individuals in civilian life, have focused on mental health issues (i.e., substance use disorders, suicidality) and medical conditions, such as HIV/AIDS in community healthcare settings (Bieschke, Perez, & Debord, 2007). In some ways, this culturally encapsulates the LGBT community using one stereotypical identity as a high-risk health statistic. Within the Armed Services and Veteran populations that are reportedly LGBT, this group has a range of critical challenges that their family members, partners, and spouses face when they return home from overseas deployment (Johnson, Rosenstein, Buhrke, & Haldeman, 2013; Military Partners and Families Coalition [MPFC], 2015). Some of these issues include mental health concerns such as posttraumatic stress symptoms, depression, and substance abuse. There are also medical-physical conditions resulting in traumatic brain injuries, blast wounds, cardiovascular conditions, and limitations of muscular skeletal functioning. Clearly, the stress of post-deployment and reintegration has multiple mental and physical healthcare challenges to service members, partners, spouses, and family members.

As a group, LGBT active duty personnel and Veterans experience poorer physical and mental health outcomes when compared to other heterosexual service members (Blosnich & Silenzio, 2013; Dilley, Simmons, Boysun, Pizacani, & Stark, 2010; Dohrenwend, 2009; Johnson & Federman, 2013; Ramirez, 2013). There are multiple causes of health disparities reported among openly LGBT military personnel. The act of “coming out” to a mental or medical healthcare provider has the potential to be a military career obstacle, especially for transgender, transsexual, or queer service personnel who are not afforded protection under the repeal of the Don’t Ask, Don’t Tell Act (DADT Repeal ACT, 2010) which will be discussed later in this article.

Indeed, research in this area is difficult. One obstacle in data collection is that of self-disclosure among the LGBT military community. Research suggests that approximately 45% of



LGBT men and women do not disclose their sexual identity to their healthcare providers (Gay & Lesbian Medical Association [GLMA], 2006). One of the primary concerns of self-disclosure is the question of how the person's sexual orientation might be reflected and documented in the electronic medical record (Johnson & Federman, 2013). Thus, many LGBT do not feel comfortable "coming out" to their health care provider. Consequently, many LGBT service members avoid or delay mental and physical healthcare and are not seen with the same frequency as heterosexual service members for fear of discrimination.

The research related to military service personnel that are openly LGBT confirm that health disparities exist for some because of: (a) lack of educational and clinical training opportunities afforded to health care professionals (e.g., physicians, nurses, counselors, psychologists, social workers) that emphasize LGBT awareness, sensitivity, and assessment of LGBT health-related concerns (Butler, 2010; Corliss, Shankle, & Moyer, 2007; Healthy People 2010, 2015; Wilkerson, Rybicki, Barber, & Smolenski, 2011), (b) reluctance and sometimes fears of patients to self-identify as LGBT to their healthcare professional(s) resulting in decreased healthcare attention in screening, diagnosis, and treatment of a variety of mental and physical health conditions (Gay & Lesbian Medical Association [GLMA], 2006; Military Partners & Families Coalition [MPFC], 2015), (c) disinclination of self-disclosure because of possible negative reactions from the military community and possible discrimination in advancement of military career and occupational service, as well as promotion in rank (MPFC, 2015), and (d) fear of retribution, negative stereotypes, and stigma attached to being openly LGBT in what has traditionally been a hypermasculine heterosexual military cultural environment (Military Partners & Families Coalition [MPFC], 2015).

Indeed, there are some critical issues in the mental and physical healthcare needs for all branches of the military regardless of sexual orientation. This is especially critical for LGBT military service members and their families because of some unique cultural characteristics that many healthcare providers may not understand that are key in the delivery of competent and ethical healthcare services. Some of these important issues have been highlighted by the American Military Partner Association (AMPA; 2015) whose mission is to connect, support, honor, and serve partners and spouses of American's LGBT service members and Veterans. AMPA notes on their website that they are the nation's largest resource and support network for the partners, spouses, families, and allies of the new "modern military family." The Military Partners and Families Coalition (MPFC; 2015) has also been noted as a significant resource and reports that it is one of the only organizations founded by partners of active duty service members. Its mission is to provide support, advocacy, education, and outreach for partners and children of LGBT active duty service personnel, reserves, National Guard, and Veterans. The point here is that health disparities among LGBT service members are highly relevant in meeting the mental and physical healthcare needs among this underserved group. Overall, it is crucial for healthcare consumers to feel safe in the expression of their sexual orientation and have a high degree of trust, rapport, and confidence with their professional healthcare provider.

### **Purpose of Investigation**

The present article investigates both qualitative and quantitative studies of the LGBT military community and offers best practices for professional healthcare providers to work

optimally with LGBT military service members, Veterans, and their families. Additionally, the literature reviewed examines: (a) barriers to effective treatment for LGBT military service members, (b) current training and continuing education received by practitioners and clinicians who work with openly LGBT active duty, Veterans, and their family members, (c) healthcare educators' training and experience to educate and provide clinical training and supervision for clinical supervisees, (d) LGBT military service members, Veterans, and their family members' experience of accessing quality mental and physical healthcare, and (e) best practices for professional providers to engage LGBT military personnel into mental and physical healthcare.

The studies reviewed for this article view "healthcare" as a combination of services offering mental and physical care (i.e., medical, psychological, mental health). The extensive literature on integrated or mind-body medicine supports the research on health disparities which suggests that extraordinary stressful and traumatic events have both a physiological and psychological-emotional cost as a basis for acquiring any number of chronic health conditions (Kabat-Zinn, 1990; Marini & Stebnicki, 2012; Saplosky, 1998; Weil, 1995; Weil 2005). This is particularly relevant for military service members who are clearly at a much greater risk for mental health issues (i.e., PTSS, SUDs, depression) during deployment and combat operations. In addition to mental health issues, conditions such as cardiovascular, dermatological, gastrointestinal, genitourinary, musculoskeletal, neurological, and pulmonary disorders are common medical complaints among active duty personnel and Veterans (Lehavot, Der-Martirosian, Simpson, Shipherd, & Washington, 2013; Schuster et al., 2013). Overall, the literature in this area is clear that most service personnel require significantly more visits to their healthcare providers based on their military connected service. Accordingly, healthcare providers should understand how to facilitate best practices in the services they provide to military personnel, Veterans, and their family members.

### **Military LGBT Culture**

Much of the literature related to the military LGBT community suggests that health disparities adversely impacts active duty and Veteran LGBT military and results in increased risk of chronic illness, disease, and negative behavioral health outcomes (Bell, Bern-Klug, Kramer, & Saunders, 2010; Blosnich & Silenzio, 2013; Dilley, Wynkoop-Simmons, Boysun, Pizacani, & Stark, 2010; Eliason, Dibble, & DeJoseph, 2010; Obedin-Maliver et al., 2011). Accordingly, it is of paramount importance that military healthcare providers have the proper awareness, knowledge, and skills to work within this unique culture. The military is, in fact, regarded as a culture unto itself. It meets the definition of a cultural group (Westwood, Kuhl, & Shields, 2013). Oftentimes, LGBT military service members find themselves living in two different worlds.

The increasing interest in the unique cultural aspects of the military and LGBT civilian community is evidenced by the number of multicultural counseling and psychology textbooks as well as other professional materials that have dedicated content related to the military culture (Johnson & Federman, 2013; Stebnicki, Clemmons-James, & Leierer, 2015) and sexual minorities in general (Hutchins, 2013; Singh & Yuk Sim Chun, 2013; Thomas, 2016). Clearly, the military with each of its different branches (i.e., Army, Navy, Marines, Air Force, Coast Guard, Reserves) each has its own operational language, rituals, values, mission, organizational, and socio-political structure (Stebnicki, 2016). However, if the unique cultural attributes are not

recognized by the healthcare delivery system then we remain in an antiquated structure where “one size fits all” which does little to serve individual patient/client needs.

Health disparities among the LGBT military population are critical issues to address for mental and physical healthcare policy makers, healthcare educators, and healthcare providers. The MPFC (2015) estimates conservatively there are between 30,000-50,000 LGBT military partners and families. Gates (2010) reported approximately 71,000 active duty service members, reservists, and retired reserve force members that are LGB with an additional 870,000 Veterans. Statistically, these numbers are difficult to gather because many in the military culture do not want to disclose their sexual orientation for fear of retribution socially, personally, professionally, and career-wise (Ramirez et al., 2013).

The deep concern in terms of the LGBT military service personnel is that this group participates in healthcare prevention, screening, and treatment at significantly lower levels than non-LGBT service members. Blosnich and Silenzio (2013) confirmed this notion and found similar results in their study of healthcare utilization among their sample of 11, 655 LGB Veterans who reported higher levels of smoking and other behavioral-health risk factors that resulted in much fewer visits to their healthcare providers in comparison to non-LGB Veterans. From an epidemiological viewpoint, the impact of these findings is significant as we identify an at-risk population that may be transitioning from active duty to Veteran status. Thus, it is anticipated that without proper screening, assessment, and treatment the prognosis for optimal mental and physical healthcare is poor.

The LGB community, as a whole, has become more visible in civilian culture in the last 45 years after the Stonewall Riots (Di Emilio, 2004). Yet, as a group, LGBT military service members are the “unseen minority” that have sworn an oath to serve and protect American lives (Blosnich & Silenzio, 2013; Johnson & Buhrke, 2006; MPFC, 2015). Interestingly, the Rand Corporation (2015) reports a majority of Americans now favor LGB individuals serving in the military. Despite a more favorable attitude towards the LGB civilian population, the military has sometimes viewed openly-LGB service members with stigma, institutionalized heterosexism, and sexual-orientation-linked to barriers in career promotion and advancement within the ranks (Johnson et al., 2013).

Regardless of sexual orientation, Adler and Castro (2013) pointed to one of the unmistakable differences within the military culture. For instance, the requirements of this particular occupation includes the demands of killing, avoiding being killed, caring for the wounded, and witnessing death and injury, all of which are part of training for military service. There are frequent geographic relocation, separation from family, friends, and loved-ones and 24/7 availability where one is always on-call. It is within this culture where service members’ lives, health, and safety depend on one another to be optimally mentally and physical fit for duty. Overall, the literature is clear that being LGB in the military culture is a much different experience than it is for heterosexual service members. When the majority of LGB active duty and Veterans fear disclosing their sexual orientation to their healthcare provider; then mental health issues, negative behavioral health concerns, and physical care needs develops into imminent healthcare concerns (Johnson & Buhrke, 2006).

## **A Cultural Shift in the Military and Repeal of DADT**

Expression of sexual orientation in the Armed Forces has historically been a considerable struggle in all areas of military life. With the repeal of “Don’t Ask, Don’t Tell” (DADT Repeal Act, 2010) which took effect September of 2011, there have been several generations of openly LGBT service personnel that have faced workplace stigma, institutionalized heterosexism, and sexual-orientation-linked to barriers in career promotion and advancement within the ranks (Ramirez et al., 2013; Johnson et al., 2013). In fact, between 1980 and 1990; 17,000 LGB military personnel were forced to separate from military service based on their sexual orientation (Jones & Koshes, 1995).

Despite the repeal of DADT persons that identify openly as transgender, transsexual, or queer are not afforded protection under this ACT. Dunam (2014) reported in his interview with former Defense Secretary Chuck Hagel, that Hagel suggested the U.S. military should review its ban on transgender individuals to serve, because “every qualified American should have the opportunity to serve” (p. 1) if they meet the qualifications. Hagel implied that because of some specific medical needs of transgendered persons the military may not be able to accommodate such medical care. This is particularly relevant in remote geographical locations where some transgendered persons may be deployed.

More recently, the AMPA (2015) reported that, according to documents obtained by *USA Today* (February 16, 2015), the U.S. Army is considering a policy change where any transgender service members may be allowed to serve. The report stated that any transgender service member who is discharged must be adjudicated by the Assistant Secretary of the Army (USA Today, 2015). Although no formal policy has been developed at the time of this writing, the Pentagon has begun a review of its medical policy under which transgender troops are discharged. Hence, it could be interpreted under the new policy that individuals with a variety of sexual orientations have due process rights prior to being discharged.

One of the more potent statements at the time of this writing was made by current Secretary of Defense, Ashton Carter, who indicated (February 24, 2015) that “transgender members should be allowed to serve” and echoed President Obama’s support of his statement during a town hall meeting (Badash, 2015, p. 1). The AMPA states that it has become abundantly clear that “both the Commander-in-Chief as well as the Secretary of Defense believe that all qualified Americans should be able to serve” (AMPA, 2015, p. 1). However, the MPFC (2015) cautions that “the invisibility and isolation that existed for LGB service members and partners under DADT in most ways remain for transgender service members and partners” (p. 15). Despite the repeal of DADT and the military’s current position on allowing transgender individuals to serve, significant psychosocial difficulties exist for upwards of 70,000 LGB service members that have sworn an oath to protect and defend the Constitution of the United States.

Regardless of whatever non-discrimination laws are enacted now or in the future, some senior military leaders do not perceive such laws to be a positive step in the right direction (Johnson, Rosenstein, Buhrke, & Haldeman, 2013). For instance, some critics believe that the DADT Repeal Act of 2010 may actually exacerbate negative attitudes and stereotypes of sexual

prejudice because of the current culture of heterosexism and hypermasculinity that is prominent within the military community. In response to this negativity and in preparation for the repeal of DADT, the Department of Defense (DoD, 2015) developed training programs for all active duty, selected reserves, and civilians who supervise military personnel that emphasized the values, mission, and diversity of the new Armed Forces for the 21<sup>st</sup> century.

Overall, the literature related to persons of transgender sexual orientation is scarce. There appears to be a misunderstanding of this particular cultural group's sexual orientation at least from a societal attitudinal perspective. Transgenderism is perceived many times by others as a destination to another gender or sexual orientation. Rarely are issues of gender identification and acceptance of self and others discussed. The media particularly can create confusion, stereotypes, stigma, and microaggressions regarding those individuals that express their sexual orientation as transgender. For instance, the recent media reporting on former Olympic gold-medalist Bruce Jenner's transition to "Caitlyn" Jenner has created both positive and negative stereotypes in public attitudes and opinion. It is beyond the scope of this article to fully discuss issues related to gender transition, sexual identity development, and sexual expression. Thus, the reader is encouraged to consult some of the resources provided in the Reference section of this article, as well as consult the American Counseling Association's division – the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC, 2015). ALGBTIC has a comprehensive list of resources and other information to increase the awareness, knowledge, and skills of working with persons in the LGBT community.

Despite the DoD's good intentions, many in the LGB military community feel that a cultural shift or attitudinal change is required (Johnson & Buhrke, 2006; Johnson et al, 2013). The persistence of sexual stigma and sexual orientation-based victimization by heterosexual service personnel results has been linked in the research to produce prejudice, harassment, and interpersonal strain, all of which contributes to psychological and emotional wounding creating a type of complex traumatic stress response for the LGB military population (Johnson et al., 2013). Consistent with the integrative medicine and mind-body research, individuals who acquire psychological wounding, high levels of daily stress, and trauma are at-risk for chronic illnesses and diseases. Using this body of research as a compass for guiding the healthcare practitioners' good intentions for best practices is a starting point for the provision of skilled and competent healthcare services to LGBT military service personnel and Veterans.

Accordingly, it is critical that military healthcare providers understand this cultural shift in order to provide optimal care to individuals that identify as LGBT. Thomas (2016) suggests that professional health care providers should anticipate and expect changes within individuals and the traditional family structure that may include: (a) single parenting, (b) married couples, (c) remarried and blended families, and (d) cohabitating adults with children, all of whom may identify as LGBT and Queer (Q) families. From a multicultural perspective the literature is clear that establishing a rapport with culturally-different clients/patients is essential in achieving an optimal working and therapeutic alliance (Ivey, Ivey, & Zalaquett, 2012; Lee, 2013; Schneider Corey & Corey, 2015). If a rapport cannot be established, some LGBT service members, partners, and families may be reluctant to continue with their healthcare provider and may discontinue services prematurely.

This cultural shift in 21<sup>st</sup> century families has never been more apparent due to the fact that the U.S. Supreme Court declared Section 3 of the Defense of Marriage Act (DOMA, 2010: Pub.L.104-199) unconstitutional in 2013 (Thomas, 2016). As a result of DOMA, significant changes took place for same-sex couples in civilian life. At the initial time of this writing, there were only 31 states and the District of Columbia that have legally recognized same-sex marriage (Human Rights Campaign, 2015). However, a landmark decision by the United States Supreme Court, June 26, 2015, voted 5-4 in favor of extending constitutional rights to same-sex couples to marry in all 50 states and the District of Columbia. This ruling has created sweeping changes not only legally, but socio-politically as well. Legal scholars anticipate these epic changes will filter their way through the LGBT military community. In fact, military policies are now being rewritten to include LGBT partners and spouses in healthcare insurance benefits. Accordingly, the impact of providing services to active duty and Veteran families of the 21<sup>st</sup> century has an overall influence of the quality of mental and physical healthcare received by LGBT service members.

While thousands of active duty personnel of all sexual orientations transition into civilian life each year either through retirement, discharge (honorable or less than honorable), or disability, they are challenged with the reintegration process (Farley, 2010; Farley, 2013; Hobbs, 2008). Almost immediately, there is a strong cultural identity among some Veteran groups that project the stereotypical hypermasculine identity such as that of a soldier, sailor, or Marine. Hobbs (2008) reinforced the notion many Veterans carry their military cultural background into civilian life. Veterans are a cultural group unto itself. They have their own language, symbols, and social gathering places (e.g., VFW) where they can discuss military/Veteran life, exposure to combat, and service to their country. However, Veterans that are LGBT many times do not fit into the traditional Veteran groups because they likely have experienced military life much differently than heterosexual Veterans.

Another major shift in our 21<sup>st</sup> century Armed Forces is the inclusion of women in combat. For instance, women and other minority groups typically have a much different experience in the military than heterosexual White males. In fact, there is a preponderance of evidence in the literature suggesting that heterosexual women report high levels of exposure to intimate partner violence (IPV) and military sexual trauma (MST; Buck, 2012; Iverson, Mercado, Carpenter, & Street, 2013; Schuster Wachen et al., 2013). Additionally, persons of color in the Armed Forces have had a long and difficult history of being accepted by their peer-enlisted ranks into equivalent status in terms of their military occupational service; despite that federal law forced compliance of all military branches with integration. Overall, it is of paramount importance for military healthcare service providers to understand some of these unique cultural differences and how to build a therapeutic alliance with LGBT service members and Veterans who are part of the new 21<sup>st</sup> century military.

### **Analysis of Healthcare Service Delivery to LGBT Service Members and Veterans**

The following section comprehensively reviews healthcare-related literature with LGBT patients/clients in four focused areas: (a) healthcare practitioners' training and preparation for working with LGBT civilian and military service members, partners, spouses, and families; (b) clinical educators' knowledge and skills they possess in order to prepare pre-professionals in

working with the unique cultural needs of the LGBT community; (c) healthcare practitioners' quality of education, preparation, and experiences during their clinical training which would prepare them to work with the LGBT community; and (d) the LGBT community's perception of the healthcare they received while active duty or as a Veteran.

For purpose of this study, the term "healthcare provider" encompasses both mental and physical care provided by physicians, nurses, psychologists, social workers, and professional counselors. The present study group chose to include the aforementioned healthcare professionals primarily because these particular healthcare specialists frequently provide services to military personnel, Veterans, partners, spouses, and family members.

### **Method for Analysis of Literature**

The methodology chosen to analyze the literature for this present study began with identifying 30 key words and terms (e.g., DADT, Veteran, active duty, military, health disparities, LGBT, sexual orientation, training, LGB healthcare) to search the MEDLINE, PubMed, and Google Scholar data bases. The present study group analyzed peer-reviewed journal articles, government reports, and other scholarly works primarily after the year 2000. The research in this area underreports experiences of LGBT individuals, so editorial commentaries and open-ended question-responses were also analyzed for thematic content.

It was noted by this research group that overall, journals relating to the LGBT military community were quite sparse. This was particularly true in the medical literature as a majority of military personnel and civilians do not self-report their sexual orientation to their healthcare provider. Likewise, explanations of health disparities among civilian LGBT community are equally sparse. Our findings are similar to Eliason, Dibble and DeJoseph's (2010) meta-analysis who found only eight (8) out of 5000 articles (0.16%) they reviewed in the nursing and healthcare-related journals which focused on LGBT healthcare-related issues. Overall, much of the literature found had both qualitative and quantitative methods within their research designs and included a diversity of healthcare providers (i.e., physicians, psychologists, social workers, professional counselors) for studying the experiences of LGBT in relation to healthcare they received within the military culture.

The primary categories of interest for analysis as stated in the introductory paragraph are represented in Table 1. An overview and extended discussion of Table 1 is provided in the following sections which examine healthcare practitioners, clinical educators, graduate student pre-professionals, and perceptions of healthcare among the LGBT military service members and Veterans.

### **Medical and Mental Healthcare Practitioners**

As Table 1 notes the majority of medical and mental healthcare practitioners report they acquire the knowledge and skills of working with the LGBT military service members, Veterans, and their families through sensitivity training, ethics training, training in health disparities, reading journal articles, books and other related materials, continuing educational workshops,

Table 1. *Categories of Training Received by Profession*

<b>Medical-Mental Healthcare Provider</b>	<b>Clinical Educators and Supervisors</b>	<b>Students/Pre-Professionals in-training</b>	<b>Perceptions of Healthcare received by LGBT Pts/CI</b>
Sensitivity training	Lectures	Seminars	Healthcare practitioners' presumption of heterosexual patient
Ethics training	Readings	Course in multiculturalism	Survey participant measures found in BRFS
Health disparities training	Clinical training	Pre-clinical training experiences	Coming "out" to healthcare provider
Reading books, journal articles	Clinical supervision	Group panel discussion	
Continuing education workshops	Policy statements of non-discrimination	Case studies	
Clinical Supervision-consultation	LGB faculty research	Workshop attendance	
Graduate training seminars	Doctoral dissertation		
Extensive practice experiences	Seminars		
	Course work in multiculturalism		
	Integration of LGBTQ issues across core course content		

clinical supervision and consultation, previous graduate-training seminars, and extensive practice experiences (GLMA, 2006; Murphy, Rawlings, & Howe, 2002; Neville & Hendrickson, 2006; Rutherford, McIntyre, Daley, & Ross, 2012; Wilkerson, Rybicki, Barber, & Smolenski, 2011). One particular deficit found in most studies related to the medical and mental healthcare provider's awareness, knowledge, and skills in working with LGBT patients/clients were any sense of outcome measures offered for best practices (GLMA, 2006; Murphy et al., 2002; Neville & Hendrickson, 2006; Rutherford et al., 2012). For instance, questions such as what skills are most important and successful in building an optimal working relationship with LGBT patient/clients? how do healthcare providers inquire about their patient/clients sexual orientation and what do they do with this information? were not addressed in most of the literature. Accordingly, once providers have reached some level of cultural awareness and gained the appropriate amount of information during various training activities, then it is unknown as to how providers facilitate a certain level quality care within their healthcare specialty and setting. Accordingly, if the healthcare practitioner did not receive specific clinical training in their graduate program it is anticipated that these providers may have some difficulties in facilitating an optimal therapeutic working alliance with their LGBT patients/clients ( GLMA, 2006; Murphy et al, 2002; Neville & Hendrickson, 2006).

The research in clinical mental health is clear that there is poorer mental health outcomes associated with serving clients within the LGBT community (Meyer, 2007; Rutherford, 2012). One distinguishing feature in the literature is that members of the LGBT community must bear



the social, emotional, and psychological stressors of having to be subjected to stigma, stereotypes, and at times, have to live in a homophobic environment.

The psychosocial and socio-cultural stress among LGBT adolescents and adults are significant. A meta-analysis from 25 different studies involving 12,000 LGBT participants found that sexual minorities are 1.5 times higher risk for depression and anxiety and 2.5 times more likely to have a suicide attempt than heterosexual mental health populations (King et al., 2008). Some studies have estimated that 26-43% of transgender individuals have attempted suicide at least once (Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011). Thus, if mental health practitioners are to advance in their awareness, knowledge, and skills in working with LGBT clients there would perhaps be less high risk individuals both in and out of therapy.

To explore an understanding of other specific mental and medical health-related risk factors among LGBT patients, Blosnich and Silenzio (2013) investigated LGBT health risk factors using the Behavioral Risk Factor Surveillance System (BRFSS; Centers for Disease Control and Prevention [CDC], 2015) in a sample of Veterans located in 10 states in the U.S. In brief, some of their key findings, indicated that there are particular risk factors present in LGBT Veteran patients (i.e., higher level of smoking, heavy drinking, and HIV/AIDS, lower levels of obesity and diabetes) compared to their heterosexual peer Veterans. The key point here in developing best practices for healthcare practitioners, is the awareness and cultural-sensitivity that is required to understand their patients'/clients' experience of sexual identity and orientation. This should be a consideration for providers with the primary intent of screening specific medical and behavioral health risk factors among LGBT patient/clients. Inquiring about such health information is critical for providing optimal healthcare and developing treatment goals that are culturally-relevant for all patients/clients that are culturally-different.

### **Clinical Educators**

As Table 1 suggests, clinical educators and supervisors in both the medical and mental health fields report a variety of teaching and training approaches they facilitate with graduate level pre-professionals. For those colleges and schools that provide education and clinical experiences in working with LGBT military and/or civilian populations, the most frequent means of providing graduate education is through lectures, readings, clinical training, clinical supervision, policy statement of non-discrimination, LGBT faculty research activities, doctoral dissertations, seminars, course work in multiculturalism, and integration of LGBT issues across the curriculum (Bidell, 2005; Corliss, Shankle, & Moyer, 2007; Dohrenwend, 2009; Eliason & Raheim, 2000; Green, Johnson, & Adams, 2006; McGarry, Clarke, & Cyr, 2000; McNari & Hegarty, 2010; Obedin-Maliver et al., 2011; Riggs & Fell, 2010; Rutherford, McIntyre, Daley, & Ross, 2012; Rutter, Estrada, Ferguson, & Diggs, 2008; Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006; Sequeira, Chakraborti, & Panunti, 2012; Tamas, Miller, Martin, & Greenberg, 2010; Wallick, Cambre, & Townsend, 1992). It is important to note that the same problem exists among clinical educators as with practitioners mentioned in the previous section; there are very few evidence-based measures that are offered to educators and clinical supervisors as related to awareness, knowledge, and skills of working effectively with LGBT patients/clients. The primary assumption here is that each instructor, clinical supervisor, department, college, or school is facilitating training and educational curriculum based on what they perceive works best

and/or facilitating the core content areas and guidelines within medical, psychological, or counselor education accreditation standards.

Clearly, gaps in LGBT educational training opportunities are evident for most all medical and mental healthcare practitioners. For instance, Rollins (2015) reports on training clinical psychology interns on LGBT patient populations at the VA Medical Center in San Francisco. The training program for clinical psychologists and other healthcare practitioners advocated in this particular setting provides a model for increasing awareness, knowledge, and skills with diverse patient populations. Clinical supervisors provide opportunities for clinical interns to focus on patient-centered skills by developing cultural sensitivity and rapport building between LGBT patients and their healthcare practitioner. Generally, it is known that when many LGBT patients present with healthcare issues, clinical interns in medicine and psychology tend to focus on the medical risk factors of HIV/AIDs, as well as other sexually transmitted diseases (Rollins, 2015). Unfortunately, this only reinforces the stereotype of single-issue medical and mental health concern for the LGBT community; inferring that they are “all a high-risk population” to serve.

In Sequeira et al.’s (2012) study of pre-clinical medical students, it was found there was an inadequate amount of training in how to communicate with patients regarding their sexual orientation as well as how to respond to the gender of the patients’ sexual partner. The thematic analysis in Sequeira et al.’s study highlighted three key issues among pre-clinical medical students: (a) students’ acknowledged they had a lack of exposure to LGBT patient issues, (b) students’ agreed that the information related to LGBT patients are essential for their future medical practice, and (c) students’ endorsed training related to LGBT healthcare issues for inclusion in their medical educational curriculum. In fact, an American Medical Association (AMA, 2010) study suggests that medical healthcare providers may have the same homophobic reactions to patients that identify as LGBT. The AMA has published educational materials and training modules for medical providers on their website to increase awareness, knowledge, and skills in working with LGBT patients.

Overall, the studies in clinical medical and mental health education and supervision agree that healthcare providers lack the awareness, knowledge, sensitivity, and skill to work effectively with LGBT patients/clients; particularly with active duty and Veterans. Consequently, very little content is offered to graduate students particularly in the medical healthcare-related graduate programs (e.g., cultural identity development, concepts in acculturation and assimilation, how to build rapport with specific racial/ethnic groups). Clearly, training opportunities related to LGBT healthcare are not well integrated into many graduate curriculums.

### **Graduate and Pre-professional Students**

As noted in Table 1, graduate/pre-professional students’ perception of what they received during their graduate educational experiences included the following activities reported with the most frequency: seminars, course work in multiculturalism, pre-clinical training experiences, case studies, and attendance at workshops (Kelly, Chous, Dibble & Robertson, 2008; Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006; Sequeira et al., 2012. In regards to the specific training of graduate level counselors, Alderson (2004) reported that past research related to

sexual minority training has been minimal and inadequate to be able to provide skilled and competent services to LGBT clients. Consequently, when graduates become licensed providers there is a great need for in-service training on working with the unique cultural aspects of the LGBT patients/clients.

With increased emphasis on multicultural education in graduate counselor training programs (prompted by counselor accreditation standards) and some developing interest within medical education programs there appears to be a need for training practitioners to work effectively with a diversity of minority groups. Currently, it is our contention that there is a minimal emphasis placed on understanding the experiences of the LGBT civilian and particularly military culture. For instance, providing services to consumers that identify with multiple minority groups, such as a woman of color that identifies herself as a lesbian, requires cultural understanding of three cultural groups (female, women of color, and lesbian). Providers that lack such awareness, knowledge, and skills to work with individuals that possess these cultural identities may truly have obstacles to serving patients/clients within this context. Thus, it may be helpful for providers to have an understanding of feminist theory (Evans & Miller, 2016) and the influence of socialization and gender as well as training in various racial/ethnic minority groups. The point being that there are complex interactions and multiple variables to consider that cannot be artificially separated by race, ethnicity, or sexual orientation. When professional healthcare providers and/or clinical educators model heterosexuality as the norm or perhaps do not recognize that the LGBT culture exists across multiple cultural groups (e.g., Latino(s), African-Americans, Asian-Americans) then this can create individual and institutionalized oppression; both unintended and intended.

Another example of patients/clients that identify with one or more cultural groups is found in a study of nursing home social workers and social service directors (Bell, Bern-Klug, Kramer, & Saunders, 2010). Here it was reported that many older LGB are often marginalized and prefer to be “invisible” with their sexual orientation which makes them a very vulnerable and population because they are older, feel invalidated many times, and must live life in secrecy for fears of social-emotional isolation. This particular study confirmed other studies that suggest fear of self-disclosure can significantly reduce participation not only in activities involving social-emotional health but physical health as well.

Overall, it is critical during clinical instruction, internships, and residencies that clinical supervisors advocate multicultural training and model culture sensitivity. Graduate students are the new healthcare providers for the 21<sup>st</sup> century and should not allow 20<sup>th</sup> century practices to dictate their future practices. There are many clinical or institutional settings that intentionally or unintentionally ignore a diversity of cultural beliefs, values, lifestyles, and worldviews; thus, creating harm to patients/clients.

### **LGBT Military Service Members and Veterans**

Generally, most studies that measured LGBT military service members’ perceptions of the healthcare they received were done so anonymously through confidential surveys. Here it was found that more LB women than GB men were likely to disclose their sexual identity to their healthcare provider. The majority of LGBT patients (75%) reported that their healthcare

provider “always” or “usually” presumes that they were heterosexual. One particular instrument commonly used to study health disparities among LGBT Veterans is the Behavioral Risk Factor Surveillance System (BRFSS; Blosnich & Silenzio, 2013; Dilley, Simmons, Boysun, Pizacani, & Stark, 2010). These studies revealed that LGBT Veterans have different health risks and poorer health outcomes than heterosexual Veterans in certain areas. For example, LGBT Veterans have higher rates of smoking, heavy drinking, longer lifetime of asthma conditions, and much less physical activity than their heterosexual peer Veterans (Coron, Mimiaga, & Landers, 2010; Dilley, Wynkoop-Simmons, Boysun, Pizacani, & Stark, 2010). Obesity among LGBT Veterans was significantly less common than heterosexual Veterans, except for lesbian women Veterans where the prevalence was much higher.

It is important to note, however, that not all studies on LGBT Veteran health disparities agree. For instance, Dilley et al. (2010) in a sample of 79,500 participants in which 498 identified themselves as gay men, 589 identified as lesbian, and 561 identified as bisexual; showed a lower risk for diabetes than in other studies. Adjusting for differences in the comorbid risk factors such as obesity and diabetes, it was reported that some studies showed a higher incidence of diabetes among bisexual females compared to heterosexual female populations. Also, adjusting for other health factors, Wallace, Cochran, Durazo, and Ford (2011) noted that gay men had higher odds of acquiring diabetes than heterosexual men.

Overall historically, there has been a small group of researchers that investigate health risk factors of LGBT military service personnel and Veterans. A primary finding in most studies are that LGBT patients/clients delay or do not receive medical and mental healthcare at the same frequency as heterosexual individuals; thus, placing this group with multiple health risk factors when compared to heterosexual Veterans (e.g., low rates of preventative health screenings, low and no follow-up with scheduled appointments, poor disclosure of important healthcare issues, hesitancy with “coming out” to a provider). With the repeal of “Don’t Ask, Don’t Tell” it is anticipated that more LGBT Veterans will “come out” to their healthcare provider because of the recognizable anti-discrimination efforts among military policy makers. Also, upon the recommendation of the Institute of Medicine (IOM, 2011) to include sexual orientation on intake assessments within the electronic medical record, the Veterans Health Administration should be prompted to include more intensive training opportunities for all healthcare providers on the awareness, knowledge, and skills to work with health-related issues of LGBT Veterans within the VA system (e.g., screenings such as HIV/AIDs, rapport building to gain patient trust for disclosure of person health-related issues, referral sources for LGBT community).

### **Recommendations for Best Practices**

Based on the findings within this comprehensive investigation of studies relating to the health disparities among LGBT military and Veteran community, the following recommendations for best practices among healthcare providers are offered.

1. Mandatory seminars for medical and mental healthcare graduate students and pre-professionals, particularly in medicine, nursing, and allied health, which include LGBT civilian and/or military service members as the primary presenter. The intention for

mandatory seminars are for LGBT to share directly with pre-professionals how they experience the quality and level of healthcare they have received for themselves their partners, and family members. Also, this would provide opportunities for newer professionals to ask questions and increase their awareness, knowledge, and skills to work with LGBT military and Veterans.

2. Form task force committees within medical, nursing, psychology, and counselor accreditation bodies to review standards of education and training with the intent on integrating cultural aspects of the military and LGBT culture. The intention would be to adopt content that facilitates educational opportunities of awareness, knowledge, and skills across the graduate curriculum.
3. Offer LGBT medical and mental healthcare training as a pre-conference to major training conferences. The intention is to dedicate specialty training for practitioners and providers on LGBT healthcare-related issues for military personnel and Veterans.
4. Develop internship and residency opportunities where LGBT patients/clients are part of the regular caseload of patients/clients seen. The intention is to provide new practitioners with the appropriate level of skills and clinical supervision to develop a working alliance with LGBT military and Veterans.
5. Improve the competencies of clinical supervisors and educators on cultural issues related to LGBT service personnel and Veterans. The intention is to graduate competent and skilled practitioners that can deal with patients/clients that are culturally-diverse. Well trained clinical supervisors and educators are essential to facilitate clinical supervision approaches that work beyond awareness and knowledge of the LGBT and military culture. Learning the essential skills to provide competent healthcare is critical for quality provision of services.
6. Develop special topic issues within scholarly journals. The intention is to dedicate a special issue within a quarterly journal related to LGBT healthcare issues. Experts within the areas of healthcare who have provided competent healthcare services within a multicultural, LGBT, and military community could be invited to submit articles.
7. Advocate LGBT resources to be included on web-based training as part of private insurance providers (i.e., Tricare, Magellan, various EAPs that offer services to military bases) so that providers on the panel can acquire appropriate levels of knowledge and skills working with patients'/clients' that are LGBT service members and Veterans.

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## **Resilience and Sports: An Innovative Approach to Rehabilitation Counseling for Veterans with Spinal Cord Injury**

MICHAEL T. HARTLEY  
The University of Arizona

AIMEE C. MAPES  
The University of Arizona

### **Abstract**

*This descriptive case study details an innovative rehabilitation project for Veterans with spinal cord injury (SCI) which utilized a resilience framework. Combining recreational adaptive sports with psychoeducational group counseling activities, the objective of the project was to assist Veterans with SCI to develop the psychosocial skills necessary for adapting to the material and social factors of disability. This article will introduce the project, present participants' experiences as described in their own voices, and consider implications to define and better support how Veterans with SCI can respond creatively and successfully to their disabilities.*

*Keywords: resilience, Veterans, spinal cord injury, recreation, education*

### **Introduction**

Rehabilitation counselors can play an important role in the provision of rehabilitation services to Veterans with spinal cord injury (SCI; Boutin, 2011; Frain, Bishop, & Bethel, 2010; Frain, Bishop, Tansey, Sanchez, & Wijngaarde, 2013; Singh, 2013). The U.S. Department of Defense (2015) has reported that 52,299 American troops have been injured in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), Operation New Dawn (OND), Operation Inherent Resolve (OIR), and Operational Freedom Sentinel (OFS) as of June 12, 2015. Of these,

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Michael T. Hartley is an Assistant Professor in the Department of Disability and Psychoeducational Studies at the University of Arizona. Aimee C. Mapes is the Assistant Director, Writing Program and Assistant Professor in the Department of English at the University of Arizona. *Address correspondence to Michael T. Hartley. E-mail: mthartley@email.arizona.edu.*

the Department of Defense has estimated that 20% involve the spinal cord (Bilmes, 2007). Whereas Vietnam era Veterans experienced an injury to casualty rate of three to one, for Veterans of OIF, OEF, OND, OIR, and OFS the rate is sixteen to one, meaning that Veterans are sustaining a higher rate of injuries than ever before (Bilmes, 2007). That is, there are unprecedented numbers of Veterans with disabilities, which poses a challenge for rehabilitation counseling and related professional who support service members as they transition to civilian life with a new disability. Indeed, an important step is to define and better support how Veterans with SCI address common psychological and social barriers associated with disability (Marini, Glover-Graff, & Millington, 2012; Stuntzner & Hartley, 2014; Smart, 2009).

Representing damage to any part of the spinal cord or nerves at the end of the spinal canal (Falvo, 2013), the American with Disabilities Act (1990) defines disability as an impairment that limits major life activities, such as “caring for oneself, performing manual tasks, walking, seeing, hearing, breathing, learning, and working” (Maki & Tarvydas, 2012, p. 87). Following the onset of a spinal cord injury (SCI), many individuals struggle with the complex challenge of examining how the disability will affect who they are and what their role is in society (Dunn & Burcaw, 2013; Dunn & Brody, 2008; Williams, Davey, & Klock-Powell, 2003). Indeed, Erikson (1963), a developmental identity theorist, was one of the first to argue that Veterans injured in war were susceptible to identity fragmentation. More recently, disability studies scholars have found that identity formation following a serious spinal cord injury is important for psychosocial recovery (Gill, 1997; Ostrander, 2008a, 2008b). Specifically, common psychological and social challenges may include learning about, adapting to, and coping with (a) disability; (b) changes in personal functioning; (c) negative thoughts and feelings as a part of the adaptation process; (d) societal and attitudinal barriers; (e) feelings associated with loss and disempowerment; (f) experiences of social injustice and discrimination; and (g) lack of access to services, housing, or meaningful employment (Marini et al., 2012; Smart, 2009; Stuntzner & Hartley, 2014). Coping with and adjusting to disability is an individualized process and two people with very similar disabilities are capable of very different outcomes and coping processes (Livneh, 1986; Stuntzner & Hartley, 2014). Some individuals learn to cope with restrictions to major life activities within a relatively short amount of time, while others require more time to adjust to disability.

Importantly, the problem is not simply adapting to biological impairments of disability, but rather contesting dominant cultural perspectives that label and position people with disabilities as diseased, broken, and in need of fixing (Conyers, 2003; Longmore & Umansky, 2001; Smart, 2009). Even as people adapting to disability face physiological, economic, and emotional changes, they are simultaneously faced with negative messages about disability. In recent years, attitudes toward individuals with disabilities have improved; however, people with disabilities continue to be treated as inferior to people who do not have disabilities (Longmore & Umansky, 2001). As a result, people with disabilities may encounter attitudinal, employment, learning, medical, societal, and environmental barriers – all of which have the ability to prevent them from participating in life to their fullest extent (Hartley, 2012; Hartley & Tarvydas, 2013; Smart, 2009). Thus, rather than biological impairments, it is social policies and practices that marginalize people with disabilities (Hartley & Tarvydas, 2013; Smart, 2009), in essence, serving “to exaggerate disability and even construct disability” (Smart, 2004, p. 42). Rehabilitation counselors recognize that social disadvantages experienced by people with

disabilities results from a complex interplay of material barriers—such as high rates of unemployment, insufficient nutrition, poor living conditions, lack of access to necessary medical and health supplies (Hartley & Tarvydas, 2013) – and intangible barriers, such as dominant cultural messages of people with disabilities as diseased, broken, and in need of fixing (Hartley, 2012).

A goal of rehabilitation counseling is to offset social disadvantages associated with disability (Maki & Tarvydas, 2012; Marini et al., 2012; Smart, 2009). As a specialty area in the counseling profession, rehabilitation counselors work with “persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible” (CRCC, 2010, p. 1). Based on a person-environment fit, a successful rehabilitation outcome is the result of understanding the reciprocal interaction between the individual and his/her environment (Maki & Tarvydas, 2012). As a relatively new research framework, resilience is one avenue to support returning military Veterans (Bowen & Martin, 2011; Weiss, Coll, Gerbauer, Smiley, & Carillo, 2010). Specifically, a resilience framework may help to explain why some Veterans are able to respond creatively and successfully to their disabilities, while other Veterans with similar impairments struggle to address common psychological and social barriers associated with disability.

This descriptive case study details an innovative rehabilitation project for Veterans with spinal cord injury (SCI) which utilized a resilience framework. Combining recreational adaptive sports with psychoeducational group counseling (Corey, 2011; Corey, Corey, & Corey, 2013), the objective of the project was to assist Veterans with SCI to develop the psychosocial skills necessary for adapting to the material and social factors of disability (Marini et al., 2012; Stuntzner & Hartley, 2014; Smart, 2009). Group sport activities fostered a community of peers (Wenger, 1998), while opportunities for reflection were a mechanism for Veterans with SCI to narrate physical and emotional lessons of disability in terms of strategic resources for personal meaning and resilience (Miller, 2003; McGeary, 2011; White, Driver, & Warren, 2008; White, Driver, & Warren, 2010; Williams & Davey, Klock-Powell, 2003). In what follows, this article will introduce resilience as a framework, overview the resilience curriculum, present participants’ experiences of the project, and consider implications to define and better support how Veterans with SCI can respond creatively and successfully to their disabilities.

### **A Resilience Framework**

Emerging from the positive psychology movement (Seligman & Csikszentmihalyi, 2000), resilience is an asset-based approach that can help individuals respond successfully and creatively to their disabilities (Miller, 2003; McGeary, 2011; White et al., 2008; White et al., 2010; Williams et al., 2003). Masten, Best, and Garmezy (1990) define resilience as “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (p. 426). One way to understand resilience is in relation to the classic stress-diathesis model, where “stress activates a diathesis, transforming the potential of predisposition into the presence of psychopathology” (Monroe & Simons, 1991, p. 406); however, from a resilience perspective, the stress-diathesis model fails to account for protective factors. As an interactionist framework, resilience is the complex interplay between an individual and his/her environment, in which the individual can influence a successful outcome by using internal and

external protective factors, defined as the personal qualities or contexts that predict positive outcomes under high-risk conditions (Eageland, Carlson, & Sroufe, 1993; Richardson, 2002).

Rather than a single trait or skill, resilience is understood to be the cumulative effect of multiple protective factors that allow an individual to be successful despite adversity, including “constitutional variables like temperament and personality, in addition to specific skills (e.g. active problem solving)” (Campbell-Sills, Cohan, & Stein, 2006, p. 586). From a resilience perspective, what matters most are the relationships between intrapersonal resilience factors, such as locus of control, emotional self-regulation, spirituality, commitment, and interpersonal resilience factors, such as social and family support (Hartley, 2010; 2011; 2013; Stuntzner & Hartley, 2014). All of these factors work together with a cumulative effect (i.e., the more success from meeting challenges, the more resilience builds upon itself). While there is a wealth of research in support of resilience as an avenue to promote healthy responses to disability (Miller, 2003; McGeary, 2011; White et al., 2008; White et al., 2010), resilience interventions have yet to be developed toward the specific needs and concerns of Veterans with spinal cord injury (SCI). The following section overviews a resilience-based rehabilitation project specifically designed for this population.

### **An Innovative Rehabilitation Project**

Coordinated by an interdisciplinary team of rehabilitation counselors and related professionals, the goal of the project was to examine the benefits of adaptive athletics with respect to supporting health, independence, and quality of life following spinal cord injury (SCI) (Dryden et al., 2004; Dryden et al., 2005). Held in the fall of 2012, the project engaged Veterans with SCI in adaptive sports as well as psychoeducational group activities focused on promoting psychosocial skills to maintain optimal health, independence, and quality of life following the onset of disability (Fleig, Pomp, Schwarzer, & Lippe, 2013; Letts et al., 2011; May, Day, & Warren, 2006). With funding from an educational grant, the project took place on the campus of a large land-grant university, which has a state-of-the-art adaptive gym and a distinguished adaptive athletics program, consisting of a director and two coaches who have run numerous sports clinics. The present project, however, extended the previous sports clinics to include an emphasis on psychoeducational counseling activities designed to promote resilience and create personal meaning following the onset of disability (Miller, 2003; McGeary, 2011; White et al., 2008; White et al., 2010; Williams et al., 2003). Over a period of five days, Veterans with SCI engaged in wheelchair basketball, tennis, rugby, road racing, weight lifting, and scuba diving as well as psychoeducational group activities to promote individualized understandings of resilience. A typical day involved early morning and late afternoon sports with midday resilience activities.

### **Adaptive Sports**

Many Veterans entered the military with a commitment toward physical exertion, discipline, and self-sacrifice, and, on a psychological level, the loss of physical functioning associated with disability and need for assistance may be antithetical to military culture (Demers, 2011; Hall, 2009; Schading, 2007). As such, adaptive athletics may be a particularly important context to promote a positive identity following disability (Bury, 2001; Gill, 1997; Ostrander,



2008a; Ostrander, 2008b) while also promoting a physical active lifestyle (Kehn & Kroll, 2009). As a competitive and team-oriented community, adaptive athletics fosters physical activity, and it champions a positive identity of disability that is strong, competitive, and attractive – traits highly valued in the dominant culture (Perrier, Sweet, Strachan, & Latimer-Cheung, 2012; Sparkes & Smith, 2005). In this way, adaptive sport is an important avenue for promoting health, independence, and quality of life, especially for Veterans with SCI (Dryden et al., 2004; Dryden et al., 2005). By addressing the social and embodied experiences of disability, adaptive athletics is critical because it interrogates negative societal messages of disability as tragic (Baker, 2009; Bircher, 2000; Conyers, 2003).

Unfortunately, obstacles, such as a lack of knowledge and resources, make the path toward a physically active lifestyle with adaptive sports challenging for many Veterans with SCI (Kehn & Kroll, 2009). The U.S. Department of Veteran's Affairs (2015) encourages adaptive sports participation for Veterans with SCI; however, the overall lack of physical activity compared to abled-bodied populations (Buchholz & Pensharz, 2003; Slater & Meade, 2004) means that Veterans with SCI face secondary health complications related to obesity and high blood pressure (Gater, 2007; Rajan et al., 2010). The result is that individuals with SCI face a higher risk of stroke, heart attack, and diabetes (Banerjea et al., 2008). Yet, by teaching Veterans the mechanics of various sports and providing a community of competitive athletes who motivate one another (Kehn & Kroll, 2009; Wu & Williams, 2001), adaptive athletics is a way to promote physical fitness, advance physical and emotional recovery, improve strength and conditioning, and enhance social development (Buchholz & Persharz, 2003; Slater & Meade, 2004). More than just physical health, recreational and fitness opportunities have been shown to promote quality of life and life satisfaction (Wahman, Biguet, & Levi, 2006; Wu & Williams, 2001), including a positive identity following the onset of a traumatic disability (Perrier et al., 2012; Sparkes & Smith, 2005).

### **Resilience Curriculum**

In tandem with adaptive sport, the authors designed a resilience-based curriculum to further support positive identifications with disability and community. Viewing resilience as something that can be taught or enhanced and that a person's current level of functioning does not dictate what they are capable of in the future (Stuntzner & Hartley, 2014), the resilience curriculum included both building psychosocial skills of tenacity, positive emotions, and peer support along with group reflection activities designed to promote personal meaning and strength (Miller, 2003; McGeary, 2011; White et al., 2008; White et al., 2010). In developing the curriculum, a review of the research found a relatively consistent list of factors associated with successful coping with the onset of disability (Stuntzner & Hartley, 2014). With an emphasis on a person-environment fit, the factors included intrapersonal resilience, such as: (a) positive emotions, hope, and the ability to tolerate stress (Farley, 2007; Mackler, 1998 Miller, 2003); (b) internal locus of control (Dunn & Brody, 2008); (c) tenacity and active problem solving (Neenan & Dryden, 2008; White et al., 2008); (d) spirituality and the belief that things will work out (Black & Lobo, 2008; Webb, 2003; White et al., 2008; Williams et al., 2003) as well as interpersonal resilience, such as (e) peer support (Black & Lobo, 2008; Neenan & Dryden, 2012) and (f) family support (Walsh, 2012; White et al., 2008). Based upon this research, the factors associated with resilience were organized into a psychosocial educational curriculum that

promoted individualized understandings of how to apply the resilience factors to promote positive psychosocial coping following the onset of SCI (Kennedy & Duff, 2001; Kennedy, Duff, Evans, & Beedie, 2003; King & Kennedy, 1999).

Stepping away from the top-down paradigm of “test-and-tell,” the intent was to link the resilience curriculum to participants’ personal goals and lifestyle preferences, making the information useful to understand the past and create change in the future (Burlew & Morrison, 1996, p. 163). In particular, the psychoeducational group counseling activities (Corey, 2011; Corey et al., 2013) utilized reflective writing and practice, which according to sociocultural learning theorists, foster a model of review and meta-analysis to discern patterns and generate a new way of thinking about a situation (Gutierrez, 2008; Yancey, 1998). Specifically, the reflective activities focused on generating positive narratives of resilience and hope (Davis & Novoa, 2013; Dunn & Burcaw, 2013) in order to increase participants’ self-awareness of day-to-day living with SCI. In line with empirically-validated coping interventions for individuals with SCI, participants were involved in small group work designed to assist participants who had similar concerns and interests to discuss how to apply the resilience factors within the context of their own lives (Kennedy & Duff, 2001; Kennedy et al., 2003; King & Kennedy, 1999).

Research on resilience identifies intrapersonal and interpersonal domains, and an important feature of the resilience-based curriculum of this project related to interpersonal skills of belonging and peer support; that is, a sense of community emerged that was fundamental to the value of the peer-to-peer interactions (Lave & Wenger, 1991; Wenger, 1998). Without community, participants had no means by which to integrate their stories within a meaningful social context. To develop a robust system of peer support, the resilience curriculum applied Wenger’s (1998) theory of communities of practice. Building upon Bandura’s (1986) social learning theory that interpersonal relations of imitation, modeling, and observation serve an individual’s cognitive processes, a community of practice extends social relations to mean an engagement with situated social practice. According to Wenger (1998), in a community of practice, new ways of knowing bear out during processes of identification (p. 215). Thus, acquiring and transforming knowledge corresponds with levels of engagement in shared practices and identities (Lave & Wenger, 1991). As part of developing individualized repertoires of resilience and coping based on personality, history, culture, and aspirations (Bury, 2001; Gill, 1997; Ostrander, 2008a; Ostrander, 2008b), identity was both an experience and “a display of competence” (Wenger 1998, p. 152). As an identity theory, communities of practice afforded the conditions necessary to engage participants in shared discussions of worthwhile futures.

## **Participants**

Recruitment for the project targeted regional rehabilitation hospitals specializing in spinal cord injury as well as national Veteran organizations, such as the Paralyzed Veterans of America (PVA). Preference was given to applicants with newer injuries and beginners to wheelchair sports, who may not have had previous opportunities to participate in adaptive sports. Applicants were selected by the date their application was received and their level of interest in both sports and higher education. Over a two-month period of time, a total of twenty-five Veterans with SCI applied from across the country. Fifteen applicants were invited; however, three participants dropped out due to health-related problems.

In all, twelve Veterans with SCI participated from across the country, including Arizona, Georgia, Florida, Massachusetts, Missouri, and Ohio. Participants included nine men and three women with an average age of 38.5 years ( $SD = 8.50$ ). Four participants were Caucasian, four were Latino, and four were African-American. Seven participants had paraplegia, five had tetraplegia, and two had Multiple Sclerosis. Average time since injury/diagnosis was 6.6 years ( $SD = 4.68$ ). Three participants traveled with caregivers, and nine of the participants had some experience with adaptive athletics. Educational backgrounds varied from no postsecondary education to participants with college degrees who were interested in further education.

## **Project Outcomes**

With approval from an Institutional Review Board (IRB), follow up interviews with participants occurred six months after the project. All of the interviews were conducted by the first author. Procedures involved asking participants an identical set of questions in a semi-structured format, such as:

1. How would you describe your experience?
2. What were your experiences like interacting with the other participants?
3. How did your interactions with other Veterans connect with who you are as a person?

While questions were asked in a similar manner, the format of the interview structure remained sufficiently open and flexible to permit participants to expand upon their responses (Charmaz, 1998).

The interviews were recorded, transcribed, and analyzed using an iterative process to look for how participants used language as means for strategic positioning with an emphasis on social relationships (Patton, 2001). A constant comparison method was used to locate language references, chart frequencies, and then analyze how language was used to represent social dynamics, metaphors of understanding, and a shared repertoire (Blommaert, 2005). From the constant-comparative analysis somewhat stable categories gained prominence, which were continually refined in order to verify the stability. Code patterns were triangulated by comparing and contrasting across interviews to capture participants' perspectives. After the coding, member checking was performed to confirm the validity of the code patterns and to ensure that the participants' narratives were accurately coded: participants received a final report of the results and to confirm the findings accurately reflected their experiences during and after the camp.

## **Participants' Perspectives**

Six months after the project, participants were interviewed to capture emic perspectives of the effects of combining adaptive sports and resilience curriculum. Across all interviews, it became evident each were motivated to fulfill personal goals no matter the context, but an encouraging pattern across participants' data demonstrated that many made future goals, in part, as a result of their experience with the resilience curriculum. In particular, four theme clusters emerged demonstrating the most relevant facets of the project:

- Competition
- Community
- Resilience
- Independence

## **Competition**

A salient feature of the project was the opportunity for competition. According to one participant, sports played a key role: “It’s amazing how even in low level competition – because that wasn’t an official game or something – but it’s amazing how even a friendly competition like that brings out in everybody where they all do their best. They don’t just sit out there.” Speaking to a theme found in all of the interviews, this participant identified how low risk opportunities with competition provided motivation and enabled active engagement with a social practice.

In terms of motivation emerging from competition, sports inspired future dreams, ranging from recreation to training for the Paralympics. For one participant, the experience “showed how much more was out there for someone in a wheelchair.... I did not know what was available for people with disabilities and for Veterans.” For others, the experience was an opportunity to measure themselves against other athletes. As an illustration, another participant described her goal in competitive weight lifting: “I want to do a record at the wheelchair games.” Similar goals were expressed by other participants, such as renewed desire to compete in the Paralympic games: “I definitely want to do rowing; I want to get into the Olympics with it. Yeah. I mean, the Olympic thing I want it really bad. It’s like, All right. I’m going to be there. I want to be there. I’m going to make it.”

As a form of engagement in a shared social practice, across interviews all participants described positive identity affiliations that emerged from engaging with sports competition; however, for some participants the focus on sports took on a more personal significance:

It was amazing because I love to play basketball. My daughter plays basketball. It’s like a family thing. To be able to say that yes I did, and in the event that I start to feel better, if I wanted to, I could get into a wheelchair and shoot around and play basketball with my daughter. I could still connect in that way. And if I hadn’t gone, I never would have experienced it. I never would have known that.

Offering a beautiful illustration of the significance of being introduced to adaptive sports, she noted that if she had not been exposed to adaptive sports during the camp, she probably wouldn’t have tried to play basketball with her daughter. Astutely, she described the positive identity she felt as “amazing” and as something she will share with her daughter. Across the interview data, participants emphasized how competition was an initial trajectory of engagement and identification (Sparkes & Smith, 2005). In addition to their own personal experience, participants recalled how important competition was to other participants. Referencing the participant above, another participant recalled:

I remember basketball was her thing. She might’ve wanted to play something else where it wasn’t such a competition, but basketball was her sport. So, it’s kind of like everyone has to find that one sport or that one thing they really like. And you could see the spirit was there and everything.

Illustrating how identification happens as part of competition, “the spirit” emphasized how having fun and playing a sport produced intrinsic motivation and engagement. In this discourse pattern, “the spirit” is used to exemplify a force within a person that can be seen as powerful and life-giving because it captured both a literal sense of physical force in sports competition and an inner power, including tenacity and ability to persist. All participants referenced friendly competition and other modes of gamesmanship that emerged during the adaptive sports activities.

## **Community**

As a result of motivation and engagement in competition, community emerged as a second salient facet of participants’ experiences. Across the interview data, participants referenced others speaking their language. On one level this functioned as a common dialect, but on a second level, frequent references to military language allowed participants to affiliate with and embody values of loyalty and commitment instilled within the military (Demers, 2011; Hall, 2009; Schading, 2007). As an example, one participant described the experience in the following way: “We all coalesced, from being individuals we all coalesced and became a unit... It’s something that’s instilled in us when we come [into the military] and it’s something hopefully we carry on through the rest of our life.” For this participant, the term “unit” tapped into his past while also allowing him to carry it forward into the future. The shared values and affinity groupings practiced through the military language seemed to impact how participants effectively negotiated and connected with one another and competitive activity catered to this.

Because participants all identified as Veterans first, people with disabilities second, both translated to productive community formation. As an example, a participant clarified that “rather than the student athletes, I talked more with the student Veterans... because they speak my language. My perception was that these were people who understand me.” In many ways, Veteran culture was an important community affiliation, and it was beneficial to embrace this identity. Another participant described the experience as “fantastic” because “there was that much of a group of people in the same situation trying to do the same thing. It was like; it was like our own little clique.” Thus, the community affiliation became a “clique” within the broader larger community of adaptive athletics. Frequently in the data, it became apparent that military cultural experiences facilitated stronger engagement by participants in adaptive athletics, as affiliations with military acted as an essential connection.

Ultimately, the shared sense of military culture among the participants became a powerful way to translate a past sense of competence into the present and future interactions within the communities of sports and education (Wenger, 1998). One participant described the experience “as a brotherhood. We’re all in this situation together... We help each other out.” Highlighting the unique community that emerged, another participant noted:

As a Veteran to see and talk with other Veterans from across the United States that aren’t just settling with a disability, but still trying to live their lives and be a positive part of everyday life. Doing a little bit more with sports and continuing their education. I just loved your program.

Recognizing the strength in their shared experiences, most participants translated these into the community, which contributed to establishing interpersonal skills of belonging and peer support. Engagement in a shared social practice through group activity was essential to the success of the project.

## **Resilience**

Most participants arrived expecting to learn about sports, but many described being surprised by how the reflective writing and practice resulted in personalized understandings of resilience (Miller, 2003; McGeary, 2011; White et al., 2008; White et al., 2010). Throughout the interviews, participants identified various material and intangible benefits for successful and creative responses to disability. As an illustration, one participant spoke to the resilience curriculum and described that he generated a new way of thinking that acknowledged his lived experience but did not give way to feelings of disappointment:

There was another thing I thought was really good – the classes you guys had where we each took time to reflect on ourselves, our injury, our goals, our strengths... because that's something the person in the chair doesn't think about. At least I didn't until I got back into school. I really felt my role was being in a chair until the day comes that I get to die. And it doesn't start off that way, but slowly your world closes in on you over time. And you do less, and less, and less, and your world gets smaller, and smaller, and smaller. And during those introspective looks at yourself and what it is you wanted out of life because the thing I learned is just because I'm in a chair doesn't mean I can't do the things I always wanted.

In this narrative, there is a shift in how he defines life in the chair. As a person who has been recovering from SCI for many years, he capably narrates how a chair can sometimes become a symbol for having less value and being closer to death. But in the moments of introspection, he felt challenged to re-author the chair as not a representation of an end but of a potential life.

Similarly, another participant described the resilience curriculum as a “sense of growth both physical and mentally.” He went on to elaborate and explained, “Yes, I may be confined to wheelchair, but you know what, my life is not done, I can still do things.” Being able to reflect also promoted a positive sense of self in the future (Bury, 2001; Gill, 1997; Ostrander, 2008a; Ostrander, 2008b). To that end, another participant noted the integral role of the group in helping to articulate these insights, something he called “epiphanies.” In referencing the writing and group reflections, he explained that “it gave us plenty of opportunity to talk with each other...and get to open up to each other.” While the project coordinators never defined insights as “epiphanies,” he aptly captured the power of reflective group practices focused on the promotion of resilience and personal meaning.

Indeed, the resilience curriculum continued to resonate with participants after the project. In the follow-up interview, one participant noted,

Personally, not only did it help me physically because it reminds me of things that I did before and will continue doing, but emotionally it helped me quite a bit because I still have a lot going on here and I'm self-conscious about things of that nature.

In other words, he explained how, through interactions with other people with SCI, the resilience curriculum promoted a productive space to work through some emotional needs. Similarly, another participant noted,

...everybody sees themselves as somebody. And so, you do your best. That's all you need. We're not saying you're out on the street as a nobody, but if it's up to me, I just try to make sure everybody feels they're just as special. And you guys did that.

While the first participant shared how the resilience curriculum helped him negotiate self-conscious feelings, the second emphasized how participants needed to feel valued; for him, the experience supported participants to feel like legitimate members of the group.

In line with a resilience framework, the group reflection activities allowed participants to recognize historical and cultural shared resilience practices that can be brought to bear in different settings, so as to gain dexterity with the applying the resilience factors in current and future contexts (Miller, 2003; McGeary, 2011; White et al., 2008; White et al., 2010; Williams et al., 2003). In this way, it became evident across interview data how micro-interactions in situated activities carried a cumulative effect to support resilience.

## **Independence**

An important outcome of the project was participants' feelings about independence. Indeed, independence emerged as an important theme in all of the follow-up interviews. According to one participant, "the camp was an awesome opportunity because the more independent we are, the better." For most of the participants, feeling independent remained an important goal for persons with SCI, and they emphasized the benefits of the resilience curriculum combined with the community activities created a sense of independence. In this way, the project's success for participants resulted from carefully sequencing group activity with the resilience curriculum.

Independence was the most relevant theme because all of the participants expressed struggling with independence. The resilience curriculum, it seems, created a foundation for learning to reflect on identity and to imagine an independent self. For instance, one participant explained: "The feeling of just being educated again, even on a small scale, like in the classroom, the projects. It was really interesting. I would like to continue my education to give me a purpose and sense of worth." Repeated across interview data, there was a strong sense of the benefits of the resilience curriculum toward feelings of independence.

At the same time, learning from some participants with more experience with SCI seemed to inspire all of the participants. As an illustration, another participant stated, "Another thing that camp does is reinforce [independence] in me. That's what the experience really does for some of us that have come a certain distance in our recovery. Now I'm more capable and

more alert even and I'm more confident in myself and my abilities." For others, it was hearing the other participants' experiences and dreams that left the deepest mark:

When you see and feel the strength, the motivation, the endurance, from all of the participants. You can see it from the youngest all the way to the oldest. You could get different perspectives. It was really, really, really cool to know that you're not alone, you're not the only person out here, you're not crazy. There are other people going through the same types of things and they are making it.

Importantly, by sharing stories of resilience and coping, participants were able to help each out and identify new strategies as noted by another participant:

Nobody's getting off easy. We're all in chairs. We're all suffering from skin sores over time and urinary tract infections. We're all suffering from the same thing over the course of the life of our injury. We're all going to have the same issues to deal with, so nobody's getting off easy, but we share our experiences with each other and help each other avoid the pitfalls.... I've been injured longer than them, but they encountered things I hadn't even known about yet.... It's almost like you get up to speed of things that rather than learning through the school of hard knocks you learn off of somebody else's experience, and you learn how to get through it easier.

Within this narrative, he noted the challenges associated with SCI that threaten independence, but rather than being discouraged, he was motivated by other people's experience. Another participant noted how powerful it was to hear about other participants engaged successfully in postsecondary education (Green & Hayden, 2013), which inspired him to consider going back to school and to become as independent as possible.

Most of the participants shared a similar sentiment. Certainly, all of them gained knowledge about adaptive athletics, but the most powerful perspective in the interviews was a shared identity of resilience and independence in the larger social world. The power of the project was in the desire to reframe disability and the struggle for independence, which depended on interrogating negative societal messages of disability as tragic (Baker, 2009; Bircher, 2000; Conyers, 2003).

### **Implications and Future Directions**

Insights from the project affirm the critical role that adaptive sports combined with a resilience framework can play in helping Veterans with spinal cord injury (SCI) to address common psychological and social barriers associated with disability (Boutin, 2011; Burke et al., 2009; Frain et al., 2010; Frain et al., 2013; Singh, 2013). With this in mind, rehabilitation counselors and related professionals need to promote not only vocational and independent living goals (Maki & Tarvydas, 2012), but also a positive identity during the transition to living with a disability (Bury, 2001; Gill, 1997; Ostrander, 2008a; Ostrander, 2008b). Emerging from the perspectives of the Veterans themselves, the following implications may lead to innovative counseling approaches that apply positive psychological concepts within a supportive social context to assist Veterans with SCI to respond creatively and successfully to their disabilities.



First, a sense of community emerged as a necessary element of the curriculum. In the follow-up interviews, a common theme was that participants identified as both Veterans and individuals with physical disability. As an approach to promote an active and healthy lifestyle following SCI (Fleig et al., 2013; May et al., 2006; Letts et al., 2011), communities of practice is different from traditional group counseling interventions in that the participants themselves direct the learning and meaning themselves (Wenger, 1998). The benefit of a community of practice framework is the attention to identity formation (Wenger, 1998). In many ways, a community of practice framework fits with a social psychology focus on the role that social attitudes and environmental factors play in the subjective experience of disability (Dunn & Elliot, 2005; Marini et al., 2012; McCarthy, 2011; Smart, 2009). In contrast to more traditional group-based counseling interventions, communities of practice highlights a sense of belonging as it emerges across mutually inclusive trajectories of identification (Wenger, 1998). In the same way that a community of practice framework has been applied to knowledge translation among rehabilitation counselors and related professionals (Bezyak, Ditchman, Burke, & Chan, 2013; Bezyak, Yan, Kang, Burke, & Chan, 2013), a similar approach may introduce and define the content that is most relevant to the needs and concerns of Veterans with SCI (Wenger, 1998), who are may be reluctant to disclose common psychological and social barriers associated with disability (Katz, 2010; Kavanagh, 1995). In the present project, a community of practice framework was particularly relevant to the integration of positive psychology perspectives within a social context, including the promotion of recreation-generated resilience and personal meaning.

Second, the resilience curriculum instilled hope and optimism for valuable futures and has since become part of a structured resilience intervention (Stuntner & Hartley, 2014). However, the data from the present project is unique because of the intersection with adaptive sports and Veterans. Importantly, rather than examining individual behavior in isolation, the interview data reinforced the benefits of exploring the reciprocal interaction between the individual and his/her environment (Maki & Tarvydas, 2012; Marini et al., 2012; Smart, 2009). Indeed, it would be impossible to tease out the effects of the resilience curriculum from the adaptive sports activities. Instead, adaptive sports activities became intertwined with the resilience curriculum (Perrier et al., 2012; Sparkes & Smith, 2005). In other words, the social context of sports became essential toward an understanding of the significance of competition and “the spirit” as an intrapersonal resilience factor related to living life to its fullest (Bury, 2001; Gill, 1997; Ostrander, 2008a; Ostrander, 2008b). Emphasizing positive psychology concepts (Dunn, & Dougherty, 2005), adaptive sports activities may be an avenue to promote resilience and reduce the deleterious effects of stress and depression following SCI (Catalano, Chan, Wilson, Chiu, & Muller, 2011; Kortte, Gilbert, Gorman, & Wegener, 2010). Offering an opportunity to better understand how positive psychology concepts, such as resilience, hope, and optimism can improve from interacting with others in a meaningful social context (Dunn & Elliot, 2005; Hartley, 2012; Marini et al., 2012; McCarthy, 2011), adaptive sports may be critical to the rehabilitation of Veterans with physical disabilities, especially spinal cord injury (SCI).

Third, identity formation is important for psychosocial recovery (Bury, 2001; Gill, 1997; Ostrander, 2008a; Ostrander, 2008b), and thus adaptive athletics is critical because it interrogates negative societal messages of disability as tragic (Baker, 2009; Bircher, 2000; Conyers, 2003). Many Veterans entered the military with a commitment toward physical exertion and discipline

(Demers, 2011; Hall, 2009; Schading, 2007), and the discourse of adaptive sports mirrors the language used in military culture, such as fighting, battle, defense, neutral zone, and unit (Perrier et al., 2012; Sparkes & Smith, 2005). Thus, adaptive sports may provide an ideal social context to extend the underlying affiliations with and embodiment of the values of loyalty and commitment instilled within the military (Demers, 2011; Hall, 2009; Schading, 2007). As a bridge between military and civilian culture, adaptive sports may be a mechanism to connect Veterans who identify as athletic, competitive, and team-oriented and reduce feelings of isolation and anxiety expressed by so many Veterans as they transition to civilian life (Christian, Stivers, & Sammons, 2009; Shaler, Hathaway, Sells, & Youngstedt, 2013; Slone & Friedman, 2008). In fact, the popularity of events, such as the National Veteran Wheelchair Games, may be an important context for rehabilitation counselors and related professionals to provide outreach, access, and services to Veterans and their families (Spornier et al., 2009). Veterans tend to rely on the Veterans Administration (VA) system and may be unaware of community services outside of the VA. Thus, through sports, rehabilitation counselors and related professionals may be able to collaborate with the VA to engage Veterans to form similarly robust bridges of belonging and identification with civilian communities (Resnik, Gray, & Borgia, 2011). In particular, Centers of Independent Living (CIL) can provide services to help Veterans with disabilities to live as independently as possible in the community (Resnik et al., 2011). In many ways, adaptive sports might be a platform to design robust, community-based and empowerment-orientated interventions to support Veterans with physical disabilities.

Moving forward, rehabilitation counseling and related professionals can partner with the functional efforts of the VA to improve rehabilitation services for Veterans with spinal cord injury (SCI; Boutin, 2011; Frain et al., 2010; Frain et al., 2013; Singh, 2013). While the U.S. Department of Veteran's Affairs (2015) is committed to assisting Veterans with disabilities, rehabilitation counseling and related professionals are particularly well situated to support Veterans with SCI during the transition to civilian life, including the development of vocational and independent living goals (Maki & Tarvydas, 2012). Indeed, one feature of the intervention described in this article involved careful collaboration across various campus units within the university. In other contexts, collaborations between rehabilitation professionals and the VA will need to be strategically defined and articulated. Importantly, a clear implication of the present intervention was that a shared sense of military culture among the participants helped to facilitate the translation of sports participation into vocational and independent goal setting. With a commitment toward physical exertion, discipline, and self-sacrifice, the loss of physical functioning associated with disability may be particularly challenging for Veterans because it is antithetical to military culture (Demers, 2011; Hall, 2009; Schading, 2007). Fostering both physical activity as well as a positive identity of disability, rehabilitation counseling and related professionals may be able to partner with the VA to use adaptive sports as a bridge to recovery and wellness following a traumatic spinal cord injury. Future research may reveal that the intervention is equally effective for civilians; however, athletics may be a particularly important for Veterans.

In addition to providing insights for rehabilitation interventions, the interview data pointed to the need for future research on the intersection of resilience, sports, and Veterans with physical disabilities. Along with the gold standard of randomized controlled trials and large-scale longitudinal studies on the efficacy of resilience-based interventions (Stuntzner & Hartley,

2014), there is a simultaneous need for qualitative research to explore the subjective experience of disability (Chwalisz, Shah, & Hand, 2008; Koch, Niesz, & McCarthy, 2013). Although the results of qualitative studies are typically not generalizable, such studies may lead to important insights regarding the realities of experience with resilience and coping that would provide ever more refined definitions of key variables like the ability to tolerate stress, internal locus of control, optimism, and facets of social support (Marini et al., 2012; Smart, 2009; Stuntzner & Hartley, 2014). So, too, qualitative studies emphasize emic perspectives so as to capture complexly lived experiences layered by social and cultural norms, especially when it comes to identity formation following disability (Dunn & Burcaw, 2013; Dunn & Brody, 2008; Williams et al., 2003). The larger point is that coping and adjustment issues in rehabilitation arise out of the complex dynamics of affective, cognitive, and behavioral response and interactions of multiple individuals the clients' social network (individual, family, and community) within the context of culture, history, and physical environment (Stuntzner & Hartley, 2014). That is, the rich data of qualitative research can illumine social and cultural patterns of relevant to returning military Veterans with disability.

### **Conclusion**

Rehabilitation counselors can play an important role in the provision of rehabilitation services to Veterans with spinal cord injury (SCI). The descriptive case study of an innovative rehabilitation project in this article revealed that the effects of physical activity integrated with resilience curriculum worked in tandem to instill hope and optimism for valuable futures. Insights from the project indicate how communities of practice may be a theoretical framework to understand the ways in which communities like adaptive athletics may be used to promote positive psychology concepts, such as resilience, hope, and optimism.

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## **Causalities of War: Children of Seriously Wounded Service Members**

ERIKA RAISSA NASH CAMERON  
University of San Diego

### **Abstract**

*Research has paid limited attention to the impact of combat-related injuries on service members' families, particularly their children. This phenomenological study examined the psychosocial risk of 79 seriously wounded service members, their spouses, and children. Findings revealed several obstacles and needs of children living with a parent wounded in combat. Based on the findings, unhealthy home environments, isolation, and role changes were some of the causes adding to the family stress and psychosocial risk of children. Participants recommended the need for specific programming among peers, parents, and in schools as a solution to obtain support services. As a result of these findings, recommendations are provided for improved counseling services for children and families of seriously wounded service members.*

*KEYWORDS: children, seriously wounded, military families, phenomenology*

### **Introduction**

Research has shown that the stress of combat and military service has lasting behavioral, physical, and psychological effects on U.S. service members' children (Hudak, Morrison, Carstensen, Rice, & Jurgersen, 2009). During previous wars, that stress was found to be associated to parent separation and youth behavioral problems during deployment (Burrell, Adams, Briley Durand, & Castro, 2006; Canon, 2011; Chartrand, Frank, White, & Shope, 2008; Hillenbrand, 1976). Recently, studies have found that children whose parents have been deployed, diagnosed with Post-Traumatic Stress Disorder (PTSD) and/or a Traumatic Brain

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Erika Raissa Nash Cameron is an Assistant Professor in the Department of School Family and Mental Health Professions at the University of San Diego. *Correspondence concerning this article should be addressed to Erika R. N. Cameron, Counseling Program, University of San Diego, 5998 Alcalá Park, MRH-215G, San Diego, CA 92110 (ecameron@sandiego.edu).*

Injury (TBI), or died in combat have shown similar difficulties such as problems sleeping, higher stress and anxiety, and declining grades, as well as parent-child problems, including increases in child maltreatment (Cohen, Solomon, & Zerach, 2011; Herzog, Everson, & Whitworth, 2011). Although the link between stress and academic, social/emotional, and behavioral challenges has been well established (Carlsmith, 1964; McGonagle & Kessler, 1990; Seiffge-Krenke, 2000), there is relatively little information on whether stress associated with living with a seriously wounded service member is related to similar difficulties.

To date there are 50,357 service members in the U.S. who were wounded in action during the Global War on Terror (Operation Iraqi Freedom, Operation New Dawn and Operation Enduring Freedom; Defense Casualty Analysis System, 2012). Of those wounded, 19,096 (38%) are parents and were classified as either Seriously Wounded or Very Seriously Wounded (Defense Casualty Analysis System, 2012). In addition, roughly half of this population resides in rural locations, which may increase the family's sense of isolation, potentially limiting contact with support systems and limiting access to services. Caring for a seriously wounded or ill family member is stressful (Card et al., 2011; Chandra et al., 2010; Chartrand et al., 2008; Chawla & Solinas-Saunders, 2011), and social or geographic isolation could compound that stress. The extent to which existing military and/or civilian support services and programs meet families' needs is not known. This study initiated the process of addressing this knowledge gap in research and providing counselors with first-hand insights and knowledge to work competently with children of this specialized military population.

## **Background and Context**

Because children's life trajectory is largely shaped early in life by the relationships in their world (e.g., family, community, and life context) the impact of parental injury can negatively affect relationships within the family system (Fivaz-Depeursine, Fitzgerald, Guedeney, & Campbell, 2008). A child's wellness could first be stunted as a result of the injuries sustained in combat affecting marriages and family life. For instance, spouses could be unable to deal with the changes in personality or physical abilities of their wounded service member (Bobrow, Cook, Knowles, & Vieten, 2013) and they may struggle with consequences, such as lost jobs, friends, and hobbies. While the spouse of a wounded service member is physically and emotionally dealing with these new challenges, it can be theorized that their children would be neglected, have increased anxiety, and experience a wide array of emotions including anger, confusion, and loneliness (Gewirtz, Pinna, Hanson, & Brockberg, 2014).

In addition, children 10-19 years of age are uniquely vulnerable to adverse health effects from parental military deployment. Healthy development, including identifying a sense of self and separation from family, can be interrupted during parents' active military service (Palmer, 2008). Furthermore, adolescence is a developmental period characterized by an increased predisposition to health risk behaviors (e.g., alcohol and other drug use, risky sexual behaviors) that may be exacerbated with parental absence (White, de Burgh, Fear, & Iversen, 2011). Several studies have reported that children over the age of 10 have higher instances of fear, worry, and anxiety about the deployed parent (Card et al., 2011; Chandra et al., 2010; Chartrand et al., 2008; Chawla & Solinas-Saunders, 2011). The adjusting and readjusting to new responsibilities and roles is a significant source of stress for young people, particularly when the deployed parent

returns home. In addition, problems with school behavior and academic performance have also been noted (Canon, 2011).

Studies of wars prior to Operation Enduring Freedom and Operation Iraqi Freedom have evaluated the negative impact of combat-related trauma on family functioning. Taft and colleagues (2008) reported that combat exposure alone leads to poorer family functioning, and Jordan and colleagues (1992) suggested that regardless of individual or family history (e.g., substance use, child abuse, other psychiatric disorders), combat-related trauma is more strongly related to poor family functioning than are other individual or family factors. To date the most extensive research on the psychological impacts of parental injuries (military or non-military) on children has been conducted by Dr. Stephen Cozza and his research team at the Uniformed Services University of the Health Sciences. They postulated that the impact of injured military parents on their children is likely to be considerable and that the risk factors for vulnerability can be assumed (Cozza, Chun, & Polo, 2005). Cozza et al. suggest that the impacts on children are predicated on how the parents respond to the notification of the injury and the amount of information they share with their children. In addition, the impact on children is a byproduct of the amount of disruption (i.e., physical relocation, absent parents, seriousness of injuries, recovery period, transition back to home, etc.) that the injury creates for the family and the amount of focus that is put on the child during this family transition. When parents choose to withhold information from their children about the injuries it is more likely that children have difficulty understanding the nature or seriousness of the injury and its realistic implications for the injured parent. While parents may have good intentions to not worry their child with all the details, the withholding of information could lead to further psychosocial issues for children and could negatively impact the relationship between parents and children in the future (Cozza et al., 2010).

In addition, the literature has shown that once a family has been notified of the injuries, the primary focus of the family often shifts from the child to the seriously wounded service member's recovery, therapy, and adaptive assistance. With this change in family focus, the psychosocial development of the child could potentially be compromised, depending on how extensive the injuries are (Cozza et al., 2010).

### **Knowledge Gap in Scholarly Research**

How counselors adapt and support families and children of seriously wounded service members are crucial questions that need to be answered in order to respond to their unique circumstances. To date, there are no known published empirical studies that directly address this challenge in the medical and mental health professions. Given the lack of research specifically addressing the psychosocial needs of children of seriously wounded service members, the primary objective of this study was to gain an understanding of the lived experiences of children of service members who have been seriously wounded in combat. The research question guiding this study was "What are the obstacles, protective factors, and needs of children of seriously wounded service members?"

## **Methods**

The study is a qualitative, phenomenological study that examined the lived experiences of children of service members who were seriously wounded in combat in an effort to provide an exhaustive description of that phenomenon. Methodologically, phenomenology typically uses data such as personal accounts of life events, historical texts, observations, and the individual meaning-making systems used by participants (Hays & Woods, 2011). Phenomenology was most appropriate for this study because the family histories varied in relation to the service member's injuries; the semi-structured interviews generally found in phenomenological studies allow participants to provide accounts of their experiences with minimal constraints from the researcher or the interview protocol. The open-ended structure allows participants to include details and dimension of the experience that they find important with minimal probing from the researchers, thus making it more likely to generate data that is minimally influenced by the researchers' a priori beliefs about the characteristics of the phenomena (Roulston, 2014). The intention is for the researcher to enter the data collection process without personal assumptions of the outcomes of the study.

### **Participants**

In total, 79 individuals from 16 different states participated in either a) a focus group located in Chicago, IL, San Diego, CA, or Oceanside, CA; b) telephone interview; or c) an in-person interview in San Diego, CA, Chicago, IL, or Washington, DC. Of the 79 participants, 28 male service members were seriously wounded between 2003 and 2012, 32 female spouses, and 19 children (9 to 26 years old) participated in the study. Table 1 summarizes total numbers and background data for all participants.

It is important to note that prior to beginning this study, a pilot study was conducted to test the feasibility and comprehension of the Interview Guide with participants. In the pilot study, it was found that there were unforeseen challenges in interviewing children under the age of nine. The research team found:

1. It is difficult to encourage parents to let their young child be interviewed.
2. Children were unable to effectively articulate their thoughts, feelings, and behaviors about how their parent's injury impacted them.
3. That all of the children were born post-injury and were unable to compare how their life has been impacted because of their parent's injury.

As a result of the pilot study, adjustments were made to the Interview Guide and children above the age of nine were recruited to participate. In addition, children were separated by age (9 – 13, 14 – 18, 19+) when participating in the focus groups, because it was assumed the cognitive and developmental difference would yield better data and comfort with the focus group process.

### **Data Collection: Procedures**

After obtaining Institutional Review Board approval, the research team identified and recruited qualified family participants (seriously wounded service members, spouses, and children) by: (a) posting the recruiting flyer on social media sites (e.g., Facebook, online chat, rooms for military wives, posting on organization websites catered for serving military families,

etc.); (b) disseminating flyers via e-mail with individuals connected through interviews, conferences, meetings, military wives' coffee groups, and so forth; and (c) disseminating flyers in-person at military installations. The goal was to interview a cross-section of seriously wounded service members, spouses, and children in one of three modes of data collection: focus groups, telephone interviews, and in-person interviews.

Table 1. *Participant Characteristics*

<b>Characteristics</b>	<b><i>n</i></b>	<b>%</b>
<b>Type of Participant</b>		
Child	19	24
Female Spouse	32	41
Male Service Member	28	35
<b>Location of Residence</b>		
West (AZ, CA, CO, WA)	47	59
South (FL, NC, SC, TX, WV)	14	18
Midwest (IA, IN, MI, OH, WI)	16	20
Northeast (CT, NJ)	3	4
<b>Military Branch</b>		
Army	10	13
Marine Corp	68	85
Navy	2	2
<b>Date of Injury</b>		
<2006	44	55
2007 - 2012	31	39
Multiple years	5	6
<b># of Children in Home</b>		
1	14	25
2	19	34
3	13	23
4	7	13
5+	3	5
<b>Age of Children in Home</b>		
<3	36	25
4 - 7	34	24
8 - 12	40	28
13-17	20	14
18+	14	9

The data resulted from participants' responses collected through (a) a background survey, which contained various questions ranging about the participant's family background (e.g., geographical residence, year of injury, number of children in the household); (b) researcher's



notes; and (c) a semi-structured interview guide. The semi-structured interview outline was developed by the research team after reviewing 75 empirically based articles focused on post-amputation service members, civilian parents who have experienced a life-changing physical injury, and personal online blogs written by spouses or families who have a seriously wounded service member. Participants were asked questions like “How has life changed for you since you found out your parent was wounded?” or “If your children could have anything to make their life easier (besides an unwounded parent), what would it be?”

Due to many of the seriously wounded service members’ families choosing to live in rural locations across the United States and limited resources for the families and researchers to travel, the research team utilized as many data collection methods (in-person interview, phone interviews, and focus groups) as possible to be able to gather the collective voice of the seriously wounded population. The phone and in-person interviews lasted between 20 and 90 minutes, with an average of 30 minutes and were conducted by a member of the research team. All interviews were digitally recorded and then reviewed and summarized by a research team member (different than interviewer). Focus groups were videotaped and lasted between 45 and 90 minutes.

### **Research Team**

The research team was comprised of a multiethnic female faculty member (author), two female graduate assistants (one Asian American and one European American, and one European American male graduate assistant). Prior to data analysis, the research team discussed the values, assumptions, and biases each research team member had concerning the study. This process of self exploration was undertaken to increase the awareness of how the individual team member’s personal views might influence the data analysis process and the development and presentation of the results (Locke, Spirduso, & Silverman, 1993; Yeh & Iman, 2007). Such self-exploration processes are considered imperative in qualitative research because the results of a study are influenced by the researchers’ involvement in the data (Creswell, 1998). Through this process, we acknowledged our negative bias about the experiences of living with a wounded service member, and we expected to hear mostly negative statements regarding the experiences of being or living with a wounded service member. We expected that there would be numerous challenges that the participants experienced and a variance in the types of experiences depending on how the service member was wounded in combat. Finally, we carried beliefs that there was a stigma held by the service member and their family about engaging in mental health services and receiving help from “civilian” programs, because of the military culture and way of life.

### **Data Analysis**

Data analysis followed a phenomenological approach to qualitative inquiry as described by Creswell (2012). In the first level of analysis, individual statements were categorized by the researcher as an obstacle or need. Content that described how participants wished their current lives was classified to be as a need. Content that hindered a participant’s ability was classified as an obstacle. Next, specific codes that closely matched the participant’s words were developed. Codes were then clustered according to their commonalities, and some similar codes were combined or refined in order to better manage the data. Each newly formed cluster was then

named and categorized as either an obstacle or need. In the next section rich and detailed descriptions of the findings are provided in order to assist readers in making decisions regarding transferability of the results to other situations or populations that share similar characteristics (Creswell, 2012). Transferability is essentially determined by the reader; thus, we made no definitive claims regarding how these results might apply to others.

To ensure credibility, dependability, and confirmability (Denzin & Lincoln, 1994) of analysis, multiple levels of triangulation were enacted. First, the author utilized the research team to check the accuracy of the transcripts and the coding of the data. Second, multiple cycles of coding and recoding were employed. Finally, members of the research team provided a final analysis, including application of the initial codes to existing theory and literature related to the research question and study sample.

## **Results**

### **Obstacles**

The primary goal of the data analysis was to identify concepts and themes that represent the obstacles and needs of children whose parents sustained serious combat injuries. A thematic analysis of the wounded service member, spouse, and children interviews identified five themes within the obstacle cluster: Role Changes, Psychological Distress, Unhealthy Home Environment, Isolation, and Military Culture. The themes are described in the paragraphs that follow and are illustrated with sample quotations.

**Role changes.** Significant role changes often take place for family members following the service member being wounded in combat. The non-injured parent has to balance previous family and work responsibilities with the recovery and/or continuous care of the injured service member. Participants' reports indicate that once the family is notified of the injury sustained by the service member, the focus of the family is often diverted away from the child. For all of the participants, the injuries sustained caused both parents to not be physically and psychologically present. "I feel like both of my parents focused on my dad's recovery ... I feel like if they would have talked to me more and help me understand I would have benefitted" (14 year old). Seriously wounded service members were focused on their recovery, and therefore, were not always available for, or capable of, parenting their children.

In addition, spouses became the primary caregivers to both the seriously wounded service member and their children. Thus, all the responsibilities of a regular household were compounded by the many added burdens of caring for an injured patient. One spouse said, "I am focused on his routine...I think that a lot of time, they [children] kind of fall through the cracks." Households with two parents in actuality functioned as single parent households despite having two parents in the home. Very often, this new family structure created heightened levels of family stress, especially for the caregiver, which indirectly had an effect on the children. One child's frustration with having to live in this new structure came out when it said, "I'm adapted to it, but sometimes at night I feel why should I have to adapt to this?"

Children in the study reported that they had to take on more of the family responsibilities. Many of the older children (13 years or older) assumed a caregiver role by providing emotional support to both parents, as well as taking care of household responsibilities and younger siblings. The acquisition of these new responsibilities often interfered with the child's activities, development, and perceived normalcy. One child said, "My friends deal with planning a party Friday or Saturday night, and I deal with whether I should drive my dad to the hospital or my mom should. It's kind of like, just frustrating, my life is frustrating."

**Psychological distress.** While this research initially set out to focus on the impacts of visible, physical wounds, it became clear that it was the psychosocial stressors of a parent's PTSD or TBI sustained in combat that produced even more stress and accompanying challenges for these families. Results indicate that children of parents suffering from PTSD or TBI experienced increased confusion and anger about their family's situation. For children, it was difficult to understand how and why their parent looked the same but acted like a different person. Spouses reported significant distress as exemplified by this quote; "The person I married is gone. It looks like him, but it is not him. It is an ambiguous loss - there is no end to the grief I experience" (Wife).

Many of the seriously wounded service members spoke about their personal challenges with TBI and PTSD and the toll it has taken on their families, and especially on their children. They knew their behavior or outbursts were often the cause of many behavioral and emotional issues displayed in their children, but did not know how to help or improve the situation. Service members also recognized that their spouses had to do most everything for the family (e.g., bills, childcare, transportation, etc.) because they themselves were not fit to help or handle these tasks. "Everything is a challenge for me. It's a challenge for me to wake up and remember that I'm supposed to eat breakfast and take my medicine. It's a constant challenge that I work with" (Wounded Service Member). Wounds to the service member resulted in psychological changes that had a direct impact on patterns of interaction and involvement within the family. The burden of caring for a spouse with serious physical combat injury and PTSD negatively impacted the caregiver's psychological well-being leaving both parents less responsive and emotionally involved with their child/ren. Although no caregiver (often the non-injured parent) or child explicitly reported having any secondary traumatization, many of them described PTSD-like symptoms in the stories they told.

I was riding in the truck with my dad. He is a double above the knee amputee, because he had both his legs blown off stepping on an IED (Improvised Explosive Device). We were headed home, until my dad lost it. He turned the truck around in the middle of the street and started driving in the wrong direction. The cars were coming right at us. He kept yelling at me, "There's an IED we need to secure the area." I kept yelling at him, but he wasn't there. He was in combat. He pulls over on the side of the road and runs up to the guardrail and is just standing there looking confused. I get out of the truck and he is holding an orange Home Depot bucket. What he thought was an IED, was a stupid bucket. Since that incident I can't go to Home Depot without having flashbacks or driving on that road. I am forever changed. (16 year old)

**Unhealthy home environments.** Participants consistently mentioned the mounting stressors that had lead or contributed to unhealthy home environments. Issues, such as mental

health problems, substance abuse, anger, volatile marriages, separation, divorce, and so forth, were mentioned by multiple participants. A 14-year old participant said, “I woke up one night to my dad yelling in another language and choking my mom in the bed. He looked awake, but was totally not responding.” One spouse said, “There is so much emotional abuse, but you know it’s not him [referring to PTSD symptoms].”

Another contributing factor to the health of the home environment was the financial security of the family. Many families’ experienced dramatic declines in the family’s financial security because their income decreased, they often had to wait for disability ratings and pay, they sometimes had more expenses, and the spouse typically had to leave his/her job in order to care for the seriously wounded service member and children. This change from a dual-income to a single income household produced stress, challenges and constant adjustments depending on the needs of the seriously wounded service member (e.g., medical expenses, house modifications, transportation, etc.) and the children (e.g., school fees, extracurricular activities, etc.).

The Marine Corps, or probably the military in general, they prepare you for the worst or the best. You make banners for homecoming or you plan for death. You don’t plan for any kind of injury and none of that is ever talked about... there’s never really any planning for what’s in between. (Spouse)

**Isolation.** After being discharged from a medical facility and retiring from active duty service, many seriously wounded service members and their families move into a civilian community. This move often puts them in a constant perceived state of not belonging and feeling that others (e.g., civilians, family, and “the country”) did not understand their experiences. “My life has been flipped upside-down, and we have to move and I have to find out where to go to school again” (11 years old). Moreover, many seriously wounded service members and their families ended up living in more rural locations because of their PTSD and TBI symptoms (being unable to tolerate crowds and loud noises). This remoteness made it more challenging to get around, specifically for the service members who were not able to drive themselves to appointments. One spouse said, “[After moving away from the military installation]... We stick out like a sore thumb.” Occasionally these families also felt isolated from their extended family members (sometimes by their own choice because of family dysfunction and/or because they felt their family did not understand them), friends, events, and familiar places that once provided comfort or escape. One wife expressed her isolation by saying, “I don’t bother to go places as a family, because he [husband] won’t go.” Thus, these isolated service members and their families had to rely on themselves and self-navigate the resources, services, and supports that were available. Some participants contended that it is this isolation that was at the root of most problems for both adults (e.g., violence, depression, suicide, etc.) and children (e.g., poor academic performance, behavioral issues, lack of social skills, etc.). “It is embarrassing to admit right now, but I don’t know how to write in cursive; because I had to move around so much I completely skipped a whole portion of reading and writing” (16 year old).

The lack of social support for the isolated family of the seriously wounded did not only hinder the recovery of the seriously wounded service member, but it also influenced the overall well-being of other family members. For example, families in transition (particularly spouses of the seriously wounded service members) were concerned that when they medically retire and

move away from the military community to other towns or to “the middle of nowhere,” they would not have access to adequate support systems. Their concern was magnified for their children because even fewer local military child-centered programs, support systems, and counselors equipped to work with military families were available to them in non-military localities. One spouse said, “...there’s nothing for kids...there’s nothing for *our* children in our area.”

**Military culture.** Participants consistently stated that being a military family meant that they needed to be, “strong, have a sense of pride, possess honor and integrity.” While these qualities were seen as honorable and important to possess by participants, it was also deemed as a limitation by multiple participants. Participants stated that the military, the military way of life, and the personality of the service member can severely deter families from seeking assistance and utilizing resources that are available to their families and especially their children. Specifically, many service members believed that getting help for themselves or their families was not the military way of doing things. If they were unable to keep their family and themselves together they would be viewed negatively by their peers and the military. One spouse said, “There is the stigma in military culture that getting help is a sign of weakness.” Moreover, participants reported that they had a tendency to mistrust and not use programs or services that have a mental health component because of the fear of being labeled. They did, however, state that if they had to see a counselor they would only go to counselors who have worked with other military families or were engaged in the military community, advocacy, or activities, because they felt many “civilian clinicians do not understand the military way of life” (Wounded Service Member). As a result, seriously wounded service member often chose not to seek assistance until the issues was too big or could no longer be hidden from outsiders. A wounded service member said, “Our experience is so profound that if someone hasn't been through it, there is a question of how beneficial they could be and what they could actually contribute to the experience.”

It was found, however, that spouses were much more willing to receive services or register their families for counseling or programs. The majority of the participants believed that their family needed family counseling, but were apprehensive in attending, because they did not want to humiliate their spouse by talking about his inability to parent or be the spouse he once was. Families who did seek services or support were much more willing to utilize services from providers who were accepted by their peers or who had a significant connection to the military community (e.g., past or current military experience, family connection to military, extensive experience working with military population, etc.).

## **Needs**

Many of the participants stated that they were informed about opportunities and resources to combat the role changes within the families, social isolation, and psychological distress with targeted activities to facilitate reintegration into social and community life at the hospital and in the community. While many of the wounded warriors had been involved in programs to deal with their disabilities, very few families talked about programs that their children were involved in. Only two percent of the parent participants could actually name a social support programs or activities geared for their children. They continually mentioned the need for counselors to

organize and lead programs that involved Peer Support, Parent Training, and School-Based Interventions.

**Peer support programs.** Many of the families stated that the importance of peer-based support programs for children of wounded service members (e.g., camps, retreats, workshops, conferences, group counseling, or recreational events) would provide children an opportunity to connect with other children their age who understand what it is like to have a parent who is seriously wounded. For children of wounded service members, they not only experience issues with deployment and the possibility of their parent being killed in action; but they also deal with a disabled parent and the issues (e.g., mobility, grief, pain, and trauma) associated with those injuries. In addition, peer support programs for the spouse would also be beneficial. Many of the wives are dealing with so much of the stress and do not have an outlet. As a result, that stress is unintentionally taken out on their children. “We need grief and loss groups so I can process my new life and responsibilities without getting frustrated” (Spouse).

**Parent education and training.** This research also revealed that a close parent-child relationship and focusing on parenting and communication skills were effective buffers in counteracting the many obstacles and stressors that these children face. There was evidence that some children were able to handle the challenges of living with a seriously wounded parent when their parents were involved and skilled in providing a safe, stable, and nurturing base of support. For example, this research revealed that many of these children are quite optimistic and have a positive disposition and outlook on life. Many parents said that since the combat wounds, their children (a) have taken on more roles within the family to help out, (b) have become more flexible, (c) have become more self-sufficient, and (d) have become more family-oriented. In addition, one notable quality that often developed as a result of their parent being seriously wounded was that children became more sensitive, tolerant, and accepting of others who were different than them. Their ability to empathize and be respectful of diversity has become a norm, and has made them better people and citizens.

One thing that was explicitly made clear by participants is that counseling services were better received if presented in the form of psychoeducation programs. Many participants emphasized the need for educating and training children and parents on grief, loss, and PTSD. “Education [on PTSD] is key...instead of thinking my husband is such a jerk” (Wife). Many of the spouses and the children commented that they were not prepared to deal with their husband or father’s behaviors as a result of the PTSD they were experiencing and had wished services had been provided to adequately prepared them to understand the process, know what to expect, be able to identify the symptoms, and have coping strategies in place.

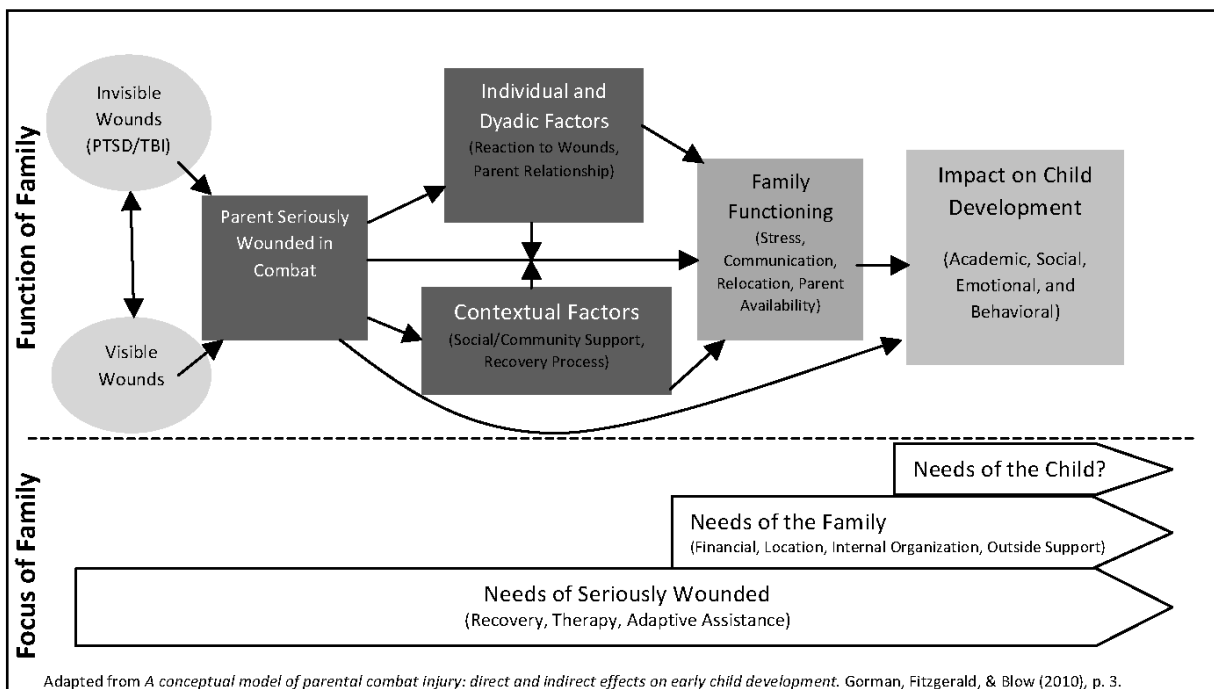
**School-based support and training programs.** Participants stated that schools and school personnel need to provide better support systems - not just for military families, but specifically for the families of seriously wounded service members, because their lives and needs are quite different from those of a typical military family. Participants felt that schools and school staff do not know what is going on for the families of the seriously wounded service members and there is a lack of sensitivity from staff and families in school environments. One parent stated, “We need more school counselors and care providers who understand our children and what they are going through. If not my child falls through the cracks.” A 15-year old also

expressed, “I try to go and talk to my school counselor, but they just always seem so busy and focused on my schedule that I don’t share what’s really going on.”

### Discussion

The current study represents one of few efforts to better understand the risks and to provide recommendations for counselors working with children of seriously wounded service members. Given the number of seriously wounded military personnel with children, clinicians, researchers, and policymakers need to be equipped with the knowledge of this specialized population to provide competent levels of care, specialized programming, and policy changes. In addition, this study provides an understanding of how the combat injuries of the parent have a psychosocial risk on the development of a child. Figure 1 illustrates the conceptual model of the impact of a seriously wounded service member on families, highlighting the potential long-term impact on children’s development (academic, social, emotional, and behavioral). Through an in-depth qualitative analysis with military families, this study brings awareness to the fact that children of seriously wounded service members experience the effects of deployment, frequent relocations, PTSD, TBI, and compounds those effects with a physically disabled parent.

Figure 1. *Conceptual Model of the Impact of the Wounds on the Function and Focus of Family*



Under the Obstacles cluster five themes emerged (Role Changes, Psychological Distress, Unhealthy Home Environment, Isolation, and Military Culture) as a risk to the development of children of seriously wounded service members. In addition, in the Need cluster three themes emerged (Peer Support Programs, Parent Training Programs, and provide School-Based Interventions and Programs) as the supports children and their families need to function in a healthy manner. In this study it was found that the disability prevented the injured parent from

being able to fully function in the same physical capacity prior to the injury. It also found that the majority of the attention that was focused on the child/ren is diverted to the recovering parent and that the role of children within the household is changed permanently. This divergence tends to affect the optimal physiological and psychosocial development that normally occurs when there is quality attachment relationship between a child and parent(s). To combat the psychological distress experienced by children and the families, successful coping strategies and the ability to maintain routines should be the focus of counseling and therapy. It is also important to note that because individual and family growth takes place across the family life cycle (Carter & McGoldrick, 1999), successful coping is not a one-time event but a process that will develop as the family adapts to the wounds and their new family system.

The physical limitations of seriously wounded service members were challenging for family members, particularly in the beginning. The entire family had to deal with the seriously wounded service member's hospitalizations, surgeries, physical rehabilitation, inability to perform daily tasks and household chores, limited physical interaction, seeing the deformity, other people staring, and so forth. In alignment with the literature on PTSD (Beckham, Lytle, & Feldman, 1996; Dirkzwager, Bramsen, Ader, & Van Der Ploeg, 2005), this study found that physical wounds were not the biggest obstacles for children and their families. Spouses have become burden with the responsibility of caring for their partners who are suffering from emotional and social alienation, depression, and anxiety as a result of having PTSD (Ben Arzi, Solomon, & Dekel, 2005; Joiner & Coyne, 1999; Beckham, Braxton, & Kudler, 1997). This has led to the negative impact of the caregiver's psychological well-being, leaving both parents less responsive and emotionally uninvolved with their child/ren.

Involvement following parental wounds requires the maintenance of the parent-child relationships with the injured and non-injured parent. The literature (Belsky & Isabella, 1988; Thompson, 1999; Waters, 1978) consistently supports the need for children to maintain a relationship with both parents. The parent-child relationship may take on new meaning as well as functional and relational changes. This is an important protective factor for long-term development of the children regardless of the changing dynamics of the family. In addition, the social support provided to all members in the family not only predicts better adjustment for the injured, but it has a buffering effect for the family (Patterson et al., 1993). Social support that improves quality of life for the injured, the caregiver, and family functioning indirectly supports the development of the child.

The majority of the families choose to live in rural locations in which they were socially isolated (65%). As a result of their choice, families had limited access to resources and counselors. Only 5% of the participants had engaged in mental health services privately and through Veteran Affairs. The families that had taken advantage of counseling services were able to develop positive relationships, find support, cope with the situation, and develop protective factors to lower levels of emotional distress. In alignment with the literature (Turchik et al., 2013), the participation in mental health services is not common within military culture, because of its perceived sign of weakness for the service member, labeling within the military unit, and civilian clinicians not understanding the military way of life. As a result, this study found that seriously wounded service members and their families often chose not to seek assistance until the issues are too big or could no longer be hidden from outsiders.



### **Limitations, Future Research, and Implications for Practice**

The current study highlights important risk factors for children of seriously wounded service members. Such risks included the changes of family roles, psychological distress, and the isolation that happens as a result of their parent's injury. Despite the importance of these findings, there are a number of limitations that should be noted. First, the participants represented a convenience sample and, therefore, the findings cannot necessarily be generalized beyond the study participants. Moreover, because of the self-selection bias, the findings could be unique to the participants who agreed to participate. Thus, the families who participated may not be typical of the seriously wounded population in any number of ways (e.g., they may be more proactive in reaching out, identifying and utilizing support and services, and taking action). This study is also limited insofar as the focus was on the families that volunteered to provide their perspectives and the majority of the families represented the Marine Corps, rather than a balanced sample from all of the Armed Forces. Lastly, this research focused on service members with serious physical combat wounds and not on those with only psychosocial stressors.

Obviously, PTSD and/or TBI often coexist with physical wounds, and, therefore, service members with both visible wounds and psychosocial stressors qualified for inclusion in this study, because they had the condition of being physically wounded which was requisite for this study. However, those service members with PTSD and/or TBI and no outward physical wounds were not included in this study because they did not have the condition of being physically wounded, as dictated by the study. Research (Carlsmith, 1964; Cohen, Solomon, & Zerach, 2011; Herzog, Everson, & Whitworth, 2011; McGonagle & Kessler, 1990; Seiffge-Krenke, 2000) has demonstrated, however, that psychosocial stressors may potentially have a much longer-lasting and detrimental impact on the children and families than the visible wounds. Therefore, there is an opportunity for future research and interventions to expand in scope for children and families of all wounded service members, regardless of whether their wounds are visible or psychosocial and the long-term effects of a seriously wounded service member on their children and family should be explored. These limitations notwithstanding, this study provides a valuable perspective on a population that is not frequently heard from. Given the limited research on this population, the findings of this study highlight important risks and suggest some feasible future directions that may enhance the research and treatment of the children and their families.

### **Direction for Future Research**

The findings from this study suggest at least three directions for future research. First, researchers need to explore in more depth the various reactions of seriously wounded service members and their families that are comprised of a more balance sample from all of the armed forces, which included service members without outward physical wounds, using qualitative and quantitative methods. This is a qualitative study and its findings are not meant to be generalized to larger groups. Future research needs to examine the phenomenon of these identified experiences using quantitative methods to discern whether they apply more broadly. Second, researchers need to analyze the types of mental health services utilized by wounded services members and their families. Such an examination would allow for a more robust understanding of the range and types of services, evidence-based practices, and programs found being helpful with wounded service members, their spouses, and children. Third, researchers must continue to

expand the inquiry of the experiences of children of wounded service members, by collecting data from military professionals, non-profit organizations, and mental health clinicians who work with military children. A collective view on the experiences, needs, and obstacles could add to this study's findings and provide a comprehensive picture of how to support the children of wounded service members.

### **Implications for Practice**

In light of the current findings, several implications exist for counselors. First, a counselor interested in working with the military population, should fully understand military culture and its protocols. Counselors can engage in professional development activities (e.g., independent study, conferences, supervision, etc.) to increase their knowledge and awareness. Furthermore, a counselor should become familiar with the community organizations, Veteran Affairs, and nonprofit resources available in their area. Volunteering and developing rapport with military families in the area is an essential way to build trust with families.

Second, when providing counseling services to children and families of seriously wounded service members, counselors should consider three things: (a) how the services are delivered, (b) the location and arrangement of the counseling environment, and (c) if childcare is available. Because of the stigma of counseling present in military culture, military personnel and their families prefer that the counseling services be disguised. For instance, for seriously wounded service members and their families, their first time at counseling would be better received if it were incorporated into camps, retreats, and workshops. This would allow children to have the opportunity to do “fun” activities and be kids; rather than worrying about having to care for their injured parent. It also allows the family to engage in activities together and to be around other families that understand what it is like to be a family with an injured service member. If providing counseling services in a counseling office, it is important for counselors to evaluate their location and environment. First off, is the office accommodating for wheelchairs and compliant with the American Disabilities Act? Is the office environment soothing and not filled with overwhelming decorations or cluttered? What types of sounds are in and around the office? All of these questions are important to be considered, because for many seriously wounded service members, the physical environment and location of the counseling office could hinder their attendance and ability to be counseled. In addition, more seriously wounded service member's spouses would engage in counseling services if there was a safe place for their children to be while in counseling. For instance, many spouses of service members with PTSD are afraid to leave their children alone with their injured spouse, because they fear the potential unpredictability of the injured spouse's action, which could put their children at risk. Many of the families with a wounded service member are isolated geographically and do not have large support networks to lean on for assistance (e.g., financially, childcare, housing), which hinders the service member and their spouse from engaging in activities that do not include their children.

Finally, when counseling children of seriously wounded service members it is important to provide specific services, interventions, and supports beyond dealing with deployment, frequent transitions, and grief. Dealing with all of these issues is important, but a child of a seriously wounded service member has a compounding issue in that their parent was wounded

and is disabled. That fact trumps all of the other issues commonly researched and counseled for with military children. As a result, it is important that when putting military children together for group counseling or psychoeducation, that counselors are sensitive to the unique needs of children whose parents were wounded. Other military children are not going through similar issues and will find it hard to relate. It is important to note that children whose parents have been seriously wounded are no longer living on military installations. As a result, these children and families tend to be geographically isolated. To ensure that counseling services are being provided to these children, more school counselors need to be trained to work with military families and understand their unique needs. School counselors can provide individual and group counseling, organize parent workshops, and conduct systemic programming in form of assemblies, guidance lessons, or school base support programs in order to provide a safe, non-threatening location for children to obtain counseling services. Additionally, schools counselors are in a prime position to educate and train school staff about families with seriously wounded members: what their life is like, the realities and challenges they face, the symptoms of PTSD and TBI, warning signs, and how to provide the best resources and supports in the most effective way (Fenell & Fenell, 2008). Utilizing school counselors and their programming can be an extremely effective way to prevent children of seriously wounded service members from falling through the cracks and, ultimately, to influence positive outcomes for these children and families.

In this study, service members seriously wounded in combat, their spouses, and children were asked to describe their lived experiences of being a military family with a parent who has been seriously wounded and its effect on the child(ren). Thematic conceptualizations of obstacles and needs emerged from their collective personal stories, providing insights into how the parental injury has contributed or hindered the child(ren)'s development and the family's stability. As with most qualitative research, transferability of these findings to other populations or situations may be made only by individual readers. These findings do suggest, however, that clients may benefit from counseling approaches that help military families to utilize and continue to use counseling services.

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## **Called to Serve: A Military Women's Wellness Series**

ANDREA BJORNESTAD  
South Dakota State University

AMBER LETCHER  
South Dakota State University

### **Abstract**

*With the increase in women serving in the military, more servicewomen are experiencing combat in roles similar to men. Women returning from deployment may experience less support from peers and supervisors as well as various stressors including an increased risk of harassment, sexual assault, mental illness, and unemployment. Due to these concerns, the development of programs focusing on the health and wellness in female service members and dependents are needed. This paper describes a series of workshops that were developed to educate female service members and dependents at a university on areas of wellness to encourage the development and sustainment of healthy lifestyles, relationships, and career choices. A discussion related to how personnel from the Land Grant University Cooperative Extension system were utilized in the workshops is provided as well as implications and future directions of the program.*

*KEYWORDS: women Veterans, career, lifestyle, wellness*

Increasing numbers of women are serving in the military, and these women are fulfilling similar roles as men. Women are returning from combat with varying concerns including mental health issues (e.g., Posttraumatic Stress Disorder, depression, and anxiety), stressful living conditions (e.g., unemployment), and military stressors such as harassment and sexual assault (Carlson, Stromwall, & Lietz, 2013). Women also report less support from peers and supervisors (Vogt, Pless, King, & King, 2005).

Due to the stress experienced by female service members, the development of initiatives has been encouraged to help strengthen the overall well-being and psychological health of military families (Strengthening our military families: Meeting America's commitment, 2011). An initiative to help support military service members involves colleges and universities

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Andrea Bjornestad and Amber Letcher are Assistant Professors in the Department of Counseling and Human Development at South Dakota State University. Address correspondence to Andrea Bjornestad, Email: [Andrea.Bjornestad@sdstate.edu](mailto:Andrea.Bjornestad@sdstate.edu).



providing adequate support. Recently, colleges and universities have experienced an increase in enrollment of student Veterans (O'Herrin, 2011). Roughly, 250,000 female Veterans are currently attending college or are planning to attend by the end of the decade (DiRamio, Jarvis, Iverson, Seher, & Anderson, 2015). Student Veterans present with varying mental health issues, and these mental health issues are concerning as almost half of student Veterans enrolled in college have contemplated suicide at some point (Lipka, 2011). Returning to civilian life, specifically the independence that occurs during college can be challenging as Veterans are used to the predictability and structure that exists during deployments. Furthermore, due to a reluctance of being singled out as a Veteran and the mental health stigma that exists in the military, establishing a campus community that promotes a sense of belonging can be difficult (Wheelus & Boes, 2015).

Support for Veterans on campus may include establishing a Veteran resource center, academic credibility, mentor program, tuition reduction, peer support, staff with military experience, and flexibility with prior credit. External partnerships with local National Guard or reserve members or community organizations focused on the well-being of service members may help them transition to college and succeed (Rumann & Hamrick, 2009). In addition to providing support to military service members, a need exists to address stressors experienced by military dependents on campus (Drummet, Coleman, & Cable, 2003).

To help provide support and promote individual and family resiliency, the Land Grant University Cooperative Extension System can be utilized on college campuses to encourage healthy development in student Veterans, specifically in females. A series of workshops were developed that involved the University Cooperative Extension System to educate female service members and female dependents at a university in the Midwest on areas of wellness to encourage the development and sustainment of healthy lifestyles, relationships, and career choices. The project was supported by a grant that involved developing innovative projects for a female audience.

### **Females Associated with the Military**

**Servicewomen.** Historically, men have comprised the majority of the armed forces; however, 14.2% of active duty service members are females, which is the largest proportion in history (Department of Defense, 2007). Approximately, 147,821 female Veterans served in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) (VA, 2011). Females are experiencing more combat than in the past, and combat experiences have contributed to mental health issues in female Veterans including posttraumatic stress disorder (PTSD), substance abuse, and depression. Furthermore, in a study of OEF/OIF Veterans, 48% of women screened positive for depression, and 21% of women screened positive for PTSD (Haskell, et al., 2010). Specifically, upon reintegration, female Veterans are 1.6 to 3 times more likely to be diagnosed with a mental disorder (Wojcik, Akhtar, & Hassell, 2009).

Female Veterans are returning from combat with different psychosocial stressors than males. Within these psychosocial stressors, an increase risk of harassment or sexual assault exists (Kelly, Skelton, Patel & Bradley, 2011). The increased risk of harassment and sexual assault may be contributing factors to the higher rate of mental illness in military women as females have

reported less support due to their minority status as women in the military. Additionally, upon reintegration, female Veterans are more likely than males to experience unemployment (Nichols, 2015). As a result of these factors, it is important to design programs to address the health of military servicewomen.

**Female dependents.** Trauma resulting from deployments may also contribute to impaired interpersonal relationships (Dirkzwager, Bramsen, & van der Ploeg, 2003), specifically within the marital unit. Spouses of Veterans with combat-related PTSD report a greater degree of psychological distress when compared to spouses of non-combat related PTSD and the general population (Renshaw, Rodrigues, & Jones, 2009). Further, if a Veteran exhibits PTSD symptoms, the spouse of the Veteran has an increased risk of developing secondary traumatic stress symptoms (Bjornestad, Schweinle, & Elhai, 2014; Nelson Goff & Smith, 2005).

Secondary traumatic stress refers to the transmission of symptoms that resemble PTSD from a Veteran who directly experienced a traumatic event to a loved one. Symptoms can be transferred via knowledge of the event or the process of helping a loved one (Figley, 1999). Initial evidence has shown that secondary traumatic stress symptoms in military spouses fit the same four factors (reexperiencing, avoidance, emotional numbness, and hyperarousal) as PTSD symptoms in Veterans (Bjornestad, Schweinle, & Elhai, 2014).

Even though the effects of trauma in military families is widely documented, the interaction of deployment, combat exposure, and reintegration upon marital health is conflicting (De Burgh, White, Fear, & Iverson, 2011), and a debate exists regarding the risk of divorce in military couples (Karney, Loughran, & Pollard, 2012). Faber and colleagues (2008) suggest that the stress associated with serving in the military may not be the only factor impacting relationships. Rather, individual factors, such as the family's coping skills, may contribute to relationship distress (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008).

In addition to spouses experiencing distress, children are also at risk of developing mental health issues. Since 2001, children and parents have coped with numerous separations and reunions as more than 900,000 children have experienced a parent's absence for a deployment (Lester et al., 2012). Children's reactions to deployment may include depression, increased anxiety, academic difficulties, and behavioral disruptions (Lincoln, Swift, & Shorteno-Fraser, 2008; Flake, Davis, Johnson, & Middleton, 2009). Similar to the effects on spouses, psychological distress in the service member predicts adjustment issues within the child (Cozza, Chun, & Polo, 2005; Lester, et al., 2010). Even though mental health risks exist in military children, social networks have been found to help decrease the risk (Flake et al., 2009).

### **Healthy Military Veterans and Family Members**

With the mental health concerns in the military, resiliency has been at the forefront of discussions. Resilience pertains to the ability to endure and recover from adversity (Walsh, 2002) and has been proposed to exist via relationships that help to create normalcy, encourage independence and resourcefulness, acquire a social network, reframe mental stressors, and acknowledge adversity (Villagran, Canzona, & Ledford, 2013). The formulation of relationships is important in resiliency as social support has been associated with greater well-being and less

symptomatology of mental health disorders in both Veterans and family members (Brailey, Vasterling, Proctor, Constans, & Friedman, 2007; Dirkzwager, et al., 2003; Fikretoglu, Brunet, Poundja, Guay, & Pedlar, 2006).

In addition to the need for adequate social support, wellness is an important aspect of resiliency. With the increasing mental health concerns of military service members and their families, the Psychological Health Program associated with the National Guard Bureau has identified five pillars of wellness to provide a road map to resiliency. The pillars include emotional wellness, physical wellness, spiritual wellness, social wellness, and family wellness. By understanding and applying the skills under each pillar, it is the belief that service members will be more effective at coping with stress, managing life transitions with fewer difficulties, and be proactive in maintaining overall resiliency (Joint Services Support, 2015).

Emotional wellness involves self-awareness and acceptance of emotional reactions, bouncing back when experiencing negative affect, and effectively coping with stress. Making positive choices related to one's own wellness and choosing positive relationships with individuals who care and understand the hardships are equally important (Joint Services Support, 2015). Furthermore, the need to understanding the signs of emotional distress and knowing when to seek help from a professional are promoted within emotional wellness.

Physical wellness is optimal when serving in the military due to the demands to be physically fit. Physical wellness refers to avoiding substance abuse, maintaining a well-balanced diet, preventing physical injuries, resting and taking adequate care of one's body, and seeking regular check-ups from a primary care provider. As a result of failing to maintain optimal physical wellness, various signs of physical distress may occur such as recurring pain, breathing difficulties, exhaustion, sleeping difficulties, and a high body mass index (Joint Services, Support, 2015).

Both emotional and physical wellness appears inherent in everyday life; however, spiritual wellness may be dismissed as less important. Spirituality is personal and may include taking time to reflect upon existential questions such as determining one's purpose in life or working to achieve increased mindfulness. Within mindfulness, a service member can work towards finding balance with his or her surroundings to acquire a greater sense of personal needs. Finally, spirituality can involve an examination of one's personal values and beliefs to act compassionately (Joint Services Support, 2015).

In addition to taking time for personal reflection, it is also important for service members to maintain social connections. When establishing social relationships, service members can become reliant on their unit for social support. However, the National Guard Bureau stresses the importance of maintaining social relationships both within military and civilian lives. Social wellness involves maintaining effective communication skills as well as finding opportunities to connect and acquire a sense of belonging. Within authentic relationships, service members fulfill their expected social roles pertaining to both their military assignment and civilian life. Furthermore, the relationships that service members establish should be with individuals who provide a positive influence. If the relationships are unhealthy, it is important for the service member to recognize the negative relationships and make appropriate adjustments (Joint

Services Support, 2015).

In addition to establishing and maintaining healthy social relationships, service members need to remain connected to family. Family wellness involves actively participating with family members by finding time to engage with them, developing a safe, stable atmosphere for children, and being a role model for children by making good choices and teaching children listening skills. Conflict may occur within families; therefore, flexibility, forgiveness, and compromise are important elements when maintaining a healthy family system (Joint Services Support, 2015).

Overall, each pillar of wellness is important to promote healthy living in service members and their families. By focusing on a holistic approach to wellness, each pillar is equally valuable in developing and sustaining adequate physical and mental health. Therefore, programming efforts targeted at service members and their families should include information on the five pillars of wellness.

### **Called to Serve: A Women's Wellness Series**

Addressing the unique needs of women who are affiliated with the military can have important implications for the health of military families. However, establishing a convenient, replicable, and low cost method for supporting these women can be challenging. In response to the stressors that commonly affect women with military affiliation, a workshop series was developed and piloted on a mid-sized, Midwestern campus. Workshops focused on the pillars of wellness and were facilitated by university extension staff with specializations in each topic area. Female students, as well as women in the community, were invited to take part in the workshops. Below, the major components of the workshop series are described.

#### **Goals and Objectives**

Five workshops were designed to educate female service members, female spouses or significant others, and female children (ages 18 years and older) of service members on the five pillars of wellness. The first goal of the workshop series was to provide practical skills to improve wellness. These practical skills, such as practicing mindfulness and making healthy, low cost snacks, could be easily integrated into their daily routines in order to enhance emotional, physical, spiritual, social, and family wellness.

Due to the comparatively limited services specifically targeting women in the military, another goal of the program was to provide a support system for participants. By providing a location where women with military affiliations could meet, it was expected that relationships would develop and be maintained among the women after the workshop series ended. Each session began with introductions and updates from participants in order to foster self-disclosure in a non-threatening manner (Morrison-Beedy, Cote-Arsenault, & Fischbeck Feinstein, 2001). Activities within the workshop also encouraged discussion and teamwork.

#### **Workshop Facilitators**

The mission of the Land Grant University Cooperative Extension System is to provide

outreach services for communities across each state. Extension agents throughout the state provide expertise in agriculture, healthy families, positive youth development, and community development. The organizational structure in the current Midwestern state includes campus-based state specialists, field specialists based in one of eight regional centers across the state, as well as county-based 4-H youth program advisors. For the workshop series, state and field specialists with expertise in the areas of the five pillars of wellness were invited to facilitate one workshop. Involving extension personnel was an efficient, cost-effective way of providing needed resources to military personnel as extension programming already existed in most topic areas.

### **Budget**

Workshop expenses were minimal. A stipend of \$100 was provided to each workshop facilitator to be used for materials and supplies. No costs were incurred for meeting space rental as all sessions took place in classrooms on a university campus which could be accessed free of charge. Light refreshments such as cookies or bagels were also served at each workshop, while a meal was provided at the final session. The final workshop, which involved the services of a local merchant, accounted for the most funds and included the meal, registration fees, travel for the facilitator, and supplies. Grant funding allowed for the additional expenses; however, an alternative social event with the original \$100 stipend could be substituted in a future workshop series.

### **Workshops**

Workshops were conducted on a bi-weekly basis over a period of three months. Participants were recruited through email list serves, posters on campus, word of mouth, and with the help of the campus Veterans Affairs office. Participants included college students as well community members. Resources were available for up to 50 participants per workshop. While some participants were active military members others were spouses or dependents of military personnel. Workshops were held in the early afternoon or evening on the college campus. The five pillars of wellness (Joint Services Support, 2015) were used as a guide for developing content for each workshop as described below.

**Emotional wellness.** A major component of emotional health is the ability to cope with, and bounce back from, stressful situations. The ability to overcome and cope with stress can be referred to as resiliency (Walsh, 2002). The resiliency extension field specialist presented a workshop on the qualities associated with resilient individuals, as well as coping strategies that can foster resiliency. Participants formed small groups to discuss challenges that families may experience and brainstorm coping strategies to help overcome those challenges. Additionally, time was provided for self-reflection related to a personal challenge and the development of an individual plan, which included coping strategies discussed during the workshop. As some members had experienced trauma, it was important to allow them privacy in reflecting on their experiences.

**Physical wellness.** The health and physical activity extension field specialist facilitated a workshop on healthy eating and physical activity. During the session, participants learned about

updated nutritional recommendations from the United States Department of Agriculture (USDA), as well as mobile apps that could be used to quickly estimate calorie intake. Additionally, participants learned and practiced basic yoga exercises for relieving tension. These maintenance exercises were a component of the workshop as they could be easily integrated into busy daily routines and were physically possible for all participants regardless of their current level of health. As one goal of the workshops was to create a safe, supportive environment, it was important that all participants felt included in the activities. The workshop culminated in preparing a trail mix recipe, which could be customized to each participant's preference. Healthy recipes and other handouts were also provided at the end of the session.

**Spiritual wellness.** The third workshop addressed spirituality from a broad perspective. In order to be inclusive of all belief systems, the non-denominational practice of mindfulness was selected as the topic. Mindfulness is described as the process of focusing thought and attention on the present moment (Kabat-Zinn, 2003a). Contemporary mindfulness practices emerged from the work of Jon Kabat-Zinn (1994), and have been used to treat stress, depression (Kabat-Zinn, 2003b), chronic pain (Plews-Ogan, Owens, Goodman, Wolfe, & Schorling, 2005), and obesity (Dalen et al., 2010) among other conditions. Mindful practice can range from brief breathing exercises to extended meditation sessions. For the purpose of the wellness workshop, brief exercises were demonstrated that were more appropriate for those with limited experience. An extension state specialist with training in mindfulness techniques led the workshop held in a yoga studio in the wellness center on campus. Participants had a chance to practice a basic body scan in which one's attention is focused briefly on each part of the body. With a basic body scan, individuals are instructed to notice any sensations from that body part; pain, tension, relaxation, and so forth. Although sensation is noted, no effort is made to change the feeling. Instead, attention is focused on the next area of the body. Additional exercises included mindful walking and mindful eating; both activities are used to keep attention focused on the present moment in an effort to avoid anxiety over past or future stressors.

**Family wellness.** Managing finances is one of the most commonly reported stressors for families (American Psychological Association, 2012). For military families, managing financial needs can be especially difficult (Hosek & MacDermid Wadsworth, 2013). For example, frequent relocation can leave the accompanying spouse without employment opportunities, and family members may find themselves responsible for unfamiliar financial matters during a deployment (Drummet et al., 2003). Therefore, assistance in budgeting, creating a saving plan, and debt consolidation were topics deemed valuable for workshop participants. The family financial planning extension state specialist provided strategies for managing finances. Participants evaluated their needs versus wants and were provided with budget templates and debt calculators. A common concern among participants was related to student loans as many workshop participants were currently attending college or had college-aged children.

**Social wellness.** As a major goal of the workshop series was to encourage bonding and creation of a support system for the women as social wellness is associated with mental health (Myers & Sweeney, 2004). Therefore, the last session served as a relaxing social event to wrap up the series. Participants were invited to a food and canvas painting event. A local merchant who hosts private painting parties facilitated the final session. Each participant had the opportunity to create a military-themed painting on her own canvas. During the session, an

emphasis was made on the importance of community and maintaining relationships. The final session had the greatest attendance of all sessions in the series, and participants remained long after the 1.5 hour scheduled meeting time.

## **Evaluation**

The current workshop series was developed as a pilot program. During this first round of workshops, initial relationships were established with military and extension personnel, which assisted with workshop implementation. The support of additional staff would be essential to the success of future programming. It was also expected that participant attendance at the pilot workshops might be low as recruitment efforts were being refined. However, an evaluation plan including a pretest and posttest assessment on perceptions of stress, social support, and wellness was developed in the event that attendance was high enough to warrant analysis of outcomes. In the pilot study, the final sample size was not large enough for statistical analyses.

## **Lessons Learned**

One of the greatest challenges in developing a program can be recruiting a participant base. Given the many responsibilities vying for an individual's time, only the most salient opportunities will receive attention. For military families, time can be an especially scarce resource. Spouses may be dealing with added responsibilities due to their partner's deployment, and active duty members may be traveling to new locations for specialized training. Others may be balancing military service, family, work, and/or post-secondary schooling (Thompson, 2000). Unfortunately, taking care of one's overall well-being may be sacrificed in favor of other demands; thus, attending wellness programming may not be a high priority. However, without adequate mental health, accomplishing multiple responsibilities can be extremely challenging. Although the previous statement makes intuitive sense, it is not always followed by reasoned action such as taking time for self-reflection, adopting an exercise routine, or seeking out a support system. Participants may need encouragement in order to put their own well-being first.

Some strategies that encouraged individuals to focus on their health were found during this pilot series. First, the timing and location of the workshops were important. Initially, workshops were staggered; occurring on different days of the week and varying between afternoon and evening. It was expected that participants would have busy schedules, and the intent was to accommodate as many participants as possible. However, late evening was the most preferred time slot as work and schooling obligations were less abundant. Also, changing the day and time made it difficult for participants to keep track of when workshops were scheduled. Having a consistent meeting day and time would likely boost participation.

Another strategy for recruitment and maintenance of participants involved building a sense of community with other members. The workshop series focused heavily on providing content and practical skills for the women. However, allowing time for informal conversation as well as personal updates to the group can encourage the development of ongoing friendships and a support network. Group work during the workshops was also important in the rapport building process. Participants were able to share ideas and experiences with others. Further suggestions, based on participant interaction in the current program, for encouraging relationships include

creating a contact list that can be shared with participants, beginning each session with personal updates since the last session, and ending each session by sharing upcoming plans.

Finally, advertising strategies have a profound effect on programming. For the current program, the Office of Veterans Affairs on campus was utilized to reach potential participants. Local National Guard leaders were asked to promote the workshop series with their soldiers. Flyers were also posted on campus and throughout the community. Additional strategies that could be considered include purchasing ad space in local newspapers. However, the cost of such advertising versus the expected return on investment must be weighed as print costs can be high, but print media is often the preferred source of advertising for certain groups including older adults so the target audience must be considered.

### **Future Directions**

Successfully evaluating the effectiveness of interventions aimed at increasing wellness among military members is a relevant next step in improving the overall well-being of those who serve, or are affiliated with those who serve, in the armed forces. In order to assess effectiveness, reliable, valid measures must be created (Roach, 2006). Future efforts are planned to develop, test, and adapt a measure focusing on the five pillars of wellness. A valid instrument would be useful in future programs wishing to assess change in wellness among participants. Additionally, a common measure used across multiple programs allows for comparison of the success of individual programs (McGlynn, 2003). Service providers can then review components of successful programs to identify which specific programs may be most appropriate for their audience. Establishing common, valid measures can assist programming targeted at the national level, such as programming for the military, in comparing outcomes across programs (McGlynn, 2003). Similar efforts are currently ongoing in extension (eXtension, 2015). Therefore, integrating extension personnel into programming may be an effective strategy in both program implementation and evaluation because extension staff may be familiar with the process.

**Sustainability.** An often cited concern related to programming is long term maintenance of the program after initial funding sources are depleted (Scheirer, 2005). The current workshop series was implemented with a minimal budget and utilized extension staff with an outreach component to their position. Communities can contact extension personnel as outreach services are available across each state. Another way to promote sustainability is through the establishment of relationships. Participants may think about creating a club or support group to continue fostering well-being. A student group aimed at military-affiliated students was recently established at the present university. Members of this group may choose to concentrate on one pillar of wellness at each meeting or target each pillar in more detail by focusing on it for an entire year. Outreach and service activities related to the pillars could also become included as part of the club's mission. Community-based organizations could form in the same way with similar activities.

**Expansion.** Plans are in place to expand the workshop series to additional communities. Communities in more rural, isolated locations are of special interest as services are not as available to those areas. Military personnel in rural versus urban communities have reported lower quality of life related to health outcomes (Weeks et al., 2004). Similarly, Veterans with



mental illness in rural communities are more negatively impacted in comparison to their urban peers (Wallace, Weeks, Wang, Lee, & Kazis, 2006). Therefore, providing services in these environments may impact well-being among individuals in need of service. Working with extension staff members who are already connected to these small communities greatly assists with the expansion of programming.

### **Conclusion**

Maintaining overall health and wellness among women affiliated with the military is essential for national security. An important component of wellness is the establishment of networks that provide support to female military members and their families. To these aims, a series of wellness workshops informed by the Pillars of Wellness (Joint Services Support, 2015) were provided to female students and community members with military connections. This pilot project was implemented at minimal cost, can be easily replicated, and established connections with local military organizations. Service providers are encouraged to implement similar programming targeted towards the needs of their specific military communities.

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