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Letter from the Editor

The *Journal of Military and Government Counseling* (*JMGC*) is the official journal of the Military and Government Counseling (MGCA; a division of the American Counseling Association). This journal is designed to present current research on military, Veteran, and government topics. I am both pleased and a bit nervous to announce that the journal will move from three to four issues per year starting with the first issue of 2018!

This issue is an eclectic collection of articles in practice, theory, and research. The first article is a follow-up to an article in the last issue. The second article introduces religion/spirituality in treating trauma in women Veterans. The third article touches on a topic that has not been covered in the JMGC – the experiences of parents caring for their Veteran children post-deployment. The fourth article presents supports for military spouses graduating from college. The final article returns to religion/spirituality as support during separation or reintegration.

I am still seeing an increase in submissions and gladly welcome more submissions for the JMCG. As we move to four issues per year, I do hope that we sustain the submission. So, ask around where you work – or try writing yourself. I'm advertising for submissions through ACA channels.

Benjamin V. Noah, PhD
JMGC Founding Editor

Training Rural Community Leaders in Suicide Prevention: Operation S.A.V.E. Outcomes

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ACKNOWLEDGEMENTS: The authors thank the National Guard State and Joint Forces Chaplains for their participation in the conduct of the interviews. We are also deeply grateful to the Veterans, their family members, congregations and communities, and other supporters of the Partners in Care program, for their participation. Finally, we are grateful to Eileen Zeller at SAMHSA and Jan Kemp at the VISN 2 Center of Excellence for Suicide Prevention for their support of the program and its evaluation.
HUMAN SUBJECTS: This study was approved by the Central Arkansas VA Institutional Review Board.

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Abstract

We were asked by the Veteran Affairs Center of Excellence for Suicide Prevention to evaluate the Operation S.A.V.E. suicide prevention training component of the Partners in Care collaboration between state National Guard chaplains and local faith community leaders. Pre- and post-training surveys and semi-structured interviews explored chaplains' (N=5) and trainee respondent (N=217) perceptions of the Operation S.A.V.E. suicide prevention training. Although chaplains (trainers) and trainees valued the information provided in the training and the potential for future collaboration, none of the chaplains planned to offer additional Operation S.A.V.E. training, citing redundancy with other suicide prevention resources or no perceived need for additional suicide prevention training. Chaplains and trainee respondents identified benefits to training, barriers to successful partnering, and suggestions for future improvements. Although the implementation of the Summit (the one day Partners in Care training) was well received and the event itself was reported to have been motivational for the support of military service members, Veterans, and their families, there was limited follow-up on its impact for suicide prevention or the continuation of suicide training.

KEYWORDS: Partners in Care Program, faith-based partnership, Veterans, clergy

One in five U.S. military Veterans return to their families living in rural areas, and one in five returns with a mental health problem (Sullivan et al., 2012; Tanielian & Jaycox, 2012; U.S. Department of Veterans Affairs, 2012). As evidence mounts regarding increased rates and risks for suicide in various military populations (Nock et al., 2014; Reger et al., 2015; Kapur, While, Blatcheley, Bray, & Harrison, 2009; Kemp & Bossarte, 2012), it becomes increasingly apparent that a multifaceted approach to suicide prevention is needed (National Strategy for Suicide Prevention [NSSP], 2012) specifically for rural individuals with limited access to mental health care (York, Lamis, Pope, & Egede, 2013). Given one-third of Operation Enduring and Iraqi Freedom Veterans return to rural or highly rural areas (Kirchner, Farmer, Shue, Blevins, & Sullivan, 2011), suicide prevention efforts must be directed at the entire military and Veteran populations. This includes individuals currently serving in the military with the Department of Defense (DoD); individuals who are enrolled or are eligible to enroll in the Veterans Health Administration (VHA) for health care or specialty services; individuals who feel disenfranchised or disconnected from care; and individuals living in rural communities without ready access to health care services. A community-based approach, engaging family members and friends can potentially maximize DoD and VHA resources, extending the 'reach' of their respective suicide prevention programs to include families in rural areas while simultaneously increasing collaboration with stakeholders in local community organizations.

Community Level Interventions

Public health approaches to suicide prevention can be conceptualized as a multifaceted integration of community and clinical strategies in which prevention activities are delivered

through diverse channels (e.g., workplaces, churches, communities; Bodison et al., 2015; NSSP, 2012; Shalowitz et al., 2009). Individuals who may be at risk can be identified prior to suicidal crisis and referred for appropriate intervention. Local clergy serve as one gateway to mental health services and a key access point for such intervention. Additionally, faith congregations have become critical stakeholders, filling gaps in services by providing local resources and support, thus addressing the psychosocial, emotional, and spiritual needs of returning Soldiers and their families (Openshaw & Harr, 2009; Sullivan, 2007; Waliski et al., 2014; Young, Patterson, Wolff, Greer, & Wynne, 2015).

Individuals with mental health problems are more likely to seek help from clergy than from formal sources of care, especially in rural areas (Wang, Berglund, & Kessler, 2003). Clergy are more available (there are more clergy than mental health providers, particularly in rural areas) and more likely to be trusted (Sullivan, 2007; Openshaw & Harr, 2009), there is less stigma associated with consulting clergy (Openshaw & Harr, 2009), and clergy do not charge for their services (Sullivan et al., 2012). However, while clergy are eager to help, they often feel they lack adequate training to detect mental illness and assist individuals with mental illness (Kramer et al., 2007), and they feel inadequate to manage and refer persons with mental health problems when those individuals may be at heightened risk for suicide (Kramer et al., 2007).

Intervention and Referral by Gatekeepers

Suicide experts advocate a multifaceted approach to minimizing suicide risk that includes educating individuals in "front line" gatekeeping roles to recognize early signs of mental distress and the individual and environmental characteristics associated with increased suicide risk, and ensuring that they have referral processes in place (Mann et al., 2005). In the international suicide prevention literature, one study found that workshop participants gained skills using a novel form of suicide prevention and intervention abilities training for adults (Tierney, 1994), while other studies investigated gatekeeper training to increase effectiveness of health care interventions (Botega et al., 2007), and to facilitate increased access to care for diverse populations (Capp, Deane, & Lambert, 2001). A randomized trial found statistically significant increases in post training queries about suicide among school personnel with natural gatekeeper roles compared to control participants (Wyman et al., 2008). Observational studies have also reported statistically significant increases in perceived knowledge and self-efficacy to intervene after gatekeeper training (Matthieu, Chen, Schohn, Lantinga, & Knox, 2009; Wyman et al., 2008).

The Partners in Care Program

Although research suggests training can improve gatekeepers' suicide prevention knowledge and self-efficacy, there are important gaps in our knowledge about how gatekeeper training can facilitate linkages among gatekeepers and community services, thus improving access to health services. The Partners in Care program was developed by Maryland National Guard chaplains to increase linkages between a state National Guard chaplain's office and faith-based communities. It aims to increase access to care and supportive services for National Guard members, Veterans, and their families, to increase their resiliency in the face of stress, and to reduce their risk for behavioral health problems including their risk for suicide. It does this by

inviting local faith leaders to an initial one-day Summit Training Program and then inviting them to enroll their congregations as Partners in Care, partnering with a network of local community faith organizations coordinated by the National Guard chaplains to provide services as needed to Guards members, family members, Veterans, and others in need.

Partners in Care, endorsed by the National Guard Bureau, was implemented in five states as a pilot project in 2012. The timing of Partners in Care pilot implementation allowed us to conduct a formal evaluation of the S.A.V.E. training programs from both the National Guard chaplain trainers and Partners in Care trainee perspective in four of the pilot states (Missouri, Virginia, Oregon, and Minnesota). We also obtained information from the National Guard chaplain in the fifth state, Arizona, but we were unable to formally evaluate data from Arizona training attendees because that Summit occurred before the evaluation was implemented.

The Partners in Care training programs used Operation S.A.V.E., the official U.S. Department of Veterans Affairs (VA) suicide prevention training program for individuals with a "front line" role (Department of Veterans' Services, 2013; King et al., 2012), as the suicide prevention component of the training. S.A.V.E. is a mnemonic for these key suicide prevention steps:

- **S**igns of suicidal thinking should be recognized,
- **A**sk the most important question, "Are you thinking of killing yourself?"
- **V**alidate the Veteran's experience, and
- **E**ncourage treatment and **E**xpedite getting help.

Operation S.A.V.E. was developed as the first Veteran-specific gatekeeper training program for suicide prevention to be used with front-line VHA staff across the nation. Evaluation of this program with VHA staff indicated an increase in confidence for responding to suicidal Veterans, increased acceptance of suicide screening as part of their job, and enhanced knowledge about suicide (King et al., 2012). Thus, while the Operation S.A.V.E. training had been evaluated within VHA it had not been evaluated in a population of community-based gatekeepers. This manuscript describes the Operation S.A.V.E. training component of the Partners in Care Summits and the results of our evaluation of that training.

Evaluation Design and Methods

Both quantitative and qualitative methods were employed to characterize multiple stakeholders' perspectives of facilitation needs related to Partners in Care program implementation. This manuscript focuses on the results of the Operation S.A.V.E. suicide prevention training, one key component of a larger one-day training to educate faith-based leaders about military culture, deployment, and ways to support Veterans, service members, and their families

This study was approved by the Institutional Review Board. Data for this analysis included results from seven items about suicide and Operation S.A.V.E. training (see Table 1) from pre- and post-evaluation surveys of the trainees and transcripts of semi-structured interviews with the trainers about Operation S.A.V.E. and suicide prevention training. The Operation S.A.V.E. training component included one- or two-hour sessions using a PowerPoint

presentation lecture format and role-play activities for attendees to practice suicide risk identification and referral skills. Operation S.A.V.E. training was provided by suicide prevention coordinators from the VA medical facility that provides services to the catchment area where the training occurred. Suicide coordinators are trained through the VA's Veteran Integrated Service Network (VISN) 2 Center of Excellence for Suicide Prevention.

Table 1. *Impact of Operation S.A.V.E. Training. The rating scale ranged from 1 for Strongly Disagree to 5 for Strongly Agree. Number (Percent) of attendees indicating responses of "Agree" or "Strongly Agree" on Pre-, Post-, 3 months post summit and 6 months post summit Training Assessments.*

Questionnaire Item	Pre-Training (n=217)	Post-Training (n=205)	3 Months Post-Training (n=26)	6 Months Post-Training (n=20)
"I know what to do and who to contact if someone is in suicidal crisis."				
	153(71%)	184(90%)	26(100%)	18(90%)
		p = <0.0001	p = 0.0992	
"I know how to find a professional or a service that can help someone who is considering suicide."				
	173(80%)	195(95%)	24(92%)	17(85%)
		p = <0.0001	p = 0.4299	
"I know what to say to someone who I think may be considering suicide."				
	122(56%)	138(67%)	20(77%)	13(65%)
		p = 0.0192	p = 0.3733	
"I am relatively comfortable talking to someone who I think may be considering suicide."				
	168(77%)	184(90%)	21(81%)	14(70%)
		p = 0.0007	p = 0.3959	
"I can recognize the signs that someone may be considering suicide."				
	150(69%)	157(77%)	19(73%)	15(75%)
		p = 0.0853	p = 0.8829	
"I think my congregation/organization could be helpful to a National Guard member in our community."				
	179(82%)	183(89%)	23(88%)	18(90%)
		p = 0.0462	p = 0.8680	
"I am familiar with military culture."				
	169(78%)	186(91%)	20(77%)	15(75%)
		p = 0.0003	p = 0.8795	

Participants

Study participants included National Guard chaplains and Summit attendees (members of a local faith-based organization and other community individuals). One National Guard chaplain (and sometimes joined by the assistant chaplain) from each of the participating states that led the Partners in Care program implementation participated in key informant interviews describing the training and use of Operation S.A.V.E. skills. National Guard chaplains organized the Summit trainings including recruiting, scheduling speakers and training sessions, and identifying and inviting leaders of faith congregations.

Data Collection

National Guard Chaplains. A VA research scientist, the principal investigator of the study, conducted semi-structured telephone interviews lasting 20-60 minutes with the National Guard chaplains at 2 weeks, 3 months, and 6 months following each state's Partners in Care training Summits. An additional Chaplain, from Arizona, was interviewed at 6 months, 9 months, and 18 months following the Arizona Summit and implementation of the Partners in Care program because that Summit occurred before the formal evaluation project was developed and funded.

Summit attendees.

Pre/post surveys. Partners in Care Summit attendees were asked to complete a pre- and a post-survey when entering and immediately following the Summits. VA and Substance Abuse and Mental Health Services Administration (SAMHSA) representatives assisted the Chaplains during the Summits. The pre/post-Summit surveys contained seven statements related to suicide and Operation S.A.V.E. Participants were asked to rate their agreement to each statement on a 5 point Likert scale where 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree Nor Disagree, 4 = Agree, and 5 = Strongly Agree (Table 1). The post-survey also included the opportunity to provide contact information for attendees willing to participate in follow-up interviews. Therefore, surveys were anonymous unless the Summit attendees identified themselves as willing to participate in follow-up interviews.

Summit attendees received the pre-training surveys as they signed in to the event and were instructed to complete them and deposit them in a designated location. At the conclusion of the training, the post-training surveys were distributed, instructing attendees to complete them and deposit them in the designated location. Each time, the surveys were collected and mailed to the VA project evaluation team.

Semi-structured follow-up interviews at 3, 6 and 18 months. Attendees who had agreed to follow-up were contacted by a member of the call center staff of the VISN 2 Center of Excellence for Suicide Prevention at three and six months following their attendance at the Partners in Care Summits for follow-up telephone interviews of 20-30 minutes. A final follow-up interview was conducted 18 months post-training by telephone by the Principal Investigator, and took 20-30 minutes. Audio recordings of Summit attendee and National Guard chaplain interviews were transcribed verbatim and entered into ATLAS.ti Version 7.0 software (2012).

Data Analysis

Pre/post survey analysis. The quantitative portions of the pre/post training surveys and the semi-structured interviews of Partners in Care Summit attendees were analyzed using SAS Version 9.3 software. A total of 217 pre-Summit and 205 post-Summit surveys were returned from four states (pre-Summit: MN=27, MO=47, OR=86, VA=57; post-Summit: MN=47, MO=38, OR=63, VA=57). Responses were calculated as a percentage of the total (N=217 and N=205 respectively). Differences in the frequency of positive responses (e.g., response of 4 indicating "Agree" or 5 indicating "Strongly Agree") between the pre- and post-surveys were analyzed by Chi-Square test with significance set at the 0.05 level. Because the Arizona Summit trainings preceded the conduct of this evaluation, Arizona attendees did not complete Summit pre- and post- evaluations.

Qualitative data analysis. All transcripts were reviewed by two staff members to identify data describing the Operation S.A.V.E. training and skills used by those who were trained. These same coders met to discuss and define the most common themes and to develop an initial top-level thematic codebook. Once agreed upon, data was analyzed and reported. Results of National Guard chaplains' and the Summit attendees' perceptions of suicide prevention training are reported below.

Results

National Guard Chaplain: Summit

The overall consensus was that the Operation S.A.V.E. training was well received. Three of the four National Guard Chaplains facilitating the Summits identified role-playing as a positive component of the Operation S.A.V.E. training: "I heard good comments about what they got, especially even the role playing;" "While it makes you nervous when you do it, you come out kind of confident that I can do this." However, the fourth Chaplain indicated the role-play activity could have been stronger and more informative, stating [attendees] "said they thought that the acting out part didn't answer any questions."

Additional training vs. oversaturation. Chaplains' perceptions of the need for additional educational training for military and Veteran suicide prevention varied. While two National Guard chaplains expressed that training was needed, two others expressed that the training was unnecessary. One National Guard chaplain indicted that with just the one training, faith-based leaders were not equipped or willing to assist individuals in suicidal crisis.

> I think there is value in that but I think suicide scares folks too. I think the thing is and I tell our Commanders, the success of our mission is not just the number of suicides. It's how many trainings we do, it's getting the message out. So that's what matters most, but when we're asking for somebody to come alongside and help we're giving them our biggest problem and saying, "oh yeah we'll call on you if something gets really bad." Well they're not really bargaining for that.

Additionally, while all National Guard chaplains identified the benefits of Operation S.A.V.E. training as a method for teaching basic suicide identification and prevention skills, they

also questioned the scope and the time required to implement Operation S.A.V.E., and its usefulness in the face of other suicide prevention programs such as Applied Suicide Intervention Skills Training (ASIST; Living Works Education, 2005), Question, Persuade and Respond (QPR Institute, 1999), and Yellow Ribbon International for Suicide Prevention (Yellow Ribbon International, 2007). "Operation S.A.V.E. may have devalued in part due [to] the numerous approved suicide prevention trainings that are available." At 18 months post-training, National Guard chaplains in three states reported continuing the Summit training but modifying it to exclude Operation S.A.V.E.

Collaboration vs. independent training. Facilitation of the Summit included support by the Action Alliance for Suicide Prevention, National Guard Chaplains and staff, VA suicide prevention coordinators, and SAMHSA representatives. At the initial Summit training for Partners in Care, four of the five National Guard Chaplains utilized the Operation S.A.V.E. suicide prevention training, and one used a suicide prevention training program that had already been developed and used to educate his community about military service members and Veterans, because that Summit was provided before the full development of the evaluation component of the pilot project.

One Chaplain indicated that "having the VA come in and do the trainings is a very good fit for how we do things. "It was in a way seamless." Not all agreed in the value of the Operation S.A.V.E. training. National Guard chaplains indicated VA collaboration was valuable because it was one less thing the NG Chaplain was responsible for but that it could have been done by the National Guard. It was considered, "nice, but not necessary. We could have taught suicide to the community using our stuff. But the benefit was that the VA came alongside us and offered their services in our event that was great."

National Guard Chaplains: Post Summit

When Chaplains were asked if there had been any suicides reported to them since the Summit, one indicated there had been "four or five" in the last several months, one indicated none, and three indicated they did not have a definitive count. Concrete numbers of reported suicide ideations, attempts, or referrals were not identified because the Chaplains indicated they do not keep records.

As discussed above, none of the chaplains indicated plans to continue offering Operation S.A.V.E. But all National Guard chaplains saw a need for engaging the community and providing support for military service members, Veterans, and their families. "The big lesson is that we need all the help we can get and getting the faith based community involved is not optional. The Army can't solve these problems on its own." One National Guard chaplain felt there was a need for more intensive training: "…it was 101 level and they want a 202 and 303 level. Because this is a tool and understanding that they can use for a lot of populations; not just Veterans." Two chaplains talked about how there is a movement toward training resilience, and how this is provided by other programs within the National Guard support services. When talking about the stressors of military life and deployment, one National Guard chaplain explained that when you teach "people learn some skills in terms of how to deal with things emotionally in their lives, events that take place, how to bounce back, and how to deal with

them." Additional quotes from National Guard chaplains concerning the need for suicide training and Operation S.A.V.E. are provided in Table 2.

Table 2. *Pros and Cons of Continued Operation S.A.V.E*

Pros Operation S.A.V.E and suicide prevention training	*"It gave a skill set that pastors can walk away with. What we do offer we just did it again..., but this added a dimension of ministry related to suicide prevention."* *"It's of critical importance to continue having ongoing conversations about suicide prevention and really not just building awareness that people have a role potentially in suicide prevention and intervention, but increasing their comfort level is doing that and so I think you know that was a really valuable thing I heard very positive comments about what they got. Especially the role playing, because while it makes you nervous when you do it you come out of there kind of confident that I can do this."* "*Suicide may not happen but once a year in that community or that suicide threat or that crisis, but having the people* [trained]*…it means being ahead of time is awesome"*; "*…it all rests back in my opinion on the cycle that the stresses of life which contribute to the thoughts of suicide, hopelessness and helplessness. And once you give them encouragement you know Mark Twain said give me one word of encouragement and I can live for two months*." "*I have had two of the pastors I trained did call me to refer people to me that they were concerned about. He said while 'I've got this Veteran at my church you know can you help me I'm concerned about him you know, I can't help him here'. They'll call when they need* help." "*I believe that there's an increase of reported suicidal ideations because of the training that we have done. In other words, it has raised the awareness where intervention is being done sooner. The last conversation I had with folks is we've seen an increase in interventions because we've increased the awareness*."
Cons Operation S.A.V.E or suicide prevention training	"*If the saturation has gotten to the point now where this is just as you know, how should I say, just a reminder type training about what you've already learned; it's not initial training it's follow up training but my concern is when I will just…I'll just put it out there like this, I'm not seeing the passion about it and I think my answer to that, why the passion may not exist is because the people that are organizing and doing the training now are not involved in regular counseling in people's lives so they can actually see and understand what's actually really needed.* *"We've taken care of the problem; it's becoming secondary in terms of what's the priorities. We are not in a crisis mode right now."* "*…the community is very supportive and caring about the suicide issue, but not really to the point that they would go to the VA or to me and say, would you come provide training for us.*"

Additionally, chaplains expressed hope that Summit training events could improve relations and collaboration between the National Guard and the VA. One National Guard chaplain also saw the Summit and VA collaborations as a means of potential future collaboration or a potential solution to previous disconnect between the local National Guard and VA. Yet, another indicated a concern and hope that after the training, the communication between him and the VA would be improved because previously this Chaplain was not able to work with the VA hospital to attend to a soldier in the psych unit after reporting suicide. However, no National Guard chaplain reported continued collaboration with the VHA or SAMHSA post summit.

Summit Attendees: Summit

In total, 217 attendees returned pre-Summit surveys and 205 attendees returned post-

Summit surveys. One hundred and 25 attendees (58%) identified themselves as a leader in a faith-based organization, 95 (44%) as a member of clergy, and 97 (45%) as involved in their organization in a non-clergy role. Of those completing pre-Summit surveys, 89 (41%) stated that they had served in the military, and 43 (19%) indicated that they had a National Guard member in their family.

Summit attendees were asked to rate seven statements both pre- and post-training concerning suicide identification and referral (see Table 1). Differences in the frequency of positive responses (e.g., response of 4 or 5) between the pre- and post-surveys were analyzed by Chi-Square test with significance set at the 0.05 level. Table 1 provides the results of the pre-post training evaluation.

Summit Attendees: Post Summit

Three and six month follow-up interviews. Summit attendees were asked if their Partners in Care program utilized the information provided about Operation S.A.V.E. Respondents indicated that the skills learned during the Operation S.A.V.E. training program were good, but they have not been needed yet (Table 3). Another respondent stated, "This portion was very good. As a retired military service member, I expected to be bored to death but it was very informative and provided a lot of information that I did not know prior." Another respondent stated "I am very grateful to have the brochures as well as a list of resources to help someone in suicidal crisis. It really does help to have that piece of paper to refer to."

Summit attendees were asked what portion of the Operation S.A.V.E. training they thought was and were not most useful in serving military personnel or Veterans in their community. The majority of attendees felt that all portions of the training were useful (see Table 3). More specifically, they indicated that the education on the levels of stress and suicide awareness, role playing skills and resources were most useful. Additionally, one respondent stated that they helped "three non-National Guard members."

In terms of the Partners in Care Summit attendees' perceived knowledge and self-efficacy related to Operation S.A.V.E. training, survey respondents at three months more strongly agreed with perceived knowledge and self-efficacy with a slight decline at six months, an expected temporal decline. As indicated in Table 2, the items that had the greatest comparative change were "I know what to say to someone who I think may be considering suicide," and "I am relatively comfortable talking to someone who I think may be considering suicide."

Eighteen month follow-up interview. When respondents were asked if there was anything that they would like other faith organizations to know about Operation S.A.V.E. training, the most salient responses (six of eight) indicated the training was valuable with comments such as: "All faith based leaders need to be educated and ready to deal with suicide," "Suicide prevention training is important for clergy. Who else to better save these souls," "…we as clergy should not be afraid to talk about it." Three participants indicated the training taught them about suicide skills that could translate to their congregation and the general public, "it is one thing to give instructions but it is different when you are in a particular situation." One attendee indicated that knowing the signs and symptoms of suicide did allow for an intervention

with a teen within the congregation and the rest indicated they knew of no suicides, attempts or ideations. Two indicated interest in more in-depth training for the future.

Table 3. *Usefulness and support for Operation S.A.V.E.*

Questions	3 months (n=46)	6 months (n=20)
If any, what portions of the Operation S.A.V.E. training do you think have been most useful in serving military personnel or Veterans in your community?		
All	13	8
None, Unknown, N/A	9	0
Have not used	4	4
Levels of stress and suicide awareness – Education	9	5
Role Play skills	6	5
Resources	5	3
Communicating at times of crisis – Emergency Intervention	3	0
If any, what portions of the Operation S.A.V.E. training do you think have NOT been most useful in serving military personnel or Veterans in your community?		
None	41	17
Giving wrong impression about stopping someone from committing suicide	2	0
Role Play	1	0
Presenters ran out of time	1	0
Wasn't very helpful	1	0
What characteristics of your church or congregation have supported the use of Operation S.A.V.E. training skills?		
All	0	1
None, unknown	21	4
Veteran Outreach	1	2
Veteran members	2	1
Elder providing prevention counseling or referral	2	0
Refusal to answer	1	0
Have not implemented	3	0
Implemented	4	0
Community/congregation awareness	2	5
Motivation and support of members	5	4
Haven't used training yet	3	3
Other	4	2
If any, what characteristics of your church or congregation make it difficult to use Operation S.A.V.E. training skills?		
None, unknown	27	14
Need for more training	9	0
Time and resources	1	0
Knowledge and comfort level to discuss suicide	3	0
Implemented – Just getting started	1	0
Members against military/war	1	0
Congregation is large	1	0
Lack of need for assistance	1	2
Rural location, or small membership	3	2
Other	2	1
No answer	3	1

Discussion

The purpose of this study was to evaluate the impact of the Operation S.A.V.E. suicide prevention training as reported by National Guard chaplain trainers and Summit trainees. The majority of National Guard chaplains and Summit attendees saw value in the open discussion of suicide and the training of suicide identification and referral skills, but there are significant lessons learned from the evaluation of this Operation S.A.V.E. training. Although there were joint meetings between government departments partnering to provide the initial trainings, there was no plan for continued collaboration or sustainment of Operation S.A.V.E. trainings. Our evaluation indicated that, post-training, National Guard chaplains did not endorse the need for continuing the VA training program, mentioning the National Guard's own version of suicide training and other programs that provide various types of suicide prevention activities. This points to a need to ensure that when conducting a suicide prevention training that you work closely with your partners to increase the possibility of sustaining the initiative. Community leaders may benefit from continued guidance on ways to transfer the knowledge gained and resources identified to families within the organizations they represent. A second lesson learned is that not all geographic locations may perceive the same need for suicide prevention and suicide prevention efforts. Some National Guard chaplains indicated that the suicide crisis had been resolved and there were more pressing issues for them to focus on or that other National Guard programs handled suicide prevention, while others indicated continued outreach was needed.

National Guard chaplains informed us, during attempted data collection on number of referrals, that they are not required to and are sometimes discouraged from keeping documentation on referrals or time spent talking privately with military personnel. This lack of data collection limited the project evaluation and the interpretation of the results. Therefore, results have been reported based on the data available but may not represent the scope to which the National Guard chaplains provided links to resources and assistance.

Summit attendees, on the other hand, indicated that the skills learned were transferable in order to assist people in their own lives and that they felt more confident after having the Operation S.A.V.E. training experience. As noted by one respondent, "the knowledge of suicide prevention practices for Veterans and military personnel can be translated into suicide prevention efforts for all individuals." As people are more aware of the signs and symptoms of suicide and have gained insight into strategies for intervening, they may be more likely to assist in times of crisis.

Data indicates that Summit attendees and the organizations they represented wanted to assist Veterans, military service members, and their families but did not know how. There was limited if any further contact with the National Guard chaplains, and no referral reported by any of the respondents. Although the facilitation of the Summit was well received and the event itself was reported to have been motivational for the support of military service members, Veterans, and their families, there was limited follow-up on its impact for suicide prevention or the continuation of suicide training. But it should be noted that a limitation to this study was the decreased participation by Summit attendees throughout the evaluation process. Therefore, the data may not represent the full scope of the attendees.

Members of the VA, DoD, and general population either have known or currently know people who have a mental illness as it occurs in all cultures, races, and geographical locations. Given that suicide is the 10th leading cause of death in the United States (NSSP, 2012), there is a need for suicide prevention efforts in all communities for all the general public. The National Strategy for Suicide Prevention (NSSP, 2012) encourages the integration and coordination of suicide prevention activities across multiple public and private sectors, specifically federal agencies. One strategy is to sustain and strengthen collaborations of federal agencies to advance suicide prevention. The National Strategy for Suicide Prevention also encourages increasing the knowledge of factors that offer protection from suicidal behaviors and that promote wellness and recovery. As we begin to destigmatize help seeking behaviors, acknowledge that mental illness and suicide are not exclusive to any culture or sub-culture, educate about mental health, and begin to engage the community in the support for our military service members, Veterans, and their families, we in turn save lives. Therefore, by governmental agencies collaborating to build a multifaceted campaign to prevent suicide among military service members and Veterans, the efforts translate to address the public health suicide crisis by creating awareness, providing skills, and normalizing the discussion of suicide symptoms. Additionally, once empowered with skills and confidence that they can assist individuals in suicidal crisis, rural faith leaders can use their trust within the community to address suicide and potential prevention efforts.

Increasing community awareness about suicide, teaching skills to identify suicidal risk and education on what to do in the event of a suicide crisis are strategies for saving lives. These strategies are beneficial for rural dwelling military and Veteran families given the limited mental health services available. Results of this study indicate the acceptability of Operation S.A.V.E. suicide prevention training as one method in a public health approach to reducing suicide in the nation, but in doing so there needs to be greater emphasis put on the goals of the training programs, the purpose of the evaluations, and the methods used to evaluate the program development and implementation. Participants should be aware this is an introduction to the signs and symptoms of suicide. Participants would need additional follow-up trainings to be more inclusive of suicide among ethnic and racial groups, geographic locations, genders, and sexuality, as the military includes all these sub-groups within its culture.

Additionally, although individuals reported high retention of knowledge three months after training their responses decreased at six months. Thus, this pilot study suggests that successful program adoption requires more than a one-time training. Further research is needed to determine how government agencies can collaborate with local communities and states as a public health approach to suicide prevention and the support of military personnel, Veterans, and their families. For continued efforts to decrease suicide, additional research will be needed to understand the suicide from the perspective of diverse populations so that treatment and prevention are effective for individuals from various ethnic populations and minority groups.

Clinical Implications

The information gained from this evaluation indicates that faith-based leaders could be a support for Veterans and military personnel at risk for suicide. Although the NG Chaplains did all identify the need for Operation S.A.V.E training, they did identify the value of providing greater support for Veterans and military personnel through there ministries. Using these lessons

learned could prove valuable in communities interested in building supportive networks for Veterans, military personnel, and their families. Additionally, for Operation S.A.V.E could be a resource for those communities with high rates of suicide and need for prevention.

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Integrating Religion/Spirituality: An Effective Treatment Modality for Veteran Women Post Trauma

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Abstract

The United States military has seen an increase in women serving on active duty status. Exposure to combat or sexual trauma increases the risk of being diagnosed with posttraumatic stress disorder and other mental health disorders (Kelly et al., 2008). Religion and/or spirituality have a unique role for women in healing from trauma (Briggs & Dixon, 2013). The purpose of this article is to highlight how religion and/or spirituality can help women who have experienced trauma within the military. This article will emphasize the importance of pastoral counseling, and how counselors can collaborate and best meet the needs of women within the military. Implications for counselors to consider along with tools and treatment modalities appropriate for this population are also discussed.

KEYWORDS: women veterans, religion, spirituality, trauma, military

Over the past two decades, the expansion in women serving within the active duty branches of the U.S. military has increased tremendously. This increase comes in the wake of three major conflicts for the United States: Operation Iraqi Freedom, Operation New Dawn in Iraq, and Operation Enduring Freedom in Afghanistan. To date, women encompass 14.3% of the active duty populations and 12% of combat Veterans who have deployed since 2001 (Rivera & Johnson, 2014). Subsequently, the exposure to combat has created a significant influx in mental health conditions for women who serve during conflict eras. Thus, women display higher rates of

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psychiatric disorders while in combat (Rivera & Johnson, 2014). The purpose of this article is to highlight the effectiveness of religion and spirituality in healing servicewomen post trauma. This will be accomplished through discussing military trauma and women, the influence of religion and spirituality with trauma and women, the role of pastoral counseling within the military, along with specific therapeutic tools and treatment for counseling practice.

Military Trauma and Women

Posttraumatic stress disorder (PTSD) among Veterans is correlated with exposure to combat and sexual trauma (Kelly et al., 2008; Rivera & Johnson, 2014; Woodhead, Wessely, Jones, Fear, & Hatch, 2012). Since the prevalence of military sexually trauma (MST) is substantially higher among women Veterans (Burgess, Slattery, & Herlihy, 2013; Katz, Cojucar, Behesti, Nakamuar, & Murray, 2012; Kelly et al., 2008; Kimerling et al., 2010), it is critical that counselors understand evidence-based treatments for PTSD in women Veterans. According to Burgess et al. (2013), "1 in 5 women and 1 in 500 men are reported to have experienced some form of MST while in active military service" (p.21).

In counseling settings, women Veterans diagnosed with posttraumatic stress disorder (PTSD) often demonstrate difficulty in maintaining healthy interactions within interpersonal relationships (Katz, Cojur, Douglas, & Huffman, 2014). In addition, women Veterans present with mental health symptoms associated with both anxiety and depression. Research demonstrates that holistic wellness based approaches that highlight spiritual implications are effective in meeting the unique mental health concerns of women veterans. Katz et al. (2014) conducted a study with 119 women Veterans with complex issues that included military sexual trauma and PTSD. The treatment intervention consisted of an integrative psychotherapy program that included a holistic approach to healing (Katz et al., 2014). Meaning and purpose were one of the themes addressed in the 12-week psychoeducational groups (Katz et al., 2014). The results of this study rendered a low attrition with only a 13% dropout rate, and 60% of the participants experienced a significant reduction in PTSD symptomatology (Katz et al., 2014).

Religion/ Spirituality and Trauma

Several studies present the significance that both religion and spirituality demonstrate in the effective recovery from various types of trauma (Bawa & Chadha, 2013). Notably, research shows that secure relationships with a higher power increase effective coping skills in managing stressors related to trauma (Bawa & Chanda, 2013; Werdel, Dy-Liacco, Ciarrocchi, Wicks, & Breslford, 2014). Reports on trauma indicate that over 90% of the adult population will encounter at least one traumatic experience throughout their lifetime (Enlow, Egeland, Carlson, Blood, & Wright, 2014). Incidentally, nearly 20% of women will develop posttraumatic stress disorder (PTSD), yet much higher rates exist within minority, lower economic income, and military populations (Enlow et al., 2014; Gore-Felton et al., 2013; Katz et al., 2012). Interpersonal symptoms of PTSD include avoidance, lack of trust, and feelings of detachment from others (American Psychiatric Association, 2013). This type of psychological trauma can impact an individual on both psychological and spiritual domains (Bawa & Chadha, 2013; McIntosh, Poulin, Silver, & Holman, 2011; Sigmund, 2003; Wimberly, 2011; Zenkert, Brabender, & Slater, 2014).

Moreover, the effects of trauma often lead individuals to seek religious and spiritual support in managing psychological symptoms. Through traumatic experiences, some individuals may explore existential questions and are more apt to partake on a search for meaning and purpose (Bawa & Chadha, 2013; McIntosh et al., 2011; Zenkert et al., 2014). In processing new information some may experience spiritual or religious growth, often referred to in the literature as posttraumatic growth, while others may experience spiritual or religious crisis (Zenkert et al., 2014). Posttraumatic growth occurs in changes: in the perception of self, relating to others, and philosophical changes that include spirituality (Werdel et al., 2014).

Religion/Spirituality and Women

Studies indicate that women are more apt to engage in more religious and spiritual practices than men (Livingston & Cummings, 2009; Williams, Jerome, White, & Fisher, 2006). It is noted that women express experiencing spirituality as a deeper level of love where a divine connection is sensed during behaviors such as mothering, social justice activities, and nurturing self and others (Briggs & Dixon, 2013). In counseling settings, women often use narratives to explore religious meanings and spiritual connectedness (Briggs & Dixon, 2013; Williams et al., 2006). Therefore, targeted interventions such as genograms, art expressions, spiritual practices, and addressing roadblocks are instrumental tools in supporting women's narrative as they unfold their spiritual journey (Briggs & Dixon, 2013). Moreover, religion and spirituality demonstrate a unique role for women in the resolution and healing of trauma. Thus, counselors who understand this phenomenon can provide support in helping women reach a place of genuineness and connectedness with themselves and others around them.

Pastoral Counseling in the Military

The United States Chaplaincy has been an integral part of the U.S. Armed Forces since 1775 when it was created by the Continental Congress (Besterman-Dahan, Gibbons, Barnett, & Hickling, 2012). A chaplain's role in the Armed Forces is to provide religious and spiritual support for military members and their families. Chaplains are trained to address spiritual and religious, healthcare, and pastoral needs (Bulling et al., 2013). Military chaplains have become a part of mobile Combat Operations Stress Control Teams, which provide acute care for combat stress in places such as Iraq and Afghanistan. While deployed, chaplains serve as a medium between mental health care providers and service members who lack access or hesitant to seek treatment.

Service members are more likely to first access a chaplain rather than a mental health provider (Bulling et al., 2013). Branches consider communication with a chaplain "privileged communication." Privileged communication is defined as any information that is considered confidential (Corey, Schneider-Corey, & Callanan, 2011). Service members find privileged communication regarding mental health issues helpful if they are concerned about the negative connotation it could bring to their career (Bulling et al., 2013).

The importance of collaboration between chaplains and mental health care providers has been identified, yet research has shown it is lacking and can be improved (Besterman-Dahan et

al., 2012; Bulling et al., 2013; Nieuwsma et al., 2014; Wester, 2009). Collaboration can occur in various ways, such as offering training for chaplains focused on mental health issues, as well as, offering training for mental health care providers from the VA and DoD that can be transferred across disciplines and highlights the varying degrees of confidentiality (Nieuwsma et al., 2014).

Implications for the Counselor

As a counselor, there are important factors to consider when working with service women. Chaplains are often the service members' first line of defense, and sometimes, the only mental health option when in combat. Due to privileged communication upheld by chaplains, many service members feel more open to discussing mental health concerns with chaplains, as chaplain services may serve as a protective barrier against potential negative consequences to their military careers. Therefore, providing integrative mental health services that include collaboration between counselors and chaplains, serves as a holistic approach when treating service members who have experienced trauma.

Spirituality and religion have shown to be significant areas of importance for service members. When engaged in spiritual or religious activities, service members feel valued due to the nature of engaging with others within a spiritual or religious, and social capacity (Bryan, Graham, & Roberge, 2015). Research demonstrates that when service members have a spiritual or religious relationship, it positively impacts their overall well - being and ability to cope (Chang, Skinner, & Boehmer, 2001). Spirituality and religion is a buffer to depression for military service members returning from war (Hourani et al., 2012). In fact, risk factors for those associated with depression and posttraumatic stress disorder (PTSD) were found to be "female, younger age, non- Hispanic, junior enlisted pay grade, avoidant coping behaviors, and moderate to high combat exposure" (Hourani et al., 2012, p.4). Overall, spirituality and religion were found to have a positive impact on depressive symptoms and a buffer to depression and PSTD with low combat exposure for service members in the military.

As a civilian counselor, it is important to learn and grasp military culture. To date, there is still a significant amount of stigma attached to seeking behavioral health services within the military. Having the ability to identify the risk factors associated with depression and posttraumatic stress disorder (PTSD) increases the overall quality and effectiveness of mental health treatment. Thus, understanding the significant role of religion and or spirituality in helping restore a sense of purpose and meaning is pivotal in aiding service members heal from trauma.

Effective Therapeutic Treatments

With heightened awareness to effectively incorporating religion and spirituality into mental health practices, researchers have developed viable alternatives to traditional therapeutic approaches. Therefore, traditional methods have been enhanced to incorporate a holistic approach to treatment. Spiritually augmented cognitive therapy is a treatment method that integrates spiritual values and cognitive behavior therapy (Verghese, 2008). Cognitive restructuring, problem-solving, hope, forgiveness, and discovering meaning and purpose are key therapeutic elements (Verghese, 2008). Choice theory/reality therapy has been noted by counselors as relatively congruent with Christian beliefs and values (Dettrick, 2004). The

concept of free choice is an existing biblical theme, which supports reality therapy's basis for total behavior (Dettrick, 2004). Though, reality therapy is not a Christian process; it is highly adaptable to exploring Christian views in therapy (Dettrick, 2004).

Formal Assessment Tools

Currently, the Veterans Administration (VA) instruments that aid in assessing for trauma related to deployment do not emphasize the constructs of religion or spirituality (United States Department of Veterans Affairs, 2015). Highlighted, are assessment tools that have demonstrated effectiveness with identifying spiritual and religious concerns with clients who have experienced trauma.

Assessment tools that focus on understanding the client's spiritual and religious values assist the counselor in gaining insight in areas of both strength and growth for the client (Gill, Harper, & Dailey, 2011). Briggs and Dixon (2013) noted spiritual genograms are helpful when working with women. A spiritual genogram is a visual map of a client's current and past familial patterns related to spirituality and religion. This intervention can be useful to identify various factors such as complex relationships, knowledge of family history, and relevance of client's spiritual or religious domain or clinical issues (Gill, Harper, & Dailey, 2011). The genogram can start during intake as an assessment and continue to be revisited to add or review during the counseling process. Spiritual genograms can serve several purposes such as helping a client to identify religious or spiritual relationships impacting self or provide a narrative for their story.

Religious and or spiritual quantitative assessment tools have also demonstrated effectiveness when working with clients who have experienced trauma. The Multidimensional Measure of Religiousness/Spirituality for Use in Health Research (MMRS, 1999) is a tool that assesses 12 key dimensions of religiousness/spirituality as they relate to physical and mental health outcomes (Fetzer, 1999). A Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) was developed from select questions from each domain of the MMRS. Currier, Holland, and Drescher (2015) used the BMMRS assessment within their research study when examining the integration of spirituality and religion with Veterans. The purpose of the study was to find empirical evidence that supported the need to address spiritually and religion as both preventive and treatment interventions for individuals who have served in the military. Currier et al. (2015) found three spiritual and religious facets of character: connection to others, relationship identification, and a hopeful outlook. Spirituality and religion moderately correlated to age, rank, spirituality, gender, education, and having children (Currier et al., 2015). The researchers combined a Veterans Administration initiative and questions from the MMRS to meet the needs of the study and the veteran population.

Veterans and current military personnel make up 18% of all suicide deaths in the United States; there is an estimate of 18-22 veterans who die by suicide each day (Centers for Disease Control and Prevention, 2014). Identifying risk for suicide is essential for counselors in treating the military population. The Spiritual Distress Scale (SDS) is a highly used instrument in assessing suicide risk among service members (Kopacz, Hoffmire, Morley, & Vance, 2015). In an exploratory study, Kopacz et al. (2015) examined the ability of the SDS to identify Veterans at risk for suicide. It was noted, that when chaplains assist with the formal assessment of suicide,

spiritual assessments (SA) are also completed. SA's are surveys that assess the spiritual and religious needs of Veterans (Kopacz et al., 2015). Five questions based on the presence or absence of guilt, sadness or grief, anger or resentment, despair or hopelessness, and feeling that life has no meaning or purpose are incorporated within the SA's at an in and outpatient setting with chaplaincy services. The five questions were found to have high internal consistency, and risk factors for suicide (Kopacz et al., 2015). The four risk factors identified were suicidal ideation, social isolation, legal problems, and reports of unemployment within the past two years before completing the SA. Veterans with higher scores on the SA were more than likely to be identified for a risk of suicide (Kopacz et al., 2015). This assessment can assist the counselor in the diagnosis and development of treatment interventions during the intake process.

Conclusion

There is an increase in women serving on active duty status in the United States military. Women within all branches of the military face potential exposure to combat and or military sexual trauma. Thus, understanding specific treatment approaches that can support the unique needs of women service members are vital. Religion and/or spirituality serve as a buffer for women in coping and managing life stressors. Hence, the counselor's ability to implement assessment tools and treatment approaches that effectively integrate religion and or spiritual are essential to assisting individuals impacted by trauma to achieve optimal healing.

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Balancing Care: Examining Parents' Experiences of Supporting Veteran Children Post-Deployment

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Abstract

Research on the post-deployment experiences of military service members and their families has thus far neglected the perspective and needs of Veterans' parents. The current study proposed to fill this gap by surveying parents of Veterans (N=63) who have served in either Iraq and/or Afghanistan to gain a greater understanding of the challenges and stresses these parents as they help their Veteran children reintegrate post deployment. Overall, the parent sample was a resilient group who provided a variety of supports and tended to use positive coping strategies when dealing with stress. Respondents used emotion-focused coping strategies most frequently, regardless of whether their Veteran child had been injured during deployment. However, a smaller group of parents, those who identified as primary support providers for their Veterans, endorsed symptoms of compassion fatigue. Data indicated that primary support providers experienced more physical, behavioral, and mood problems. Most of these parents also indicated that they support multiple individuals which may exacerbate symptoms.

Keywords: coping, compassion fatigue, social support, stress

The impact of the War on Terror (Operation Iraqi Freedom, Operation Enduring Freedom, Operation New Dawn) on military spouses and children has been a popular focus of

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concern among media, politicians, and educators who often stress the fact that half of deployed troops have been married and are parents (Institute of Medicine, 2013). The flip-side of this fact, which has been sorely neglected, is that nearly half of those deployed have been young and single with close to 20% being under the age of 24 at the time of deployment (Institute of Medicine, 2013). When deployed to a war zone, these young service members often rely on their parents to take care of responsibilities stateside and to provide them with a sense of stability and hope through regular communication (Domenici et al., 2013).

Parents also play an instrumental role in helping their military sons and daughters successfully reintegrate post deployment, regardless of whether their Veteran is single or married. Upon returning home, many troops have problems and need assistance readjusting to civilian life (Sayer, Noorbaloochi, Frazier, Carlson, Gravely, & Murdoch, 2010). Some need housing and financial assistance, whereas others need help in seeking employment or continuing their education (Domenici et al., 2013). Thousands require supportive care and rehabilitation to help with their recovery from disabling physical injuries such as traumatic brain injury (TBI), burns, blindness, hearing loss, amputations, and spinal cord injuries (Fischer, 2013). Regardless of the specific need, parents are there to provide help and support (Domenici et al., 2013).

Additionally, many Veterans return with psychological injuries and/or mental health problems such as posttraumatic stress disorder (PTSD), anxiety, depression, and/or substance abuse (Fischer, 2013; Sayer et al., 2010; Tanielian & Jaycox, 2008). In 2008, the rate of mental health disorders among returning Veterans was estimated to be 37%, up from 6% in 2002 (Litz & Schlenger, 2009; Seal et al., 2009). Further, Veterans have often been reticent in admitting they need help, and are particularly averse to seeking mental health services (Ben-Zeev, Corrigan, Britt, & Langford, 2012). Because of this, family members, and parents in particular, are frequently on the front lines when it comes to identifying problems in their Veteran children and researching/seeking out services to assist them. The fact that parents take on these various responsibilities for their Veteran children highlights the need to better understand the impact taking on such significant roles may have (Hirsel, 2007; US DoD Task Force on Mental Health, 2007).

Parents and family members also provide emotional and social support for their Veteran children returning from deployment, support that has been shown to be a protective factor against the development of posttraumatic reactions following trauma (Ozer, Best, Lipsey, & Weiss, 2008). Given this, understanding the nature and functioning of service member families after warzone deployment is of even greater import.

Although there has been increased attention towards military members' spouses (Mansfield, et al., 2010), children (Chandra et al., 2010), and siblings (Rodriguez & Margolin, 2011), research on parents of military members is still lacking. Young service members and Veterans are a large and high risk group, yet their family and social support issues have received far less attention than have family issues involving military spouses and children. A single qualitative study of parents' experiences during their adult children's deployment found that parents had significant feelings of fear, worry, and concern, which for some, negatively impacted their marriages and overwhelmed their ability to cope (Crow & Myers-Bowman, 2011).

Parents' worries do not end when a Veteran child returns home; they continue throughout the time the Veteran is adjusting to civilian life post deployment (Domenici et al., 2013). That being said, service member parents have received minimal attention with respect to their worries, concerns, and/or experiences supporting their sons and daughters *following* deployments to Iraq and/or Afghanistan. To date, there are no studies examining the post-deployment costs of caring on these parents; costs such as compassion stress and compassion fatigue (Bride & Figley, 2009; Figley, 1995). Nor are there studies describing the strategies parents of military Veterans use to cope with the stress of caring for their children post deployment. The current study proposes to fill this gap by surveying parents of Veterans who have served in either Iraq and/or Afghanistan to gain a greater understanding of the concerns, challenges, and stresses they face. The goals of this study was to gain insight into the experiences of this group of parents as they provide support to their children who are in the process of reintegrating into life away from the war zone; and secondly, to increase our understanding of the physical and psychological impacts caring for Veteran children may have on these parents.

Secondary Traumatic Stress and Compassion Fatigue

Secondary traumatic stress is one potential impact of supporting returning service members post deployment. Secondary traumatic stress, occurs when "caregivers of persons who have directly experienced psychological trauma may themselves become indirect victims of the trauma" (Bride & Figley, 2009, p. 315; Bjornestad, Schweinle, & Elhai, 2014). For example, Barnes (1998) discusses how parents of injured/traumatized children are at risk for secondary traumatic stress. He explains that secondary traumatic stress may occur as the parents are dealing with their child's trauma, and as they are coping with the after effects of the trauma (e.g., physical and emotional changes in their child). Though Barnes (1998) and previous research has focused on parents of younger children, the situations and reactions he describes holds true for parents of returning Veterans, particularly parents whose service member children have been injured and/or suffer from posttraumatic stress. For these parents, secondary traumatic stress can result from just learning about their service member's military experiences while serving in Iraq and/or Afghanistan. Secondary traumatic stress may also manifest as parents support their Veteran children throughout the reintegration process, which includes coping with emotional and behavioral changes in their sons and daughters following deployment (Domenici et al., 2013).

The ongoing impact of secondary traumatic stress combined other stresses related to the care of a Veteran child may lead to compassion fatigue, described as a state of physical and emotional exhaustion resulting from the stress of caregiving (Figley, 1995). The signs and symptoms of compassion fatigue, sometimes referred to as secondary traumatic stress disorder, parallel those of posttraumatic stress disorder (PTSD). However, compassion fatigue results from exposure to, and/or helping, someone who is suffering rather than from experiencing trauma directly. Compassion fatigue, which has been studied most often in professionals, may also be experienced by parents and family members (Figely, 1995; 1998). For example, Day and Anderson (2011) demonstrated the applicability of Figley's (1995) model of compassion fatigue for family caregivers of dementia patients. Their review of the literature shows that informal caregiver's symptoms of compassion fatigue parallel symptoms identified in formal caregivers: hopelessness, helplessness, isolation, apathy, and emotional disengagement. Additionally, Day and Anderson suggest that for those caring for family members with dementia, the consequences

of compassion fatigue may include depression, caregiver burden, caregiver strain, and decreased relationship quality with the person who has dementia.

Parents' compassion for improving their service members' life may lead them to experience similar symptoms and consequences. The stress of taking care of their service members, especially if they are sacrificing their own needs, may affect their own mental and physical health, ultimately putting them at risk for compassion fatigue (Domenici et al., 2013). Importantly, this risk may be moderated by the coping styles and strategies utilized by the parent.

Stress and Coping

As stated above, caring for service members as they reintegrate post deployment is stressful and can take a toll on parents physically, psychologically, and emotionally (Domenici et al., 2013). For parents and others dealing with the stress of caregiving, healthy coping can serve to mitigate stress (Cummings, Greene, & Karraker, 2014). In other words, the strategies parents use to manage the stresses related to supporting their service member sons and daughters affect how much that stress impacts their lives. Moreover, as healthy coping lessens the effect of stress, the use of healthy coping, and positive self-care strategies may also help prevent compassion fatigue.

The transactional theory of stress and coping (Folkman & Lazarus, 1980; Lazarus, 1966; Lazarus & Folkman, 1984) provides a framework for understanding the relationship of stress and coping. In this model, coping is an interactive process between an individual and his/her environment. When a situation, (i.e., the 'environment') is perceived to be stressful and challenging to one's resources/affecting his/her well-being, coping responses are generated to manage the stress. Further, Lazarus and Folkman (1984) describe these coping responses as functioning in one of two ways. Problem-focused strategies are used to control and/or change the stressful situation while emotion-focused strategies are used to manage emotions related to the stressors. Lazarus and Folkman also note that emotion-focused strategies are often employed when the perception is that nothing can be done to change the stressful situation, whereas problem-focused strategies are used when the appraisal of the situation suggests change may occur.

Following Lazarus and Folkman's (1984) conceptualization of problem focused and emotion focused coping, other researchers began to elaborate and expand on these distinctions as they created new measurements for assessing the strategies people use to respond to stress. For example, Carver, Scheier, and Weintraub (1989) identified 15 dimensions of coping as they developed their instrument, the COPE Inventory. Using theoretically identified categories, Carver et al. identified additional aspects of problem-focused coping (e.g., active coping and planning) as well as strategies that are more emotion-focused (e.g., positive reframing and acceptance). Carver et al. made a further distinction and proposed that some coping strategies may be maladaptive. These are strategies that may help ameliorate stress in the short run, such as the venting of emotions and mental and behavioral disengagement, but may be unhelpful and are therefore dysfunctional ways to cope long term.

In addition to the categories and functions of coping identified above, experienced clinicians, stress experts, and others note that regular self-care (e.g., sleeping and eating well, regular exercise) and mind-body practices such as meditation and yoga, may reduce stress and the risk of compassion fatigue (Goyal et al., 2014; Sharma & Rush, 2014; van der Kolk et al., 2014). However, as with the investigation of the impacts of caring for returning Carver et al. Veteran children, no research has investigated the coping strategies used by parents as they deal with the stress of supporting a service member's reintegration post deployment.

Purpose of the Study

Although many parents play a vital role in helping and supporting their service member children during the process of reintegration post deployment, minimal attention has been paid toward understanding the unique sacrifices they make and the assistance they provide. The purpose of the current study was to gain insight into these costs by examining parents' experiences as they support their service member children and by assessing the impact(s) of caring for Veteran children post deployment. To begin, the present study seeks to understand the concerns parents have about their Veteran children who have served in a warzone, especially in regards to the injuries their child may have incurred. Secondly, this research will explore the types of supports parents provide their Veteran children upon their return from deployments in Iraq and/or Afghanistan. Third, this study will begin to identify physical and psychological reactions parents have as they provide support to their Veteran children post deployment, including an examination of whether the impacts are different for parents of Veterans injured during their service as compared to parents of those who returned without injury. Fourth, this study determined the types of self-care and coping strategies used by parents to deal with stress following their Veteran child's return from deployment; again, with an assessment of potential differences between coping strategies used by parents of injured service members compared to parents of non-injured service members. Finally, this study identiford the supports and resources parents use as they care for their Veteran children returning from deployment.

Methods

Survey Development

A comprehensive survey was developed to collect information about the experiences parents have as they support their Veteran children post deployment. Ethics approval for all procedures and measurements was obtained from the institutional review board (i.e., the Human Subjects Research Committee) at Lewis and Clark College. Specifically, the survey was designed to collect both qualitative and quantitative data about the characteristics, concerns, impacts, coping strategies, and types of support provided by parents of Veterans who have served in Iraq and/or Afghanistan. The survey was divided into five sections, the first two of which were demographic questions about the respondents and their Veteran children. Included were questions regarding age, gender, branch and type of military service, and family composition. Additional data gathered on Veteran children included dates of deployment, number of deployments, and current military and employment status.

The next section of the survey was comprised of questions regarding the service member's health following deployment. The focus of this section was on physical and/or psychological injuries the Veterans may have sustained during deployment, the treatment they received, and the concerns parents had regarding their Veteran child's health moving forward. Additionally, as a gauge of other concerns parents may be dealing with, this section included questions about behaviors (e.g., drug and alcohol use, suicide attempts) that may have led to problems for the service members after they returned from deployment.

The fourth section of the survey was a series of open-ended questions about the care that parents provided for their Veteran children post deployment. These questions allowed parents the opportunity to describe, in their own words, the support they provided to their returning Veteran children. This section also included questions about who, if anyone, besides the respondent was providing care and support for the returning Veteran.

The last section of the survey was devoted to examining the physical and psychological impacts of caring for Veteran children and also the coping and self-care strategies parents utilized to deal with stresses they had experienced since their child's return from Iraq and/or Afghanistan. The coping and self-care questions in this section included items from the Brief COPE (Carver, 1997) which is described in more detail below, as well as examples of other self-care activities (e.g., vacations, hobbies, yoga). The survey ended with questions about resources that parents found helpful and/or could have used as they cared for their returning Veteran.

Instruments

Brief COPE. The majority of items from the Brief COPE (Carver, 1997) were used to measure the coping strategies used by parents of returning Veterans. The Brief COPE is a shortened version of the COPE Inventory (Carver, Scheier, & Weintraub, 1989), a multi-dimensional inventory developed to identify and evaluate coping strategies used in response to stressful situations. The Brief COPE is a 28-item questionnaire that assesses fourteen different types of coping strategies including acceptance, positive reframing, venting, and self-blame. The Brief COPE has been shown to have good internal consistency reliability (Carver, 1997), as well as convergent and concurrent validity (Cooper, Katona, & Livingston, 2008).

Items from the Brief COPE measuring humor as a coping response were not used in this survey. Additionally, one item was created to assess overall support rather than using the four items from the instrumental and emotional support scales of the Brief COPE.

Cooper, Katona, and Livingston (2008) further grouped items from the Brief COPE into three subscales: emotion-focused, problem-focused, and dysfunctional coping. The emotion-focused coping scale includes acceptance, positive reframing, religion, and support (emotional and instrumental). The problem-focused scale includes active coping and planning. The dysfunctional coping scale includes behavioral disengagement, denial, self-distraction, self-blame, substance use, and venting. They tested the validity and reliability of these subscales by interviewing dementia patients' caregivers three times (by one-year intervals) over two years. The findings indicated that the three subscales have good internal consistency, test-retest reliability, and construct validity. Following the procedures identified by Cooper and colleagues

(2008), we computed three similar subscales of coping strategies: an emotion-focused scale, a problem-focused scale, and a dysfunctional coping scale.

Procedure

Online data was collected from summer 2013 through fall 2014. A paper-pencil copy of the survey was also given to persons attending the Blue Star Moms conference in July 2013. A link to the survey was also sent to military support organizations, with a request to post the link on their websites. The request included a short description of the study along with the specification that their child had been deployed in Iraq or Afghanistan during the current conflicts.

Participants

Participant characteristics. Sixty-three persons completed the survey, most of whom were women (89%). Participants ranged in age from 40 – 81 with more than half (54%) in their fifties. Two mothers and four fathers had themselves served in the military and another thirteen had spouses who had served in the military. Just over two thirds (69%) were married or involved in a partner relationship (two divorced and remarried, one divorced and partnered, one separated); the average length of their marriages was just under 24 years. Almost two-thirds of the participants (62%) reported being married for twenty years or longer.

Participants' Veteran children characteristics. Fifty-eight parents answered questions regarding their Veteran child. Only one parent had a daughter who had served in Afghanistan, the rest of the participants had sons who had been deployed. The range of ages of service member children was from 18 – 53, with a mean age of 28.88. Forty (63.6%) of the returning Veterans were reported as continuing to be on active duty, 41 (65.1%) were reported to be employed, 7 (11.1%) were unemployed, and six (12.7%) were identified as students.

Age related characteristics. As several demographic characteristics of the Veteran children varied by their ages, we created three age categories to illustrate these differences: "emerging adults" (ages 18-25), "young adults" (ages 26 – 30), and those "over 30." Sixteen (27.6%) of the returning Veterans were emerging adults; another 25 (43.1%) Veterans were young adults; and 17 (29.3%) were over 30.

Eighty percent of the Veterans considered to be emerging adults were single compared to 29% of the young adults and 13% of those over thirty. In contrast, 67% of the Veterans who were over 30 were married, while only 29% of the young adults and 20% of the emerging adults were married. The young adult group had the largest percentage of persons who were divorced (33%) compared to 13% of those over 30. None of the emerging adults had been divorced at the time of the survey.

Warzone deployments. All of the Veterans in the sample had deployed at least once; their deployments had been to both Iraq and/or Afghanistan. As would be expected, the average time they had served in the military as well as the average number of deployments increased with age. Sixty-seven percent of those identified as emerging adults had only been deployed one time,

while 61% of the young adults had been deployed two or more times and 43% of those over 30 had been deployed 3 or more times.

Warzone injuries. Overall, half of the respondents indicated that their child had been injured during their deployment with 34.5% reporting that their son/daughter had received a physical injury and 65.5% reporting that their son/daughter had received both physical and psychological/mental health injuries. Of the 19 parents who reported their child receiving both physical and psychological/mental health injuries, 17 reported that their child had PTSD, one reported that the child had combat stress related issues, and one did not describe the type of injuries their child had received. Nine Veterans had a disability rating determined by the VA which ranged from 50-90%.

Age was also related to whether the Veteran had been injured or not. At the time of responding to this survey, 6 of the 16 (10%) Veterans under 25, 16 of the 24 (27.5%) young adult Veterans, and 7 of the 17 (12.1%) of those over 30 had been injured during deployment.

Results

Concerns Regarding Impact of Injury

Qualitative findings. Ninety percent of the parents whose children had been injured reported that they had concerns about their son/daughter related to their injury. Generally speaking, the concerns were regarding their children's quality of life, either related to current quality of life or what their quality of life would be in the future. One parent commented on that directly by stating: "Is this going to affect his quality of life?…;" while others stated "as he grows older medical problems will be worse, it will affect his ability to work the kinds of jobs he can do…;" and "he has chronic pain due to back injury. This will be a lifetime problem. Also shows signs of PTSD."

All of the parents whose children had received a psychological injury and/or had mental health problems in addition to their physical injuries reported that they had concerns about their son/daughter. Examples of these concerns include: "…but more importantly getting the mental health care that he needs to help him deal with the mental/emotional issues;" "how he is coping, his mental health since being back, his aggressiveness since being back, his sleeping, his eating;" and "the help and support is not there for these guys. My son is hyper alert, even after almost one year at home. Quick to anger and makes poor financial decisions."

Quantitative findings. When parents were asked about any potential problems/behaviors that their Veteran had engaged in during the year following deployment, alcohol use and expression of anger were the behaviors seen most often by parents. Fifty-eight percent reported their son had used alcohol once a week or daily and 32% reported their son exhibiting anger once a week or more. Five parents reported that their child had attempted suicide "once or twice." All five had been injured during deployment with one sustaining a physical injury and the other four sustaining physical injuries and psychological injuries.

A multivariate analysis of variance (MANOVA) was conducted to determine if there were any differences in the frequency of problem behaviors based on whether or not the returning Veteran had received a physical injury, received both a physical and psychological injury, or was not injured during deployment. A significant multivariate effect was found between having received an injury during deployment and engaging in problem behaviors (Wilks's $\Lambda = 0.600$, $F_{(10, 84)} = 2.45$, $p < .05$). Those with both physical and psychological injuries were reported to have engaged in almost all of the problem behaviors more often than either of the other two groups. However, follow-up univariate analyses showed that the only significant difference between groups was in the frequency with which anger was being expressed by those with both physical and psychological injuries.

Following the questions about problem behaviors, parents were also asked whether engaging in those behaviors had impacted their child's life. Responses were based on a 5-point scale where 1 = "not at all," 3 = "somewhat," and 5 = "extremely." Approximately two-thirds (67.7%) reported that engaging in these behaviors had impacted their child's lives at least somewhat. As with the frequency of engaging in problem behaviors, there were significant differences in life impact between groups based on injury status of the returning Veteran ($F = 5.76$, $p < .001$). Parents of Soldiers who had sustained both a physical and psychological injury reported that engaging in the problem behaviors had impacted their child's life significantly more ($M = 4.14$, $SD = 1.10$) than either those who had received only physical injuries ($M = 2.75$, $SD = .78$) or had not been injured during their deployment ($M = 2.67$, $SD = 1.58$).

Support Offered by Parents

Parents were asked about the types of support they gave their returning Veteran children and also whether they considered themselves to be the primary source of support for those children. Of the 56 persons responding to the question, 14 (25%) reported being the primary support for their child while 42 (75%) did not consider themselves their child's primary source of support.

Many of the parents were supporting other people in addition to their returning Veteran. For example, one participant reported supporting "a disabled son who is 28 (his brother) and my 92-year-old mother." Another reported "my husband is disabled (has multiple medical problems), I care for our 7-year-old niece, I have health issues as well, with lesions on my brain. Our 21-year-old son is out of work...again..." Further examples included "caring for elderly (89 and 92-year-old) parents," and "our daughter who has cerebral palsy." Seventy-nine percent of those who reported being the primary source of support for their returning Veteran children were also supporting others at the same time. In contrast, only 34% of those who did not consider themselves to be their child's primary source of support reported caring for other people in addition to their Veteran children.

Types of support provided. Forty parents answered the open-ended question regarding the types of support they provided for their returning Veteran children. Responses were analyzed thematically to identify the type and/or types of support parents were providing. Using House's (1981) conceptualization of social support as a framework, each response was then coded to identify whether the parent had provided emotional support, instrumental support (also called

tangible support) and/or appraisal support. Emotional support includes feeling of love, trust, respect and care. As one parent reported: "I, as his mother, am his confidant, I try very hard not to be negative, just to listen and try to help him get through whatever caused him to have a panic attack or what caused the problem that he was so angry about that he needed to get away." Instrumental support is defined as offering practical and material assistance, such as spending time together, financial support, doing household chores and grocery shopping, and so forth. For example, one parent stated: "my husband gets him to his medical appointments and assists with his VA disability claim. I assist him with keeping track of his appointments, going online with issues he needs to do such as banking and taxes and I also help supervise him with daily tasks such as cooking, laundry, and shopping." Informational support is conceptualized as providing information or advice based on one's expertise. For example, one parent disclosed "...try to guide him in the right direction to get any support he may need..." Finally, appraisal support is providing feedback for one's behaviors or performance which included responses like "…just try and tell him I think he has PTSD."

Sixty-five percent of those responding provided instrumental support to their Veteran and 57.5% provided emotional support to their Veteran. Less than 10% of parents provided appraisal support for their Veteran and a similar percentage reported that their child didn't need or would not accept their support. Looking at the percentages more closely we found that a greater percentage of parents who are their child's primary source of support provided instrumental support (85%) for their children compared to those who are not the primary source of support (57%). In contrast, a non-significantly greater number of parents who were *not* the primary source of support reported providing emotional support for their Veteran than those identifying as the primary support providers (60% vs. 50%).

Physical and Psychological Reactions Due to Being a Support

As with previous questions, participants were asked both qualitative and quantitative questions to assess the associations between physical and mental health effects of providing support to a child who had returned from deployment in a war zone. Qualitative questions included items such as "if you provided care to your child following his deployment, please describe how this has impacted you?" and "have you had any personal health problem(s) that you were facing either during or after your child's deployment?" To quantitatively assess the impact of supporting their Veteran children, parents were asked to respond to items regarding their physical and mental health (e.g**.,** anxiety, sleep problems, depression) on a Likert scale ranging from (1) 'not at all' to (5) 'daily.'

Qualitative findings. Forty-nine percent of respondents reported experiencing some sort of physical health problem before or after their child's deployment. Although a fairly high percentage of health concerns were reported, not all of these health concerns were necessarily related to the Veteran's deployment. Responses to this question included "…an emergency surgery and six weeks hospitalization began the night of his first welcome home party" and "yes, but nothing related to his active duty. I have had some small skin cancers removed, cataract surgery, and dental problems. Normal stuff."

Twenty-six parents reported mental health problems/issues such as anxiety, depression, increased substance use, and sleeplessness. Responses included: "…it has had an effect on my sleep, my eating, my anxiety. I rarely consumed alcohol prior but since I consume alcohol on a more regular basis." Several responses were related to the amount of stress the parents were feeling, such as "very stressful… walking on eggshells. Helpless feeling," and "it has impacted me negatively making life even more stressful," and "stressful...but it's my job, I'm his mom..."

Quantitative findings. A multivariate analysis of variance (MANOVA) was conducted to evaluate the behavioral, emotional, and physical effects of being the primary support provider for a returning Veteran. The MANOVA was significant (Wilks's $\Lambda = .611$, $F_{(10, 33)} = 2.36$, $p < .05$). The partial eta square ($\eta^2 = .39$) indicates a large effect between being the primary support provider and physical and emotional symptoms. In all cases those who identified as the primary support provider for their Veteran child indicated that they had experienced the symptoms more often than those parents who were not the primary source of support (see Table 1). Specifically, in terms of emotional impacts, primary support providers reported experiencing depression, anxiety, and anger significantly more often than those who were not the primary source of support. Primary support providers also experienced physical impacts such as sleep problems, nightmares, and fatigue significantly more often than non-primary support providers. Finally, primary support providers reported using alcohol more frequently than those who were not the primary source of support.

Table 1. *Physical and Psychological Effects on Primary and Non-Primary Support Providers*

	Primary Support Providers		Non Primary Support Providers			
Variable	*M*	*SD*	*M*	*SD*	*F*	*P*
Sleep Problems	4.36	1.08	3.21	1.57	6.25	.016*
Alcohol Use	2.86	1.70	1.65	1.252	7.47	.009*
Fatigue	4.07	1.21	2.94	1.60	5.67	.021*
Anxiety	4.14	1.41	3.29	1.45	3.47	.069
Depression	3.64	1.69	2.32	1.59	6.58	.014*
Anger	3.07	1.59	1.88	1.09	8.90	.005*
Headaches	2.79	1.58	2.38	1.50	.70	.408
Jumpiness	2.07	1.49	1.97	1.40	.05	.825
Nightmares	2.93	1.59	1.79	1.18	7.48	.009*
Change in Appetite	3.29	1.68	2.62	1.81	1.41	.242

Note. $N = 52$. *indicates significance with a $p<.05$. Between-subjects multivariate analysis of variance (MANOVA) performed.

Coping Strategies and Self-Care Used by Parents

Overall, the participants' utilized emotion-focused coping strategies more often than other types of coping strategies. They also reported that they attended services and/or engaged in personal spiritual practice more than other self-care activities. In contrast, dysfunctional coping strategies, practicing Yoga and receiving counseling/mental health services were the least likely

activities to be engaged in by the participants. The means and standard deviations for each type of coping and self-care strategy/activity are presented in Table 2.

Table 2. *Coping and Self-Care Strategies*

Strategy	Mean	SD
Brief Cope Strategies		
Emotion-Focused Strategies (Overall)	2.59	.80
Problem-Focused Strategies (Overall)	2.27	.92
Dysfunctional Strategies (Overall)	1.61	.51
Emotion-Focused Strategies		
Acceptance	2.77	1.10
Receiving Support from others	2.65	1.10
Positive Reframing	2.29	.94
Religion	2.73	1.11
Problem-Focused Strategies		
Active Coping	2.37	.99
Planning	2.20	1.10
Dysfunctional Strategies		
Behavioral disengagement	1.25	.51
Denial	1.24	.61
Self-distraction	2.13	.83
Self-blame	1.67	.85
Venting	1.75	.83
Additional Self-Care Strategies		
Education	2.08	1.18
Receiving Counseling/Mental Health Services	1.61	1.00
Vacation	1.83	.83
Practicing Yoga	1.38	.67
Exercising	2.54	1.09
Hobbies	2.33	1.17
Online Support	1.84	1.11
Attending Religious Services +/or Engaging in Spiritual Practice	2.63	1.24
Receiving Appropriate Medical Care	2.34	1.17

Note. $N = 52$. SD = standard deviation. This table represents the coping strategies used by all participants.

Differences in coping strategies used. A repeated measures ANOVA was used to evaluate (a) whether there were differences in the coping strategies used by parents whose children were injured and those who were not injured and (b) whether participants were more likely to utilize one type of coping more than others. The repeated measures ANOVA revealed a significant within subjects effect for type of coping strategy used (Wilks's $\Lambda = 0.936$, $F_{(10, 84)} = 2.45$, $p < .05$). However, there were no significant differences between the coping strategy used and whether the Veteran had been injured.

Three paired-samples *t*-tests were performed as post hoc follow-ups to ascertain which copings strategies were used most often by parents of Veterans, regardless of injuries (see Figure

1). The first two paired-samples *t*-tests found that emotion-focused coping strategies (M = 2.60, SD = .80) were used significantly more than either problem-focused (M = 2.27, SD = .92) or dysfunctional coping strategies (M = 1.60, SD = .51) ($t_{(51)} = 3.10$, $p = .003$); ($t_{(51)} = -8.95$, $p = .000$ respectively). The third *t*-test indicated that problem-focused strategies were also used significantly more than dysfunctional coping strategies ($t_{(51)} = -5.84$, $p = .00$).

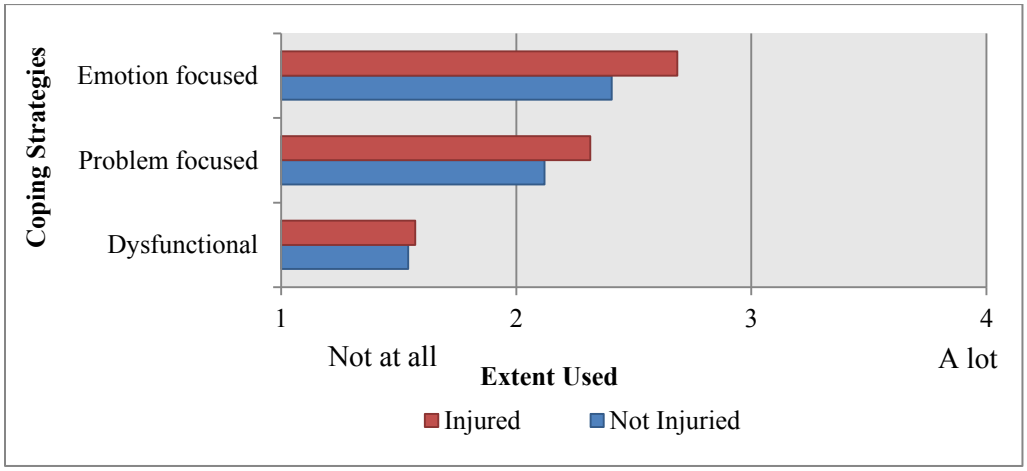

Figure 1. Brief-COPE Subscale Scores for Parents with Injured and Non-Injured Veterans

Differences in use of emotion-focused strategies. Fisher's Exact Tests were performed to assess whether parents of injured Veterans were more likely to use specific types of emotion-focused coping strategies than parents of Veterans who were not injured. Results showed that parents of injured Veterans practiced acceptance coping strategies (77.8% v. 48.0%) much more than parents of non-injured Veterans ($p = .026$). All other types of strategies did not differ between groups (see Table 3).

Table 3. *Brief-COPE Subscales and Strategies Utilized (Cooper, Katona, & Livingston, 2008)*

Emotion-Focused (NI v. I)	Problem-Focused (NI v. I)	Dysfunctional (NI v. I)
Acceptance (48% v. 78%)	Planning (44% v. 56%)	Behavioral Disengagement (8% v. 4%)
Positive Reframing (48% v. 56%)	Active (56% v. 60%)	Denial (8% v. 7%)
Religion (64% v. 60%)		Self-Distraction (44% v. 44%)
		Self-Blame (20% v. 31%)
		Venting (20% v. 33%)

Note. $N = 52$. NI = parents of non-injured Veterans; I = parents of injured Veterans; percentages based off dichotomous rating of "using coping strategy at least minimally" or "did not use coping strategy"; does not include substance use, emotional support, or instrumental support; all percentages rounded up.

Supports and resources used by parents

The participants were asked which resources they found helpful for their own self-care (utilized resources) as well as what resources were absent, but would have helped to assist in their own self-care (desired resources). A total of 47 participants responded to the question

regarding which resources were utilized and a total of 37 participants responded to the question regarding desired resources.

The question of utilized resources was thematically coded into three themes: social support, which included 36 responses; individualized resources, which included 12 responses; and informational/educational resources, which included 4 responses. Five responses from participants were put into a category for not applicable and two were categorized as none/nothing. The total count for each theme's category was tallied by the number of times it was mentioned by participants. If the same answer was mentioned multiple times by one participant, that particular theme was only counted once.

Within the social theme, several categories such as professional care services (5 responses), family, friends and talking (8 responses), and community groups (24) were included. Community/groups had the highest number of responses. This category contained responses about different online and in-person groups, specifically groups like the Blue Star Mothers organization and other organized groups intended for parents of Veterans. Professional care services included responses about mental health professionals and medical professionals. Meeting with and having conversations with friends and family members was categorized as family, friends, and talking.

The individualized resources theme consisted of exercise and meditation (4 responses), spirituality and prayer (5 responses), and self-reliance (3 responses). The informational/educational resources theme was composed of reading and education (4 responses). Those who cited spirituality and prayer commented on "God" and/or prayer. This differed from those who referenced "church/church groups" which was coded into the social category of community and groups. Many participants reported that reading literature around the topic of military families as well as self-help books were useful. Meditation and exercise were explicitly stated in four different answers, though no context as to whether this was in group or individual settings was indicated. Three people said that they primarily relied on their own strength.

The question of desired resources was coded into five themes. The counting system for these themes was identical to the question regarding utilized resources as explained above. The themes included: greater information and communication (5 responses), professional care (6 responses), community/groups (6 responses), not applicable/unsure (8 responses), and other (2 responses). Greater information and communication included access to legal and medical resources as well as greater communication with the military service. Professional care primarily included the option of mental health counseling. People who wanted community/groups to be available were focused on specialized groups with people who have gone through similar experiences. Five participants said they either did not know what could be beneficial or said nothing else would be beneficial besides what they already had access to. The category of "other" included having money in savings and "toughing it out."

Discussion

The purpose of this study was to gain a better understanding of the experiences parents have caring for and supporting their Veteran children following deployment(s) in Iraq and/or Afghanistan. We focused on several aspects of parental experiences including the concerns they have for their Veteran children, the types of support they provide, how they cope, and the physical and psychological impacts of caring for and supporting a returning Veteran.

Parental Worries, Parental Support

Taken as a whole, parental worries and concerns revolve around their Veteran children's readjustment and reintegration following deployment. Their responses mirror, in many ways, other studies on adjustment and re-integration issues for Soldiers deployed in Iraq and Afghanistan (Britt et al., 2008; Burnett-Zeigler et al., 2011; Institute of Medicine, 2013; Sayer, Noorbaloochi, Frazier, Carlson, Gravely, & Murdoch, 2010). For example, 58% of the respondents reported that their Veteran children are using alcohol once a week or more and 28% reported that their children are having problems with anger once a week or more. Parents of Veterans who had received both physical injuries *and* had PTSD and/or other mental health issues reported that their child exhibited problems with anger significantly more often than the parents of non-injured or solely physically injured Veterans. These parents also reported that engaging in risky/problem behaviors (e.g., alcohol use, drug use, gambling, unsafe driving, etc.) had a significantly greater impact on their child's life than the parents of non-injured or physically injured Veterans.

Parents of service members who had been injured during deployment have ongoing concerns about the impact of the injuries. Parents are particularly concerned about their child's current and future quality of life, their ability to work, and the long-term effects of the injuries. For parents whose children were injured both physically and have PTSD and/or other psychological injuries, the concerns also include worries about their child's ability to cope and the specific manifestations of PTSD such as anger, flashbacks, and withdrawal. A few of these parents also voiced concerns about whether their children were receiving the mental health services they needed.

Care and Support. Returning Veteran parents help their service members in a variety of ways during the transition back to stateside life. Parents reported providing both tangible support (e.g., financial help, transportation, provide a place to live) and emotional support (e.g., listening, providing a safe space, being available when needed) to their children. Interestingly, those who were not the primary supporters provided emotional support more often than primary supporters. Additionally, one quarter of parents considered themselves to be the primary source of support for their service members.

Impacts of Caring

Coping. Parents in this sample used emotion-focused coping strategies (e.g., acceptance, positive reframing, religion, support from others) to deal with stresses related to their Veteran children significantly more often than problem-focused coping strategies and/or dysfunctional

strategies. These findings parallel and extend to post deployment the qualitative findings of Crow and Myers-Bowman's (2011) study on the experiences of parents whose children were currently deployed. Crow and Myers-Bowman found that 47% of parents reported using spirituality or faith as a way of coping and 28% relied on informal social support systems to help cope while their children were deployed. These findings show that parents continue to use faith, spirituality and social support for dealing with the stresses that accompany their child's return from deployment and reintegration.

Acceptance. As stated above, the parents in this sample used emotion-focused coping strategies more often than other types of coping strategies; these strategies were used whether their child had been injured or not. Looking at emotion-focused strategies individually, however, we found that parents of injured Veterans utilized acceptance (i.e., accepting "the reality of a stressful situation;" Carver et al., 1989, p. 270), more often than parents whose children had not been injured. Carver and colleagues' conceptualization of acceptance posits that it is a functional coping response, one that is especially important for those situations when the "stressor" must be adapted to and/or adjusted for, such as having a child injured during wartime service. The use of this strategy by more than three quarters of injured Veteran's parents, while not surprising, speaks to their strength and resilience and underscores their ability to move forward and adapt to the new circumstances of their child's life.

Physical and psychological effects. Although parents use positive coping strategies to deal with stresses related to their Veteran children, the findings also show that caring for service member children post-deployment had physical, psychological, and in some cases financial impacts on many parents. The qualitative responses from the participants revealed that more than 60% of the parents experienced a personal health issue and almost 50% had experienced some kind of mental health issue such as worry, anxiety, depression, and/or chronic stress either during and/or since their child's deployment. Three (5%) parents reported that there was a heavy financial impact of caring for their son/daughter. The quantitative results show similar physical/psychological effects with more than 60% of parents experiencing sleeplessness and/or fatigue once a week or more and 50% experiencing anxiety once a week or more. The impact of caring is even more apparent on those who are the primary source of support for their Veterans. Compared to those who are not the primary source of support, this subgroup of parents experienced physical and emotional symptoms including fatigue, alcohol use, sleep problems, depression, anger, and nightmares significantly more frequently.

These physical and emotional effects parallel compassion fatigue symptoms (Day & Anderson, 2011; Newell & MacNeil, 2010) and suggest that some of the parents who are primary support providers may be at risk of developing compassion fatigue. Day and Anderson (2011) contend that dealing with many life demands may be a factor in the development of compassion fatigue in informal caregivers. Given that the great majority (85%) of primary support providers are also supporting other family members, it is possible that these multiple, competing pressures are compounding the risk for these parents.

Resources and Supports

Overwhelmingly, the resources parents found helpful were those that provided them social support and connection: organizations and community groups for military families such as the Blue Star mothers, churches/faith communities, friends and family, on line support groups, and/or professional help and support such as counseling. Many parents also identified their own faith and/or prayer as a resource that helped them. A few reported that their strongest resource was themselves.

However, some parents felt that they did not receive enough support either during or after their children's deployment, findings that reflect other research describing gaps in resources available to Veterans and barriers to accessing those services (Britt et al., 2008; Crow & Myers-Bowman's, 2011; Institute of Medicine, 2013). The disparity in available services only grows when one considers that the parents of Veterans do not have access to the same services that their Veteran children and/or their "immediate" family members do (Institute of Medicine, 2013). This lack of resources suggests that the needs of parents of returned Veterans remain unidentified and/or are being overlooked by military-related family support programs. As some of the participants indicated, frustration with communication(s) from the many different military organizations and institutions, another explanation may be that that access to and availability of services is poorly communicated to parents.

Of particular note are the findings regarding mental health services. Although many parents reported that they found mental health services important and wished services were available, very few reported utilizing counseling for themselves or their children. Many factors may account for this, including the reticence of service members and military families to share their feelings/problems (Armstrong, Best, & Domenici, 2006; Ben-Zeev et al., 2012); to not knowing what services are available and/or how to access these mental health services; to the cost of counseling/therapy from well-trained professionals. Advocacy is needed within the mental health provider community to ensure that parents are aware that mental health services are beneficial and available – if not from the VA or other military organizations, then from non-profits offering free services to service members *and* their families (e.g. Returning Veterans Project of Oregon & SW Washington).

Limitations

The limitations of this study are primarily related to the size and characteristics of the sample. The relatively small sample size was partially due to the difficulty of contacting parents of Veterans. The sample size could be increased in the future if researchers are able to send study announcements through the VA and/or other military email networks.

The characteristics of this sample may also limit the generalizability of these findings. To begin, many of the respondents came from the Blue Star Mothers of America. Given that one of the purposes of this organization is to provide support for military mothers, these respondents may feel they have more support than other military parents. Having more support may have been a factor in the resiliency observed within this group. For these reasons, this sample may not be representative of military parents in general.

An additional limitation was the breakdown of gender in both the respondents as well as their Veteran children. The majority of the responses received were from mothers of Veterans. Responses a mother provides may differ from those of a father, particularly given societal gender norms, roles, and ideals. Secondly, it would have also been beneficial to receive more responses from parents of daughters who served in the military. While the overwhelming majority of Veterans are male, a comparison of Veteran gender differences in respect to their resulting post-deployment needs and the impact upon parents would be valuable.

Implications for Counseling/Counselors

First and foremost, there is a need for greater awareness within the mental health community and general population about the challenges parents of Veterans' face. Counselors and other mental health professionals need to understand and recognize that deployment not only affects the psychological well-being of the Soldier, it also affects their parents and other family members. As one respondent stated:

> I wish the military recognized that families are impacted by deployment. Not just spouses of the service members, but parents and siblings as well. We suffer before, during, and after. I would love to receive post-deployment family counseling. I wish there were someone to talk to that could tell me if what I'm seeing is normal. To help us deal with our own PTSD issues."

Specifically, it is essential that counselors receive training to understand that parents may experience secondary traumatic stress from the experience of having their child serve in a warzone and that they may continue to be impacted both physically and psychologically when their child returns home. Further, if one is to work with parents, understanding the stresses they face as they support their Veteran children also means receiving training about the issues facing Veterans themselves (e.g., re-integration issues, the impact of physical injuries and/or symptoms, behaviors associated with mental health concerns such as PTSD), as providing support to parents necessarily includes providing them with accurate information regarding re-integration issues and deployment-related mental health concerns.

Finally, as stated above counselors should be aware that for some parents, the stress of supporting Veteran children may lead to compassion fatigue (Domenici et al., 2013). These findings suggest that this risk may be increased for parents who are the primary source of support for their Veteran child. These parents, who are often supporting other family members in addition to their Veteran child, are often under great strain. For counselors working with these parents, it is important to understand the multiple demands, and to stress the importance of self-care strategies including social support to a mitigate against the impact of stress and ideally prevent the development of compassion fatigue.

Conclusion

Overall, the parents in this study were a resilient group, one that provides valuable support to their Veteran children as they struggle to reintegrate and cope with deployment-related injuries. Further, parents utilized positive coping strategies to deal with their own stresses

associated with their child's deployment and re-integration. However, for some parents, providing ongoing care and concern for their Veterans has had an impact on their physical and emotional health. Mental health and other health care providers need to be aware of the needs and stresses military parents face to ensure that these parents also receive the support and care they deserve.

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Supporting Military Spouse Graduation Rates through Specialized Institutional Support and Authentic Appreciation

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Abstract

The purpose of this qualitative descriptive research study was to seek participant experiences in order to capture the essence of the experiences of military spouses in an online college program. In this article, the results of two research questions that were asked via a survey are provided, along with the descriptions of a meaningful collegiate experience, which is followed by a discussion, implications, and suggestions for future research. As a whole, the findings from 120 completed surveys revealed that financial support and connection are most important to military spouses as they pursue higher education.

KEYWORDS: military spouses, higher education, online college programs

A shift has occurred in our country regarding the way military families are viewed. This has resulted in a new awareness of the needs of these families and the amount of support required to keep our volunteer force at strength (Drummet, Coleman, & Cable, 2003). With the draft no longer in place and more females volunteering to serve, the needs of all family members have risen to the forefront. Providing greater opportunities for military spouses to gain an

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education is just one of the many changes being initiated to improve the quality of life for military families.

The number of military spouses eligible for post-secondary tuition remission is vast. This is due to the Post 9/11 GI Bill, which allowed the transfer of GI Benefits to the spouses and family members of U.S. Veterans (U.S. Department of Defense [DoD], 2009). On August 1, 2009, nearly two million military spouses and family members became eligible for higher education benefits. According to Carter (2010), more than a half million service members applied for this benefit, one year after it went into effect. The benefit was used by 300,000 to enroll in higher education (White House, 2010). This has led to many colleges and universities making the needs of this unique population a priority (Ford, Northrup, & Wiley, 2009). Successful recruitment of military spouses and their retention requires an understanding of best practices in serving military spouses who are most deserving of an education (Brown & Gross, 2011).

Along with transferred GI Benefits, military spouses are also eligible for grants through the Department of Defense (Gleiman & Swearengen, 2012). It is predicted that this will result in an increase in military spouses seeking online education in the future (American Council on Education, 2011). In order to best serve these students, it is imperative that adequate supports be implemented to assist military spouses as they seek to reach their educational goals. Military spouses are experts at understanding and articulating their educational needs. The aim of this qualitative study was to discover what university supports were most meaningful to military spouses in pursuit of an online degree.

Students are seeking online education at increasing rates (Allen & Seaman, 2007). This is not only true for the general population but for military personnel and their spouses alike (Ford, Northrup, & Wiley, 2009). In order to foster student success it is imperative that universities study the needs of military students to improve the quality of the program and services available to the students. It is further recommended that universities foster programs that are flexible and show appreciation to military students.

Although spouses of military personnel face unique challenges, they are committed to pursuing their education (Education & the Military Spouse: The Long Road to Success, 2007). A study in 2006 found that 87% of military spouses have a personal goal of attaining education and training (Department of Defense, 2006). More recent data was obtained from the 2012 Survey of Active Duty Spouses which indicated that 43 percent of military spouses expressed an interest in attending school (Defense Manpower Data Center, 2013). One of the educational barriers faced by military spouses is the challenge of completing a degree prior to their family's next relocation assignment. Online educational offerings allow the pursuit of the military spouses' goals of degree attainment without the risk of interruption of studies from a required move.

Another barrier alleviated by online education is childcare. Institutions of higher learning can best support military spouses by creating policies that are flexible, being open to life challenges, and helping military spouses find the support services needed to be successful in an online program (Gleiman & Swearengen, 2012). A final Department of Defense report given in 2009 at the National Leadership Summit on Military Families stressed the importance of faculty

being culturally sensitive to the needs of this exclusive population without giving special treatment (Booth, Segal, & Place, 2009).

When military spouses pursue their own education the personal benefits are immense. The gains reported include a sense of control, a new identity, and a support system made within the educational community (Gleiman & Swearengen, 2012). As they pursue their own education, military spouses find comradery amongst themselves and an awareness of the unique needs of the group to which they belong. They desire to be heard and possess knowledge that is invaluable to educational institutions.

One model drawn upon to inform programming in higher education is the learning partnership model (Wilson, 2005). This model is based on the assumption that knowledge is complex, socially constructed, and impacted by one's identity. The construct of knowledge is gained by learners and teachers sharing their expertise and authority. This theory sets the stage for learning experiences that foster self-authorship and a teaching approach which validates the student's capacity for learning. This grounded theory supports the need for flexible educational programs that promote cognitive and relational maturity, active citizenship, and an integrated identity.

Military spouses are adult learners who bring to the classroom life experiences that shape their learning. By fostering a sense of community among these learners, college advisors who understand this population can make a positive impact on the military's spouse's educational experience (Gleiman, & Swearengen, 2012). A large mixed methods study was conducted by the RAND Corporation to better understand the needs of this unique population. The findings indicated that when compared to their civilian counterparts, military spouses often had young children, lived in cities and had some college experience. This group also consists of more racial and ethnic minorities who have come from long distances to relocate (Harell, Lim, Castaneda, & Golinelli, 2004).

A surprising finding was that military spouses who are working in the same city as non-civilian spouses earned a lower wage. When comparing the unemployment rate, military spouse's rates were higher. The reported barriers to seeking a post-secondary education included the frequent moves required by military families and the work schedules of the service member (Harrell, Lim, Castaneda, & Golinelli, 2004). It's important that educational programs for military spouses be offered in a format that allows for distance learning and that fees do not increase if the learner moves out of state.

Starr-Glass (2013) recommends that faculty of online courses remove stereotypes when teaching learners who are actively involved in the military. These stereotypes, when persistent block the ability to create the responsive learning environment necessary for online learners (Shea, Vickers, & Hayes, 2010). It is important for the online instructor to be aware of the culture of the military and the individual experiences of each learner. Though the spouse may be the only one on active duty, the entire family plays a role in the service to our country (Starr-Glass, 2013). As such, this impacts the educational experience of the online military learner.

Method

Overview

The researchers utilized a qualitative descriptive study design to understand military spouses' experiences in a private, online education program. A qualitative descriptive design was deemed most appropriate for this study in order to describe participants' experiences in their own words (Sandelowski, 2000, 2010). The two-fold aim of qualitative descriptive research is to: (a) provide a description or re-presentation of participants' experiences, and (b) deepen our "understanding of human experiences and events that are not commonly described or adequately understood" (Willis, Sullivan-Bolyai, Knafl, & Zichi-Cohen, 2016, p. 13). Moreover, the results generated from the qualitative descriptive design provided "a basis for the transformation of taking richly described ideas, themes or concepts from participants and developing them into pragmatic educational or behavioral interventions" (Willis et al., 2016, p. 16).

The researchers gathered data that described specific information pertaining to online education programs, and then a research team organized, tabulated, and described the data collection. Information was gathered via online surveys that asked participants to provide narrative descriptions, and then researchers began the coding process. Standards of quality were addressed through researchers' immersion in the data, and frequent member checks during data analysis. In addition, the use of rich, thick descriptions of participants' experiences supported by their own words contributed to maintaining the standards of quality in qualitative research.

Role of the Researchers in Study Design and Data Analysis

It is important to note the roles of each of the four researchers involved in this study: Ester, Katie, Laurel, and Lori. Ester's role was primarily focused on the qualitative analysis of the data. In qualitative research where the researcher is the human instrument, a critical component of the process is bracketing. Bracketing is the careful reflection upon and reporting of "potential sources of bias and error" (Patton, 2015, p. 58) that may influence data analysis. Ester was eager and excited to join the research team and to serve as the human instrument in the study of supporting military spouses in online education. Her career as an administrative faculty member and adjunct instructor of an online undergraduate program has provided her with numerous opportunities to interact with military spouses in the online program. One of the first reactions she has when she think of military spouses is an overwhelming sense of gratitude for their family's service and sacrifice. Hence, she approached this study with the expectation that she was taking part in something that had the potential to uncover new information that could be used to help a much deserving population.

Katie's role also heavily focused on qualitative analysis of the data. Katie was excited to participate in the data analysis as she identifies as a military spouse herself, and seeks innovative ways to incorporate learning opportunities for military spouses. Katie did not have personal experience with online education programs, but her husband did while serving. Katie is interested in learning more about online teaching and pedagogy to insure that rigorous programs are available to those who experience high mobility. Throughout the coding process and during research team meetings, Katie journaled about her reactions to the data.

Laurel (along with a colleague) designed the research study and questions. She then obtained approval from the Institutional Review Board before working with the military affairs office to send the electronic survey out to military spouse students who had graduated the week before the survey was sent out. Laurel has completed educational programs via traditional and online methods while a military spouse, and had a vested interest in learning more about other military spouses in order to improve the process for those who have sacrificed so much.

Lori's role included completing a thorough search of the literature to find the gaps regarding the topic being researched. She has not worked with military spouses or had any pre-conceived notions about their experiences in online education. Once data was collected she reviewed the raw data, and then expanded the literature review. After the data analysis was completed she reviewed the code books and themes. Bracketing was used to journal her thoughts as the research process continued. Collaboration with the team of researchers continued throughout the process and was instrumental to the research design.

Trustworthiness

Two researchers began the conceptualization process by reviewing transcript responses, moving through each research question and responses line by line. Categories were created based on participant responses via individual code books. Then, consensus coding was created as was a condensed codebook. Further, a research team was formed to process assumptions and uncover biases, and trustworthiness was maintained. The research team held debriefing sessions to discuss perceptions, alternative approaches to data analysis, and to provide a sounding board for data interpretation. Finally, the two researchers who analyzed the data engaged in bracketing by recording reflective memos throughout the analysis stage.

According to Lincoln and Guba (1996), there are four aspects of trustworthiness in qualitative research: credibility, dependability, transferability, and confirmability. Credibility of a qualitative study can be established by using various data collection and verification methods, prolonged engagement, peer debriefing and expert review, and member checks by study participants. In the current study, researchers spent a significant amount of time analyzing the data. In addition, researchers participated in regularly scheduled peer debriefings. Dependability was established by maintaining a written audit trail and reflective memoing. The use of rich, thick descriptions of the qualitative study establishes transferability, providing readers with the opportunity to decide for themselves whether the findings can be transferred from one setting to another. The current study includes detailed descriptions of participants' responses as evidenced by the use of "strong action verbs, and quotes" (Creswell, 2013, p. 252). In order to establish confirmability, the researchers kept written audit trails and reflective memos to record the decision-making processes that were employed throughout the study.

Participants and Data Collection

An online survey was distributed to military spouses who graduated in the spring of 2015. A total of 1,811 military spouse graduates were invited to participate, with a total of 140 military spouse graduates starting the survey and 120 completing the survey. Only two of the participants were male. Regarding age, mean and median were both 40 and mode was 29. Ten

participants were completing a Doctoral degree, 55 were completing a Master's Degree, 44 were completing a Bachelor's Degree, 21 were completing an Associate's Degree, eight were completing a Certificate, and two degree programs are unknown. The mean GPA is 3.45, the median GPA was 3.55 and the mode was 4.0. Of those who completed the survey, 60 had spouses currently serving in the military (48 active duty, seven National Guard, and five reserves). After reading and responding to an informed consent form along with providing some basic demographic information, participants answered three opened ended questions:

1. How has this university supported you in your educational pursuit?
2. How could this university have supported you better in your educational pursuit?
3. As you reflect on your experiences at this university, please describe one meaningful experience you've had.

Data Analysis

The raw data from the participants' responses to the three open-ended survey questions was saved to a Microsoft Excel spreadsheet for analysis. Two members of the research team independently conducted qualitative content analysis to manually code the raw data line-by-line in Microsoft Excel. Elo and Kyngas (2007) described content analysis as "a method of analyzing written, verbal or visual communication messages" (p. 107) with the purpose of describing a phenomenon in a condensed yet broad manner. Content analysis provided the systematic approach needed to code and categorize the large amount of text into smaller categories (Elo & Kyngas, 2007; Vaismoradi, Turunen, & Bondas, 2013). These categories were then grouped into higher order headings to arrive at condensed descriptions of the phenomena.

In the current study, there were as many as 118 responses per question with a combined total of 347 responses. Microsoft Excel software was employed to store and organize the data. According to Saldana (2013), Microsoft Excel provides "excellent organization with individual cells holding thousands of entries and their accompanying codes" (p. 26). Raw data from the three open-ended questions was initially saved to a single Microsoft Excel worksheet.

The first researcher created a separate worksheet for each open-ended question prior to initial coding. The second researcher began coding by hand before creating separate worksheets for each research question. The first worksheets created contained raw data. Each row was assigned a case number and contained participants' responses to the three questions, one column per question. The second worksheet contained responses to question one and included the following columns: Case #, Initial Code(s), and Researcher's Memo. The third and fourth worksheets contained responses to questions two and three, respectively, and included the same columns as the second worksheet. The Researcher's Memo column in worksheets two through four provided analysts with a space to document analytic decisions via reflective memoing throughout the coding process. Memoing served as an audit trail for the current research. Following initial coding, higher level categories were created by collapsing similar codes. The two sets of higher level categories were compared against each other for consistency, then presented to the other two members of the research team for review.

Results

The initial (structural) coding phase was completed through the process of structural coding, in which the initial raw data was reviewed by two researchers. Researchers built series of codes inductively through data analysis. Initial descriptive coding for Research Question One yielded 45 codes from 118 responses. There was often more than one code applied to the same passage or sequential passages of text, which resulted in a total count of 256 codes. Open coding was followed by axial coding, thus the 256 codes were regrouped into 45 codes identified in the code list. Initial descriptive coding for Research Question Two yielded 43 codes from 112 responses. There was often more than one code applied to the same passage or sequential passages of text, which resulted in a total count of 55 codes. The 55 codes were then grouped into the 43 codes identified in the code list. Finally, the initial descriptive coding for Research Question Three yielded 63 codes from 117 responses. There was often more than one code applied to the same passage or sequential passages of text, which resulted in a total count of 172 codes. The 172 codes were then grouped into the 63 codes identified in the code list.

The following 14 categories were constructed during second cycle or pattern coding to decipher what participants deemed as supportive in their educational pursuit: Financial, Advising/Support Staff, Emotional, Professors, Flexibility, Communication, Spiritual, Personal Growth, Academic, Classroom Presentations/Assignments, Activities for Military Families, Formal and Traditional Ceremonies, Face to Face Meetings, and Gratitude for Service. Then, six categories were identified as ways in which educational institutions can better support online learning: Advising and Program Offerings, Personal Connections, Financial Incentives, Professors, Documentation, and Employment Assistance. The following eight codes were participant responses regarding meaningful experiences: Financial, Advisors, Online Learning, Graduation, Spiritual, Military Events, Community Building/Friendships, and Academic Rigor.

Then, the labels were grouped into larger categories or themes. These metacodes were used to identify aspects of specific ways in which military spouses felt supported in their online education: (a) personal connection, which included encouragement, activities, formal and traditional ceremonies, spiritual, and communication; (b) monetary support which encompassed various forms of financial assistance; (c) intrinsic factors such as personal growth; and (d) staff support such as academic guidance, assistance, and flexibility. The following metacodes were created to share military spouses' thoughts on how educational institutions could better support educational pursuits: (a) foster partnerships through required content meetings, formal gatherings; (b) employment of culturally inclusive persons; and (c) future planning in which participants noted that employment assistance would have been appreciated. Finally, the following metacodes describe meaningful experiences of participants' online educational pursuits: (a) academic support such as financial assistance, knowledgeable advisors, and flexibility via online learning format; (b) events that provide opportunities for community building such as graduation, appreciation; and (c) inclusion of spirituality.

Current Support

Participants in the current study reported that they felt most supported in their educational pursuit when they were provided with additional financial assistance. Further, spouses seeking

post-secondary education also appreciated university/institution funded financial assistance. One spouse commented: “The military program and discounts have helped a great deal eliminating the financial burden.” A second spouse said, "Just the opportunity to return to college and be able to afford tuition is the greatest blessing.” And a third spouse stated: “The tuition rate discount and book vouchers made it affordable to continue my educational pursuit.” Several participants expressed similar sentiments. Further analysis of the data from this study encompassed the significance of holistic support where educators provided academic, spiritual, emotional, and social support. One participant mentioned: “Each class had a section on the blackboard where we can request for prayers and support. Link for prayer support. The professors were very supportive in providing us encouragement.” Referring to academic support, another participant commented: “Professor[s] are very encouraging and understanding, always providing positive criticism as well as [feedback] on assignment[s] which has help[ed] me improve in the areas I struggle.” Participants reported that the majority of employees and faculty displayed flexibility. Participants reported that the flexible nature of courses equated to faculty support in attaining educational goals. One participant shared that “the flexibility of completing course[s] online at my convenience regardless of my current location is priceless. The professors are willing to understand and accommodate overseas irregularities such as internet challenges, time zone differences, and field experience scheduling.” Another spouse stated, “The teachers are very understanding on the issues that occur in the military world and gave grace on due dates.” Additionally, participants reported feeling connected and supported by professors, advisors, and support staff. One participant reported receiving “wonderful encouragement from academic advisors and staff. Advisors calling to see if I have questions or need anything. Great professors who always offer support and encouragement.”

Ideas for Additional Support

Participants indicated that their university could better support military-connected students pursuing post-secondary education in several ways: financial support, emotional support, academic support via flexibility, creating space for connection among peers, and providing opportunities for students to engage in experiential activities. Interestingly, participants reported that they were supported as the university seemed to focus on the importance of hiring knowledgeable employees and provided additional financial assistance, yet the vast majority of participants also indicated that more financial assistance would have equated to more support. One participant expressed a desire to see “more grants, to allow cost to be even lower.” Another participant believed that flexibility would be appreciated, "I believe sometimes, when our spouses deploy, a little 'wiggle room' on extended deadlines would be appreciated," and a third participant echoed that, "during PCS (permanent change of station) moves be flexible with assignment due dates."

Meaningful Experiences

A main theme that emerged through analysis was that of connection. Participants reported that they felt most connected to their online learning experience when able to attend special military events sponsored by the university. Many participants mentioned the military spouse ceremony as particularly meaningful. For one participant, “it meant the world to be recognized by the school.” Another participant appreciated that the university "provided

webinars that I could participate in to gain information about how to care for my Veterans," and another participant liked when the university "informed [students] of its military programs and activities throughout the year for service members and their spouses." Participants stated that they appreciated professors' willingness to create space for community/relationship building within courses as friendships made were meaningful. One participant described making numerous friends, and mentioned one in particular who is a professor: "She went above and beyond what was expected from a professor. She made her students feel appreciated, cared for and as if they mattered." Additionally, participants indicated that spiritual support and space to express spiritual needs was meaningful. One participant loved "how the professors constantly encouraged and even asked for prayer requests. They were very understanding and great teachers." Attendance at the graduation ceremony was particularly meaningful. One participant described attending graduation as very meaningful, exciting, and welcoming:

> I could not believe how welcoming the entire campus was. Also, seeing the other graduates, especially all that were graduating with Master's degrees, made me even more determined to further my education and I am now considering going for my Master's after I complete my Bachelor's degree. I cannot wait to come back to the campus in two years when I receive my Bachelor's, and I am hoping to come back sooner possibly for Homecoming.

Discussion

This study sought to identify existing supports that are embedded in higher education institutions for students seeking online degrees as well as identify additional supports needed to aid in student success and degree attainment. Finally, researchers sought information on meaningful experiences. Results indicated that knowledgeable and compassionate academic advisors, faculty, and support staff were instrumental in navigating online programs and degree attainment. The second most important form of support was feeling connected, building relationships with others in the class, speaking of spiritual connections, or attending face to face activities. The third most mentioned form of support was financial assistance that was offered via tuition discounts, book vouchers, military benefits, and waived fees.

In terms of additional support, participants indicated that institutions could better support the educational pursuits of online learners by employing knowledgeable advisors, compassionate professors, and by offering more financial assistance. More specifically, participants indicated that advisors should be familiar with specific degrees or fields of study, and professors could be more flexible and understanding when it came to due dates and deadlines. Timely responses and consistent feedback were also noted as critical in supporting students enrolled in online courses. Furthermore, participants reported that scholarships for individuals wanting to earn graduate degrees would have aided in educational pursuits. This finding supports the idea that Gleiman and Swearegen (2012) introduced in that the GI Bill (and other government funding) drastically increase the number of military spouses able to seek post-secondary education. Thus, participants indicated that employment of individuals who understand the GI Bill and are familiar with additional funding sources was pertinent to their feeling supported. For example, faculty and staff can help military spouses seek grant monies funded by the Department of Defense (Gleiman & Swearengen, 2012). The American Council on Education (2011) reported that additional funding may increase military spouses seeking online education.

Furthermore, Mackenzie, Fogarty, and Khachadoorian (2013) found that online courses are most successful when deemed military centric. Higher education institutions can best support military spouses by creating policies that are flexible, account for life challenges, and assist military spouses in finding the support services needed to be successful in an online program (Gleiman & Swearengen, 2012; Mackenzie et al., 2013). Moreover, universities with online student populations need to consider student perspectives and seek feedback on programming, support, and experiences (Mackenzie et al., 2013). The 2009 Department of Defense Report, given at the National Leadership Summit on Military Families, stressed the importance of faculty being culturally sensitive to the needs of this exclusive population without giving special treatment (Booth, Segal, & Place, 2009). Mackenzie and colleagues (2013) reported that self-paced programs increased completion rates in online programs. Participants reported that the university could have better supported educational goals better by providing further financial support/assistance to help cover books.

Overwhelmingly, the most meaningful experiences reported by participants were feelings of connectedness with faculty, staff, and classmates. This increased sense of community and togetherness in an online format lead to individual feelings of accomplishment, which in turn increased feelings self-confidence and consequently, degree attainment. The findings showed that perceived sense of community among participants played an important role in helping these military spouses master course material when immersed in environments where change is constant which is consistent with Castaneda and Harrell (2008) who reported that military spouses would benefit from access to childcare, increased awareness of employment programs, and information pertaining to licensure and reciprocity.

Additionally, when professors foster safe learning environments where peers are encouraged to connect social support is naturally facilitated (Whiteman et al., 2013). Therefore, student connections to other military spouses or professors/staff were positively correlated with successful experiences. A sub-theme to feeling connected was identified pertaining to course content and material. Students requested more access to experiential learning, veering away from the banking model and working towards social constructivism (Freire, 1993). Participants specifically requested that professors incorporate more role-playing activities and experiential learning.

Strengths and Weaknesses

This qualitative study utilized a team of researchers from different universities who collaborated through conference meetings. Data analysis was completed by two researchers who triangulated the data after multiple cycles of coding. Trustworthiness was increased by the researchers independently coding the data and then collapsing their code books. This increased the reliability of the findings (Armstrong, Gosling, Weinman & Martaeu, 1997).

Through an online survey rich qualitative data was collected by a larger pool of participants than is typically found in qualitative research studies (Mason, 2010). The online survey afforded the participants the convenience of answering the questions at their chosen place and time without concern of interviewer bias. The participants were seeking various levels of education from a certificate program to a doctorate degree. They were all successful as indicated

by their grade point average. The findings however may not be transferable to students in other educational institutions.

Many factors determine the sample size needed for qualitative inquiry (Morse, 2000). While uncommon for a qualitative study, 120 participants completed the online survey. This large number of participants was manageable because the data was collected through an online survey. The responses to the three open ended questions were brief, which aided in data analysis. The narrow aim of the study allowed for data saturation to come more quickly during the analysis phase. This strength was also found to be a limitation. While the online survey provided the participants anonymity as they shared answers to three open ended questions, the absence of an interview did not allow clarification or elaboration of the participants' responses.

The limitation of the sample must also be considered when generalizing the findings to online learners. The response rate was less than seven percent; however, online surveys have been found to have a lower response rate than other means of surveying participants (Fan & Yan, 2010). Incentives were not offered to participants though they have been found to increase the response rate in survey data collection (Erwin & Wheelright, 2002). Another limitation was the homogeneity of the participants. All but two participants were female. This is representative, however, of the group being studied as the number of military spouses continues to be predominately female (Meadows, Griffin, Karney, & Pollak, 2016).

Implications

Based on the findings of this study, there are a number of considerations that higher education institutions might consider giving to military spouses. This section will describe implications in the areas of connection, support, and finances.

The military spouses who participated in this study disclosed a need or want to feel connected to the university and each other. Suggestions for increasing or enhancing connectivity include frequent check ins such as advisors emailing or calling the military spouse students weekly, and even offering live face to face meetings with individual students or with small groups of these students. Another suggestion is to consider offering a mentor program, which could either be peer to peer (perhaps with a student farther along in his or her program coming alongside a student just starting out) or a faculty to student mentor program. Additionally, offering military spouse gatherings and ceremonies (such as for graduation) could offer more connection. Higher education institutions may also consider creating school chapters for military spouses. Online resources such as social media groups set up by the university or via sharepoint on the university server to ensure confidentiality.

Along with connection comes support. Military spouses indicated a desire for university representatives to demonstrate a better understanding of military culture. The knowledge of military culture could be increased or enhanced by offering training to the faculty and staff. Training programs could be delivered via live training that is recorded in order to be provided to online faculty members. Additionally, military spouse students would likely benefit from some flexibility on the part of the faculty members. For example, if the military service member is leaving for or returning from deployment and the military spouse gets delayed on an assignment,

offering an extension without penalty would go a long way. This is not to say that military spouses should or would use their status as an excuse, but that the faculty member displays cultural sensitivity to these types of events in the spouses' lives.

A third implication in this study is related to finances. The financial support offered by the military to service members, Veterans, and their families for education is complex and beyond the scope of this study or paper; however, it is noted that military spouses desire more financial support. One option for higher education institutions, which was already provided to the spouses who participated in this particular study, is to provide a tuition discount to military spouses. If they receive educational benefits from the Department of Veterans Affairs, their benefits would go farther with university discounts. If they do not receive educational benefits from the Department of Veterans Affairs, and are paying for post-secondary education themselves via personal financing or loans, university discounts would reduce the financial burden placed on them. Another action that would have to be taken directly by the Department of Veterans Affairs, but could be advocated for by colleges and universities, is providing for housing benefits for those who are attending programs online. While there are other implications for this study, connection, support, and finances are three important areas to consider and address.

Recommendations for Future Research

It is suggested that a future study be facilitated using fewer participants who are interviewed and asked to respond to a greater number of questions. One recommendation is to offer an exit interview to willing military spouse graduates. This could potentially be audio or video recorded. There was a desire among the research team to have a deeper connection with the research participants, and this suggestion might promote this.

Although compared to female military spouse the number of male military spouses is relatively small, it continues to grow and is currently between 6-10%, according to numerous sources including *Stars and Stripes* (Ziezulewicz, 2009). It may prove to be beneficial to specifically target male military spouses for a replication study in order to learn about the differences between male and female military spouses in terms of their needs in order to enhance the educational experience for both genders.

Conclusion

In summation, this study was conducted to identify the need for competency among higher education professionals in secondary settings who teach military-connected individuals. Military families are tasked with a unique set of challenges when obtaining higher education. Not only are military families subjected to the educational demands of rigorous coursework, but they are faced with military relocation, childcare, and related military stress. Researchers from this study encourage counselors to adopt a holistic lens that focuses on the needs of all family members. This level of cultural awareness requires additional support from institutions for higher education, such as infusing culturally sensitive pedagogy that would acknowledge when military-connected individuals are experiencing phases of deployment and/or reintegration. The benefits from receiving a higher education are significant: individuals are provided with a sense of

control and a newly defined identity. This qualitative descriptive study was administered in effort to better understand the ways in which military spouses were actively supported by higher education online programs. Participants were asked to answer two questions (a) "How has the university supported you in your educational pursuits?" and (b) "How could the university have *better* supported you in your educational pursuits?" Participants were then asked to describe one meaningful collegiate experience. Several metacodes emerged from the data: personal connection, monetary support, intrinsic factors, and staff support. The data reflected a need for increased holistic support for military spouses that encompass the academic, spiritual, and emotional needs of military families. However, personal connection was essential to the overall success of military spouses in an online setting. Moving forward, it is imperative that higher education professionals understand the dynamic, multifaceted experience of military families. Increased competency in working with military families is essential to their overall success.

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The Influence of Spirituality and Religion during Combat Deployment: A Qualitative Study Examining Separation and Reintegration

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Abstract

A paucity of research exists examining spirituality/religion (S/R) as protective factors for combat-deployed military personnel. Understanding the impact of deployment and reintegration can be of significant value for military personnel, family members, and counselors. The purpose of this study was to understand the role of faith/spirituality as part of the deployment cycle, specifically deployment and reintegration, for 279 combat-deployed military personnel. This article addresses qualitative data collected from a mixed methods study. Findings revealed several themes including faith and spirituality and family as key supportive factors in deployment and reintegration transition. Bureaucracy and lack of support were other factors identified that complicated the deployment cycle. Suggestions to improve the reintegration process were identified. Implications and future research are discussed.

KEYWORDS: military, combat-deployment, spirituality, religion, coping

The impact and effects of military combat and deployment on military personnel and their families have been the focus of the media and research since the Authorization for Use of Military Force Against Iraq Resolution was passed in 2002 and Operation Iraqi Freedom began

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in March 2003. Congressional Research Services (2015) reported statistics on fatalities and physical injuries including a total of 6,779 U.S. troop fatalities (including killed in action and non-hostile action) and 52,002 wounded in action (WIA) during Operation Iraqi Freedom and Operation Enduring Freedom. In addition, Operation New Dawn, Operation Inherent Resolve, and Operation Freedom's Sentinel resulted in 76 troop fatalities (including killed in action and non-hostile action) and 329 wounded in action (WIA). Regarding U.S. troop fatalities, 98% were male; 91% non-commissioned officers; 82% active duty, 11% National Guard; 74% Caucasian, 9% African-American, 11% Latino; 54% were under the age of 25, and 72% were from the Army. Of the total number of wounded troops reported, 20% included serious brain or spinal injuries. This total for wounded troops excludes psychological injuries. According to the U.S. Department of Defense (2013), 30% of all troops who were deployed reported a serious mental health (MH) concern within three to four months after returning from deployment.

Spirituality/Religion and the Military

Sayer, Noorbaloochi, Frazier, Gravely, and Murdoch (2010) conducted a study of 754 returning deployed troops. Participants reported the following coping issues upon reintegration after a war-zone deployment: inability in confiding personal thoughts and experiences with others, dealing with strangers, making new friends and getting along with family, keeping or finding a job, finding meaning and purpose in life, controlling anger, taking care of health issues, and doing assignments or tasks in a timely manner. Participants also stated they had turned to or increased substance use, encountered legal problems, and lost touch with their spirituality and/or religion. Marchione (2012) suggested these are unique issues encountered by Veterans of this war and stated that more than 400,000 have been treated by the Veterans Administration (VA) for a variety of MH problems and life issues consistent with those mentioned. She reported the VA are serving more Veterans from the Reserves and National Guard who are filing disability claims based on mental health issues. In all, it appears that recent war Veterans have different types of injuries than previous Veterans due, in part, to changes in weapon uses, body protection from weapons, and improved battlefield care. These changes allowed many returning Veterans to survive wounds that in previous wars proved fatal.

Recent research on deployed military and their families has focused on stressors associated with combat deployment and depression, violence, PTSD, and other issues on reintegration within the family and society. Much of research has focused on variables affecting PTSD and MH-related issues; however, research has also concentrated on the stressors associated with deployment on family members (Bartone, Vaitkus, & Adler, 1998). As is true with other MH issues, counseling interventions for this population most often occurs post-deployment, after the military member returns home and when a MH concern is evident. A dearth of research has been conducted evaluating coping mechanisms and qualities of resilience and interventions while an individual is deployed.

An area receiving little attention in the literature has been how the lack of, or inclusion of, spiritual and religious (S/R) involvement may affect military personnel during combat deployment (Sterner & Jackson-Cherry, 2015). Religion and spirituality are two constructs that frequently have been used interchangeably. The concept of spirituality integrates aspects of purpose, meaning, transcendence, and connectedness which may, or may not, include a higher

power (Young & Cashwell, 2011). Religion or religiosity involves an organized belief system often connected to a religious institution and the integration of common practices or rituals (Frame, 2003). The two may or may not be mutually exclusive. For example, many individuals who define themselves as religious may also find their rituals, beliefs, and practices connected to their spirituality and development. In this situation, a person may be defined as "religious and spiritual." On the other hand, some individuals may not align with any organized religious group but integrate spiritual aspects that lead to a deeper spiritual existence. In this situation, a person may be viewed as spiritual but not religious. Although these concepts were defined for participants in the current study, how they were used to answer the questions is not known.

Spirituality/Religion and Mental Health

A plausible number of studies exploring the relationships among spirituality, religion, and depression have been conducted with various civilian populations. Sixty-nine percent of Americans reported being very or moderately religious and 40% reported attending religious services on a regular basis (Newport, 2012). Maselko, Gilman, and Buka (2009) found a positive relationship between high levels of religiosity and lower levels of depression. Higher levels of spirituality also yielded lower levels of depressive symptoms with patients from large urban community counseling clinics (Doolittle & Farrell, 2004) and patients diagnosed with terminal illnesses such as cancer and AIDS (Nelson, Rosenfeld, Breitbart, & Galietta, 2002).

Unfortunately, a paucity of literature exists within both the civilian and military populations that examine the relationship between spirituality and religion and mental health disorders such as anxiety and suicide. Further, within the military population, few studies exist exploring the relationship between spirituality, religiosity, mental health, coping, and resources (e.g., support). Berg (2011) sampled Vietnam Veterans and found a positive connection between spiritual conflicts among combat exposure and depression. Pargament and Sweeney (2011) investigated spirituality as a component in resilience with combat Veterans and decreasing mental health issues. Hourani et al. (2012) conducted one of the largest military studies sampling 24,000 active duty military to determine the impact/buffer of religion/spirituality and combat exposure on the following mental health concerns: depression, posttraumatic stress disorder (PTSD), and suicide. Results showed high levels of religiosity/spirituality had a positive protective effect on symptoms associated with depression symptoms, while medium levels of spirituality buffered mental health concerns to varying degrees. The impact of combat exposure also impacted mental health concerns. Participants who reported low and medium levels of spirituality positively correlated with depression symptoms but only among military who also reported moderate combat exposure. Medium level of spirituality also predicted PTSD symptoms among those with moderate levels of combat exposure and predicted self-reported suicidal ideation/attempt among those never deployed. By employing a preventative approach, military personnel would be better positioned to evaluate effective and positive coping mechanisms and the importance of support helpful in non-combat situations and apply these strategies while in combat.

Supporting spiritual health and well-being is recognized as a part of a comprehensive approach to suicide prevention (U.S. Department of Health and Human Services, 2012). Spiritual well-being is thought to mitigate suicide risk by helping to reduce dissonance in how one

perceives, engages with, and experiences the external world (Kopacz, Silver, & Bossarte, 2014). Recent research (e.g., Sterner & Jackson-Cherry, 2015) has emerged examining the role of spirituality/religion and coping for currently deployed military personnel; however, much of the existing literature focuses on the military Veteran population.

A common spiritual factor among Veteran populations, especially among those dealing with wartime trauma, is the attempt at meaning making of their experiences while deployed (MacDermott, 2010; Owens, Steger, Whitesell, & Herrera, 2009; Steger, Owens, & Park, 2015). Similarly, deployed military personnel demonstrate an attempt to make meaning throughout the deployment preparation process, particularly how it will impact their family and social supports. Veterans are also known to actively seek-out pastoral care services for religious and spiritual, as well as mental health support (Blosnich, Kopacz, McCarten, & Bossarte, 2014; Kopacz & Karras, 2014; Nieuwsma, Rhodes, Cantrell, et al., 2013; Nieuwsma, Rhodes, Jackson, et al., 2013). Research findings indicate spiritual well-being to be positively linked with health and inversely related to a number of pathologies (Koenig, King, & Carson, 2012; Miller & Thoresen, 1999). Furthermore, different aspects of spiritual functioning (e.g., meaning, values, beliefs, and forgiveness) are also recognized as being essential for health outcomes research (Fetzer Institute, 2003).

In addition to the studies mentioned that examined spirituality/religion, mental health, and stress/trauma, other studies have found a direct correlation between (a) reported positive outlook on personal faith, MH, and coping skills and (b) negative outlooks on faith to negative MH outcomes and coping (Bradley, Swartz, & Kaslow, 2005; Witvliet, Phipps, Feldman, & Beckham, 2004). Gerber, Boals, and Schuettler (2011) found positive religious coping practices were related to posttraumatic growth and decreased symptoms associated with posttraumatic stress. In a study of current deployed military, Harris et al. (2011) found individuals who perceived their Higher Power as a source of validation and acceptance were more likely to find healthy meaning in their deployment and recovery from trauma. Those who reported their Higher Power as being judgmental, punishing, and rejecting had increased difficulty recovering from combat-related trauma.

Moral Injury/Moral Repair and Reintegration

Encounters with moral, spiritual, and religious injuries or conflicts have been the least noted in literature as well as how to assist with moral repair. Moral repair is the ability to restore or create trust and hope in a shared sense of value and responsibility (Walker, 2006) when one experiences and perceives events leading to moral injury. Moral injury often involves degrees of shame, guilt, and self-condemnation. Litz et al. (2009) suggested that potentially morally injurious actions such as perpetrating attacks (even for the safety of comrades), witnessing atrocities, seeing dead bodies, inability to assist with victims, witnessing acts that conflict with spiritual or religiously held beliefs, failing to prevent events causing damages to others may have devastating and long lasting effects on military personnel.

Of course, if one does not perceive moral injurious behaviors during war time as conflicting with personal morals or values or causing disruption due to the setting of war, then moral repair may not be an important factor of focus (Hayden & Jackson-Cherry, 2018). If one

does perceive acts of war committed by others, self, or as witnessed events as wrongful, then it is important to understand the meaning of the moral injury and what is necessary for moral repair (Hayden & Jackson-Cherry, 2018). In addressing moral injury, moral repair often requires aspects of acceptance and forgiveness (Maguen & Litz, 2012) which may be impacted by one's spiritual or religious beliefs and practices. How spiritual and religious beliefs and practices assist individuals in their moral repair or lessen perceptions of moral injury may be a valuable aspect in the treatment of individuals exposed to trauma.

Reintegration

Reintegration is listed as the final stage in the deployment cycle (pre-deployment, deployment, and post-deployment or reintegration) and is defined as the reentry of the service member into their daily life that was experienced prior to deployment (Erbes, Polusny, MacDermid, & Compton, 2008). For many, since 9/11, this stage may be a continuation of the cycle, rather than an ending, where there may be a preparation for a re-deployment (Erbes et al., 2008). The stage of reintegration depends on the service member and the need for the individuals to be redeployed, potentially lasting for months or years to retirement. For other service members, reintegration may include developing new norms into a new civilian life, defined as separation (Note: Due to the unique situations connected with separation, it has been included in the stage of reintegration and is the focus of the next section). The overwhelming majority of service members, spouses, and children demonstrate a high degree of resilience and often experience a healthy reintegration process (Chandra, Martin, Hawkins, & Richardson, 2010). For other service members and families, reintegration can result in a degree of family dysfunction.

During reintegration many family units encounter multiple challenges often structured around the family attempting to restore pre-deployment normal family functioning. Adler, Zamorski, and Britt (2011) predicted that relationships and family dysfunction may not be experienced until 4 to 9 months' post-deployment/reintegration. A key family challenge centers around family roles and the experiences in shifts in responsibilities and expectations (Erbes et al., 2008). It is normal for families to assign new roles while a service member is deployed. The adaptation of these new roles often needs to be renegotiated upon reintegration for a healthy reintegration for the entire family unit (Hayden & Jackson-Cherry, 2018). Families and relationships that can adjust and reassign roles during reintegration often experience less stress (Hayden & Jackson-Cherry, 2018).

During reintegration, a service member may experience physical, psychological, social (Adler et al., 2011), and spiritual challenges. Adler et al. (2011) indicated these transitions can affect health, work, relationships, and meaning in life. They identified three themes in the literature: (a) Feelings/thoughts that the service member does not fit into the family and are not needed to the degree as they were needed prior to deployment due to changing roles and expectations (sense of meaning or purpose in the family); (b) feelings/thoughts of separation from the military culture, whether it be separation from the role in deployment or from the military; and (c) adapting to interpersonal interactions with possible changes in behaviors due to deployment experiences (Adler et al., 2011). If there is a separation from the military, there can be a perceived separation from their identity. One may need to develop a new identity as a civilian which may not have been perceived as positive while in the military (sense of meaning

and purpose of identity and vocation). Deployment may impact one's ability to manage frustration and anger, changes in coping skills, hypervigilance, and social withdrawal, all of which may be influenced by deployment, trauma situations, or reintegration issues. Changes in behaviors may impact the family unit as it shifts from the norm of pre-deployment.

Separation from the Military

Although the stage of reintegration includes separation from military life to civilian life, the variables that contribute to the actual separation from the military warrant additional considerations for individuals working with the service members. Service members who separate from the military on their own terms or who perceive their mission complete and identity intact and want to move to the next stage will experience relatively little impact during their transition. However, variables including the reason for the transition, who decided the transition, and support or non-support of the individual continues to be important considerations during the separation period (Hayden & Jackson-Cherry, 2018).

Conflicting data exists regarding suicide rates among the military population following service members returning home from war-zone deployments. Recently, media attention reported an increase in the rate of suicide among service members (Roan, 2012). Some have reported a significantly higher rate of suicide in the Veteran than nonveteran population (Kaplan, McFarland, Huguet, & Newsom, 2012). The *Military Times* (2015) conducted the largest study to date exploring suicide rates of military members. Their study consisted of 3.9 million service members either in active or reserve duty during from 2001-2009. They reported a total of 31,962 deaths, including 5,041 suicides. They found the suicide rates were not higher for military deployed to Iraq, Afghanistan, or other war-zone countries. Of the 5,041 total suicides, 1,162 involved military personnel who had deployed and 3,879 involved military who never deployed. This study found the suicide rate for the military was 17.78/100,000 compared to 18.1/100,000 from the general population. The rate of suicide increased slightly to 19.92/100,000 for multiple deployments. However, the greatest increase in suicide rates, 26.48/100,000, occurred for those who were categorized as early separation with deployment. The *Military Times* (2015) reported that the rate of suicide increased to 28.1/100,000 for those in the United States Army who had experienced early separation and no deployment. Similarly, the United States Marine Corps experienced a rate of 32.6/100,000 for members who had experienced early separation and no deployment (Military Times, 2015).

Separation from the military appears to be a determining factor when evaluating increased suicide risk in the military with suicide rates of 26.06/100,000 after separating from military service compared to 15.12/100,000 for those who did not separate (Military Times, 2015). It is possible that many service members who separate from the military may have had pre-existing mental health or medical risk factors that may have contributed to their separation leading to a "less than honorable" or "dishonorable" discharge (Hayden & Jackson-Cherry, 2018). In the military, the connection of meaning, purpose, and identification to one's career may be another reason the connection with separation from the military and higher suicide rates were discovered (Hayden & Jackson-Cherry, 2018). Likewise, the support and connection while in the military is considered a strong support mechanism. Separation from this support may increase suicide rates, especially if the type of discharge or circumstances associated with the discharge resulted in a degree of shame or humiliation (Hayden & Jackson-Cherry, 2018). Understanding

factors that led to separation provides critical information for crisis counselors and the field of counseling. When working with military personnel, asking about military separation is crucial.

Purpose

This study focused on the qualitative aspects of military service personnel and their perspectives related to support, coping, and spiritual/religious beliefs as part of their combat deployment experience. Qualitative data originated from a larger mixed methods study (Sterner & Jackson-Cherry, 2015) that examined military personnel's experiences during combat deployment. The purpose of the qualitative component was to better understand how combat-deployment affected participants' spirituality and faith, coping with difficult events, sense of meaning/purpose in life, reintegration post-deployment, and stress associated with deployment. This study explored these phenomena through the narratives of combat-deployed military personnel. To investigate these issues, the following research questions were proposed:

1. What experiences/events have tested your faith/spirituality?
2. What gives you strength when bad things happen in life?
3. What makes you feel at peace?
4. Have there been aspects of your deployment that have made things more stressful?
5. Prior to deployment what was helpful in making your transition easier?
6. What things would be helpful to make reintegration less difficult or stressful?

Method

Participants

Participants were members of all four branches of the U.S. Armed Forces and government contractors deployed in a combat zone. The survey was distributed by a high-ranking military official/undisclosed co-investigator for this study who was deployed to this region. Two chaplains, also deployed during this time frame, reviewed this survey prior to distribution. The information provided for this study regarding demographics of respondents was reported by the military service member and co-investigator. Respondents self-reported their position during deployment (military service member or contractor) and only military service members were used in this study. It is estimated that 3,000 active military personnel and government contractors had access to the survey, with 285 individuals responding yielding a 9.5% response rate and a final usable sample of $n = 279$ (six participants did not complete a significant majority of the items and were deleted consistent with the suggestion by Hair, Anderson, Tatham, and Black, 1998). The average age was nearly 38 years ($M = 37.91$, $SD = 9.20$) with age ranging from 20 to 63 years. Length of service was slightly over 15 years ($M = 15.46$, $SD = 8.26$) with years of service ranging from 1 to 39 years. Regarding military rank, over 51% of respondents ($n = 143$) identified as enlisted personnel (most frequent ranks: E-4 to E-8), over 43% ($n = 121$) identified as officers (most frequent ranks: O-3 to O-5), and nearly 6% ($n = 15$) did not identify a rank. Over 80% of respondents were male ($n = 224$) and 19% were female ($n = 53$) with 1% not reporting ($n = 2$). A large majority of respondents (71%) identified as White ($n = 199$), 13% as Black/African American ($n = 35$), 6% as Latino American ($n = 18$), 6% as Asian American ($n = 17$), 1% as Native American ($n = 3$), 2% as mixed race ($n = 6$), and 1% did not respond with any category ($n = 1$). Over 73% were married ($n = 204$), 14% were never

married (*n* = 38), 10% were divorced (*n* = 28), 3% reported cohabitating (*n* = 9). Regarding education, 8% were high school graduates (*n* = 22), 21% completed some college (*n* = 58), 12% completed an Associate's degree (*n* = 33), 31% a Bachelor's degree (*n* = 87), 24% a Master's degree (*n* =67), and 4% a doctorate or professional degree (*n* = 11).

Even though all four branches of the military were represented, a majority (62%) were from the Army (*n* = 173), 15% Air Force (*n* = 42), 8% Navy (*n* = 22), less than 1% Marines (*n* = 2) over 13% indicated they were in the Reserves/National Guard (*n* = 39) and less than 1% did not respond (*n* = 1). Over 70% indicated this was not their first combat deployment (*n* = 197) compared to 29% who indicated first combat deployment (*n* = 80) with the average time spent in the current deployment being slightly greater than five months with the expected term of deployment lasting 12 months and less than 1% did not respond (*n* = 2).

Regarding S/R affiliation, 70% identified as Christian (*n* = 196), 7.5% as agnostic or atheist (*n* = 21), 7.5% as non-denominational (*n* = 21), 3% as Buddhists (*n* = 8), 1% as Islamists (*n* = 3), 1% as Jewish (*n* = 3), <1% Hindu (*n* = 1), and 9% reporting other affiliations/beliefs/practices, however, they did not identify a specific affiliation/belief/practice within this category (*n* = 26). Approximately 70% indicated they were involved in S/R practices prior to deployment (*n* = 199) with 5 out of 10 reporting daily or weekly attendance and nearly 7 out of 10 reported engaging in specific S/R practices throughout the day or week.

Instrument

Participants completed the *Spirituality and Religious Reintegration Scale (SRRS),* an author-developed questionnaire designed to assess S/R involvement, MH, coping, beliefs, support, transition, and stressors associated with combat deployment and post-deployment reintegration. The *SRRS* was initially comprised of 65 total items divided into three sections: (a) demographic content and background; (b) intrinsic and extrinsic characteristics/qualities associated with dealing with combat deployment, and (c) pre/post deployment transitions/stressors. The qualitative portion of the study focused on the six open-ended questions, outlined in the purpose section, designed to expand and provide greater contextual detail to the participants' quantitative responses.

Procedure

This study was approved by the University's Institutional Review Board (IRB #11-26). The original study used a mixed methods quantitative descriptive survey design and phenomenological inquiry. An open invitation was posted on a US Army bulletin board in Iraq accessed by combat-deployed military personnel. Participants were directed to an Internet URL that contained the web-based survey including instructions and an informed consent. Data were collected using *Survey Monkey* during the initial invitation period only due to unanticipated time restrictions to military personnel and limited access to the listserv. As a result, scheduled follow-ups at 1, 3, and 7 weeks were unable to be conducted, yet if conducted likely would have yielded a higher response rate given the initial interest. Criteria for participation included: (a) current active duty status in any of the U.S. Armed Forces four branches or Reserves/National Guard and (b) current deployment in a combat zone.

The mixed methods approach was deemed the best design to provide the researchers with detailed information and a better understanding of the issues and phenomenon related to combat deployment and reintegration than either a quantitative or qualitative alone (Creswell & Plano Clark, 2007). Further, given the inherent contextual problem posed by quantitative research and the potential for personal bias and interpretations often associated with qualitative inquiry, using a mixed methods approach addresses the weaknesses of both forms of inquiry (Creswell & Plano Clark, 2007). It should be noted that while most of the questions in the overall study focused on exploring quantitative results, the qualitative questions detailed in this study were developed to provide contextual elaboration and enhancement of quantitative responses, especially considering the limitations of conducting face-to-face interviews or follow-up due to logistics considerations and participant setting and circumstances. This process appears to meet the definition of mixed methods inquiry (Creswell & Plano Clark, 2007). The qualitative component used a phenomenological inquiry to examine the meaning or essence of the lived experience of combat-deployed military personnel related to support, coping, beliefs, and reintegration. It was preferred over other qualitative traditions because phenomenological study allows the researcher to search for "the central underlying meaning of the experience and emphasize the intentionality of consciousness where experiences contain both the outward appearance and inward consciousness based on memory, image, and meaning" (Creswell, 1998, p. 52).

Results

The six open ended questions were coded and evaluated. The answers to the six questions were uploaded into NVivo and evaluated individually. Participant responses were coded into primary themes and subthemes. Some participant responses overlapped and were included in multiple themes. Themes were identified after continuity across coded responses was established. Each question highlights individual themes and sub-themes.

Analysis of Research Questions

Question #1: "What experiences/events have tested your faith/spirituality?"

Respondents (n = 100) reported that the stress of living away from home/being away from family is what tested their personal faith/spirituality while deployed. Within that overall theme, two subthemes appeared: (a) stressors while deployed and (b) stressors at home. Regarding stressors while deployed, the most frequent response was combat exposure (n = 40), particularly knowing or witnessing the death of another soldier or innocent child. As to stressors at home, a majority of those who responded to this question (n = 60) indicated a combination of marital issues and divorce. Some respondents did not experience divorce, but mentioned that helping others through their marital issues had an impact resulting in vicarious stress. Life stressors related to legal and financial issues were also mentioned as events that created stress while deployed; however, these events were not reported as frequently as marital issues and divorce. One participant reported specific experiences that tested faith during deployment included "living as an infidel in a Muslim area." Other participants stated their faith was tested by "witnessing civilian children killed/wounded, US military killed/wounded, reality of war vs. what I was taught as a child…" One participant elaborated on an experience that tested his faith "a couple of traumatic experiences, but the one I remember the most is when I accidentally killed a very young Iraqi girl during a firefight and maybe other lives I've taken during combat…" Another participant talked more globally about

experiences testing faith and stated "The dichotomies of war. We face death for our freedom and the freedom of others. We kill in order to save others from killing. We destroy in order to build**.**"

Many participants discussed stressors at home, specifically marital issues and divorce, and how these concerns were exacerbated by combat deployment. A number of respondents identified concerns with infidelity by the spouse at home and pending/recent divorce as issues that have challenged their faith/spirituality. One participant reported faithfulness was clearly a concern and conveyed a sense of not having any control over the outcome when he stated he was "struggling with faithfulness and whether or not my spouse is faithful*."* One participant reported multiple marital complications that tested his faith "my wife's adultery and my divorce." For those experiencing multiple deployments, marital issues that arose during previous deployments created specific stressors and tested their faith during the current deployment. One respondent stated he was concerned because "my spouse had an affair while I was deployed the last time."

Question #2: "What gives you strength when bad things happen in your life?" Personal faith (*n* = 112), spirituality (*n* = 85), and family (*n* = 79) were the most commonly identified themes. Many respondents directly referred to God as their source of strength during difficult times while others specified certain religious practices, with praying and reading the Bible as the most common responses. One respondent emphasized the importance of their personal faith "I know that God has a plan for my life, a plan for good and not evil. So no matter what happens, I trust God, that's what Jesus died for." Respondents also identified family and/or partner support as a source of strength. One respondent stated, when discussing the importance of family support, "My current/3rd wife is my rock." Shared family experiences prior to deployment such as set time together in prayer, practicing their faith as a family, and taking their children to church appeared to have beneficial and positive effects on respondents during deployment. Some respondents commented on the comfort in knowing their family was being raised with God by their partner while they were deployed. Others found strength within their spiritual support group, such as being members of their home church, and drew off that during deployment. Several mentioned a key source of strength was knowing others were praying for them. Outside of their spiritual support group, several respondents mentioned they rely on other Soldiers and supervisors. Some chose a non-traditional method to find strength, which was categorized as "creative expressions." Within creative expressions respondents indicated (from highest to lowest frequency) listening to music, exercising, meditating, and practicing yoga provided them a means to manage troubling situations.

Question #3: "What makes you feel at peace?" Top responses to this question included faith (*n* = 86), spirituality (*n* = 77), and connection with family (*n* = 64). Respondent reported that talking to their family was the event that made them feel most at peace. One respondent mentioned that thoughts of "holding my child" helped bring about a sense of calm and peace. Some respondents said that when life gets stressful, various physical activities (e.g., running, exercising, and yoga) and mindfulness practices (meditation) as well as engaging in meditative prayer have been valuable centering tools. Varied responses to this question demonstrate how respondents use activities, sometimes in combination, to help them feel at peace during combat. Some examples include: *"*attending weekly mass and yoga," "the realization that I can project positive karma within the negativity of conflict by always attempting to do some kind of good wherever I am," "my wife introduced me to country music and there are so many songs about

loving your children. I enjoy listening to them the most. The song, 'You're Gonna Miss This' by Trace Adkins…speaks to me." "My memories of home; solitude/a few hours of me time."

A subtheme emerged to this question indicating a sense of disillusionment at attaining a sense of peace given the combat environment and the deployment mission. Some respondents challenged the notion of the existence of a higher being and others pointed to instances of hypocrisy as sources of disillusionment. "I have seen too much death and destruction to believe in this higher power crap." "The question assumes that all of those who take this survey believe in a god or some form of 'higher power,' when this is not always the case." "Watching 'religious' soldiers completely contradict the principles they cram down your throat." "My first deployment (when) I saw a lot of combat. Everything I experienced made me further question the concept of God and religion and fully cemented my atheistic beliefs."

Question #4: Have there been aspects of your deployment that have made things more stressful? Respondents reported lack of support (n = 76), bureaucracy and military leadership (n = 55), and missing life at home (n = 34) were factors making deployment stressful. Numerous participants reported military leaders and government bureaucracy caused most of the stress for them and their family. Decisions that prioritize military mission over family seemed to create added stress in their personal lives. Respondents expressed concern about the ongoing influence of military bureaucracy during and after deployment. Specifically, they indicated that although they were back home with their families they would still be "bothered" by leadership and the demands placed on them. Lack of support not only included family concerns, but also issues and stress with their employers. One individual stated that "difficulties with my boss" were causing added stress during deployment. Another individual reported that "difficulties with interpersonal relationships with co-workers and difficult career decisions" were compounded by the deployment process. Missing life at home seemed particularly concerning to some participants because they were not able to witness important life events. One soldier captured the essence of this theme and how being away from home resulted in missed opportunities to make memories or say goodbye to loved ones "it was difficult missing benchmarks in their children's lives and also when loved ones pass away." Another expressed concern that deployment creates more pressure on his spouse to keep the household functioning and stated "my spouse is working hard and dealing with the kids by herself."

Question #5: Prior to deployment what was helpful in making your transition easier? Several respondents (n = 64) indicated family assisted in the transition to deployment and mentioned the value of additional supports for the family (n = 23). Most reported what would be helpful is for the military to offer more supportive programs to improve reintegration into the family. While some respondents reported that no additional planning was needed or taking a "just do it" mentality is sufficient, a majority believed that preparing their families and partners by taking time off work to be with families prior to deployment, reviewing plans and finances to prepare for the time away, and placing their children/family in counseling to work through the transition was beneficial. Suggestions to ease the transition ranged from requiring family counseling to shorter deployment times. A majority of respondents provided examples of what may be helpful including, training for family as to what to expect, counseling services for families, and education for soldiers who are being deployed for the first time.

Question #6: What things would be helpful to make reintegration less difficult or stressful? Participants' responses reinforced concerns raised in previous question, specifically with respect to the importance of family support and more time with family. Three main themes emerged: (a) suggestions to improve reintegration (n = 78), (b) uncertainty on how to improve reintegration (n = 33), and (c) time with family and time away from military duties/responsibilities (n = 27). A subtheme that emerged within the theme of improving reintegration were issues with mandatory meetings and administrative requirements and how they interfere with the reintegration process. A sampling of responses includes "LESS TIME IN THE ARMY "REINTEGRATION PROCESS," "fewer mandatory meetings, fewer surveys and questionnaires," "less micromanagement from leadership," and "less bureaucracy" appeared to capture the concerns of respondents. Some appeared frustrated that these meetings were taking time away from family, activities were redundant, and greater focus of reintegration processes could take place prior to the end of their tour. Regarding ways to address reintegration issues, respondents provided detailed suggestions to improve the process including (a) "the briefings about going home and expecting things to be different help out a lot. Having spouses and loved ones know that things are going to be different too upon reintegration would help out so everyone expects some turbulence upon the homecoming of their soldiers." (b) "A 'cooling off period' between combat zone and home. A time to do any and all paperwork so that there are no nagging issues to deal with after arriving home." (c) "More organizations set up that make sure that everyone is included and that actually live up to the phrase that we all supposedly live by; "No one is left behind." (d) "More flexibility with block leave after the deployment would help a large number of people." Many commented about how family also needs to be prepared for reintegration not just the individual returning from combat. One respondent stated that "sometimes I think reintegration is harder on spouses left behind. Teach them how to articulate their new role in the relationship after the military member returns." Integrating family into the reintegration process was viewed as valuable. One respondent stated "more family oriented activities through the unit that do not seem mandated. Mandatory fun days never result in a relaxing day with your family. They are usually time constrained and a cluster of confusion." Another added that both parties need to be engaged in the reintegration process and articulated that "knowledge and acceptance that it is a process. Realizing that both parties (the deployed person and those at home) have changed during the time period of being separated. It is important to keep contact as much as possible while separated to help with reintegration."

Some respondents were not sure what needed to be changed regarding reintegration. Several individuals also mentioned that this was their first deployment so they have not had the reintegration experience and were not able to comment on how the process could be improved. A few responses indicated it was the individual's responsibility to deal with the reintegration process. Others indicated that the reintegration process did not need to be changed yet did not elaborate on what specifically was working well.

Time with family and being away from military responsibilities were important considerations to adjusting to being home. Several respondents indicated that the time they spent with their families was a beneficial part of the reintegration process and helped them ease into life at home. One individual commented he found a sequential process of integrating himself back into home life that involved "gradual reintegration, family first, then close friends, then everyone else." Another mentioned the time with family is minimal and indicated the inherent

time struggles with a military life. This individual stated the challenge is "to make reintegration last. Just when I get back to being dad and husband, woops, time to go again." Others expressed concern that more time away from military responsibilities would make the reintegration more meaningful. Several mentioned that there needs to be "more free time, and less pressure to return to work ASAP." A number indicated that built in vacation time would enhance the reintegration experience and reduce stress, especially if this involved time with family. One individual stated "Time off... the vacation deals for soldiers on leave should be extended for those coming off of a deployment. Probably just as important right after a deployment…helps to get away to a nice place with your spouse and family to deal with everyday stress."

Discussion

Deployment into combat zones can be one of the most difficult assignments facing military personnel. For many of these individuals, reintegration can also present challenges as they attempt to navigate home/work life often while dealing with the residual of war. Accounts of the psychological, emotional, and physical toll are abundant and well documented throughout the literature; however, scant research exists examining what importance military personnel place on spirituality/religiosity as it relates to protective factors for deployment and reintegration. Understanding how military personnel view spirituality/religiosity within the deployment cycle better positions counselors to deal with some of the unique issues resulting from combat. Participant responses to the six questions indicate that faith, spirituality/religiosity, and family were central themes. For the first research question, participants indicated that being away from family and stressors associated with deployment challenged their faith/spirituality and how they are coping with situations. Given the hardships and trauma associated with combat deployment, most respondents reported that living away from home and not being with the family was what tested their faith/spirituality the most.

Many indicated the stress on relationships, marital issues, and divorce were the main concerns. Reviewing specific relational concerns, stress about infidelity seemed to be a predominant issue. In terms of stress associated with deployment, participants focused on the casualties of war, including civilian deaths as key issues challenging their beliefs. Interestingly, the ratio of responses to stressors at home compared to stressors with deployment was 2.5:1 indicating that participants seemed more concerned about unresolved problems/issues at home than the daily difficulties/stressors associated with deployment. One possible explanation for this may be that they perceive having more control over and support for the day-to-day challenges of deployment compared to what is happening at home. It should be noted that since the study did not focus on morally injurious actions, it is unclear whether faith and spirituality had a moderating effect, especially given that the effects of these actions often do not fully manifest until the reintegration phase of the deployment cycle. Results from this question also appear lend support to the coping issues facing returning deployed troops identified by Sayer et al. (2010), specifically getting along with family.

Participants noted what gives them strength and a sense of peace was faith, spirituality, and family. While many participants indicated challenges at home tested their faith and spirituality, family also seemed to be an important source of support and strength while deployed. When examining the frequency of responses as to what gives them strength,

participants identified faith and spirituality more frequently than family. One possible interpretation may be that spiritual/religious beliefs one ascribes to and how these beliefs are integrated into one's worldview may be perceived as having greater influence over outcomes than tangible sources like family, especially when dealing with existentially-based issues such as meaning of life, reality of death, and their purpose in life. Participant responses seem to support MacDermott (2010), Owens et al. (2009), and Steger et al. (2015) finding that spirituality may assist military personnel in making meaning of their deployed experiences. For some respondents, creating a feeling of peace was hindered by combat deployment and their mission. There seemed to be a degree of disillusionment with the concept of God and hypocrisy with those who profess an allegiance to a specific religion, yet not integrating or following its underlying principles and tenets.

The themes of support and family were also evident in research questions four and five. Participants viewed lack of support and concerns with missing experiences at home as contributing to the stress of deployment. Several concerns were also raised about employment issues and how this created stress during deployment. In situations where family and employers were supportive, participants noted that pre-deployment transitioning was easier. Some participants identified religious support or pastoral care services as aiding in the transition. Their comments seem to reflect the connection between spiritual well-being and mental and physical health that supports the research findings of Koenig et al. (2012) and Miller and Thoresen (1999), who found a positive link between spiritual well-being and health. One theme that emerged related to aspects of deployment that created stress was the bureaucracy and how policies and military leadership contributed to stress. In some instances, concerns were raised about how bureaucracy and leadership would leach into planned leaves or other scheduled downtime. Bureaucracy and leadership issues also created concerns for those attempting to navigate deployment/reintegration issues with employers.

Understanding factors that improve the reintegration phase of the deployment cycle was of interest in this study given the plethora of physical, psychological, and social challenges (Adler et al., 2011), family issues (Erbes et al., 2008), and moral injury concerns (Litz et al., 2009) that accompany military personnel home from combat. Several participants made suggestions on ways to improve reintegration including decreasing mandatory meetings, less bureaucracy, better organization of the reintegration process, and less time filling out paperwork and dealing with related materials. Importance of time with family was also viewed as a way to improve the reintegration process. Involving family as early as possible was mentioned repeatedly given that both parties need to adjust to the family and family dynamics and start working through any concerns/issues due to separation. This suggestion seems to capture the importance of Adler et al.'s (2011) assertion that relationship and family dysfunction may not manifest for many months' post-deployment so engaging family from the beginning may assist in a healthier reintegration. Engaging families early in the reintegration process may help minimize conflicts in family roles and provide clarity and understanding regarding responsibilities and expectations (Erbes et al., 2008). Hayden and Jackson-Cherry (2018) mentioned that healthy reintegration involves successful renegotiating of roles and responsibilities. This is particularly salient considering one of the biggest challenges facing these families is how to navigate back to pre-deployment normal family functioning (Adler et al., 2011).

Implications for Counselors

Counselors working with military personnel deployed to combat zones must be cognizant of the multiple physical, psychological, emotional, and spiritual factors facing these individuals, especially given that evidence of stress and trauma may not manifest until post-deployment reintegration. Counselors need to integrate treatment to account for experiences associated with combat deployment as well as soldier reintegration into the family and community. Understanding the degree to which S/R influences the client's ability to cope with and manage stress is critical to addressing combat-related experiences. Counselors need to assess the importance S/R plays in a client's life and what role it contributes to one's well-being. Counselors also need to be aware of the specific stressors and issues facing individuals who are preparing for combat-deployment, are deployed, and have completed their tour of duty. Familiarity with how these stressors impact the individual and family are key considerations for establishing treatment. Helping clients prepare for and cope with combat deployment is an important process, especially given that counselors may not be aware of the resources necessary to assist in this transition. Providing support for those desiring to exercise S/R practices while deployed may be effective in reducing stress during deployment.

Working with families at pre and post-deployment to understand what impact deployment has on interpersonal relationships and dynamics may help minimize stress and provide better coping strategies and outcomes, especially during long tours. Counselors should be aware of resources that are available within the community to assist in preparation for deployment and reintegration. Access to spiritual/religious leaders and resources can complement treatment and provide valuable pre and post-deployment transitioning. For those who are deployed, working in conjunction with chaplains may provide valuable support specifically as it relates to drawing on spiritual/religious beliefs to cope with stress and trauma. Counselors working with younger military personnel need to assess deficiencies in coping skills that may enhance vulnerability to combat issues and how these vulnerabilities may be exacerbated during reintegration. Increased focus on family throughout deployment cycle can provide valuable support and help families remain connected thus potentially reducing concerns and challenges as families renegotiate roles and responsibilities.

The utilization of faith in the context of spirituality was identified as a support for the majority of respondents. Research further supports that spirituality may be relevant in treatment for combat related posttraumatic stress disorder (PTSD; Currier, Holland, & Drescher, 2015). Pargament, Koenig, and Perez (2000) documented that many people coping with trauma are attracted to spiritual teachings, beliefs, values, and practices. Findings by Currier et al. (2015) support spirituality as a multidimensional construct that covers a range of intrapersonal and communal aspects that may aid in the coping of combat exposure and stressful situations involved in deployment. Park (2013) adds that engaging in religious/spiritual organizations can enhance coping skills. The use of mediation and prayer have been found to reduce negative symptoms of PTSD, while experience positive emotions during troubles. Currier, Drescher, and Harris (2014) found that daily spiritual experience, practices, and activity in religious organizations relieved PTSD symptomatology among clinical samples of Vietnam and Iraq/Afghanistan eras. Conversely, other studies recognize that trauma due to combat exposure can disrupt spiritual practices and beliefs. For example, some may express thoughts of being

abandoned by God/Higher Power or accept that what they are experiencing is a form of divine punishment. Results from the qualitative data support a majority of respondents who find support in their faith and through their spiritual practices.

Limitations

Participant responses were self-reported and collected on a new instrument so no a priori item reliability and validity was established. The response rate was less than 10%, which likely resulted in the disproportionate responses across the four military branches, including those in the Reserves and National Guard. The response rate was lower due to unanticipated time restrictions to military personnel and limited access to the listserv. The survey was Internet-based, which may have hindered some from responding due to the sensitive nature of certain questions and concerns that superiors may have access to their responses even though the site was secure and anonymity was assured to the extent possible.

Future Research

Understanding the function and role of spirituality and religion in the context of real-time combat deployment continues to be an important research consideration. Surveying military personnel deployed in combat zones continues to be problematic due to lack of or limited access. This lack of access continues to hinder efforts by researchers from fully understanding the combat experience thus limiting objective, effective, and timely treatment options and training needs. Many military personnel who are discharged after deployments often access civilian MH clinicians when they are unable to cope or their current military supports have dissipated. Research needs to be undertaken that can assist in understanding unique military factors while deployed in order to implement the appropriate clinical interventions based is imperative to assist former military who may struggle with issues connected with deployment.

Future research should also investigate the unique issues encountered by the National Guard and Reservists who become activated during war time. When deployed, they encounter the same events as active duty military personnel but often are not offered, or perceived to have, the same unique supportive community before, during, or after their activations. Deployed reservists, just by the nature of their status, are not from the same daily military community but live in civilian communities. Reservists and their families may be a group that will access civilian counseling more often than active military personnel. Therefore, as much information is needed regarding experiences deployed, differences in guard and reservists' experiences, and support networks in order to meet their unique needs. Additional research is needed to examine protective factors such as S/R as part of a comprehensive assessment of the client. Given that a majority of this sample fit a specific demographic profile, a broader more representative sample across all four military branches is needed.

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