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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 presents a short history of U.S. combat mental health efforts and proposes a model for training Forward Surgical Unit personnel based on the Crisis Intervention Team training model for police officers. The second article is a study that examined U.S. Army Family Support service providers' perceptions of the barriers, benefits, and methods for expanding collaboration among service providers assisting families during deployment. The third article touches on a topic that has not been covered in the JMGC – the attitudes and beliefs of ROTC students toward stigma and seeking help for mental health issues. The fourth article presents a pilot study to develop an assessment to be used with service women to gauge their social, emotional, and spiritual concerns. The final article describes a program to address the career decision-making needs of military Veteran students at a four-year public university.

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

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Mental Health Triage in the Combat Theater: A New Training Model for Forward Surgical Teams

LEIGH FALLS HOLMAN
The University of Memphis

PAUL DUNAWAY
The University of Memphis

Abstract

Soldiers presenting at Forward Surgical Units (FSUs) for medical treatment display peri-traumatic aggression/anger, peri-traumatic dissociative behavior, and suicidality. This results in less efficient treatment of medical injuries. Although significant advances have developed to address mental health issues in the combat theatre, those who are tasked with this are often not available due to logistical, weather, or combat-related situations. This leaves untrained FSU personnel as the first to intervene. Our manuscript discusses the history of U.S. combat mental health efforts and proposes a model for training FSU personnel based on the Crisis Intervention Team (CIT) training model which teaches police officers who encounter mentally ill citizens how to assess, de-escalate, and stabilize the situation pending mental health treatment.

KEYWORDS: Forward Surgical Units, combat mental health, Crisis Intervention Team

Exposure to combat increases the likelihood of trauma reactions (Kline, Falco-Dodson, Sussner, Ciccone, Chandler, & Losonczy, 2010). Although there are Combat Stress Control Teams (CSCTs) close to forward positions to assist with presentations of peri-traumatic or suicidal impacts of combat, these personnel are in short supply and often are not accessible by Forward Surgical Units (FSUs) who are the first to interact with both medical and mental health casualties of war. We will discuss the history of mental health treatment in the combat theater to lay a foundation for our position that FSU's need training in how to deal with these situations.

ACKNOWLEDGEMENT: The following Crisis Research Team members were involved in planning and conducting training: Richard James; Michael Skirius; Kaitlin Ducket; James Moore; Rebecca Clement; Becky Pierce. Dr. David Rudd served as a consultant, and Melissa Janoske, Katherine Friedel, and Meeman 901 Strategies designed the Smart Cards.

Leigh Falls Holman is an Assistant Professor in the Department of Counseling, Educational Psychology and Research at The University of Memphis; Paul Dunaway is a PhD student at The University of Memphis. *Address correspondence to Leigh Falls Holman. Email: lfalls@memphis.edu.*

Finally, we will propose a new model for training FSUs to conduct mental health triage and de-escalation when CSCTs are not available.

Combat Stress and Psychological Casualties of War

Combat stress reactions have been labeled shell-shock (WWI), combat neurosis, combat fatigue (WWII), combat exhaustion (Korea and Vietnam), and combat stress reaction or battle shock (Glass, 1971). These disorders were thought to be acute stress conditions that could be quickly relieved so the soldier could return to battle. More serious long-term forms of these disorders were historically considered to be a result of pre-existing mental health issues (Pols & Oak, 2007). However, this view changed after Vietnam when psychiatrists began to realize, with the addition of Post-traumatic Stress Disorder (PTSD) diagnostic criteria to the DSM, that war could have devastating long-term mental health impacts on combat Veterans (Trimble, 1985, p. 12).

History of Combat Mental Health

The goal of combat mental health is to sustain as many troops on the front lines as possible (personal communication Maj. Gen. Wilmoth, July 2016). For those in combat who suffer mental health issues, the goal is to provide immediate intervention for acute war-related peri-traumatic reactions in order to return them to the battle field. We will review the history of pre-deployment screening and then the history of mental health intervention in the combat theater to provide a foundation for the prevention/intervention we are proposing.

Military Mental Health Screening

The first line of defense in mental health is always prevention. In this vein, a U.S. psychiatrist, Thomas W. Salmon, advised the government during WWI to screen military recruits for mental illnesses such as schizophrenia and mental retardation (Streker, 1944; Pols & Oak, 2007). However, in spite of this screening process, there were more cases of "mental breakdown" identified among soldiers post-deployment than the military anticipated, resulting in the conclusion that screening had not been "sufficiently stringent" (Pols & Oak, 2007, p. 2133). In WWII, psychiatrists believed they could improve the screening process (Porter, 1941). At this time, Harry Stack Sullivan became a consultant for the Selective Service System in late 1940 to assist in developing a screening program. He reasoned that if a person could not adjust to the normal demands of life, then he would certainly be unable to adjust to the demands of war (Sullivan, 1941a: Sullivan, 1941b). From 1941 to 1944, this method "excluded 12% (almost 2 million) of 15 million men examined, which was about 6 times the rejection rate of World War I (Pols & Oak, 2007, p. 2133-2134).

World War I (WWI)

Although screening involves identifying a pre-disposition for mental health issues among potential recruits, intervention for shell shock is conceptually differentiated from screening. In

WWI, shell shock was considered a disorder resulting because a Soldier was exposed to war (Pols & Oak, 2007). In 1915, the French Army introduced the concept of forward psychiatry to intervene in cases of shell shock. In December 1916, a unit leader for the French Second Army, reported that 91% of Soldiers with the disorder were successfully treated and that "600 were cured through a simple and energetic psychotherapy and sent back to the front after a few days" (Roudebush, 1995, p. 89).

In 1917, the British were also treating Soldiers for shell shock, a condition affecting 15% of their personnel at that time (Salmon, 1917a, 1917b). However, only 21% returned to military service and even less to the front lines (Shephard, 1996). Salmon developed the US Army's intervention for shell shock based on his observation of what the British were doing. Psychiatric personnel were placed as close as possible to the battle lines for immediate treatment of combat-related mental health symptoms using a three tier approach. Tier one was supportive psychotherapy including rest, food, and optimistic persuasion including normalizing the reactions the soldiers were having to an unnatural experience (Solmon, 1917 a, 1917 b). Approximately 65% of soldiers returned to the front lines after 4 to 5 days of rest (Strecker, 1919). Tier Two occurred in psychiatric hospital wards about 5-15 miles behind the front lines where Soldiers remained for up to three weeks. Finally, Tier Three of the intervention occurred at a base hospital about 50 miles from the front lines where the most severe patients were treated for up to six months before either returning to battle or being sent home.

The British and US army's utilized the principles of forward psychiatry under the acronym "PIE" (Jones, Thomas, & Ironside, 2007). PIE stands for: Proximity, placing intervention as close as possible to the front lines; Immediacy in treatment of symptoms in the here-and-now; and Expectancy of recovery and return to the battle field (Artiss, 1963). Doctors reported about 80% of those treated with PIES returned to the front lines. Relapse rates for US Soldiers after returning to battle were reported at only 4% (Salmon, 1919a; Strecker & Appel, 1945). However, these relapse estimates were found to be optimistic (Jones & Wesseley, 2003). The aim of PIE was not to be therapeutic, rather it was "designed to . . . assist the 'ego in repressing or enduring anxiety,' in contrast to abreaction and 'uncovering' which they recommended for resistant cases referred to base hospitals" (Jones & Wessely, 2007, 414).

World War II (WWII)

Because American military psychiatrists were confident screening would completely eliminate shell shock among combatants, they did not even consider forward psychiatry in the early part of WWII (Pols & Oak, 2007). However, because large numbers of Soldiers were returning home due to psychiatric issues, the military agreed to consider these programs (Offer & Freedman, 1972). Initially, Grinker and Spiegel (1943) began interventions in forward positions with the US Army Air Force through injections of sodium pentothal to induce a dream state that would help the airmen re-experience the traumatic experience and thereby "loosen the stranglehold on their minds." Their unique perspective was that military psychiatrists should be less concerned with those breaking down in battle than with those who were not experiencing these reactions, given the unnatural experience of war (Grinker & Spiegel, 1943). They suggested that a 'normal' man's breaking point would be between 100 days and 1 year of active duty, which is why the military later limited deployments to one year. Initial reports indicated

that the use of forward psychiatry using PIEs resulted in up to 80% of Soldiers being returned to battle (Bartemier, Kubie, Menninger, Ramono, & Whitehorn, 1946). However, once again, these were adjusted downward following the war clarifying that most returning Soldiers were placed in non-combat roles (Brill & Beebe, 1955; Brill, Tate, & Menninger, 1945).

An important observation that grew out of forward psychiatry in WWII was that most Soldiers were primarily motivated by their battle buddies and respect for their commanding officers, rather than by American ideals or hatred of the enemy (Spiegel, 1944). Based on these observations, Spiegel advocated for focusing on group cohesion as a preventative measure against mental breakdown. This was later supported by research indicating "morale was inversely related to breakdown incidence and intimately linked to the trust soldiers had in their officers, their training, their outfit, their weapons, and their fellow soldiers" (Stouffer, Suchman, DeVinney, Star, & Williams, 1949). Additional research also provided support for this thesis, finding those Soldiers who experienced lower levels of morale, including notably African American Soldiers who were segregated from other military personnel, had higher levels of mental breakdown even when not on the front lines (Dwyer, 2006).

Korean War and Vietnam

Differences in the types of situations faced by military personnel in Korea resulted in challenges implementing forward psychiatry interventions. Front lines were quickly changing in Korea and covered a lot of land (Ritche & Owens, 2004). In spite of this, forward psychiatry teams (FPTs) using PIEs were implemented within eight weeks of the outbreak (Jones & Wessely, 2007). Although Viet Nam demonstrated similar quickly changing front lines as Korea, FPTs were in place from the beginning of US involvement (Scott, 1992). Due to research from WWII, deployments in country during Viet Nam were limited to 1 year with frequent periods of rest.

At the time, combat stress reports were less than 5% of all medical cases, which military psychiatrists attributed to the changes in conditions from WWII (Bourne, 1970a; 1970b). In spite of forward psychiatry interventions, following the war The National Vietnam Veterans' Readjustment Study (Kulka et al., 1990a, Kulka et al., 1990b) found 15.2% of male and 8.5% of female Vietnam Veterans met the diagnostic criteria for PTSD. Not surprisingly, they found that those serving in combat had much higher levels of PTSD (men 35.8% and Women 17.5%). We are uncertain whether these estimates initially under-represented the true incidence of combat stress or whether forward psychiatry principals may have simply delayed the onset of acute symptoms resulting from combat stress (Pols & Oak, 2007).

Operation Desert Shield (ODS) and Desert Storm (DS)

Through an extensive search of the literature we found little specifically discussing mental health intervention in the combat theater during ODS/DS. The only relevant information indicated that combat stress control teams (CSCTs), which will be discussed in detail below, were used as referral resources for Soldiers who were experiencing stress (Marshal, Davis, & Sherbourne, 2000). CSCTs focused on prevention, triage, and short-term intervention. However, unlike previous wars CSCTs were not deployed into forward positions. There were four CSCTs,

which were staffed by psychiatrists (1-2), psychologists (1-3), and psychiatric technicians (1-3). These teams used the principles of forward psychiatry within a structure of the Five R Method: Reassurance of normality of experience, Rest from extreme stress, Replenishment of physiologic well-being, Restoration of confidence by treatment as a person (not a service member) and retelling or debriefing, and Return to duty, if possible in their own unit (Stokes & Jones, 1995).

Over 650,000 service members served in ODS and DS from 1990-1991, but there was very little loss of life due heavy reliance on intensive air strikes as a war strategy (Marshal, Davis, & Sherbourne, 2000). This resulted in differences in the nature of stress experienced by these military personnel. The mental health stressors for ODS/DS included short notice of deployment, widespread speculation about chemical and biological warfare, high estimates of casualties, exposure to immense human and physical destruction, and a quick return from the combat theater to life back home (Holsenbeck, 1996; Perconte, Wilson, & Ponteus, 1993; Rodell, Cooley, & Altheimer, 1992; Wright, Marlowe, & Gifford, 1991). The Department of Veteran's Affairs (2011) estimate 30,000 ODS/DS Veterans were diagnosed with PTSD.

Following the ODS/DS, PIEs was reformulated as BICEPS for use with the US Air Force and Navy, which stands for brevity (hours-days), immediacy, centrality (treated at central location), expectancy, proximity, and simplicity (US Department of the Army, Combat Stress: Field Manual 6-22.5, 2000). Although the Navy centralized mental health interventions, the Army maintained that location for treatment should be as far forward as possible in order to attain proximity and immediacy under PIEs (Stokes & Jones, 1995).

Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)

OEF and OIF are different than previous wars in that the volunteer pool used to deploy troops is much lower than the voluntary military force needed in the Gulf War or the large pool of draftees during Vietnam (Tanielian & Jaycox, 2008). This results in increased stress on those deployed. A resulting challenge is that there are inadequate resources available to staff the current military mission. OEF/OIF deployments are often expanded beyond one year. Additionally, re-deployments and training away from home, even when in the states, are commonplace (Congressional Budget Office, 2005).

A new intervention in OEF/OIF was the examination of deployment-related mental health issues by Mental Health Advisory Teams (MHATs) that were annually deployed by the Army Surgeon General between 2003 and 2006 (Tanielian & Jaycox, 2008). MHAT reports reveal that the nature of the combat operations changed over time from troop buildups leading to major combat operations, followed by a period of relative calm, followed then by a growing insurgency, and these changes correlated with changing occupational stressors. MHAT identified acute stress in combat zones at about 15% across all MHAT assessments other than 2004 when it was about 10% (Tanielian & Jaycox, 2008). They also report depression in theater around 5%-9% (Tanielian & Jaycox, 2008).

During OEF/OIF, the Army CSCTs incorporated BICEPS from the US Marine Corps to replace PIES (Combat and Operational Stress Control Manual, 2006). The Army COSC Manual (2006, 1-8) specifies BICEPS as Brevity (rest and relaxation up to 4 days or increase level of

care); Immediacy (treatment as soon as possible after symptoms present); Contact (think of self as a fighter not a patient, command is directly involved in the soldiers recovery, focus on reintegration with unit); Expectancy (tell soldier his reaction is normal); Proximity (close as possible to unit but separate from medical patients); Simplicity (use brief simple wellness oriented interventions).

Combat Stress Control Teams

Combat stress involves all of the "physiological and emotional stresses encountered as a direct result of the dangers and mission demands of combat" (Combat and Operational Stress Control Manual, COSCM, 2006). Combat Stress Control Teams (CSCTs) are trained mental health providers that offer prevention and intervention to combat Soldiers with the primary intent to return them to battle. Some duties of CSCTs include providing education to unit command, briefings on suicide prevention, and informal support for deployed personnel; conducting surveys of the interpersonal unit morale; and providing information about post-deployment reintegration (Solomon, Rami, & Mikulincer, 2005).

According to COSCM (2006), "mental health sections are located in medical companies assigned to brigades, divisions, corps, and theater-level medical units" (p. 2-1). Every combat division's primary medical support service includes mental health staff; however, Armored Calvary, Ranger regiments, and other smaller detachments do not have mental health personnel immediately available. Medical Company CSCTs are assigned to a medical company supporting up to five divisions based on troop populations, moving quickly into areas that need more support during mass casualties.

CSCT mission priorities are primarily preventative with regard to PTSD, battle fatigue or contingency fatigue, and stress-induced misconduct that would invalidate the humanitarian mission of US operations if observed by non-military personnel or violations of the Uniform Code of Military Justice or international law (2006). According to the Combat Stress Control Manual, CSCTs have six combat stress control mission functions including,

1. Consultation-Liaison providing advice, preventative and educative services, and interventions for unit leaders, medical personnel, chaplains, and so forth.
2. Reorganization/Reconstitution Support for field units.
3. Proximate Neuropsychiatric Triage classifying level of stress to maximize return to duty using PIES (S= safety of the Soldier).
4. Stabilization of individuals presenting with severe stress reactions which present a safety risk to self or others.
5. Restoration of up to three days in a forward medical facility.
6. Reconditioning/retraining with treatment lasting up to two weeks in a more secure combat stress control facility (2006; DOD, 2013).

According to the Table of Organization and Equipment (TOE) report, at each medical company there should be six mobile COSC preventative teams, along with four mobile restorative teams, with each team being able to handle up to 40 Soldiers (COSCM, 2006, p. c-1). The CSCT restoration teams provide stabilization, neuropsychiatric triage, and up to three days of restoration (Patriot Outreach, 2011). They also provide consultation support to commanding

officers and medical personnel. If the CSC consultation results in a recommendation for evacuation to a combat support hospital, there are neuropsychiatric wards available Although each medical team should ideally have six prevention teams and four restoration teams, staffing limitations prevent this from occurring (Stokes & Jones, 1995). Limited availability of mental health specialty personnel, combat conditions, weather conditions, as well as other logistical issues result in less than optimal CSC resources in many situations (personal communication Lt. Col. Oemke, June 2016; personal communication Maj. Gen. Wilmoth, July 2016). Additionally, Stokes and Jones (1995) report there are no mental health services directly available at Mobile Army Surgical Hospitals and combat support hospitals which treat casualties in the most forward positions.

Problem Presented

Stressors for military personnel currently deployed include multiple deployments; shorter time at home between deployments; longer stays in country; the unique challenges of military service with the current use of counter-insurgency (COIN) methods; and the negative stigma Soldiers experience for seeking mental healthcare (Helmus & Glenn, 2005). For these reasons, current Soldiers likely experience an increased risk for developing peri-traumatic symptoms of combat exposure. Given that Forward Surgical Units (FSUs) are the first line of medical care offered to injured Soldiers, it is a logical conclusion that these units will be the first to interact with Soldiers demonstrating mental health issues related to combat exposure.

A complicating factor is that the CSCTs, which are tasked with providing supportive consultation to medical personnel, are not always available due to manpower shortages, weather or combat conditions, or combat priorities impacting their ability to travel to or communicate with medical personnel in forward positions (Stokes & Jones, 1995). As far back as 1924, Salmon suggested that all medical staff be educated about forward psychiatry principles in order to improve their ability to treat military personnel presenting with combat stress; however, training is not provided for FSU personnel regarding how to deal with mental health casualties (personal communication Lt. Col. Oemke, June 2016; personal communication Maj. Gen. Wilmoth, July 2016). As a result, the University of Memphis' Crisis Research Team (UMCRT) was approached by an experienced commanding officer of a FSU scheduled to re-deploy to Afghanistan. This officer requested we develop a condensed Crisis Intervention Team (CIT) training for the FSU based on the CIT model developed by Dr. Richard James, 30 years ago (personal communication, Lt. Col. Oemke, June 2015).

Crisis Intervention Team Training

Crisis Intervention Team (CIT) training was developed in 1988 to teach police officers how to triage and de-escalate situations involving individuals with mental illness in order to decrease the potential for violent outcomes to both the mentally ill subject (MIS) and the police officer (Compton, Broussard, Munetz, Oliva, & Watson, 2011; Dupont & Cochran, 2000; Steadman, Borum, & Morrissey, 2000). The CIT program encourages partnerships with trained mental health professionals (Deane, 1999; Watson & Fulambarker, 2013). The model was developed by Dr. Richard James at the University of Memphis in collaboration with the

Memphis Police Department (MPD) as a response to a police shooting involving a MIS. It is now called the Memphis Model (Dupont & Cochran, 2000; Watson & Fulambarkter, 2013).

The CIT training we provide consists of one week (40 hours) of contact with the CRT focusing on identification of mentally unstable behaviors, continual triage of the severity of the individual throughout contact, and use of interventions that match the level of severity assessed (Dupont, Cochran, & Pillsbury, 2007). There is a didactic component to the training and a practicum component where police officers demonstrate skill application in simulated real-life situations. Officers learn how to de-escalate situations in a manner that is frequently counter-intuitive to officers trained to use demonstration of power and control as a strategy to overcome subjects. Additionally, they learn how to collaborate with mental health professionals in order to direct people who need it to mental health treatment, rather than jail (Compton, Broussard, Munetz, Oliva, & Watson, 2011). It is estimated that there are over 3,000 CIT programs across the world (CIT International, 2012).

CIT has demonstrated improved outcomes in terms of safety to the officers and the MIS and more effective diversion to mental health intervention over jail (Dupont & Cochran, 2000; Steadman, Dean, Borum, & Morrissey, 2000; Teller, Munetz, Gil, & Ritter, 2006). One qualitative study found that officers reported a reduction in risk to injury to both officers and MIS when they used CIT skills (Hanafi, Bahora, Demir, & Compton, 2008). Additionally, Dupont and Cochran (2000) noted a lower number of SWAT team use when CIT officers were involved in calls. CIT-trained officers were also found to use force less often, and when force was employed, they were more likely to use low-lethal methods (Morabito, Kerr, Watson, Draine, & Angell, 2012; Skeem & Bibeau, 2008). The differences were attributed to the use of the CIT officers' assessment of dangerousness of the mentally ill individual.

CIT training improves both officers' knowledge and their perception of mentally illness (Compton et al., 2006). As a result, Chicago CIT officers were found to have increased rates of directing people to mental health treatment and to resolve mental-health-related calls with some action rather than non-CIT officers who reported contact only without intervention (Watson, Ottati, Draine, & Morabito, 2011). Additionally, mental health utilization by those people with severe mental illness was actually increased in one 12-month follow up study (Broner, Lattimore, Cowell, & Schelenger, 2004). CIT officers also report improved confidence in both the command structure's response and their own ability to effectively respond to calls involving mentally ill subjects (Borum, Deane, Steadman, & Morrissey, 1998; Wells & Schafer, 2006).

Modified CIT for Forward Surgical Units

The most significant modification we made to the CIT Memphis Model was condensing the training from one week to one day. The modified model, similar to CIT training, included didactic instruction and practicum experiences. There were six modules in the modified FSU CIT including Module 1: Triage Assessment; Module 2: Basic Skills; Module 3: Suicidality; Module 4: Peri-traumatic Anger/Aggression; Module 5: Peri-traumatic Dissociation; and Module 6: Grief and Traumatic Loss. Each module was condensed to 90 minute sections. The decisions regarding what material to include were made through extensive consultation with the commanding officer of the FSU, a member of the FSU, and a medically retired Army combat Veteran, the latter two

being CRT members. We utilized a train-the-trainer model, consistent with the Master Resilience Training (MRT) widely adopted by the Army (Reivich, Seligman, & McBride, 2011). There were four FSU members who volunteered to travel to Memphis to attend the training. These FSU personnel planned to train additional FSU personnel already deployed in Afghanistan once they arrived. We have provided ongoing consultation via email and phone to FSU members while deployed.

Didactic instruction for each module was followed by a practicum experience. Each member of the FSU had the opportunity to apply the knowledge and skills from the didactic portion of the training in a role-play situation. Members of the CRT prepared scenarios based on information from the FSU commanding officer which reflected real situations encountered during her previous deployment. Scenarios were modified through a process that involved the entire CRT working through potential issues related to how realistic the scenarios were. Consultation with our military and Veteran resources were crucial during this period. In preparation for the training, CRT members practiced role playing these scenarios by acting as if they were Soldiers accompanying medically wounded battle buddies to the FSU and who were exhibiting suicidal intent, peri-traumatic anger/aggression, peri-traumatic dissociation, or traumatic loss. Following each role play situation, the FSU members received feedback through a round-robin style feedback session with select members of the CRT who observed and took notes during the practicum about their performance in skill application. The final piece of the training experience involved development of Smart Cards (SCs) consistent with those used by combat Soldiers as a quick reference for important information and skills. We provided enough cards for the four FSU members trained at the university and 36 others who would receive training in-country.

Module 1 Triage Assessment Form

The first module is based on the Triage Assessment System (TAS; Myer, Williams, Ottens, & Schmidt, 1992) which was developed as an efficient means to assess crisis situations. The system is intended to be used as a continual assessment measure during a crisis situation so that the assessment of crisis level would inform interventions used by the crisis response personnel. It has demonstrated efficacy in studies of use by police officers, psychologists, social workers, nurses, EMTs, student affairs staff, and crisis phone workers, and others (James et al., 2015). The Triage Assessment Form (TAF) is one of five instruments developed based on TAS (Myer, 2001). The form provides a consistent method to monitor intervention, justification of intervention strategies and decisions, and data for advocating for specialized intervention (James et al., 2015). The TAF requires individuals to assess the level of severity for a subject from one to ten in three domains: affective, cognitive, and behavioral. Ratings are a numerical representation of the subject's ability to control their affect/thoughts/behaviors, the intensity of the affect/thoughts/ behaviors, and the duration of their affect/thoughts/ behaviors.

The three scale scores are added for a total score that indicates the level of response and strategies necessary to de-escalate or control the situation. Scores may be in the single digits to scores in the 20's. The purpose is to help non-mental health trained personnel to respond rather than react to people experiencing mental/behavioral health crises. Single digit scores indicate affect in line with what would be expected in the situation, purposeful behavior, and rational

thinking. The level of support indicated would be assuring a support system is in place, for example battle buddies or commanding officer support and release back to the front lines. A total score from 11-19 indicates affect and behavior are erratic and potentially dangerous and the subject's ability to think clearly is significantly negatively impacted. These individuals may demonstrate difficulty making sense out of what is going on around them. These scores would suggest a need for more support; more time spent de-escalating or containing the situation, and an increase in level of directedness from the CIT-trained personnel.

The most concerning are those people with scores in the 20's who require immediate attention, close supervision, and a high level of support, and when possible a referral to a combat support team for further intervention. As scores go into the mid-20's, hospitalization may be a necessity. These individuals present with distorted irrational thinking patterns, being 'out-of-it,' and/or either labile affect or alexithymic (inability to identify feeling states). At this point the Soldier has depersonalized the crisis and may be dissociative. The subject's behavior would be erratic and difficult to control. At this level the Soldiers likely presents a danger to themselves or others because they have clearly defined plans, lethal means, and motivation to pursue action.

Participants had didactic instruction on each sub-scale followed by case study practice and total scale practice. Participants received feedback from CRT members both individually and in group formats. We discussed scores as a group and identified those participants who tended to score higher than accurate or tended to score lower than accurate in order to improve their awareness of their own biases in perception of crises. A SC was developed that had the TAF on one side and appropriate responses based on total score on the other side.

Module 2 Basic Skills

This module focused on basic skills which are commonly taught in basic counseling courses or communication skills workshops. Additionally, the concepts of levels of directedness or non-directedness based on the TAF score were discussed. We reviewed 28 Do's and Don'ts for crisis situations. The focus of this module was to enable the participants to develop auditory, verbal, and physical techniques to calm and de-escalate out-of-control individuals. The basic skills were provided in a SC including information on open leads, closed ended questions, restatements, reflection of thoughts and feelings, and owning statements.

Module 3 Suicidality

Didactic information based on a thorough literature review conducted by the CRT was shared with the FSU personnel about management of suicidality among military personnel. We first focused on identifying and dispelling myths about suicidality. Then we covered a four step process including verbalizations and behaviors that might be observed by the participant when a soldier is suicidal. The steps covered were: Step 1: Recognizing warning signs; Step 2: Identifying internal coping skills, the likelihood of using these skills, and identifying barriers to using internal coping skills; Step 3: identifying people and situations where the suicidal individual is able to be distracted, engaged, or less withdrawn; and Step 4: Reducing lethal means, which is a particular challenge that needed to be discuss in a combat zone where everyone has weapons. A SC was developed with Suicidality Do's and Don'ts.

Module 4 Peri-traumatic Response: Anger/Aggression

Per-traumatic responses are responses to traumatic events that are thought to be normal under the circumstances of war, but which would be abnormal in civilian life. These symptoms have been documented in self-reports following trauma exposure during and immediately following these experiences (Marmar et al., 1994, 1999; Mattos, Perdrini, Fiks, & deMello, 2016). We approached the discussion of per-traumatic responses from the foundational assumption that these reactions are to be expected in a combat zone, particularly when the Soldier has been injured or is accompanying a battle buddy to the FSU who needs medical attention.

Bremner (1999) identified two potential subtypes of PTSD, one associated with hyperarousal and intrusive symptoms that are consistent with peri-traumatic anger and aggression, and one associated with peri-traumatic dissociation, which we discuss in Module 5. Understanding that many in the military have negative reactions to the suggestions of developing PTSD, we approached the module by first teaching behaviorally observable cues for anger and aggression by having the participants focus on their own experiences of anger. We then expanded those reflections to other situations. Finally, we taught ways to respond using basic skills previously taught and de-escalation techniques using the acronym DISARM developed by one of our CRT members, Mike Skirius (2015). DISARM stands for Distance (attention to physical proximity), Inertia (awareness of the soldier's level of activity or withdrawal), Short-term (focus on the here-and-now), Assess (continual assessment in the present moment), Repeat (repeat steps until situation is contained or resolved), and Model (display the behavior – calm and direct – you want the soldier to display).

Each participant had the opportunity to practice these skills in two practicum scenarios. We observed this module's practicum was the most challenging for the FSU personnel. Their tendency was to escalate rather than de-escalate. To address this observation we acknowledged that the response to attempt to control the situation by asserting verbal or physical dominance was understandable given that they were prepared for being under constant threat; however, we then discussed that although it is counter-intuitive to approach the situation differently, the behavioral evidence indicated that our techniques de-escalated the situations that were otherwise escalated by the attempts to assert control. We found them to be open to our re-framing.

Module 5 Peri-traumatic Response: Dissociation

Stress resulting from traumatic events is associated with both acute stress and peri-traumatic dissociation, and these have been linked to the subsequent development of PTSD (Fulleton et al., 2000; Murray, Ehlers, & Mayou, 2002; Shaley, Peri, Canetti, & Schreiber, 1996). When these reactions occur during or shortly after a traumatic event, as one might expect from a combat situation, it is called peri-traumatic dissociation (PD; Marmar et al., 1994). Peri-traumatic dissociation is a neurological effect of the brain's inability to synthesize and make sense of overwhelming traumatic information (Herman, 1997; Maguen et al., 2009; Van der Kolk, Van der Hart, & Marmar, 1996). In Module 5, we identified observable behavioral cues that indicated a Soldier is experiencing a dissociative state. Then we discussed the research about

underlying emotional function of the dissociative behavior including that it allows the Soldier to compartmentalize his experience to enable him to cope (Nijenhuis & van der Hart, 2011; Van der Kolk & Van der Hart, 1989).

Specifically important for the current population, several studies support a correlation between killing someone and subsequent peri-traumatic dissociation (Fontana & Rosenheck, 1999; MacNair, 2002; Maguen et al., 2010; Maguen et al., 2009). Gibney and colleagues (2013) suggested that "engaging in killing may elicit dissociation because personal responsibility for killing can be particularly difficult to accept emotionally and harder to displace than observing a killing" (p. 262). Research also indicates that people who are aware of the potential traumatic threat, like Soldiers in war, may be "more likely to experience peri-traumatic dissociation than those who experience it without warning because they have greater opportunity to perceive the threat, and thereby engage in more dissociative responses" (McDonald et al., 2013, p. 2).

Following the discussion of peri-traumatic dissociation, we taught and practiced physical and psychological grounding techniques to refocus the Soldiers' attention on their immediate environment. We discussed changing perceptions of traumatic situations to reduce the negative emotional impact on the Soldier in the present moment through reframing. The techniques used in this module included physical and psychological distancing, guiding objective thinking, reframing negative attributions, and refocusing using soft commands and identification of meaning or purpose for their contribution to their unit. A SC was provided with reminders of what to do in situations of peri-traumatic anger/aggression and peri-traumatic dissociation.

Module 6 Grief and Traumatic Loss

The final module we covered provided information on grief and traumatic loss. First, we focused on dispelling myths about grief and loss and distinguishing between normal grief and traumatic grief. Simple Do's and Don'ts were once again provided. The role of unit cohesion was discussed as it relates to the manifestations of grief. It was important for us to facilitate the participant's ability to minimize expectations about how long an intervention will take so that they would not feel pressured to 'fix' a situation that really needs someone to bear witness. Finally, the adaptive model of grief was covered to discuss different types of grieving. Under the adaptive model, intuitive grievers respond to loss in terms of emotion, and instrumental grievers process grief through thinking or acting on it. We specifically discussed identifying the type of grief and approaching the soldier from their preferred mode of processing. Participants once again practiced applying their knowledge and skills in two practical scenarios.

Planned Program Evaluation

For program evaluation purposes, we conducted pre- and post-tests on attitudes towards mental health issues and seeking mental health treatment. Similar to police organizations we have worked with, the military has an established negative stigma about mental illness. We propose that these attitudes negatively impact both openness to the material we teach in CIT trainings and the approach someone will use to deal with a Soldier with a mental health issue. We used the Beliefs about Mental Illness instrument to survey these attitudes, which we will analyze using *t*-tests. Consistent with our CIT trainings with the police, we administered pre- and

post-tests on the knowledge and skills taught didactically throughout the modules. We will also analyze this data using *t*-tests. During the practicum portions of the training, the first author made notes of behavioral observations to analyze the impact of this training component. At the end of the day, we also held a de-briefing focus group interview with the participants about what they found helpful and what they would change. Their primary concern was the need for more time to practice skills. Researchers noted that time was a limiting component and concluded for future training, a minimum of 16 hours will be required. The data gathered from the instruments, notes on behavioral observations during the training, a post-training focus group, analysis of in-country consultation and communication, and planned post-deployment interviews once the unit returns from Afghanistan will be summarized in a program evaluation document, which we hope to publish once complete along with recommendations for modifications for future FSU CIT training.

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Addressing Needs of Military Families during Deployment: Military Service Providers' Perception of Integrating Support Services

SETH CHRISTIAN WALTER HAYDEN
Wake Forest University

HARRIET GLOSOFF
Montclair State University

SANDRA LOPEZ-BAEZ
Walden University

LEIGH GREEN
West Texas A&M University

Abstract

Service providers are increasingly recognizing the need to develop effective methods for delivering supporting services to military families during deployment. The integration of services is viewed as an essential component of providing quality care for families experiencing deployment. Given the unique experience of deployment for military service members and their families, research into effective modalities of service delivery to attend to their needs is warranted. To enhance our understanding of this aspect of service delivery, a mixed-method study was conducted incorporating descriptive statistics and conventional content analysis of the perceptions of military family service providers' perceptions of collaborating with other professionals to support families experiencing deployment. The Support Service Integration Assessment designed to elicit views of the process of collaboration when supporting U.S. Army families during deployment was distributed using census sampling to 101 U.S. Army Family Centers in the United States. We received a total of 29 completed surveys and conducted six follow up interviews obtaining qualitative responses regarding U.S. Army family service providers' perceptions of collaboration. Results indicated service providers' perceived collaboration between civilian and military family providers as beneficial, ongoing communication as key to collaboration, and a need for policies and procedures that encourage collaborative care when working with military families. Limitations and implications for both practice and research also are discussed.

KEYWORDS: military deployment, support services, military family service providers

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Seth Christian Walter Hayden is an Assistant Professor in the Department of Counseling at Wake Forest University; Harriet Glosoff is Professor of Counseling and Educational Leadership at Montclair State University; Sandra Lopez-Baez is Core Faculty in Counselor Education at Walden University; Leigh Green is an Assistant Professor of Education at West Texas A&M University. *Address correspondence to Seth Hayden. Email: haydensc@wfu.edu.*

Men and women in the United States military experience unique circumstances related to their service. Throughout American history, these individuals and their families have sacrificed a great deal for their country with the recent conflicts in Afghanistan and Iraq as well as ongoing engagement in foreign lands presenting significant challenges to this segment of our population. While experiencing deployment, military family service providers play a pivotal role in ensuring the well-being of both the service members and their families. Given the multi-faceted nature of the deployment experience, several layers of support are often needed to effectively address ongoing concerns of military families. Collaboration between providers of this support has been indicated as important (Booth, Segal, & Place, 2009), yet little is known related to this process. The context in which military families operate is useful when considering elements of support services.

The climate of service in recent engagements has involved long periods of deployment, a high likelihood of being redeployed, and exposure to potential physical and psychological harm. The experience of deployment has been found to be a stressful experience for military families (Amen, Jellen, Merves, & Lee, 1988; Jensen, Martin & Watanabe, 1996; McCubbin & Dahl, 1976; McNulty, 2005). This stress typically leads to negative mental health outcomes within the family system (Barnes, Davis, & Treiber, 2007; Gibbs, Martin, Kupper, & Johnson, 2007). Vergakis (2013) reported that looming budgetary concerns increased stress amongst military family members due to the potential strain related to a smaller force supporting missions, which increased the likelihood of extended and repeated deployments. These concerns often contribute to military family members seeking support services.

When accessing services, family members may experience additional stress because family support services are often inconsistent and disconnected from each other (Booth, Segal, & Place, 2009). There is an understanding within the military family support system of the benefits of service collaboration and integration (Booth, Segal, & Place). However, there has been a paucity of research examining the level of collaboration and integration that exists within the military family support system and the processes by which family members may access such services (Hoshmand, & Hoshmand, 2007).

The Need for Integration of Services

The integration of support services is a continuing point of discussion within the field of military mental health. Though a myriad of programs designed to support military families with the stress of deployment exist, it is essential that these programs are utilized and are beneficial to the spouses and children of deployed service members (Adams et al., 2005). Military spouses often have a desire to utilize supportive services, but a significant number do not perceive these programs as available to them (National Military Family Association, 2006). Military researchers and practitioners only recently started to acknowledge the broader community and the power of both formal and informal networks endemic to a community perspective as a viable partner in supporting the mental health of military families (Huebner et. al., 2009; Tanielian et al., 2008).

Though the deployed service member is tangibly impacted by the experience, researchers have suggested higher rates of stress for the non-deployed partner (Haas, Pazdernik, & Olsen, 2005; Jenson, Martin, & Watanabe, 1996; McNulty, 2003). For example, there have been

indications of up to four times a higher rate of child neglect and three times a higher rate of child maltreatment related to the stress of deployment for those at home (Gibbs, Martin, Kupper & Johnson, 2007). This presents unique concerns for those who assist military families during deployment.

There is recognition of the importance of collaboration on the part of service providers (Booth, Segal, & Place, 2009), but the apparent lack of service integration requires an examination of this process (Hoshmand & Hoshmand, 2007) to determine facilitative and inhibiting elements of collaboration amongst providers. To better understand the manner this occurs, we conducted research to examine U.S. Army Family Support Service Providers' perceptions of the barriers, benefits, and methods for expanding collaboration among service providers assisting families during deployment. The following discussion outlines the theoretical foundations for the study, the methods and results of the research, and the implications for counselor, counselor educators, and public policy.

Theories of Ecology and Integration

The Community Capacity Model (Chaskin, 2001) and Bronfenbrenner's ecological systems theory of development (1979, 1986) were both used as a framework for this study. The community capacity model factors include the existence of resources, a network of relationships, leadership, and participation by community members in collective action and problem solving skills (Chaskin, 2001). This model addressed the shift from solely military providers to more community-based support services for families during deployment. The objective of the model was to identify resources and relationships that could support families. In addition, Bronfenbrenner in his ecological systems theory of development (1979, 1986), emphasized the impact of various external systems on members of a family. Those who conceptualize development through Bronfenbrenner's model view the environmental system as comprised of nested structures (i.e., schools, social welfare systems) that affect individuals and stress the importance of focusing on the impact of these systems and the interaction between them on family members. This model emphasizes the importance of addressing issues of family members' development in the context of these structures.

Utilizing a community capacity approach, with an emphasis on integrated services, provides a framework in which to address the multifaceted needs of military families encountering the stress of deployment. There has been previous consideration of this service structure as the integration of supportive services has been recognized as a useful approach to assist military families, but appears not to be implemented in a significant manner (Booth, Segal, & Place, 2009). There has been a call to examine process factors that are crucial to successful partnerships and program implementation (Hoshmand & Hoshmand, 2007). This study was conducted to examine the perceptions of military family service providers about the process of collaborating with other providers to support families during deployment.

Research Questions

The following four research questions guided the study.

1. In what ways do service providers working with military families integrate their work with other service providers when a family member is deployed?
   a. With whom do service providers attempt to implement an integrative approach to service provision for military families experiencing deployment?
2. What, if any, benefits do service providers to military families see to an integration of supportive services during the experience of deployment?
3. What do service providers view as barriers to the integration of services for military families experiencing deployment?
4. In what ways do service providers believe that the integration of services could be expanded in future work with military families experiencing deployment?

Methods

For participants, the authors contacted the l01 U.S. Army family centers listed in a contact database acquired through the National Military Homefront website, inviting service providers to participate in the study. Due to the differences in social and cultural experiences of service providers abroad and the nature of their integration of services, only family centers in the United States were utilized in this study. From the population of service centers, a sample of 29 service providers responded to the online survey. There were two phases of data collection. First, the survey was distributed to the aforementioned centers to provide service providers with the opportunity to respond. The second phase involved interviews with providers who responded to the initial survey and indicated a willingness to speak in depth about their perceptions of collaboration.

Within the sample of the initial survey respondents, 65.5% identified as female, 31% identified as male, and 3.4% identified as "other," but did not provide any additional information regarding their gender identity. In terms of the gender of the interview participants, one interviewee was female (16.6%). The other five (83.3%) interviewees were males. The largest category of survey respondents was Caucasian/Non-Hispanic (82.8%). While the representation from other groups such as Latino/Hispanic (3.4%) and Native American (3.4%) was minimal, each group was represented in the survey. The Midwest was the most frequently (48.3%) identified region. The South was the second most represented region (17.2%) followed by the Northeast region. The West region also had similar (13.8%) representation and the Southwest region had the smallest percentage (6.9%).

The respondents to the study consisted of a diverse group of professionals who assist military families during deployment. The "other" category was the most frequent response (72.4%) to the professional orientation question. Participants included the following position titles: family programs manager, battalion soldier and family assistance staff, deployment/ mobilization manager, family assistance coordinator, licensed marriage and family therapist, non-profit (as indicated by the respondent), program administrator, and supervisor. The second most frequently identified category was social worker with six (20.7%) respondents. Two (6.9%) service providers identified as psychologists.

The respondents to the online Support Services Integration Assessment (SSIA) were largely non-military (65.5%). Thirty-one percent indicated they were either active duty military

or a Veteran of the US Armed Forces. To gauge a sense of the length of time the respondents had worked with military families experiencing deployment, they were asked to provide a general time frame in which they had been working with military families experiencing deployment. From these categories, eight (8) years and above was the most frequently (48.3%) indicated time of experience selected by respondents. The second most frequent response was 3-5 years (31%), followed by 0-2 years (13.8%), and lastly 5-7 years (6.9%).

Trustworthiness

The concept of trustworthiness in qualitative analysis indicates whether readers should deem the findings of a study worthy of consideration (Lincoln & Guba, 1985). Credibility, confirmability, dependability, and triangulation were the primary means utilized to establish the trustworthiness of this study.

Credibility

A peer debriefer or reviewer was used to determine if the conceptual interpretation of the original data sets appeared "credible" (Lincoln & Guba, 1985). The debriefer was continually involved in the development of this research and possessed an informed awareness of the nature of the study. We continually tracked the process of analysis by journaling and creating analytic memos to provide a rationale for findings. Process notes were used to track the process from the beginning of the study until its completion. Discussions with family service providers and research team members, key decisions related to both in implementation and analysis, and challenges and successes experienced in the research were included in these notes.

Confirmability, Dependability, and Triangulation

An audit trail was maintained allowing for an independent auditor to review all steps of data collection and analysis. The audit trail consisted of the IRB approval for this study, a copy of the raw qualitative data, process notes, explanations of all coding decisions, definitions of codes and themes, and a reflexive journal discussing thoughts and reactions to the process of analyzing the data.

As previously mentioned, we enlisted a peer reviewer to evaluate the process of analysis and interpretation of the information. The peer debriefer, who at the time of the study was a doctoral student researcher and is now a full-time counselor educator, was familiar with qualitative research as well as a mixed methods approach to examining research questions. The peer debriefer determined that the process appeared sound and that the results of the study were consistent with her perceptions of the research.

We also ensured confirmability by providing the phone interview participants with the transcripts of the interviews to determine the accuracy of the transcriptions. All six interviewees indicated the transcriptions were an accurate accounting of our discussion.

The first author generated analytic memos detailing data analysis for transparency in addition to providing an opportunity to reflect on the process. Investigator and data triangulation

were also utilized. The first author enlisted the input of fellow doctoral level researchers regarding their input of the process of coding the responses to both the online SSIA and the SSIA phone interviews. The data were triangulated using both the qualitative responses to the SSIA and the transcripts of the phone interviews. These two forms of triangulation provided verification of both the process and findings of the analysis.

Researcher as Instrument

The first author was the primary instrument for analyzing the results of this study. While this was appropriate given the nature of the research, he was aware of the potential influence of his perspective in the analysis of the data. Given that he possessed awareness of previous research regarding military family support service integration, it was essential to enlist others' input regarding the analysis of the qualitative elements of the study. While his previous knowledge shaped the study, it created the potential to discount findings inconsistent with previous research or emerging themes. He consulted with research team members as well as fellow doctoral level researchers to minimize the impact of previous knowledge and investment in emerging sub-themes.

Definition of Terms

Given the varied definitions of the key constructs, the following are defined terms related to the study. This will assist with grounding the discussion of later findings.

Military deployment refers to the experience of military personnel in relation to their service away from home and involves five phases; pre-deployment (from notification to departure), deployment (from departure to return), sustainment, redeployment, and post-deployment (Pincus, House, Christiansen, & Adler, 2005).

Integrated service refers to collaboration amongst military and community support service providers working with families experiencing deployment (Batten & Pollack, 2008).

Support Service Providers refers to family advocates, mental health and school counselors, primary care physicians, or any other professional who assist in a military family's well-being during the deployment experience.

Measure

Participants completed an online survey, the Support Service Integration Assessment (SSIA), which was developed specifically for this study, on the nature of collaboration and service integration among family support providers. The survey consisted of seventeen items that yielded both quantitative and qualitative data designed to collect information related to: participants' professional orientation (i.e., counselor, family advocate, psychologist, social worker, other); ethnic and racial identification; number of years in military mental health services; and, the average number of military members served over the past year from the point of data collection who have experienced deployment. This information was used to provide a

detailed description of the sample to assist with data analysis and discussion of implications for practice and future research.

Measurement Development

Items for the SSIA (see Appendix A) were developed based on the information shared in the review of the literature on this topic. Given Bronfenbrenner's (1979, 1986) discussion of the influence of systems as well as Hoshmand and Hoshmand's (2007) indication of the benefits of community involvement in supporting military families, a list was developed of five topics related to military family support services. The topics developed from the literature included: (a) current level of integration, (b) with whom military support service providers collaborate, (c) the perceived benefits of integrating family support services, (d) the perceived barriers to family support service integration, and (e) future considerations regarding methods for enhancing and expanding military family support service integration. The final instrument items used on the SSIA were designed to elicit information from the service providers regarding their perceptions of their collaboration with other family support service providers. Given the call for support service integration (Booth, Segal, & Place, 2009), the survey items were designed to focus specifically on the family support service integration process from the perspective of the military family support providers. The items also were designed to address participants' perceptions of various barriers to support service integration identified in previous research (Hoshmand & Hoshmand, 2007).

After requesting demographic information such as gender identity (male, female, other), cultural/ethnic identity, general region of the U.S. in which providing services, and length of time working with military families experiencing deployment, the assessment specifically asked participants about their perceptions regarding collaborating with other service providers to support military families experiencing deployment.

The SSIA provided participants with the opportunity to answer qualitatively; for them to expand on their view of the benefits, barriers, and opportunities for increasing collaboration among military family support service providers. Participants were then asked if they would be willing to participate in a follow up interview in which they could further elaborate on their perspectives regarding support service integration.

Interviews

At the end of the survey, participants were offered the opportunity to participate in a short interview (see Appendix B for the interview question guide). The purpose of the interviews was to provide a rich description of military family service providers' perceptions of collaborating with other service providers to integrate support services for families experiencing deployment. The interviews with six participants were conducted by telephone and lasted approximately 10-20 minutes. The first author conducted semi-structured interviews, with the discussions addressing questions in a nonlinear fashion. The interview question guide was constructed similarly to the online SSIA, with consideration of previous literature around collaboration and the use of community-based programs (Chaskin, 2001; Hoshmand & Hoshmand, 2007; Huebner et al., 2009) and with the opportunity for participants to further elaborate on barrier, benefits, and

opportunities for expanding collaboration amongst military family service providers. These responses provided an expanded understanding of the participants' view of the integration of family support services.

Analysis

For the quantitative elements of the data, descriptive statistics were utilized for several reasons. First, this information provides a specific description of the participants in the study indicating the generalizability of the results. Second, when describing aspects of the measures utilized, this data can establish potential relationships between variables or groups. Finally, this information may be pertinent in the replication of a study (Balkin & Kleist, 2017).

A conventional content analysis approach (Hsieh & Shannon, 2005) was utilized in the coding of qualitative responses on the SSIA and interview responses. The purpose of this process of content analysis is to provide a "subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes" (Hsieh & Shannon, 2005; p. 1278). This method of analysis is inductive and descriptive (Hsieh & Shannon) and is appropriate due to the paucity of research on the collaboration of service providers assisting families during deployment. The themes of benefits, barriers, and expansion were derived from the codes established from the quantitative data. Given the lack of previous qualitative research on this topic, the process of building themes inherent was an effective method of analysis.

Results

Certain questions were designed to examine various perspectives of the family service providers' perceptions of the process of collaboration. One item asked participants to what degree service providers working with family members integrated their work with other service providers when a family member was deployed. "Always" was the most frequently indicated answer (51.7%). The second highest response was "Very Often" (31.0 %). The "Sometimes" category had four (13.8%) responses with the "Rarely" response yielding only a 3.4% response rate. No service provider indicated "Never" attempting to collaborate with other family support service providers when working with military families experiencing deployment. This indicates a high degree of an attempt to collaborate with other family support service providers.

Research question 1a sought further information on the identity of service providers with whom participants collaborated. Military mental health providers (79.3%) were the most frequently indicated group reported by respondents when working with families of members who were deployed. The second most frequently noted group was civilian mental health providers (72.4%), followed by civilian school counselors (62.1 %). The group with the fourth most frequent responses was civilian primary care physicians (48.3%), followed by the "Other" category (41.4%) and military primary care physicians (37.9%). The least frequently indicated group with which the respondents attempted to collaborate to integrate support services are military school counselors (27.6%).

For research question 2, participants were asked what benefits they perceive for family members during deployment when integration of supportive services occurs. There was almost

unanimous agreement on the part of the service providers in viewing collaboration with other service providers as beneficial to families who are experiencing deployment. Ninety-three percent of the respondents indicated agreement that collaboration with other service providers is beneficial to families experiencing deployment. A very small percentage (6.9%) of service providers reported they were undecided whether collaboration with other service providers is beneficial to families experiencing deployment. This indicated a high level of agreement amongst the respondents to the online SSIA regarding collaboration being beneficial to families experiencing deployment. A follow up item allowed respondents the opportunity to expand on their perceptions of the benefits of collaboration with other professionals.

Service providers were also asked about perceived barriers to the integration of services for military family members during deployment. This information related to research question 3 was both quantitatively descriptive and qualitative in nature. A majority (58.6%) of the respondents responded "no" to whether there are barriers to collaboration with other professionals. Twelve (41.4%) participants reported there are barriers to collaboration with other professionals.

Qualitative data related to perceived barriers was also collected both in the online survey and through the interviews related to the benefits, barriers, and potential to expand collaboration. We used the qualitative information gathered in the open-ended items as well as the interviews to address research questions 2, 3, and 4. The qualitative data provided insight into the service providers' perceptions of collaborating with other professionals when assisting families experiencing deployment.

We identified several sub-themes related to the theme of *Collaboration* (see Table 1; *T* – indicates sub-themes indicated in the interviews). *Expansion of Services* (14; *T*- 6) was a most frequently reported byproduct of collaboration followed by *Accessibility* (5; *T*- 4) as it relates to services for military families and *Awareness* (3, *T*- 5) of services on the part of both providers and military family members. In relation to the *Barriers* to collaboration theme (see Table 2; *T* – indicated sub-themes identified from the interviews), there were significant differences in the survey and interview responses in relation to the sub-themes. *Competition* (2; *T*- 3) did appear in both the online survey and interview responses. *Lack of Awareness* (*T*- 5) in regards to elements of collaboration such as an awareness of the nature of various services was also a frequently indicated sub-theme, but was only identified in the interviews, as was *Procedures* (*T*- 4) such as the tracking of provided services. In relation to this sub-theme, providers endorsed the focus solely on the military families' utilization of services as opposed to the implementation of services limited collaboration. Finally, the third main theme of *Expansion* as it related to collaboration was identified (see Table 3; *T* – indicates sub-themes indicated in the interviews). Within this theme, the sub-theme of *Communication* among providers serving military families was the most frequently indicated (4; *T*- 5) followed by *Outreach* (5) to other providers, *Contact* (*T*- 5) with others assisting military families, and *Organization of Services* (*T*- 5) in regards to the potential homogenization of family support services delivery structure across the branches of the military.

Table 1. *Collaboration Sub-themes within the online SSIA Responses and the Phone Interview Transcripts*

Collaboration Sub-themes	Frequency	References
Accessibility	5	5
Awareness of Services	3	3
Consultation	1	1
Continuity of Care	3	3
Efficiency	4	3
Expansion of Modalities	2	2
Expansion of Services	14	14
Quality of Care	5	3
T – Accessibility	4	4
T – Awareness	5	5
T – Contact	3	2
T – Continuity of Care	2	2
T – Efficiency	1	2
T – Expansion of Services	6	5
T – Quality of Care	1	1

T- indicates sub-themes developed from phone interviews

Table 2. *Barrier Sub-themes within the online SSIA Responses and the Phone Interview Transcripts*

Barrier Sub-themes	Frequency	References
Client Resistance	1	1
Communication	1	1
Competition	2	2
Cooperation	2	2
Cultural Detachment	3	3
Distance	2	2
Ignorance of Military Culture	3	2
Leadership	1	1
Process	1	1
Time	2	2
T – Accessibility	1	1
T – Client Resistance	1	1
T – Communication	1	1
T – Competition	3	2
T – Expertise	1	1
T – Knowledge of Services	3	2
T – Lack of Awareness	5	2
T – Nonexistence	1	1
T – Procedures	4	2

T- indicates sub-themes developed from phone interviews

Table 3. *Expansion Sub-themes within the online SSIA Responses and the Phone Interview Transcripts*

Expansion Sub-themes	Frequency	References
Accessibility	2	2
Communication	4	4
Community Projects	1	1
Continuity of Care	1	1
Cultural Detachment	3	3
Education	1	1
Financial	1	1
New Inclusion	1	1
Organization of Services	1	1
Outreach	5	4
Status Quo	2	2
T – Communication	5	2
T – Contact	5	2
T – Financial	2	2
T – Leadership	3	2
T – Organization of Services	5	2
Expansion Sub-themes	Frequency	References
T – Procedures	2	2
T – Status Quo	1	1

T- indicates sub-themes developed from phone interviews

Discussion

Perceptions of Collaboration

Service providers responding to the online SSIA as well the phone interviews offered several different methods in which they collaborated with other service providers experiencing deployment. These methods were embedded within responses to items and imbedded in each theme of *Collaboration, Barriers,* and *Expansion*.

Service providers engaged in collaboration by attempting to communicate with professionals both within the military service apparatus and the surrounding community. Service providers discussed the importance of accessibility to both service providers and those receiving services as a strategy of integrating support services. Based on the results of this study, involvement with community projects aimed at reaching out to military families in civilian areas and collaborating with community agencies designed to address such issues as family violence or other issues of concern to military families experiencing deployment is significantly important.

The perceptions of service providers focusing on whom they collaborate with when supporting families experiencing deployment offered some interesting results. Per responses to the online SSIA, three of the top four professionals who service providers attempt to collaborate with were civilian service providers (i.e., civilian mental health providers, civilian school

counselors, and civilian primary care physician). This is consistent with the body of research discussing the need for community programs as an invaluable resource for military families experiencing deployment (Hoshmand & Hoshmand, 2007). The current budgetary considerations, as well as the magnitude of recent military conflicts, may increase the need for military families to access services within the community while experiencing stressors related to deployment. The need for collaboration between civilian and military service providers was illustrated by the perceptions of the service providers responding to the SSIA.

The variety of service providers in the "Other" category highlights that family support service providers who responded to the SSIA access a wide variety of other service providers when assisting families experiencing deployment. This network of support demonstrates the complexity of needs experienced by military families. This complexity seems consistent with previous research regarding the involvement in community-based programs in supporting military families (Hoshmand & Hoshmand, 2007). This also speaks to Bronfenbrenner's (1979, 1986) contention regarding the influence of several systems on an individual and/or family. Military families experiencing deployment are positioned within a community context with additional resources to support them during this unique experience. Connecting these entities provides a network of support to address a myriad of concerns a family may encounter during deployment.

Overall, the respondents to the SSIA indicated a myriad of methods and service providers involved in the process of supporting families experiencing deployment. The respondents also indicated a high level of involvement on the part of civilian service providers.

Benefits of Collaboration with Other Service Providers

Service providers unanimously viewed collaboration as beneficial for families experiencing deployment. They offered several ways in which collaboration is beneficial such as increasing access to services and improving the continuity and quality of care. In addition, the respondents endorsed the expansion of services for families experiencing deployment as a result of service integration on the part of family support service providers.

The valuing of collaboration along with the apparent practice of integrating care with other providers demonstrates the importance of this practice on the part of military family service providers who responded to this survey. Expanding access to services on the part of military family members due to collaboration aligns with the initial views of the research team members and is worthy of consideration when serving a population with often compounding needs.

Barriers to Collaboration with Other Service Providers

A majority the participants did not view barriers to collaboration with other providers. This was a surprising finding due to the seemingly continual calls for an increase in collaboration in professional literature, indicating some element of barriers to support service integration. In fact, less than half of the respondents (41.6%) to the online SSIA reported barriers to collaboration with other professionals.

For those who did respond to the affirmative regarding barriers to collaboration, this may be linked to the cultural understanding civilian providers feel towards the military apparatus and thus military families. A discussion of the military as a cultural entity was presented within the *Barriers* theme and has been extensively discussed both in previous studies of military personnel and families and by those within the military apparatus (Huebner et al., 2009; Stroul, 2007). The responses from participants posited the cultural aspects of the military as an "us" and "them" orientation involving a general lack of awareness by civilian providers regarding various aspects of the military environment. This cultural divide was viewed as a barrier to supporting service integration. Civilian providers would benefit from an understanding of the military culture as they assist military personnel and families.

Additional barriers regarding awareness of the issues of this population and procedures which hinder collaboration were reported by the service providers participating in the study. An unexpected finding in the study was the competition between service providers for resources as well as competition between branches regarding the manner in which they provide services as there are significant differences in the structure of service delivery. Competition as a barrier to the integration of support service is useful information when considering the experience of those providing services.

Perceptions of Ways to Expand Collaboration

Participants discussed reaching out to other service providers as well as having first hand contact with other professionals working with families experiencing deployment as ways in which to expand collaboration. The organization of services with an elimination of the branch specific support services creating a single military service provision apparatus was indicated as one way in which to expand support service integration for families experiencing deployment. Though a military service member may reach out to providers in other branches, there are clear differences in the framework in which services are provided. Participants also discussed involvement in community projects and setting military families as a primary priority as ways in which collaboration among service providers can be expanded to integrate support.

Expanding collaboration through community-based approaches, which also involves leadership and communication, is consistent with Chaskin's (2001) findings regarding leadership, relationships, and the shared goal of problem solving being key components in collaboration. These findings also appear consistent with Huebner, Mancini, Bowen, and Orthner's (2009) community capacity approach. This approach positions the family within the community and emphasizes the valuing of networks designed to address the needs of families, viewing community members as partners and assets as opposed to beneficiaries of services.

Limitations

The focus on service providers, as opposed to military families, is one limitation of this study. The time frame of the study did not allow for contact with military families due to the requirement to submit the research for military institutional review board approval. An additional limitation was that the study focused on military family service providers as opposed to providers working with unmarried service members. Although previous research (Hoshmand &

Hoshmand, 2007) indicated a need to focus on the families, given their number, this focus limits the transferability to non-married partners.

The focus on bases within the United States also limits the generalizability and transferability of the results. There may have been certain cultures and social influences at each location that influenced the military spouses experiencing deployment. An additional limitation was the focus on deployment. While deployment presents a unique reality for military families, the limiting constraints of discussing the issue of collaboration with service providers working with families experiencing deployment does not account for the needs of military families who are not currently, or have not experienced deployment. An additional limitation of this study was that no prior research regarding this topic had seemingly been published. Although the items on the SSIA were based on previous literature regarding the integration of service process within the military, the psychometrics of the assessments need further support. The psychometric qualities of the instruments have yet to be affirmed due to being constructed by the research team to examine the perceptions of service providers. The SSIA could be enhanced by instrumental rigor. Finally, given the lack of research on the collaboration among service providers serving military families, the small sample size prohibits the generalization of the findings beyond those who responded to this study. This was, however, a seemingly useful first step to gain insight into this process to inform future research in this area.

Implications

Mental Health Service Providers

Three main implications for service providers assisting military families emerged from this study. First, the findings offer insight regarding the degree that continual communication was critical among service providers serving this population. While constraints of time often make it difficult for providers to be able to communicate with others working with families, this communication offers a way to effectively support families experiencing deployment. Secondly, civilian service providers would be wise to consider the military as a culture and educate themselves on how that culture influences the manner of providing services as well as those who receive them. In turn, military providers could also benefit from a continued willingness to access agencies and entities within the community that could significantly benefit families during the deployment experience. This synergistic approach to support service provision could have significant benefits to those receiving services. A final implication for mental health service providers was the willingness of participants to include various service providers in an organized service provision framework. The indication of primary care physicians, school counselors, and a myriad of other service providers seems to indicate that a structured approach to support service integration could provide families with an effective and efficient network of support services including a variety of service providers based on the needs of the family during deployment.

Counselor Educators

Counselor educators are preparing current and future service providers to work with a diverse population experiencing a wide array of issues. Educators who may be uninformed of the unique experience of a military family would benefit from becoming educated on the needs of

this population to ensure the appropriate training of aspiring counselors who are likely to encounter a military family at some point in their work. Recent developments regarding the formal inclusion of counselors within the occupational structure of the Veterans Administration have created a greater need for skilled counselors to successfully address the needs of military families. This requires taking responsibility for learning effective means of collaboration to integrate support services for families experiencing deployment. Additionally, counselor educators would benefit from learning the structure of support service provision within the military apparatus to ensure their students are aware of the various roles of providers working with military families. Awareness of the meaning of various acronyms, a common language within the military culture, would also be helpful when sharing with students the function of various entities which will interface with military families during deployment.

The preparation of school counselors is also important to consider. Given that participants frequently identified school counselors as a group for collaboration, focusing on the unique experience of children of military families in the preparation of school counselors could significantly enhance the awareness of school counselors of the needs of this population.

Counselor educators are a vital asset in the effort to address the needs of military families during deployment. Those with knowledge and/or experience with providing services to military personnel and families are in a unique position to significantly contribute to the preparation of service providers who will be collaborating with other professionals to integrate support services.

Policy Considerations

Crafting future policy and procedures is also an aspect of support service integration. While many have called for an increased expansion of support service integration and collaboration, barriers such as time and communication exist related to the need for collaboration. For example, developing policy and procedures which account for these barriers prioritizing the task of collaboration in prescribed duties and building in time for this type communication within the regular work day could dramatically increase collaboration and encourage support service integration on the part of service providers assisting families experiencing deployment. A willingness to remove unnecessary and repetitive procedures which inhibit collaboration could also enhance integration. Finally, informing community and military leadership of support services available within both civilian and military communities, and encouraging service providers to collaborate could increase the likelihood of an integrated approach to service provision.

Suggestions for Further Research

There are several future considerations related to this research. The collaboration among service providers to support families during deployment is a continually evolving issue. While current issues may surround deployment, as the nature of conflicts change, the way in which service providers assist military families must adjust to account for their needs. Service providers who work with military families, and those who educate and supervise them, need to stay abreast of the issues within this population.

More research regarding approaches to providing services is an additional consideration. Given the uncertainty regarding federal and state funding for services, it is critical for service providers to effectively structure their time and efforts to address the needs of military families. Research is also needed regarding the perceptions of military families who receive services. The specific focus on speaking with the service providers was a useful starting point for the current study. This potential contrast between the perceptions of families and providers could provide vital information to further inform future policies and procedures. Studying the perceptions of those who receive services will provide an additional layer of information that can inform service providers and decision makers regarding the needs of this population.

Continuing to develop models of service provision in which the process of collaboration is defined in a protocol, as opposed to a good idea, is a future consideration of this research. Taking the identified themes and providing statistically substantiated findings around the sub-themes and their associations would further enhance the elements of collaboration to integrate support services. All the indicated themes may not equally impact this process. Additional research might provide greater clarity of the different degrees of importance of the various aspects of this process. Creating and investigating statistically substantiated models of service provision could enable the integration of services to be implemented by several entities within civilian and military communities.

Conclusion

Despite the limitations discussed, it appears this study provides evidence, through the perceptions of military service providers, of the importance of collaborative service delivery when supporting families experience deployment. In addition, potential barriers to this process and possible ways in which collaboration might be expanded were identified. While this study is a starting point related to service delivery models that address familial stress during deployment, the researchers began to look at alternative methods of supportive service delivery to military families during deployment. Given the needs of the population and the apparent benefits of integrated services, developing an understanding of effective means for connecting providers could positively impact military families both now and in the future.

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APPENDIX A. Support Service Integration Assessment Demographic Information

For the purposes of this study, please answer the follow items related to your professional orientation and region where working, your degree of work with families experiencing deployment, and your demographic information.

1) What is your gender identity?
Male ___ Female ___ Other (You may specify in the following line) _____

2) How do you identify yourself culturally/ethnically?
(These categories are limited for classification purposes. Please feel free to write your cultural/ethnic identify in the line provided after the categories)
African-American ___ Asian ___ Caucasian (Non-Hispanic) ___ Caucasian (Hispanic)
Latino/Hispanic ___ Native-American ___
Category not provided_____

3) What general region of the United States do you provide services?
Northeast (CT, DE, ME, MD, MA, NH, NJ, NY, PA RI, VT) ____
Southeast (AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV) ____
Midwest (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI) ____
Southwest (AZ, NM, OK, TX) ____
West (AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY) ____

4) What is your professional orientation?
Counselor ____Family Advocate ____ Psychologists ____Social Worker ___
Other (Please write in your specific profession) _____

5) Are you active-duty military or a veteran of the U.S. Armed Forces?
Yes ___ No ___

6) Have you had experience working with families experiencing deployment?
Yes ___ No ___

7) Have you worked with families who have had a member deployed to Iraq and/or Afghanistan??
Yes ___ No___

8) How long have you worked with military families experiencing deployment?
0-2 years ___ 3- 5 years ___ 5-7 years ___ 8 years and above ___

9) What is a rough estimate of the number of families you have worked with who have experienced deployment?
0-10 families ___ 11-20 families ___ 21-30 families___ 31-40 families___
41 and above families ___

Support Service Integration Assessment

Before we begin, here are a few definitions of terms to provide a frame of reference for completing the items.

Cycle of Deployment – The cycle can be divided into five distinct phases; pre-deployment (from notification to departure), deployment (from departure to return), sustainment, redeployment, and post-deployment. Due to the nature of deployment, deployment will be limited to families experiencing deployment to Iraq and/or Afghanistan.

Integration of Support Services/Collaboration – The intentional collaboration between family support service providers in order to integrate support services for families experiencing the cycle of deployment.

Family Support Service Providers – This can be anyone who provides services to families experiencing the cycle of deployment. It may be counselors, family advocates, financial advisors, primary care physicians, psychologists, social workers, etc.) These professionals can be civilian or military.

These terms will be used throughout the assessment and will provide structure to the information presented.

Please answer the following questions regarding collaborating with other service professionals and the integration of family support services for families during deployment.

10) Do you attempt to collaborate with other family support service providers when working with military families experiencing deployment to Ira and/or Afghanistan?
Never ___ Rarely ___ Sometimes ___ Very Often ___ Always ___

11) Do you agree or disagree that collaboration with other service providers and professionals working with military families is beneficial to families experiencing deployment?
Completely Disagree ___ Slightly Disagree ___ Undecided ___
Slightly Agree ___ Completely Agree ___

12) If you do view collaboration as beneficial to families experiencing deployment, in what way(s) is collaborating with other family support service providers beneficial? (Please provide a brief description of your view)
_____
_____
_____

13) What other professionals do you attempt to collaborate with in order to integrate family support services?
Civilian mental health providers (counselors, psychologists, psychiatrists, social workers) ___
Military mental health providers (counselors, psychologists, psychiatrists, social workers) ___
Primary Care Physicians ___

Civilian ___ Military ___
Civilian school counselors ___
Military school counselors ___
Other ___
(Please write in other professionals you collaborate with)
_____

14) Are there barriers that prevent you from being able to collaborate and integrate your services for military families experiencing deployment?

15) If so, what are these barriers?
_____
_____
_____

16) In what ways, if any, could your collaboration with other family support service providers be expanded in the future?
_____
_____
_____

17) Are you willing to participate in a phone interview lasting approximately 10 minutes to elaborate on your perceptions of the integration of family support services for families experiencing deployment?
(Your agreement does not mean you will definitely be interviewed. Your agreement along with criteria within the study will be used to evaluate participants for the interview.)

Yes ___ No ___

If you are willing to participate in the phone interview, please provide a phone number where you can be reached during regular business hours. _____

Thank you for your time. After the completion of the analysis and discussion of the study, you will receive a brief findings sheet reporting the results. This will provide you information regarding service providers' perception of collaboration and the integration of family support services for families experiencing deployment.

APPENDIX B. Support Service Integration Assessment (SSIA) Phone Interview Questions Guideline

Script for Phone Interviews

Hello, my name is Seth Hayden. I am a doctoral candidate in counselor education and supervision at the University of Virginia. I am calling because you have indicated your willingness to take part in a brief phone interview at the conclusion of your completion of the online Support Service Integration Assessment. Thank you for agreeing to take part in this phone interview regarding collaboration amongst family support service providers working with military families experiencing deployment.

The purpose of the phone interviews is to expand on the information you provided in the online survey. This interview is not an evaluation of your effectiveness as a family service provider to families experiencing deployment, but is intended to describe the process of collaboration amongst family support service providers in order to integrate services for military families.

As mentioned on the online survey, your identity is confidential. The only people who are aware of your identity are myself and my dissertation co-chairs, Dr. Harriet Glosoff and Dr. Sandra Lopez-Baez. No one else will be aware of your identity. You are welcome to stop this interview at any time and your responses will not be included in this study. Given what I have mentioned, do you agree to take part in this brief phone interview?

1) Describe your view of the benefits of collaboration with other family support providers working with families during deployment?

2) What are some of the issues related to collaborating with other family support service providers?

3) Please provide an example of a time you collaborated with another family support service provider who was working with the same family experiencing deployment that you were?

    a. What was the result of the collaboration and integration?

4) What is you view of the barriers or obstacle to integrating family support services for families experiencing deployment?

5) If there are barriers, what do you suggest be done to remove these barriers/obstacles to collaboration between support service providers working with families experiencing deployment?

6) What are your comments and/or suggestions regarding future policy and procedures which will affect the nature of collaboration and integration of family support services for families experiencing deployment?

Thank you for your time. Your willingness to participate in the interview is immensely important in providing a detailed account of service providers' perceptions of family support service integration. Please let me know if you have any questions in the future.

Assessing the Mental Health Beliefs of Military Pre-Leadership

KRISTOPHER G. HALL
University of San Diego

KIRSTEN ALFARO
University of San Diego

CARMEN CROUCHER
University of San Diego

MARISSA LINK
University of San Diego

Abstract

Extended tours in the Middle East expose service members to hazardous conditions which may lead to mental health issues. Although several resilience and mental health programs exist, some service members are reluctant to seek treatment due to mental health stigma. Researchers have found that service members are more likely to seek treatment when they feel leadership is more open towards help-seeking. While the mental health beliefs of leadership are well researched, the beliefs of pre-leadership has been left unexplored. The following study explored the mental health belief systems of pre-leadership to assess their beliefs regarding stigma and help-seeking. The authors found that pre-leadership students are fairly open to help-seeking but there are elements of mental health stigma.

Keywords: military, mental health stigma, help-seeking, ROTC

As a result of increased presence in Iraq and Afghanistan, more service members have been engaged in various forms of combat. This exposure has led to increased exposure to dangerous situations, possibly leading to mental health issues (Adams, Camarillo, Lewis, & McNish, 2010). Between 2001 and March 2015, 685,540 service members were seen in the VA for mental health issues (Epidemiology Program, 2015). However, authors have found that although diagnosed, 33% of service members do not seek treatment for mental health disorders with help-seeking behaviors limited due to perceived stigma (Hoge et al., 2004). While

Kristopher G. Hall is an Assistant Professor in the Department of Marital and Family Therapy at the University of San Diego; Kristen Alfaro is a graduate student at the University of San Diego; Carmen Croucher is a graduate student at the University of San Diego; Marissa Link is a graduate student at the University of San Diego. *Address correspondence to Kristopher G. Hall. Email: kghall@sandiego.edu.*

the presence and beliefs regarding stigma have been uncovered, the sources of these stigmatic beliefs are currently under-researched. Additionally, leadership has been found to be a strong mitigating factor in help seeking for enlisted service members (Britt, Wright, & Moore, 2012). While research on current leadership is strong, research on pre-leadership is sparse. The purpose of this study was to investigate pre-leadership in the form of the ROTC training program to assess health beliefs and possible stigmatic thinking.

Mental Health Prevalence

Service members experience unique stressors which contribute to mental health issues. As stated above, almost 700,000 service members have utilized the VA for mental health issues since 2001. An analysis the VA Healthcare Utilization Report shows that approximately half of those who visited within the last two years received a diagnosis for a mental disorder. The most prevalent diagnoses included posttraumatic stress disorder (PTSD), depressive disorders, and neurotic disorders (VA Healthcare Utilization Report, 2015). Researchers are also investigating this population. Barlas, Higgins, Pflieger, and Diecker (2013) found that out of 45,866 participants, 5% reported high post-traumatic stress symptoms, 16.7% reported high anxiety symptoms, and 9.6% reported high depressive symptoms. Additionally, 7.9% of participants reported suicide ideation since joining the military. One can gather from these statistics that a significant amount of service members are seeking some form of treatment.

Substance abuse has been found to be comorbid with mental illness in military populations (Bray et al., 2010). Service members may abuse substances as a coping mechanism for developing mental health issues, creating a compound issue of substance abuse and mental health. Bray and associates also found that alcohol abuse among service members is elevated after age 25 when compared to civilian populations. Also, according to the VA Healthcare Utilization Report (2015), approximately 200,000 service members received a diagnosis for alcohol/drug dependence or nondependent abuse of drugs in the fourth quarter of 2015 alone. One can surmise that substance abuse is a significant issue and may be indicative of deeper problems.

Stigma

Stigma can be defined as negative attitudes about a population based on stereotypes resulting in an observable change in treatment of an individual based on group affiliation (Corrigan, 2004; Corrigan & Penn, 1999). Regarding mental health, specifically, Corrigan (2004) detailed a continuum of how mental health stigma is instigated and perpetuated. Observable, negative manifestations of mental health create initial images of illness, creating a cultural view of disease. These cultural views then become stereotypes which are used to judge those with mental illness. Prejudiced individuals then endorse the negative stereotypes, which can lead to discrimination.

Overall, stigma can be divided into three categories. External stigma corresponds to the negative beliefs and attitudes held by a cultural group regarding a sub-group. Internal or self-stigma is the internalized negative messages regarding a stigmatized population, which can lead to lowered self-esteem and self-efficacy (Corrigan, Larson, & Reusch, 2009; Livingston & Boyd,

2010). Finally, anticipated stigma entails those with a possibly stigmatic issue avoiding divulging information for fear of being placed in the stigmatized group (Earnshaw & Chaudoir, 2009; Earnshaw & Quinn, 2012). Hanem and Bruckert (2012) assessed stigma within organizations and how this may cross factors such as race and mental illness. Through this work, the authors assert that stigma may be embedded into the system and dictates responses acceptable to the stigmatized group. These systemic responses were created to target stigmatized groups, manage risk, and govern interaction with these individuals. Given the descriptions and how stigma can be interwoven into systems, one can see how stigma can find its way into the culture of the military.

Stigma and the military. Seminal work completed by several researchers (Britt, 2000; Hoge et al., 2004) has confirmed the presence of mental health stigma within military populations. In more recent studies, authors have indicated self-stigma as an inhibitor to help seeking behaviors (Wade et al., 2015). Service members, enlisted service members and officers, report fears of consequences for disclosing mental health diagnoses (Gibbs, Rae Olmstead, Brown, & Clinton-Sherrod, 2011; Kim, Britt, Klocko, Riviere & Adler, 2011). Even those who receive treatment may have positive beliefs about mental health care, but not necessarily lowered stigmatic beliefs (DeViva et al., 2016). Service members who were in treatment were more likely report more barriers to care and those with negative attitudes about seeking treatment were less likely to do so (Kim et al., 2011).

Stigma and leadership. As stated above, one of the deterrents of help seeking behavior was fear of career impact. This is greatly affected by leadership, as commanding officers are the gatekeepers for promotion. Gibbs et al. (2011) found that both officers and enlisted membership feel that their leadership abilities will be questioned if mental illness is disclosed. Westphal (2007) completed work detailing the beliefs of enlisted and commissioned sailors regarding help-seeking for mental health issues. Among themes, the author lists (a) fitness for duty, (b) mission readiness, (c) malingering, (d) referral decisions, (e) help-seeking, and (f) career impact. Overall, the author found that stigma was not a primary influence on leadership's attitude towards mental health services; instead, the commanding officers were more interested in Fleet Mental Health (FMH; Westphal, 2007).

Simultaneously, enlisted members preferred officers who were open regarding their mental health status (Westphal, 2007). This dichotomy can create a paradox where service members will seek treatment if their officers are open about their own mental health status; however, leadership may not disclose, as their own leadership ability may be questioned. Additionally, the authors found that non-commissioned officers (NCO) were more likely to keep mental health issues hidden than enlisted members. This would suggest that leadership engages in self-stigma due to fears of being seen as less competent by their subordinates, further perpetuating the aforementioned paradox.

Taken together, one can see that leadership is a strong mitigating factor for help-seeking behaviors. Research has shown that trust in leadership and strong unit cohesion has been shown to reduce anticipated stigma (Britt, Wright, & Moore, 2012; Wright et al., 2009). The opinions of commanding officers are taken into account when deciding when to seek mental health treatment. Although there has been a reduction in anticipated stigma since the Hoge et al. (2004) study, some service members still fear changes in perception based on mental illness (Warner,

Appenzeller, Mullen, Warner, & Grieger, 2008). Knowing that leadership has this much influence, it is therefore imperative to understand leadership's beliefs regarding mental health. The aforementioned research has been presented regarding the feelings of leadership currently on the job but the experiences of pre-leadership is still under researched. Their beliefs are important as the ROTC program exists as a crucial intervention point for training regarding mental health before they encounter enlisted members with issues.

Program Implementation

To combat stigma, the Department of Defense (DoD) has implemented programming within each branch of the military, primarily stress and resilience training (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). The primary goal of these programs are to use psychoeducation to assist service members in identifying symptomology in themselves and others, teaching and increasing resilience, and stress reduction (Morgan & Bibb, 2011). The programs also use the group cohesion built into the military structure to encourage treatment seeking. For example, the Army has instituted resilience training for years with the aforementioned goals as primary components of the training (Adler, Blieise, McGurk, Hoge, & Castro, 2009; Harms, Herian, Krasikova, Vanhove, Lester, 2013; Lester et al., 2012). These programs have had varying levels of success and are undergoing consistent testing and revisions. The success of these programs may lie in the attitudes of the implementing officers. Much of the presented research is from the perspective of the service member with little attention paid to commanding officers. Therefore, it is necessary to understand the thoughts and views of leadership as they often determine service members' willingness to seek treatment.

It is important to document the experience of pre-leadership as they will eventually be the ones to implement mental health programming and recommendations. The top-down structure of the military dictates that officers will be teaching and enforcing mental health norms and expectations to lower ranking service members. Currently, at the officer training level, ROTC students are engaged in work to understand, assess, and alleviate prevalent mental health issues. However, research detailing their beliefs about mental health is scant. As the aforementioned norms and expectations will be filtered through their lens, it is necessary to examine stigma and help-seeking in pre-leadership to understand how they feel about mental health prior to implementing these initiatives. This work holds particular relevance as negative bias could affect how they deliver and uphold programming and, as has been previously mentioned, leadership has a large effect on service member help-seeking behaviors (Britt, Wright, & Moore, 2012; Wright et al., 2009).

Rationale for Study

The purpose of this study is to begin to investigate the gap in literature between pre-leadership and their mental health beliefs. As presented above, service members experience a myriad of mental health issues during active duty. There are several resources available to these service members but they may not engage due to perceived or internalized stigma (Hoge, 2004). Leadership can be a strong factor in encouraging help-seeking behavior but the experience of pre-leadership has gone under researched. Currently, there is very little detail regarding the mental health beliefs of service members in their early career stages. ROTC students enter

officer training with their own ideas regarding mental health which are then shaped by leadership training. However, it is unknown how previous beliefs and early training blend at the beginning of the military career. This study illuminates the overall beliefs of early stage pre-leadership regarding mental health through qualitative inquiry by assessing multiple influences of belief systems while also assessing stigmatic leanings and help-seeking.

Methodology

Research Design

Authors (Gall, Gall, & Borg, 2007; Moustakas, 1994) have argued for qualitative inquiry at the beginning of a course of research. Before one can quantitatively measure the mental health beliefs of a population, it is necessary to know what these beliefs are. This preliminary work is the foundation for deeper understanding about the population. Results from this study may lead to information which can be used for theory generation and empirical study. To this end, this study used qualitative inquiry to explore the lived experience of the ROTC students. The intention of the researchers was to find the commonalities among beliefs regarding mental health while assessing for stigma and help-seeking behaviors. The work serves as a base for further research as it is not possible to create higher level assessments without understanding the experiences of the population regarding the phenomena (Creswell, 2013).

Sampling

Site. This study was conducted on the campus of a medium sized, liberal arts college in southern California. This college is the central hub of four other ROTC programs in the area at other colleges. The site hosts Navy, Army, and Marine ROTC programs and conducts most of the program's classes.

Participants. Participants were required to be members of the ROTC to ensure similar characteristics of the subgroup (Creswell, 2013). There were nine participants from the various branches. Six were from the NROTC, two AROTC, and one MROTC. Participants were primarily male and between the ages of 18 and 21. Most of the participants were in the early stages of training being primarily freshmen and sophomores; there was one junior. The study consisted of 5 males and 4 females, presenting a mostly equal distribution. Finally, the participants were primarily White with one participant identifying as Pacific Islander and one identifying as Hispanic.

Recruitment occurred in two phases, during their spring and fall classes with the approval of the Naval Commanding Officer on campus. During the fall semester, the primary investigator visited each class and explained the research to the students. In the spring, research assistants completed the class visits. The students were given a schedule and a means of contact to participate. During this time, the participants were also informed of the monetary incentive ($20 gift card) for completing an interview. Students were also told that they would be able to maintain confidentiality and that there would be no reports to commanding officers regarding who completed an interview. At the end of the explanation, the students were invited to ask any questions they may have had about the study or the research process.

For the purposes of this study, the interviews were ended after the second round of recruiting when no new participants came forward after a week of the final interview. After initial data analysis, the researchers determined that there was enough similar information to conclude data collection, feeling that saturation had been reached. Starks and Trinidad (2007) suggest 7-9 participants to begin qualitative work and the current study reached this number.

Instrumentation and Protocols

Interview questions. The researchers used questions generated during dissertation research by Hall (2014) on the same topic. These questions were formulated after a review of literature, primarily using the work of Britt (2000), Hoge et al. (2004), and Ward and Besson (2013). The interview questions were grouped by category on the research protocol and included assessments regarding military culture, thoughts, feelings, and beliefs about mental health, mental health stigma, and beliefs regarding mental health help-seeking.

Data collection. Data collection consisted of interviews, field notes in the form of observation forms, and notes during researcher discussion. Interviews, the most common form of data collection in qualitative research (Creswell, 2013), were an average of 30-40 minutes. Every interview was conducted in the office of the primary researcher. Using a research protocol for consistency, the participants were again informed of the purpose of the study and reminded about confidentiality and the monetary incentive. Participants were required to give recorded, verbal consent before the interview and were given a copy of the informed consent for their use. The interviews were semi-structured with the primary researcher only diverting from the protocol to ask clarifying questions or to explore concepts shared by the interviewee. The primary interviewer and at least one research assistant were present for each interview.

The researchers used a data collection method suggested by Tessier (2012), which included recorded interviews and field notes directly after the interview. Data was also made available through observation forms completed by the research assistants. The observation form was adapted by Angrosino (2010) and included details such as the space, participant description, and reactions to questions. The research assistants were also encouraged to take notes during each interview of any personal observations which weren't found on the form. After each interview, the primary researcher and the assistant debriefed each other, discussing any underlying observations (Glesne, 2011). The key ideas from these sessions were also recorded by the assistant and the entire interview was later transcribed by the same assistant.

Data Analysis

Coding and theme development. Coding and theme development happened over several stages with the primary researcher, the three research assistants, and an outside auditor. The stages of data analysis can be found in Table 1. The first stage used structural and in-vivo coding as outlined by Saldana (2015). Each transcript was analyzed independently by the research team by category of question (culture, thoughts, etc.) and key words were pulled from each narrative to ascertain the main idea of the text. Coding was completed using a chart in Microsoft Word (Version 15.20) where a line of text, a code, and a definition was used to record that piece of the narrative. After the completion of the first transcript, the researchers met to discuss their codes at

that point to ensure inter-coder agreement as outlined by Creswell (2013). The purpose of this meeting was to check if the researchers were finding the same passages as important, despite code names.

Table 1. *Stages of Data Analysis*

Coding Stage	Step	Work Completed
Stage One	Step One	Independent, categorical, in-vivo coding
	Step Two	First intercoder agreement meeting
Stage Two	Step One	Independent, categorical, in-vivo coding/condensing
	Step Two	Second intercoder agreement meeting
	Step Three	Independent theming
	Step Four	Intercoder descriptive coding, memoing, theming
Stage Three	Step One	Independent, external theming
	Step Two	Final thematic meeting

The second stage of coding occurred after the inter-coder agreement meeting where the researchers again used structural and in-vivo techniques to code the remaining documents. Individually, the researchers condensed their codes across each participant into a master code list. The researchers again met as a team to then condense codes into one code book. Again, individually, the researchers condensed the codes into a list of themes and regrouped to discuss and condense themes. During this meeting, the researchers shared notes made during the coding to assess for any biases or observations made at this time. As the primary researcher was the only one present during all interviews, the research team shared their memos made during their respective interviews. Descriptive coding (Saldana, 2015) was completed to assess if any findings were the same across demographics. Subsequent themes and codes were then input into Dedoose qualitative software for ease of categorization.

Validity and verification strategies. To reduce bias inherent in qualitative research (Creswell, 2013; Glesne, 2011), the researchers employed several validity and verification strategies throughout the research study. Following Carlson's (2010) model, the researcher used several of the author's suggested methods of trustworthiness including audit trails, reflexivity, and triangulation. Audit trails were used in the form of researcher notes and interview recordings. To ensure consistency between interviews, a research assistant completed observation forms for every session. Reflexivity was addressed using the positionality statement found below. Triangulation included gathering several types of data including recordings and transcriptions. The researchers also collected several notes in the form of field notes, observation forms, and compilations of conversations after each interview.

The final form of triangulation occurred during the third stage of data analysis. It should be noted that before beginning coding, the researchers noted the high number of NROTC participants (n=6) versus the other branches (AROTC = 2; MROTC = 1). Therefore, the researchers decided to code only on this population as their responses would have dominated the narrative. The remaining narratives were used as a form of member-checking by an outside auditor and only received thematic coding. These experiences were checked against those from the NROTC to assess for conflicting themes.

Beyond the methods noted by Carlson (2010), the researchers also employed peer review to ensure validity. Beginning with research design, the primary investigator consulted with other faculty members regarding the research process and verification strategies. The interview questions were reviewed by the commanding officer of the Navy ROTC to ensure they were culturally relevant to the population. Finally, the research team also met several times during the data analysis process to verify inter-rater reliability.

Positionality Statement

The primary researcher for this study is a counselor educator who writes in the area of military mental health, has been his field of study since 2013, and has never served in the military. The research assistants are all masters level students studying clinical mental health counseling. One of these students is a Navy Veteran. All of the researchers in this study engage in counseling Veterans with addictions at a local facility.

Results

After data analysis the researchers discovered five themes regarding the participants' beliefs about mental health. These themes, Perceived Cultural Standard, Socially Endorsed Stigma, Resource Hierarchy, Exposure and Awareness, and finally, Leadership and Views of Help-Seeking, illustrate a narrative that outlines their reasons for joining the ROTC and best practices for addressing mental health. The following section will detail the mental health beliefs of the Navy ROTC program participants.

Perceived Cultural Standard

The first theme outlines the perception of ROTC students themselves and their future subordinates regarding their reasons for joining the military. Specifically, this theme outlined the expected behaviors of those who join the military prior to and during their time serving. From their perceptions, military culture dictates the expectation that individuals who join attain and maintain a state of peak mental and physical fitness. These beliefs were rooted in some masculine norms as reflected in the responses, "Don't, don't show it, suck it up, just…don't be a [explicative] I guess (laughs)." Those that don't perform at their peaks fuel the perception that they are weaker, incompetent, or inadequate, which causes those who may seek treatment to refrain from doing so. Speaking about the Marines, a participant shared, "hey look at weakness, and they're like, oh, you know, they kind of, they kind of make fun of each other – so it might be more organizational culture." In order to feel as though help seeking is more acceptable in their culture, it should be for reasons related to combat or deployment.

Resource Hierarchy

This theme included an understanding of the resources available to participants when one does choose to seek mental health. There is a known and rigidly adhered to structure regarding resource seeking that the participants outlined in their narratives. The ability to talk with someone at their level, peers or friends, as a first step holds strong impact. For example, one participant stated, "it's just nice to talk to somebody who's…like the outsider," meaning

beginning with someone who is outside the military to gain a fresh perspective. Participants also recognized that their peers in the ROTC are a first step to help-seeking.

Pre-leadership students recognize that there are several avenues for help-seeking; however, there is a level of self-assessment that takes place prior to selecting the best resource. Using self-reflection, participants recognized that they may not be equipped to address the issues of their future subordinates, “Um… as somebody who’s not trained, I’m not entirely sure how to handle it.” If student recognize they are un-equipped to handle an issue themselves, they are aware of other resources which may be available to those seeking treatment. This assessment process alludes to a hierarchy within the chain of command where mental health issues are addressed at a specific level of authority. For example, a participant outlined this specific thought process:

> We haven’t really gotten much training on mental health per se, but we’ve gotten a lot on kind of, if your friend is hurting… whether it be like, they have an alcohol problem or a drug problem, I think along those lines, it could be like if they have a mental health problem, like if you’re very depressed, then you go and seek help and you go and tell your officer, your senior enlisted about what’s happening.

Through training, the participant understands that some issues must be shifted up the chain of command to be addressed properly.

Finally, in the military, it becomes a command issue to remain aware of how these mental health issues influence mission readiness. Due to this, the participants are taught that the chain of command should be an option for those seeking assistance, “But...like, the really like push that, like you can feel free to talk to like certain people and...be confidential to like talk to your chain of command” There is an understanding that belief systems are put to the side for the good of the unit.

Socially Endorsed Stigma

The participants shared an undercurrent of mental health stigma which was gleaned from various sources. There is a socially constructed notion that those with a mental health disorder pose some may pose a threat to others around them. Some acknowledged a perception of instability regarding a friend diagnosed with bipolar disorder, stating "We all are civil and hang out and stuff but, just kind of like in the back of your mind, you know that she’s very unstable." Those who viewed mental health through a stigmatic lens perceived those with a mental health disorder are perceived as erratic and atypical, leading to a belief that they should be avoided entirely.

However, several participants expressed a desire to help someone with a mental health disorder; concurrently expressing a reluctance to do so that is related to a level of fear for safety in those situations, "And like why they’re acting in the way that they’re acting. Cause like sometimes like, it could help to talk to them and sometimes it could be harmful for me and them to talk to the, or like, try to help them I guess." The participants recognized a need to assist those with mental health issues but without putting themselves in danger.

This notion could also be specified into the active military culture in which the mental health disorder serves as evidence that the person is inadequate or unfit for their job. A number of participants felt echoed this sentiment, likening seeking mental health services in the military as a weakness:

> Like, it's hard to get help, and so, um, because a lot of times it – people do think it is a sign of weakness. Like, I personally have never gone to help because of, I personally think that it would be a sign of weakness of myself.

The negative beliefs about mental health can silence pre-leadership and service members with mental health issues through the fear of receiving reprisal from the command and criticism from others, which taints their reputation. Participants who directly correlate help seeking in the military as weakness viewed subsequent backlash as the perceived expectation for doing so:

> Where uh, if you showed weakness then… they're just gonna rip you apart, they're gonna yell at you, they're gonna tear you down even more, so they don't … they don't go and admit that they…that they need help.

Exposure and Awareness

Exposure to outside observations/experiences, previous mental health education, and ROTC training have contributed to pre-leadership's current awareness and insight. These experiences allow the person to identify what mental illness is, how it impacts functioning and how it impacts life, whether it is visible to the eye or not. Participants reported experiences with family such as assisting service connected family members with PTSD. Another participant remembered classes about addiction and spoke about a brother battling this issue. As a result of this exposure, one participant noted, "And so, I realized that they, they're pretty much normal people, they just have slight issue." This indicates that the time spent with those who have experienced mental illness changed their outlook on disorders. It is important to note that exposures preceded their initiation into military culture.

Regarding training, participants explained ROTC programming for mental health to various degrees. They reported specific instruction in working with future service members who may be in distress, "So, they give, they do videos, um, just – the Navy has, I guess, standardized videos, and like trainings that they send out." The training was primarily focused on reduction of stress and addressed specific behaviors/diagnoses such as suicide or PTSD. One participant remembered the training this way, "Mostly just like…we get briefs on like suicide and stuff and dealing with stress...but not really anything that like dealing with mental illness." The trainings are used to give information regarding how to assess for mental health issues and address them without always explicitly stating "mental health."

The exposure also gives more context to the awareness gained through formalized teaching. This insight has helped them to appreciate not only the value of living without mental health struggles personally, but also recognize the difficulties someone with mental health issues may face. Regarding recognizing these differences, a participant stated, "I just think it's very important for people to watch out for each other, and recognize the signs that somebody might not be 100% and you know… how to help them if you recognize that." Given their previous exposure to those with mental health issues, participants were better able to identify those who may have mental health issues.

As a result of the exposure or education, some pre-leadership individuals modify their behaviors around those with mental illnesses to be more accommodating and are more tolerant and sympathetic. "I try to treat her like a normal person, but she's kind of like…she's acting different, now that she like knows that she's bipolar, but I try to treat them like normal people." However, some may avoid interacting with the individual all together due to feeling uncertain about how to respond to the person or because of feelings of apathy.

Leadership and Views of Help-seeking

Pre-leadership recognizes its role as the potential head of several service members. This role is taken seriously and it is understood that they will be responsible for the well-being of several people. There is pride in being able to help others and recognize when additional assistance is needed. A participant shared the following:

> And what it means to be a future officer of the Navy, that like, I do need that sense of accountability, I do need to be responsible for not only myself, but try and be responsible for other people as well. Maybe when they fall, and like, I don't know they can't get back up and I'm gonna help them and push them to get where they need to be so, I think that's huge and motivating others.

This participant recognized his/her role as a leader and a motivator, ensuring those under his/her command are in proper condition to serve. It should be noted here that the audit found that the Army/Marine participants deviated from these beliefs. They asserted that self-reliance was necessary for those seeking membership in the military. Therefore, help-seeking may be necessary for mental health issues but one should first look inwards for assistance. There was also the belief that those who need to help-seek may not have the qualities necessary for military membership.

All pre-leadership believes that mission readiness is at the forefront; however, there appears to be two schools of thought. One group believes that help-seeking takes precedence over mission readiness when the individual faces legitimate problems and exercises self-awareness on how stressors and maladaptive mental health is affecting their lives.

> I don't think, I don't, once again I don't think there is a bad time. Because even if it's (incomprehensible) like even if you're even in the middle of a mission like, you could be and you think you need help like at that point, you probably are affected and you're not in the frame, not in the right frame of mind and like you can't enter into a battle if you're not in the right frame of mind.

This participant asserted that service delivery is necessary at any time to return the service member to battle readiness. The other group alluded to the idea that mission readiness is more important than help-seeking for fear of negative career impact. This was especially apparent as many participants shared a fear of disqualification, "I feel like it's really easy to get disqualified from the Navy, or like, the military in general if you have a mental illness."

Finally, the perception that one's failure to perform duties affects everyone, not just the individual, exists. Thus, a person with mental health problems is often placed in a conflicting cycle of needing to access help but getting penalized for requesting or receiving such help.

Limitations

Although the study provided insight into a previously unknown phenomena, the results should be viewed in light of some limitations. The first is self-selection bias, as those who are particularly interested in mental health may have been specifically motivated to participate. Additionally, as with qualitative research, these results are not as widely generalizable as those of quantitative research. The researchers did not have access to a national sample so the results of this population may not generalize to other parts of the country, ROTC programs, or branches. This reduces the applicability of the results to other ROTC populations. Additionally, the participants are at an early stage of cultural indoctrination; therefore, it is difficult to tell how much prior or military experience influenced their beliefs. Finally, although all branches of the ROTC were recruited for the study, the majority of the participants were from the Navy ROTC. Therefore, the primary themes were analyzed through the lens of these participants, meaning that the results aren't generalizable to other branches. The researchers attempted to mitigate this by having an outside auditor analyze the themes against the remaining participants in the other branches (Army and Marines).

Discussion

The military is based on a set of cultural norms which dictates much of the decision making. Therefore, it is important to understand the perceptions future leadership, as these perceptions will influence expectations and help-seeking behaviors. The researchers of this study found that participants believed service members were expected to be at the peak of physical and mental awareness. Due to the strenuous nature of many military jobs, this expectation has been found to be a common cultural norm (Hall, 2016). However, these expectations mean that physical or psychological weakness is only tolerated for very specific reasons; reasons which may or may not include mental health. Often, there is fear that those who divulge mental health issues will be seen as weak or malingering by leadership, a fear confirmed by Zinzow and colleagues (2013). Additionally, these views may be related to ideas of masculinity, which can cause difficulties for those who challenge these rigid norms (Langston et. al., 2010). However, it should be noted that participants of both sexes endorsed physical and mental fitness as requirements for strong service members. As help-seeking is seen as a feminine trait (Creighton & Oliffe, 2010), more investigation into how masculine norms shape help-seeking behaviors in military populations is necessary. It is important for those working with ROTC students and service members to understand that seeking assistance for mental illness may not be accepted in many circumstances. However, when one does seek services, this may be at the behest of fellow service members or to ensure the success of the mission. Therefore, it is necessary to know how ROTC members view the culture of the military and help-seeking to eventually encourage more service members to seek treatment.

The participants in this study received information about mental health from various sources. Both enlisted and ROTC members receive extensive training on how to identify and assist those who may be experiencing mental health issues. For example, the Navy/Marine Combat/Operational Stress Control Program attempts to build resilience and help service members mitigate stress issues (Laraway, 2010). There is also the BOOTSTRAP intervention, which is aimed at "high risk" Navy recruits (Williams, Hagerty, Yousha, Horrocks, Hoyle, &

Liu, 2004). These programs include both enlisted and leadership training institutes with similar programs being instituted in Officer Candidate and Command Leadership Schools (Laraway, Need, Harris & Darnell, 2012). Given the responsibilities of military leadership, early identification of mental health issues is important to ensure mission readiness. The participants in this study were able to recount their training regarding mental health and appreciated being able to identify and understand mental illness. These programs are important as researchers have found that resilience regarding mental health helps to decrease stigma and increase help-seeking (Crowe, Averett, & Glass, 2015). The techniques for identification and resilience may serve to help increase help-seeking in enlisted service members upon commissioning.

Due to the early career status of many of the participants (1st and 2nd year students), many of their influences regarding mental health came from experiences prior to their time in the ROTC. It has been found that views about health can be shaped by exposure to those with a given illness or diagnosis (Diefenbach & Leventhal, 1996; Moss-Morris et al., 2002). For example, perceptions of mental health are often shaped by messages received by peers, family, and other professionals (Ben-David, Cole, Spencer, Jaccard, & Munson, 2017). For example, Goodwin, Savage, and Horgan (2016) found that culture can have a negative impact on how teenagers view mental health. Perceptions about those with mental health are also shaped by exposure to those with mental health issues and higher education levels (Raevely, Jorm, & Mprgan, 2016). For this population, exposure to those with mental health issues created a unique awareness which, when combined with military instruction, opened the participants' thoughts to help seeking. The blending of early exposure to mental illness and military education may create leadership that is more understanding of mental health issues once they have been commissioned. However, it is unknown how much their views will change after being exposed to further military cultural indoctrination. Further research should include those in later years of the ROTC or newly commissioned service members to assess if their beliefs regarding mental health will change upon more military exposure.

Despite the openness to help-seeking, some participants echoed issues of mental health stigma found in enlisted membership. Self-stigma is prevalent in Naval populations as researchers have found that those who met the threshold for stress during testing were more likely to report anticipated and internalized stigma (Langston et al., 2010). This finding was consistent across rank as the study included junior enlisted, senior enlisted, and commissioned officers. Researchers have found that stigma regarding mental health deeply affects help-seeking behaviors (Britt, Jennings, Cheung, Pury, & Zinzow, 2015; Hoge et al., 2004). This may be related to the belief that those with mental health issues may not be mission ready (Gibbs, Rae-Olmstead, Clinton, Sherrod, 2010; Westphal, 2007). This is important for this population as these individuals will determine mission readiness upon commissioning. Although the ROTC students endorsed stigmatic thinking reflective of enlisted members, it is important to note that these ideas are not fixed. Work has been completed which demonstrates that self-stigma in adolescents does affect help-seeking (Kaushik, Kostaki, & Kyriakopoulos, 2016); however, at this time, there is scant research on stigma within the ROTC population (Hall, 2014). As these students have not had exposure to daily military life, more investigation is required to understand the root of these beliefs. When compared to other services, the Navy most frequently endorsed stigmatic thinking regarding career damage (Barlas et al., 2013). This is why it is important to assess stigma in this population to curb negative views before full military cultural indoctrination.

As a function of military training, the participants in this study understood that issues must be carried through a chain of command. If issues can be solved without escalation, this is preferable. The point of the chain of command is to ensure that directions are explicitly followed in theater (Hall, 2016). In regards to mental health, this is important as service members are more likely to help-seek using family or spouses before addressing commanding officers (Iversen et al., 2010). The participants in this study clearly understood how mental health issues should be escalated due to ROTC training. As will be discussed in the following paragraph, the openness of leadership to listen to those who may have mental health issues is important to facilitating better mental health outcomes. Researchers have found that Seamen believed that those who disclosed experiencing stress may be avoided or given "tough love" (Langston et al., 2010). Therefore, it is necessary to know how ROTC students respond to disclosure of mental health issues as their responses or escalation could influence future help-seeking. This is also important as service members may not always have access to mental health services due to time constraints or effective practitioners in their vicinity. Therefore, it is important for ROTC students to be educated on how to operate as a resource; knowledge of some clinical symptomology is helpful for acting as a triage until clinically trained services can be reached. Finally, it should be reiterated that this is the only area where the responses of the Army/Marine participants differed from those of the Navy. They felt that self-reliance was an important factor to help-seeking and that one should first attempt to address problems on their own. More research is necessary to understand if this is a universal belief or specific to these participants.

Despite the reports of stigmatic thinking, the ROTC students in this study understood their importance as a leader for the enlisted service members. This is important as there have been links found between perceptions of leadership regarding mental health, help-seeking, and stigma (Britt, Wright, Moore, 2012). As reported, certain students linked career advancement to mental health issues and these factors should be sacrificed for mission readiness. This echoes research regarding enlisted membership's fears of advancement upon divulging mental health issues to superiors (Stecker, Forney, Hamilson, & Ajzen, 2007). For example, the author reported that leadership was interested in reducing the number of Seamen in need of mental health services for the purposes of mission readiness. This observation coincides with fitness for duty, where Seamen needing time off can affect the ship's schedule (Westphal, 2007). Taken together, Seamen may be reluctant to seek treatment knowing that leadership will look negatively upon them due to the need to make adjustments for missing Seamen. While leadership promoted help-seeking, with peers playing a major role, help-seeking may not occur given the reasons above. Finally, Seamen may have reason to fear career advancement issues, as leadership combined physical and mental health ailments as issues which affect mission readiness. If these are being seen as the same, Seamen may not want to disclose mental health issues as they may feel that any reports will go into their file, impacting future advancement. This can be particularly detrimental to advancement as officers, more than senior enlisted membership, felt that mental health issues could negatively affect career development.

Students in this study were primarily open and understanding regarding mental health issues and promoted help-seeking behaviors. However, there are still strains of stigma found in this population, even at this early stage of their careers. As much of their contact with the mentally ill came prior to college, one can assume that pieces of this stigma may have come from

their time in the ROTC. Future research should focus on the training processes regarding mental health and the trainers who impart this information.

Impact and Future Research

The research conducted illuminated a previously unexplored area of leadership within the military. Primarily, research around leadership has assessed those currently in the military without an analysis of their beliefs prior to taking command. Outside of dissertation work (Hall, 2014), this is one of the few articles to address the perspective of pre-leadership. This is important as, upon commissioning, these students will be put into leadership positions which can influence the mental health of service members. Therefore, it is necessary to continue to explore this perspective for more targeted interventions.

While this study is important, there is still room for future research. Next steps can include comparisons of multiple sites to assess for differences between ROTC programs. Regional differences in mental health beliefs may affect views on stigma and help-seeking, which would necessitate further investigation. Finally, quantitative research could help to assess the degree with factors such as stigma, masculinity, and mental health beliefs affect help seeking. By giving more attention to this area prior to commissioning, counselor educators have the opportunity to work with the military community to create new or streamline existing programming. This may include interventions to decrease stigma or clinical interventions from a perspective of wellness and growth.

Conclusion

Service members experience a myriad of issues which may contribute to mental illness. However, given the culture of the military, there is a contingent who may not seek treatment, despite a diagnosis. Leadership can greatly contribute to help-seeking when seen as a resource, therefore, it is important to understand the attitudes of pre-leadership as they will shape norms regarding help-seeking. The preceding study illuminated the mental health beliefs regarding pre-leadership including views on stigma and help with promising results. Although stigma still existed, several participants were open to service member help-seeking. Hopefully, these beliefs will persist as they enter their military careers.

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Service Women's Assessment of Wellness and Reintegration (SWAWR): Measuring Service Women's Wellness

LAUREN S. ZAPF
Marymount University

WILLIAM R. STERNER
Marymount University

Abstract

This article examined service women's wellness, specifically focusing on the constructs of emotional, social, and spiritual wellness. The purpose of this study is twofold: (a) to assess the unique social, emotional, and spiritual concerns of service women and (b) to conduct a pilot study to create a comprehensive wellness assessment to assist counselors when working with this subgroup. Participation was solicited from several nonprofit military-related organizations with a total of 354 participants completing the survey. Results yielded 18 spiritual, social, and emotional wellness items explaining 56% of the variance of the Service Women's Assessment of Wellness and Reintegration (SWAWR), reflecting themes including feminism as a protective factor, the cultivation of resilience, the effects of moral injury, and overall wellness. Implications for practice and future research are discussed.

KEYWORDS: service women, wellness, assessment, military

Women have been informally part of the U.S. military since the Revolutionary War and have been formally part of the nation's defense since 1901 (Katz, Cojucar, Davenport, Pedram, & Lindl, 2010; U.S. Department of Veterans Affairs [USDVA], 2011). Women became a permanent part of the U.S. military through the passage of the *Armed Services Act of 1948*, legislation that while formally recognizing women's contributions, still restricted them to only 2% of the military until 1967 (USDVA, 2011). From 1973 to 2010, the number of enlisted personnel decreased by approximately 738,000. Filling the void created by voluntary service, women emerged as integral members of the U.S. military, especially with the repeal of parts of the combat exclusion policy in 1993, which had prevented women from flying combat aircraft and from serving on combatant ships (USDVA, 2011). The post-9/11 environment created more opportunities for women to serve in combat roles, with over 200,000 women having served in support of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF; USDVA, 2011).

Lauren S. Zapf was a doctoral student and adjunct professor at Marymount University, and William R. Sterner is an Associate Professor in the Department of Counseling at Marymount University. *Address correspondence to Lauren Zapf. E-mail: lauren.zapf@me.com.*

The USDVA (2011) projected the percentage of service women, and women Veterans in particular, will increase by over 67% by 2035. The USDVA (2013) reported that there are approximately 2.2 million women Veterans, representing 9.8% of the Veteran population. Military One Source (2012) mentioned that women comprise 14.5% of active duty forces, with approximately 203,000 women serving among 1.4 million service members. Over 11% of service members stationed in combat zones from 2001 to 2010 were women (USDVA, 2010) and 159 women died in U. S. military operations in Iraq and Afghanistan while over 900 women have been injured (U.S. Department of Defense [USDOD], 2014). With the repeal of the ground combat exclusion ban in January 2013, service women's efforts in combat zones, such as those in Iraq and Afghanistan, are being formally acknowledged (USDOD, 2013).

With more military women being recognized for sacrificing their safety and lives, mental health clinicians are attempting to better understand women's experiences through a wellness lens (Mulhall, 2009). Because of the inherent ambiguity of military operations, including difficulties identifying combatants and defending against unconventional warfare tactics, combat roles became increasingly difficult to discern, creating environments where women served directly on the frontlines (Feczer & Bjorklund, 2009). Following deployment, service women voiced similar responses to their male counterparts, with many women reporting resiliency and a strengthened sense of purpose, while other service women reported struggles with posttraumatic stress, unemployment, and relationship difficulties (Florida Commission on the Status of Women, 2011). As was the case with service men, service women experience a wide range of emotions that are difficult to capture through posttraumatic checklists and post-deployment questionnaires. However, service women have unique needs and strengths that differ from their male counterparts including nuanced characteristics such as empathy and sensitivity for the underrepresented (Bailey, 2009).

Compared to service men, service women were more likely to have a service-connected disability rating, a measure of injury or disability incurred or aggravated during service, less likely to use USDVA health care, less likely to be insured, more likely to have no earnings or income, and more likely to live in poverty (USDVA, 2013). Some service women experience a sense of disrespect, lack of recognition, heightened military sexual trauma symptoms, and diminished social support after their military careers (Foster & Vince, 2009). Other service women emerge from the military with a new sense of empowerment, having been immersed in a male-dominated profession where they had to prove themselves daily. Their minority status may have also helped them to cultivate an acute sense of empathy, developing into advocates for the underrepresented (Bailey, 2009).

Unfortunately, a dearth of information exists regarding how service women adjust to their military and post-military lives (Katz et al., 2010; USDVA, 2011). Foster and Vince (2009) conducted one of the most illustrative surveys of women Veterans' civilian adjustment. Surveying a large sample of service women, they found the most pressing concern was experiencing a lack of respect or recognition. Findings indicated that 18% of service women reporting lack of respect was their primary concern followed by employment (12%), and mental health needs (8%). One area that was not addressed was service women's overall wellness. Service women's nuanced experiences differ from most civilians, and cannot be captured through traditional assessments. Lee (2013) emphasized that clinicians must use multicultural

perspectives with the military population, in general, recognizing the dominant influence of traditional masculine gender roles and developing alternative models to their existing therapeutic approaches.

Theoretical Foundations of the SWAWR

Wellness and feminist identity serve as the theoretical basis for the SWAWR. Integrating a wellness model into the SWAWR allows for counselors to view the client's health from an integrated and multidimensional perspective. Infusing a wellness approach considers all aspects of the individual so one can strive for optimal functioning to allow for maximizing their potential (Dunn, 1977). The SWAWR is also rooted in the feminist identity movement which strives for equality for women. Feminist identity theory argues that traditional gender roles have been constructed through the lens of the dominant male culture, with women's work given less social value, further strengthening the patriarchy (Tobias, 1998).

Wellness

Although wellness is difficult to define because of the subjective nature of the term and the inherent value judgment, researchers have recently shifted their attention to clarifying the term through wellness instrument analysis and development (Roscoe, 2009). Dunn (1977) defined wellness as "an integrated method of functioning, which is oriented toward maximizing the potential of which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment where [s]he is functioning" (p. 4). Wellness is a multidimensional, synergistic term that involves balancing multiple dimensions of health (Roscoe, 2009). It is represented on a continuum, not as an end state, and involves moving towards higher levels of optimal functioning by exerting personal responsibility; and when referencing wellness, there is an assumption of an absence of illness (Roscoe, 2009).

Shifting to a wellness philosophy that incorporates resiliency factors, as opposed to a pathology-centered approach, is not only important in conveying respect for service women, but also in intervening early with clients and, consequently, promoting cost-effective care. The idea is that researchers and clinicians must start exploring what is working (i.e., what service women are doing well), not simply what is failing for service women. The wellness philosophy, with an emphasis on resiliency factors, reflects tenets of positive psychology, an approach primarily used in Peterson, Park, and Castro's (2011) Global Assessment Tool (GAT); one of the most widely administered military wellness instruments. The development of the Service Women's Assessment of Wellness and Reintegration (SWAWR) reflects the underlying wellness philosophy. As a holistic measure, the SWAWR accounts for a complex view of an underrepresented subgroup, further analyzing the strengths and needs of service women by exploring the unique, and sometimes adverse, military culture through multiple constructs.

Sound cross-cultural research helps investigators identify values and behaviors that are common in different cultures and those that need to be treated differently, considering both etic and emic perspectives. When these differences are found, such as when service women's perspectives differ from service men and from the population at large, other measures of

wellness must be created (Myers & Sweeney, 2005). The exploration of service women's strengths and needs reflects the wellness principle that humans can change, and that other humans can help effect this change. Construction of service women's wellness assessments must be developed not from a pathological focus, but rather an understanding that a holistic analysis of service women's wellness can help improve overall life satisfaction (Myers & Sweeney, 2005).

Feminist Identity

The feminist movement has worked toward achieving equality for women (Beasley, 1999; Hawkesworth, 2006). Millett (1970), drawing from feminist theory, asserted that both gender and sexual politics play integral roles in the development of the patriarchy and its associated privilege with little effort or interest in making a change. Many feminists argue that service women's participation in a traditionally patriarchal organization actually subverts the hegemonic masculinity of the military, helping women become equal citizens, while increasing their levels of self-efficacy and competence (Sasson-Levy, 2003). Yet others, including many feminists such as Enloe (1988) and Feinman (2000), opine that women Soldiers are simply pawns in a bigger game, participating in unethical violence and becoming a part of chauvinistic culture that oppresses women, ultimately damaging them emotionally (Sasson-Levy, 2003).

Supporters of this liberal approach suggest that developing a feminist identity and eschewing the acceptance of a patriarchal culture, endorsement of traditional gender roles, and denial of sexism increases resilience (Backus & Mahalik, 2011). Additionally, feminism's focus on valuing women and their sexuality and wellness, while also addressing power differentials, is likely to contribute to better relationships, including those with men. An adherence to these ideals of equal rights, along with belonging to a minority group, suggest that women often have to prove their competence, working harder than men to gain respect (Goldsmith, Freyd, & DePrince, 2012). A strong work ethic and acute awareness of being underrepresented can be catalysts in a healthy reintegration into civilian society and can be an impetus for the development of empathy for those who have been oppressed (Bailey, 2009).

Overview of Established Wellness Instruments

Prior to developing the SWAWR, several wellness instruments were reviewed to determine whether wellness constructs focused on the unique needs of service women. The focus of this review was to look at relevant comprehensive wellness instruments designed to measure holistic views of health. These models targeted civilian population and thus did not account for the unique needs of service women. Military measures were also examined and concerns with both were accounted for in the SWAWR.

Comprehensive Wellness Instruments

Several wellness instruments were designed to capture the holistic view of health including *Wellness Evaluation of Lifestyle* (*The* 5F Wel; Myers, Luecht, & Sweeney, 2004), the *Optimal Living Profile* (Renger et al., 2000), and the *Perceived Wellness Survey* (Adams, Bezner, & Steinhardt, 1997). Despite the sound psychometric properties of these instruments, none specifically focus on the military population, including the needs and strengths associated

with deployment, training, and military rituals. Moreover, because service women have unique experiences and needs, the content and context of these wellness instruments do not capture their specific needs and strengths associated with military service.

Military Wellness Instruments

The USDOD and the USDVA have made considerable progress in transforming their services to meet the mental health needs of service members and Veterans, including designing wellness-based instruments like the Comprehensive Soldier Fitness (CSF) Program's *Global Assessment Tool* (GAT; Peterson et al., 2011) and the *Deployment Risk and Resilience Inventory-2* (DRRI-2; Vogt et al., 2013). Both wellness instruments focused on the military population and included protective and risk factors; however, they only addressed women's concerns through subscales and did not capture the essence of service women's experiences (Vogt et al., 2013). Additionally, these instruments focused on active duty or reserve service members and did not focus on service women transitioning out of the military who may experience additional stressors. Further, researchers have examined service men and women together (Di Leone et al., 2013) which may bias how wellness is perceived for service women.

Although many researchers, including Peterson et al. (2011), contributed to our knowledge of resilience within the military, and specifically to our analysis of service women's needs, they do not offer a comprehensive view of service women's wellness, including how emotional, social, and spiritual components affected service women's daily functioning and their ability to reintegrate into civilian life. Instead, efforts focused on discrete and incomplete spheres of service women's psychological and physical health. Even though the GAT is comprehensive and emphasizes the resilience of service members, it is also limited in scope in that it was only used with Army Soldiers and only 20% of initial respondents were women, most of whom scored lower across the ranks on levels of trust than did their male counterparts. Peterson et al. (2011) suggested that further research was needed to understand the needs and challenges of female Soldiers to help increase overall morale. Additionally, the GAT ignores service women's unique strengths, including increased empathy and enhanced work ethic.

Wellness and Service Women

A review of civilian wellness and military-based strengths assessments was conducted to assess the need for the SWAWR. Emotional, social, and spiritual wellness were the most frequently identified factors of overall wellness. The World Health Organization (2014) included emotional, social, and spiritual facets as three of the most important factors in their most recent definition of wellness. Intellectual, physical, and environmental dimensions, often included in emotional, social, and spiritual constructs, were also evaluated. To align with the counseling profession's adherence to a holistic wellness model, the SWAWR included both intrapersonal and interpersonal elements, such as items addressing coping skills, meaning-making strategies, communication abilities, dealing with emotionally demanding situations, and finding support.

Emotional Wellness

As defined by Hettler (1980), emotional wellness involves intrapersonal and

interpersonal facets, including an awareness, acceptance, and expression of feelings in oneself and others, as well as an integration of feelings, cognition, and behavior. An example of emotional wellness is managing stressors. Stressors, such as those experienced in the military, increases the need to reach out to others to be soothed (Skopp et al., 2011). However, due to their minority status and concerns with gender harassment during deployment, service women's support network can be minimal, causing further stress and feelings of invalidation (Street, Gradus, Stafford, & Kelly, 2007).

Many service women perceive that others, including their spouses or partners, view them as not being real warriors. The lack of understanding can be especially hard to cope with since an intimate partner's emotional validation of a traumatic event is more important for a service woman, compared to her male counterpart (Skopp et al., 2011). Further, service women are often faced with understanding the complex relationship they have with their sexuality and gender (Adams-Curtis & Forbes, 2004). The challenge for service women is to cultivate healthy perceptions about themselves in regards to their esteem and competence, sexual identities, beliefs about their intimate partners, and platonic relationships with men, many of whom are their peers and leaders (Browder, 2010).

Social Wellness

Hettler (1980) defined social wellness as a focus on the promotion of the common welfare of the community by working for mutual respect and cooperation among the other individuals. Service women's social wellness themes include a strengthened sense of purpose due to helping underrepresented groups and the cultivation of feminism as a protective factor. Like service men, service women have experienced physical and emotional wounds; they have also developed meaning and an altruistic worldview from their service because of their gender, attributes that can prove beneficial in promoting social justice and ensuring equal rights in the community. The military remains one of the last examples of assigning traditional masculine social values and sustaining the patriarchy (Herbert, 1998). Consequently, service women play important roles in taking back control over the meaning and interpretation of gender construction, further demonstrating professional equality and changing sexual politics.

Spiritual Wellness

Spiritual wellness includes the ability to make meaning from previous experiences and to reintegrate into civilian society. Additionally, spirituality is highly personal and developmentally different for each person (Myers & Sweeney, 2005). As opposed to traditional views, the modern view of spirituality is not necessarily one that includes a path of ascending, but one of descending into more of our higher and truer selves (Myers & Sweeney, 2005).

Although Veterans experience difficulties during transition from the military to civilian life, specifically with making meaning and developing their identities exclusive of their military titles, women, in particular, struggle to adjust (Boyd, Bradshaw, & Robinson, 2013). For example, service women are four times more likely to be homeless than their civilian women counterparts (Boyd et al., 2013). Part of this struggle is due to the lack of recognition and respect

they receive, with many women Veterans reporting being underappreciated in both their professional and personal spheres (Disabled American Veterans [DAV], 2014).

Additionally, spiritual wellness involves a deeper understanding of the complexity of moral injury. Litz et al. (2009) defined moral injury as the consequence of perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations. Moral injury is an integral theme of spiritual wellness due to the disruption of one's systematic worldview, including the loss of values that give unity, purpose, and goals to hopes, strivings, thoughts and actions (Hettler, 1980; Litz et al., 2009).

Purpose

Myers and Sweeney (2005) mention that cross-cultural studies of wellness remain largely unexplored. Because values, behaviors, and definitions of health and mental health vary across cultures, additional measures of wellness must be developed (Myers & Sweeney, 2005). Due to women's growing stature in today's Armed Forces, researchers need to analyze service women's concerns and strengths from a holistic perspective. Browder (2010) identified specific concerns and strengths including greater scrutiny compared to male counterparts, gender and sexual harassment, working harder to overcome stereotypes compared to their male counterparts, enhancing competitiveness and focus, developing empathy, and making meaning from adverse living and working conditions.

Currently, there is a paucity of information regarding how women who served in Afghanistan and Iraq are adjusting to civilian life and, consequently, how we measure their strengths and needs (Katz et al., 2010). Foster and Vince's (2009) research reiterated the need for researchers to further understand the experiences of women Veterans so that they can design assessments that meet their needs. Ample self-reports exist that summarize both service women's successes and struggles; however, existing assessments fail to capture these complexities. Creating a holistic assessment specifically designed for service women will signify that clinicians are not only interested in addressing their psychological wounds, but also are interested in cultivating and strengthening service women's positive attributes and unique characteristics that often remain unaddressed in research studies.

The purpose of this study was twofold: (a) to assess the unique social, emotional, and spiritual concerns of service women and (b) to conduct a pilot study to create a comprehensive wellness assessment, using exploratory factor analysis, to assist counselors when working with this subgroup. Prospective constructs that were investigated included: (a) emotional wellness, including developing interpersonal and intrapersonal resilience; (b) social wellness, including promoting the common welfare of the community and working towards social justice and equal rights; and (c) spiritual wellness, including making meaning from previous experiences and integrating spiritual and/or religious practices and beliefs into daily life. For this study, two research questions are examined: (a) What are the primary factors that contribute to service women's wellness? (b) To what extent does each item measure each of these factors?

Methods

Participants

Target population requirements included service women who were planning to separate or retire from the military within the next two years and those women who had recently separated or retired. The purpose of these requirements was to obtain a sample of participants who had gained enough military experience to fully reflect upon their service or who were already focusing on their transitions to civilian life. By working with multiple national Veteran nonprofit organizations with diverse missions, the authors hoped to obtain a sample that was representative of the women Veteran population.

Study participation was solicited from several nonprofit organizations. Organizations and estimated number of members included: *Team Red, White, and Blue* (*n* = 300), *The Mission Continues* (*n* = 50), and *Women Veterans Connect* (*n* = 150), as well as from Facebook groups such as *Women Are Veterans, Too* (*n* = 5,000) and *Women Veterans* (*n* = 2,000). We identified and targeted these organizations due to service women's growing interest and involvement in organizations and their connection to the mission and outreach activities of these groups. Social media was included as a recruitment tool to expand our outreach to this population and to capture those who were not affiliated with targeted organizations. Snowball sampling was also used to identify individuals who may not be members of these organizations. Because the assessment's objective was to determine comprehensive wellness, the nonprofit groups to which the prospective participants belonged represented a diverse sample of service women, including those interested in the following missions: (a) increasing Veteran athletic camaraderie (*Team Red, White, and Blue*), (b) providing community service opportunities (*The Mission Continues*), (c) linking service women to business and entrepreneurial resources and mentoring (*Women Veterans Connect*), and (d) providing social support and connection (*Women Are Veterans, Too; Women Veterans*). A total of 7,500 service women had access to the survey through social media links.

Costello and Osborne (2016) report strict sample size rules in EFA have mostly disappeared. For example, in determining sample size, it is important to evaluate both the number of participants and the ratio of participants to variables. Comrey and Lee (1992) provided the following rating scale for factor analysis sample sizes: 100 = poor, 200 = fair, 300 = good, 500 = very good, 1,000 or more = excellent. Costello and Osborne (2016) described the influence that the raw number of participants has on the average percent of Type II errors, concluding that there is no minimum participant-to-item ratio. However, Gorsuch (1983) and Hatcher (1994) both recommended a ratio of at least 5 to 1. Although participant-to-item ratio makes a significant contribution beyond sample size, EFA is still considered a large-sample procedure, so the more participants, the better (Costello & Osborne, 2016). In developing the SWAWR, the authors focused on obtaining a sample size of at least 300 with factor loadings of .45 or higher (Comrey & Lee, 1992). Of the 7,500 service women who belonged to the organizations to which the link was shared, a total of 354 participants completed the survey, for a participation rate of 4.72%.

A majority of the survey participants were White/Caucasian (82%), heterosexual/straight (86.75%), Christian (70%) women who had earned a bachelor's degree or higher (65.1%), with the average age of the respondents being 40.41 years (*SD* = 8.10). The Navy was the most well represented branch with 45.4% participants having served. A majority of participants (55.2%) had separated from military service after having served an average of 11.52 years (*SD* = 6.83). A majority of participants (64.1%) reported that they had been deployed at least once, with respondents averaging 2.47 deployments (*SD* = 1.97), with 46% participants having been deployed to a combat zone. Nearly three-fourths of the participants (73.5%) reported that they had experienced a traumatic stressor in their lifetime, with 28% of participants having formally reported a sexual assault while serving in the military. Two-thirds (66.3%) had sought counseling in their lifetimes and 76.5% had an immediate family member who had served in the military.

Instrument

In order to evaluate wellness in the context of the military, several established assessments, including civilian wellness and military resilience instruments were reviewed. Based upon information obtained in the literature review, the authors assessed the strengths of these assessments, including the instrument developers' foundational theories of wellness, as well as the existing gaps, in order to conceptualize and develop original items for the SWAWR. A total of 97 items were initially developed that reflected the constructs of social wellness (e.g., "I value the relationships that I made in the military"), emotional wellness (e.g., "I practice good self-care strategies"), and spiritual wellness (e.g., "My military service has contributed to a greater sense of purpose in my life"). All items were scored using a 1 to 5 Likert scale (1 = *Strongly Disagree*; 3 = *Neither Agree nor Disagree*; 5 = *Strongly Agree*). To ensure that all of the relevant themes were included in the initial SWAWR, Fabrigar, Wegener, MacCallum, and Strahan (1999) suggested that the number of initial instrument items be approximately three to five times the number of final items. The final SWAWR was expected to have between 19 and 32 total items.

In addition to the instrument items, 19 demographic questions were included in the survey. These items addressed: (a) age, (b) race/ethnicity, (c) military status, (d) length of service, (e) time (years) since military service, (f) sex, (g) sexual orientation, (h) service branch, (i) highest military rank attained, (j) number of times deployed, including deployments to combat zones, (k) highest level of education, (l) spiritual/religious group affiliation, (m) traumatic stressors and when they occurred, (n) formal reporting of military sexual trauma, (o) experience with counseling, and (p) immediate family members who served in the military.

The *Marlowe-Crowne Social Desirability Scale* (MCSDS; Crowne & Marlowe, 1960), a ten item instrument used to assess participants' desire to be viewed favorably by others, were included within the questionnaire. The MCSDS, a psychometrically sound instrument with high internal consistency ($\alpha = .88$) and test-retest reliability ($r = .89$), is often used in developing self-report instruments when socially desirable responding can be a concern. The average participant score for the MCSDS was 25.5 (scores can range from 10--lowest to 50--highest score), with participant scores ranging from 10 to 41 (*SD* = 5.80), suggesting that social desirability had little impact on SWAWR responses.

Procedures

A quantitative descriptive classification design was used to establish an assessment to measure service women's wellness. Approval for the study was obtained from the University's Institutional Review Board (application #243). Experts across mental health disciplines, including counselor educators with extensive knowledge of scale development and other clinicians such as clinical psychologists who identified as either having worked with service women or who were service women, evaluated the initial SWAWR items for content validity. The expert panel was asked to give specific feedback regarding how relevant they thought each item was to wellness, how clear and concise the items were, and if any information should be added to further capture the construct (DeVellis, 2012). The expert panel members were given the comprehensive definitions of each wellness construct. Unique service women wellness themes were also provided to the expert panel members.

Based on the expert panel's feedback, the refined scale containing 97 items was pilot tested, which included distributing the SWAWR to a developmental sample of four service women of various ages and military branches. Based on these women's feedback, items were reevaluated, modified, or dropped if they demonstrated lack of applicability to service women's wellness or were difficult to understand. After modifications, the pilot study was conducted with the larger participant pool via SurveyMonkey. Participants had access to the survey through a URL in an email sent directly to them. The researchers also posted the URL directly to the organization's webpage or social media site. Follow-up reminders were sent at two, four, and seven weeks after initial notification. Due to the personal nature of some of the questions, participants were also given contact information for the USDVA crisis hotline, along with a link to the USDVA women Veteran's case management and counseling needs homepage.

Results

Initial inspection revealed no evidence of miscoded data or univariate outliers that would significantly affect the results. An analysis of missing data was conducted for the overall SWAWR. Thirty-one participants did not complete over 50% of the survey items and were deleted, consistent with the suggestion by Hair, Anderson, Tatham, and Black (1998), resulting in a final sample size of 323. To evaluate the type of missing data, Little's Missing Completely at Random (MCAR) test revealed that data were not MCAR [$\chi 2$ (8,494) = 9,013.03, $p < .01$]. A visual scan of the data set further suggested that data were Missing at Random (MAR). The average item non-response rate was < 1%, with item non-response rates ranging from 0% to 1.9%. To address missing data, a regression imputation was conducted since this imputation method uses the most sources of information to provide good estimates for missing data (McDonald, Thurston, & Nelson, 2000).

The assumptions for EFA and initial factorability of the 97 SWAWR items were examined. Correlations were run and 92 of the 97 items correlated at .3 or above with at least one other item. The diagonal values of anti-image correlation matrix were all greater than .5, supporting the inclusion of each item in the factor analysis (Hair et al., 1998). Inspection of the correlation matrix revealed that 5,963 of 9,409 (63.38%) were significant at either the .01 or .05

levels. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was .878, which is above the recommended value of .6, and Bartlett's Test of Sphericity was χ^2 (4,656) = 17,104.50, $p <$ .001. Additionally, the communalities, or the proportion of the variance in the variable that can be accounted for by all extracted factors, were all above .3, suggesting that each item shared common variance with other items (Tabachnick & Fidell, 2001). SWAWR item skewness and kurtosis values were also examined, with 94 of 97 items demonstrating normal skewness (absolute values < 2) and 95 of 97 items demonstrating normal kurtosis (absolute values < 7). Finally, homoscedasticity and linearity were analyzed and were found not to have impacted the observed correlations (Hair et al., 1998). Based on these indicators, factor analysis was conducted with all 97 items.

Data Analysis

Costello and Osborne (2016) explained that common factor analysis (FA) is preferable to principle components analysis (PCA) since researchers rarely collect and analyze data without an a priori idea about how the variables are related. The FA method assumes that the variance in a given variable can be explained by underlying common factors and by variance that is unique to the variable (Pett, Lackey, & Sullivan, 2003). In FA, unlike PCA, the shared variance of a variable is separated from its unique variance and error variance to show the underlying factor structure; hence, only shared variance appears in the solution (Costello & Osborne, 2016).

The extraction of components was conducted using maximum likelihood. This method was selected based on the data being relatively normally distributed (Fabrigar et al., 1999). Additionally, only items with a minimum loading of .32, which equates to approximately 10% overlapping variance with the other items in that factor, were considered (Costello & Osborne, 2016).

The initial extraction yielded a 24-factor solution based on the latent root criteria (eigenvalues > 1.00). However, Velicer and Jackson (1990) mention, factor extraction based on eigenvalues is the least accurate method and alternate tests, including the scree test, and item loadings should be used. Based on the initial scree plot, eight factors were retained above the break, with eigenvalues of these factors greater than 1, explaining 45.4% of the total variance. Items were deleted if they did not load on any factors or if they showed evidence of cross-loading. Henson and Roberts (2006) and Park, Dailey, and Lemus (2002) recommended examining both the highest and second highest factor loadings and retaining primary loadings that are greater than .5 or .6 with secondary loadings of no more than 0.3 or 0.4. The authors adhered to these cross-loading guidelines throughout the analysis. Factors were also deleted if they did not contain at least three items.

The initial extraction resulted in deletion of 62 items. Deleted items focused on themes such as coping skills (e.g., eating, sleeping, drugs and alcohol use, and counseling support) and inclusion (e.g., LGBT rights, sexual orientation, and racial/ethnic diversity). Item communalities ranged from .200 to .946. Tabachnick and Fidell (2001) indicate items with small extraction communalities cannot be predicted by the factors and should be eliminated if too small (< .20). Therefore, no items were initially eliminated based on extracted communality values.

Following the initial extraction, the factors were rotated using an Oblimin rotation to control the degree of obliqueness, or correlation, allowed by the factors (Nunnally & Bernstein, 1994). Based on the goal of obtaining the simplest structure, the final factor structure revealed a clean, parsimonious 18-item, three-factor solution and further rotation would not have clarified the structure (see Table 1). All items had primary loadings of over .45 and no items had cross-loadings on the final factor, pattern, and structure matrices. Final extracted item communalities ranged from .279 to .940 (see Table 1).

Table 1: *Factor Loadings for the SWAWR*

Item	Spiritual Wellness	Social Wellness	Emotional Wellness	Communality (h^2)
1. My spiritual and/or religious beliefs help me on a daily basis.	.978			.940
2. My spiritual and/or religious practices help me on a daily basis.	.933			.846
3. I turn to a higher power/divine being when I am struggling.	.918			.840
4. My connection to a higher power/divine being has been strengthened by military service.	.592			.358
5. Military stressors have helped me grow more spiritually.	.466			.334
6. I am motivated to create equality for women.		.954		.856
7. I am willing to go out of my way to create equal opportunities for all.		.743		.612
8. My military experiences made me more of an advocate for women's equality.		.713		.484
9. I feel comfortable speaking up about women's issues.		.646		.484
10. I am comfortable standing up for the rights of oppressed groups.		.610		.496
11. I can make decisions pretty easily.			.632	.392
12. I seek out challenges.			.605	.370
13. I often feel emotionally numb.			.539	.279
14. I am able to take charge in a group.			.524	.304
15. My perspective of the world helps me make more sense of my own life.			.507	.410
16. I have been able to maintain my integrity.			.498	.314
17. I've never lost track of who I am.			.478	.236
18. My military experiences have strengthened my relationships with men.			.475	.229

The factor labels that were initially proposed suited the extracted factors and were retained. The three factors on the SWAWR explained 56% of the cumulative variance, with the spiritual wellness factor explaining 28% of the variance, the social wellness factor explaining 16% of the variance, and the emotional wellness factor explaining 12% of the variance. A reliability analysis examined internal consistency of the three factors and results revealed good internal consistency. Cronbach's alphas were good to high, with spiritual wellness = .91 (five items), social wellness = .86 (five items), and emotional wellness = .77 (eight items). No significant increases in alpha for any of the scales could have been achieved by eliminating additional items. SWAWR demonstrated convergent validity with the *Perceived Wellness Survey*

(PWS; Adams et al., 1997), as evidenced by a significant, positive Pearson product-moment correlation between the SWAWR and the PWS (r = .554, p = .01). Some of the final extracted communality values were low; however, since the factors would not be used as either dependent or independent variables in additional analyses and the sample size was considered good, the low values were not concerning (Rietvald & Van Hout, 1993; University of Texas, 2015). A larger sample size of 1,000, for example, would have compensated more effectively for these low values.

Discussion

The need for valid and reliable instruments that address service women's issues has been cited as a limitation in research (DAV, 2014). The results of this study suggest that the SWAWR has the potential to be a useful self-report measure of service women's spiritual, social, and emotional wellness. The SWAWR may also have utility as a screening instrument for identifying service women in need of therapeutic interventions to enhance wellness and as an evaluation instrument to measure the impact of therapeutic interventions.

A total of 97 items were created to assess spiritual, social, and emotional components of overall psychological wellness. The results of the EFA supported a priori knowledge, with 18 spiritual, social, and emotional wellness items explaining 56% of the cumulative variance of the SWAWR. The factor structure of the SWAWR is consistent with the findings of other researchers, including Adams et al. (1997), Myers and Sweeney (2005), and Hettler (1980), who also emphasized spiritual, social, and emotional wellness components, as well as the World Health Organization (2014) which included these three components in their most recent definition of wellness.

The spiritual wellness subscale contained five items focusing on spiritual and/or religious practices, beliefs, and personal growth due to military service. These items reflected Hettler's (1980) definition of spiritual wellness, which involves developing a systematic worldview, along with purposeful and integrated values. The social wellness subscale contained five items focusing on social justice and equality within a patriarchal environment, emphasizing feminism beliefs as protective factors. These items reflected Hettler's (1980) definition of social wellness, which involves promoting the common welfare of the community by respecting and cooperating with others. The emotional wellness subscale contained eight items focusing on intrapersonal and interpersonal resilience, specifically emphasizing flexibility, openness, leadership, self-awareness, and relationship building. These items reflected Hettler's (1980) definition of emotional wellness, which involves the awareness and acceptance of a wide range of feelings in the self and others and the free expression and management of feelings to arrive at personal choices and decisions autonomously based upon the integration of feelings, cognition, behavior and a degree of self-awareness, self-acceptance, and flexibility.

The SWAWR items reflected additional themes from the literature, such as feminism as a protective factor (Sasson-Levy, 2003), the cultivation of resilience and hardiness (Peterson et al., 2011), and the overall promotion of wellness (Myers & Sweeney, 2005). Specifically, this study reflects the tenets of liberal feminism, including empowerment of women, promotion of equality between the sexes, and the questioning of societal pressures such as gender roles and sexism

(Prochaska & Norcross, 1999). The inclusion of feminist-themed items on the SWAWR supports the research of Gould and Obicheta (2015) of *The Mission Continues*, an innovative nonprofit organization dedicated to helping Veterans find meaning through community service.

As discussed, Peterson et al. (2011) developed the Army *Global Assessment Tool* (GAT) and Vogt et al. (2013) developed the *Deployment Risk and Resilience Inventory-2* (DRRI-2) in response to the mental health community's tendency to primarily address only the vulnerabilities and weaknesses of service members. Instead of using a deficit-based approach, these researchers focused on resilience and hardiness. The SWAWR emphasizes these themes, further described by Meredith et al. (2011) in the military context, as including positive coping, positive thinking, realism (or pragmatism), behavioral control, altruism, clear communication, support, closeness, adaptability, connectedness, and collective efficiency (Meredith et al., 2011). The SWAWR also emphasized moral injury, an issue that can complicate other mental health concerns, including posttraumatic stress symptoms. The SWAWR includes items that reflect these subjects (Currier, Holland, & Malott, 2014).

Implications for Counseling and Research

Currently, mental health clinicians' views of the military continue to be shaped by the service men majority (DAV, 2014). Often, mental health clinicians narrowly focus on trauma symptoms and ignore how the military landscape affects women, specifically how women develop resilience in and make sense of a challenging environment where they are often part of a small minority (DAV, 2014). This strengths-based instrument can be used by mental health clinicians to identify service women's intrapersonal and interpersonal strengths and challenges, fostering growth by identifying attributes that allow service women to thrive. Specifically, the results of the EFA suggest that the most salient intake questions should focus on meaning-making, feminism and social justice, resiliency, and the effects of moral injury (Litz et al., 2009; Peterson et al., 2011; & Sasson-Levy, 2003).

Katz et al. (2007) indicated if Veterans are presented with a series of direct questions about symptoms and behaviors, they may be more likely to effectively communicate their experiences to mental health providers. This may be especially helpful for civilian clinicians working outside of the USDVA who may not fully understand the military environment. A structured assessment like the SWAWR helps mental health clinicians broach concerns that service women may be reticent to share. As suggested by Pietrzak and Southwick (2011), therapeutic interventions that enhance perceptions of purpose and control, bolster support, and promote resilience significantly mitigate PTSD symptoms. Therefore, strengths-based assessments like the SWAWR are especially important when working with service women, many of whom have experienced a loss of control and a lack social support (Demers, 2013). Adapting feminist-oriented therapeutic approaches, including being egalitarian and cognizant of socialization processes is also recommended (Worell & Remer, 2003).

If clinicians assess these experiences accurately, including service women's use of feminism as a strength, they may be able to develop better therapeutic interventions. Many of the SWAWR items support the inclusion of feminism and resilience in conceptualizing clients. Moreover, because researchers like Backus and Mahalik (2011) have supported the importance

of feminism in strengthening resilience, a construct that includes meaningful purpose, self-efficacy, and the ability to learn and grow from both positive and negative life events (Bonanno, 2004), the importance of including these concepts in the SWAWR must be highlighted.

Clinicians must be cognizant of the implications of gender in the military, including pride from service, the meaning of representing all women, and the connectedness that service women may experience, both with other service women and with service men. Clinicians who use a feminist therapeutic approach suggest that raising awareness of the dominant patriarchal culture can empower women, increasing self-esteem, self-confidence, and self-efficacy (Prochaska & Norcross, 2009). By using the SWAWR, clinicians can better understand service women's spiritual, social, and emotional wellness in the context of a male-dominated environment. Once clinicians analyze the results of the SWAWR, they will be better able to focus on clients' protective factors, including resilience, as well as areas of growth (i.e., what is working for clients and what is not working for clients) in the context of having been in a patriarchal environment.

Clinicians should maintain an open-minded approach to both service women's concerns and to the military in general. This means helping service women discover their authentic voices, including encouraging the sharing of both positive and negative aspects of service, while also respecting many of these women's reverent views of the military as an institution. The SWAWR promotes clinician objectivity by posing research-based, standardized questions that describe nuanced experiences and perspectives.

The SWAWR helps the clinician establish initial rapport with a population with whom they may not be familiar. Specifically, the SWAWR may assist clinicians in establishing credibility, respect, and trust with service women clients by approaching the session in an objective and organized manner. Use of a valid and reliable instrument like the SWAWR helps clinicians focus on the client, as opposed to being influenced by media or political reports regarding military affairs.

Additionally, because there is consensus that mental health problems emerge from more than just fear-based stressors, it is important to understand the complexity of military experiences and to implement appropriate interventions (Currier et al., 2014; Finlay, 2015). When counseling service women who may be struggling with moral injury, as may be suggested by their responses to SWAWR items 1-5, 13, 16, and 17, Finlay (2015) suggested considering two additional clinical perspectives: (a) viewing guilt as an important, adaptive, relational emotion that can lead to meaning, value, and/or reparation, and (b) viewing war-related guilt within a client's particular political, philosophical, and moral frameworks.

Limitations

The SWAWR relied on self-reports. Although the MCSDS was used to assess this bias, which was found to be minimal, participants may have responded in ways to reflect lower or higher wellness scores, since they were aware of the constructs that the SWAWR was measuring. Additionally, participants were affiliated with positive, socially minded groups, which may have resulted in different responses compared to those service women not wanting or needing

affiliation with other Veterans. The response rate was less than 10%, due, in part, to the use of social media and the lack of a researcher-participant relationship, which likely affected overall responses. The survey was also Internet-based, which may have hindered some service women from responding due to anonymity concerns, even though confidentiality was assured to the furthest extent possible.

The participants, although representative of all military branches and from both enlisted and officer ranks, were not as diverse as the service women population. To obtain an adequate sample size, participants included both active duty, separated, and retired personnel; however, some questions were created to address experiences retrospectively, so participant responses could have been influenced by the number of years since discharge or retirement, as well as their subjective memories. Finally, the binary conceptualization of gender is considered a limitation. The instrument construction focused on biological rather than self-identification conceptualization of gender and did not fully account for wellness issues associated with transgender service personnel.

Suggestions for Future Research

Because of the reductive and preliminary nature of the analysis, the authors did not fully address other service women themes, many of which were initially described in the literature review. These themes include gender performance, relationships with supervisors, relationships with other women, the positive and negative effects of tokenism, experiences of not being recognized as Veterans, deleterious effects of betrayal trauma, and use of specific coping skills, including counseling, exercise, and social support activities. The exclusion of these themes can, in large part, be attributed to the nature of the constructs the authors were addressing (Pett et al., 2003). Therefore, future service women-focused research should focus on a more in-depth analysis of these themes.

Other relationships, including demographic information and composite wellness scores, were not fully addressed. Therefore, future research should focus on how demographic variables, including race, ethnicity, sexual orientation, branch of service, deployment history, trauma history, history of counseling, and military sexual trauma reporting behaviors, may influence both composite SWAWR scores and SWAWR subscale scores.

Finally, it is evident that there are two emerging themes: Feminism as a protective factor and the need to focus on morally injurious experiences (MIE's). Future research should be devoted to understanding how these two SWAWR themes impact service women. Specifically, more research is recommended to further understand how service women view feminism in the context of their service and how they maintain their authenticity and values in spiritually challenging and stressful military environments.

Conclusion

This study addressed the rationale for SWAWR development. The goal of this study was to create an assessment for service women continue to be underrepresented in the literature. Through an analysis of three constructs—emotional wellness, social wellness, and spiritual

wellness—the author attempted to illuminate service women's most salient experiences, including their challenges and successes. If mental health clinicians can conceptualize both the strengths and concerns of service women more effectively during an initial session, as described by the final 18-item, three-factor SWAWR, they will be in better positions to establish rapport and understand their clients, as well as track their clients' progress throughout treatment.

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Phenomenological Evaluation of a Career Transition Assistance Program for Military Veteran College Students

TERRI D. HOWE
Texas A&M University – Corpus Christi

A. STEPHEN LENZ
Texas A&M University – Corpus Christi

MARVARENE OLIVER
Texas A&M University – Corpus Christi

Abstract

Transitioning from military to civilian life can be challenging because for many Veterans, leaving the military means ending one career and beginning another. A career center at a four-year public institution in South Texas has designed a program to address the career decision-making needs of military Veteran students. A phenomenological study was utilized with undergraduate military Veterans and included six purposively selected individuals that gave voices to the students as they experienced the process. Analysis of findings identified six themes that summarized the components participants believed contributed most to their new vocational identity: finding direction, shaping career narrative, transition, assessments, goal setting, and interactions with the counselor. Implications for career counseling unique populations and recommendations for future research were made.

KEYWORDS: transition, Veteran, civilian, career decision-making

The United States Veterans Administration estimated that there has been a 42% increase in military Veterans enrolling in college since the 2009 signing of the Post-9/11 GI Bill (National Center for Veteran Analysis and Statistics, 2015). Although each branch of the military has a transition program that provides information for transitioning to civilian life, these programs do not consistently include a career counseling component. Among colleges and universities, many rely on programs such as the Veteran's Affairs Internship Program (VA Learning University, 2016) that assist student Veterans (SVs) in securing internship sites to promote career transition.

Terri D. Howe is the Director of the Department of Career Services at Texas A&M University – Corpus Christi; A. Stephen Lenz is an Assistant Professor Department of Counseling at Texas A&M University – Corpus Christi; Marvarene Oliver is Interim Associate Dean, College of Graduate Studies & Professor, Department of Counseling and Educational Psychology at Texas A&M University – Corpus Christi. *Address correspondence to Terri Howe. Email: terri.howe@tamucc.edu.*

Within these internship-based programs, career counseling and guidance are not provided. Potential deleterious consequences include poor utilization of government paid tuition dollars, unsuccessful re-careering, and career dissatisfaction among SVs. This is concerning given the supposition by Luke, Diambra, and Gibbons (2014) that identifying career goals and developing related vocational opportunities are central to student Veteran success.

It is plausible that an alternative to internship-based programming, which features career decision-making and career goal setting during transition from active duty to Veteran status, could be instrumental for promoting academic and vocational success. Therefore, it is imperative that career counselors in university settings identify interventions that promote successful career decision-making among SVs.

This task has proven difficult on many college campuses given the disparities between SVs and their traditionally aged classmates. Often these disparities are grounded in experiences related to completing a career in the military which may have featured formal training programs (National Center for Veteran Analysis and Statistics, 2015). The culture of military service members adds to the complexity of transition issues when accounting for unique attributes bounded by the trappings of language, writing style, relational norms, member identity, rank structure, value systems, and laws (Rausch, 2014). Some SVs have completed specialized vocational training programs while enlisted, while others have completed entire careers before enrolling in a 2 or 4-year college.

In many cases SVs have experienced trauma associated with their previous vocations. In many cases, these traumatic events may lead to depression, anxiety, post-traumatic stress disorder, or traumatic brain injuries (Rausch, 2014). Additionally, SVs completing first-year coursework are typically chronologically older than traditional undergraduates and have received specialized vocational training. However, they are still searching for a career that matches their abilities and aptitudes. Taken together, the previous developmental, vocational, and psychological experiences of SVs converge to establish a unique set of needs that may be only partially met and largely underserved.

The number of career counseling programs designed to meet the needs of retired or discharged military personnel who enroll in 4-year universities is disproportionately small compared to the need (McBain, Kim, Cook, & Snead, 2012). Among the approximately 4,100 colleges and universities in the United States, 44% of the institutions who participated in the Campus Programs for Veterans and Service Members Survey reported having career planning services for Veterans and service members (McBain et al., 2012). A reported 3,864 colleges and universities who responded to the survey did not provide career counseling services specifically for Veterans. Among those colleges providing programming, many lacked a career counseling component in which the participants are able to evaluate how previous experiences and current interests could support informed career choices (McBain et al., 2012). Consequently, few studies of post-secondary Veteran career transition assistance programs have been conducted to determine the perceived usefulness of these programs to contributing to their career decision-making or perceived value of these programs by the participants (McBain et al., 2012). These data signify a need for an increase in Veteran specific programming at universities that provide career counseling strategies, including one-to-one career counseling that incorporates career goal

setting, assessment of readiness to make a career decision, and experiential activities like job shadows or internships.

Experiences of Student Veterans Completing Transition Assistance Programs

The body of research on the topic of military Veteran transition to college life is robust and yet few researchers have focused on Veteran college transition programs that aid in vocational identity (Brown & Gross, 2011; Cook & Kim, 2009; O'Herrin, 2011; Persky & Oliver, 2011; Rumann & Hamrick, 2009). Rumman and Hamrick (2010) identified some of the most prominent challenges of transitioning to life on a college campus were establishing relationships with non-veteran students, renegotiation of identity from military member to college student, and reconciling the disparity between the maturity of SVs and non-veteran students. DiRamio, Ackerman, and Mitchell's (2008) participants reported a lack of Veteran specific programs in financial assistance, disability services, mental health counseling, academic advising, and career counseling. This contributed to difficulty in acclimating to college life. Hassan, Jackson, Lindsay, McCabe, and Sanders (2010) suggested that rather than focus on the SVs' deficits, programming should identify strategies to capitalize on their strengths of courage, sacrifice, perseverance, and future-mindedness to promote success in school and work. These studies indicate a perception among SVs that the process of identifying a new career path post-military poses a challenge for some individuals without the aid of Veteran-focused programs and strategies.

For some, it is difficult to determine how previous military work experience can be transformed into civilian work. Hayden, Ledwith, Dong, and Buzzetta (2014) surveyed military Veterans at a large southeastern university to identify SV-perceived career development needs. Of the 92 respondents, 55% reported difficulty in transferring military skills and experience into a civilian work setting. Findings in DiRamio, Ackerman, and Mitchell's (2009) qualitative study included a perceived need by SVs for programs that focused on the unique concerns of Veteran students such as acclimating to the less-structured environment of a college campus, learning study strategies to ameliorate the negative effects of PTSD or other mental or physical issues, and making career choices that can be very different from their military jobs.

Taken together, these findings suggest that many existing TAPs for undergraduate SVs lack a career counseling component in which participants are able to evaluate their experiences to make more informed career choices. Additionally, the literature available for career counselors concerning the development of a comprehensive CTAP is limited in its utility for guiding best practice among career counselors and administrators alike. Therefore, a greater understanding of the perceived usefulness of these programs as they contribute to the career decision-making and overall value among SVs experience is warranted.

Purpose for Study and Research Questions

The purpose of this study was to implement a phenomenological case study to identify participant perspectives about a Career Transition Assistance Program (CTAP) that were salient and contributory to vocational identity development. A study evaluating the career experiences of college students who are military Veterans can provide essential information about the

benefits that SVs experience in career decision-making activities. Additionally, student perceptions of these career exploration strategies are essential to improving CTAPs across college campuses in the United States.

Therefore, the present study was completed to answer two research questions: (a) What are the experiences of the undergraduate military Veterans who participate in a CTAP in a university setting?; and (b) To what programmatic factors do participants attribute to their ability to make a career choice? With this information accounted for, career counselors in university settings can provide career counseling that meets the unique needs of Veteran students.

Method

A phenomenological case study approach was implemented to identify participants' perceptions about what aspects of a CTAP for supporting Veterans to develop new vocational identities was helpful to them and how program components were associated with their ability to make career choices. A sample of six participants from the population of student Veterans who completed the CTAP were purposefully selected for inclusion in the study based on a diversity of academic classification and major, military branch, and gender. The sample was composed of adults (M = 28.83 years, SD = 5.34) who identified as undergraduate freshmen (n = 2), sophomore (n = 1), junior (n = 1), and senior (n = 2). Majors represented were mechanical engineering (n = 2), computer science (n = 2), psychology (n = 1), and bio-medical science (n = 1). Representation for military branches were Navy (n = 2), Marines (n = 1), Air Force (n = 1), Army (n = 1), and Coast Guard (n = 1). Four of the participants were men and two were women.

Measurement of Career-Related Constructs

Career Thoughts Inventory. Sampson, Peterson, Lenz, Reardon and Saunders (1996) created the Career Thoughts Inventory (CTI) to assist clients with understanding self and career choices. The test results consist of the three construct scores: decision making confusion (DC), commitment anxiety (CA), and external conflict (EC). It consists of 48 negative statements and responses are made on a Likert-type scale ranging from strongly disagree (SD) to strongly agree (SA) (Sampson et al., 1996). A Total CTI score is also expressed as a percentile and T score with higher Total CTI scores reflecting greater dysfunctional career thinking. An analysis of the construct scores and individual items can help determine the specific nature of dysfunctional thinking.

The professional manual reported an internal consistency of the CTI Total score and construct scales was determined by calculating coefficient alphas for each of the respective norm groups (Sampson et al., 1996). The alpha coefficients for the CTI Total score ranged from .97 to .93 and alpha coefficients for the construct scales ranged from .94 to .74 (Sampson et al., 1996). Given the college student population from which this instrument was normed, the convenience of taking it, and the short amount of time involved in both administering and interpreting it, this instrument has merit for being a possible solution to assisting military Veteran college students with career decision-making.

Choices Interest Profiler. The Choices Interest Profiler was developed to provide clinicians and clients with a brief yet inclusive assessment of career insights based on Holland's RIASEC model (Choices, 2017). It is a shortened, computerized, self-report version of Holland's Self-Directed Search and is composed of 60 items, each describing a work activity (Choices, 2017). Users are asked to choose answers for each of the activities and responses are formatted in a 3-point Likert-type scale ranging from 1 (Like) to 2 (Not Sure) to 3 (Dislike). The manual reports the Interest Profiler is appropriate for users 14 years of age or older with eighth grade or higher-level reading skills (Choices, 2017). The Bridges software scores this instrument as the participant takes it and at completion of the assessment, six occupational interests are presented in order of the user's highest interest type to lowest interest type (Choices, 2017).

Examples of items include questions like, "How would you like to build kitchen cabinets?" (Realistic), "How would you like to conduct experiments in a laboratory?" (Investigative), "How would you like to be in a theater production?" (Artistic), "How would you like to counsel someone who is depressed?" (Social), "How would you like to manage a company?" (Enterprising), and "How would you like to calculate payroll for a company?" (Conventional) (Choices, 2017). The manual reports all six scales demonstrated a high degree of internal reliability with coefficient alphas ranging from .95 to .97(Choices, 2017). Additionally, there was a very high correlation between corresponding scales, ranging from .71 (Enterprising) to .86 (Conventional) with a median value of .82 (Choices, 2017).

Procedure

Following IRB approval, participants were recruited in the Spring of 2016 from the Student Veteran Organization (SVO) and a freshmen seminar class designed specifically for undergraduate military Veterans. The SVO advisor contacted the Veteran students who actively participate in SVO and asked if they would be interested in participating in the study. The freshmen seminar instructor announced the study to the class and informed the prospective participants that those interested in the CTAP study could contact the researcher. The purpose of the study and what participating in the study entailed was explained to students who agreed to participate in the program. The CTAP was based on the format and structure of the CIP intervention (Sampson et al., 2004) but was modified to meet the specific needs of college students who identified as military Veterans. Similar to the goals of CIP, the CTAP goal was to assist students in making career decisions both now and in the future. The program was 10 weeks during the fall 2016 semester and the participants met once a week with me, as I [Editor's note: first person pronouns refer to Terri Howe] served both as researcher and counselor for the program.

CTAP Intervention

Initial interview. The initial interview was conducted during the first week to identify the participants' worldview, previous work experiences in the military, and whether they saw a connection between their past experiences and anticipated future career paths. This interview provided me with details about participants' current status in career decision-making while also supporting their self-knowledge.

Preliminary assessment. Participants completed the CTI and the Interest Profiler in Choices using online access prior to the counseling session. Results for the CTI and Choices were reviewed to facilitate increased awareness of their readiness to make a career decision. High scores in decision making confusion, commitment anxiety, and external conflict indicated the level of support needed by the client and the specific area that needed the most attention in order to make a career choice. Reviewing the Choices RIASEC scores with the client during this meeting helped the participant to understand the relationship between self, their interests, and their prospective vocational identity.

Problem identification and analysis of causes. During the third meeting, work involved coming to a mutual understanding of their career-related issues and variables impeding their career decision-making process. Some issues identified by Veteran college students in this session included the disparity between military and civilian identities and lack of support in making decisions about their academic programs. This meeting presented me with an opportunity to assess the influence of client worldview on career decision-making and potential choices for ameliorating identified issues.

Goal formulation. Collaboration between counselor and client occurred during the fourth meeting to formulate attainable short, mid, and long-term goals. These goals were stated in behavioral terms to address removing challenges to career choice. Depending on the readiness of the client and time permitting, we began working on an individualized plan (IP) to attain their goals. The IP was a modification of CIP's individual learning plan (Sampson, Reardon, Peterson, & Lenz, 2004).

IP development. The meeting of week five was concentrated on the development of activities that assisted the client in attaining the short, mid, and long-term goals. As part of the process, resources to be used in the activities were identified, the time needed to complete the activities was estimated, and a sequence for goal attainment was established. An important part of the discussion was working with the client to determine what goal attainment looked like for him/her. Depending on client readiness, an internship or job shadow was assigned as one of the activities.

IP implementation. The meetings for weeks six through ten involved the client checking in with me to monitor the client's progress on his/her goal attainment. For clients completing an internship or job shadow as part of their goals, this involved exploration of the clients' experiences to evaluate whether the internship or job shadow was a potential career choice. As the client gained self-knowledge, goals were adjusted or altered to accommodate changes in the client's desired outcomes.

Program review. During the tenth meeting, the client took the CTI again to assess readiness to make a career decision. As the results were reviewed, discussion centered on what changes occurred in the client's thinking about vocational identity and what steps the client could make to continue progression towards career choice.

Data Collection

Data were collected using semi-structured interviews, personal observations, document analysis, and reflective journals. Pseudonyms were used in recording and transcribing all data.

Interviews. Semi-structured interviews were conducted at the conclusion of the CTAP by an experienced qualitative interviewer who has been conducting qualitative research for seven years. All interviews were conducted in offices of the university career center, were 30 to 45 minutes in duration, and audio-recorded. All participants took breaks as needed during the interviews. Interviews were guided by the following questions:

1. How has your military service impacted your thoughts about civilian careers?
2. What led you to join this program?
3. What was the experience like taking Choices?; Taking the Career Thoughts Inventory?
4. In what ways was the internship (or job shadow) helpful/ not helpful?
5. How did your military career influence the way you experienced this program?
6. What did you think of working with a counselor who is not a veteran?
7. Is there anything else that you would like to share with me?

Documents. The documents gathered for this study included CTI and Choices assessment results and individualized plans that outlined the students' short, mid, and long-term goals. Identifiable information was erased and documents were photocopied. Original documents were returned to each participant.

Reflective journals. In the last fifteen minutes of the weekly sessions, participants were encouraged to respond to a prompt. The writing prompt was the same for each session, "What was helpful or not helpful about this session?" This gave the participant an opportunity to reflect on the session and decide what was beneficial and what they determined as less helpful to their career decision-making.

Observations. After each meeting with the client, a technical journal entry and a reflective journal entry were completed. In the technical journal, the process for each session documented and detailed information the client shared that related to the CTAP steps. The reflective journal was used to detail my observations of each client during the counseling sessions. These journal entries included case notes and observations of the client's affect.

Lens of the Researcher

As a practicing career counselor at a four-year public university for fifteen years, I have had extensive experience working with military Veterans and have close family members who are Veterans. These experiences were influences on interpretations of the observed behaviors of the participants. Because my experiences with Veterans have been positive, I expected positive outcomes from my interactions with Veteran student participants.

As a career counselor, I have assisted many students in the career decision-making process utilizing a theoretical framework composed of contextual career counseling, cognitive information processing, and Holland's RIASEC model. I attempted to understand the client's

worldview, assisted in identity of career interests that correlate to work environments and supported them in developing problem-solving skills that promote vocational identity and equip them to make future career decisions (Rausch, 2014; Holland, Daiger & Power, 1980; Clemsens & Milsom, 2008). As part of the research process, I completed a reflective journal which allowed me to describe thoughts, perceptions, observations, feelings, and decisions about changes in content of the program during the career decision-making process. This journal documented my view, or lens of the study and provided context for analyses that were made.

Trustworthiness

Information was gathered through the use of interviews, document review, observations, and reflective journaling. Use of multiple data sources provided credibility (Patton, 2002). Another method for providing trustworthiness in this study was through the use of member checking. Texts of transcribed participant interviews were provided to the participants to review. Creswell (2000) stated that providing these texts to the participants and getting their feedback on the accuracy of the transcriptions allows the participants to believe that their stories are being heard. Finally, trustworthiness was established through prolonged engagement with the participants. I established a rapport and developed a relationship with the clients over the ten weeks we met.

Data Analysis

Data analysis proceeded simultaneously during data collection in accordance with the guidelines depicted by Braun and Clarke (2006). Data obtained throughout the interviews, observations and document materials were coded and analyzed utilizing thematic analysis (Braun & Clarke, 2006). Thematic analysis involved identifying, examining, and recording patterns within the collected data to support describing phenomena (Braun & Clarke, 2006). Steps in thematic analysis included: (a) organizing and preparing the data for analysis, (b) coding all of the data, (c) generating descriptions of the setting and participants through the coding process, (d) developing the themes and descriptions that will be represented in the narrative, and (e) making an interpretation of the findings (Braun & Clarke, 2006).

Coding was an explicit and iterative process in which the researcher reviewed two to three lines of text at a time, determining key words, concepts, and reflections. Codes were modified as ideas emerged, revealing clear images of themes. As the coding stepped proceeded, the researcher routinely consulted with and received feedback on the process from an experienced qualitative researcher who has been conducting qualitative inquiry for twenty years.

Results

The purpose of this study was to implement an exploratory research program to identify participant perspectives about CTAP that were salient and contributory to vocational identity development. An analysis of the data revealed six overarching themes: finding direction, sharing their career narrative, transitioning to college culture, participating in the assessment process, setting career goals, and interacting with the counselor. As shown in Table 1, these themes

summarize how participants experienced CTAP and describe the components they believe contributed most to their ability to make a career choice.

Table 1. *Overarching Themes Identified by Participants and Related Definitions*

Themes	Definitions
Finding Direction	Refers to participants' thoughts concerning developing a vocational identity and a plan to attain that identity
Sharing the Career Narrative	The opportunity of relaying their career history, including their military experiences
Transitioning to College Culture	The process of acclimating to both civilian life and college campus culture
Participating in the Assessment Process	The participants' views of how assessments played a role in their career decision-making
Setting Career Goals	The development of goals and strategies to attain a new vocational identity
Interacting with Counselor	Rapport, relationship development and conversational exchanges with the counselor

Finding Direction

For the purposes of this study, direction refers to participants' thoughts concerning developing a vocational identity and a plan to attain that identity. For most, participants (n = 5) indicated they joined CTAP in order to gain direction for their career path. As Veteran 3 stated, "...when I got out (of the military), I had no direction. What really interested me in the CTAP is that they were going to assist me in that way." Veteran 1 expressed a need to "reinvent myself" and "do something entirely different" from his military career. He indicated that CTAP helped him avoid making the same mistake he made when he joined the Marines. He stated,

> …when I went into the Marine Corps, I went in blindly. You don't know what it's like to be a Marine until you are one. It was completely different than what I thought. I don't want that to be my career choice as well. I want to know ahead of time what I'm getting into.

Some factors cited by participants as impeding their ability to find direction were anxiety over choosing the one perfect career, feeling stuck in their thought process because they lacked information about careers, and pressure from significant others to choose a career. Veterans 1 and 2 reported lacking direction because they had an interest in a field of study in which they believed they could earn a high salary with, but were unsure of what the work in that field

actually entailed. Veteran 1 indicated a need for direction to a path that would lead to a high paying position. Veteran 1 said,

> …today motivated me a lot more as I was able to better define a path to a career. I know I want to go into engineering because you can make six figures in it. I just need a little more help figuring out what job in engineering is right for me.

Veteran 2 wrote,

> …I do feel confused about what to do with my major. I know that computer science has a lot to offer and I could make some good money with it. I just don't know where to go with it. I hope this program helps clear some of this up for me.

Veteran 4 joined the program because he was "…stuck with my idea or stuck with what the hell am I doing? I didn't really know what I wanted to be doing or how to get to that place of knowing."

Sharing the Career Narrative

Telling their own stories about their lives in the military was important for many of the participants (n = 4). Detailing their experiences provided an opportunity for them to share the aspects of their military experiences they believed meaningful in gaining insight about themselves and their career interests. Veteran 4 believed that, "…going back through time and telling my history gave me a sense of who I am right now. I don't know where I want to be but I know where I have been." As Veteran 6 indicated,

> … what was most helpful to me was being allowed to tell my story. Telling my story allowed me to remind myself of the journey that made me who I am today. It made me realize how strong I am and that I can do anything.

For Veterans 2 and 3, sharing the details of their military story contributed to their comfort with participating in CTAP. Veteran 2 stated, "… it was helpful to go over my background as far as my military experience and home life. It creates a more personal environment and experience." Veteran 3 wrote

> What I found helpful today was the questioning about my past experiences in the military. Since I am a shy and reserved individual, it's an easier way for me to feel comfortable. It also helped relieve any anxieties that may be present.

However, Veterans 1 and 5 did not view telling their stories as important. Veteran 1 did not see the relevance of his military past to his current career decision-making and wrote, "Today, we talked about what I did in the Marines. I'm not sure where this information is going to go. I don't want to do that kind of work anymore." Veteran 5 was concerned about sharing his military experience because of the security sensitive nature of his work in the Navy, "… it made me a little nervous to discuss because I did security sensitive work and I wasn't sure how to describe some things."

Transitioning to College Culture

Transition from military life to civilian life in general as well as to a college environment was a concern for all of the participants (n = 6). Veteran 2 reported one of the reasons she joined the program was assistance with the transition to college life, "… (joining the program) was kind

of a transition for me. I'm a freshman and the school thing is still really new to me. I figured anything that is going to help is good." She stated that talking about the transition process with me helped her "...transition because I am leaving that world (military) behind and I am making a different life for myself."

Veteran 5 indicated his struggle in understanding how his military experiences transferred to a civilian environment contributed to a difficult transition.

> I didn't feel like a lot of my skill from the military really, uh, transferred over to the civilian world. Even when I was getting out, they (military) kind of trained us on what to expect, but they were like, 'We don't really know how to transfer that over into a civilian skill set.' So, it was a struggle to figure out how a lot of my military background actually transferred over. It (the military transition program) was more just like a checking the box type of thing in the military and now that I'm out, it's just really difficult.

Veteran 4 cited the differences between civilian and military work ethic made his transition from the Coast Guard to a civilian environment difficult. He stated,

> ...in the Coast Guard, I saw that organization as more egalitarian than most civilian groups. So, the way I view civilian things is like I don't really want to work with a lot of civilians. I would rather start a company or be in a company that's all Veterans because of the work ethic that is behind that.

Veteran 3 believed that going from a structured environment in the military to an unstructured environment in civilian life was the most challenging aspect of transition. He stated,

> … the military, it's your given direction. It's not really your choice. They just tell you this is what needs to be done; this is how it needs to get done. For the civilian sector, I've noticed from a lot of my friends who didn't join the military, they're just given a task and just told complete it however they feel like completing it. I don't really appreciate an unorganized type of work environment.

Participating in the Assessment Process

All participants (n =6) indicated that the assessments were helpful in gaining insight about their interests and what they perceived as challenges to gaining vocational identity. For most (n= 5), the Choices Interest Inventory information aided in their understanding of what careers may be more rewarding to them in terms of how their interest align with the careers. Veteran 2 wrote in her journal, "… I appreciated taking the interest test. It was pretty much me and what I like to do." Veteran 4 wrote

> Looking at the Choices questions was helpful in understanding the things I felt were most like me. It helped to read them out loud in order to get a better feel of it. Although I'm still confused, I feel that looking at a list of careers will help with the career I choose after college.

Veteran 5 wrote, "… my interests were conventional and investigative. This is true." In his interview, Veteran 5 explained, "… I still felt the questions were kind of childish but it was very plainly me." Veteran 6 believed the interest inventory affirmed her career interests, "… the assessments today were helpful by confirming my interests in the medical field. It was nice to see the assessment corresponded with my interest."

All participants (*n* = 6) believed the CTI provided information about perceived challenges to making a career choice that they didn't know or hadn't considered. After reviewing the CTI results with me, Veteran 1 stated,

> … when she (the counselor) read it (CTI results) back to me and she was saying that my career anxiety was just like through the charts, I was like, 'well yeah.' It pretty much put what was going on inside my head in a more concrete way on paper.

Veteran 3 wrote,

> ... (CTI) helped me see the connection between my anxiety and the difficulty of selecting a field of study. I do have high end levels of anxiety and the test showed that I have career commitment anxiety and I do have issues with decisions and making commitments.

For Veteran 5, the CTI helped him understand that the he struggled with external conflict in the form of comparing himself to his family. He stated,

> … they had one where it was outside influences I believe and it did definitely make me think. I do judge myself by my family a lot. I judge myself highly by how I compare with my family or how my family affects me.

Setting Career Goals

For participants in this study, the process of setting specific goals was experienced as helpful. These goals were developed and refined throughout the program. After the first session of goal setting, Veteran 4 journaled,

> Goal writing is awesome! I didn't realize I had short, medium, and long term goals. I had done this in the past, but not with the information from the previous sessions. This led up to the goals. Really helpful way to keep things in line in order to feel a sense of purpose which I felt was lacking when I first entered the program.

Veterans 2 and 3 found the process of goal development helpful because it aided in their conceptualization of the steps needed to take to realize their vocational identity. Veteran 2 wrote, "… this week was helpful and how to accomplish them (goals) in the best sequence. Some goals I had I didn't know were goals. So, that helped in how I mentally pieced together my future plans." Veteran 3 indicated, "Laying out my goals, short, mid, and long on paper was really helpful. It lets me see what I need to do to achieve those goals." Veteran 1 believed goal setting was beneficial because it was similar to a process he experienced in the Marines, "… short, mid, and long term goals really help. It reminds me of a military fragment order where after one goal is completed, it is condition set to move onto the next goal."

Interacting with the Counselor

Most participants (*n* = 5) noted that interactions with the counselor were an important part of their experience. Participants cited the use of questions, listening and paying attention, flexibility, and encouraging discussion aided in their ability to evaluate their career concerns and supported the development of strategies to address their concerns. In her interview, Veteran 2 stated, "… from talking with Terri and the questions that she is asking and what she notices by us talking and conversing, that helped me to be like, 'okay, well maybe this is more important

than I realize'." Veterans 1and 3 believed that, having someone to listen to them helped them evaluate their career concerns. Veteran 1 indicated, "… it was mainly just someone making me talk about it (concerns) out loud because before I just, you know, I'd be awake at night thinking like what am I going to do?" In his interview, Veteran 3 said, "... with Terri, she sits back and lets you talk to her. It's almost like she provides a direction to the conversation but she kind of makes you get there yourself in that she lets you reach the point."

Most participants (n = 5) believed my flexibility to change session topics to be responsive to their perceived needs was helpful. Veteran 2 described her experience as,

> … she has helped me in more than just a job, because I mean, in reality, it is more than just a job. It was not just a one-track; we have to do this and that. She is very versatile and it was very versatile on what we talked about and what we were able to have out of each meeting.

Veteran 6 also appreciated the flexibility to discuss other concerns that were impeding her ability to meet her goals. She wrote, "… venting to Terri about my stressors at home and at school allowed weight to be lifted."

Veteran 5 believed that he would have been more comfortable with a counselor who was more structured and less empathic. He informed the interviewer,

> ... she had that more, I guess, nurturing side and I sometimes need that person to just tell me, 'This is what you need to do. This is why you need to do it,' type of attitude. I'm still very structured in the way I do things. It's just, for me personally, I think if there would have been more structure to it, it would have been, it would have felt more natural.

Discussion

An analysis of the data revealed an important step towards a new vocational identity for the CTAP participants was to find direction for their career decision-making. For many who embark on the journey of career decision-making, determining the first step in the process for finding direction are the most challenging. CTAP participant responses indicated that this was primarily achieved through telling their story, identifying impediments to transition, setting attainable goals, completing assessments that aided in identifying their interests, and having meaningful interactions with the counselor.

The challenges CTAP participants associated with transitioning to a college campus and subsequently impeding career choice such as establishing relationships with non-veteran students, renegotiation of identity from military member to college student, and reconciling the disparity between the maturity of SVs and non-veteran students are consistent with the literature (Rumman & Hamrick, 2010). CTAP participants acknowledged the cultural differences between SVs and non-veteran students that impacted their process for career decision-making. In order for these transitional challenges to be resolved, higher education institutions must increase efforts to assist SVs with their transition needs (Rumman & Hamrick, 2010).

Additionally, some CTAP participants' perceived difficulty in transferring military skills and experience into a civilian work setting. This perception aligns with previous research (Hayden, Ledwith, Dong, & Buzzetta, 2014). Analysis of the findings in this study indicated that

assistance with resolving these issues allowed the SVs to find their direction for a new career path. Once the SV identified strategies to mitigate the differences between self and college culture, they were able to develop the direction for their new vocational identity. Without a focus on the unique needs for this population, colleges may fail to assist with adjusting to college and subsequently, SVs may not persist and graduate (Rumman & Hamrick, 2010).

Finally, this study's findings indicated that the use of assessments and goal setting enabled CTAP participants to capitalize on their strengths instead of focusing on problems or deficits. Similar to Hassan, Jackson, Lindsay, McCabe, and Sanders' (2010) findings, by focusing on strengths such as courage, sacrifice, perseverance, and future-mindedness, CTAP participants were able to develop goals that supported their perceived outcomes for success in school and work. Without guidance in identifying their interests and developing attainable goals to reach their desired outcome, there is potential for failure in acquiring a new vocational identity.

Limitations and Recommendations for Future Research

Although this study provides some insights into the experiences of the participants, some caveats related to state-of-the-art, data collection, and sample are present. Foremost, while there are studies of career development needs of military Veterans, few studies focused on career counseling programs at higher education institutions for this population. As the body of qualitative research grows in this area, the findings of this study will provide greater context for consideration by career counselors. Also, this study featured self-report data viewed through the subjective lens of the researcher, to some degree, restricted by the fact that it is difficult to independently verify across studies (Brutus, Aquinis, & Wassmer, 2013). Therefore, in addition to qualitative data, quantitative studies assessing changes across important career-related constructs may provide a more complete picture of their experience in the program.

Additionally, the sample for this study included participants at various ages and stages of career development, both men and women, as well as representation from different military branches. While perceived career development needs of this heterogeneous group were explored, future researchers may consider a more homogenous sample to identify specific needs for SVs. A group comprised of participants with at least broad similarities could produce more effective strategies for vocational identity development (Correll, 2001).

Implications for Career Counseling

An implication for career counseling practice is for career counselors to place the client's career decision-making within the context of the client's worldview. To effectively assist the CTAP participants with their identification of new career choices, it was important that the counselor developed an understanding of their worldview. This can be challenging for counselors who have never served in the military and may not share the SVs unique cultural view of civilian life.

Therefore, a critical first step in assisting SVs in career decision-making is gaining insight into how their military experiences influenced their interpretation of civilian careers. This

practice of attempting to understand the context of the client's worldview is important, not just with SVs, but with any client seeking career counseling. Drawing as complete a picture of the client's experiences, beliefs, and values as possible can lead to customization of strategies to assist the client. This more complete picture will inform the selection of more effective approaches for assisting the client with their presenting concerns (Hall & Yager, 2012).

Additionally, the importance of telling their stories was consistent with findings in the literature on higher education programming for student veterans. Just as DiRamio, Ackerman, and Mitchell's (2009) study found, SVs in CTAP believed their ability to making career choices was due in part, to a focus on their unique concerns. Participants believed their distinctive challenges to career decision-making were diminished because they were able to relay the story of their military career. Consequently, an implication for career counseling can be the strategy of allowing the client to relay the experiences and circumstances that have shaped their work history and contributed to their need for a change in career paths.

Finally, the use of CIP theoretical framework and specific assessments for pre and post determination of change can be implications for career counseling not only student Veterans, but other college student populations. By aiding the client to gain self- knowledge with the use of CIP strategies and pre/ post assessments, the client is better equipped to make career decisions that are closer aligned to who they perceive themselves to be (Sampson et al., 2004). Engaging the client in analyzing these data and their experience in career counseling can support the career choice process.

Conclusion

The focus of this study was a career transition assistance program that was designed to address the career decision-making needs of military Veteran undergraduate students. The study included a purposively selected sample of six individuals that provided insight to the military Veteran students' perceptions as they experienced the process. Six themes: finding direction, sharing the career narrative, transitioning to college culture, participating in the assessment process, setting career goals, and interacting with the counselor were identified as programmatic factors participants attributed to their career decision-making. Recommendations included adding quantitative studies to assess changes across career-related constructs and collecting data from a more homogeneous sample were made to develop strategies to aid in the career decision-making process. Transitioning from military to civilian life can be challenging because, for many Veterans, retirement from the military means ending one career and beginning another. With universities implementing CTAPs, the challenges to transition may be ameliorated and the process of developing a new vocational identity more easily attainable.

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