Working with Military Families: Impact of Deployment

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner

Margaret Donohue, PhD

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for social workers, therapists, counselors, psychologists, and other mental health professionals involved in the care of veterans and active-duty military troops and their families.

Accreditations & Approvals

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. NetCE maintains responsibility for this course.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

This course, Working with Military Families: Impact of Deployment, Approval #07012022-15, provided by NetCE, is approved for continuing education by the New Jersey Social Work Continuing Education Approval Collaborative, which is administered by NASW-NJ. CE Approval Collaborative Approval Period: September 1, 2020 through August 31, 2022. New Jersey social workers will receive 5 Clinical CE credits for participating in this course.

A complete Works Cited list begins on page 27.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

This course is considered self-study by the New York State Board of Mental Health Counseling.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed marriage and family therapists. #MFT-0015.

This course is considered self-study by the New York State Board of Marriage and Family Therapy.

Designations of Credit

Social Workers participating in this intermediate to advanced course will receive 5 Clinical continuing education clock hours.

NetCE designates this continuing education activity for 3 NBCC clock hours.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to provide mental and behavioral health professionals with the tools necessary to address and prevent the negative repercussions of deployment on military families.

Learning Objectives

Upon completion of this course, you should be able to:

1. Describe the basic demographic profile of military personnel.
2. Explain how the military culture affects how family members cope and adjust to deployment and help-seeking.
3. Identify stressors for family members associated with each stage of the deployment cycle.
4. Evaluate different theoretical frameworks to understand how deployment affects military families.
5. Discuss the physical, social, and psychologic effects of deployment on the family.
6. Outline the impact of social problems in military families.
7. Describe assessments when working with military families in relation to coping with deployment.
8. Explain different interventions and treatments for military family members experiencing deployment.
9. Identify ethical issues for practitioners working with military personnel and families within a military context.

INTRODUCTION

The effects of deployment on the family system tend to be overlooked. If families are viewed as a system in which all the parts are interdependent, inter-related, and interconnected, it is easy to see that a change in one dimension of the family system will affect the other parts of the system. The stressors for the ones who remain behind are great. It has been said, for example, that spouses of deployed military personnel are the "overlooked casualties" of war [1]. They experience increased levels of anxiety, marital maladjustment and discord, and depression [1]. Children are also affected, with the effects somewhat contingent on age. Preschool-age children may display regressive behaviors such as bedwetting, crying for attention, and aggression [2]. Because school-age children are more cognitively developed than preschool-age children and can begin to understand the potential implications of deployment, they may exhibit their stress with depression and inattentiveness in school [3]. Adolescents have even greater comprehension regarding the implications of deployment and can easily access news stories. Consequently, they are exposed to the realities of military operations as well as the public's sentiment toward a military mission [4]. They also have an understanding of what it means to have a parent injured or die. As such, parental deployment can affect them negatively in a variety of ways.

The goal of this course is to provide practitioners with an overview of the psychosocial effects of deployment on family members. The course will discuss the five phases of the deployment cycle and each phase's unique challenges. In addition, the military culture and how this culture affects how families cope, adjust, and seek help will be explored. Finally, various treatments, interventions, and best practices will be offered for practitioners working with military families. In this course, the terms "military personnel" or "service member" will refer to any individual who is a member of any branch of the military, including the Army, Air Force, Navy, Marines, and Coast Guard, and all duty statuses (e.g., active or reserve) [5]. Although there are unique aspects of each branch of military service, a discussion of these differences is beyond the scope of this course. This course aims to give practitioners an overview of the basic skills necessary to acquire military cultural competence, as military culture and veteran lifestyle can impact their and their families' health, mental health, and psychosocial life [135]. A practitioner competent in serving military clients will be able to more effectively engage with military family members.

MILITARY PERSONNEL: DEMOGRAPHIC OVERVIEW

According to the U.S. Department of Defense, there were 3.47 million military personnel as of 2021 [6]. The Army has the largest number of active duty members, followed by the Air Force, the Navy, and the Marine Corps [6]. In 2021, California, Virginia, and Texas were home to the greatest number of active duty military personnel [6]. Men make up the majority of active-duty personnel at 81.1%, with women comprising the remaining 18.9%. Since 2005, the percentage of active-duty female members has increased 15.6% [6]. Women are a growing segment of users of Veterans Administration services [8]. The majority of active-duty personnel are white, with 29.5% classifying themselves as belonging to a racial/ethnic minority group. Among activity-duty members, Black Americans are the largest racial/ethnic minority group (19%); the smallest segment is Native American Indians (1.1%) [6]. Approximately 23.1% of active-duty officers are 41 years of age or older. However, 50.8% of enlisted active-duty personnel are 25 years of age or younger [6]. A large proportion (84.6% of officers hold a Bachelor's degree or higher education, and the vast majority (99.4%) of active-duty enlisted individuals have graduated from high school and/or have completed some college [6]. In addition, one-half of the active-duty force is married, with 7.0% of active-duty personnel in dual military marriages [6]. In general, military individuals tend to marry at a younger age compared to the civilian population [9]. Both active duty and reserve personnel have an average of two children [6].

MILITARY CULTURE AND LIFESTYLE

It has been said that the military is an example of a social institution that is "greedy," meaning that the military requires from its members a great amount of commitment, loyalty, time, and energy, which ultimately affects other role commitments [10]. Family members of military personnel are expected to relocate frequently, and this uprooting necessitates spouses and children to make transitions and adjustments to their lifestyles, to make new friends, and to develop new social networks [10]. For example, it is estimated that 20% of families in the United States relocate annually; however, approximately 33% of military families relocate each year [11]. It is estimated that children of active-duty parents will move more than 20 times over the course of their childhood, three times more often than their civilian counterparts [7]. Inevitably, the frequency of relocations brings about multiple levels of stress. In a focus group of military youths, military spouses, and school personnel, the youths stated that they sometimes felt angry toward their parents for having to move multiple times and expressed a feeling of loss for having to separate from friends. Some wondered whether it was even worthwhile to invest in making new friends. Some parents felt that multiple relocations could help children learn important skills of adjusting, but indicated concern that it would affect the children's ability to make commitments to relationships.

Military spouses tend to have a more difficult time finding jobs because their transience makes them less desirable to employers [10]. When they do find jobs, their wages tend to be lower compared to their civilian counterparts who share the same demographics (e.g., age, educational level, ethnicity/race) [12]. In some cases, career advancement may be negatively affected [7]. Those who are not working and not seeking work report that there are too many barriers to employment including child care issues and the demands of the military lifestyle. Although some of these barriers are experienced by civilians as well, military families frequently cannot rely on extended family members for support [12]. In addition, military personnel often work long and unpredictable hours, which also impacts the family and the scheduling of activities. It is estimated that service personnel work an average of more than 50 hours per week, and it is higher (60 hours per week) for officers [10].

Despite the negatives of a military lifestyle, there are many positive benefits for families as well. There is a sense of belonging among families living on base or post, and they rely on each other for support. Military service members experience a sense of camaraderie, and their family members may also experience this sense of deep rootedness and affiliation. There are also financial benefits, as military families have access to medical care, job security, and other benefits, often extending into retirement [10].

The military culture is also a powerful factor. This military culture has specific institutional laws, traditions, vocabulary, symbols, codes of justice and discipline, norms, and values shared by a specific collective group [13; 102]. Although there is tremendous diversity within the military, as represented by the different branches and hierarchical ranks, there is one common denominator: service before self. This value system is embedded in every veteran's identity [135]. Military culture strongly influences military personnel's behaviors and value system and, as a by-product, affects their families [102]. Although each branch of the military has its own ethos, there are some common themes that run throughout the institution [14]. As mentioned, it is a culture that demands loyalty, integrity, commitment, and courage from its members. They have to be ready at any given moment to deploy and relocate, and their family members are expected no less [14; 15]. It is also a culture that draws itself into the personal lives of its personnel and their family members. For example, the military is involved in marital discord, substance abuse, and health and mental health issues because these factors can impede how military personnel do their work [15]. This has both positive and negative

ramifications. On the one hand, the military has programs and resources such as counseling, mental health services, and health resources available to address these issues. However, because of the closed nature of the culture, some military personnel are reluctant to seek help for fear it might have negative impact on their careers, and family members may be fearful that private information will not be kept confidential and that they will become objects of public scrutiny [15].

Military culture is also hierarchical and male-dominated. Consequently, ideals of being tough, self-sufficient, and strong (i.e., "the masculine warrior") are reinforced, with the belief that these norms will help to ensure that service members are mission-prepared and will survive in difficult circumstances [16; 17]. Emanating from this norm is the belief that all problems can be solved given enough time and effort [103]. This belief, referred to as the "warrior ethos," is based on the conviction that the mission is paramount and defeat should not be accepted [104]. The common mottos "tough it out" and "push through" conveying the importance of perseverance and overcoming adversity [136]. This belief is conveyed at the very start of recruits' training, during which they are taught that selfless service is paramount [136]. However, the downside of this type of promoted ideal is that experiences of psychologic, social, and/or emotional distress are viewed as signs of weakness; the military tends to reinforce the notion that a true soldier (or airman, seaman, etc.) does not need assistance [13; 16]. Therefore, obtaining formal help further places them at risk for stigmatization [16]. As a result, many rely on the peer support of other military service members rather than professional help [18]. This mutual support has its benefits, but it only goes so far.

The military culture has been described as authoritarian and marked by a rigid class system. When a service member enters the military, the individual enters an authoritarian relationship with the government, whereby the service member forfeits autonomy [137]. In terms of it being authoritarian, Hall notes [19]:

> There are clear rules, often with narrow boundaries, for behavior and speech; there is little tolerance for questioning of authority or disagreements; there are often frequent inappropriate violations of privacy; and often children are discouraged from engaging in activities or behavior that hint at individuation. Not only do military personnel have to adapt to the authoritarian structure, but their families do as well.

The military culture places emphasis on hierarchy and adherence to the hierarchical system by employing rank and grade [104]. This automatically communicates the individual's position and authority and the amount of power he or she has [104]. The military class system is divided into officers and enlistees [19]. Families are not only isolated from "civilian society," but the class system at times inhibits the intermingling of families of officers and of enlisted military personnel. Consequently, families may feel alienated [19].

The military culture is also characterized by values that emphasize teamwork, obedience, and the collective [16; 17]. The work environment, particularly deployment, fosters a brotherhood among service members [137]. These bonds are viewed as pervasive and lifelong. Individualism and autonomy are not the predominant values; rather, members are expected to dedicate themselves wholeheartedly and sacrifice for their unit, their mission, and the military system [14; 20; 103]. Although there is a sense of great solidarity and camaraderie, this can foster an "us" and "them" attitude, where "us" is the military and "them" is civilians [14].

CYCLE OF DEPLOYMENT

The cycle of deployment and the associated transitions made by military personnel and their family members are significant. This cycle consists of five different phases: pre-deployment, deployment, sustainment, redeployment, and post-deployment or reintegration. In each of these phases, military personnel, spouses, children, and other family members experience a range of challenges and adjustments [21].

PRE-DEPLOYMENT

In the pre-deployment phase, the individual receives a notice that he/she will be deployed. This phase involves "looking ahead" (planning) and saying goodbye [21]. The exact timing of departure is not always clear, and it can range from a few days to a year [22; 138]. During this phase, the stress of uncertainty and the vacillation among different emotions (e.g., anger, resentment, fear, anxiety) can trigger family members lashing out at each other and children regressing or acting out at home and/or in school [22]. Some military spouses report withdrawing to cope with their emotions and fears. Others use the time to emotionally connect with the deploying spouse [138]. In addition, the deployed military member and his/her spouse or partner may be busy arranging their legal affairs, such as wills or powers of attorney, and home preparations [105]. During this time, families also create strategies to maintain routines and promote security and attachment for their children [139]. For example, developing a video or audio recording of the deployed spouse reading to a child that can be played during deployment to preserve a semblance of family routine [139]. Such preparations, discussions, and arrangements may affect the marital dyad and the entire family system [22]. A quantitative study with 151 Army National Guard soldiers and their spouses found that deployment preparations and strategies can mitigate depressive symptoms [140].

DEPLOYMENT

The next phase is the actual deployment, when the service member departs. It is the separation phase, and for some families, the holding pattern of the pre-deployment phase is so stressful that the actual deployment is viewed as a temporary relief of the anticipation of separation [21]. This loss associated with deployment is referred to as "ambiguous loss," meaning it is not physical but psychologic [23]. Unlike death, a permanent physical loss, the family of the military personnel experiences ongoing psychologic loss, and this uncertainty can lead to difficulties in decision making and planning for the future [22]. Within this context, spouses may experience negative mental health symptoms. In one study, spouses of deployed service members experienced higher levels of anxiety, depression, sleep disorders, and adjustment disorders compared with those without deployed spouses [24]. In a qualitative study about the stressors impacting military families during the Desert Storm deployment in the early 1990s, researchers found that families experienced three types of stressors: emotional (e.g., missing the deployed family member, feeling anxious about his/her safety), the day-to-day practicalities of life (e.g., budgets, powers of attorney, child care), and general life events [25]. The major stressors the families identified were loneliness, financial concerns, and childcare and disciplining. Not all families had social support networks readily available, as family, friends, and/or other extended family members were often not living nearby [25]. With modern video communication options (e.g., Skype), family members can see and speak in real time with the deployed family member. These opportunities may mitigate anxiety and loneliness, but witnessing realities of combat (e.g., hearing explosions or seeing injuries) may be traumatic, especially for children [105].

SUSTAINMENT

In the sustainment, the family works at sustaining itself without one of its family members. This phase takes place approximately during the second through the fifth month of deployment [26]. New routines emerge without the deployed family member, and each family member readjusts to the challenges, stressors, and new responsibilities [21; 106]. New social support structures may develop, and the family members who are left behind begin to see some equilibrium and experience some sense of control [26].

REDEPLOYMENT

The redeployment phase, also called the reunion phase, involves notification that the deployed family member is returning home. Both the deployed individual and the family members prepare themselves for the homecoming, and there is a tremendous amount of anticipation [26; 27]. As with any potential change in the family system, there may be some anxiety about how the returning family member will affect the routines that have been established and the power and role dynamics and relationships [26; 27]. During this time, family members are often attempting to prepare for the homecoming to ensure that everything is as perfect as possible [28]. Children may be asked to help in order to prepare.

POST-DEPLOYMENT

During the post-deployment or reintegration phase, the service member returns and the entire family is involved in helping him/her integrate back into the system [21]. A 2022 study examined predictors to family adjustment and how long it took to adjust using a secondary database of data collected at Walter Reed Army Institute of Research [141]. The data analyzed 333 female spouses of Army service members who were deployed to Afghanistan. About 13% of spouses indicated the reintegration period took six months or longer; 19% reported three to five months of reintegration. The spouses' perception of the returning soldier's mental health and treatment needs were linked to length of reintegration.

There is usually a honeymoon phase, but awkwardness and tension often follow [106]. Family roles may have changed during this time, and the returning member will need time to adjust. For example, new parenting strategies may have surfaced in order to deal with being a "single parent" during the deployment. Upon homecoming, the soldier should not expect family dynamics to have remained the same, but he/she may report feeling like a guest in his/her own home [22]. Some may not recognize their child, especially if the child was recently born or just an infant when they left. Similarly, children may not recognize the returning parent or express wariness of this returning stranger. As a result, the military parent may experience distress and hurt [105].

Some military families will encounter challenges during the post-deployment phase, including substance abuse, post-traumatic stress, and domestic violence. In fact, it is estimated that the rate of relationship and family problems is four times higher during this phase than the other phases [29]. In a study involving 19,227 active U.S. soldiers from brigade combat teams who served in Iraq or Afghanistan between 2003 and 2009, problems of marital quality were reported and separation/divorce intentions increased during the reintegration period [51].

THEORETICAL FRAMEWORKS

Theories are logical systems that provide a framework for organizing and understanding observations and concepts. They are intended to offer comprehensive, simple, and dependable principles for the explanation and prediction of observable phenomena. In addition, theoretical frameworks guide how the service provider will proceed during various phases of the change process. They define the problem and its etiology and, ultimately, guide assessments and interventions. The following theoretical frameworks can offer practitioners a foundation to understanding the context of deployment and how it impacts military family members and how to best assess and intervene in these families.

FAMILY SYSTEMS THEORY

Family systems theory asserts that changes in the environment will inevitably result in changes (not necessarily negative) within the family structure [30]. One family member's behaviors and symptomology will inevitably affect other family members in the system [142]. The family structure is further defined as the organizational patterns or characteristics of the family [31]. Within all family structures, there are boundaries that determine who is in or out of the family system and who belongs in which subsystem. Subsystems consist of members of the larger family system on either a temporary or permanent basis with specific roles and can be organized by sex/gender, age, power/rank, past history, interests, or other factors [31]. Furthermore, family structures are guided by family rules, which are the expectations for behaviors that shape and direct family function, and family roles, which consist of beliefs regarding each individual's specific function(s) [30]. Ultimately, healthy family systems have clear boundaries between the subsystems and flexible rules and roles to promote individuality but still maintain healthy generational hierarchies and promote growth and adaptability [32].

When applying family systems theory to military families, some questions arise. How does deployment affect the entire family system and each individual family member? To what extent is the family an open or closed system? For example, the more open a family system is, the greater flexibility members have to maintain its viable-ness and use outside resources [33]. When tasks and responsibilities alter as a result of deployment, it is necessary to examine the family boundaries [107]. Consider how the family system adjusts in order to meet the challenges of having one member temporarily gone. Does any family member take on new roles? How does this affect the overall family structure?

Ambiguous loss, which is a type of grief, can ensue as a result of ambiguous family boundaries [108]. This type of loss can result when the military family member is absent physically (i.e., deployment) but remains psychologically in the family system, or if the military family member is physically present but is psychologically absent [108]. It is also important to consider unpredictable and distressing PTSD behaviors in the returning spouse and how these might affect children and their sense of security [142].

ECOLOGIC THEORY

Ecologic theory is based on the inter-relationships of the individual and his/her behaviors on four different levels: macrosystem, exosystem, microsystem, and ontologic [34]. The core assumption is that alignment between individuals and the environment in which they operate is necessary, as resources and support are derived from the environment [35].

The macrosystem level of ecologic theory includes the broad social and cultural values that affect the individual. In understanding the impact of deployment on military families, practitioners should examine how the sociocultural context of the military affects families. What are the social norms about relocation, military readiness, and resilience? How are families of the deployed individual expected to respond and cope?

The influence of formal and informal social structures (e.g., work, peer groups, support groups, friendships, school settings, community, neighborhoods) on larger social problems and individual behaviors is referred to as the exosystem level [34]. In terms of understanding how military families cope and adjust to deployment, understanding how the family draws upon formal and informal structures in their network is helpful. For example, consider how military families who relocate often adapt to their new communities, jobs, schools, and/or religious/spiritual organizations [103]. Do military spouses have a supportive network of family members, friends, and community members from which to draw strength and resources? With each deployment, family members navigate the different systems levels and may bring into the new deployment phase new strengths, coping skills, supports, temperaments, and resources [142].

The microsystem level refers to the family unit. This level includes the physical characteristics of the immediate family, interactions within the family system, and how each family member perceives the familial environment [34]. On the family level, military families struggle with loneliness, communication problems, and parenting, all of which can lead to maladaptive coping and even violence [109]. Therefore, it is important to assess the emotional states of all family members.

The ontologic level refers to the factors inherent to the individual (e.g., developmental history, skill level, behavior patterns, personality structure). When considering these levels, assess the individual's personality styles, coping skills, and ability to adapt and be resilient.

RESILIENCE THEORY

As the name implies, resilience theory focuses on humans' capacity to overcome challenges, adversity, struggles, and pain, ultimately leading to transformative changes in their lives [36]. Family resilience is a strength-based resource that draws on each family members' thought patterns, behaviors, emotions, and other situational factors, which can ultimately mitigate the effects of stress on the family system [143]. Family resilience can include problem-solving skills, positive outlook, sense of mastery, communication, spirituality, and connectedness [143]. This is a move in focus from pathology and dysfunction to the positive effects of healthy coping and perseverance [37]. Resilience has been linked to internal factors, such as temperament and attitude, and external factors, such as community, family, faith, spirituality, and religiosity [36]. Many military families are able to transition from crisis to coping and adaptation in response to war and deployment [38].

There are three categories of resilience [39]. The first is overcoming the odds, which encompasses positive outcomes despite adverse conditions. The second category is sustained competence, which involves being able to harness inner and outer resources to cope with adverse conditions. Finally, the third category is recovery from trauma, which comprises the capacity to move on, progress, and function in a healthy manner despite past and ongoing stressors.

In the context of military families, instead of focusing on the crisis and challenges that deployment and war might bring, resilience theory would explore the factors that allow some families to stay healthy and even thrive in the face of risk and adversity [40]. For example, there is some research that suggests military families' frequent relocation may not lead to negative outcomes (e.g., poor social and academic adjustments in children). Rather, some studies have shown that increased levels of family coping were a result of frequent relocations and that the many relocations brought new opportunities, including meeting new people and appreciating diverse cultures [41]. As another example, some have argued that aspects of military training such as field exercises, promotion of leadership, and sense of cohesion in military units can lead to preparedness and stress inoculation [41].

There is a misconception that military spouses fall apart when their spouses are deployed. Some research indicates that spouses who are left behind take over family decision making, assume new roles, and seek assistance, ultimately demonstrating tremendous role flexibility [41]. Indeed, military families tend to be resourceful, flexible, and adaptable due to the many transitions they have undergone. Examples of resiliency in these families include an enhanced ability to make new friends, deftly transitioning from dual-parent to single-parent households and back, and adjusting to diversity [39].

Psychologic processes that help foster resiliency include making meaning and finding hope/positives. More than 65% of spouses of active-duty military members reported that understanding the larger mission of their spouses' deployment helped with their coping [110].

Similarly, interventions based on resilience theory focus on promoting resilience and identifying specific mechanisms that promote resiliency [37]. For example, family members often experience anxiety, sadness, and worry in anticipation of deployment but may feel they should avoid discussing these emotions in order to protect the deploying family member. Interventions focusing on resilience could involve coaching family members to develop methods for checking in with each other or encouraging them to access internal resources, such as religion

and spirituality [110]. Specific behavioral coping strategies include teaching relaxation techniques, reframing, and activity planning [37]. This is based on the belief that families are resilient and can be provided additional skills to enhance their resilience. Some studies have shown that spouses who feel they have mastered negotiating roles and responsibilities when their spouses were deployed experience higher levels of marital quality during the post-deployment phase [110].

STRENGTHS-BASED PERSPECTIVE

The strengths-based perspective was developed in the 1980s in order to move away from traditional theoretical models in mental health care that emphasized deficits and pathology [42]. It is now applied in many areas of mental and behavioral health. The core assumptions of the strengths-based perspective are that humans have the strengths and resources necessary to change the circumstances of their lives, and in doing so, they can learn and grow [42]. Strengths include a client's innate abilities and skills as well as external resources in the community and family. After the problem is identified, the goal is to move away from focusing on naming the problem or deficit and to move toward identifying possible solutions [43]. The strengths-based perspective encompasses honoring the past and acknowledging the gifts of varied life experiences [111]. In the case of working with families with a deployed member, the practitioner will not necessarily focus on asking one family member why he or she is depressed. Instead, the practitioner will spend time and effort with the client identifying the strengths within the individual, the family, and the community that can be garnered to help support the family members during deployment. Military families, like any family, experience challenges and strengths, and the strengths-based perspective is beneficial in working through issues unique to these families' circumstances [44]. For example, a family can focus on the benefits that result from the numerous relocations (e.g., new skills, adaptability) [103]. Families that value the social connectedness of living on a military base are more likely to adjust to family stressors [144].

A study with 6,382 adolescents whose parents serve in the military found that the children tended to do well in school, have good relationships with their teachers, engage in extracurricular activities, and report good parental support, all of which are resources during times of stress [45]. Furthermore, because of their early socialization to the military structure, military children generally demonstrate greater levels of respect for authority figures and are more adaptable, flexible, and responsible and have greater ability to make friends with those who are different from themselves [46]. So, based on the strengths perspective, the role of the practitioner is to collaborate with clients to identify the strengths and resources already available to them and to pursue whatever actions and solutions the client decides [43].

EFFECTS OF DEPLOYMENT

With a solid theoretical backdrop and foundation having been set, it is important to explore the specific effects of deployment on the family unit, the marital dyad, and children.

FAMILY SYSTEM

It has been said that it is not only the military member who serves the country when he/she enlists in the military, but the entire family [29]. When military personnel deploy, the associated stressors can affect marital and parental relationships and the family's integrity and stability [13]. The family system is expected to adapt rapidly to establish equilibrium after the deployment; however, this equilibrium can be difficult to re-establish because the separation may be unanticipated, lengthy, and/or fraught with uncertainties [13].

The types of stressors that military families experience vary tremendously depending upon numerous factors; therefore, it is important to keep in mind that there is no one homogenous military family system. Families who have experienced multiple deployments may have developed coping mechanisms and family rituals to handle the family member's departure. Living on or off a military base

can also affect the types of stress family members experience. For example, if a family is surrounded by others with deployed members, there may be a shared understanding of deployment and necessary adjustments. Living in a non-military community may translate to less understanding of the emotional strains that a military family member is going through and greater levels of isolation [29]. Young, recently married military families may experience the greatest amount of stress because they are less financially stable [13]. Young enlistees are usually a lower hierarchical rung of the military, with low pay, and the economic stress can be great for family members who are left behind. Some may require government assistance, which can negatively impact self-esteem [13].

When a family member deploys, a spouse is often left behind to make decisions about the day-to-day functioning of the family, including medical, financial, schooling, parenting, and childcare issues. Although technology can foster better communication over significant distances, the spouse who is left behind must decide how much to communicate with the deployed spouse. For example, if there are troubles at home, should they be communicated to the deployed spouse? Is it better to minimize bad news so he/she can focus on the military assignment [29]? The extent of communication and what is shared during deployment also affect how the family reintegrates when the military family member returns [47].

In a qualitative study with 12 military service men and 18 military wives, one of the main themes that emerged was the importance of staying connected and communicating [48]. They spoke about wanting to be connected by sharing events of the day, and although the wives understood that their deployed husbands withheld information from them, they still derived much value of communicating frequently. Just as the spouse at home wrestles with how much to share, the deployed individual also must determine how much information he/she can and wants to disclose. Some of this is due to the confidential nature of military operations [48]. Again, this can contribute to family members feeling that they should be stoic and reticent about events at home [29].

In research involving deployed military personnel and their communication with their spouses, barriers to communication included security restrictions, technical challenges related to unreliable communication, and translation issues [145]. Using a large-scale dataset from the Millennium Cohort Family Study with a sample of 1,558 military service members and their spouses, stressful communication during the deployment stage affected both spouses' perceptions of stress at the reintegration or reunion stage [145]. Because family members are so far removed from the realities of a war zone, it can be difficult for military personnel to satisfactorily express their experiences and feelings. The problems with translation stemmed from being unable to convey intent with nonverbal gestures, facial expressions, and tone of voice can lead to "mistranslated" information [49].

Family members also report constantly worrying about the welfare of the deployed member. In order to learn more about their loved one's whereabouts or activities, they may obsessively watch television news, search for information on the Internet, and/or read newspapers [29]. If a deployed individual sustains a combat injury, this will also affect the family system. In a study of 41 spouses of service members who sustained a combat injury, spouses reported high levels of distress among their children after the injury was sustained [50]. This often affects sleep quantity and quality. A large-scale survey of 1,805 female military spouses found that 18% reported short sleep duration, with worse sleep quality when their spouse was deployed [112].

MARITAL DYAD

The military lifestyle places tremendous stress on marriages. Military spouses not only have to deal with the challenges of having their spouse deployed and the stressors of being a single parent, but the military structure and traditions place inordinate amount of implicit pressure on them. Spouses at home are expected to assist in volunteer efforts in their community and within the military structure.

Many military spouses feel that volunteering is necessary to help their spouses advance in their military careers [13]. Demographic context can contribute to marital instability. For example, younger age, lower education, and personal history of childhood trauma predicts marital instability [146]. Financial stressors and isolation are also major contributors.

When individuals are deployed, the spouse who is left behind assumes the responsibility of keeping the family intact and maintaining traditions and family rituals (e.g., birthdays, holidays). They tend to feel responsible for the morale of the family and fulfilling the roles of the deployed spouse. Many essentially become single parents, which can be overwhelming and taxing, leaving them feeling isolated [13; 48]. Some families end up doing "geo-bach," which is short for "geographic bachelor." A geographic bachelor is a service member who goes to a new post, but the family opts to stay behind in their home area [147]. Motivations for "geo-baching" often involve finances, if a spouse needs or wants to continue working at a civilian job. This situation results in the civilian spouse essentially assuming all parental duties when children are involved [147]. Depression, loneliness, and other mental health problems are common, and many are reluctant to seek help for fear of the stigma and of damaging their spouses' military careers. Others may find that, after an initial period of adjustment, they assume these new roles well, feeling more self-confident and enjoying a new sense of independence [48]. But this can cause problems as well. If a military spouse does not want to forfeit these new roles when his/her spouse returns, marital tensions can result [48].

Conversely, military service members assume new family roles when deployed. In a qualitative study, deployed spouses described needing to learn to forfeit involvement in daily routines and parental decision-making [148]. In other words, they had to accept being a family outsider when deployed in order to maintain family cohesion. One female service member participant described noticing her toddler drinking chocolate milk during a video call and restraining herself from commenting.

In a study of 300 married couples in which the deployed husband was active duty in the Army and the wife was a civilian, stress existed for both partners [52]. However, it was higher overall for the wives, despite the fact that the husbands experienced more physical threat. The researchers speculate that there may be several reasons for this trend. First, the husbands' military training may help them to better deal with the stressors or perhaps make them more reluctant to admit to stress. The lack of information given to the wives was found to increase their stress levels [52]. It is not surprising then that a study examining outpatient medical visits of wives of active-duty Army personnel during a three-year period found that 36.6% had at least one mental health diagnosis, compared with 30.5% of wives whose husbands were not deployed [24]. The most common diagnoses included depression, anxiety, sleep disorders, and acute stress and adjustment disorders [24]. Prolonged periods of deployment were associated with higher risks of mental health diagnoses and greater frequency of medical outpatient visits [24].

The risk of divorce increases as the cumulative number of deployments increases [113]. The majority of divorces typically occur after the military spouse returns. The risk of divorce also increases when the service member is female, suggesting that male spouses are less willing to adapt compared with female spouses.

Extensions to deployment are also related to a range of mental health, household, work-related, and marital problems in spouses at home. For example spouses of active-duty Army personnel whose deployments were extended expressed higher dissatisfaction with the Army, more communication problems with their spouses, a greater number of mental health issues, and more work issues (e.g., having to leave a job or reduce work hours) [53].

It is interesting to note that anxieties and fears about deployment can also bring couples closer. Some military wives indicated that the fear of possibly losing their spouse increased the level of communication and intimacy in the marital dyad. The deployed husbands expressed similar sentiments, reporting valuing their wives and marriages more [48]. Consequently, it is crucial not to generalize all military marriages as burdened with stress and marital discord due to deployment. For example, older spouses, those who are married to military personnel in higher ranks, and spouses with more military experience tend to experience fewer challenges [53]. Protective factors that can mitigate marital stress and instability include couples' communication and their involvement with and access to formal and informal support and resources [146].

PARENT/CHILD DYAD AND CHILDREN

Attachment theory may provide a helpful theoretical framework in understanding the potential effects of parental deployment on children. Attachment theory is based on the belief that children have a need to attach themselves to a key figure, such as a parent, and separation results in displays of emotional distress. The parental bond is crucial to developing healthy emotional relationships when the child moves to adulthood; childhood separation is linked to depression, anxiety, aggressive behaviors, and other emotional and psychologic problems throughout life [54]. Based on attachment theory, lack of secure relationships with peers, teachers, and/or other authority figures could also have adverse consequences. It is estimated that, on average, military children attend six to nine different schools by the end of high school.

Parental deployment may also negatively impact a child's need for security and can result in despair, anger, withdrawal, or detachment [7]. However, empirical findings are somewhat mixed when it comes to understanding how this extends to children's mental health. Some studies have found that children with deployed parents exhibit higher levels of depression and anxiety compared to children with nondeployed parents, although the symptoms were not pathologically severe. Some studies have found a 19% increase in behavioral and stress disorders in children with deployed parents [144]. In a 2011 quantitative research study with 106 military parents and 72 youths, children with a deployed parent experienced higher levels of school-related problems and internalizing and externalizing symptoms compared to children of nondeployed parents [55]. Twice as many children with a currently deployed parent scored in the "at-risk" category for emotional and behavioral problems compared with children of nondeployed parents. For example, in one study, teenagers were nine times more likely to binge drinking during the parental deployment [114]. However, the relationship between psychosocial outcomes and status of parental deployment is not simple; there is a host of other variables. Greater number of deployments and longer deployment periods are correlated with increased behavioral problems, although not significantly so [56]. Indeed, it is not merely the length of a deployment but the cumulative length of all separations experienced during the child's lifetime that correlates with psychosocial challenges during the deployment and reintegration phases [57].

The "healthy warrior effect" should also be considered when exploring the role of deployment and outcomes in children and family [149]. Deployed service members are generally better adjusted than those who do not get deployed, so there are other moderating or mediating variables that affect child and family functioning.

Children may experience distress and have higher maladaptive behaviors immediately after they separate, but this appears to lessen over time [115]. Further research indicates no statistically significant relationship between deployment and negative social and emotional development for children between birth and 5 years of age [116]. However, older children (6 to 10 years of age) tend to experience more problems with peers if one of their parents were deployed in their early childhood.

The mental health of the primary caregiver is also an important factor. The most consistent predictor of how well a child will adjust to a parent's deployment is the primary caregiver's own psychopathology [58]. Military service members who develop PTSD as a result of experiences during deployment may display moodiness, unpredictability, and negative behaviors that affect their children's mental health, adjustment, and academic performance [150]. In families with deployed members, there is a direct relationship between caregivers who experience poorer mental health outcomes and poorer academic functioning among their children [57].

Gender differences also exist. Girls tend to have more difficulties during the reintegration phase when the deployed parent returns than boys [57]. This may be because girls typically assume more household responsibilities during the military parent's absence. As noted, although there are studies indicating that military children experience more negative emotional, social, and psychologic outcomes compared to their non-military counterparts, there are studies that show no differences between the two groups. In a study with 213 children of military parents, between 6 and 12 years of age, the children's emotional symptoms were similar to national norms. However, the parents' reports of their children's emotional problems were higher than the national norms. It is possible that parents' own stress levels influence the reports of their children's functioning [59].

Social support is also crucial. Children of military families who live on the bases and attend schools sponsored by the Department of Defense have additional social supports, including peers who understand deployment and the military milieu [115]. It is clear that military children are not a homogenous group. There are variables that influence the diversity of this group and how they respond to parental deployment. Like any other children, most responses are contingent on age, developmental level, cognitive ability to understand the situation, pre-existing parental-child relationships, and the family environment [2].

OTHER KEY SOCIAL PROBLEMS

DOMESTIC VIOLENCE

It is estimated that the intimate partner violence perpetration rate is three times higher among military service members and veterans compared with their civilian counterparts [151]. However, the prevalence of domestic violence among military families is difficult to determine due to the closed nature of the military. This closed nature partially explains why instances of intimate partner violence are less likely to be reported by those with a military connection compared with the civilian population [152]. This appears to be specific to intimate partner violence, as studies show similar reporting rates for other crimes (e.g., robbery). It is also important to note that most statistics related to domestic violence in the military are derived from samples from only the Army, so it can be difficult to derive conclusions about trends across the different military branches [117].

In one review of the Army's central registry, researchers found that, between 1989 and 1997, there were 61,827 initial substantiated cases, 5,772 subsequent incidents, and 3,921 reopened cases [60]. Victim rates varied between 8 and 10.5 per 1,000 married persons. More than 65% of the victims were female, and almost half of the referrals were from law enforcement. The vast majority (93%) involved physical violence resulting in minor injuries [61]. Other Department of Defense data indicate that 19 of 1,000 Navy and Air Force wives and 21 of 1,000 Army wives were abused in the last year. In a 2010 analysis of data from the U.S. Air Force Family Advocacy Program, there were a total of 33,787 substantiated incidences of spousal abuse [62]. Physical abuse was the most frequent type of abuse to be substantiated, while neglect was the least likely to be substantiated. Newer reports from the Congressional Research Service indicate that among the active-duty population, there were 16,912 reported incidents of spouse and intimate partner abuse in 2018. Among these, 8,039 reports (6,372 victims) met the DoD definitions. Physical abuse accounted for the highest number of reports (73.7%), followed

by emotional abuse (22.6%), sexual abuse (3.6%), and neglect (0.06%) [63]. A meta-analysis assessing 69,808 military participants found that the pooled prevalence rate for physical intimate violence was 21% among men and 13.6% for women [153]. In another study, most of the physical and verbal violence reported was mutual, and more research is needed to evaluate the extent to which mutual violence is occurring [154].

Female veterans appear to be at increased risk of physical and sexual violence from their intimate partners (33%) compared with nonveteran counterparts (23.8%) [66]. Female veterans who experienced previous childhood sexual abuse are three times more likely to be victims of spousal abuse, and those who experienced an unwanted incidence of sexual victimization during military service were more likely to have experienced interpersonal violence in the last year. Being in the Army (versus other military branches) is also a risk factor for past-year victimization [131]. In a study examining directionality of abuse, a sample of 248 women enlisted in the Army and married to civilian spouses were assessed for domestic violence [64]. Researchers found that the enlisted women were four times more likely to be victimized by minor violence and three times more likely to be victims of severe violence than to be perpetrators. A disconcerting 60% of all types of violence reported was bi-directional (i.e., both parties were inflicting the violence) and severe [64]. These couples tended to be younger and more recently married. Furthermore, if an enlisted woman's spouse was employed less than full-time, bi-directional violence was more common compared to families with full-time employed civilian spouses.

The stressors associated with deployment and perhaps even being in the military have been explored as possible predictors of domestic violence. However, research findings are mixed. In a mail survey with wives of deployed and nondeployed soldiers, military deployment did not predict domestic violence during the first 10 months of the post-deployment period, even after taking into account race, age, and previous history of domestic violence [65]. Another study examined whether the cultural milieu of the military (i.e., violence as part of training) would spill over into domestic violence. Using the National Survey of Families and Households dataset, researchers compared male veteran and non-veteran use of violence in marriages and found that the veterans had lower incidences of spousal abuse compared with their non-veteran counterparts. However, a study of Army wives found that they were more likely to experience moderate (13.1%) or severe (4.4%) abuse perpetrated by their husbands compared with demographically matched civilian wives (10% and 2%, respectively) [66]. In a 2013 study, 2% of married deployed personnel had perpetrated physical or emotional spousal abuse during the study period [132]. Rates of moderate and severe abuse and abuse involving alcohol were significantly higher in the post-deployment period.

Having a psychiatric disorder can also increase the risk of domestic violence. In a systematic review, 27.5% of men with PTSD disclosed to perpetrating physical violence in the last year and 91% reported psychologically abusing their partner [118]. A male military member with depression has an almost four times increased likelihood of perpetrating physical violence against his partner compared with male members without depression [118]. It is difficult to determine whether the psychiatric disorder in itself heightens the risk or whether there are other underlying factors. For example, veterans with PTSD express feeling less satisfied in their intimate relationships and struggle with emotional expressiveness compared with veterans without PTSD [119].

Prior to 2006, the Department of Defense required healthcare personnel to report all domestic violence incidences. However, this mandatory requirement was revised in 2006 to include two types of reports. Restricted reports give victims the chance to report domestic violence and access health, social services, and advocacy services through the Family Advocacy Program. The caveat is that this does not automatically instigate any legal investigations or processes [67]. With unrestricted reports, however, domestic violence victims can report the incident to the police or military commanders and the incident would be investigated. Victim advocacy and health services are available in either case [67].

CHILD ABUSE

In 2021, the Department of Defense reported a rate of child abuse and neglect of 13.2 per 1,000 children [155]. The overall rate of child maltreatment in the United States appears to be decreasing, but rates in military families may be increasing [155]. According to a study published in 2013, there was a 40% increase in cases of child abuse in Army families between 2009 and 2012 [68]. Interestingly, in a study of child abuse in Air Force families, emotional abuse was the most likely to be substantiated, with physical abuse the least likely to be substantiated [62].

It is unclear if child abuse rates differ among military and non-military families. A study using the National Child Abuse and Neglect Data System examined all cases of child maltreatment in Texas between 2000 and 2002 [69]. Researchers found that the rate of child maltreatment in military families was 5.05 for every 1,000 children, while in civilian families the rate was 7.89 for every 1,000 children. The higher rates in the civilian population were attributed primarily to greater financial difficulties (18.7%) and use of public assistance (28.2%) compared with their military counterparts (5.2% and 8.9%, respectively) [69]. Data from the Department of Defense and the Children's Bureau indicate that instances of child physical abuse are only slightly higher (19.7%) in the military population compared with the civilian population (18.3%) [156]. Child neglect is much lower in the military population (57.4%) than the civilian population (74.9%), but infants in dual military families are 2.5 times more likely to experience abusive head trauma [156]. Data from the Millennium Cohort Study indicate that military infants born prematurely were twice as likely to experience child maltreatment before their second birthday than those born in civilian families [157]. In a study of records from four Army installation bases, lack of supervision (35.3%) was the most common form of child neglect/abuse, followed by emotional neglect (31.8%) [120]. Instances of child abuse/neglect were most likely in young enlisted families [120].

Identifying factors that may predict child abuse is complex, as child abuse/maltreatment is a multidimensional social problem. In one study that examined perpetration of child abuse among military mothers and fathers, marital dissatisfaction, low levels of social support, and low levels of family cohesion predicted perpetrating child abuse for mothers. For fathers, low levels of family expressiveness predicted abuse. In both cases, depression, family conflict, and parental distress were predictive factors [70]. Deployment appears to be another predictor. A 2017 analysis indicates that the risk for child abuse was highest within the first six months of a parent returning from deployment [133]. The risk of moderate-to-severe child maltreatment by a female civilian parent is 3.85 times higher during deployment than times of nondeployment [121]. In a study of 1,771 dual-parent families of enlisted Army soldiers who experienced at least one combat deployment between 2001 and 2004, a total of 1,858 parents abused their children [71]. Researchers found that the overall rate and severity of child abuse increased during combat-related deployments. Child neglect rates nearly doubled during deployment, but physical abuse rates decreased [71]. Furthermore, the rate of child abuse increased 30% for each 1% increase in active-duty military being deployed or returning from a military operation [72].

Continual relocations can be stressful for military families, leading to isolation and uprooting of social supports. The military environment does offer safety nets and resources, including comprehensive health care, family services, and housing allowances for military families [156]. However, the positive core military values of duty and honor may make service members reluctant to seek help. Family problems are often viewed as a sign of weakness, and allegations of child abuse are often perceived to risk jeopardizing a service member's career path [156].

SUBSTANCE AND ALCOHOL ABUSE

Among all military service members, the overall prevalence rate for heavy alcohol use in the past 12 months is 5.4% [73]. A Department of Defense report indicates that the heaviest rates of drinking were among Marines (12.4%), followed by the Navy (6%), Army (4.1%), Coast Guard (3.5%), and Air Force (2.7%) [73]. When comparing illicit substance use among civilian and military populations, civilian past-year usage is higher (16.6%) compared with military servicemen and women (0.7%). This lower rate of illicit substance use is due in part to the military's random testing procedures and zero-tolerance policies [73]. According to the Department of Defense, in 2021, there were 100,000 deaths related to opioid misuse, an increase of 15% compared with 2020 [158]. There has been some speculation that veterans and service members with PTSD may be self-medicating with opioids [158]. Military spouses are also affected by the opioid crisis. In one study, 48% of military spouses had employed their health insurance to fill at least one opioid prescription in the Military Health System during a two-year time period [159]. During this same time, 7% met the criteria for high-risk opioid prescriptions. Adverse childhood experiences, social isolation, and experiencing physical pain were predictors of high-risk opioid prescriptions.

Binge drinking has spiked since the wars in Iraq and Afghanistan started; in 2008, almost half of active-duty military members reported binge drinking [122]. Based on secondary data analysis from Millennium Cohort Study, heavy drinking was associated with military separation, particularly for female service members [160]. In that same time, the use of prescription pain medications (particularly opioids) have increased; between 2001 and 2009, the number of prescriptions written by military physicians increased fourfold [122]. Because drugs and alcohol can inhibit negative feelings and disconcerting memories, it may be used to self-medicate, particularly among those who have witnessed or experienced suffering related to war and deployment.

Substance and alcohol abuse can cause tremendous harm, strain, and burden on the family system. It inevitably impacts communications, roles, finances, routines, parenting, employment, and other dimensions of family life [74]. The Stress-Strain-Coping-Support (SSCS) model has been employed to understand how substance and alcohol abuse impact the family [75]. This framework postulates that: a family member using substances or alcohol causes stress and strain on the entire family; family members may exhibit stress or strain through a variety of physical, emotional, and psychologic symptoms; family members frequently try to determine what is wrong and what they can do to fix the problem; and the way family members cope and respond to the situation is often influenced by how others in their immediate social support system respond [75].

For military families, deployment and reintegration trigger additional stressors that can lead to substance and alcohol abuse. For example, servicemen and women returning from deployment have a higher prevalence rate of new-onset drinking problems compared to nondeployed active-duty personnel [76]. In a study examining veterans returning from Iraq, 13.9% of the veterans were determined to have probable post-traumatic stress disorder (PTSD), 39% probable alcohol misuse, and 3% probable substance abuse [77]. Military members who have been in combat and who have PTSD are more likely use substances and alcohol to cope [78]. However, one study found that a clinical diagnosis of PTSD was a less important predictor of alcohol, substance, or aggressive behavioral problems than the presence of symptoms of a stress response [78]. In another study, the prevalence rate for alcohol use disorder among transgender service members was 8.6%; the rate for drug use disorders was 7.2%, and the rate of comorbid alcohol and drug use disorders was 3.1% [161]. Social and economic stressors, such as housing instability, family problems, and military sexual trauma, were more prevalent among this group. The authors recommended targeting social and economic risk factors in screening and interventions for this highly marginalized group.

ASSESSMENT

Military personnel returning from deployment are required to complete the Post-Deployment Health Assessment [79]. This medical screener is composed of 10 mental health questions and must be completed by a medical provider within 30 days of returning from military assignment [79]. In addition, the mental health departments in the Army and Navy use the Post-Deployment Psychological Screener, which consists of 22 questions assessing for symptoms for depression, PTSD, communication issues, interpersonal problems, alcohol abuse, and anger [79]. PTSD is commonly assessed due to the many distressing events that military personnel experience in combat. However, avoidance behaviors such as substance and alcohol abuse, withdrawing from others, and dissociating should be assessed as well [80].

Holistic family assessments that include the family, community, school, and social structures are crucial to understanding how deployment and reintegration affect each family member's emotional, social, spiritual, psychologic, and physical well-being and how these domains are impacted by the larger environment. As such, the ecologic theoretical framework and the person-in-environment perspective are beneficial in evaluating military families' needs [81]. For some families, a military member's injury may affect the family system and result in new challenges in the family in terms of roles, communication, stress, and coping skills [81].

For other families, combat stress can trigger secondary traumatization for family members [82]. Those who witness their loved one's startled responses, nightmares, irritability, sleep difficulties, and hypervigilance may express fear and anxiety, particularly children [79]. Therefore, family members should be included in assessments. Children should be assessed for behavioral issues. Difficulties in school, declining grades, poor peer relationships, and/or aggressive behaviors should be noted, as they may be symptoms of difficulty adjusting to family transitions [82]. Parents should be asked about overall family functioning and adjustment and how they are dealing with child-rearing.

VISUAL ASSESSMENT TOOLS

Visual assessment tools can be helpful during the assessment phase. Deployment narrative maps, for example, can be used. The goal with these tools is to have family members tell their stories about deployment individually and describe how it brought about concerns, stresses, and challenges [82]. Any family challenges identified in the stories are graphically depicted on a timeline. After everyone completes their narrative, all family members are brought into a family session to review the deployment narrative maps and see how certain events triggered stress or reactions. Not only can narrative maps be used as an assessment tool but they can instigate greater communication and foster problem-solving strategies [82].

Genograms are another useful visual assessment tool that can be employed to help families see intergenerational transmissions of trauma, mental health issues, emotional disturbances, behavioral problems, and patterns of coping [39]. Risk factors and protective factors/strengths can be identified, which can be empowering for families [39]. Given the unique needs and circumstances of military families, military genograms are tailored to address specific challenges. For example, the following assessment questions may be used to generate a military genogram [39]:

- What is the military member's history of service, rank, length of service, honors, discharge status, and nature of discharge?
- What is the immediate family's attitude toward the military?
- What is the extended family's attitude toward the military?

- What is the family's cultural attitude toward military service? Attitude toward war?
- Was the military family member drafted or did they volunteer?
- Has the service member served during a time of war? If so, when? What war(s)?
- Has the military family member ever experienced wartime trauma? If so, what? Has it affected their functioning? If so, how?
- Has the service member experienced and/or witnessed casualties, injuries, disabilities, or prisoners of war?
- Did the service member lose friends or comrades in a war? If so, how many? What were the circumstances?
- What is the level of self-disclosure about the military experiences for the service member?
- What is the attitude toward mental health treatment or emotional illness?
- Does the service member have a drinking/drug use problem? If so, was it a problem prior to deployment?
- Does the service member use military-extended networks or Veterans Affairs services?
- What was the service member's role prior to deployment? Has it changed post-deployment?
- What are the family members' political affiliations?
- Does the family live on or off base?
- What is the current sociopolitical climate and how does it impact the family?

An ecomap and a genogram may be employed when analyzing how deployment affects various generations in a family system [123]. An ecomap is a visual depiction that portrays all the systems at play in an individual's life (i.e., micro, mezzo, and macro). Within each system, a genogram diagrams each generation. For example, on the microsystem level, the practitioner would assess how relationships and roles are negatively affected by deployment and post-deployment with an emphasis on multidirectional effects [123].

A military genogram is meant to be used within a solution-focused framework; instead of focusing on problems and barriers, the goal is to identify strengths and protective mechanisms and to generate concrete, specific, and workable tasks for the military member and family members to work toward [39].

ONLINE RESOURCES

The Department of Defense maintains a website, https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/PHCoE-Clinician-Resources, that offers self-assessment tools for use by the military community, their families, and practitioners [83]. If a practitioner has a meeting with a military family member or military personnel, he/she can use this online resource portal to learn more about military culture and services offered by the military and/or use the military-specific online assessments or handouts [83]. Future interventions can also be designed using the resources offered online, including plans that include viewing videos about anger, PTSD, depression, adjustment, and wellness and completing assignments based on the information provided for future sessions [83].

INTERVENTIONS

Collaborative relationships between practitioners in the civilian and military community are important [15]. Many veteran medical centers offer family psychoeducation services. However, military personnel and their families may not always seek mental health, counseling, and social services from the military. Therefore, providers in the civilian community should have a good understanding of the issues military personnel and their family members' experience.

EMOTIONAL REGULATION

Interventions to teach family members and military personnel how to regulate emotional responses, such as anger, frustration, and numbness, are vital. This includes skills such as deep breathing, yoga, meditation, exercise, and other deactivation activities that can decrease the intensity of stress reactions and even trauma [84]. When a deployed man or woman returns home, it is inevitable that things will have changed for the whole family. All family members will have to adapt to a "new normal" [84]. This "new normal" may mean adjusting to physical injuries and the new caregiving activities associated with new limitations. Practitioners may help the caregiving spouse engage in self-care and reduce stress [85]. During deployment, there is also a "new normal," however temporary, and the now single parent may benefit from concrete child-rearing and parenting strategies (e.g., specific scripts to use when feeling angry or tips for providing clear directions to children) [85]. Similarly, children may require assistance regulating their emotions and communicating their fears and anxieties when a parent deploys or returns home injured or traumatized [85].

FAMILY EDUCATION AND SUPPORT

Military families can benefit from education and support during the various phases of the deployment cycle. As discussed, each phase brings unique stressors and challenges, and interventions should be tailored both to the family and to the phase. One resource is Families OverComing Under Stress (FOCUS), a service initiated by the Navy's Bureau of Medicine and Surgery, tailored for military family members and offered at 18 Navy and Marine Corps installations across the United States and Japan with the goal of providing family resiliency services [86]. Family members can use the tools available online at https://www.focusproject.org to develop or enhance their ability to regulate emotions, communicate, problem solve, set goals, and manage deployment.

The Military and Family Life Counseling Program is available for active-duty service members and their family members, National Guard and reserve service members (regardless of activation status) and their family members, designated Department of Defense expeditionary civilians and their family members, and survivors [134]. The program supports service members, their families, and survivors with nonmedical counseling worldwide. Issues that may be addressed through this counseling include improving relationships at home and work, stress management, adjustment difficulties, parenting, and grief or loss. Active suicidal or homicidal thoughts, sexual assault, child abuse, domestic violence, alcohol and substance use disorders, or serious mental health conditions are not appropriately addressed through these programs [134].

interactive activity

Visit Families OverComing Under Stress (FOCUS) online resiliency training at https://www.focusproject.org, and explore the interactive, online educational tool that helps military families become stronger in the face of challenges.

The Sesame Workshop provides a service to military family members and children addressing the challenges related to deployment [8; 124]. In videos and toolkits created specifically for young children, familiar characters work through issues of grief, coping with parental absence or injuries, and new traditions. The initiative also provides materials for parents with information on starting difficult conversations with young children and using appropriate language. Families can view various videos together and have the opportunity to talk about the feelings and emotions they experience.

interactive activity

Visit the Sesame Street for Military Families website at https://sesamestreetformilitaryfamilies.org for videos and tools for discussing deployment and related feelings with young children.

MilitaryKidsConnect (https://militarykidsconnect.health.mil) is a website that provides resources for military families with an emphasis on assisting children in enhancing their coping skills [125]. It offers web-based psychoeducation along with online support groups [125].

Traditional psychoeducation can also be adapted for the different issues related to deployment and military life. One example is a psychoeducational program for families of veterans who have experienced traumatic brain injury [87]. Some family members and veterans may not understand trauma and blame themselves for symptoms or feel that they have somehow triggered certain behaviors. Psychoeducation can help reduce stigma and provide educational information and support [162]. Educational workshops and group sessions would include topics such as injury, stigma, communication, marital commitment and distress, focused strategies and problem-solving skills, and family functioning [87]. Other family educational topics could include parenting skills, coping with stress, violence, coping with loneliness and isolation, and adjusting to loss [109].

FAMILY THERAPY

As discussed, family systems theory maintains that the family is composed of subsystems that are defined by boundaries, rules, power structures, and rituals, and stress and challenges will inevitably affect the entire family system [30]. Establishing a "new normal" for military families after the return of a military spouse is often the primary goal for family therapy. The family therapist can facilitate communication in order to generate a shared story of the deployment and its effects on the present and the future [84].

Another goal for family therapy is to address the stress emanating from all phases of a deployment. A therapist can help assist the nondeployed parent to establish equilibrium in the family system by maintaining existing rules, routines, and rituals during all phases of deployment [85]. Humans in general, but particularly children, strive for stability and predictability, so maintaining routines, rules, and rituals can be very grounding [85]. Before deployment, spouses should work together to agree on parenting, disciplining, and child-rearing practices so a united front is presented to children [85].

Because the family system is not isolated, it is important for family therapists to garner resources from schools, the community, neighborhoods, and institutional systems. A community family therapist navigates networks and collaborates with various systems in order to supplement existing family strengths with external resources [88]. First, therapists may work with the client and family members to cope with the stressors specific to deployment and the military lifestyle; coping involves using both internal and external resources [88]. Second, the therapist assists the family in identifying a personal network system, which may consist of extended family members, friends, neighbors, and the community, that can be used for support. Practitioners can facilitate contact with available social services, such as day care, legal services, parenting classes, and other services, as needed. Concrete services, such as transportation, can be a barrier for some veterans and military family members. Rural veterans and family members are

less likely to initiate family therapy [163]. However, once they are engaged, they are likely to continue family therapy past five sessions. It has been postulated that this difference may be in part due to barriers such as transportation or child care issues. Finally, practitioners should empower clients and family members so they may serve as advocates for other military families, in a sense giving back to their communities. This could involve a military spouse helping run a support group for other military family members and sharing his/her experiences [88]. Families that have successfully coped with the challenges associated with deployment are the best equipped to empower and support other military family members [89].

PROMOTION OF FAMILY RESILIENCE

A strengths-based approach may be used to develop interventions that promote family members' resilience [85]. This is crucial in a military context, in which self-sufficiency and strength are emphasized among military personnel and their family members. In these cases, a pathology-based model might impede military members and their families from seeking mental health and social services due to the stigma. Exploring spouses', parents', and children's strengths and how to integrate those identified strengths into interventions can foster empowerment and develop a collaborative relationship between the practitioner and families. Identifying goals rather than problems promotes a positive outlook toward the future [85].

Home visiting interventions have become more popular for military families in part because they reduce the stigma of public help-seeking [126]. These interventions are implemented in the home and reflect a strengths-based perspective; many help family members handle deployment, address communication challenges, cope with isolation and loneliness, and connect family members to support and resources [126].

INTERPROFESSIONAL COLLABORATIONS IN THE MILITARY CONTEXT

The World Health Organization defines interprofessional collaboration as situations in which "multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care across settings" [164]. It is a partnership or network of providers who work in a concerted and coordinated effort toward a common goal for clients and their families to improve health, mental health, social, and/or family outcomes [165]. Interprofessional collaboration deviates from the silo model and shifts to a team perspective. Efficiency, cost containment, and measurable outcomes are key to interprofessional collaboration.

The core features of interprofessional collaboration include sharing, interdependency, mutual trust, respect, and communication [166]. Interprofessional collaboration can be contextualized within the unique military environment. In a scoping review of literature, how the military context affected interdisciplinary health teams was explored [167]. For example, military rank disparity was found to have the potential to adversely affect communication and team cohesion. Because service members and their families often relocate, there can be near-constant turnover of staff members, making it difficult to promote team cohesion and trust. In the military health context, there can also be additional rules and regulations among the various disciplines. This can introduce confusion regarding roles and essential task completion. Despite these potential barriers, the bonds of military service can be a unifying factor for interprofessional health teams [168]. A sense of camaraderie among team members, the common experience of being part of military culture, and being connected by core military values can promote interdependency and mutual trust and respect [168].

COLLABORATING WITH SCHOOLS

School-age children in military families do not necessarily attend a school for military children. It is estimated that more than 80% of military children attend public schools [127]. It is very important for practitioners to work with administrators and teachers to formulate holistic interventions for children of deployed parents. When schools integrate information related to the military into curricula, children from military families may feel there is less of a dichotomy between home and school. Children from non-military families may also gain greater empathy for schoolmates with a deployed parent. In English classes, a curriculum could include pen pal programs with deployed military personnel or reading novels with military themes [90]. Math classes could integrate calculations of differences in time zones [90]. Teachers in computer technology classes may design activities involving developing websites for deployed men and women that allow for posting encouraging notes, photos, or poems [90].

Practitioners can provide professional development or in-service training for teachers regarding best practices when working with children from military families. Outlining the deployment cycle and normal reactions versus more problematic academic, emotional, and behavioral issues that require referrals is vital, as are teaching strategies to help children who are in transition [90; 127; 144]. Schools can also support children and parents of the military by offering extra services, such as support groups or seminars on coping, dealing with anger, and/or communication. Students who have a deployed parent may benefit from partnering with others for peer support [90].

TRAUMA-INFORMED CARE

A trauma-informed care framework is based on the assumption that trauma is pervasive and insidious, affecting individuals, systems (including families), and organizations. Trauma-informed care operates from a strengths perspective rather than a deficits perspective [162]. There are five main principles of trauma-informed care [162]:

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

The goal of trauma-informed care interventions is to support service members and military families who have been exposed to trauma. As discussed, aside from military-specific trauma, military families are vulnerable to intimate traumas, such as partner violence, child abuse and neglect, and substance use disorders. Children may develop trauma-related symptoms, such as nightmares, hyperarousal, flashbacks, and changes in mood [169]. Spouses of veterans who experience PTSD or traumatic brain injury also experience higher levels of sleep disturbances, headaches, depression, and anxiety [170]. Taking a trauma-informed approach to the care of military families builds rapport and improves outcomes.

ETHICAL ISSUES

Unique ethical issues emerge when working with military personnel and their families. Throughout this course, no distinction was made between practitioners who are affiliated with the military and those who are civilians. However, there are specific ethical issues that emerge for the military practitioner, and this section will cover both scenarios.

DUAL RELATIONSHIPS

One of the main ethical dilemmas for practitioners employed by the military is the issue of dual relationships. Practitioners working with military families often have multiple roles, which can cause ethical tension [128]. For example, counselors should have a goal of building rapport and conveying empathy, but this can be difficult if the counselor outranks the client. Alternatively, counselors are expected to act in the role of expert, but this can be difficult if he or she is subordinate to the client [128]. Furthermore, practitioners who reside and work on military bases may frequently encounter their military clients and family members, which challenges personal and professional boundaries [171].

In general, practitioners have two obligations: to the client (i.e., the military member and/or his or her family member) and to the military institution (e.g., the Department of Defense) [91; 92]. This is also referred to as mixed or dual agency, indicating the military practitioner must take into account the needs of both the client and the military [91]. For example, if a military member is referred by his commander for an evaluation to determine if he is fit for duty, the practitioner must take into consideration both the needs of the mission and the well-being of the individual [171]. This then raises the ethical issue of beneficence and determining whose best interest is ultimately to be served [93; 171]. The civilian practitioner's focus is on the client's best interest, but in the military environment, multiple stakeholders are often involved, all of whom have a vested interest in the military member's disposition [93]. Unfortunately, referring to one's professional code of ethics and the mandates of the Department of Defense is not always definitive. There can be incongruities between the two, which can result in dissonance for the military practitioner [93]. Civilian practitioners do not confront the issue of dual relationships as strongly because they do not have an affiliation with the military and can refer the client elsewhere. However, this is not an option for the military practitioner [92]. Furthermore, military practitioners may be more likely to see their clients in day-to-day settings (e.g., at the commissary), making boundary crossings more likely [128].

CONFIDENTIALITY

Another ethical challenge is in the area of client confidentiality and informed consent. In a civilian environment, confidentiality in the client/practitioner relationship is paramount. However, in the military environment, client records usually belong to the military, not the practitioner [92]. Military commanders may feel a client's information is crucial to the management and safety of the unit. Consider a military family member who seeks counseling. If a military commander contacts the practitioner for information on the case because she feels that issues at home affect the military member and ultimately the unit, a civilian practitioner could easily invoke confidentiality. However, military practitioners have additional reporting obligations that are not part of the usual protocols as delineated in the ethical codes for counseling, social work, or psychology [129; 172]. Consequently, they may feel that their responsibilities to their employers and/or higher-ranking officers are more important. Military clients should be advised of the different components of informed consent and, particularly, the limits of confidentiality.

The ethical values of self-determination/autonomy and social justice that underpin professional ethical codes take on different meanings in the military environment [94]. Practitioners working with military personnel and their family members must resolve the needs of the military along with the needs of the client [94]. Informed consent forms should clearly outline the limits to confidentiality outside standard protocols [128; 129].

CULTURAL COMPETENCE

For civilian practitioners, cultural competence is one of the most salient ethical challenges when working with military personnel and family members [95; 173]. Civilian practitioners without a longstanding history and experience working with military personnel and their family members will find that the military is a distinct cultural entity. In many cases, professional training does not adequately prepare practitioners to work in this environment. The first area for civilian practitioners to become familiar with is the military language, norms, and etiquette [95; 173]. Military-specific acronyms, procedures, ranks, and terms associated with missions and the general lifestyle arise frequently in work with military personnel and their family members. Practitioners who do not have a full grasp of the meanings of these terms can miss crucial information during the assessment and treatment phases. Stopping to ask for a definition of a term during the therapeutic encounter can interrupt the flow and impede the clinical process in addition to jeopardizing the practitioner's credibility [95]. Civilian practitioners should seek supervision from a practitioner who has experience in working in the military mental health system [129].

VICARIOUS TRAUMA AND SELF-CARE

For both military and civilian practitioners, the issues of vicarious (or secondary) trauma, self-awareness, and self-care are vital [173]. The stressors and challenges encountered when working with military members and their families can trigger acute trauma reactions, burnout, and compassion fatigue, which can ultimately have negative outcomes for a practitioner's professional competence.

Burnout refers to extreme stress experienced by practitioners that depletes emotional, mental, physical, and psychologic resources [96]. Signs of burnout include depression, physical and mental exhaustion, anger, cynicism, acting out, frustration, lack of productivity at work, and difficulty controlling feelings [97]. A practitioner experiencing burnout often feels drained or tired and at times emotionally detached from clients [96]. Vicarious trauma is defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" [98]. Vicarious trauma can affect practitioners' beliefs about the world, others, and self, including concepts of safety, trust, control, and intimacy [99]. Hearing stories of trauma, military missions, and killings, as well as family members' anxieties and fears, can affect practitioners' worldviews, their own sense of safety and control, and sense of self [100]. Some practitioners will help deal with a military member's death and family members' loss and grief, which can ultimately raise personal reactions to death [100]. Practitioners should engage in self-care techniques, including seeking social support, spending time with friends, engaging in hobbies and recreational activities, and seeking out other professionals for consultation and professional supervision in order to address vicarious trauma and avoid burnout.

Practitioners should also exercise self-compassion, which involves being gentle with oneself, realizing that everyone has failings, and acknowledging it is not possible to do everything [130]. Along with vicarious trauma, there can also be personal post-traumatic growth [130]. By focusing on the potential to grow as a person and professional, coping can be enhanced.

CONCLUSION

Since September 2001, military families have been experiencing longer and more frequent deployments. More than 2.77 million members of the U.S. Armed Forces have now served on 5.4 million deployments in the Iraq and Afghanistan wars beginning in 2001 and 2003, respectively [101]. For each deployment, those left behind continue caring for their families, raising children, and navigating the different challenges that come with the day-to-day aspects of life. Military families have to create and adapt to a "new normal" when an individual is deployed while coping with the continual worry for their safety and ambiguous loss, which can be taxing for the entire family. Practitioners can work with families to facilitate the identification of family members' inner resources and resiliencies, empower family members and military personnel, and link families with various resources.

RESOURCES

Center for Deployment Psychology
https://deploymentpsych.org

Families OverComing Under Stress (FOCUS): Resiliency Training for Military Families
https://focusproject.org

Military Health System
https://www.health.mil/About-MHS

Military.com Spouse
https://www.military.com/spouse

MilitaryBridge
https://www.militarybridge.com

MilitaryKidsConnect
https://militarykidsconnect.health.mil

Military One Source
https://www.militaryonesource.mil

National Guard Family Program
https://www.militaryonesource.mil/national-guard/national-guard-family-program

National Military Family Association
https://www.militaryfamily.org

Operation Homefront
https://www.operationhomefront.org

Our Military Kids
https://www.ourmilitarykids.org

SAFE Program: Mental Health Facts for Families
https://www.ouhsc.edu/safeprogram

Sesame Street for Military Families
https://sesameworkshop.org/our-work/impact-areas/military-families

U.S. Army Quality of Life
https://www.army.mil/qualityoflife

U.S. Department of Defense Deployment Health Assessment Programs
https://www.usar.army.mil/DHAP

U.S. Department of Veterans Affairs National Center for PTSD
https://www.ptsd.va.gov

Works Cited

1. de Burgh HT, White CJ, Fear NT, et al. The impact of deployment to Iraq or Afghanistan on partners and wives of military personnel. *Int Rev Psychiatry*. 2010;23(2):192-200.
2. Lincoln A, Swift E, Shorteno-Fraser M. Psychological adjustment and treatment of children and families with parents deployed in military combat. *J Clin Psychol*. 2008;64(8):984-992.
3. Murray JS. Helping children cope with separation during war. *J Spec Pediatr Nurs*. 2012;7(3):127-130.
4. Mmari K, Roche KM, Sudhinaraset M, Blum R. When a parent goes off to war: exploring the issues faced by adolescents and their families. *Youth Soc*. 2009;40(4):455-475.
5. Sheppard SC, Malatras JW, Israel AC. The impact of deployment on U.S. military families. *Am Psychol*. 2010;65(6):599-609.
6. U.S. Department of Defense. 2021 Demographics Report: Profile of the Military Community. Available at https://download.militaryonesource.mil/12038/MOS/Reports/2021-demographics-report.pdf. Last accessed April 7, 2023.
7. Riggs SA, Cusimano A. The dynamics of military deployment in the family system: what makes a parent fit for duty? *Fam Court Rev*. 2014;52(3):381-399.
8. O'Donnell L, Begg L, Lipson L, Elvander E. Trauma spectrum disorders: emerging perspectives on the impact on military and veteran families. *J Loss Trauma*. 2011;16(3):284-290.
9. Amato PR, Booth A, Johnson DR, Rogers SJ. *Alone Together: How Marriage in America is Changing*. Cambridge, MA: Harvard University Press; 2007.
10. Segal DR, Segal MW. America's military population. *Population Bulletin*. 2004;59(4).
11. Bradshaw CP, Sudhinaraset M, Mmari K, Blum RW. School transitions among military adolescents: a qualitative study of stress and coping. *School Psych Rev*. 2010;39(1):84-105.
12. RAND National Defense Research Institute. Working Around the Military: Challenges of Military Spouse Employment. Available at https://www.rand.org/pubs/research_briefs/RB9056.html. Last accessed April 7, 2023.
13. Knox J, Price DH. The changing American military family: opportunities for social work. *Soc Service Rev*. 1995;69(3):479-497.
14. Coll JE, Weiss EL, Yarvis JS. No one leaves unchanged: insights for civilian mental healthcare professionals into the military experience and culture. *Soc Work Health Care*. 2011;50(7):487-500.
15. Savitsky L, Illingworth M, DuLaney M. Civilian social work: serving the military and veteran populations. *Soc Work*. 2009;54(4):327-339.
16. Momen N, Strychacz CP, Viirre E. Perceived stigma and barriers to mental health care in Marines attending combat operational stress control program. *Mil Med*. 2012;77(10):1143-1148.
17. Greene T, Buckman, J, Dandeker C, Greenberg N. The impact of culture clash on deployed troops. *Mil Med*. 2010;175(12):958-963.
18. Langston V, Gould M, Greenberg N. Culture: what is it its effect on stress in the military? *Mil Med*. 2007;172(9):931-935.
19. Hall LK. The importance of understanding military culture. *Soc Work Health Care*. 2011;50(1):4-18.
20. Lunasco TK, Goodwin EA, Ozanian AJ, Loflin EM. One shot-one kill: a culturally sensitive program for the warrior culture. *Mil Med*. 2010;175(7):509-513.
21. DeVoe ER, Ross A. The parenting cycle of deployment. *Mil Med*. 2012;177(2):184-190.
22. Laser J, Stephens P. Working with military families through deployment and beyond. *Clin Soc Work J*. 2011;39(1):28-38.
23. Boss P. Ambiguous loss theory: challenges for scholars and practitioners. *Fam Relat*.2007;56(2):105-111.
24. Mansfield AJ, Kaufman JS, Marshall SW, Gaynes BN, Morrissey JP, Engel CC. Deployment and the use of mental health services among U.S. Army wives. *NEJM*. 2010;362:101-109.
25. Di Nola GM. Stressors afflicting families during military deployment. *Mil Med*. 2008;173(5):v-vii.
26. Pincus SH, House R, Christensen J, Adler LE. The emotional cycle of deployment: a military family perspective. *J Army Medical Department*. 2001;615-623.
27. Logan KV. The emotional cycle of deployment. *US Naval Institute Proceedings*. 1987;113:43-47.
28. Lowe KN, Adams KS, Browne BL, Hinkle KT. Impact of military deployment on family relationships. *J Fam Studies*. 2012;18(1):17-27.
29. Darwin J. Families: "They also serve who only stand and wait." *Smith Coll Stud Soc Work*. 2009;79(3):433-442.
30. Larøi F. The family systems approach to treating families of persons with brain injury: a potential collaboration between family therapist and brain injury professional. *Brain Inj*. 2003;17(2):175-187.
31. Vetere A. Structural family therapy. *Child Psychol Psychiatry Rev*. 2001;6(3):133-139.
32. Navarre SE. Salvador Minuchin's structural family therapy and its application to multicultural family systems. *Issues Mental Health Nurs*. 1998;19(6):557-570.
33. Sherwood E. Clinical assessment of Canadian military marriages. *Clin Soc Work J*. 2009;37(4):332-339.
34. Bronfenbrenner U. Toward an experimental ecology of human development. *Am Psychol*. 1977;32(7):513-531.
35. Greene RR. *Human Behavior Theory and Social Work Practice*. 3rd ed. New York, NY: Transaction Publishers; 2008.

36. Greene RR, Galambos C, Youjung L. Resilience theory: theoretical and professional conceptualizations. *J Hum Behav Soc Environ*. 2003;8(4):75-91.
37. Saltzman W, Lester P, Beardslee W, et al. Mechanisms of risk and resilience in military families: theoretical and empirical basis of a family-focused resilience enhancement program. *Clin Child Fam Psychol Rev*. 2011;14(3):213-230.
38. McCubbin H, Boss P, Wilson L, Lester G. Developing family vulnerability to stress: coping patterns and strategies wives employ. In: Trost J (ed). *The Family and Change*. Uppsala: International Library; 1980: 89-103.
39. Weiss EL, Coll JE, Gerbauer J, Smiley K, Carillo E. The military genogram: a solution-focused approach for resiliency building in service members and their families. *Family J*. 2010;18(4):395-406.
40. Patterson JM. Integrating family resilience and family stress theory. *J Marriage Fam*. 2002;64(2):349-360.
41. Palmer C. A theory of risk and resilience factors in military families. *Mil Psychol*. 2008;20(3):205-217.
42. Saleebey D. *The Strengths Perspective in Social Work Practice*. 4th ed. White Plains, NY: Allyn & Bacon, Inc.; 2005.
43. Weick A, Rapp C, Sullivan WP, Kisthardt, W. A strengths perspective for social work practice. *Soc Work*. 1989;34(4):350-354.
44. Park N. Military children and families: strengths and challenges during peace and war. *Am Psychol*. 2011;66(1):65-72.
45. Strobino J, Salvaterra M. School transitions among adolescent children of military personnel: a strengths perspective. *Child Sch*. 2000;22(2):95-107.
46. Hall LK. *Counseling Military Families: What Mental Health Professionals Need to Know*. New York, NY: Routledge; 2008.
47. Goff BSN, Crow JR, Reisbig AMJ, Hamilton S. The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *J Fam Psychol*. 2007;21(3):344-353.
48. Baptist J, Amanor-Boadu Y, Garrett K, et al. Military marriages: the aftermath of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) deployments. *Contemp Fam Ther*. 2011;33(3):199-214.
49. Hinojosa R, Hinojosa MS, Högnäs RS. Problems with veteran-family communication during Operation Enduring Freedom/Operation Iraqi Freedom military deployment. *Mil Med*. 2012;177(2):191-197.
50. Cozza SJ, Guimon JM, McKibben JB, et al. Combat-injured service members and their families: the relationship of child distress and spouse-perceived family distress and disruption. *J Trauma Stress*. 2010;23(1):112-115.
51. Riviere LA, Merrill JC, Thomas JL, et al. 2003–2009 marital functioning trends among U.S. enlisted soldiers following combat deployments. *Mil Med*. 2012;177(10):1169-1177.
52. Allen ES, Rhoades GK, Stanley SM, Markman HJ. On the home front: stress for recently deployed army couples. *Fam Process*. 2011;50(2):235-247.
53. SteelFisher GK, Zaslavsky AM, Blendon RJ. Health-related impact of deployment extensions on spouses of active duty Army personnel. *Mil Med*. 2008;173(3):221-229.
54. Bowlby J. *Attachment and Loss*. Vol . 2: Separation. London: Pimlico; 1998.
55. Aranda MC, Middleton LS, Flake E, Davis BE. Psychosocial screening in children with wartime-deployed parents. *Mil Med*. 2011;176(4):402-407.
56. Barker LH, Berry KD. Developmental issues impacting military families with young children during single and multiple deployments. *Mil Med*. 2009;174:1033-1040.
57. Chandra A, Lara-Cinisomo S, Jaycox LH, et al. Children on the homefront: the experience of children from military families. *Paediatrics*. 2009;125(1):16-25.
58. White CJ, de Burgh HT, Fear NT, Iversen AC. The impact of deployment to Iraq or Afghanistan on military children: a review of the literature. *Int Rev Psychiatry*. 2011;23(2):210-217.
59. Jensen PS, Xenakis SN, Wolf P, Bain MW. The "military family" syndrome revisited: by the numbers. *J Nerv Ment Dis*. 1991;179(2):102-107.
60. McCarroll JE, Newby JH, Thayer LE, et al. Trends in child maltreatment in the U.S. Army: 1975–1997. *Child Abuse Negl*. 1999;23(9):855-861.
61. Brannen SJ, Bradshaw D, Hamlin ER, Fogarty JP, Colligan TW. Spouse abuse: physician guidelines to identification, diagnosis, and management in the uniformed services. *Mil Med*. 1999;164(1):30-36.
62. Foster RE, Stone FP, Linkh DJ, Besetsny LK, et al. Substantiation of spouse and child maltreatment reports as a function of referral source and maltreatment type. *Mil Med*. 2010;175(8):560-566.
63. Congressional Research Service. Military Families and Intimate Partner Violence: Background and Issues for Congress. Available at https://fas.org/sgp/crs/natsec/R46097.pdf. Last accessed March 16, 2023.
64. Forgey M, Badger L. Patterns of intimate partner violence among married women in the military: type, level, directionality and consequences. *J Fam Violence*. 2006;21(6):369-380.
65. Newby JH, Ursano RJ, McCarroll JE, et al. Postdeployment domestic violence by U.S. Army soldiers. *Mil Med*. 2005;170(8):643-647.
66. Heyman RE, Neidig PH. A comparison of spousal aggression prevalence rates in U.S. Army and civilian representative samples. *J Consult Clin Psych*. 1999;67:239-242.

67. Lutgendorf MA, Snipes MA, Rau T, Busch JM, et al. Reports to the Navy's Family Advocacy Program: impact of removal of mandatory reporting for domestic violence. *Mil Med*. 2012;177(6):702-708.
68. Sandza R. The Army's Hidden Child Abuse Epidemic. Available at https://www.ethicalpsychology.com/2013/08/the-armys-hidden-child-abuse-epidemic.html. Last accessed March 16, 2023.
69. Rentz ED, Marshall SW, Martin SL, et al. Occurrence of maltreatment in active duty military and nonmilitary families in the state of Texas. *Mil Med*. 2008;173(6):515-522.
70. Schaeffer CM, Alexander PC, Bethke K, Kretz LS. Predictors of child abuse potential among military parents: comparing mothers and fathers. *J Fam Violence*. 2005;20(2):123-129.
71. Gibbs DA, Martin SL, Kupper LL, Johnson RE. Child maltreatment in enlisted soldiers' families during combat-related deployments. *JAMA*. 2007;298(5):528-535.
72. Rentz ED, Marshal SW, Loomis D, et al. Effect of deployment on the occurrence of child maltreatment in military and nonmilitary families. *Am J Epidemiol*. 2007;165(10):1199-1206.
73. U.S. Department of Defense. *2015 Department of Defense Health Related Behaviors Survey*. Washington, DC: U.S. Department of Defense; 2018.
74. Templeton L, Velleman R, Russell C. Psychological interventions with families of alcohol misusers: a systematic review. *Addict Res Theory*. 2010;18(6):616-648.
75. Velleman R, Arcidiacono C, Procentese F, Copello A, Sarnacchiaro P. A 5-step intervention to help family members in Italy who live with substance misusers. *J Ment Health*. 2008;17(6):643-655.
76. Jacobson IG, Ryan MAK, Hooper TI, et al. Alcohol use and alcohol related problems before and after military combat deployment. *JAMA*. 2008;300(6):663-675.
77. Eisen SV, Schultz MR, Vogt D, Glickman ME, et al. Mental and physical health status and alcohol and drug use following return from deployment to Iraq or Afghanistan. *Am J Public Health*. 2012;102(S1):S66-S73.
78. Brown JM, Williams J, Bray RM, Hourani L. Postdeployment alcohol use, aggression, and post-traumatic stress disorder. *Mil Med*. 2012;177(10):1184-1190.
79. Johnston SL, Dipp RD. Support of Marines and sailors returning from combat: a comparison of two different mental health models. *Mil Med*. 2009;174(5):455-459.
80. Erbes CR, Polusny MA, MacDermid S, Compton JS. Couple therapy with combat veterans and their partners. *J Clin Psychol*. 2008;64(8):972-983.
81. Beder J. Social work in the Department of Defense hospital: impact, role and intervention. *Mil Med*. 2009;174(5):486-490.
82. Lester P, Mogil C, Saltzman W, et al. Families overcoming under stress: implementing family-centered prevention for military families facing wartime deployments and combat operational stress. *Mil Med*. 2011;176(1):19-25.
83. Psychological Health Center of Excellence. Health Assessment Programs. Available at https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/PHCoE-Clinician-Resources Last accessed March 11, 2023.
84. Makin-Byrd KG, McCutcheon E, Glynn SS. Family and couples treatment for newly returning veterans. *Profess Psychol Res Pract*. 2011;42(1):47-55.
85. Gewirtz AH, Erbes CR, Polusny MA, et al. Helping military families through the deployment process: strategies to support parenting. *Prof Psychol Res Pr*. 2011;42(1):56-62.
86. Bureau of Medicine and Surgery. Families OverComing Under Stress (FOCUS). Available at https://www.focusproject.org. Last accessed March 16, 2023.
87. Perlick DA, Straits-Tröster KD, Norell DG, et al. Implementation of multifamily group treatment for veterans with traumatic brain injury. *Profess Psychol Res Pract*. 2011;42(1):70-78.
88. Hollingsworth WG. Community family therapy with military families experiencing deployment. *Fam Ther*. 2011;33(3):215-228.
89. Black WG. Military-induced family separation: a stress reduction intervention. *Soc Work*. 1993;38(3):273-280.
90. Harrison H, Vannest KJ. Educators supporting families in times of crisis: military reserve deployments. *Preventing School Failure*. 2008;52(4):17-24.
91. Kennedy CH, Moore B. Evolution of clinical military psychology ethics. *Mil Psychol*. 2008;20(1):1-6.
92. McCauley M, Hughes JH, Liebling-Kalifani H. Ethical considerations for military clinical psychologists: a review of selected literature. *Mil Psychol*. 2008;20(1):7-20.
93. Johnson WB. Top ethical challenges for military clinical psychologists. *Mil Psychol*. 2008;20(1):49-62.
94. Simmons CA, Rycraft JR. Ethical challenges of military social workers serving in combat zones. *Soc Work*. 2010;55(1):9-18.
95. Reger MA, Etherage JR, Reger GM, Gahm GA. Civilian psychologists in an Army culture: the ethical challenge of cultural competence. *Mil Psychol*. 2008;20(1):21-35.
96. Patrick PKS. Stress-induced challenges to the counselor role: burnout, compassion fatigue, and vicarious traumatization. In: Patrick PKS (ed). *Contemporary Issues in Counseling*. Boston, MA: Allyn and Bacon; 2007: 210-250.

97. Azar ST. Preventing burnout in professionals and paraprofessionals who work with child abuse and neglect cases: a cognitive behavioral approach to supervision. *J Clin Psychol*. 2000;56(5):643-663.
98. Figley CR. Compassion fatigue: toward a new understanding of the costs of caring. In: Stamm BH (ed). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators*. Lutherville, MD: Sidran Press; 1999: 3-28.
99. Cunningham M. Impact of trauma work on social work clinicians: empirical findings. *Soc Work*. 2003;48(4):451-459.
100. Linnerooth PJ, Mrdjenovich AJ, Moore BA. Professional burnout in clinical military psychologists: recommendations before, during and after deployment. *Profess Psychol Res Pract*. 2011;42(1):87-93.
101. Wenger JW, O'Connell C, Cottrell L. Examination of Recent Deployment Experience Across the Services and Components. Available at https://www.rand.org/pubs/research_reports/RR1928.html?adbsc=social_20180320_2212921&adbid=975928167633334272&adbpl=tw&adbpr=22545453. Last accessed March 16, 2023.
102. Ross PT, Ravindranath D, Clay M, Lypson ML. A greater mission: understanding military culture as a tool for serving those who have served. *J Grad Med Educ*. 2015;7(4):519-522.
103. Canfield J, Weiss E. Integrating military and veteran culture in social work education: implications for curriculum inclusion. *J Soc Work Educ*. 2015;51:S128-S144.
104. Redmond SA, Wilcox SL, Campbell S, et al. A brief introduction to the military workplace culture. *Work*. 2015;50(1):9-20.
105. Louie AD, Cromer LD. Parent-child attachment during the deployment cycle: impact on reintegration parenting stress. *Prof Psychol Res Pr*. 2014;45(6):496-503.
106. Knobloch LK, Basinger ED, Wehrman EC, Ebata AT, McGlaughlin PC. Communication of military couples during deployment and reunion: changes, challenges, benefits, and advice. *J Fam Commun*. 2016;16(2):160-179.
107. Crow JR, Myers DR, Ellor JW, Dolan SL, Morissette S. Military deployment of an adult child: ambiguous loss and boundary ambiguity reflected in the experiences of parents of service members. *Marriage Fam Rev*. 2016;52(5):481-509.
108. Boss P. Ambiguous loss theory: challenges for scholars and practitioners. *Fam Relat*. 2007;56:105-111.
109. Frey JJ, Collins KS, Pastoor J. Social workers' observations of the needs of the total military community. *J Soc Work Educ*. 2014;50(4):712-729.
110. Wright KM, Riviere LA, Merrill JC, Cabrera OA. Resilience in military families: a review of programs and empirical evidence. In: Sinclair RR, Britt TW (eds). *Building Psychological Resilience in Military Personnel: Theory and Practice*. Washington, DC: American Psychological Association; 2013: 167-191.
111. Dreger HE. Optimizing health: redefining health from a strengths perspective. *New Social Worker*. 2015;22(4):16-17.
112. Holliday SB, Haas A, Shih RA, Troxel WM. Prevalence and consequences of sleep problems in military wives. *Sleep Health*. 2016;2(2):116-122.
113. Negrusa S, Negrusa B, Hosek J. Gone to war: have deployments increased divorces? *J Popul Econ*. 2014;27(2):473-496.
114. Acion L, Ramirez MR, Jorge RE, Arndt S. Increased risk of alcohol and drug use among children from deployed military families. *Addiction*. 2013;108:1418-1425.
115. Rodriguez AJ, Margolin G. Parental incarceration, transnational migration, and military deployment: family process mechanisms of youth adjustment to temporary parent absence. *Clin Child Fam Psychol Rev*. 2015;18(1):24-49.
116. Mustillo S, Wadsworth SM, Lester P. Parental deployment and well-being in children. *J Emot Behav Disord*. 2016;24(2):82-91.
117. Aronson KR, Perkins DF, Olson J. Epidemiology of partner abuse within military families. *J Fam Soc Work*. 2014;17(4):379-400.
118. Trevillion K, Williamson E, Thandi G, Borschmann R, Oram S, Howard LM. A systematic review of mental disorders and perpetration of domestic violence among military populations. *Soc Psychiatry Psychiatr Epidemiol*. 2015;50(9):1329-1346.
119. Tasso A, Whitmarsh L, Ordway A. Intimate partner violence within military families. *Fam J*. 2016;24(2):114-121.
120. Cozza SJ, Ortiz CD, Fullerton CS, et al. Types, subtypes, and severity of substantiated child neglect in U.S. Army communities. *Mil Med*. 2015;180(11):1147-1153.
121. Milner JS. Child maltreatment in United States military families: the Military Family Advocacy Program has given increased attention to the prevention of family violence. *Child Abuse Negl*. 2015;47:102-113.
122. Department of Defense. Substance use disorders in the U.S. Armed Forces. *Mil Med*. 2015;180(3):243-245.
123. Ohye BY, Brendel RW, Fredman SJ, et al. Three-generation model: a family systems framework for the assessment and treatment of veterans with posttraumatic stress disorder and related conditions. *Prof Psychol Res Pr*. 2015;46(2):97-106.
124. Sesame Street for Military Families. Available at https://sesamestreetformilitaryfamilies.org. Last accessed March 16, 2023.
125. Blasko KA. Military Kids Connect: web-based prevention services for military children. *Psychol Serv*. 2015;12(3):261-266.
126. Barbee EK, Correa VI, Baughan CC. Understanding the effects of deployment on military families: implications for early childhood practitioners. *Early Child*. 2016;44(3):4-11.
127. Risberg S, Curtis L, Shivers L. A professional development school in action: meeting the needs of military-connected students and families. *Educational Considerations*. 2014;42(1):43-48.

128. Johnson BW. Multiple roles in embedded military environments. In: Herlihy B, Corey G (eds). *Boundary Issues in Counseling: Multiple Roles and Responsibilities*. 3rd ed. Alexandria, VA: American Counseling Association; 2014: 254-259.
129. Prosek EA, Holm JM. Counselors and the military: when protocol and ethics conflict. *Prof Psychol Res Pr*. 2014;4(2):93-102.
130. Johnson WB, Bertschinger M, Snell AK, Wilson A. Secondary trauma and ethical obligations for military psychologists: preserving compassion and competence in the crucible of combat. *Psychol Serv*. 2014;11(1):68-74.
131. Iverson KM, Mercado R, Carpenter SL, Street AE. Intimate partner violence among women veterans: previous interpersonal violence as a risk factor. *J Trauma Stress*. 2013;26(6):767-771.
132. Rabenhorst MM, McCarthy RJ, Thomsen CJ, et al. Spouse abuse among United States Air Force personnel who deployed in support of Operation Iraqi Free/Operation Enduring Freedom. *J Fam Psychol*. 2013;27(5):754-761.
133. Strane D, Lynch KG, Griffis HM, et al. Family characteristics associated with child maltreatment across the deployment cycle of U.S. Army soldiers. *Mil Med*. 2017;182(9-10):e1879-e1887.
134. Military One Source. Military and Family Life Counseling: The Essentials. Available at https://www.militaryonesource.mil/confidential-help/non-medical-counseling/military-and-family-life-counseling/military-and-family-life-counseling-the-essentials. Last accessed March 16, 2023.
135. Isserman N, Martin J. Teaching military cultural competency to clinicians and clinical students: assessing impact and effectiveness. *Journal of Community Engagement & Scholarship*. 2021;13(4):1-13.
136. Ganz A, Yamaguchi C, Koritzky BPG, Berger SE. Military culture and its impact on mental health and stigma. *Journal of Community Engagement & Scholarship*. 2021;13(4):1-13.
137. Gin JL, Kranke DA, Weiss EL, Dobalian A. Military culture and cultural competence in public health: U.S. veterans and SARS-CoV-2 vaccine uptake. *Journal of Humanistic Psychology*. 2022; [Epub ahead of print].
138. Cafferky BM, Reyes CAD, Beaver SL, Shi L. "We'll just draw the curtains!:" Military wives' postures toward predeployment emotional preparation. *Family Relations*. 2022;71(1):389-407.
139. Louie AD, Barlaan DR, Cromer LD. Pilot study of a pre-deployment parent coaching program for military families with young children. *Military Behavioral Health*. 2021;9(2):151-159.
140. Collins CL, Lee K-H, MacDermid Wadsworth SM. Family stressors and resources: relationships with depressive symptoms in military couples during pre-deployment. *Family Relations*. 2017;66(2):302-316.
141. Sullivan KS, Dodge J, Park Y, et al. Predictors of reintegration adjustment among female U.S. Army spouses: a preliminary exploration. *Journal of Military, Veteran & Family Health*. 2022;8(3):84-95.
142. Paley B, Lester P, Mogil C. Family systems and ecological perspectives on the impact of deployment on military families. *Clinical Child & Family Psychology Review*. 2013;16(3):245-265.
143. Pflieger JC, Porter B, Carballo CE, Stander VA, Corry NH. Patterns of strengths in U.S. military couples. *Journal of Child & Family Studies*. 2020;29(5):1249-1263.
144. St. John LV, Fenning P. Supporting the behavioral and mental health needs of military children. *Preventing School Failure*. 2020;64(2):99-105.
145. Mallonee S, Riggs D, Stander V. The impact of family stressors and resources on military spouse's perception of post-deployment reunion stress. *Military Psychology*. 2020;32(6):369-379.
146. Pflieger JC, Richardson SM, Stander VA, Allen ES. Risk and protective factors predictive of marital instability in U.S. military couples. *Journal of Family Psychology*. 2022;36(5):791-802.
147. Rossiter AG, Ling CG. Building resilience in US military families: why it matters. *BMJ Military Health*. 2022;168(1):91-94.
148. DeVoe ER, Ross AM, Spencer R, et al. Coparenting across the deployment cycle: observations from military families with young children. *Journal of Family Issues*. 2020;41(9):1447-1469.
149. Briggs EC, Fairbank JA, Tunno AM, et al. Military life stressors, family communication and satisfaction: associations with children's psychosocial outcomes. *Journal of Child & Adolescent Trauma*. 2020;13(1):75-87.
150. McGaw VE, Reupert AE, Maybery D. Partners of veterans with PTSD: parenting and family experiences. *Families in Society*. 2020;101(4):456-468.
151. Cancio R. Military cohorts, substance use, and male-perpetrated intimate partner violence. *Violence Against Women*. 2021;27(3/4):399-424.
152. Becker P, Bachman R. Intimate partner violence in the military: an investigation of reporting crimes to law enforcement officials. *Journal of Family Violence*. 2020;35:315-324.
153. Sparrow K, Dickson H, Kwan J, Howard L, Fear N, MacManus D. Prevalence of self-reported intimate partner violence victimization among military personnel: a systematic review and meta-analysis. *Trauma, Violence, & Abuse*. 2020;21(3):586-609.
154. Park Y, Sullivan K, Riviere LA, Merrill JC, Clarke-Walper K. Intimate partner violence perpetration among military spouses. *Journal of Interpersonal Violence*. 2022;37(15-16):NP13497-NP13517.

155. U.S. Department of Defense. Report on Child Abuse and Neglect and Domestic Abuse in the Military for Fiscal Year 2021. Available at https://download.militaryonesource.mil/12038/MOS/Reports/FINAL-DoD-FAP-Report-FY2021.pdf. Last accessed April 10, 2023.

156. Rooks VJ, Wood JR, Hamele MT, Farnsworth GM, Nienow SM. Perspective: child abuse in the military. *Pediatric Radiology*. 2021;51(6):883-890.

157. Sullivan KS, Richardson S, Ross A, et al. Pre- and perinatal risk factors for child maltreatment in military families across the first two years of life. *Child Maltreatment*. 2023;28(2):209-220.

158. U.S. Department of Defense. Alcohol and Substance Use Disorders Research Program. Available at https://cdmrp.health.mil/asudrp/pdfs/ASUDRP%20glitz%20sheet_26May22.pdf. Last accessed April 10, 2023.

159. McDonald DC, Radakrishnan S, Sparks AC, et al. High-risk and long-term opioid prescribing to military spouses in the Millennium Cohort Family Study. *Military Medicine*. 2020;185(9/10):e1759-e1769.

160. Porter B, Rodriguez LM, Woodall KA, Pflieger JC, Stander VA. Alcohol misuse and separation from military service: a dyadic perspective. *Addictive Behaviors*. 2020;110:106512.

161. Fletcher OV, Chen JA, van Draanen J, et al. Prevalence of social and economic stressors among transgender veterans with alcohol and other drug use disorders. *SSM Population Health*. 2022;19:101153.

162. Herzog JR, Whitworth JD, Scott DL. Trauma informed care with military populations. *Journal of Human Behavior in the Social Environment*. 2020;30(3):265-278.

163. McKee GB, Knopp K, Glynn SM, McDonald SD. VA family service access and utilization in a national sample of veterans. *Psychological Services*. 2022; [Epub ahead of print].

164. World Health Organization. Framework for Action on Interprofessional Education and Collaborative Practice. Available at https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf. Last accessed April 10, 2023.

165. Bridges DR, Davidson RA, Odegard PS, Maki IV, Tomkowiak J. Interprofessional collaboration: three best practice models of interprofessional education. *Medical Education Online*. 2011;16.

166. D'Amour D, Oandasan I. Interprofessionality as the field of interprofessional practice and interprofessional education: an emerging concept. *Journal of Interprofessional Care*. 2005;5(Suppl 1):8-20.

167. Varpio L, Bader KS, Meyer HS, Durning SJ, Artino AR, Hamwey MK. Interprofessional healthcare teams in the military: a scoping literature review. *Military Medicine*. 2018;183(11-12):e448-e454.

168. Hamwey M, Bader-Larsen KS, Cruthirds DF, Varpio L. The ties that bind: camaraderie in military interprofessional healthcare teams. *Military Medicine*. 2021;186(3):42-47.

169. Ridings LE, Moreland AD, Petty KH. Implementing trauma-focused CBT for children of veterans in the VA: providing comprehensive services to veterans and their families. *Psychological Services*. 2019;16(1):75-84.

170. Saban KL, Griffin JM, Urban A, Janusek MA, Louise-Bender Pape T, Collins E. Perceived health, caregiver burden, and quality of life in women partners providing care to veterans with traumatic brain injury. *Journal of Rehabilitation Research & Development*. 2016;53(6):681-692.

171. Reamer FG. Eye on Ethics: Novel Boundary Challenges — Military Social Workers. Available at https://www.socialworktoday.com/news/eoe_091214.shtml. Last accessed April 10, 2023.

172. Strom TQ, Gavian ME, Possis E, et al. Cultural and ethical considerations when working with military personnel and veterans: a primer for VA training programs. *Training and Education in Professional Psychology*. 2012;6(2):67-75.

173. Leppma M, Taylor JM, Spero RA, Leonard JM, Foster MN, Daniels JA. Working with veterans and military families: an assessment of professional competencies. *Professional Psychology-Research and Practice*. 2016;47(1):84-92.