Clin Soc Work J (2011) 39:28–38
DOI 10.1007/s10615-010-0310-5

ORIGINAL PAPER

Working with Military Families Through Deployment and Beyond

Julie Anne Laser · Paul M. Stephens

Published online: 21 November 2010
© Springer Science+Business Media, LLC 2010

Abstract Military families experience considerable stress, periods of long separation, and changes to the family system due to family members planning to enter a war zone, actively living in a war zone, and reuniting after being in a war zone. Anticipation and understanding of the stages of deployment improves family, couple and individual functioning. The issues that the family and the couple are confronting at each stage of deployment: pre-deployment, deployment, and post-deployment are presented. Clinical interventions for the family and the couple are presented at each stage of deployment. Additionally, the impact of the service member's war time experience on the family, couple, and her/himself is discussed.

Keywords Military families · Deployment · Family therapy · Couples therapy

Introduction

Stress, separation, and change are universal to all families. However, military families experience considerable stress, periods of long separation, and changes to the family system due to family members planning to enter a war zone, actively living in a war zone, and reuniting after being in a war zone. These events put unique demands on military families.

The configuration of the military has changed to an all-voluntary force, where many service members are older and have established their own families. It has been estimated that half of all military personnel are married with children (Duckworth 2009; Petty 2009). Thus, more spouses and parents are leaving for war than ever in the past. With an increased number of deployments to war zones per service member and increased duration of deployments (Duckworth 2009; Hall 2008; Mmari et al. 2009), family and couple issues are on the increase. Additionally, these service members are not all men; over 356,000 women now serve in the armed services or the reserves, which accounts for 16% of the military population (Alvarez 2009).

Though we will focus on traditional two-parent families where one parent is being deployed, it should be noted that military families like all other American families are comprised of many different family configurations such as single-headed households, dual deployed parents, non-married families, and gay/lesbian families. Each family system has its own particular issues and stresses when a loved one is being deployed. Single parent families and dual deployed parents will need to grant guardianship of her/his child(ren) to a family member or friend. Non-married families and gay and lesbian families are often not afforded the same level of support and information sharing as those who are legally wed.

Additionally, there are differences in family needs between enlisted service members, National Guard, and Reservists. Families of an enlisted service member often have better support networks and resources. The enlisted service member family may have greater knowledge of what to expect about deployment due to the family's proximity to the base and to other military families. National Guard or Reservist families may be isolated from other military families or military support. Additionally, the deployed National Guard or Reservist family may experience greater financial hardships since their military

J. A. Laser (✉) · P. M. Stephens
Graduate School of Social Work, University of Denver, Craig Hall 337, 2148 S. High St., Denver, CO 80208-7100, USA
e-mail: Julie.Laser@du.edu

pay may be less than what they were earning in the civilian sector. The National Guard or Reservist may also be in jeopardy of losing her/his job due to lengthy or recurrent deployments (Darwin 2009).

As the number of military personnel, active and veteran, increase in the United States, there is a growing need for mental health providers in and outside the military (Castro 2009; Hall 2008). At each stage of deployment, clinical social workers can provide support to military families to improve family functioning and coping. This article summarizes the stages of deployment with emphasis on the issues the family, couple, and service member face at each stage of deployment. Additionally, suggestions are given for therapy at each stage of deployment. The impact of the service member's wartime experience on the service member, her/his family, and on the clinician is explored. Finally, a brief case is presented.

Stages of Deployment

There are three major stages of deployment: pre-deployment, deployment, and post-deployment. Understanding the stages of deployment improves family, couple, and individual functioning.

Pre-Deployment

Pre-deployment is the period that begins with the service member receiving a warning order that s/he will be deployed and ends when s/he leaves home. The duration of pre-deployment can vary from several weeks to over a year (Hall 2008; Pincus et al. 2008; Rotter and Boveja 1999).

Family Issues

There may be a great deal of dissonance in the family system and within the individual psyche during pre-deployment. The family is trying to cope during pre-deployment with the contradiction between denial that the loved one is actually going to war and anticipation of loss of the loved one from the family system (Hall 2008; Pincus et al. 2008). Additionally, the military family may be experiencing feelings of fear, anger, resentment, and hurt (Rotter and Boveja 1999). These feelings may be directed at each other. Tempers may flare, feelings may easily get hurt, and each family member may be very defensive.

During pre-deployment, the service member is often in training where s/he is bonding to unit members and distancing her/himself from family members (Hall 2008; Pincus et al. 2008; Rotter and Boveja 1999). The service member is making her/himself ready for battle, which includes emotionally separating from the family so that s/he can be singularly focused for war. The service member may want to spend time with her/his unit members when not in training which may heighten feelings of separation and impending loss for the family members being left behind. The service member may be excited and enthusiastic about the mission while the family only dreads the separation.

Children may act out with tantrums and poor behavior once they are told that her/his family member will be leaving (Hall 2008; Petty 2009; Pincus et al. 2008). Research has shown that the most stressful time for children is prior to deployment (Kelley 1994). Depending on the stage of development, children may interpret the parent's departure in different ways. For instance, younger children may not be able to fully grasp the amount of time their parent will be gone or why they are leaving. Younger children, however, will be able to sense that family life has changed, and that their parents are acting differently, which may elicit negative reactions. Magical thinking may cause the young child to believe that the deployed parent is leaving because of her/his bad behavior; this misunderstanding needs to be corrected. Younger children may be very angry with their parent leaving them, but may take out their anger and sadness on the parent who is remaining at home. Due to the young child's magical thinking, s/he may feel that if s/he is openly angry with the parent who is leaving, something awful may happen when s/he is away (Darwin 2009). This behavior can be very difficult for the parent who is remaining at home to understand and endure. Older children and adolescents may be very fearful for their parent's safety and saddened by the upcoming loss of their parent in their daily lives. Youth may openly or covertly have anxiety and stress about their parent's departure.

Couple Issues

Partners often complain during pre-deployment that their service member is emotionally distant. Some partners would prefer that their service member were already gone rather than having a prolonged period of time to contemplate their absence (Hall 2008; Pincus et al. 2008; Rotter and Boveja 1999). The service member is also trying to get all of her/his affairs in order. This includes everything from home maintenance, to taxes and wills, which can exacerbate feelings of fear, loss, anxiety, and stress (Hall 2008; Pincus et al. 2008; Rotter and Boveja 1999). The financial and insurance issues that need to be completed by Reservist families may feel even more daunting since they are less likely to have military supports or mentors to help them prior to deployment.

Arguments are often commonplace during pre-deployment due to the high level of stress that is being placed on the couple because of the serious issues that need to be discussed and planned (Hall 2008; Pincus et al. 2008; Rotter and Boveja 1999). For couples with a greater history, these arguments may be better tolerated, but for newer couples these arguments may be extremely destabilizing for their relationship (Hall 2008; Pincus et al. 2008; Rotter and Boveja 1999). Old arguments that that have been dormant, but never resolved, may resurface due to the stress of getting affairs in order.

Sexual relationships are either extremely intimate or ambivalent during this time period. The final week before deployment, the couple may experience feelings of confusion, ambivalence, anger, and a sense of pulling away from each other (Hall 2008; Rotter and Boveja 1999).

Some service members during this time will rush to be married. This gives the service member an added sense of purpose while away and a feeling that someone is waiting for them. It also solidifies the commitment to each other to be faithful in each other's absence. Some service members may feel that they should experience being married because they are unsure whether they are returning. This fear of not having "fully lived" prior to being deployed also causes impulse buying, and taking risks that they would normally not consider. Additionally, the service member receives a higher rate of pay as married than single, which may also influence her/his choice (Duckworth 2009).

Fears of infidelity while apart, regardless of the couple's marital status, can cause stress and feelings of suspicion (Hall 2008; Pincus et al. 2008). These fears should be discussed openly so that expectations are clear and articulated.

Therapy During Pre-Deployment

Historically, there has been a great deal of stigma for service men and women to seek mental health services (Bowen and Richman 1991). In the past, there has been an unwritten rule that the discussion of feelings and emotions would make the service member weak and less valuable in battle. However, attitudes to clinical services for military personnel are changing. Recently, there are increased numbers of military families using clinical services prior to deployment, during deployment, and post deployment (Hall 2008). Family members may be concerned that seeking clinical services may negatively impact their service member's career; therefore many may choose to seek mental health services outside of military instillations (Armstrong et al. 2006; Hall 2008). Military websites and veteran affairs websites now both advocate seeking counseling and share information about coping with emotional issues (see www.militaryonesource.com, www.battlemind.org, www.realwarriors.net, www.va.gov as examples). This promotion of mental health services by the military has made it more acceptable to seek counseling. However, concerns about possible negative repercussions for the service member's career persist.

Affective Education

In therapy, families often need to learn that the multitude of strong emotions that they currently are feeling, which may be manifesting themselves in erupting anger, are often masking feelings of pain, fear, and loss due to the anticipated departure (Hall 2008; Pincus et al. 2008). Using affective education (understanding one's emotions, where the emotions are coming from, what triggers the emotions, and what the emotion may be signifying) is helpful for family and couples therapy during pre-deployment.

Exploring Roles

It should be stressed in therapy that both the service member and the family left behind have difficult issues to contend with and both need to be valued for their contributions to the family. Role playing, where each partner assumes the role of the other may help increase empathy and understanding of each other's responsibilities while they are separated. Therapy sessions that discuss each partner's expectations of the other during deployment need to be fully communicated. By creating open frank communication prior to deployment, each partner can anticipate each other's behavior, emotions, and needs (Pincus et al. 2008).

Exploring Unresolved Conflicts

Unresolved conflicts in the couple's relationship can cause the service member to have difficulties concentrating when away; therefore therapy during this stage can improve functioning for the service member at war (Pincus et al. 2008). This may be a salient point if the service member is less inclined then the partner to be involved in therapy. Couples may need to be reminded in therapy that they can not completely "tie up all loose ends" prior to deployment nor can they completely bury recurrent arguments in their relationship. Helping the couple turn toward each other for support, rather than pull away from each other should be stressed in counseling during pre-deployment.

Expectations of Fidelity

Fears of infidelity also need to be addressed in therapy (Hall 2008; Pincus et al. 2008). Stories of romantic trysts of

service members in theater and partners on the home front are ubiquitous. Even though the couple's relationship may be strong, they will have probably heard stories of unfaithful behavior and have unsettled feelings inside. Addressing this fear, allows them to discuss it and their expectations for fidelity to each other.

Interventions Benefiting the Children

For school age children and youth in therapy, activities that help children learn to express their emotions such as feeling face cards (Petty 2009), naming emotions, giving examples of when the emotion has occurred is helpful. Parenting practices that stress routine and provide opportunities for family play should be advised (Petty 2009). The parents should not bring older children into the "co-parent" role (Petty 2009), even though they can use the emotional and physical help. The parents need to support their children to be children and not mini-adults.

Deployment

Deployment is the period of time that the service member is away from home.

Family at Home

Early Deployment

The family adjusts to the loss of the service member. The family, during the first months, may feel a sense of abandonment, loss, emptiness, pain, and disorganization (Duckworth 2009; Pincus et al. 2008; Rotter and Boveja 1999; Slone and Friedman 2008). This loss has been termed an "ambiguous loss" where the service member is physically absent, but psychologically present (Boss 2007, 2010). Ambiguous loss has been attributed to undermine coping and block decision-making of the family members left behind (Boss 2007, 2010). The partner at home may have trouble sleeping or have feelings of anxiety (Pincus et al. 2008). It has been found that when a service member is sent to a war zone, it increases the vulnerability of the partner to depression and exacerbates personality disorders (Kelley 1994). The stressful event of deployment may trigger mental health issues for the partner. Therefore, in therapy a thorough understanding of mental health functioning prior to deployment vis-à-vis current functioning should be evaluated.

Children that were found to be the most effected by their parents' deployment had parents who were experiencing more stress (Duckworth 2009). Therefore, therapy for the parent may have a strong positive effect on the child's functioning while the service member is away.

Therapy for the Partner

The partner may be experiencing stress, loneliness, anxiety or depression. These symptoms may be aggravated by increased work and responsibility, and decreased sleep, and economic stability. Functioning is improved with interventions that are strength-based, help the partner learn to reduce stress, and reframe problems. Techniques that help the partner relax such as deep breathing techniques, muscle relaxation, and meditation have been found to be helpful. Cognitive behavior techniques that help the partner come to realize where s/he is making thinking errors are also effective.

Children and Deployment

It is estimated that a half-million children currently are living in a family where one or both parents are deployed (Petty 2009). Depending on the child's stage of development, s/he may experience the absence of her/his parent in a wide variety of ways. Young children may experience the absence of the parent in somatic ways such as refusing to eat, crying, refusal to sleep alone, and bathroom accidents (Petty 2009; Pincus et al. 2008). School age children may experience the absence of the parent by whining, complaining, and aggressive behavior (Petty 2009; Pincus et al. 2008). Teens may be irritable, rebellious, isolate from family members or friends, use drugs or alcohol or become promiscuous (Mmari et al. 2009; Pincus et al. 2008). Additionally, both school aged children and adolescents' grades may be affected. Teachers and school social workers should be made aware of the parent's deployment (Mmari et al. 2009).

Interventions for Children and Youth During Deployment

The child should be encouraged to have a normal routine and learn how to discuss her/his feelings when s/he is feeling sad, lonely or missing her/his parent rather than keep them inside (Mmari et al. 2009; Petty 2009). Teens have found that it is helpful to create support groups with other teens whose parents have been deployed (Mmari et al. 2009). Children should be protected from viewing war footage or hearing news stories about the war. War stories can often be too scary for the child and legitimizes her/his fear for her/his parent. At holidays and important events in the child's life where the parent is missing, the child should be encouraged to take photos (Petty 2009), draw pictures or take video to commemorate the event so

that s/he can share the event with her/his parent via email, Facebook, YouTube or when the parent returns.

Mid-Deployment

After the first few months of separation, the family adjusts to the absence of the service member. The family begins to be more self-sufficient and has increased periods of growth and confidence in their new roles (Duckworth 2009; Pincus et al. 2008; Rotter and Boveja 1999). The family begins to establish new routines and sources of support (Pincus et al. 2008).

Therapy During Mid-Deployment

When working with the family or the partner in therapy, it is important to help them celebrate their resilience and growth. Additionally, accolades should be given to the partner for her/his problem-solving ability and perseverance.

Support Groups

If the family lives on or near a military base the partner may participate in a Family Readiness Group (FRG) or as a Reservist family at the National Guard Armories. The FRGs provide social support and networking for the partner (Duckworth 2009; Hall 2008; Pincus et al. 2008). However, unhealthy FRGs are notorious for rumor mongering, and in some instances these rumors can travel all the way to the war zone where they can negatively affect the service member (Pincus et al. 2008). When working with the family, it is important to help them connect to organizations and groups that can be supportive and to differentiate between activities that can offer support and those that may undermine the family.

Late Deployment

The last few months before reunification, the family begins to feel a mixture of apprehension, excitement, high expectations for the future, and worry (Rotter and Boveja 1999). The partner may have concerns that s/he will need to relinquish her/his newly found independence and decision-making ability once the service member returns (Hall 2008; Pincus et al. 2008). The partner may second-guess her/his decisions, so that they are closer in alignment to the desires of the returning service member (Hall 2008; Pincus et al. 2008). Some partners will have increased fears that their service member will have an untimely end prior to her/his leaving the war zone. This is a period of time of heightened excitement and fear due to the fact that the end of separation is in sight.

Therapy in Late Deployment

In therapy, it is helpful to work with the family to set realistic expectations for reunification. It can be beneficial for the family to consider that during the period of deployment they have grown and changed and so has their service member. Family members can be asked to create a list of areas where they have grown or changed during the intervening months. Using this self-knowledge helps the family members consider that the service member has also experienced changes. Getting to know each other again without preconceived ideas of how the reunion will transpire should be stressed in therapy. The practitioner can help family members anticipate that time is needed for the family system to readjust.

Service Member Away

The service member needs to adjust to the routine of war (Pincus et al. 2008), which includes the skills needed to survive in a war zone. Service members who have difficulties with separation from family may externalize their behaviors into anger and misbehavior (Rotter and Boveja 1999; Slone and Friedman 2008).

During lengthy deployments, the service member may be granted a leave for a week or two. This can be a great opportunity to rejoin and reconnect with the family for a short period of time or can cause the family to revert to the pre-deployment feelings of anger, suspicion, hurt, and resentment. It may also make it more difficult emotionally for the service member to return to theater after her/his leave. Some service members will choose not to return home, but go on leave with members of their unit to avoid the emotional "rollercoaster" of feelings and remain more combat-focused. However, the service member's not returning home for leave can be interpreted negatively by the family.

Prior to returning home, the service member may experience apprehension, excitement, high expectations, worry, and fear for the reunion with her/his family (Rotter and Boveja 1999). S/he may feel these emotions simultaneously or in quick succession.

Communication During Deployment

Research shows that keeping connected through deployment maintains stronger relationships (Mmari et al. 2009; Slone and Friedman 2008). When telephone calls go well, they can boost morale for the family and the service member (Pincus et al. 2008). Most telephone calls are short in duration. The interval between phone calls may be as long as several weeks and can be sporadic (Hall 2008; Pincus et al. 2008). Calls can be unsettling for both the

partner and the service member if they do not connect emotionally during the call (Hall 2008; Pincus et al. 2008). Telephone calls from the partner should try to diminish problems on the home front. The reasoning for this is that issues the service member cannot address while s/he is away will only increase feelings of anxiety and stress for the service member and may make her/him less focused in the war zone which could have devastating repercussions. In turn, the service member may not be able to state much of what is actually happening to her/him while in theater. Therefore, communication by phone is often reduced to shallow, non-specific dialogue in order to avoid problems between the couple (Darwin 2009).

Email can filter out strong emotions and issues. It may be the best choice for families where there are unresolved conflicts. Skype and other visual communication tools are also available at larger bases. These tools are great to see each other, but after the conversation is over can add to loneliness and feelings of loss.

In therapy, the partner may feel the need to speak of her/his inability to communicate in the way s/he wishes with her/his service member. S/he may really miss being able to talk to her/his partner about behavioral issues of their children, malfunctioning cars, problematic issues with home appliances, health issues or loneliness. Helping her/him find a support network helps her/him contend with the stresses of daily living and normalizes the experiences s/he is facing.

Post-Deployment

Family Reunification

The family is feeling a blur of excitement during reunification (Rotter and Boveja 1999). The family needs to begin to communicate and reconnect (Sayers et al. 2009). The service member may want to reassert her/his role in the family, however, the family has learned to cope without her/his daily input and may not welcome re-changing the family organization (Pincus et al. 2008; Rotter and Boveja 1999; Sayers et al. 2009). Some returning service members report feeling like a guest in her/his own home (Sayers et al. 2009), which can be both hurtful and frustrating.

The service member may return with underlying physical or mental issues that will need to be addressed. It is estimated that more than 300,000 service members suffer from Post Traumatic Stress Disorder (PTSD) and 320,000 service members suffer from Traumatic Brain Injury (TBI) from the current wars in Iraq and Afghanistan (Darwin 2009). Prior to rejoining their family, service members must go through physical and mental exams, but some issues may not be reported or visible at this time. Many service members feel that if they do share how they are feeling during discharge, they may have to delay their reunion with their family or it may undermine their military career in the future.

Reunification with Children

Younger children may not remember their parent and may need time to get to know her/him, which may be painful for the returning service member (Petty 2009). School age and adolescent children may be loyal to the parent who has cared for them and may quietly or openly refuse to be parented by the returning service member (Hall 2008; Petty 2009; Sayers et al. 2009). Interestingly, it has been found that for adolescents the service member's return is the most stressful period in the deployment cycle (Mmari et al. 2009). It may take several months for children to reestablish bonds with the returning parent (Petty 2009; Pincus et al. 2008; Rotter and Boveja 1999; Sayers et al. 2009; Slone and Friedman 2008). In therapy, the returning parent should be helped to understand that the distance the child feels is normal due to her/his developmental stage and that s/he should try not to take it personally. Activities that support family play should be suggested such as going to the park or playing board games or cards.

Couple Reunification

Reunion begins with a honeymoon stage, which ends with the first argument (Rotter and Boveja 1999; Slone and Friedman 2008). The couple will often reunite physically, but not emotionally for some time (Pincus et al. 2008). This reconnection may be punctuated with arguments and jealousy. The service member may feel more comfortable with her/his unit members than her/his partner and may actively seek time with unit members rather than her/his partner. The partner may resent the service member's inability to rejoin the family and feel a sense of abandonment, frustration, and anger (Hall 2008).

Therapy Directly Post-Deployment

In therapy, a discussion between family members about needs and expectations should occur. The service member remembers how the family functioned before s/he left and cannot readily see the growth in the family. The family is well aware of the changes that they have experienced over the intervening months; they also remember their service member exactly as s/he was when s/he left for war.

Revisiting Family Roles

In therapy, both, those who were left behind, as well as, the service member, need to learn who each are now. Roles

need to be clarified and reestablished. The roles regarding decision-making will need to be negotiated, especially if prior to deployment the service member was the primary decision maker and in the intervening months the partner was the decision maker (Pincus et al. 2008; Rotter and Boveja 1999). The practitioner can help the couple explore how they can share the decision-making process.

Opening Communication

Communication that highlights patience and taking time to get to know each other should be stressed (Hall 2008; Pincus et al. 2008). Techniques in therapy that focus on the couple taking turns to actively listen to each other and then repeat what they have heard are helpful. Additionally, the practitioner should address that both partners need to learn to not be guided by pre-conceived ideas of how their relationship should be. This may include lowering expectations and not making comparisons to earlier times in their relationship or the relationships of others.

Creating Opportunities for Appreciation and Caring

The partner's feelings of resentment to the service member should be investigated. Often the partner feels that s/he was the real hero who has taken care of the family "single-handedly" in the service member's absence (Hall 2008; Pincus et al. 2008). In therapy, helping each partner discuss what they value in their partner can improve functioning for the couple. The couple should work on reconnecting and appreciating each other and the gifts and talents that they each bring to the relationship and the family.

The Impact of the Service Member's Wartime Experiences on Her/Himself and the Family

The service member may have experienced difficult, if not horrible events during her/his deployment. Upon return, the service member may have trouble sleeping, nightmares, stomach issues, fear of crowds, loud noises, or new situations (Armstrong et al. 2006; Darwin 2009; Sayers et al. 2009; Slone and Friedman 2008). Panic attacks may also be normal after returning from war. However, if they last longer than 6–8 weeks, the service member should seek individual counseling (Slone and Friedman 2008).

The partner should try to understand that the service member needs to heal from the terrors of war and may need time to do so (Hall 2008; Slone and Friedman 2008). The partner may not be able to fully understand or appreciate the depth of the issues that the service member experienced or is currently feeling. The returning service member may be afraid that if s/he shared all s/he experienced, loved ones would be as disturbed as s/he is (Armstrong et al. 2006). Additionally, when the returning service member is continually on edge it can act as a contagion for the partner, creating increased volatility in the couple (Armstrong et al. 2006). The stress that is felt by the returning service member may become generalized throughout the entire family (Mmari et al. 2009).

The returning service member may need time to grieve the losses that s/he has experienced during the war (Armstrong et al. 2006). Feelings of depression can occur if the service member has lost a friend during the war (Slone and Friedman 2008). Additionally, the solider may have feelings of guilt if s/he survived when others s/he was close to did not (Armstrong et al. 2006; Lifton 2005). The experience of surviving may actually connect the service member to earlier experiences of trauma compounding the effect of the current trauma (Lifton 2005). The returning service member may withdraw to deal with these losses, however, in doing so s/he distances her/himself from the family and the support that s/he may need (Armstrong et al. 2006). The service member may need time to contemplate any wisdom that can be gained from her/his experience of survival and how s/he wants to honor those who have fallen (Lifton 2005).

However, the service member's withdraw from the family can be interpreted by family members as rejection (Armstrong et al. 2006). In therapy, helping the family understand why the service member needs time alone or with unit members to heal can help family members better understand the service member's behavior, so that they can act with compassion rather than contempt.

Post-Traumatic Stress

In the current wars in Iraq and Afghanistan, where there is an ambiguous frontline, post-traumatic stress is more likely to occur (Castro 2009; Hall 2008). Post-Traumatic stress includes symptoms of emotional numbing, over active startle reflex, hyper-arousal, lack of impulse control, and emotional explosiveness (Armstrong et al. 2006; Darwin 2009; Ginsburg 2009; Hall 2008; Sayers et al. 2009; Taylor 2006; Tick 2005). In the war zone, these adaptations may be effective for staying alive. However, it is the "staying in combat mode" post deployment that can be self-destructive (Sontag et al. 2008). Post-traumatic stress occurs more frequently in those who have been closest to combat, have been injured or with someone who was injured (Castro 2009; Hall 2008). Additionally, service members who are deployed more than 13 months are more likely to be affected by PTSD (McFarlane 2009). Current statistics report that 30% of service members who experienced a medium level of combat exposure, and 40–50% of service members who experienced a heavy level of combat

exposure suffer from PTSD (Castro 2009). With prevalence of PTSD this high, it has caused some in the field to suggest that PTSD is a psychological injury of war and not a disorder (Shay 2009). Depression may occur simultaneously to post-traumatic stress (Castro 2009; Shay 2009; Slone and Friedman 2008). Some negative behaviors related to post-traumatic stress include substance abuse, risk-taking, over-working or overeating (Armstrong et al. 2006; Shay 2009).

Mental health services are usually needed to overcome post-traumatic stress and depression for the returning service member (Slone and Friedman 2008; www.ptsd.va.gov). However, guilt can undermine the ability of the returning service member to get the help s/he needs because s/he may feel s/he does not deserve to feel better (Armstrong et al. 2006). It may be necessary to refer the returning service member to a clinical social worker who specializes in post-traumatic stress for individual treatment prior to family or couples therapy. An individual with severe PTSD may be at risk for suicide and/or domestic violence if s/he is not first stabilized in individual treatment (Darwin 2009).

Cognitive Behavioral Therapy (CBT) has been found to be one of the most effective therapies for working through trauma issues (Dass-Brailsford 2007; Mulick et al. 2005). By helping the returning service member reappraise and revise her/his cognitive schemas, as well as creating cognitive dissonance in current thinking errors, the client can improve functioning. The CBT techniques that are particularly helpful are: relaxation techniques, role playing, restructuring negative thoughts, anger management techniques, guided imagery, positive self-talk, creating thought records, and learning distraction techniques (Beck 1995; Dobson 2001; Dass-Brailsford 2007; Greenberger and Padesky 1995; Laser and Nicotera 2011). In each of these techniques by changing the returning service member's thinking about the traumatic event(s), her/his emotions and behaviors change.

Retelling the trauma story to the practitioner has been found to be useful in reducing PTSD symptoms (Dass-Brailsford 2007; Mulick et al. 2005). The act of retelling the trauma story until it no longer holds power over the returning service member helps in recovery. This therapy technique takes both time and trust but can be a very powerful intervention.

A technique called Battlemind Training has been found to be effective in giving returning service members a vocabulary to discuss mental health issues, and talk with other service members about their experiences in theater thereby normalizing their experiences (Castro 2009; www.behavioralhealth.army.mil/battlemind/index.html). Battlemind Training works by discussing the skills that are necessary for being successful in a combat zone, and then in juxtaposition, discussing how those skills need to be modified when reentering the civilian world. Battlemind Training helps the service member understand that in different environments different skills are needed and valued. Battlemind Training does not diminish her/his identity as a warrior, but explains that the skills necessary for being in theater are different than the skills needed at home.

Family therapy that uses Family Focused Treatment (FFT) has been found to be effective with returning service members experiencing post-traumatic stress and their families (Miklowitz 2008). FFT uses the family as allies and supports to the returning service member. FFT involves educating each family member about the illness and treatment issues (Miklowitz 2008). Family members complete homework assignments and make a commitment to be involved in therapy (Miklowitz 2008). FFT works to improve communication and problem solving in the family. The family learns to anticipate specific problems prior to their occurrence. FFT teaches the family skills they can use when problems arise (Miklowitz 2008).

Domestic Violence

Returning service members with higher levels of war related trauma and post-traumatic stress have been found to have decreased levels of family functioning and increased incidence of domestic violence compared to those who have not experienced trauma and post-traumatic stress (Sayers et al. 2009). Domestic violence can often be a negative outcome of post-traumatic stress with the returning service member unable to control her/his emotions (Hall 2008).

In therapy, issues of anger management need to be discussed. Interventions that help the service member assess and understand when and why anger is beginning to envelope her/him and how to de-escalate those strong feelings are beneficial. Additionally, the safety of the partner and the children need to be explored.

If the couples' relationship was unhealthy prior to deployment, the time apart may have only made the relationship more problematic. Service members, who left for war with marital conflict, have been found to return from war with an increased propensity for domestic violence (Sayers et al. 2009). Therefore, the volatility of the relationship may predate deployment. With these couples in therapy, it is important to get to the root cause of marital disharmony, which has been exacerbated by the couple's separation.

Divorce

The divorce rate for returning service members has increased with over a thousand more divorces in 2008 than 2007, which has been attributed to multiple deployments

(Darwin 2009; Duckworth 2009). Returning service members with depression or post-traumatic stress are five times more likely to have problems readjusting to family life than returning service members who do not experience depression or post-traumatic stress (Sayers et al. 2009). Additionally, returning service members with post-traumatic stress are twice as likely to become divorced than those who do not have post-traumatic stress (Hall 2008). These statistics underscore the importance of therapy for the returning service member and her/his partner and the adverse affect for the family system if mental health services are not sought.

Suicide

Though the government does not track suicide among veterans, anecdotal stories suggest suicide is a significant concern for returning service members (Kerr 2007). Therefore, the clinical social worker should assess if the returning service member has suicidal ideation, suicidal intent, and a suicide plan (Laser and Nicotera 2011). Additionally, the service member's family should be educated about the particular signs associated with suicidal behavior.

Concerns for the Clinician's Mental Health

The practitioner should be aware of her/his own involvement in the family system and counter-transference (Watkins 1985). The stories of bravery and the willingness to sacrifice for one's country may make the practitioner want to cheer for the returning hero and the family that supported her/him rather than create and maintain appropriate boundaries with the family or service member. Additionally, the experiences the service member witnessed during deployment may create feelings of sympathy or pity that may undermine the work that needs to be done in the therapeutic process. The anger, rage or despair that the returning service member feels may be internalized in the practitioner (Herman 1997). Feelings of guilt, shame, anger, helplessness, and incompetence can envelope the clinician when working with a returning service member (Tyson 2007).

Moreover, the enormity of the issues heard and the successive hearing of many stories of the horrors of war can cause "compassion fatigue" for the clinician. Compassion fatigue has been termed as the "extreme state of tension and preoccupation with the suffering of those being helped" (Figley 2005, p. 1). Compassion fatigue can lead to a secondary trauma reaction where the practitioner is no longer able to function optimally (Figley 2005; Herman 1997; Tyson 2007). Therefore, clinical social workers that work with returning service members and their families need to practice self-care by respecting their own need for rest, relaxation, and renewal (Figley 2005; Herman 1997; Tyson 2007). Practitioners who are feeling despondent, helpless, incompetent, distrustful of others, or isolating themselves from their support systems need to seek therapy themselves. To reduce compassion fatigue, colleagues need to connect to each other as a support network. The support network can act as a mechanism to assess if clinical support is needed for one of its members and help access support for her/him. Additionally, organizations need to show appreciation and recognition for the important work that is being done (Figley 2005) and to reduce caseloads for those working with returning service members (Tyson 2007).

Case Example

Henry has been married to Maria for 6 years. Henry is 25 and Maria is 24, they were high school sweethearts prior to getting married. Henry just returned from his second deployment. They have two children: Benji age five and Laura age two. Henry's most recent deployment lasted 16 months.

Maria had a really hard time during this last deployment juggling her work, single parenting of two small children, and maintaining the family home. She was often stressed, lonely, and exhausted. Maria was so relieved when Henry returned home safely. She hoped that he would be able to jump into the Dad role and give her the break she felt she deserved. However, this has not happened.

Henry was involved in an exercise while in theater that ended in a group of school-age boys throwing homemade bombs and rocks at them. Several of Henry's friends were hurt, one severely. Henry thinks about the event frequently and how these children were filled with so much anger and hatred to people who were only trying to help. He has not shared much of his experiences in theater with Maria.

Henry, who normally is jovial and charming, returned from war sullen and distant from Maria. Maria feels like she has undergone a huge ordeal, and has done so to help Henry further his military career. Henry seems not to notice all she has done or the sacrifices she has made for the family. Maria is hurt, angry, and frustrated by Henry's distancing her.

When Henry left, Laura was only 7 months old. As a 2 year old, Laura has no memory of Henry. Laura is not comforted by Henry and wants only Maria when she cries. Benji remembers his father, but Henry does not laugh so much anymore and wants to go out with his buddies from his unit instead of spending time with him. When Benji talked to his dad on the phone during deployment, Henry used to tell Benji how he was looking forward to playing catch with him. Benji asks his dad to play catch almost

every day, but Henry is usually too busy at his work, with other grown-ups or is too tired.

Case Discussion

Using Henry, Maria, Benji and Laura as a case example, individual, couples and family therapy techniques will be discussed briefly.

Individual Therapy

Henry's experience of war related trauma should be evaluated to ascertain if individual therapy for post-traumatic stress or depression is needed apart from couples or family therapy. Henry's change of affect and personality post deployment should be considered in this evaluation. It is recommended that a clinical social worker that specializes in post-traumatic stress be sought for the evaluation.

Couple's Therapy

Though it may not be necessary to tell Maria all of the details of the ambush by the school-aged boys, the couple can benefit from Maria becoming aware of the situation and understanding the need for Henry to have time to heal. By giving Maria this knowledge, she can understand Henry better and be more compassionate to Henry rather than harbor anger and resentment to him. Education for Maria that helps her learn how to best support Henry through the process of healing would be beneficial. Henry also needs to come to understand that Maria has also had a trying experience in the 16 months they were separated. Helping Henry articulate to Maria how her work on the home front supported his being strong at war would strengthen their relationship.

In couple's therapy helping Henry and Maria remember why they originally got married should be stressed. Both Henry and Maria need to learn how to communicate their appreciation of each other in a manner where the other can hear it. Both partners should articulate to each other why they stay in their relationship, what gives them strength in their relationship, and what needs to change in their relationship. Changes in the relationship should include both what they each would like more of in the relationship and what they would like less of in the relationship. Henry and Maria should also be reminded that rebuilding trust and intimacy takes time. Practical homework activities during the week such as having a weekly date night and creating 10 min of uninterrupted daily talk time with each other should be suggested.

Family Therapy

Family therapy that strengthens communication between all family members would be beneficial. During family therapy, helping the family organize a schedule that incorporates shared family time, couple time, and personal time should be created. This would allow each family member to feel that her/his needs were being better met. In general, the family needs time to get to know each other again. The family should try to be planful in creating opportunities for shared time. Henry needs to make time to reconnect with each of his family members and understand the importance of making this effort. Maria needs to allow Henry the time and flexibility to heal. With love, understanding, lowering expectations, and compassion, the family can be made whole and strong again.

Conclusion

Military families facing long and repeated deployments are under a great deal of stress. Understanding the issues that face military families prior to deployment, during deployment and post-deployment are crucial for providing appropriate clinical services. With a better understanding of the issues facing military families, better mental health services can be provided.

References

Alvarez, L. (2009). Women at arms: G. I. Jane Breaks the Combat Barrier. *New York Times*. Retrieved from http://www.nytimes.com/2009/08/16/us/16women.html?_r=1&pagewanted=print.

Armstrong, K., Best, S., & Domenici, P. (2006). *Courage after fire: Coping strategies for troops returning from Iraq and Afghanistan and their families*. Berkley, CA: Ulysses.

Beck, J. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford.

Boss, P. (2007). Ambiguous loss theory: Challenges for scholars and practitioners. *Family Relations, 56*, 105–111.

Boss, P. (2010). The trauma and complicated grief of ambiguous loss. *Pastoral Psychology, 59*, 137–145.

Bowen, G., & Richman, J. (1991). The willingness of spouses to seek marriage and family counseling services. *Journal of Primary Prevention, 11*(4), 227–293.

Castro, C. (2009). Impact of combat on the mental health and well-being of soldiers and marines. *Smith College Studies in Social Work, 79*(3), 247–262.

Darwin, J. (2009). Families: "They also serve who only stand and wait". *Smith College Studies in Social Work, 79*, 433–442.

Dass-Brailsford, P. (2007). *A practical approach to trauma; empowering interventions*. Thousand Oaks, CA: Sage.

Dobson, K. (2001). *Handbook of cognitive behavioral therapies* (2nd ed.). New York: Guilford.

Duckworth, D. (2009). Affects of multiple deployments on families. *United Sates of America War College (USAWC) Strategy Research Project*. Carlisle Barracks: PA. Retrieved from http://www.dtic.mil/cgibin/GetTRDoc?Location=U2&doc=GetTRDoc.pdf&AD=ADA498029.

Figley, C. (2005). Compassion fatigue: An expert interview with Charles R. Figley, MS, PhD. Retrieved from http://www.medscape.com/viewarticle/513615.

Ginsburg, H. (2009). Meeting the emotional needs of returning war zone veterans. *Psychiatric Annals, 39*(2), 37–44.
Greenberger, D., & Padesky, C. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: Guilford.
Hall, L. (2008). *Counseling military families: What mental health professionals need to know*. New York: Routledge.
Herman, J. (1997). *Trauma and recovery*. New York: Basic Books.
Kelley, M. (1994). The effects of military-induced separation on family factors and child behavior. *American Journal of Orthopsychiatry, 64*(1), 103–111.
Kerr, J. (2007). Post-deployment suicide: A closer look. *Military times.* Retrieved from http://www.militarytimes.com/news/2007/05/ap_suicide_070528/.
Laser, J., & Nicotera, N. (2011). *Working with adolescents: A practitioner's guide*. New York: Guilford.
Lifton, R. (2005). Americans as survivors. *New England Journal of Medicine, 352*(22), 2263–2265.
McFarlane, A. (2009). The duration of deployment and sensitization to stress. *Psychiatric Annals, 39*(2), 81–88.
Miklowitz, D. (2008). *Bipolar disorder: A family focused treatment approach*. New York: Guilford.
Mmari, K., Roche, K., Sudhinaraset, M., & Blum, R. (2009). When a parent goes off to war: Exploring the issues faced by adolescence and their families. *Youth and Society, 40*(4), 455–575.
Mulick, P., Landes, S., & Kanter, J. (2005). Contextual behavior therapies in the treatment of PTSD: A review. *International Journal of Behavioral Consultation and Therapy, 1*(3), 223–238.
Petty, K. (2009). *Deployment strategies for working with kids of military families*. St. Paul, MN: Redleaf.
Pincus, S., House, R., Christenson, J., & Adler, L. (2008). The emotional cycle of deployment: A military perspective. Retrieved from http://hooah4health.com/deployment/familymatters/emotionalcycle2.htm.
Rotter, J., & Boveja, M. (1999). Counseling military families. *The Family Journal: Counseling and Therapy for Couples and Families, 7*(4), 379–382.
Sayers, S., Farrow, V., Ross, J., & Oslin, D. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry, 70*(2), 163–170.
Shay, J. (2009). The trials of homecoming: Odysseus returns from Iraq/Afghanistan. *Smith College Studies in Social Work, 79*, 286–298.
Slone, L., & Friedman, M. (2008). *After the war zone: A practical guide for returning troops and their families*. Philadelphia, PA: Da Capo.
Sontag, D., & O'Leary, A. (2008). Dr. Jonathan Shay on returning veterans and combat trauma. *New York times.* Retrieved http://www.nytimes.com/2008/01/13/us/13shay-interview.html?_r=1.
Taylor, S. (2006). *Clinician's guide to PTSD: A cognitive-behavioral approach*. New York: Guilford.
Tick, E. (2005). *War and the soul: Healing our nation's veterans from post-traumatic stress disorder*. Wheaton, IL: Quest Books.
Tyson, J. (2007). Compassion fatigue in the treatment of combat-related trauma during wartime. *Clinical Social Work Journal, 35*, 183–192.
Watkins, E. (1985). Counter transference: Its impact on the counseling process. *Journal of Counseling and Development, 63*(6), 356–364.
Battlemind Training Website. Retrieved from www.behavioralhealth.army.mil/battlemind/index.html.
Veterans' Administration PTSD website. Retrieved from www.ptsd.va.gov.

Author Biographies

Julie Anne Laser is an associate professor at the Graduate School of Social Work at the University of Denver. She has lived, worked, and taught on a military base abroad.

Paul M. Stephens is a pilot who flew both military cargo contracts and civilian passengers. He is now pursuing his MSW.