Effects of Deployment on Military-Connected Children, Spouses, and Families

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Introduction

While many aspects of military life can introduce stress into family systems, deployments are often described by military families as the most stressful [1]. Since the start of the Global War on Terror in 2001, over 2.7 million service members have experienced more than 3.3 million wartime deployments [2, 3]. The impact of deployment on service members has been extensively researched; these may include physical injuries, mental health symptomatology, substance use, and suicidality, problems which may be exacerbated by barriers to seeking treatment [4–7]. A smaller but growing body of evidence explores the impact that deployments have on the spouses, children, and families of service members [8–11]. As of 2017, 49.4% of service members are married and 39.5% have children [12]. Findings from empirical research with this population suggest that the majority of families weather the stressors of deployment successfully, but a subset of families may be struggling and at risk of adverse outcomes [13, 14].

Deployment is often described in the literature as a cyclical process rather than a discrete event, including 5 phases: (1) predeployment, (2) deployment, (3) sustainment, (4) redeployment, and (5) postdeployment or reintegration [15, 16]. A family's exposure to risk and access to protective factors are theorized to vary across this cycle. Though this perspective is often referenced when describing the impact of deployment on families, it is important to note that high operational tempo and other

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unique elements of recent conflicts have sped up and compounded this cycle. Among those who have deployed in service of the Global War on Terror, 43% did so multiple times [17]. Further, changes in technology have dramatically impacted how families experience the deployment cycle. More frequent communication between service members and their families during deployments may attenuate some of the stressors associated with separation but may also introduce new stressors as both service members and their families are more aware of the other's experiences [18, 19].

As the body of literature on this topic has grown significantly, an adequate treatment requires some specifications about scope. This chapter will describe the impact of deployment experiences on military-connected spouses, children, and families; this impact is considered distinct from the potential effects experienced during the reintegration period following deployment. While these are undoubtedly intertwined, deployment is time bound while reintegration is a subjective experience that can vary significantly in length depending on the adaptive capacities of the service member and their family [9]. Further, this chapter is written for civilian providers. While many military families receive health and mental health care from military providers, approximately 50% of military-connected families may receive some care from civilians [20, 21]. Services shift toward civilian providers particularly during deployments [22], and these providers may be less aware of the unique needs of this population. In order to explore the interrelated concepts discussed, a composite clinical case will be introduced below. Elements of this case will be presented throughout the chapter to amplify key points and illustrate the impact of treatment on outcomes described.

Vignette

The Fisher Family is a family of 5 (father-John (50), mother-Leslie (48), son-Byron (28), son-James (25), daughter-Jane (21)). They presented at a free family-based care clinic for service members/veterans and their families to process the loss of their eldest son, Byron (28), who died from an overdose of prescription medication. The 4 surviving members of the family came with the intention to process their grief together. The family participated in a 6-week resiliency-building family intervention that was designed as a preventative treatment for military families. While the primary reason for the visit was to process the loss of their son, unprocessed events and emotions that arose during John's military service emerged as treatment unfolded. The parents' goals for treatment were to gain coping skills to manage their recent loss. The children's goals were to develop communication skills to connect with each other and express how they were feeling.

Risk and Resilience Framework

The stress of deployment is not experienced in a vacuum but rather against a backdrop of other demands and in the context of the family's resources. This chapter employs a risk and resilience framework (see Fig. 22.1) to discuss the impact of

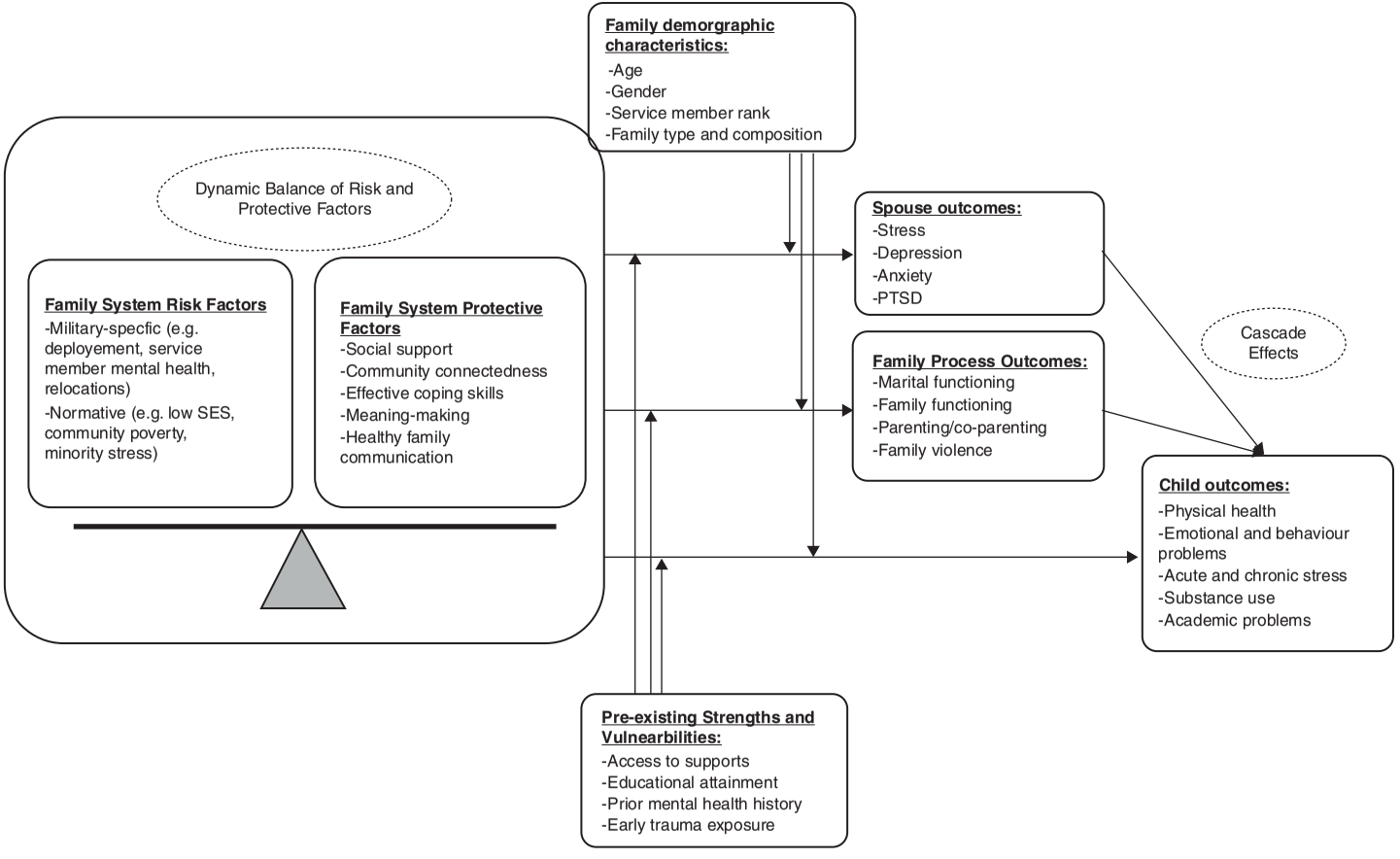

Fig. 22.1 Risk and resilience framework

deployment, in which resilience is defined as the dynamic balance between family-level risk and protective factors that determine whether a family is able to maintain or return to a previous level of functioning in the face of adversity [23–25].

Risk Factors

The deployment cycle is hypothesized to introduce risk, which may be exacerbated by a family's pre-existing vulnerabilities and counter-balanced by a family's internal and external resources. Risk factors may be military-specific or normative, referring to elements experienced by military and civilian families alike [26]. Beyond deployment, other relevant military-specific stressors could include the mental health of service members (discussed further below), experiences of relocation, un/underemployment of military spouses, and foreign postings [27–29]. Deployment itself can be experienced as an acute or a chronic stressor, represented as the number of prior deployments, cumulative days of deployment, or the percentage of a family's life that a service member has been deployed [9, 30–34]. Further, the timing of deployments in the family life cycle may compound risk. For example, deployments that coincide with a spouse's pregnancy can have negative outcomes that could influence the prenatal environment and have consequences for children in these families at birth [35]. Research has shown that deployment stressors are associated with elevated depression scores during pregnancy and in the post-partum period [36]. Normative stressors may include lower socioeconomic status [26, 37] and minority stress [38].

The case of the Fisher Family, they experienced both normative and military-specific risk factors that contributed to their clinical presentation. Their most pressing concern was the recent loss of their son, an experience which can impact military and civilian families alike. This normative stressor was experienced alongside several military-specific stressors. John served 20 years as a Marine and completed 4 combat deployments. During his combat tours, he witnessed the death of several close friends and took lives of the enemy. The family described how hard it was to live with John once he returned home. John's lack of communication, anger outbursts, and militant daily routines created conflict, but the family learned to cope through avoidance.

Protective Factors

Protective factors that counteract risk may be critical to understanding why many families successfully navigate the challenges that deployment presents [34, 39]. All military families possess a set of strengths that not all families in the general population possess. By definition these families have at least one employed parent with at least a high school education or equivalent, favorable pay and benefits, and access to high quality health and child care [40–42]. Beyond these factors, access to formal and informal sources of social support [30, 43–46], feeling connected to one's

community [45, 47], effective coping mechanisms [48], the capacity to make meaning out of challenges [49, 50], and healthy family communication [33, 51] have all been shown to protect against adverse outcomes in this population.

In the example of the Fisher Family, Leslie and the children reported they coped well during John's deployments because they always lived close to family or had family visit regularly, which was an important source of social support. Further, there was a strong sense of love and commitment among the family that motivated each member to be open to different communication styles as well as to making collective meaning from their experiences. The family also had access to critical resources as a result of their military status. For example, John had a college degree that was paid for through his service, which contributed to the family's comfortable standard of living, and health insurance, which offered the possibility of seeking mental health services, though John was reluctant to pursue this option at the outset of family treatment.

Pre-existing Strengths and Vulnerabilities

A family's strengths and vulnerabilities that predate military service (e.g. educational attainment, pre-existing mental health problems, or prior traumatic experiences; [52]) may exacerbate or attenuate the relationship between this balance of risk and protective factors and the family's outcomes [26, 53, 54]. In some studies, for example, deployment experiences alone are not a significant predictor of adverse outcomes when considered alongside other stressors like parent mental health and community poverty [26].

The Fishers' extended family was a significant source of strength, which predated John's military service. Leslie reported that she never questioned whether their family would be there for her and the children during John's deployments, a sense of confidence that allowed her to access this critical source of social support during difficult times. Further, John shared that he had always experienced difficulty managing strong emotions, even during his childhood. Leslie observed that her husband's tendency toward isolation and occasional volatility was only exacerbated by combat exposure. She worried that he did not have the temperament to manage these experiences.

Outcomes Associated with Deployment

Experiences of deployment, considered in the context of the family's cumulative exposure to risk and protective factors, have been found to influence outcomes for military-connected spouses, children and families. The majority of these findings have suggested that deployment can have adverse consequences for a subset of military-connected family members. While there are potential stressors present at all stages of the deployment cycle, the most significant changes for spouses, children and families have been observed during deployment separations [33, 55].

Positive Outcomes

Though not regularly measured in quantitative studies, qualitative work suggests some positive outcomes from deployment. Adolescents in military families discuss opportunities for growth and development that arise particularly around the increased responsibilities they take on during the deployment of a parent [56]. Some military spouses express a sense of pride in the leadership role they play while their spouse is deployed [25]. Perhaps because they are physically distant from day-to-day stressors, recent findings suggest that service members have more positive views of their parenting and marital relationships during deployments [33]. Though these relationships have yet to be examined quantitatively, it is possible that positive outcomes associated with deployment are facilitated in families with greater access to resources.

Spouse Adverse Outcomes

The spouses of deploying or deployed service members may experience adverse outcomes across the deployment cycle**.** Rates of depression among some spouses appear to increase prior to deployment separations [57]. While service members are deployed, spouses may exhibit increased depression, anxiety, PTSD, or global distress [31, 33, 58]. Using health care records, an increased prevalence of diagnosed depression, anxiety disorders, sleep disorders, adjustment disorders and acute stress reactions were observed among spouses with a deployed service member [59]. Longitudinal explorations suggest that spouses' depression symptoms increase linearly during a deployment but level off and begin to return to pre-deployment levels as reunion with the deployed service member approaches [55].

A number of factors may impact these adverse outcomes. Perceived stress appears to be an important proximal factor, which may increase among spouses of deployed services members and is associated with increases in somatization and poorer physical and mental health [57, 60, 61]. Treatment seeking and stigma are also important considerations. Compared to spouses of non-deployed service members, experiencing a deployment is associated with increases in psychiatric service use and decreases in primary health care visits, implying less use of preventive care [22]. Despite this uptick in psychiatric care, several studies have identified low rates of treatment seeking compared to estimates of need in this population. In one sample, in which 79% of service members were deployed, only 41% of spouses screening positive for a mental health diagnosis actually sought specialty mental health treatment, citing logistical barriers like access to child care, difficulty getting an appointment, and concerns about stigma as barriers [58]. Spouses also report that concerns about harm that could come to their partner's career are a barrier to seeking treatment [57].

At the outset of treatment for the Fisher family, both John and Leslie presented with elevated symptoms of PTSD and depression. John wore sunglasses for the first two sessions to hide his grief. Leslie cried through most of the beginning sessions. John described feeling distant from his family and reported he did not know how to

reconnect. John's isolation created significant stress for Leslie as she felt like the mediator between her husband and children, reporting that she never knew what was going to set John off. Leslie encouraged John to seek individual mental health treatment prior to pursuing family services. John complied and went to a nearby VA medical center but had such a bad experience getting an appointment that he vowed to never seek treatment again. John was easily upset when individual treatment was brought up in family sessions, but was compliant with family treatment because he did not want the tragic loss of his son to cause additional harm to his family.

Over the course of the family intervention, John was able to listen to his family's concern and was open to additional treatment at a local VA medical center. Additionally, the children expressed concern for their mother's overall mental health. Leslie regularly vocalized to her daughter how the disconnect between her children and husband made her sad. She cried frequently and expressed feelings of hopelessness about interactions with her husband on his bad days. Leslie was referred to an individual therapist through a veteran family support organization. Both John and Leslie were in individual treatment at their 10-month follow-up appointment and reported lower depression and post-traumatic stress symptoms.

Family Adverse Outcomes

Marital Functioning Conclusions about the impact of deployment on the health and stability of marital relationships has been mixed. In the context of the Global War on Terror, some findings suggest deployment does not impact relationship functioning [62], while other findings suggest the opposite [63]. In families with children, greater exposure to deployment has been associated with greater marital instability [2]. Longitudinal examination of these processes suggest that couples become less satisfied with their marriages across the deployment cycle, but more frequent communication during deployments may improve this trajectory [33]. Though younger couples may be at greater risk [64], overall there is little evidence that deployment exposure alone increases risk for divorce [65]. In contrast to these mixed results, findings are consistent regarding the adverse impact of PTSD symptoms, particularly in combat-exposed service members, on relationship functioning [62, 66].

Parenting There have also been mixed findings regarding the effect of deployment on parenting. With regard to the non-deployed parent, some research suggests deployment does not affect parental sensitivity [67], while others have found that parental responsiveness declines across the deployment cycle and continues to decline at reunion [55]. Satisfaction with the parenting relationship may also decline across the deployment cycle for non-deployed parents, while deployed parents report higher parenting satisfaction [33]. With regard to the deployed parent, disruption in primary caregiving relationships as a result of deployment separation may impact parenting, as children need consistent interaction in order to view caregivers as reliable sources of support and comfort [68]. Attachment may also be impacted by the physical and mental health of the deployed parent on their return [69].

Family Functioning Limited research on family functioning also suggests mixed effects. In longitudinal findings the deployment cycle has not been associated with significant changes in the family environment [33], but cumulative deployment exposure may adversely impact multiple elements of family functioning, including affective involvement, communication, and problem solving [2]. Another way to explore family-level impact is through examination of family violence outcomes associated with deployment. Each military branch operates a Family Advocacy Program (FAP) charged with preventing, investigating and addressing child maltreatment and intimate partner violence in military families [70]. Using FAP data, studies suggest increases in rates of maltreatment during periods of higher operational tempo [71–73] and spikes in maltreatment, and particularly neglect, during deployments [71, 74, 75]. Regarding intimate partner violence (IPV), some evidence points to a decrease in psychological and physical aggression across the deployment cycle [33], while other evidence has found a relationship between a history of deployment in the last year and an increased likelihood of spousal aggression [76]. This relationship may be accounted for by the consistently demonstrated link between PTSD symptoms and IPV perpetration [77].

At the outset of treatment, members of the Fisher family were isolated from one another. Communication between John and his children was stilted, and tension was high in early sessions. Though there was a history of violence in the family, there was no indication of current violence between John and Leslie or within the family as a whole. Through treatment, John learned and practiced active and reflective listening skills. John also shared some of the hardships he went through during his military service, which he had kept to himself in an effort to protect his family. The children were appreciative of this disclosure because they felt in the dark about what their father had been through. Additionally, through treatment, each member of the family was able to learn new emotion regulation skills. Through the awareness of how emotions can affect behavior, each member was able to practice different activities to help them calm down when they felt dysregulated.

Child Adverse Outcomes

Studies have taken a number of different methodological approaches to exploring mental, emotional, or behavioral health outcomes of military-connected youth and their relationship to deployment experiences, including school-based surveys that disaggregate outcomes for military and non-military-connected children [78–80], large-scale examination of pediatric health care records [32, 81], qualitative studies [82], as well as cross-sectional [30, 31, 83] and longitudinal survey research [33, 55]. One meta-analysis [8] and several reviews [9, 11, 38, 52, 84] suggest that parental deployment adversely impacts the adjustment and psychological well-being of children, though these associations may be small. Increases in mental health service utilization parallel increases in mental health concerns among military-connected youth [33]. In children ages 3–8 who experienced a parental deployment, mental and behavioral health visits increased by 11% overall, by 19% for behavioral disorders, and by 18% for stress disorders [81]; these increases were even greater for children whose parents were injured in combat [75]. Similar results were observed among military-connected youth ages 5–17, in which an excess of diagnoses including acute stress reaction/

adjustment, depression, and behavioral disorders were observed in children who experienced deployment. During parental deployment, increases in the use of prescription antidepressant and antianxiety medications have also been observed among military connected-youth [22]. While many factors may moderate these associations, findings consistently demonstrate that longer cumulative exposure to deployment and poor functioning of the at-home parent are associated with more negative mental health outcomes for youth [9, 32, 33, 78, 85].

Other critical outcomes for military-connected youth may also be impacted by deployment experiences. Physical health symptoms, including elevated heart rate and blood pressure, may increase during deployments [86]. Suicidality and substance use may also increase among adolescents both during and after deployments [33, 78, 87, 88]. Finally, modest negative relationships have been observed between deployment experiences and academic functioning [82, 83, 89, 90]. Deployment of a parent may also be associated with increases in other adverse experiences in school, including physical fighting, weapon-carrying and gang membership [91, 92].

Specific to the Fisher family, at the outset of treatment James would tear up when he talked about Byron and had taken time off work to grieve. Jane had a hard time putting into words how she felt, but was able to identify activities and people that offered her comfort. Both children described tension at home and difficulty communicating with their father. During treatment, both Jane and James were preparing to go back to school, which meant leaving the home. Soon after the death of her brother, Jane adopted an emotional support cat which she took with her when she left. In the wake of his brother's death, James began running on the beach with one of his friends. Running and talking with a close friend helped James feel more calm. Both decided they did not need any individual treatment at the end of family treatment. However, at 10-month follow-up, both wanted assistance in finding a full time therapist.

Interconnected Family Relationships and Developmental Cascades

While research often considers the discrete effects of deployment experiences on individuals or specific family relationships, theory suggests that these associations are not linear. Rather, family systems theory posits circular causality in which individual members of a family system and their relationships with one another have ongoing and reciprocal effects that reverberate through the system [93]. Developmental cascades capture the phenomenon of spreading effects across levels within a family system [94] and help to explain the "spillover" of stress associated with military family life between members of the system [95]. This concept has been observed in the critical role that at-home parents play in maintaining the wellbeing of military-connected youth across the deployment cycle. Increased anxiety, depression, perceived stress, and parenting stress in at-home parents consistently predicts increased adverse outcomes for children in military families [31, 83, 96, 97], suggesting that maintaining the health of at-home spouses may have a positive impact across military family systems.

While these effects are conceptualized as a family-level risk factor here, the impact of service member mental health parallels the cascade effects of spouse and family-level outcomes. Though an extensive review is beyond the scope of this

chapter, a significant body of literature explores the impact of poor service member mental health, particularly PTSD, on parenting, intimate partner relationships, and individual child and spouse outcomes [33, 42, 66, 98]. Findings suggest adverse effects on parenting, marital or relationship functioning, family violence, and spouse psychological wellbeing, all of which likely have consequences for child outcomes [66, 98]. In particular, the numbing and avoidance symptoms of PTSD may be problematic for family functioning, as these symptoms may interrupt emotional expression that is critical to developing and maintaining close family relationships [66]. Spouses of combat veterans with PSTD may exhibit emotional distress in the form of stress, loneliness, somatic and psychiatric symptoms [99]. Similarly, children may exhibit increased fear, anxiety, behavior problems, and aggression, though findings among children are more mixed [99, 100]. Intimate relationships also appear to be adversely impacted by PTSD resulting in greater conflict and less intimacy [99]. Though studied less frequently, severity of depression symptoms among combat veterans may also be associated with increased family problems and intimate partner violence particularly during the reintegration period [100].

Demographic Moderators

A number of characteristics of military families may strengthen or attenuate the relationship between deployment experiences and adverse outcomes. For example, a meta-analysis of the relationship between deployment and adjustment among children concluded that the small association found was moderated by age. In this study, this relationship was detectable in early and middle childhood, but not in adolescence [8]. Other studies, however, have also found significant relationships between deployment experiences and adverse outcomes among older children and adolescents [30, 33]. Findings associated with child gender as a moderator are mixed. In one study, for example, girls exhibited increased externalizing behaviors during a parents' deployment compared to following their return, while boys exhibited the opposite pattern [31]. Other studies have suggested that boys may be more impacted during deployments [101]. Similarly the gender of the deployed parent may also be an important factor in understanding the strength and direction of the relationship between deployment and adverse outcomes, though evidence is similarly inconclusive [81, 102]. Service member rank may also moderate these relationships, although it is not clear whether these distinctions are related to the unique experiences of service members at different ranks or are ultimately a function of socioeconomic status which is closely tied to rank [37, 101]. Finally family type may also impact these relationships; dual military and single parent military families are rarely researched but their experiences during deployment may be significantly different [21].

Mechanisms

While the adverse impact of deployment on spouses, children and families has been relatively well documented, the mechanisms that underlie these associations are less well understood and may be of particular importance to clinical interventions.

Qualitative research with military spouses and children suggests a number of experiences associated with deployment may explain increases in adverse outcomes. For example, spouses reported increased stress associated with the challenges of single parenting as well fear and worry for the well-being of their loved one [103]. Further, increased demands on spouses' time during a deployment may prevent them from accessing protective factors, like exercise and social connections, that could counteract increased stress [104]. Qualitative work with military-connected adolescents also suggests that worry about their deployed parent, increases in responsibilities at home, and increased conflict or tension in family relationships may accompany parental deployment, which could explain adverse outcomes for some youth [46]. Further quantitative research is necessary in order to better understand these underlying mechanisms.

Interventions

Though an exhaustive treatment is outside the scope of the present chapter, there are several existing evidence-based interventions that address the unique needs of military families. Families OverComing Under Stress (FOCUS) is a preventative intervention that teaches resiliency skills surrounding the deployment cycle or transitions in military life [2, 105, 106]. After Deployment, Adaptive Parenting Tools (ADAPT) is an intervention designed for military parents with children ages 5–12 years old who have experienced a combat-related deployment [107]. Other programs include STRoNG Military Families [108, 109], HomeFrontStrong [110] and Strong Families Strong Forces [111], though these programs are only available in certain locations. Clinicians interested in referring to these programs or getting trained should visit program websites.

While the majority of programs focus on active duty families, some address the transition out of the service, including Sesame Street for Military Families: Transitions [112]. In addition, standard mental health treatments have also been evaluated in military populations, including behavioral couples therapy [113], or cognitive behavioral therapy for military children coping with deployments [114]. Further, several non-profits have started to provide free family-based services, including the Cohen Veterans Network [115]. See Table 22.1 for a list of free, national, in-person and remotely available resources for military families.

Treatment for the Fisher family included meeting with parents and children in separate sessions to build rapport and explore issues from different perspectives before bringing the whole family together. Once together, treatment was guided by the family's goals. Based on these goals, sessions focused on developing and practicing coping and communication skills. Coping skills included developing emotion regulation capacity and identifying activities that grounded each family member when feeling dysregulated. Communication skills included active listening, paraphrasing, and using I-statements to describe feelings.

Through this brief resiliency training, all members of the family were able to build on their greatest strength, love for and commitment to each other, as well as address areas of vulnerability, including communication and individual mental health. Brief preventative approaches to treatment can be particularly beneficial in military families because they can serve as an entry point into individual mental health care. Through this entry point, additional referrals to ongoing services were made.

Table 22.1 In-person and remotely available clinical resources for military families

In person military family resources	Remote military family resources
Give an Hour: A national network of mental health professionals who provide free mental health services for specific populations in need. Give an Hour has been serving military families since 2005 • www.givenanhour.org • Email: info@givenhour.org	**DoD family readiness council information page**: This page is a Facebook informational page where active duty families can learn about the Department of Defense Family Readiness Council, including getting a family needs assessment[a] www.facebook.com/DoDMFRC
The Fisher House Foundation: Builds comfort homes where military and veteran families can stay free of charge while a loved one is in the hospital. Homes are located at military and VA medical centers around the world • www.fisherhouse.org	**Operation We Are Here**: One-stop hub of resources for the military community and military supporters that offers a variety of resources for families • www.operationwearehere.com
Veterans Affairs Intimate Partner Violence (IPV) Assistance Program: This program is committed to helping Veterans and their partners who are impacted by IPV. Click on the link below to see what options are available in your location[b] • www.socialwork.va.gov/IPV/Index.asp	**Blue Star Families:** Bridges the gap between military family communities and the general public by providing free resources, services, and opportunities to more than 1.5 million military family members. Services are tailored more for active duty but they also offer support to veteran families as well • www.bluestarfam.org
Tragedy Assistance Program for Survivors (TAPS): Offers compassionate care to all those grieving the loss of a loved one who died while serving in our Armed Forces or as a result of his or her services[d] • National Military Survivor Helpline: 800-959-TAPS(8277) • www.taps.org	**National Military Family Association:** This association uses a grass roots approach to speak up on behalf of military families and empowers husbands, wives, and children of service members to understand and access their benefits[a] • www.militaryfamily.org
Cohen Veterans Network: Serves veterans and their families by providing high-quality, accessible, and integrated mental health care in person or through tele-health. Has clinics across the country[d] • www.cohenveteransnetwork.org	**Military OneSource**: Military OneSource (MOS) supplements existing family programs by providing a website and a worldwide, 24 h, seven-day-a-week information and referral telephone service to ALL active, Guard and Reserve Soldiers, deployed civilians and their families. Services are provided at no-cost • Call: 1-800-342-9647 • www.militaryonesource.mil

Families OverComing Under Stress (FOCUS): Provides resiliency training to military children and families who are active duty or in the reserve. It teaches practical skills to meet the challenges of deployment and reintegration, to communicate and solve problems effectively, and to successfully set goals together and create a shared family story[d] • www.focusproject.org	**Yellow Ribbon Reintegration Program**: Department of Defense-wide effort to promote the well-being of National Guard and Reserve members, their families and communities, by connecting them with resources throughout the deployment cycle. Through Yellow Ribbon events, Service members and loved ones connect with local resources before, during, and after deployments[c] • www.yellowribbon.mil
The Armed Services YMCA (ASYMCA): Has provided support services to military service members and their families for more than 140 years. It offers essential programs such as childcare, hospital assistance, spouse support services, food services, computer training classes, health and wellness services, and holiday meals, among many others[b] • www.asymca.org	**Penn State Clearing House**: Built for clinicians providing services to military families, the Clearinghouse Continuum of Evidence is an interactive, searchable database of evidence-based programs that address a wide variety of family and mental health issues, such as healthy parenting, financial literacy, nutrition and physical activity, stress, anxiety, and depression. • https://www.continuum.militaryfamilies.psu.edu/search
Family Readiness Systems: A network of agencies and services that promote the readiness and quality of life of all military families. Programs provide a range of services from financial management to child abuse prevention. Visit the website below for a list of contact points for all services[a, d] • https://www.militaryonesource.mil/family-relationships/family-life/keeping-your-family-strong/family-readiness-system	**Sesame Street for Military Families**: Sesame street has created several online programs for military families with young children covering a range of topics from leaving for or returning from a deployment to leaving the military altogether. Their website outlines the programs available by topic • www.sesamestreetformilitaryfamilies.org

[a] Services available for active duty only
[b] Veteran family focused
[c] National Guard and Reserve family focused
[d] Both in-person and remote or telehealth services available

Conclusions

Though limitations in current research exist, including a relative lack of longitudinal data and studies including multiple reporters from the same family, the existing literature suggests that the majority of military families are resilient, but that a significant subset is in need of additional supports from military and civilian communities alike. Families that have experienced longer or more deployments and families in which the at-home spouse has been adversely impacted may be at particularly elevated risk. Adverse impacts experienced at the individual level, by military-connected children or spouses, or at the family level have the potential to spread to other individuals or subsystems within a family. Thus, informed and timely prevention and intervention efforts to support the wellbeing of these individuals and families can have a compounding positive effect on military families as a whole. As a nation that benefits from their sacrifices, clinicians, researchers, and policy makers share a responsibility to respond effectively to the needs of military families experiencing deployment-related stressors.

Clinical Pearls

When working with military families, it is important to keep in mind several unique aspects of this population:

- A service member's military service may not be their main reason for seeking treatment. However, issues related to their service may still be present and important context for presenting problems.
- Military families may also seek treatment for reasons that are not specific to their family member's service. Military families experience many of the same stressors as the civilian population; the family should guide the focus of treatment.
- If a military-connected child is experiencing mental health issues, it may be important to assess the child's parents, considering the strong empirical relationship between parent and child mental health problems in this population.
- A complete biopsychosocial assessment that considers both normative and military specific risk and protective factors is critical when working with military spouses, children or families. As in work with civilian families, understanding the interplay between these factors will ultimately determine the focus of treatment.
- Military families have many strengths that can be leveraged to achieve positive treatment outcomes. These may include practiced resiliency through the experience of hardships and transitions during service, potentially stable income and housing, and free access to supports and services including health care and educational benefits (see Table 22.1).
- There is significant stigma and self-stigma around help seeking in the military culture, which extends to the spouses, children and families of service members. Civilian providers should be sensitive to the challenges stigma presents to seeking and following through with mental health services. During treatment, it may be necessary to reframe seeking mental health treatment as a strength in order to combat the effects of self-stigma.

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