The Potential Benefit of Child Life Services for U.S. Army Soldiers and Their Families

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Master of Science

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This thesis titled
The Potential Benefit of Child Life Services for U.S. Army Soldiers and Their Families

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ABSTRACT

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Child life specialists in the most basic sense are, “trained professionals with expertise in helping children and families overcome life’s most challenging events” (Child Life Council, n.d). While the vast majority of certified child life specialists (CCLS) practice in hospital settings there is a growing demand for child life supports beyond the hospital. With one-half of American military personnel currently married with children and nearly 500,000 children under the age of eight experiencing the deployment of one or both parents (Petty, 2009), the potential benefit of child life services for the military family population needs to be reviewed and child life interventions developed.

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CHAPTER 1: INTRODUCTION

Background Information

Child life specialists in the most basic sense are, “trained professionals with expertise in helping children and families overcome life’s most challenging events” (Child Life Council, n.d). While the vast majority of certified child life specialists (CCLS) practice in hospital settings there is a growing demand for child life supports beyond the hospital. Child life specialists have established positions in bereavement programs, camp settings, the legal system, child advocacy centers, and trauma and crisis teams (Hicks, 2008). Child life specialists, irrespective of setting, utilize adapted practices from the core concepts of child life: coping, distraction, education, developmental play, and support.

These concepts can be applied to any child or family experiencing a stressful situation. With one-half of American military personnel currently married with children and nearly 500,000 children under the age of eight experiencing the deployment of one or both parents (Petty, 2009), the potential benefit of child life services for the military family population needs to be reviewed and child life interventions developed and explained. The military family and hospitals/medical facilities are not mutually exclusive. As of January 2005, more than 1,400 members of the U.S. Armed Forces were killed serving in Operation Iraqi Freedom (OIF). These deaths resulted in more than 900 children losing a parent. Thousands of more families have experienced life-altering injuries. It is “of the utmost importance that children be properly prepared before visiting the hospital” (Cozza, Chun, & Polo, 2005, p. 374). Opportunities also exist for educating
families on possible experiences before, during and after deployment; providing coping strategies for dealing with the anxiety that presents itself during a time of family crisis; and, developing programs that emphasize the need for play as an outlet in times of stress.

Statement of the Problem

Serving in the military requires a sincere commitment to both mission and family. No other occupation requires families to be on constant alert for impending physical and emotional danger (Petty, 2009). Military families consistently experience stressful life events including permanent change of station (PCS), deployments, risk of injury or death, and stress caused by media portrayal of military conflict. Several studies indicate a strong need for trained professionals to assist military children and families cope with these stressors, provide education and preparation (especially preparing children to see injured family members), and assist in the reintegration process for family members after long separations (Cozza et al., 2005; Di Nola, 2008; Harrison & Vannest, 2008; Hoshmand & Hoshmand, 2007; Knox & Price, 1999; Lamberg, 2004; Lamberg, 2008; Palmer, 2008; Rotter & Boveja, 1999; Ryan-Wenger, 2001).

Research Questions

Having one or both parents serving in the military places a child in a perpetually stressful situation. Child life specialists have the training and skills set necessary to assist these families. This study seeks to answer the following questions: (a) What life stressors do military families experience?; (b) How can child life skills be applied to help U.S. Army families cope with the stressors of military life?; and (c) How do the principles of family-centered care correlate with the experiences of U.S. Army families?
Purpose of Study

This study provides an opportunity to gain insight into a population that consistently experiences stressful life events as well as a chance to evaluate the potential benefit of child life services for this population. With the scarcity of pertinent qualitative research on the topic of overall military family well-being is it also my hope that this research will assist others in further research and the development and implementation of child life programming and interventions for this deserving population.

Limitations

The qualitative nature of this study will prohibit the knowledge achieved from being widely generalized to other populations. The views and experiences of the participants will entirely shape the collected data.

Also, the scarcity of research in the field of child life combined with the lack of well-coordinated evidence-based practice for current military family service programs present a significant challenge. Much of the available data on military families was gathered post Operation Desert Storm. Because there are significant differences in the length of tours, the number of tours completed by individuals, and the effects the repeated deployments have had on families since the onset of Operation Iraqi Freedom and Operation Enduring Freedom (Cozza et al., 2005), there is a great need for research to reflect these differences.

Definition of Terms

*Joint Commission on the Accreditation of Healthcare Organizations (JCAHO):* The Joint Commission is an independent, not-for-profit organization that accredits and
certifies more than 17,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationally as a symbol of quality and reflects an organization’s commitment to meeting certain performance standards. (The Joint Commission, 2010).

*Permanent Change of Station (PCS)*: PCS is an acronym commonly used by the Army to refer to a soldier or family’s move or transition from one base to another.


*Chaplain Assistant*: Chaplain Assistants provide much needed support to the Chaplains during missions and everyday activities. A Chaplain Assistant primarily provides support for the Unit Ministry Team programs, worship services, and crisis intervention (U.S. Army, 2010).

*Chaplain*: A Chaplain is an Officer who leads a Unit Ministry Team. Chaplains care for the spiritual well-being of Soldiers and their families. Army Chaplains are the spiritual leaders of the Army and also perform religious ceremonies (U.S. Army, 2010).

*Infantry Captain*: An Infantry Captain is an Officer who commands and controls 62 to 190 Infantry Soldiers (a company) with an assistant. The Captain teaches skills at service schools and training centers.

*Chief Warrant Officer*: A Chief Warrant Officer becomes a commissioned officer as provided by the President of the United States. A Chief Warrant Officer is a tactical
and technical expert who provides the direction, guidance resources, assistance, and supervision necessary for subordinates to perform their duties (U.S. Army, 2010).

*Infantry Sergeant:* An Infantry Sergeant is enlisted and typically commands 9 to 10 Infantry Soldiers (a squad). A sergeant is considered to have the greatest impact on soldiers because sergeants oversee soldiers in their daily tasks (U.S. Army, 2010).
CHAPTER 2: CRITICAL REVIEW OF LITERATURE

Child Life

Child life is a relatively new field. In the early twentieth century, the number of children receiving treatment at hospitals began to increase. At the time it was thought that children who were sick enough to be in the hospital were in essence too sick to play. These children suffered greatly as they had nothing to do but lie in bed and wait for the next potentially scary or painful treatment or procedure. Regardless of external factors, play is vital to childhood (Wojtasik & White, 2009). The earliest programs, formed in the 1920’s, had play leaders who educated volunteers and nursing staff on communication through play. In 1955, Emma Plank created a program to address the non-medical needs of hospitalized children at Cleveland City Hospital. The field of child life experienced rapid growth in the 1970’s and 1980’s and the Child Life Council (CLC) was officially formed in 1982. The CLC is the representative group for individuals who seek to assist children and families during challenging events. Members include child life specialists, child life assistants, educators and students, hospital staff and others who work in related fields (CLC, n.d). The professional certification method of credentialing was established in 1986, and the professional method of certification by exam decided upon in 1998 (CLC, 2006). Currently more than 600 organizations worldwide have members in the Child Life Council (CLC, n.d).

According to the CLC (2006) the goal of child life programs is to “support and enhance existing child and family abilities to cope with potentially difficult or even overwhelming circumstances, with the belief that with each experience can come a sense
of mastery that is the foundation for coping with future stressful situations” (p. 1). This goal is accomplished through the specialists’ application of knowledge of growth and development as well as effective family and child preparation, communication, and play (CLC, 2006).

**Healthcare Stressors**

The CLC has compiled a list of the variety of stressors children and families encounter in healthcare settings. They include: “(a) fear of unknown materials and procedures, (b) both physical and emotional pain, (c) isolation, (d) waiting, (e) loss of control over their situations” (2006). Hospitals, physicians’ offices, dental clinics and other healthcare settings are full of materials and fixtures that can be threatening to children who have not had previous experiences with such equipment. These unknown materials are often utilized during procedures the child is also unfamiliar with. Routine procedures such as the use of an otoscope to view the inside of the ears or a stethoscope to listen to the heart and lungs can be unnerving to children who do not understand the materials that they are being examined with or the purpose of the procedure itself. Unfortunately many medical procedures are not pain free. Children and their families experience both physical and emotional pain as the result of medical treatment. Physical pain can be the result of an accident or injury that requires medical attention, or the outcome of a surgery, blood draw, or immunization. Emotional pain results from the anxiety medical treatment may cause as well as cases in which no treatment exists. Children with chronic medical conditions or serious injuries that require lengthy or frequent hospitalizations may also experience isolation if their family members are
unable to remain with them in the hospital. Families experience isolation too; managing the healthcare needs of their children can easily become a full time experience leaving little time for friends and hobbies as well as the feeling that those who have not experienced living with an ill child are unable to comprehend the situation (Boss, 2007). The act of waiting is a frequent stressor in the healthcare realm. There is the waiting that occurs in doctor’s offices for appointments and test results as well as the longer waiting times for example, waiting to see if a treatment has been successful, waiting for a transplant to be available, or waiting for a treatment to be developed. These stressors all include the element of loss of control. In healthcare settings families are constantly adjusting to the fact that there is little they can control in the way of their child’s illness. This loss of control can lead to feelings of helplessness for both the patient and the family.

As research revealed the negative impact of these stressors, pediatric health-care professionals began to develop preparation programs aimed to reduce anxiety in the children and their families and to promote effective coping strategies (Mahan, 2005). Studies continually demonstrate the psychological benefit of effective preparation for hospitalization and medical procedures for both parents and children (Stanford & Thompson, 1981). Mahan stated “The most effective programs are shown to contain four key elements: (a) conveying information to the child in a developmentally appropriate manner, (b) encouraging the expression of feelings about the information or event, (c) including the participation of parents or other significant family members, and (d)
establishing a trusting therapeutic relationship between families and staff members (2005).”

By conveying information to the child in a developmentally appropriate manner, the child life specialist ensures that the preparation itself does not become an overwhelming experience. Also, through the course of developmental assessment, the preparation is tailored to the child’s developmental level as opposed to chronological age. Encouraging the expression of feeling about the information or event allows the child life specialist to address concerns that are raised and correct any misconceptions that may exist. Including the participation of parents or other significant family members ensures that family members have the same understanding and demonstrates respect of the fact that family members are the people who know the child the best. Establishing a trusting therapeutic relationship with staff members provides a means for open communication in the future as well an outlet for patients and families to turn to when they need support. By providing preparation for the family as well as the patient, the family becomes an active participant in the healthcare experience as opposed to a bystander.

**Family-Centered Care**

Family-centered care is an approach to healthcare that aims to promote coping in families through partnerships between family members, patients, and healthcare staff. The family is the unit in an individual’s life that remains constant, and family-centered care capitalizes on this constant by recognizing that it has great impact on the well-being of the individual. The relationships between healthcare staff and families are fostered through collaboration and discussion of needs, family dynamics, and priorities (Bell,
Johnson, Desai, & McLeod, 2009). The concept of family-centered care has evolved substantially over the past 50 years. During this time, patients and families began to seek more control over their care and greater access to psychosocial support (Johnson, B. H., 2000). A shift was also seen in hospital administration as parents, who were originally viewed as visitors with strict visitation policies, were granted 24-hour access to their children (Bell et al., 2009).

Family-centered care is crucial to successful child life interventions. Bell et al. (2009) identified nine best practice elements of family-centered care: (a) recognize that the family is the constant in the child’s life, while healthcare professionals and services systems often change; (b) facilitate parent and professional collaboration at all levels of healthcare; (c) honor the racial, ethnic, cultural, and socioeconomic diversity of families; (d) share complete and unbiased information with parents on a continuing basis and in a supportive manner; (e) implement comprehensive policies and programs that provide emotional and financial support to meet family needs; (f) recognize individual family strengths and respect various methods of coping; (g) understand and incorporate the developmental needs of infants, children, and adolescents and their families into healthcare systems; (h) encourage and facilitate family-to-family support and networking; and (i) design accessible healthcare delivery systems that are flexible, culturally competent, and responsive to the needs that families identify. These elements are utilized in all facets of care. Not only do they dictate patient interactions, they guide the planning and implementation of new programs, the language used in hospital publications, and job descriptions as well. Adherence to the elements of family-centered care is required for
accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) (Bell et al., 2009; JACHO, 2002). Many of these elements have the potential to transfer to a military setting and will be explained further in Chapter 5.

Special Issues for Children in Healthcare Settings

Infants and Toddlers (Birth to 3 years)

The hospitalization of an infant creates a plethora of stressors for parents. In a time where they are supposed to be loving, feeding, and comforting a new child, they are faced with the reality that their baby is very ill. The main issues surrounding hospitalization for infants are separation, lack of stimulation, and pain. Separation anxiety and the negative impact it has on development is one of the reasons parental involvement is key. Parents can also provide a sense of comfort and support for infants experiencing painful procedures. Studies have shown that for this age group, providing a supportive environment for parents is also essential to creating positive parent-child bonding in later life (Pearson, 2005).

As infants grow to toddlers, they gain autonomy and master experiences through play. Toddlers also experience comfort in routines. As such, it is important to respect routines from home in the hospital setting whenever possible to provide a sense of normalcy for the child. When the toddler experiences a drastic change in routine or loss of situational control, they are likely to regress to earlier behaviors as a means of coping with the change. Toddlers are also developing the capacity to remember procedures and may respond with physical resistance and uncooperativeness when they anticipate or perceive stress. With this capacity for memory, however, toddlers are also able to benefit
from medical play and developmentally appropriate preparation for procedures. Parents of toddlers also benefit from preparation, and when a parent is less anxious their child responds similarly (Pearson, 2005).

Preschoolers (Ages 3 to 5)

Preschool children are more independent than toddlers and, as such, are more likely to have negative responses to the loss of control and mobility the hospital often causes. Children in this age group are magical thinkers. They often believe that they can change things by wishing or magic. They may also view hospitalization as a form of punishment. In both cases, it is essential to provide concrete reasons for procedures. Preparation and medical play can also be used to assess where potential misconceptions may lie in order to address them before they overwhelm the child. Preschoolers still utilize play to discover and learn about their world and, as such, providing opportunities for play is essential. Places for play should also be places free from painful procedures. Designating “safe spaces” is essential in the development of a child’s sense of security even away from their home (Pearson, 2005).

School-Age Children (Ages 5 to 11)

School-age children have accomplished a great deal of developmental tasks since their preschool years. They are more social and able to form bonds with adults and peers outside their family unit. School-age children are also cognitively able to process and comprehend the meaning and need for treatment and medical procedures when explained. The primary stressor associated with hospital stays for school age children is being separated from their families. By providing support for both patient and families and
providing effective means of communication when separation is necessary, child life professionals can ease the stress caused by these separations. Child life support is also essential with this age group, because they are able to process the effect an illness or injury may have on their daily functioning. Normalizing the hospitalization as well as life after the diagnosis as much as possible is critical for further healthy development (Pearson, 2005).

**Adolescents (Ages 11-19)**

During adolescence, children begin to rely more on their peer groups than family units. Hospitalization disrupts this process both by causing separation from peer groups, and by forcing adolescents’ dependency on adults. Adolescents also struggle with insecurities about their image and self-worth. The hospitalization experience can also disrupt a time of planning for the future. Interventions for adolescents should focus on providing peer support to aid in their ability to form relationships with peers. Respecting the insecurities adolescents have is also very important, for example, by making sure the adolescent is given privacy when needed and by ensuring that normal tasks like shaving, washing hair, and applying makeup can be completed whenever possible. Providing links to peer groups outside the hospital is important for helping adolescents maintain contact with their friends even when they cannot participate in familiar activities (Pearson, 2005). Assisting adolescents to find supportive peers with similar conditions can also be accomplished through the use of programs outside the hospital setting, many of which also employ child life specialists.
Alternative Child Life Settings

While child life specialists have traditionally utilized their skills in hospital settings, the growth of the field has provided the opportunity to explore the application of child life practices in alternative settings. Providing coping strategies and preparation can apply to a variety of family-oriented avenues without a medical focus. While one working outside the hospital setting may not be called a child life specialist, the competencies and skills required for providing assessment and interventions to families dealing with stressful life experiences remains the same (CLC, 2006).

Camp Programs

Camp programs provide memorable experiences for children by providing opportunities to experience new and diverse activities, develop social skills, cultivate friendships, and realize spiritual growth. In a study of 80 camps accredited by the American Camp Association, parents, campers, and camp staff alike reported significant levels of growth in self-esteem, independence, leadership, social comfort, peer relations, values and decisions, and spirituality (Philliber Research Associates & The American Camp Association, 2005). A multitude of specialty camps exist to provide opportunities for children who are medically unable to attend typical camps and to bring together groups of children who are experiencing similar stressful situations like the serious illness of a sibling or the military deployment of a parent (Kinik, 2008; Shafer, 2008).

Some of these medical specialty camps already benefit from the presence of child life support. In the camp setting, child life specialists can provide many services, from assistance in program development and facilitation, providing assessment and appropriate
developmental interventions for camp issues like homesickness and separation anxiety, to acting as a liaison between the camp and family members. Child life staff may also provide consultation with newly diagnosed families and those who have not experienced camp before (Hicks & Sweeney, 2008).

School Programs

Children experience a diverse array of stressors throughout the course of childhood. Some may be hospitalized as a result of a serious car accident or the diagnosis of a chronic illness. Many more, however, have relatively short hospital stays for elective surgeries. Many children also experience the stress involved with grief and loss whether it is the death of a grandparent or even that of a beloved pet. While child life services provide many preparation and support programs, not all children receive these programs.

One rural New York school developed a program to support children who were having surgery or had parents or siblings who were injured or ill. This program allowed children to receive child life support at school (Brown, 2008). The program located in the school’s Wellness Center, provided a comfortable atmosphere for children to visit and receive preparation for doctor’s visits and surgical procedures from a certified child life specialist after the school receives parental permission. The children were given materials to help them cope with the hospitalization experience, the opportunity for medical play, as well as a scrapbook to help them document their surgery and take ownership in the experience by sharing the scrapbook with their classmates upon their return to school if they chose (Brown, 2008).
The child life program at the Wellness Center was also able to provide long term professional support to these students through emotional expression games, story-telling, education on coping techniques, and music and relaxation activities (Brown, 2008). These interventions were essential as research has shown that children who experience traumatic life events showed decreased academic performance and prolonged anxiety (Abdelnoor & Hollins, 2004). The child life specialist in the school setting is also centrally placed to create a coping team with parents, teachers, social workers, school psychologists, and the medical professionals associated with the children’s care.

Trauma or Crisis Teams

Child life specialists who work on trauma or crisis intervention teams utilize their skills to aid children and families who have experienced or been exposed to an event that overwhelms their current coping abilities. The scope these crisis teams operate within is extremely varied and includes natural disasters such as hurricanes or earthquakes as well as human created crises like murders, robberies, or motor vehicle accidents. In typical medical situations, child life specialists make initial assessments and then tailor interventions to the specific needs of the child or family. In a crisis team setting, child life specialists work in conjunction with emergency services to provide coping and support measures as well as educational debriefs following traumatic incidents (McCue & Johnson, 2008). Child life specialists’ presence outside the hospital is also seen in funeral homes, legal systems, dental clinics, bereavement programs, private practice, and in a consulting capacity.
Military Families

In 1978, Lagrone utilized the phrase “military family syndrome” to define a set of traits he associated with the negative ramifications of growing up in an autocratic military family or community (Cozza et al., 2005). Recent studies however, show that there are no significant differences among children in military and civilian children in measures of anxiety and other psychopathology (Ryan-Wenger, 2001). Many now attribute the creation of such a syndrome to overwhelming antimilitary sentiment after the Vietnam War (Cozza et al., 2005). Recently the main concerns surrounding children who have military parents include deployment related stress, illness, injury or death of a parent, and family relocation (Burrell, Adams, Durrand & Castro, 2006; Cozza et al., 2005). According to Cozza et al. (2005), “It would be destructive to assume either widespread pathology or uniform resilience as a result of these wartime experiences” (p. 372). Although thousands of families share similar experiences with the military, their reactions to these stressors can vary greatly.

Deployment

Roughly 1.6 million American soldiers have deployed to war zones since the onset of Operation Iraqi Freedom and Operation Enduring Freedom. More reserve troops are being called to deploy than ever before (Sammons & Batten, 2008). One-third of these soldiers have served at least two tours in a combat zone (American Psychological Association, 2007; Lincoln, Swift, & Shorteno-Fraser, 2008). These soldiers are leaving behind their friends and families to work in dangerous war zones. The majority of military couples are under the age of 35 (Hoshmand & Hoshmand, 2007) and, quite
frequently, the families they leave behind include children. Approximately 44% of active
duty soldiers have children; two-thirds of these children are less than 5 years old
include two parents on active duty. All military family members face inordinate amounts
of stress as they learn to operate without vital members. Families have difficulty coping
with the reality that they will never be able to return to the “normal” lives they knew
before deployment (Boss, 2007).

The deployment experience is typically described as a five-stage cycle. The stages
are: predeployment, active deployment, sustainment, redeployment, and postdeployment.
Predeployment is the period of time from the notification of an upcoming deployment
until the day the soldier leaves. This can be a tumultuous time for families as preparations
are made for the separation. Active deployment describes the first month of the
deployment in which attempts are made to establish new routines and cope without the
deployed family member. Sustainment lasts until one month before the deployed soldier
returns home. For the most part, the family has established new routines and has
developed a support network to aid in coping. Redeployment is the final month of the
deployment in which preparations are made to reunite the family. While this can be a
very exciting time, it is also a time of mixed emotions, because changes must once again
be made to the family routine. Postdeployment is the period of time following the return
of the soldier and can last for up to six months. Renegotiation of family roles and tasks
occurs during this time (Lincoln et al., 2008; Pincus, House, Christensen & Adler, 2005;
Zero to Three, 2007). Postdeployment can often be more stressful than the deployment
itself. While families have worked diligently to adjust to the change of having a deployed parent, the deployed parent has not been able to see such changes and often expects the family to function in the same way as before he/she deployed (Lombard & Lombard, 1997).

The stressors surrounding deployment begin to appear long before a parent or loved one leaves. During wartime, in military communities and reserve families alike, there is always the fear that the parent’s unit will be mobilized and deployed (Huebner, Mancini, Wilcox, Grass, & Grass, 2007). While both military children and civilian children tend to believe there is nothing good about war, military children tend to have more anxiety surrounding the idea of war. Military children believe that the war will “take” their parents, and that the deployed parent will die. This anxiety is present in military children during any instance of war, whether the parent has received deployment orders or not. Military parents, however, are not the primary sources of information about war. Military children are more likely to obtain information from teachers and the media. This phenomenon exists because many military families avoid discussion of the topic in order to keep their children from developing anxieties about what war could mean to their family (Ryan-Wenger, 2001). According to Lincoln et al. (2008), “having a parent sent to an active combat zone with an undetermined return date may rank as one of the most stressful events of childhood, especially as the coping resources of the remaining parent may be compromised by his or her own distress and uncertainty” (p. 984).

When the unit is mobilized, the stressor becomes finding a way to function while the family member is gone. After the unit deploys, the family fear shifts to concern for
the well-being of the deployed family member with anxieties ranging from “where are they now? “ to “will we ever see them alive again?” Even if the unit redeploys safely, a new group of challenges emerge as the service member attempts to reintegrate into the family (American Psychological Association, 2007; Huebner et al., 2007). Even a safe return cannot diminish the stress and familial strain experienced during the deployment (Huebner et al., 2007).

*Risk of Injury or Death*

Another major stressor for families is the fact that not all soldiers redeploy safely. While the worry about the potential for injury or death while serving may be ever present, true panic sets in upon the notification of a casualty. Although there have been improvements in the notification process, it is not unusual for initial information to be inaccurate or incomplete, thereby causing more anxiety for the family (Cozza et al., 2005).

The number of soldiers surviving serious injuries in Iraq and Afghanistan has risen dramatically with advancements in military medicine and improvements in protective body armor (Collins & Kennedy, 2008; Sammons & Batten, 2008). The physical injuries most commonly sustained are blast injuries, a result of the improvised explosive devices used in insurgency warfare. Blast injuries are often traumatic to multiple body systems and can require extensive rehabilitation (Collins & Kennedy, 2008). With vast technological advances, the American military has reached a point where physical injury associated with combat is vastly surpassed by psychological morbidity. The number of soldiers returning home with posttraumatic stress disorder
(PTSD) continues to climb (Sammons & Batten, 2008). Combat exposure has been directly associated with higher experience of PTSD symptoms and poorer family outcomes such as substance abuse, spousal or child abuse, and marital struggles (Taft, Schumm, Panuzio, & Proctor, 2008).

The development of PTSD can also have a significant impact on a family’s ability to function and the marital relationship of the parents. Marital adversity as marked by increases in infidelity, partner violence, divorce, and separation has been shown to increase directly with exposure to combat (Gimbel & Booth, 1994; Taft et al., 2008). Though it is hard to gather accurate statistics substance abuse and depression are on the rise as well (Sammons & Batten, 2008). It is imperative to recognize that the long-term rehabilitation needs of these soldiers have a substantial impact on their families (Collins & Kennedy, 2008).

According to Collins and Kennedy (2008), “families of patients with traumatic brain injuries (TBI) show an increase in stress, caregiver burden, depression and social isolation over time” (p. 995). These changes in the family members are strongly related to the emotional and personality changes of the injured family member. While many families of injured soldiers had considered the possibility of severe physical injury or death as a result of combat few envision long-term personality changes, loss of behavioral functions or the potential for minimally conscious states of brain function (Collins & Kennedy, 2008).
**Permanent Change of Station**

Deployment is not the only reason for military family separation. Soldiers may also be separated from their families for field-training exercises, educational opportunities, and peacekeeping missions (Burrell et al., 2006). Mobility is a consistent factor in the lives of soldiers and their families. To accomplish the Army’s mission, relocation is expected every two to three years (Burrell et al., 2006). This relocation is known in the Army as a Permanent Change of Station (PCS). Research studies on the effects of multiple moves on children have yielded mixed results (Palmer, 2008). Some report that academic performance may be negatively impacted (Long, 1986; Palmer, 2008; Temple & Reynolds, 1999). Others report that frequent moves may not be the cause of any academic struggles or psychosocial problems (Jensen, Lewis, & Xenakis, 1986; Palmer, 2008). Parental attitude and adjustment to the relocation process and the move itself often play a more influential role in the reactions of children (Finkel, Kelley, & Ashby, 2003). Palmer (2008) suggested that assessing how parental attitudes influence parent-child interactions “may be important in understanding how relocation may be a risk factor for some military families and not others” (p. 207). It is also important to note that the sheer number of relocations plays less of a role in the outcome of the experience than the frequency of the relocation (Weber & Weber, 2005).

**Foreign Posts**

Soldiers in the U.S. Army may also be stationed at posts in foreign countries. Residence in a foreign country can cause added family stressors, because families must adjust to a different culture and language. While foreign residence provides for
educational opportunities and new experiences, it may also lead to negative family outcomes such as decreased physical and psychological well-being (Burrell et al., 2006).

Current Support Systems

Active duty Army families are offered formal support systems through Family Readiness Groups (FRG). Early FRGs can be dated back to the Civil War, at which time they were referred to as Wives’ Clubs. The formal implementation of the FRG followed the Persian Gulf War. All branches of the U.S. military have similar programs. The role of these programs is to keep families informed and updated throughout times of deployment (Di Nola, 2008). While these programs can be beneficial for the spouses of deployed soldiers they do not always provide information that is developmentally appropriate for the children in the family.

Another professional family support is the presence of social workers in a variety of military facilities including hospitals, mental health clinics, child advocacy and family violence units, and family support and assistance centers. The military has hired an increasing number of civilian social workers over the past 30 years, virtually replacing the recruitment of professional social workers as soldiers. These social workers function as part of a multidisciplinary team alongside military lawyers, chaplains, and Morale, Welfare and Recreation officials. Social workers also present workshops for adults and children alike to forge a sense of community in the families who face similar stressors as well as to assist in the explanation of deployment (Knox & Price, 1999).

Army Family Team Building (AFTB) is a volunteer-led program that teaches family members about Army life by providing education on military topics as well as
information on what formal and informal supports are available to families and how to access them. Participation in AFTB is completely voluntary, and any family may choose to participate. Participants in AFTB gain knowledge and an increased perception of fit with Army life. The knowledge gained also lead to a higher level of satisfaction with the family environment within the Army (McFadyen, Kerpelman, & Adler-Baeder, 2005).

Both actual and perceived resources impact how families cope with separation. Families that are actively involved in the community and friendships perceive less stress surrounding the separation. The availability of support from other families of deployed soldiers also decreases perceived stress (Rohall, Segal, & Segal, 1999). The ability to develop a strong support network is a skill that provides soldiers and their families with greater ability to cope with separations. Higher ranking soldiers report better family adjustment than lower ranking soldiers due, in part, to more developed social networks (Rohall et al., 1999).

Though many supports currently exist, they are not always utilized to their full potential due to the fact that some families fear that using programs will cause them to be classified as unable to handle their own problems (Di Nola, 2008).

Special Issues for Children

The minor children of U.S. Army soldiers do not enlist in their parents’ lifestyles; they do not fight wars or deploy. The military culture is simply the lifestyle they were born into. Without ever signing up these children often serve from birth (Sinor, 2003). There are many issues that affect the youngest members of an Army family.
Multiple Deployments

Military dates of deployment and return are tentative. While this is a difficult concept for most adults to grapple with, it is nearly impossible for children, and can exacerbate children’s feeling of loss and insecurity in situations where the deployment is extended (Petty, 2009). In addition to the idea of extended deployments, children in military families must learn to cope with the fact that their parent(s) will most likely deploy again. For a child just regaining a sense of normalcy during the postdeployment period, this idea can be devastating (Petty, 2009).

Media

Children, especially adolescents, are very aware of the possibility that their parent may return home permanently disabled or perhaps not return home at all. Explicit media coverage of military conflicts continually reinforces this awareness (Huebner et al., 2007). Cozza et al., (2005) stated, “The media (particularly television) serves as military children’s most significant source of stress related to potential parent death” (p. 377). It is important to note that even if a deployed parent returns safely the stress and worry the family experiences during the separation is not diminished (Huebner et al., 2007).

Communication Surrounding Injury

As soon as a family has been notified of a serious injury a whirlwind of events takes place. Children may be relocated to relatives or family friends as the soldier’s spouse journeys, potentially overseas, to be with the injured soldier. This can cause serious disruptions in families already strained by deployment as well as missed school and loss of structure if the children travel. Often, the information shared with children
about the injury is not developmentally appropriate. Rather than focusing on the needs of the children, the anxieties of the uninjured parent may take precedence. It is not uncommon for an excess of information to be shared, causing confusion and anxiety beyond children’s level of coping. Conversely, sharing too little information also leads to situations where children may feel inadequately able to process the severity of the injury.

The rationale behind what information parents choose to share with their children varies from family to family. Some parents withhold information based on their personal desire to prevent their children from experiencing unnecessary worry. This scenario can cause negative family outcomes if the children are developmentally able to handle the information about the injury. The withholding of information from older children and adolescents can create an environment in which parent-child trust is breached and may negatively impact the relationship in the future. Sharing more information than a child is capable of handling, or forcing a child to view an injury in a particular way can also cause overwhelming anxiety (Cozza et al., 2005).

Extended Family

The injury or death of a soldier profoundly impacts significantly more people than the immediate family. Younger siblings, cousins, nieces, and nephews are all examples of children who may be affected by an injury and yet have no access to military support (Lamberg, 2008).

Divorce and Remarriage

While children in military families experience a variety of situations specific to military life, traditional family stressors exist as well. According to Adler-Bader, Pittman
and Taylor (2005) “military service members marry, divorce, and remarry earlier than individuals in the general U.S. population” (pp. 102-103). These shifts in family dynamics provide for a large number of blended families in the military.

*Infants and Toddlers (Birth to 3 years)*

While infants may be cognitively incapable of processing the world around them in the same fashion as adults, they are able to perceive changes in routines as well as emotional changes in their caregivers. Very young children may express their own stress as a result of a deployment or change in parental behavior in several ways including: increased crying or clinging behavior, changes in sleeping and eating patterns, withdrawal, regression in behaviors or skills, and increased attention seeking (Lincoln et al., 2008; Zero to Three, 2007). Around 9 months of age infants develop the capacity to experience sadness and loss; this is the point at which they realize a parent is absent and can develop anxieties when they try to figure out if the parent will return (Petty, 2009).

Those children over the age of 3 are more likely to show external behaviors (Chartrand, Frank, White, & Shope, 2008) such as resisting typical daily behaviors like eating and sleeping (American Psychological Association, 2007; Lincoln et al., 2008). At the point of separation, it is also important to provide even the youngest children with an opportunity to acknowledge the separation by verbalizing goodbye and the intent to return, creating a ritual to share during the separation, or providing a memento to help them understand that the important people in their life do not just disappear (Zero to Three, 2007).
Upon the return home of the deployed parent, very young children may be happy to see their parent, but they may also be fearful or shy. Toddlers are still developing their ability to remember and, while they are capable of recalling an image of a loved one in their minds, the excitement of the situation may make that recall difficult. Being greeted by a crying or frightened child can be devastating for the returning parent. It is important to remember that very young children may need time to “warm-up” to the returning parent (Zero to Three, 2007).

*Preschoolers (Ages 3-5)*

Preschool-age children are experiencing rapid development in the areas of language acquisition as well as gross and fine motor skills. It is not uncommon for preschoolers to exhibit separation anxiety when a parent deploys. This anxiety may manifest itself as excessive clinging to the remaining parent or other caregivers (Petty, 2009). Preschool children are also more likely to regress to behaviors they have previously outgrown (Lincoln et al., 2008; Petty, 2009). Preschool children are capable of expressing some of their emotions in words. They are also able to pick up basic emotional cues from others. It is important to provide preschoolers with information about an upcoming change as soon as it is definite. This preparation allows preschoolers to practice needed coping skills for the actual separation (Petty, 2009).

*School-Age Children (Ages 5-11)*

School-age children are often more cognizant of the inherent dangers associated with war and, as such, can be more prone to sleep disturbances due to worry. Concern for loved ones’ safety can also reduce attention spans; in turn, this may lead to academic
troubles (Lincoln et al., 2008). Prior to a deployment school-age children are often sad about the upcoming separation and may also be angry with the deploying parent for leaving. During the deployment school-age children are more likely to exhibit somatic complaints and changes in mood. Upon reunion, school-age children are usually happy to see the returning parent, but may also act out or express anger about the deployment (American Psychological Association, 2007).

*Adolescents (Ages 11-19)*

Adolescence is, in itself, a time of rapid physical and emotional maturation. Adolescents in military families are not exempt from the typical challenges of adolescence, and yet they also experience both the exciting opportunities and the unique stressors military life provides. While military teens overwhelmingly cite their parents as role models, they also note emotional difficulties when resenting parents who may miss important events like graduation during a deployment (National Military Family Association, 2008). When confronted with an impending deployment, adolescents may withdraw or deny feelings about the separation (American Psychological Association, 2007).

Adolescents are cognitively able to appreciate the realities of wartime and may struggle with the reality that their parent may have their tour extended or be injured or killed during a deployment. Coupled with traditional adolescent anxieties like school and friendships, the deployment of a parent may create added responsibilities for older children especially if there are younger children in the home. While adolescents may welcome added responsibilities and freedoms it is imperative for adults to ensure that...
they are not overburdened (National Military Family Association, 2008). When the deployed parent returns home, it is important that adolescents’ contributions are acknowledged. Changes in household tasks and roles can lead to defiant behavior or disappointment if adolescent feel that the work they did during the deployment was not valued (American Psychological Association, 2007).

By the time an adolescent child in a military family reaches high school, it is likely that they will have spent time in multiple school districts across the country. These changes can be especially difficult during adolescence, because teenagers are more likely than younger children to experience or perceive social rejection and difficulties in establishing themselves in social groups (Drummet, Coleman, & Cable, 2003).

Ambiguous Loss Theory

Ambiguous loss is any loss that remains unclear. In an ambiguous loss there is always a lack of certainty on the whereabouts or status of a loved one. Such loss is traumatizing for the individuals and families who experience it (Boss, 2007). Family groups that consistently face ambiguous loss are military families dealing with deployment, families who have ill children being cared for far away from the home, family members with chronic physical or mental illness, missing persons, and in situations of adoption or divorce (Boss, 2007; Huebner et al., 2007).

Types of Ambiguous Loss

According to Boss there are two types of ambiguous loss: “leaving without goodbye” which describes the absence of a military parent from the home and “goodbye without leaving,” which better describes a patient with a traumatic brain injury, dementia,
or Alzheimer’s disease (2007). It is important to understand that, although the causes of the ambiguous losses may be varied, they have similar effects on the families that must endure them. In either case, there is no possible closure for the families. The ambiguity also causes relationships outside of the family to dissipate, because friends and neighbors do not feel comfortable addressing or relating to the ambiguous loss (Boss, 2007).

Ambiguous loss is present for both military families and the families of children with healthcare needs. For both groups, the loss of “leaving without goodbye” is present. In military families, it is experienced during periods of occupationally related separation in which the family separates with the hope of reuniting but without the guarantee that such a reunion is possible. Families experience this in the health care setting as well, e.g., when they are separated during a surgery. “Goodbye without leaving” is also present for both groups, usually as the result of injury or prolonged illness. In this case, the disabled family member is no longer capable of remembering or effectively communicating with other family members. Regardless of the form of ambiguous loss, families experience grief and anxiety surrounding the ambiguous loss in the same way one would grieve for the physical loss of a loved one.
CHAPTER 3: METHODOLOGY

This qualitative study provides an opportunity to gain insight into the lives of military family members, a population that consistently experience stressful life events, as well as a chance to evaluate the potential benefit of child life services for this population. The study particularly focused on family experiences surrounding deployment, relocation, and communication with children about the hazards of a military occupation. The research questions for this study were: (a) What life stressors do military families experience?; (b) How can child life skills be applied to help U.S. Army families cope with the stressors of military life?; and (c) How do the principles of family-centered care correlate with the experiences of U.S. Army families?

Recruitment

For this qualitative study, an initial convenience sample (Berg, 2007) of two husband-wife dyads was recruited via key informants stationed at an Army base in the Southwestern United States. After the initial interviews, snowball sampling (Berg, 2007) was utilized to identify other dyads for participation in the study. Participants were not recruited until Institutional Review Board approval was obtained.

Study Site

This study was conducted at U.S. Army Installation in the Southwestern United States.
Sample

Participants were required to meet the following criteria: (a) currently married dyad in which one member was serving on Active Duty in the U.S. Army; (b) have at least one child over the age of 2; and (c) be willing to participate in the study.

Description of the Sample

Participants in the study included five married couples (N = 10) in which the husband was serving on Active Duty. Each family had between three and five children with the children’s ages ranging from 20 months to 19 years. In the sample, one mother was employed outside the home as a nurse consultant; the other four mothers were not formally employed. Two fathers were Officers, one father was a Chief Warrant Officer, and two fathers were Non-Commissioned Officers (NCO).

Informed Consent Process

Ohio University’s Institutional Review Board approved the informed consent document on December 16, 2009 (see Appendix A). Participants were given two copies of the informed consent form prior to the interview. The interviewer offered to read the information aloud to each participant and addressed any questions that arose prior to the start of the interview. Before beginning the interview, the interviewer also reminded participants that they were welcome to withdraw from the study at any time. After written consent was obtained, the consent forms were stored in a locked file. All consent forms will be destroyed upon the completion of this research in order to protect participants’ confidentiality.
Interview Procedures

After recruiting two dyads, the initial interviews were conducted in participants’ homes. All efforts were made to ensure the interview was conducted at a time convenient for the participants. All couples consented to be interviewed together and to allow the interview to be recorded digitally utilizing a MacBook and GarageBand software program. Field notes of nonverbal behaviors or interactions were also recorded during the interview. All data collected were transported to and from the interview site by the interviewer. Data located on the MacBook were password protected. The MacBook and all written data were transported in a locked suitcase. During travel via airplane, all data remained in-cabin with the interviewer and were placed into a locked filing cabinet upon completion of travel prior to data analysis.

Interviews were conducted in a narrative interview format. Open-ended questions comprised an interviewer-developed semi-structured protocol (see Appendix B). Since family experiences cannot be easily categorized into numeric and patterned form, the qualitative nature of the study allowed for a more in-depth understanding of family experiences. The interviewer began the interview by providing a basic overview of the child life profession. After that, the dyad was encouraged to share general information about their family and family dynamics. The next portion of the interview focused on the families’ experiences with deployments and PCS. Then, the dyad was asked to discuss how they spoke to their children about the inherent dangers of a soldier’s occupation as well as Army life in general. Finally, participants were asked to share their thoughts on the potential benefit of child life services for Army families. Additional probes were used
to clarify participants’ responses when necessary. The interviews lasted between 20 minutes and 1 hour. The interviewer closed by answering any questions the participants had and thanking them for their participation. Following the interview, participants in the initial wave were asked if they knew any other families who fit the criteria and might be willing to participate in the study. Three additional families were contacted as a result. All families received a thank you note and a $5 Wal-Mart gift card for their participation.

Data Analysis

The digitally recorded data were transcribed verbatim. During the transcription process, all personally identifying information was removed and replaced with a pseudonym or participant number. The transcriptions were then analyzed by the researcher to see if common themes emerged from participants’ responses. The researcher also used the principles of ambiguous loss theory to guide the analysis. From the time the data were collected until analysis was completed, all data were kept with the researcher; personally identifying information was removed as soon as possible. After analyses were completed, the digital interview files were deleted to ensure confidentiality.

The transcriptions were color coded by theme to aid in qualitative data analysis. Data analysis followed the method outlined by Berg (2007). Initially, the transcriptions were read multiple times. Then general themes like deployment and PCS were assigned color codes and flagged in the transcripts. After the initial codes were marked, more specific themes began to emerge such as methods for coping with the length of deployment, and the initial codes were color coded and flagged.
The 10 codes used for categorizing data included: (a) preparation (how families prepared their children for impending deployments as well as moving); (b) deployment and reunion (the families periods of separation); (c) communication (how parent’s talked to their children about the dangers inherent in military life as well as the methods used for keeping in touch during a deployment.); (d) school (what information did parent’s share with the children’s school as well as supports available to military children at school); (e) PCS (how the families coped with relocation); (f) methods for coping with the length of deployment (unique family strategies for managing the deployment length); (g) news (what actions were taken, if any, to shield children from disturbing stories and images in the news); (h) developmental age (how parents gauged what information was appropriate to share with children or what form of preparation to use); (i) honesty (the importance of sharing truthful information with children); and (j) extended family and military friends (relationships outside the immediate family).

Qualitative methodology was utilized to gain substantial insight into the functioning of military families in the face of an inherently stressful lifestyle. The use of a narrative interview format provided the families with the opportunity to share their stories of life in the Army and through those stories data were obtained that could not have been gathered through any other method. This study has also provided initial insight into the potential for expansion of child life services into a new arena and may potentially be used to frame future research in this area.
CHAPTER 4: U.S. ARMY FAMILIES AND THEIR EXPERIENCES WITH MILITARY LIFE

This study focused on how families’ experiences with military life have shaped the way they function as a family to handle the stressors inherent in having a family member serving in the U.S. Army. As mentioned previously the research questions that directed this study include: (a) what life stressors do military families experience?; (b) how can child life skills be applied to help U.S. Army families cope with the stressors of military life?; and (c) how do the principles of family-centered care correlate with the experiences of U.S. Army families?

Provided below is a profile for each participating dyad and their family. The participating families discussed multiple experiences with the military including managing a deployment, PCS, and the stressors of family reintegration postdeployment. The intersections with, and similarities to, child life practices are noted. After analysis, the some of the original codes were merged and others separated to form the themes used for categorization in this chapter. These themes include: (a) managing deployment, (b) communication, (c) developmental age, (d) school, (e) reunion, (f) PCS, and (g) military community as family.

Participant Profiles

The following profiles outline the characteristics of the families who participated in this study. The characteristics included: (a) the length of the parent’s marriage and note of previous marriages, (b) the ages and genders of their children, and (c) the mother’s and father’s occupations.
The first couple had been married for 6 years. Both mother and father had been married previously. They had one daughter together who was 5 years of age. The father also had three children from his previous marriage: an 18-year-old son, a 16-year-old daughter, and a 14-year-old son. The 18-year-old son was developmentally delayed and had bipolar disorder; he previously lived with the couple but now resides in a group home. The 16-year-old and 5-year-old daughters resided with the couple at the time of the interview. The mother was a registered nurse and worked outside the home as a clinical consultant. The father was a senior level chaplain assistant and a career soldier.

The second couple had been married for 19 years. They had 5 children together: a 14-year-old daughter, a 13-year-old daughter, a 10-year-old son, a 4-year-old son, and a 2-year-old daughter. The mother was a stay-at-home mother and provided home schooling for her children. The father was a chaplain who worked previously as a pastor. The family was new to the Army and this was their first post.

The third couple had been married 13 years. They had 3 children together: a 9-year-old daughter, a 6-year-old son, and a 3-year-old daughter. The mother was a licensed social worker who was not working outside the home at the time of the interview. The father is an Infantry Captain and a career soldier.

The fourth couple had been married for 20 years. They had three daughters ages 19, 14, and 10. The mother defined her occupation as a career military spouse and notes that while she was not formally employed during her marriage thus far she has led multiple family readiness groups during her husband’s many deployments. The father was a Chief Warrant Officer and a career soldier.
The fifth couple had been married for 8 years. The mother had one 8-year-old son from a previous relationship. The couple had two children together: a 6-year-old son and a 2-year-old daughter and were expecting another son at the time of the interview. The mother was a stay at home mom who was working to complete an Associate’s Degree online. The father was an Infantry Sergeant and had been enlisted in the Army for 8 years.

Themes

Managing Deployment

As stated previously, in Chapter 2, deployment is typically experienced in five stages: predeployment, active deployment, sustainment, redeployment and postdeployment (Lincoln et al., 2008; Pincus et al., 2005) There are often many emotions surrounding an imminent deployment and the tumult begins as soon as a soldier is notified of an upcoming deployment. When asked to describe what happens upon notification, one wife provided the following explanation of her feelings:

I have a rule that he’ll come home and say ‘I’m leaving’. I’m going to be mad; I’m going to be angry. I know he can’t change it, he is a soldier preparing for war, period, that’s your career. I don’t care what anybody says that’s what they train you for. I’m mad, I’m angry but after 24 hours it’s like, ‘okay what’s the first step, what have we got to do?’

Many families echoed this statement, while anger and resentment may be present upon notification of deployment; the family state of mind soon shifts to preparation. One family stated that prior to the “second (deployment) we did a lot of talking about where
Dad was going to be, why he wasn’t going to be able to come home.” The amount of communication about the deployment increased in order to help their preschooler grasp the concept and allow opportunities for their older children to ask questions and express concerns. In addition to increased communication, this family utilized a few of the many resources available to assist military families in preparing their children for upcoming deployments and found them to be very beneficial.

“I think the Sesame Street video gave [our youngest] a little bit of an idea. The other thing we had was a book that a counselor also gave me. It was something about your Dad deploying and soldiers coming back with injuries. It was a child level hard paged book and we did that with her too and she liked that.”

The Sesame Street video, *Talk, Listen, Connect* is a three-part DVD series designed to help preschoolers comprehend deployment, reunion, and parental injury through the use of familiar characters like Elmo and Big Bird and traditional Sesame Street episode format. The *Talk, Listen, Connect* program also provides a guide for parents and facilitators on preparation and coping as well as activities families can do together to decrease anxiety. The program is available free of cost to all military and reserve families via the informational website ArmyOneSource.com. There is also a multitude of children’s books available to help explain deployment to younger children as well as books that share the stories of children who have experienced the deployment of a parent for older children. These preparation strategies are very similar to those utilized by child life specialists in hospital settings. The use of pictures, books, and videos for procedural
preparation as well as diagnosis education are common (Goldberger, Mohl, & Thompson, 2009).

Another family used the children’s favorite storybooks in another way: “The first deployment [we recorded Dad reading] some books on tape and the kids enjoyed that.” This allowed the family to continue to have Dad read a bedtime story every night as part of their daily routine even though he was on the other side of the world.

When the parent actually deploys family dynamics shift to accommodate daily life with one less adult present in the household. The families in the study pointed out that this time was easier to deal with if they focused on the positive aspects of the separation no matter how small. For example:

While Dad’s gone we can have shrimp now because Dad doesn’t like it.

We also did projects and things that we could do that Dad wouldn’t be a part of normally and just trying to look at the positive of it.

Similarly, another mother stated, “I have three girls and we embrace that it is girl’s time. We do what we like to do that we know Daddy wouldn’t enjoy. That makes it a little bit more special.” While focusing on the positive aspects is important, it cannot detract from the often overwhelming length of a deployment. Managing the length of a deployment was a topic on which many families had ideas to share. One mother stated:

You do not count 365 days or gosh forbid a 15 month deployment. You don’t start from day one and think, ‘gosh I’ve got 15 months’. You’ll make yourself nuts. You just say ‘I made it through day one.’
Do it however, this is how many recycling days you’ve got or the holidays. ‘I’ve got 21 holidays to make it through.’

It was important for many families to break the deployment into more manageable segments. The concept of a 15-month deployment can be very daunting especially when one parent is left alone to fulfill both parenting roles; creating segments of time to “survive” allowed families to feel a sense of accomplishment more frequently than the accomplishment of managing an entire deployment. Another mother also employed a segmenting strategy to help her daughter who was not old enough to grasp concepts of time like months and weeks. She said:

Because [our youngest] couldn’t understand calendar and length of time, we’d set by holidays and events. So we did short term, okay remember after Easter if it was Easter and then your birthday party and then you go to swim lessons and then school starts and then it’s Halloween and then it’s Thanksgiving and then Dad comes home.

While her daughter did not always have a strong understanding of when swimming lessons would start or how many days are between Halloween and Easter, providing her with events she had previously experienced and remembered gave her events to look forward to that also marked the passage of time until her father returned. This family also employed a visual aid to help the children conceptualize the passage of time:

The girls and I got a huge glass jar on the last deployment, a massive jar, and they decorated it with paint pens however they wanted to and it was Dad’s jar…we dumped a ton of chocolate Hershey’s Kisses in it because
everything was visual for [our youngest] and that way every night we ate a Hershey Kiss to see the jar going down to see that we were getting closer to Dad coming home. That was fabulous at her age; she was 3½ or 4.

The need for a visual was stronger for the family’s youngest child, however, the decorating of the jar and sharing in the nightly event of removing a chocolate was beneficial for the family’s adolescent daughter as well. It provided an opportunity for an activity the sisters could share together and an outlet for creative expression.

The anxiety surrounding deployment is ever present for military families. Even when a parent returns from a deployment, there is the reality that they will be separated again in the future (Huebner et al., 2007). The families of soldiers who internalized this fact reported that they were able to find strategies to help their family cope with multiple deployments. Several families noted that when a family serves on active duty prior to the birth of children, those children grow up in a culture where deployments are just a part of life. One mother, discussing all of their children noted, “obviously they are sad the day he leaves, they’re sad the day he comes home and has to return (to Iraq).” Her husband added, “I don’t think [they] know anything different, I don’t think [they’ve] ever not handled it.”

**Communication**

Communication between families during deployments and other routine separations is important to family stability at home as well as troop morale abroad (Richtel, 2003). Increases in technology have afforded new and more rapid methods of communication. Internet access alone provides opportunities for email, video chatting,
and instant messaging. The families in the study who experienced deployments prior to the widespread use of the internet recalled the lack of communication opportunities, one family elaborated by saying: “During Desert Storm, there was nothing, there were two phone calls the entire time they were gone and maybe three letters.” The families in this study who had several separation experiences feel those previous experiences provided them with a profound respect for the communication possibilities available now. One family specifically mentioned that the increased levels of communication eased the stress caused by separation by stating:

Now I think that’s why it’s easier because we remember what it was like before. Now you know, you can talk everyday you’re on the computer, you got an email, you have instant messaging, web cameras, texting, there’s always communication.

The types of communication families chose to utilize are often dependent on the age of the family members. While Internet communication provides an effective means of communicating quickly, many families noted the importance their children place on receiving traditional mail addressed specifically to them. One father mentioned:

For my wife and I, it’s the Internet, the instant messaging and email but for the kids it’s the paper stuff, it’s actually getting something in the mail with a little stick figure I drew on there, it’s getting something personal.

Some parents made it easier for the children to receive mail by purchasing small gifts, post cards, and birthday cards prior to the deployment and preaddressing and placing stamps on envelopes so the deployed parent did not have to worry about finding things to
send home regularly. Internet communication, especially video conferencing, was an especially valuable tool for parents with preschoolers; the ability to provide a child with a visual image of their deployed parent was helpful in calming fears as well as allowing the deployed parent to see the child develop even from a distance. One family discussed using the program Skype with their youngest daughter:

We did Skype, Skype helped her a lot because she was so young, she was only 3½ when he left so she needed that visual…Skype was wonderful to help ease her…and when she had a really bad time we would try to Skype him; if his computer was on he’d pick it up so it was almost like she had a little bit of control over talking to him which normally you don’t.

In addition to providing their daughter some control, using Skype was a skill they were able to practice as a family before the deployment by making video calls between computers located in different rooms of the house.

In addition to the methods of communication families utilize to stay connected; the manner in which families communicate and the information they share with one another was also discussed frequently during the interviews. As stated previously, many military families avoid conversations about war in order to prevent their children from developing anxieties about the direct impact a military conflict may have on their family (Ryan-Wenger, 2001). One father discussed the censorship of his experiences when he communicated with his family, especially after noting the negative impact of elaborative communication on the part of other soldiers. Noting his observation he stated:
When you’re down range you never…I would see some guys would tell their family or their wife exactly what they were doing…no, you never tell them anything. As far as they are concerned you are bored out of your mind not doing anything.

His wife laughed at this statement and pointed out that it was not as if her husband shared no information at all, rather, he was a good judge of what was appropriate to share. She said, “he is very good at telling us what we need to know and not going into too much detail so that we can function better at home.” Many other families also noted that sharing vital information was important but providing too many explicit details was difficult for the deployed soldier as well as the family at home.

The idea of sharing vital information with children was also discussed in detail. Honesty was central to these discussions. One couple explicitly stated:

I think we’re pretty honest and pretty transparent about the possible dangers that are associated with (military service)…we would not lie to them but I think that there’s information that’s appropriate for a 14-year-old that’s not appropriate for a 4-year-old.

Many other dyads echoed that honesty was important in their discussions with children. They provided information about impending deployments and returns as it was made available; however the manner in which the information was communicated always depended upon the developmental level of the children. One mother stated: “You only have to give them enough information to satisfy that curiosity; you don’t have to go any further than that.” All families agreed that when children asked questions it was
important to provide them with honest answers even when the conversations may center on difficult topics. The level of curiosity and the need for information often depends on age of the child.

*Developmental Level*

Children’s responses to deployment can also vary greatly based on their developmental level. For example even children under 12 months of age are capable of experiencing loss and anxiety about whether or not a loved family member will return (Petty, 2009). Reunion can be an especially difficult time for families with infants and toddlers. As very young children thrive in familiar environments bringing an essentially new adult into the daily routine can be very stressful at first. One mother shared the difficulties her family experienced in the six months it took their daughter to warm up to her father again. She said, “she was 2 and she would not go anywhere near (her father when he returned); she avoided him and if he was anywhere near me or her sister…it was the hardest…I would say 5 or 6 months.” Another father shared a similar experience stating:

> When I got home…she was a little over a year old, she didn’t want to be with me; she only wanted to be with her Mom but then after awhile when I had more contact with her, kind of playing with her and whatnot she kinda opened up a little bit.

For some preschool children, deployment is a stressor that can cause regression to previously outgrown behaviors or a change in behavior. These changes manifest as young children seek a way to make sense of or control their environments (Petty, 2009). One
mother described the changes in her daughter’s behavior by saying: “when he first left
[our 5-year-old] was very clingy, more emotional at school, had more of an attitude, more
defiant. She was a handful, she was usually very easy going.” She also added, “whenever
you would discipline her she would cry and say she wanted Dad and we couldn’t call him
so she just had to deal with me.” While separations can be difficult for preschoolers, one
mother described her belief that experiencing a move, whether across town or across the
country, is actually easiest with this age group. She stated:

    I think it’s easier when they are younger. It’s that stress level for them,
    okay their room is gone but you can prepare them for when you get on the
    other side, they get a whole new area and then in two or three days they’ve
got new friends. When they’re older it’s much harder.

    Remembering just how much a child can develop over the span of 12 to 15
months was a struggle for a few participants in this study, especially as their children
reached adolescence. Physical and emotional maturation occur rapidly during
adolescence and behavior changes are often present as children develop a strong sense of
who they are as individuals (National Military Family Association, 2008). One mother
described her daughter’s transition during her father’s deployment thusly:

    Our oldest had a hard time, obviously it was the age, she was a teenager
    and when Daddy left she was a tomboy, Daddy’s girl, and when he came
back she was a young lady. She still had that tomboy side but it was a
definite change.
Adolescents experiencing the deployment of a family member have most likely experienced a deployment previously; as such, they are able to remember what it was like before and take on more responsibilities around the house to assist the remaining parent. Valuing the contribution adolescents make to the family wellbeing during deployment is essential (American Psychological Association, 2007). One mother described her daughter’s ability to take initiative during a deployment by saying:

[Our 16-year-old] tries to take a more parental role and she kind of, she missed her Dad, she missed joking around with him, but being a teenager she stepped right into the routine, I didn’t have a whole lot of issues with [her]…I would say she jumped right onboard and did great while [Dad] was gone. She pitched in and helped in extra areas when I needed her at home.

Each family had their own methods of handling the stressors of military life, but was also able to recognize that the stressors and the ways of handling them as a family change with the developmental age of the children. This was especially true in the ways parents spoke to their children about what their jobs entailed. One father noted, “my 5-year-old knows I help people, that’s about it, I keep it age appropriate, my 16-year-old has spent time with me at work, she knows what my job is.” His wife added an extra explanation about how they communicate with their son whose developmental level does not match his chronological age:

With our son it’s letting him know that Dad’s job isn’t combat like infantry like you would see on the news. So it was trying to reassure him
that Dad’s (in a) support (position); so even though he’s deployed and it’s always scary…trying to explain it on his level (with his disorder); he was often delusional.

Providing reassurance and developmentally appropriate information for all children was key during communication about parents’ occupation.

Research has shown that the most significant source of stress military children face related to the potential loss of a parent is the media, especially the news (Cozza et al., 2005). Families in this study were very cognizant of this fact. One mother expressed concern over the impact of watching the news on television for all of her children regardless of age by saying: “I didn’t play the news for all of my kids. I try not to keep the news on because they get so extreme that the kids get very unsettled and have nightmares.” Another mother added, ”they’re pretty protected as to what they watch on TV and stuff.” She also discussed limiting her children’s access to the Internet and keeping newspapers out of sight for all of her children. Parents in this study were concerned with sharing the truth about their personal situations with the military with their children in developmentally appropriate levels, but aware that irrespective of developmental level the news posed an added and unnecessary stressor for the family.

School

Children who live on a large military post while one of their parents or guardians is serving may attend a school also located on the post. In this situation the children have the opportunity to interact with other children who also face the stressors that encompass being part of a military family. However, this is rarely the case for children of reserve
families. One family whose children attended school on post described the benefits by saying: “[At the schools] on post they have good social workers and counselors …and they’re around other kids experiencing the same thing; that’s a big deal, that’s important.” Extracurricular activities focused on helping children through deployments are often popular at base schools as well. Several families discussed deployment clubs for students and were excited about the concept. The general complaint, however, was that the programs were usually temporary and not available for all age groups.

With all schools, civilian or military, parents noted the importance of communication between school and families. By informing teachers of an impending deployment parents increase the number of people involved in the child’s life capable of noticing behavior changes that may indicate a lack of positive coping. One mother said:

I prep[ped] [my 5-year-old]’s school and let them know that if they saw a change in emotions or a change in behavior, anything that’s not her normal, to let me know right away and if I saw anything at home I’d let them know and we ran through a couple of bumps but went through it smooth because we were all on the same page.

Creating a line of communication with children’s teachers is also important to address issues that may arise at school:

I know the first deployment they tried to really bring [the deployment up] at school for [my son] and he was having night terrors of all kinds and I had to go into his school and tell them, ‘I know you’re trying to do a good thing but it’s too much for him.’
While some children benefit from an opportunity to share their unique experiences, others can be overwhelmed by the attention. Teachers can be a valuable source of information for children in military families (Ryan-Wenger, 2001). Parent-teacher communication is essential to ensure the information shared about war is beneficial rather than detrimental to children of soldiers.

The frequent relocation of military families also has an impact on the education of military children. With frequent moves come frequent changes in schools and curricula; this can be especially difficult for high school students (National Military Family Association, 2008). One mother described a frustrating transition for her children:

This time we tried to move in the summer but things kept getting pushed back so again they had to start school [in North Carolina], miss school [here] that started in July and we didn’t get here till October and they started school in the end of August so they missed a lot of school. It’s been a hard transition on [our older daughter], she’s in her junior year and all kinds of honors classes so that was a tough transition.

While moving can create frustrations for families with children in traditional schools, it can provide a welcomed educational opportunity for families who educate their children at home. The family in this study who home school their children noted: “[The move] wasn’t all bad because we got to take a cross-country tour on our way [out here] and it was something we wanted to do and it was a perfect opportunity to do it.” They explained that the cross-country move allowed them to visit historical landmarks and provided many interactive history lessons.
Reunion

While the end of a deployment can bring overwhelming feelings of relief to family members, it is also a time of stress. Many families cite the process of family reintegration that follows reunion as more stressful than the deployment itself (Lombard & Lombard, 1997). One mother described this difficulty by saying, “what was hard about (him coming home) is that we weren’t used to being so together, even though that’s what we wished for the whole time.” The difficulties that accompany reunion include a shift in household responsibilities and parenting duties, and the soldier must also readjust to life with a family as opposed to life with other soldiers in a war zone (American Psychological Association, 2007). The difficulties in the adjustment process can vary with age, for very young children it is often a reintroduction process. The families in this study found this process to be disconcerting and felt ill-prepared for their young children’s reaction. One father described this experience by saying:

Our middle daughter was a year when I left and 2 years when I came back a lot of younger couples I see have a hard time especially the husband when the child doesn’t immediately come to them when they get back from a deployment and I was put off by that also. Because, back then, 15 years ago, we really weren’t taught a lot of coping skills.

It can be very disconcerting for parents when their child experiences stranger anxiety with the returning parent (Zero to Three, 2007). While anxiety can be present in older children as well preschool aged children with more cognitive development process the
reunion differently. The following is the description of the reunion experience of one preschool aged child:

When he returned [our 5-year-old] was like his shadow; she didn’t want him out of her sight. She was afraid he would leave and not come back. She was constantly needing attention. She’d follow him around like the whole time but when it came to knowing the routine and asking questions, like no matter what he said she’d come to me and ask me and tell me what he said and say that it was wrong.

The reunion experience of older school-age children and adolescents revolves around the recognition of their achievements and placing value on the roles and responsibilities they have accepted during the deployment (American Psychological Association, 2007). One mother described her perception of her teenage daughter’s reaction to the reunion:

It kinda crimped her style when Dad came back…because the teenage side she got a little more freedom a little more responsibility and then Dad came back and took the parent role and she was kinda like ‘but I do that, that’s my thing with Mom, that’s our thing, we watch that show together’. So it was kind of a little bit harder [for her] when he came back more so than when he left.

In order to counteract the frustrations experienced by their adolescent daughter, the parents decided to try to find other outlets for their daughter to demonstrate her responsibility and the skills she gained during the deployment.
The reunion experience is different for every family and depends greatly on the length and type of separation as well as the ages of the families’ children and the families’ level of coping with the separation. While some families plan vacations following deployments the families in this study who had experienced deployments preferred to relax at home post-deployment. One family shared the way they make reunions special for their children:

When he comes home we don’t plan this big trip where we’d be (busy for) two weeks going, going, going. It stresses him it stresses us so it’s just what’s the one thing you want to do with Daddy when he comes back. That’s probably the only thing we do plan. For most of them it’s ‘I’d like to go to the bookstore’ or ‘I’d like for him to take me out to lunch’…whatever it is that’s their time one on one and when that’s done, then it’s us. But you’ve gotta get that reconnection.

After hearing his wife’s description of the reunion planning, one father mentioned that while the reunion process can be difficult for the children it is also difficult for the parent who has been at home providing care during the deployment. He said “and I know it’s hard on Mom’s. She just wants to get away from the children and all I want to do is be with the children and be with the family so you work out a happy medium.” Finding this happy medium is what is vital to a family being about to reconnect and discover their new normal post-deployment (American Psychological Association, 2007; Huebner et al., 2007).
Mobility, like separation, is a constant factor of life in the military. Army families move or experience Permanent Change of Station (PCS) on average every 2 to 3 years (Burrell et al., 2006). For example one family listed their moves: “We’ve been to Georgia, Kentucky, Maryland, Korea twice for myself. My family didn’t go (they were in) Montana. Then we went to Illinois, North Carolina and [our current post]…we’re moving to Colorado in the summer.” It’s important to note that throughout these changes in physical location the family also experienced more than five deployments and the birth of their three children. In order to make the moves successful for the family, it is essential to note that parental attitude toward the move is the factor that has the greatest impact on the children’s adjustment (Finkel, Kelley, & Ashby, 2003). One family described their PCS as a very positive experience based on the fact that they had had prior experiences and limited external stressors other than moving. The mother said, “The move from here to North Carolina went very well because we knew everything we were doing, we prepared the family, we transitioned through the holidays. I’d say that move went great.” However, the same family had a very difficult time during another PCS due to the external factor of their son’s handicap. When asked to describe the difference, the mother said:

[The move out here] was very rough because at the time we didn’t know the extent of our son’s mental problems. We were in the middle of working that up because he had moved in with us 6 months before that and
so out of his routine and moving and in a hotel, a huge time change, out of school, a very difficult time to transition him.

With all of the difficulties they experienced while struggling with their son’s mental health needs, they were particularly distraught when given orders to move back to the continental United States around one year later.

We tried to stay in here because we finally had [our son] plugged into the programs he needed, got him stabilized on meds, stabilized with his doctor, everything was good and the Army up and moved us in less than a month. We tried and we fought to stay because it takes so much work to move him and keep him stable. And when we moved to North Carolina within 4 weeks he was hospitalized for 4 months because he couldn’t handle the change. Even though we planned ahead and we did everything we needed to do, he still fell apart and ended up in a group home.

In this situation, even though the family expressed a positive view of Army life and an understanding of the need for frequent relocation as well as the proper steps to prepare their family for the moving process, an external factor proved to make the experience significantly more stressful for the family as a whole.

Another family who recently experienced their first PCS described it as a positive experience overall with the exception of a lack of preparation on what to expect. They found themselves without a substantial amount of their personal belongings due to a lack of knowledge of the transportation timeline. They also described their struggle with the
temporary housing many families utilize while searching for a permanent residence or waiting for base housing to be ready. The mother described this experience by saying:

I mean there were stresses in [the move]. It’s stressful to get all of your stuff loaded up and probably the biggest stress was on this end because we were in a hotel for 5 weeks when we moved here and 5 weeks with 5 kids it’s…and they don’t have cooking facilities there so that was probably the most stressful.

Overall the families expressed an understanding that PCS was just another part of military life and felt, with experience and utilizing a support network of families who had previous experiences, they were able to help their families through the transition. One mother summed it up nicely by saying, “with military life, you know it’s not forever, we’ve been very spoiled to be here as long as we have.”

Extended Family and Military Friends

The families in this study expressed the importance of having a support system to aid in times of need. In traditional settings many people rely on close friends and family members to fulfill this support role. Military life, however, does not always allow for this as military families are often stationed a great geographic distance from their families of origin. Some of the families in this study described strained relationships like, “we have minimal contact, dysfunctional families on both sides.” Others cited the difficulties in keeping connected with the children’s grandparents and aunts and uncles due to the geographic distance. One mother mentioned:
The difficulty in staying connected is the time difference because all our family is on the east coast so we have anywhere between 5 to 6 hours. So our normal habit is to call in the evening when the day is done and that’s too late for them.

Another difficulty for families is having enough support during important transitions. The families in this study felt they were too busy organizing their new homes and helping the children adjust to a move and a deployment to take time out to research and locate support services. While many support services are available through the Army, families often desire the support of a family member or close friend. One family reflected on the benefit of having a grandparent present to assist during transitions:

His mom came out for a few weeks and I kind of rotated breaks within the time that he was gone to get a little bit of help but then again they all work so it wasn’t like someone could move in with me. But if I could have had one of our parents move in I would have brought them to me to help keep the kids stable.

The support of another caring adult was very helpful in providing stability for that family’s children during the move and beginning of their father’s deployment. For others, having family present is not an option. It is those families who focus significantly on the bonds developed between military families. One father reflected, “we don’t have that family where we could say come help. So it’s us; so your family ends up being your military friends.”
The difficulties in remaining connected with family members who are far away or not having reliable support through extended family necessitates the development of alternative means of support. One family described how this can be exceptionally difficult for families who are new to the Army in general or new to a particular base:

A lot of spouses are just dumped here you know, their husband is here for like two weeks [before deploying] and then if they are stuck at home with children especially young children it’s hard to find the close girlfriends that would know your family as well … especially in a place like Hawaii or Alaska that, or overseas when you are more than likely away from your extended family.

Another mother echoed these frustrations by describing her own experience in being new to the island:

So being on an island with my husband deployed and having a baby I was extremely frustrated because we were so far from family and I don’t have family that’s retired that could come and stay with me so I was on my own. It would have been really nice to have programs, a developed program, a better put together program with people who could come in and say we have these resources.

Families who valued the benefit of viewing military friends as family also discussed the importance of leadership in providing new families with support. One of the fathers who is an officer defined this leadership as a duty he felt compelled to perform by saying:
That’s just a leadership deal. I mean if you have young soldiers and young married couples you invite them over and you talk to them about the military and you try to pass on what you know and that’s just something we all do … it’s something that was done for us.

Reactions to Child Life

When asked about the potential for child life programming for Army families, everyone who participated in the study responded positively with enthusiasm. After one family discussed their personal experience with a medical emergency their child experienced, the researcher communicated the role child life could have played in that situation. The family stated the importance of having someone available who can step outside the immediate emergency and help the family with education instead of the overwhelming emotion that emergent situations can cause. Families also addressed the need for a trained individual to help support groups that are currently in place to address the developmental needs of the children more effectively.
CHAPTER 5: CONCLUSION

Study Findings

The purpose of this study was to answer three questions: (a) What life stressors do military families experience?; (b) How can child life skills be applied to help U.S. Army families cope with the stressors of military life?; and (c) How do the principles of family-centered care correlate with the experiences of U.S. Army families? By using scholarly research and qualitative interviewing techniques, the researcher was able to draw several parallels between the healthcare setting and the experience of U.S. Army families. The intersection of stressors faced by families in the healthcare setting and in military life, the experiences of children in military families separated by developmental stage, and the correlations between principles of family-centered care and military family life are discussed below.

Intersection of Healthcare and Military Stressors

Healthcare Stressors

In the healthcare setting, a myriad of stressors exist for children and their families, all of which have the potential to impact coping. For infants, the stressors are environmental such as over stimulation or, conversely, sensory deprivation. The hospital environment can be very loud at times due to irregularity in room lighting as doctors and nurses enter for exams, vitals checks, and medication administration at all hours. These situations can be very stressful for infants especially when injury or illness has already lowered their ability to cope with their environment. However, the lack of constant
parental presence, and medically necessary limitations placed on contact can also lead to sensory deprivation in hospitalized infants.

Several fears that are prevalent stressors for older children include the fear of pain or bodily mutilation, the fear of needles, and the fear of death. The fear of pain develops in toddler years as children develop the ability to recall images of previous experiences in their heads. The memory of past painful experiences can trigger a fear of pain in similar situations or locations where pain is remembered or anticipated. The fear of bodily mutilation presents itself first in preschool aged children. The preschooler has a limited grasp on the concepts of body integrity and functioning and therefore struggles to grasp the necessity for, or ability of, surgery to fix a problem. Fear of the illness itself or fear of death develops in school age and adolescent children who have gained the ability to think logically and understand the implication that events in the present can have on the future.

As children develop, they experience an increasing level of stress surrounding the loss of independence and autonomy that can be attributed to hospitalization. Children who are hospitalized become increasingly dependent on adults to assist them in daily functioning and tasks that they may have formerly been able to accomplish on their own. Feeding and using the restroom are can be frustrating for patients who experience the loss of ability to complete these tasks independently. Factors that can contribute to loss of autonomy also include immobility or loss of other motor skills that may be illness or injury induced or triggered as a result or regression during hospitalization.

Isolation is a stressor that affects the entire family. Patients may experience physical isolation when separated from family and friends. They may also experience
emotional isolation when contemplating the situation that necessitated the hospitalization. For example, an adolescent who is newly diagnosed with leukemia may feel as if no one else has ever experienced the emotional struggles they are presently facing. Families as a whole can feel isolated as well, especially in the time following a new diagnosis or complication (Pearson, 2005).

Military Stressors

The families of soldiers who serve in the military are faced with a number of stressors based upon the occupation of one or more of the members. Perhaps only one member of a particular family has chosen to serve in the armed forces; nonetheless, all members of the family are impacted. To accomplish the Army’s mission, families are relocated every 2 to 3 years (Burrell et al., 2006). This means that children in Army families are constantly going through the process of being the “new kid” at school and building friendships. If a family member does not have government employment, the moves may represent a frequent search for new employment. Also, when the relocation process occurs regularly, an added stressor for families can be anxiety about the next relocation or deployment.

Deployment itself can contribute to a variety of stressors for military children. Those family members who do not deploy must cope with a fear for the safety of the deployed member. This is especially true of school-age children and adolescents who have developed the capacity to think logically and understand the consequences of war (Burrell et al., 2006). For older children, the deployment of a parent can also mean taking on added responsibilities at home; managing these tasks can be stressful (National
Military Family Association, 2008). Another deployment stressor exists for both the deployed family member and those at home; the passage of time during a deployment means that important milestones and events will be experienced while the family is separated. Even the long anticipated point of reunion after a deployment can be stressful for families as they work to reintegrate and form a new family “normal” post-deployment.

Shared Stressors

While the stressors of healthcare settings and the stressors military families experience are different in some ways they are very similar in others. Children in both situations experience periods of separation from a caregiver. Children whose parents are unable to stay at bedside with them experience the same sense of ambiguous loss, the mental memory of the caregiver during the physical absence, as those children whose parents are either deployed or are on military training missions. They also experience stress as a result of changes in developed routines and schedules. While military children move frequently from one base to another, children in hospitals also move departments. They may be admitted from the emergency room and transfer to the intensive care unit. Later, they may move to an inpatient floor. After adjusting to life on an inpatient floor, they may be switched to outpatient treatment. Military children may have to adjust to different daily schedules when one parent deploys just as children with health concerns may have to organize their days based on treatment or medication schedules. As with all extraneous stressors children with medical needs and those in military families are at risk for lowered self-esteem.
The cognitive immaturity of children can also present difficulty in both areas in the understanding of setting-specific jargon. For example, hospitalized children and families may initially struggle to associate meanings with the acronyms, IV (intravenous), MRI (magnetic resonance imaging), and EKG (electrocardiography) among many others. Military families have their own acronyms to learn such as IED (improvised explosive device), MRE (meal, ready to eat), and EFMP (Exceptional Family Member Program). Both groups must also develop an understanding of professional hierarchy. Titles based on training level vary in most all areas of medical practice for example when thinking about doctors: there are interns, residents, fellows, board certified doctors, and specialists. In all branches of the military there are enlisted, warrant officer, and commissioned officer ranks.

Both groups also have the potential to experience fear of the unknown and loss of situational control. For families of children with chronic illnesses there is no way to definitively define the length of many treatments, likelihood of remission, or the length of time a child will feel healthy before becoming ill again. Tentative dates and timing are also a factor of military life. Soldiers do not receive guaranteed dates of deployment or return. The length of time a family will remain at one station before transferring again is also vague. Constantly living with factors in life external to their control can be a struggle for families.

When environmental stressors negatively impact parents, children also experience adverse effects even when they have no direct interaction with the stressor. For example when a wife is anxious during the deployment of her husband their infant child may
exhibit increased fussiness in response to the mother’s stress (Zero to Three, 2007). The
same principle holds true for the healthy children at home whose parents are concerned
about a hospitalized sibling or a high-risk pregnancy. Toddlers and preschool aged
children are also at risk from the stressors caused by egocentric and magical thinking.
These young children are unable to grasp the concept of individualized thought and
alternative perceptions of situations (Pearson, 2005; Petty, 2009). As such they may view
negative situations as punishment for example, “Mommy has to go to Iraq because I was
mean to my sister” or “I have to have surgery because I did not share my toys.” These
children also have a tendency to think magically about situations that are a realistically
outside of their control. Magical thinking is the description of the belief that wishing can
change outcomes or explain situations. Both egocentric and magical thinking can
contribute to multiple misconceptions and require concise and consistently repeated
explanations. Regardless of developmental age or type of stressor, a limited grasp of
techniques for positively coping with that stressor can provide added difficulty for
families. The intersection of stressors for families in healthcare settings and military
families are visually represented in Figure 1.
Figure 1. Intersection of stressors for families in healthcare settings and in military life from the child’s perspective.
Family-Centered Care

As stated in Chapter 2, family-centered care is a model for healthcare interactions based on a series of partnerships between professionals in the field, patients and their families. Family-centered care reaches beyond direct provider-patient interactions to better healthcare experiences for the entire family by ensuring all people are treated respectfully, communication is complete and unbiased, families build upon their own strengths and collaboration, and education for all parties is maintained (Bell et al., 2009). While the principles of family-centered care have been developed to enhance family experiences in the healthcare setting, the large number of commonalities between family experiences with military life and healthcare provides an opportunity to discuss the application in an alternative setting. In 2009, Bell et al. described nine best practice standards for family-centered care in healthcare settings. Several of these standards can be applied to the life of the military family they are discussed below.

Family as the Constant

Irrespective of the setting, it is important to note that the family unit remains a constant in the life of a child. In the hospital setting healthcare providers change, as often as every few hours. There is also a significant change in setting and limited opportunities for normative peer interaction. Even within the hospital setting a child can experience multiple inconsistencies moving from one unit to another, switching from outpatient to inpatient treatment or moving to a more specialized hospital. Throughout changes in treatment, injury or illness and recovery, or even significant loss the family unit remains constant. It is therefore essential that those who provide treatment use the knowledge of
the family members to their advantage. Simply asking questions about a child’s routine at home or the level of family involvement in treatment and encouraging parents and children to share information and concerns, health care providers show respect and capitalize on the knowledge of the family unit (Bell et al., 2009). It is also essential to address the needs of family members outside the hospital in order to care for the family as a whole. Just as military families experience stress when a family member deploys to war, families with healthcare needs experience similar stresses when a child “deploys” to the hospital for a lengthy stay. Looking at the family as the strongest constant requires providing care for the entire unit.

For a military family, the level of inconsistency can vary drastically. While there is some level of change in family member presence during deployment, the family is still the greatest constant in the life of the child. Also, as stated previously, Army families relocate every 2 to 3 years. These relocations cause families to change homes, schools, friends, family physicians, dentists, hairstylists, grocery stores, and favorite restaurants; the list is endless. With all of these changes, it is important that anyone providing care for a military family member be attuned to the familial needs. By asking questions and utilizing the information a family provides, it is possible to provide better service to that family, even for just the few years they may be living in your area.

_parent-professional collaboration_

Parent-professional communication and collaboration is essential at all levels of healthcare. In much the same way as recognizing the family unit as the constant in a child’s life, encouraging communication between parents and healthcare professionals
fosters a mutual respect for the knowledge of both parties. Also, when parents and families are involved in planning they can be more actively involved in evaluation of interventions (Bell et al., 2009).

Participants in this study spoke of the benefits of parent-professional collaboration, especially in the school setting. As military children experience a number of stressors outside the realm of typical childhood development, providing information about those experiences, specifically deployment, to teachers and daycare providers can aid the parent remaining at home in watching for signs of poor coping. In addition if a school is aware that a child is experiencing the deployment of a parent or close family member they may also be able to provide accommodations for families around the date of departure and return as well as on leave periods during the deployment (National Military Family Association, 2008). Communication between parents and the professionals providing care for their children can also serve as a support for parents during a time of transition. Especially when a family is new to an area, professionals can also serve as a resource for recommending other services and organizations to aid in the family’s transition.

*Recognize Individual Strengths*

Every family is different—from the way they make major decisions to the way they fold their laundry. For this reason it is essential to avoid making assumptions when working with families. Recognizing the strengths each individual family possesses is important in any setting in which families are involved. Just as no two families cope in the same way with a cancer diagnosis, no two families experiencing a deployment
manage in the same way. In this study several families mentioned strategies for managing the length of deployment; while some separated the time by holidays others counted recycling days and another family marked the passage of time with Hershey’s Kisses in a large jar. Though the strategies were different from one another they all met the needs of the families who employed them.

When working with families, communication is key; find out what methods of coping a family currently employs and ensure those methods are respected (unless they are physically harmful or illegal). When assessing a family’s coping, it is best to focus on what they do well as opposed to any coping deficits that may exist (Bell et al., 2009).

*Family-to-Family Networking*

Family-to-family networking can be a valuable asset in any situation where families experience similar stressors. In a healthcare setting families who have experienced a similar diagnosis or treatment protocol can actively provide support and advice to one another. Face-to-face support is not always possible or necessary for bonds to be developed. It is important to recognize that supports exist on a variety of levels from institutional to international. Community groups, national support groups, and online chat rooms all provide opportunities for families to interact and share their experiences. With all experiences, the desire to share information with others can change over time as can a family’s level of need for peer support. When caring for families, remembering that these changes occur is key. By regularly inquiring about a family’s needs, a professional will be better able to recommend appropriate outlets for support (Bell et al., 2009).
Limitations

Several limitations influenced the current study. First, as with any small qualitative sample, the sample group for this study cannot be generalized to represent an entire population. Second, the narrative interview format required that participants reflect on previous experiences and relied on their ability to accurately and honestly relay those experiences to the researcher. Third, some families may have been more enthusiastic about their participation in the study and, as such, provided more detailed responses. The respondents for this particular study were active duty Army families. It is important to note that differences exist between active duty and reserve families in the Army. Differences in experiences, deployment length, frequency of relocation, and overall structure also vary for those families serving in the Air Force, Coast Guard, Marines, and Navy.

Implications and Directions for Future Research

Several connections between the family stressors of healthcare experiences and Army experiences have been addressed. Similarities in the explanation of experienced stressors as well as the application of the principles of family-centered care to military family experiences provide a foundation for future research and potential child life program implementation for military families. In the field of child life, patient puppets are often used to illustrate bodily functions as well as the operation of several types of medical conditions and interventions such as burns, broken bones, internal organ damage, nasogastric tubes, sutures, and catheters. These puppets are widely used to help explain
injuries and illnesses to children, their parents and siblings and may have the potential to help military children understand and cope with parental injuries.

Providing opportunities for family education that meets multiple needs for military family members is also an important area for research. For example the implementation of a “parent’s night out” program in which children receive developmentally appropriate education about an upcoming deployment or reunion, while simultaneously engaging in enjoyable activities with peers experiencing the same situation, can be beneficial for the children while providing an opportunity for parents to spend time planning for a deployment or taking a break from being the sole care provider while a spouse is deployed.

Further research is needed to ascertain whether the connections made between healthcare stressors and those shared by Army families are consistent with those families serving in other branches of the military. Research conducted by certified child life specialists is also essential in forming potential programming for this population. Examples include: collaboration with Family Readiness Groups, and the department of Morale Welfare and Recreation; locating opportunities for child life specialists to join current Army psychosocial care providers to form more diverse teams; researching opportunities with other military branches; and, creating potential child life interventions that are transferable to the military setting.

Conclusion

In conclusion, the stressors shared by U.S. Army families serving on active duty and the families of children with healthcare needs are many. Child life services have been
developed to better the lives of hospitalized children. These services are provided in accordance with the principles of family-centered care. Many of the principles of family-centered care can also be related to life of the military family. While further research is needed to develop child life programs to benefit the families of those serving in the U.S. Army, this study provides a starting point. All programs developed should focus on recognizing the family as the constant in a child’s life, providing opportunities for collaboration between parents and professionals, recognizing the individual coping strengths of a family, and encouraging networking among families.
REFERENCES


Richtel, M. (2003, March 12). The military: Commanders worry more about their troops’ e-mail than their loose lips [Threats and Responses]. *The New York Times, A14*


APPENDIX A: INFORMED CONSENT FORM

Ohio University Consent Form

Title of Research: The Potential Benefit of Child Life Services for United States Army Soldier and Their Families
Researcher: Melissa E. Huist, Graduate Student, Ohio University, Child and Family Studies

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to sign it. This will allow your participation in this study. You should receive a copy of this document to take with you.

Explanation of Study

It is my goal to gain a better understanding of how Army families with children function under the constant stressors occupation in the Army presents. The interview will last approximately 1 hour. During this time I will explain the occupation of a child life specialist and I will ask you to tell me about your family’s experiences with the Army, especially communications you have had with your children about your occupation. Your responses will help me evaluate the potential benefit of child life services for Army families.

Risks and Discomforts

There are minimal risks for you as a participant. During this interview you may be asked questions that evoke emotional responses, as you will be asked to talk about yourself and personal experiences. You may skip any question that makes you feel uncomfortable or discontinue the interview at any time.

Some participants in this study may be married parents. If you are interviewed with your partner you will hear each other’s answers to the questions posed in the interview. You may ask to be interviewed separately or discontinue the interview at any time.

Benefits

As a participant you have the potential to gain a better understanding of child life services and the benefit they may be able to provide. Discussion may also provide the
opportunity to reflect on family experiences leading to positive outcomes for you and your family. Overall this research has the potential to help us better meet the needs of children whose parents are in the military.

Confidentiality and Records
This interview will be digitally recorded. Your name and any personally identifying information will be removed in the transcription process. The audio files will be password protected while on the computer and in a locked filing cabinet once transferred to compact disc. These files will be destroyed upon the completion of research, no later than June 11, 2010.
All personally identifying information shared will be kept strictly confidential. Signed consent forms and audio recordings will be kept in locked carry-on baggage during travel and in a locked filing cabinet upon return to Ohio University. Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:
* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

Compensation
For your participation you will receive one $5 gift card.

Contact Information
If you have any questions regarding this study, please contact
- Melissa Huist (Primary Researcher) Email: mh136704@ohio.edu Phone: (937) 750-3148
- Dr. Jennifer Chabot, CCLS, Associate Professor, Family Studies (Faculty Advisor) Email: chabot@ohio.edu Phone: (740) 593-2871
- If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

By signing below, you are agreeing that:
- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions
- known risks to you have been explained to your satisfaction.
- you understand Ohio University has no policy or plan to pay for any injuries you might receive as a result of participating in this research protocol
- you are 18 years of age or older
- your participation in this research is given voluntarily
- you may change your mind and stop participation at any time without penalty
or loss of any benefits to which you may otherwise be entitled.

Signature ______________________________________ Date ____________

Printed Name ___________________________________________
APPENDIX B: INTERVIEW SCRIPT

Thank you again for your willingness to participate in my thesis research. Your personal stories and experiences will help me better understand the potential benefit child life services may have for families like yours. My degree is in family studies and my focus is in child life, while I would find work as a child life specialist in any hospital setting fulfilling my ultimate goal is to work for the military helping prepare children to see injured soldiers.

Before we get started I just want to remind you that if at anytime you feel uncomfortable or do not wish to answer a question, you do not have to. I am excited to be here and I want you to have a positive experience too. Everything we talk about today is confidential, your identity and the identity of your child(ren) will not be shared with anyone. Is it still alright for me to digitally record our conversation? TURN ON RECORDER!

- Child life is not a profession most people are familiar with is there anything you would like me to clarify about the profession or what I would like to do
- Will you please tell me a little bit about yourself (rank, age, marital status, hobbies, ect.)?
- Please tell me about your family
  - How many children?
  - Children’s ages?
  - Married? How long?
  - Close knit?
o Extended family?

- Has your family ever experienced
  o A deployment
  o Permanent Change of Station
  o If yes, can you please tell me about that experience

- How do you talk about your job with your children?

- Have your children ever asked questions about your job?
  o Your safety?
  o If yes, how did you respond

- Who is your designated Family Care Provider
  o What steps did you take in selecting this individual
  o What factors were most important to you

- Are there any other significant experiences your family has had with the military that you would like to share?

- What could have made any of these experiences easier
  o For you?
  o For your child?

- Now that you know a little more about child life do you think that the services the profession provides could benefit you and your family?
  o Why?
  o Why not?

- Is there anything else you would like to add?
• Do you have any questions for me?

TURN OFF RECORDER

Thanks again!