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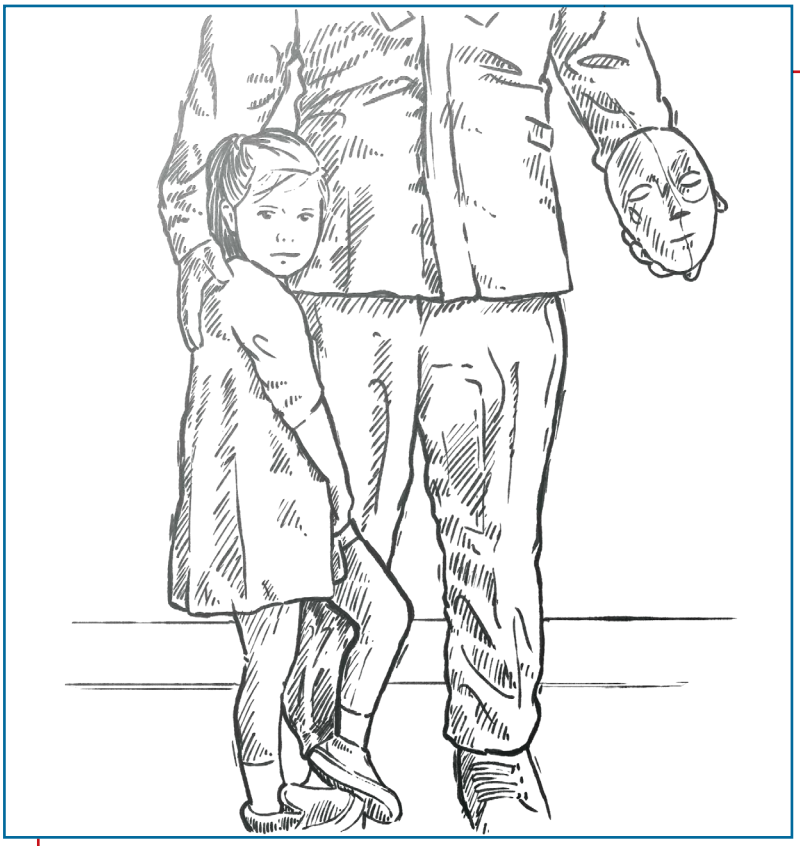

Military and Veteran Family Needs Assessment and Literature Review: Considerations for Arts Providers and Creative Arts Therapists

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INTRODUCTION

Service members and veterans as well as military families, spouses, and caregivers face many challenges with the military lifestyle both during and after active-duty service. Addressing the unique health, socioeconomic, and psychosocial needs of these individuals often demands a networked approach by a comprehensive support network of community-based clinical and nonclinical health and human service providers. Creative arts programming plays an important role in this broad approach to improve military-connected individuals' well-being and quality of life.

Creative arts programming takes multiple forms (visual, performing, and applied), and varies widely from clinically based therapeutic interventions to community-based engagement activities. Within this range, creative arts programming not only helps to address military-connected population needs through clinical approaches, but also builds resiliency and community connections through community arts participation and engagement. To establish a knowledge base to inform current and future creative arts programming in the United States, understanding the needs of military-connected populations as they relate to creative arts programming is critical.

To this end, the National Endowment for the Arts' (NEA) Creative Forces: NEA Military Arts Healing Network ("Creative Forces") collaborated with the Institute for Veterans and Military Families (IVMF) at Syracuse University to conduct a literature review and needs assessment that reveals critical insights and implications for how arts programming can most effectively address the needs of military-connected individuals. This report includes the latest multidisciplinary research findings that document the needs and resiliency factors influencing the overall health, well-being, and quality of life for veterans, service members, their families, and caregivers. The report also reveals important expert practitioner insights and considerations pertaining to arts programming with military-connected populations, across settings ranging from clinical to nonclinical, or community-based. Data collected from subject matter expert interviews are integrated into the report, and a complete summary of findings from these interviews is included as Appendix B.

Study Approach

This project was completed by the IVMF research team over a twelve-week period. The study was conducted in three concurrent phases, which included a comprehensive literature review, interviews with subject matter experts, and knowledge analysis and translation for application by practitioners.

First, the authors conducted a data and literature review covering the various stressors, challenges, and experiences of service members, veterans, military and veteran family members (including children), and caregivers. In this step, the research team sought out existing peer-reviewed journal articles, white papers, and reports to gather key findings specific to these military-connected subgroups on topics related to health and wellness, mental health, and other population needs, as well as existing clinical and community-based arts and non-arts programs and interventions. Second, together with key leaders from within Creative Forces, the project team codeveloped a selection matrix of key organizations and individuals across different service delivery settings (e.g., clinical, community, government), target subgroups (e.g., service member, veteran, family member, caregiver, youth), and intervention type (e.g., visual art, music, theater, creative writing, etc.). Third, the authors held confidential semi-structured interviews with nineteen subject matter experts, purposely elected to represent diverse perspectives about personalizing service and support to the target subgroups.

Finally, the project team synthesized and grouped findings from the literature review and expert interviews by target subgroup to summarize existing needs, approaches, gaps, and opportunities for Creative Forces service providers.

Key Terms and Definitions

A number of key terms (see Appendix A) are used in this report, when referencing specific types of arts programming and settings.

Arts, as used in this report, refers to a physical expression of creativity through visual or performing modalities including visual art, photography, dance, theater, music, film, and creative writing. ***Intervention*** references the mechanism that is acting on the identified population; in many cases, we reference ***arts interventions***.

Practice settings identified throughout the report include ***clinical settings***, settings where medical services are provided to assess, diagnose, and provide treatment for clinical mental health conditions such as PTSD, depression, and traumatic brain injury, and ***community-based settings*** that include any public or nonprofit setting that offers services to military-connected individuals within the community where they reside. Examples of a community-based setting include veteran-serving organizations, museums, community arts centers, and educational institutions. The term ***service provider*** is used when referencing all types of providers, arts, and non-arts, clinical and nonclinical.

Arts programming offered to military-connected populations are referred to as creative arts therapies or community-based arts programming. ***Creative arts therapies*** include the distinct regulated health professions of art therapy, dance/movement therapy, drama therapy, music therapy, poetry therapy, and psychodrama. Professionals in these fields use their art form to achieve clinical and therapeutic outcomes. Each of the professional disciplines possesses a definition of the profession which encompasses the scope of practice, educational competencies, standards of practice, a code of ethics, and evidence-based research. Creative arts therapists share the feature of encouraging creative expression through a specific art form. However, each profession stands alone as distinct (Lambert et al. 2017).

Community-based arts programming refers to community-based arts programs and therapeutic arts programs that promote the integration of healing arts practice as part of daily life (National Endowment for the Arts, 2018). Such programming is typically offered by someone with a background in the arts and in some cases by a professional credentialed creative arts therapist. Programming can be offered in community-based settings or clinical settings (e.g., an artist offering an arts engagement group in a hospital setting).

Organization of the Report

This report is organized into four primary topical sections and a summary. The primary topical sections each synthesize findings from the literature and key themes from subject matter expert interviews focused on four target population subgroups:

1. Service members and veterans
2. Spouses and families of service members and veterans
3. Children of service members and veterans
4. Military caregivers

Each topical section defines and describes the key subgroup attributes, population needs, the community needs, and challenges followed by implications and considerations for arts programming. In addition, the report includes an appendix that provides a detailed summary of findings from the subject matter expert interviews.

SERVICE MEMBERS AND VETERANS

The U.S. Armed Forces consists of five branches of the military (Army, Navy, Marine Corps, Air Force, and Space Force) and the Reserve Component (Ready Reserve, standby Reserve, Retired Reserve). Men and women are drawn to military service for many reasons, from wanting to serve their country to seeking a steady income, affordable technical training and higher education. Despite the many benefits of serving in the U.S. Armed Forces, current and veteran service members also face many challenges stemming from their time in the military. These can present problems in both professional and personal aspirations and even everyday interactions as current service members transition to civilian life.

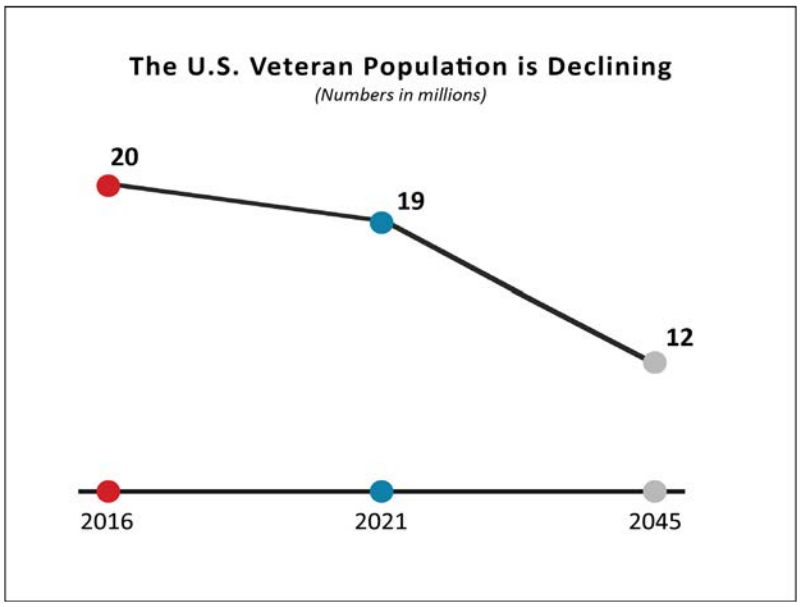
This report will explore the strengths, unique needs, and challenges of both current and former service members and provide guidance to help create more effective art programs tailored to the identified needs of veterans and service members.

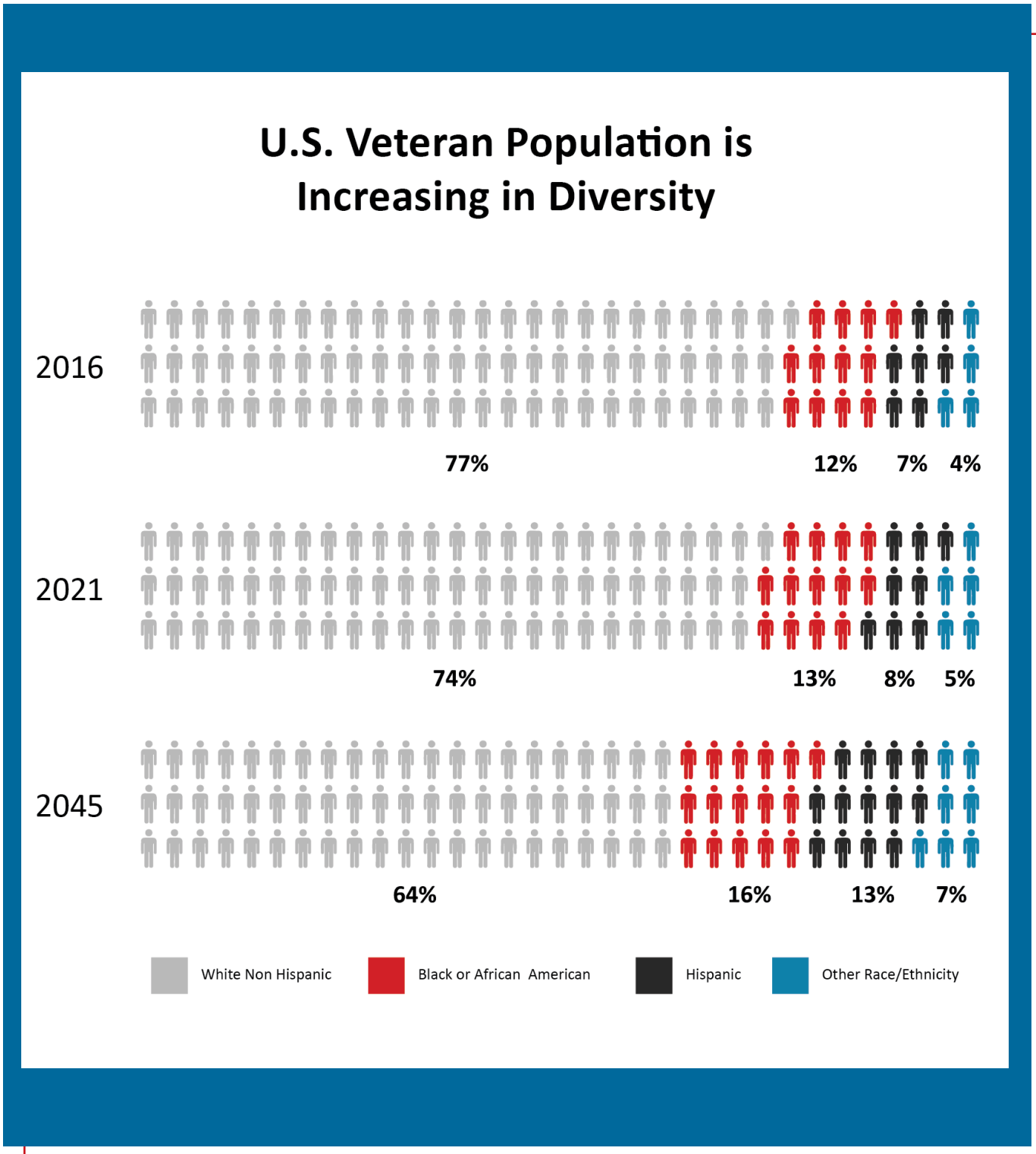
Veterans

A veteran, as referenced in this report, is a person who has served in the U.S. Armed Forces for any length of time. In 2016, there were roughly 20.4 million U.S. veterans. This represents less than 10% of the total U.S. adult population (Bialik 2017), and that overall percentage is declining with just 7% of U.S. adults reporting as veterans in 2016, a drop from 18% in 1980 (Bialik 2017). Since 1968, during the draft era, the number of people on active-duty has dropped from 3.5 million to 1.3 million. Projections made by the Department of Veterans Affairs show a decline in the veteran population, forecasting that it would decrease by 40% by 2045 (Bialik 2017).

In 2016, Gulf War–era veterans represented the largest portion of all U.S. veterans, with 6.8 million Americans having served in the Vietnam War and 7.1 million having served in the Gulf War (Bialik 2017). That same year, 77% of veterans had served during wartime and just 23% had served during peacetime (Bialik 2017). 2016 data show that 91% of veterans are men and 9% are women; however, it is anticipated that by 2045 the female veteran population will double to 18% while the male veteran population will drop from 18.5 million to 9.8 million (Bialik 2017). This reflects an overall trend of a decreasing veteran population. The veteran population is also expected to become more racially and ethnically diverse, with the share of Hispanic veterans increasing from 7% to 13% and the share of African American veterans increasing from 12% to 16% by 2045 (Bialik 2017).

Overall, the veteran population is declining in the U.S. while also becoming more diverse with more women, Hispanic and African American veterans.



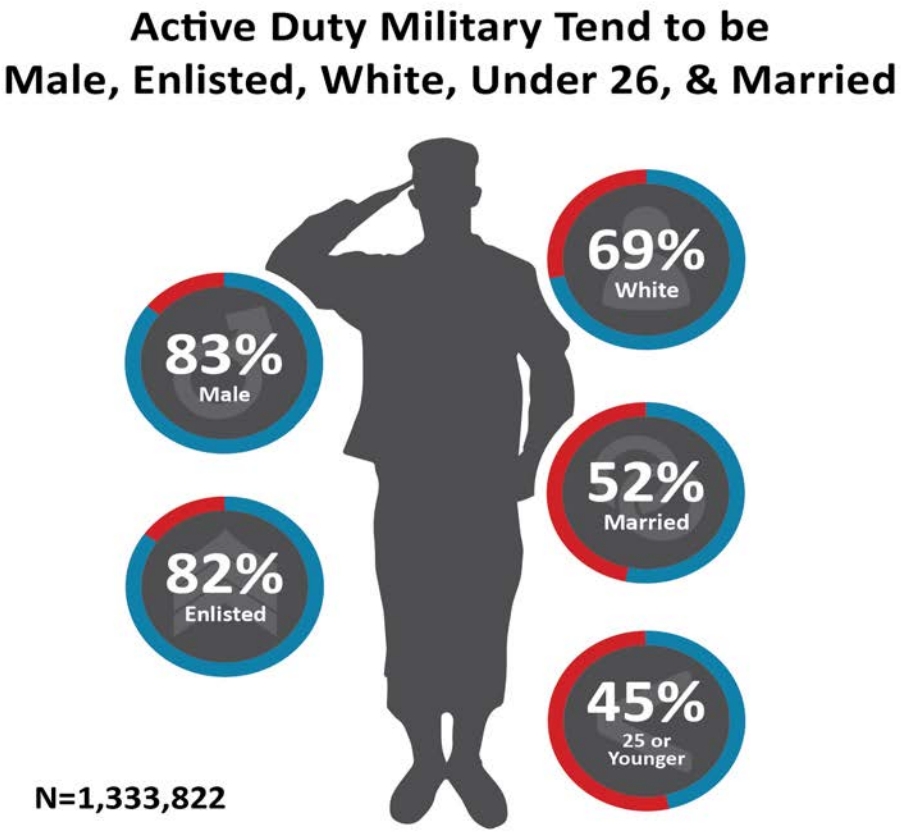

U.S. Veteran Population is Increasing in Diversity
2016
77%
12%
7%
4%
2021
74%
13%
8%
5%
2045
64%
16%
13%
7%
White Non Hispanic
Black or African American
Hispanic
Other Race/Ethnicity

Service Members

A service member, as referenced in this report, refers to a person who is a current member of the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, or Space Force), including those who are Active Duty, National Guard, and Reserve. Roughly 82.4% of active-duty personnel are enlisted members, with just 17.6% serving as officers (U.S. Department of Defense 2020). Of these current active-duty members, the highest percentage report themselves as White (68.9%), followed by Black or African American (17.2%), Asian (4.8%), multiracial (3%) American Indian or Alaska Native (1.1%), and Native Hawaiian or other Pacific Islander (1.2%).

In 2020, the active-duty population was 17.2% female and 82.8% male. Over 40% of active-duty members are 25 years of age or younger, with another 20.3% between 26 and 35 years of age, leaving 23.9% of the active-duty population at 36 years of age or older (U.S. Department of Defense 2020).

Almost a third of active-duty enlisted members have at least a high school diploma or some college (62.6%) while 15.2% have achieved a bachelor's degree, and 8.3% have an advanced degree. Active-duty officers are more likely to have a bachelor's degree or higher (84.8%). More than half of active-duty members are married (51.5%), a percentage that is higher among officers (67.5%). When it comes time to separate from the service, 44.7% have voluntary separations, 26.8% retire from the service, and 28.1% separate involuntarily (U.S. Department of Defense 2018). The average length of service in the military is ten years (Blaisure et al. 2012).



Source: U.S. Department of Defense. 2020. 2020 Demographics Profile: Profile of the Military Community.

Reserve and National Guard

A Reserve or National Guard member, as referenced in this report, refers to a person who is a trained civilian and prepared to serve if called to active-duty, but who is not presently on full-time active-duty. In the 1970s, a total force policy was implemented by the U.S. government, which calculated the total U.S. military force as a combination of Active Component service members (Army, Navy, Marine Corps, Air Force) together with the Reserve Component service members (Ready Reserve, Standby Reserve, Retired Reserve), along with certain government civilian employees. Ready Reserve personnel include Selected Reserve, Individual Ready Reserve, and the Inactive National Guard. Individual Ready Reserve and Inactive National Guard members have typically served as active-duty service members or Selected Reserve in the past and are not currently participating in training (U.S. Department of Defense 2018). Selected Reserve members participate in training throughout the year, training that also includes annual active-duty preparation.

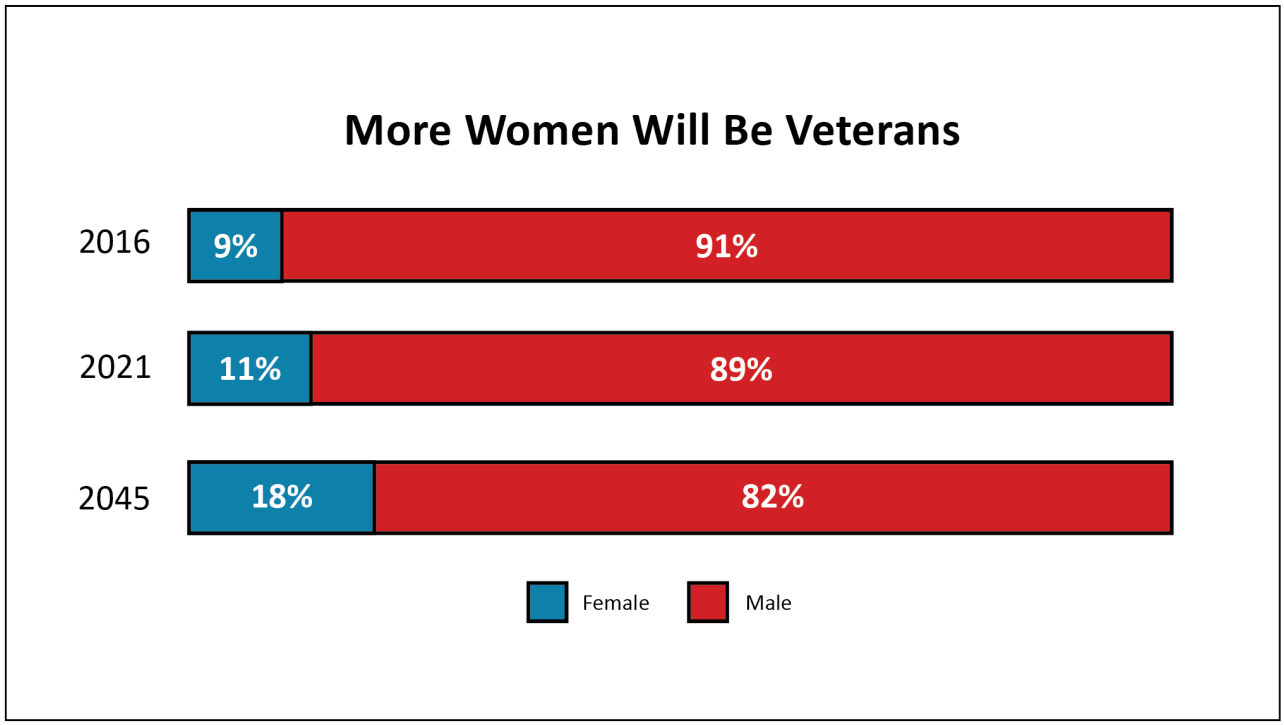
As of 2020, the Ready Reserve and its 1,021,613 members represent the Army National Guard, Army Reserve, Air Force Reserve, Air National Guard, Marine Corps Reserve, Navy Reserve, and Coast Guard Reserve. The Ready Reserve represents 29.8% of the total military force. There are 802,248 members in the Selected Reserve, 16.9% of whom are officers and 83.1% of whom are enlisted members. The Army National Guard represents the largest proportion of Selected Reserve (41.9%) followed be the Army Reserve (23.5%) and Air National Guard (13.4%; (U.S. Department of Defense 2020). Active Duty, Reserve, and Guard members represent 46% of the total force in the Army and 22.1% of the Air Force (U.S. Department of Defense 2018).

Selected Reserve members are 78.9% male and 21.1% female (U.S. Department of Defense 2020). The largest proportion of Selected Reserve members report themselves as White (72.5%) followed by Black or African American (15.9%), Asian (4.5%), other/unknown (3.7%), multiracial (1.8%), and American Indian or Alaska Native (0.8%) (U.S. Department of Defense 2020). The age range of selected reserve members represents a more even distribution across the lifespan than the veteran population. There is a smaller proportion of Selected Reserve members who are 25 years of age or younger than the veteran population (32.9% compared to 45.6%), a comparable proportion between age 26 and 35 (34.3%), and a greater proportion of members who are 36 years of age or older (32.7% compared to 18.5%) (U.S. Department of Defense 2018). Education levels and marital status of Selected Reserve are comparable to the veteran population.

Special Populations

Subgroups of service members and veterans may have distinct needs in addition to sharing the collective needs of other service members and veterans. Despite the trend toward a more diverse military, minority groups, including racial and ethnic minorities and gender and sexual minorities, have been underrepresented in needs assessments conducted across the nation (Van Slyke and Armstrong 2019).

Women. Women represent 17% of the total military force and 9% of the veteran population (U.S. Department of Defense 2020; Bialik 2017). An estimated 12% of the 2.1 million active-duty military deployed through 2010 to Iraq and Afghanistan were women (Institute of Medicine 2010). The top three reasons that women join the military include educational benefits; opportunities to pursue new experiences, adventures, or travel; and a desire to serve their country (Maury et al. 2018). Women also strengthen personal and professional skills during their military service, including teamwork, mental toughness, perseverance, and an ability to cope with adversity (Maury et al. 2018). Despite the integral role women play in the military, the literature, research, and programming do not adequately address the gender-specific needs of this population (Hawkins and Crowe 2018).



Source: Bialik 2016, Schaeffer 2021

LGBTQIA. Over one million veterans and between 66,000 and 75,000 service members are lesbian, gay, bisexual, transgender, queer, intersex, and/or asexual (Ahlin and Douds 2018). Transgender individuals, those whose gender identity is different from their assigned sex at birth, serve in the military at rates that are two to three times higher than the general population (Chen et al. 2017; Harrison-Quintana and Herman 2013). Transgender veterans and service members report high rates of discrimination including biased hiring and firing, police harassment, and eviction for being transgender; in addition, they also experience family rejection, higher rates of lifetime homelessness, and suicide rates that are twenty times higher than that of other veterans (Chen et al. 2017).

Population Needs

The U.S. Armed Forces, much like any other entity with more than one million members, has its own culture. This includes an emphasis on self-reliance and dedication to the group rather than the self. While this serves the needs of the military well, it can also lead to service members with unaddressed problems, particularly mental health needs. Both special populations as well as the general service member and veteran population share similar challenges that should be considered when designing arts therapy programs.

Stigma. Stigma associated with mental health and seeking care and services is a concern that affects the U.S. population broadly and presents distinct challenges for veterans and service members due to the additional layer of military culture that can affect help-seeking behaviors. Military culture places an emphasis on self-reliance (Teeters et al. 2017). This value may lead veterans and service members to try to address mental health and substance use issues on their own (Teeters et al. 2017). Veterans and service members may feel the need to "protect" family and friends from the reality of their symptoms and struggles, presenting another barrier to help-seeking behaviors (Teeters et al. 2017). Hoge and colleagues documented several barriers cited by active-duty service members in relation to seeking mental health services, including concern that they would be seen as weak, that unit leadership would treat them differently, that members of their unit would treat them differently,

that it would be difficult to get time away from work for treatment, and that it would harm their career. Concerns over how peers and leaders view people with mental health needs often carry over into civilian life, as veterans worry about the personal and professional implications of having a mental health diagnosis.

Discrimination in healthcare settings may lead LGBTQIA veterans to delay treatment or conceal their sexual and gender identities (Ruben et al. 2019). Nondisclosure has been identified as a risk factor linked to missed opportunities for health education and appropriate health care screenings, and poorer reported health and wellbeing (Ruben et al. 2019). Greater incidents of discrimination in healthcare were connected to poorer provider communication, less comfort with disclosures, and increased symptoms of anxiety (Ruben et al. 2019). One study identified that older LGBTQIA veterans (age 50 and greater) reported less harassment and rejection related to their LGBTQIA identity (Cortes and Fletcher 2020). LGBTQIA veterans in this age demographic measured higher in resilience than younger LGBTQIA veterans (age 49 or younger) (Cortes and Fletcher 2020). Another study reported that fewer LGBTQIA women reported feeling welcome at the Veterans Health Administration (VHA) when compared to non-LGBTQIA women who reported feeling welcome (Shipherd et al. 2018). LGBTQIA women in this study reported feeling unsafe at the VHA and reported experiencing harassment by male veterans at higher rates than non-LGBTQIA women. Higher quality provider communication was related to increased frequency and comfort with disclosing sexual orientation and was also related to less tobacco use (Ruben et al. 2019). However, when individuals reported high levels of discrimination in healthcare settings, the positive effect of high-quality provider communication diminished (Ruben et al. 2019). Findings highlight the need to reduce discrimination in healthcare settings. A qualitative study on the lived experiences of transgender veterans identified several reoccurring themes including access to health-care and providers, discrimination, rejection versus acceptance, concealment versus authenticity, the importance of community as well as positive experiences such as personal strength, and growth from adversity and advocacy (Chen et al. 2017).

> ***A participant in our study recognized the impact of stigma on the service member and veteran population and stated: "More work needs to be done at the ground level to overcome stigma and normalize challenges associated with transitions in the lifecycle of service members and their families." Programs that have a wellness focus can shift the focus from diagnosis and disorder to health and wellness, promoting a positive, strengths-based approach to working with veterans and their families.***

General health and wellness. Literature on veteran and service member health and wellness shows that both groups are more likely to experience complex conditions than the civilian population. These conditions involve an intersecting combination of physical, cognitive, psychological, and behavioral health concerns (Hull et al. 2015). Traumatic brain injury (TBI) has become a common injury of the Iraq and Afghanistan wars with associated health outcomes that include memory loss, headaches, dizziness, sleep disturbances, concussions, intracranial hemorrhage, and head injuries (Nworah et al. 2014). Post-traumatic stress disorder (PTSD) is a common co-occurring condition for veterans and service members with TBI (Pietrzak et al. 2009). In addition, there are medical conditions that commonly co-occur with PTSD.

Other common medical conditions reported by veterans and service members include pain, irritable bowel syndrome, chronic fatigue, anxiety, depression, sleep disturbances, and neurological dysfunction (Hull et al. 2015). Pain and pain-related conditions are the most common medical concerns identified by veterans of the Iraq and Afghanistan wars (Nworah et al. 2014). Further, there are also health disparities in transgender veterans across twenty different medical and mental health conditions, including alcohol abuse, depression, PTSD, cardiovascular disease, and breast and prostate cancer (Chen et al. 2017).

Mental health. Deployment for combat operations has been associated with mental health concerns among veterans and service members (Hoge et al. 2004; Tanielian and Jaycox 2008). A study of post-9/11 veterans found that 36% believe they have suffered from post-traumatic stress (Parker et al. 2019). The psychological symptoms that are common with combat stress, particularly when sustained at high levels for a long duration of time, have also been connected to an increased risk for suicidal ideation (Mansfield et al. 2011b). Common mental health concerns that veterans and service member face include PTSD, major depression, and TBI (Institute of Medicine 2010; Hoge et al. 2004; Tanielian and Jaycox 2008). A 2008 study conducted by the RAND Corporation estimated that these conditions would affect approximately 300,000 U.S. veterans of the wars in Iraq and Afghanistan (Tanielian and Jaycox 2008). The study estimated that 26% of returning veterans from the wars in Iraq and Afghanistan would potentially meet the criteria for a mental health condition, most commonly PTSD, major depression, or generalized anxiety (Tanielian and Jaycox 2008). Post-9/11 veterans are twice as likely than pre-9/11 veterans to have served in a combat zone and combat veterans are roughly twice as likely to have served with someone who was killed while on duty (Parker et al. 2019).

A recent study explored the changing rates of mental health disorders among veterans treated in the Veterans Health Administration (VHA) from 2007 to 2013 (Hunt et al. 2019). The study found a 15% increase in the VHA population during this timeframe, and a 38% increase in veterans who were diagnosed with bipolar disorder, psychotic disorders, drug/alcohol dependence, anxiety disorders, post-traumatic stress disorder, depression and adjustment disorder (Hunt et al. 2019). They found that during the timeframe studied the largest diagnostic group represented in those with a behavior health diagnosis was depression (30.4%), followed by post-traumatic stress disorder (23%). When compared to prevalence rates among the general U.S. adult population, the rates for veterans we significantly higher (18.6% for general population and 32.6% for veterans in 2013) (Hunt et al. 2019). Changes in prevalence rates can be attributed to many factors including increased screening, efforts to decrease stigma and increased access (Hunt et al. 2019). However, findings do signal an increased need for services for veterans within the VHA and in community-based organizations.

Some reports indicated that women are more likely than men to experience PTSD, although they are less likely to be diagnosed (Heineman 2017). In women, common co-occurring conditions include lumbosacral spine disorders, headache, lower extremity joint disorders, skin disorders, tendonitis/myalgia, dental disorders, allergies, vision defects, acute upper respiratory tract infections, and obesity (Frayne et al. 2010). Likewise, common co-occurring conditions in men with PTSD include lumbosacral spine disorders, lower extremity joint disorders, hearing problems, hyperlipidemia, tendonitis/myalgia, skin disorders, dental disorders, hypertension, sleep disturbance, and other joint disorders (Frayne et al. 2010).

Combat exposure (Wolfe et al. 1993) impacts veterans' overall ability to successfully transition from military to civilian life. Studies have documented a link between heavy combat exposure and greater difficulty adjusting post-war (Hoge et al. 2004; Morin 2011; Parker et al. 2019; Seal et al. 2009; Wolfe et al. 1993), a positive correlation between combat trauma and poorer family adjustment (Gewirtz et al. 2010; Pemberton et al. 2013; Sayers et al. 2009), and a relationship between PTSD and transition difficulty (Pietrzak et al. 2010b; Sayer et al. 2010). Heightened mental health problems have been associated with the length of deployment, multiple deployments, and the intensity of combat exposure (Castro 2009). This can in turn lead to broader difficulties, with veterans who experienced post-traumatic stress much more likely to have difficulty with adjustment after leaving the military (Parker et al. 2019). Of these, 61% report trouble paying their bills, 42% report difficulty obtaining medical care, and 41% identify struggles with alcohol or substance abuse (Parker et al. 2019).

Normalizing post-traumatic stress responses along with other mental health challenges can help to engage veterans and service members in seeking mental health services when they are needed.

Study participants emphasized that veterans and service members may benefit from services that promote resilience and build on strengths. Some treatment approaches endorsed by interviewees included teaching grounding strategies, using guided imagery to promote relaxation, teaching basic cognitive behavioral therapy skills such as recognizing and tolerating emotions, and offering interventions and programs that build community connections among military-connected individuals and with the civilian community. One participant talked about offering an approach to therapy that examined dominant narratives to help veterans and service members explore personal strengths and resilience and build on positive characteristics as they work to transition from military to civilian life. Narrative approaches can also support a shift in therapy from being deficit-focused to strength-focused, as veterans begin to tell their stories in a different light and move toward a narrative that builds on feelings of being a strong, capable, and contributing citizen.

Substance use and abuse. Substance use has a long history in the military dating back to the American Civil War when alcohol was used medically because it was thought to enhance coping skills before engaging in battle (Rubin and Barnes 2013). During the Vietnam War, alcohol use continued to be prominent and marijuana use increased, concurrent with an increase in use of marijuana in the civilian sector (Rubin and Barnes 2013). The use of alcohol, illicit drugs, and tobacco have long been viewed as a part of military work culture, as service member use has served recreational purposes, as a reward for hard work, to ease personal tensions, and for unit cohesion and bonding (Institute of Medicine 2013; Teeters et al. 2017). Alcohol consumption also has been commonly used to help service members cope with stressful or traumatic events (Thomas et al. 2010) and marijuana has been the most commonly used illicit drug since the early 1980s (Institute of Medicine 2013).

Studies have demonstrated an increase in alcohol use in active-duty service members over the past two decades (Institute of Medicine 2013) and high levels of combat exposure have been associated with higher rates of problematic alcohol use (Bray et al. 2013). Increased use of prescription drugs has also become a concern for active-duty service members as prescription drugs have become a common form of pain management (Institute of Medicine 2013). Throughout the years, the military has taken steps to prevent and treat substance abuse, as it has been shown to decrease the performance of service members—a particularly problematic and potentially dangerous consequence for service members on the battlefield, where optimal performance is tied to survival (Rubin and Barnes 2013). Rates of problematic drinking in the military continue to surpass rates in the civilian population, suggesting that cultural norms or expectations may encourage drinking, that military interventions aimed at prevention and treatment have not been successful, or both (Institute of Medicine 2013).

Substance use is also a concern among veterans, as rates of substance abuse continue to rise and substance use disorders have been associated with many negative outcomes for veterans including medical issues, mental health conditions, relationship issues, vocational impairment, and increased rates of suicidal ideation and suicide attempts (Teeters et al. 2017). Alcohol use disorders are the most common form of substance use disorder in the veteran population (Teeters et al. 2017). Misuse of prescriptions drugs is also an increasing concern, as veterans are commonly prescribed these medications to help address common medical issues such as headaches and chronic pain (Teeters et al. 2017). Illicit drug use in the veteran population mirrors the civilian population in prevalence and the most common illicit drug used by veterans is marijuana (Teeters et al. 2017).

Substance use disorders and co-occurring mental health disorders. Substance use disorders often present with other co-occurring conditions, the most common of which are PTSD, depression, and TBI (Karney et al. 2008). Rates of PTSD and substance use disorder co-occurrence range from 34 percent to 88 percent in veteran populations (Pedersen et al. 2019). Alcohol use disorder is the most common co-occurring condition with PTSD and depression with rates of co-occurrence ranging from 16 to 69 percent (Pedersen et al. 2019). Alcohol use

increases the risk of depression, can exacerbate symptoms of PTSD and depression, and can make a suicide attempt more likely (Mansfield et al. 2011b). In addition, substance use issues can often develop secondary to PTSD and substance use commonly precedes depression (Karney et al. 2008). Co-occurrence of PTSD and depression have been associated with higher rates of alcohol use (Pedersen et al. 2019).

Evidence has shown that substance abuse comorbidity is more difficult to treat (Karney et al. 2008), though many barriers may prevent veterans with co-occurring substance abuse and mental health disorders from seeking care. Veterans may avoid seeking treatment due to perceived stigma, fear of repercussions (i.e. harm to career, loss of benefits), or logistical challenges like the high costs or difficulty finding services (Pedersen et al. 2019). When they do receive care, veterans with co-occurring conditions have poorer treatment outcomes than veterans presenting with a single condition (Pedersen et al. 2019). Veterans who receive treatment for a single condition, rather than seeking treatment for the co-occurring conditions simultaneously, may find that they cycle between treatment for mental health and substance abuse, a cycle that does not support recovery for the veteran (Pedersen et al. 2019). Evidence-based, integrated care that addresses both mental health and substance abuse is recommended. In addition, recreation services, like art therapy, can provide healthy outlets for emotions, help veterans to reconnect with a sense of joy, and provide a positive social activity that veterans can engage in without substances (Pedersen et al. 2019).

It is important to note the disparities among racial and ethnic minority groups regarding diagnosis and treatment of substance use and mental health disorders. A study conducted by the Veterans Administration examined service utilization from 2001-2013 and found that rates of care in mental health outpatient, primary care, and emergency services were comparable for racial and ethnic groups, however, veterans of color were admitted to psychiatric inpatient care at lower rates than white veterans (Pedersen et al. 2019). Diagnosis rates varied across groups, with Asian American/Pacific Islander veterans having lower rates of mental health diagnosis; American Indian/Alaska Native males with higher rates of PTSD; depression and substance use disorders than white male veterans (Pedersen et al. 2019). Barriers to accessing care also varied across race /ethnicity. Higher percentages of black and Hispanic veterans identified not feeling welcome as a barrier to accessing care in the VA (Pedersen et al. 2019). Further, black veterans more often stated that they were not aware of or did not know how to apply for benefits (Pedersen et al. 2019). Providers must consider the distinct needs, challenges, and barriers to care experienced by the diverse veterans they serve and develop strategies to accommodate needs that vary by race, gender, or ethnicity (Pedersen et al. 2019).

Women veterans and service members. A qualitative study explored the experiences of 22 women veterans and found that several psychosocial factors impacted the mental health of women who served (Evans et al. 2018). The four broad categories of factors identified included mental health conditions related to histories of trauma in childhood and the military, and discrimination; post-military socio-economic stressors; shifts in social roles and adverse social support; and loss of personal identity after military service (Evans et al. 2018). It was noted that women veterans were more likely than civilian women to report childhood trauma and adversity, and that all types of traumas increase the risk for substance use disorders, post-traumatic stress disorder, depression, and suicidal ideation (Evans et al. 2018). The authors described substance abuse, poor social support, and isolation as risk factors for homelessness in the women veteran population (Evans et al. 2018). Women veterans who participated in the study identified that re-defining their personal identity after service support positive health and wellness outcomes (Evans et al. 2018). Considerations for building resilience among women veterans included creating opportunities for social support and mentoring relationships (Evans et al. 2018).

LGBTQIA veterans and service members. The LGBTQIA veteran population presents with psychosocial and healthcare needs that may be different than other subgroups of veterans (Ahlin and Douds 2018). Lack of culturally competent care may create additional barriers for LGBTQIA veterans that impact the quality of their

care and their motivation to seek help (Ahlin and Douds 2018). LGBTQIA veterans may have encountered unique stressors during their military services that can include the need to conceal their personal information, harassment from other service members, and fear of being discharged for their sexuality or gender identity (Ahlin and Douds 2018). Research has shown that LGBTQIA veterans are more prone to health issues and higher rates of mental health concerns, substance abuse, smoking, sexually transmitted diseases, and suicidal ideation, and they experience military sexual trauma at higher rates than the overall veteran population (Ahlin and Douds 2018; Ruben et al. 2019). Concealment of identity while in the service appears related to risk for mental health conditions post-discharge (Cochran et al. 2013). It has been documented that LGBTQIA veterans may avoid seeking health care and counseling services because they are concerned that providers would not accept their sexuality (Ahlin and Douds 2018).

Military sexual trauma. Military sexual trauma refers to sexual assault or repeated threatening, sexual harassment that occurs while a service member is in the military (Heineman 2017). In a survey of women veterans 55 year of age and older it was found that 1 in 5 women between the ages 55 and 64, and 1 in 10 between the ages 65 and 74 have experienced military sexual trauma (Gibson et al. 2020). A screening conducted by the Department of Veterans Affairs in 2010 found that 0.7% of men and 15.1% of women veterans of the Iraq and Afghanistan wars reported experiencing military sexual trauma (Heineman 2017). Transgender veterans and service members report twice the rate of military sexual trauma and one and a half times the rate of incarceration (Chen et al. 2017). Military sexual trauma plays a larger role in PTSD than combat exposure (Carlson et al. 2013).

Military sexual trauma is associated with several physical and mental health conditions. Related mental health conditions include depression, PTSD, anxiety, suicidal ideation, sleep disorders, suicidal ideation, and decreased quality of life (Gibson et al. 2020, Cichowski et al. 2017). Physical conditions associated with military sexual trauma include chronic pain conditions, irritable bowel syndrome, obesity, and, for women, hyperthyroidism, and an increased prevalence of hysterectomy (Cichowski et al. 2017). Chronic pain conditions associated with women's experiences of military sexual trauma, include chronic pelvic pain, back pain, joint pain, fibromyalgia, dyspareunia, and headaches (Cichowski et al. 2017).

Other studies found that sleep apnea in women veterans was strongly associated with MST (Gibson et al. 2020). Authors also found a significant association between opioid use and MST, suggesting that women who have experienced MST may be in a higher risk category for abuse (Gibson et al. 2020). Notably, older women veterans who had experienced MST were over 7 times more likely to be diagnosed with PTSD, and 2 times more likely to experience anxiety, depression, and suicidal ideation (Gibson et al. 2020). Similarly, wartime exposures that included dealing with death, perceptions of threat, job pressures, and sexual harassment and discrimination were associated with worse health outcomes for women veterans later in life (Smith et al. 2020). Data collected in 2012 on a sample of 4,219 women veterans from the Vietnam-era showed significant associations linking wartime exposures to poorer functioning and increased disability over four decades later (Smith et al. 2020). PTSD was linked with poorer physical health, mental health, and increased disability (Smith et al. 2020). Authors noted that the long-term impacts of sexual harassment and discrimination on health outcomes signaled the need for continued efforts to prevent these experiences and treat them with trauma-informed services when they do occur (Smith et al. 2020).

Strengths and resilience. Protective factors are conditions and characteristics that increase well-being, health, and positive outcomes, and/or reduce the impacts or risk factors. A focus on wellness and resilience can draw attention to service members' and veterans' existing protective factors and work to build on them. Many veterans and service members identify positive aspects of their military service and express pride when leaving the military (Parker et al. 2019). A study of post-9/11 veterans found that those who served in combat reported that their combat experiences helped them to feel closer to fellow service members, demonstrated that they were stronger than they thought they were, and provided them with new perspective about what was important in life (Parker et al).

Several protective factors that moderate or help mitigate the effects of stress, trauma, and combat exposure have been identified in the literature, including:

- Social support
- Increased military preparedness and coping skills
- Increased understanding of combat conditions
- Family cohesion
- Higher post-service income and benefits
- Use of the G.I. Bill of Rights
- Use of mental health treatment (Smith-Osborne 2009).

Greater resilience and social support can help to protect against the development of PTSD and depression and may serve as a buffer against suicide (Pietrzak et al. 2010a). Protective factors help build resilience, and one of the strongest components influencing resilience in veterans and service members is social support (Mansfield et al. 2011b). Post-deployment accessibility of friends and family and a sense of purpose and control also have been shown to be protective factors against suicide (Pietrzak et al. 2010a).

> ***Study participants identified several factors that contribute to veteran and service member resilience, including mental and physical toughness, propensity toward self-sacrifice and selfless service, and the drive to be a productive and contributing citizen. Participants identified that mental and physical toughness are developed during service members' careers and can support veterans' resilience in the face of adversity. Participants also expressed how it can be important for some veterans to give back to other veterans through advocacy, volunteerism, and mentorship. As one veteran expert who was interviewed stated: "When we finish, we want to be as productive in civilian society as we were in service."***

Community Needs

Identification and connection. Early outreach to veterans and service members who are returning from deployment and offering a continuum of community supports can help to mitigate psychosocial difficulties and promote a healthy and successful transition to civilian life (Pietrzak et al. 2010a). More than seventy needs assessments have been conducted over the past fifteen years, many of them within the last five years, that examine the overall needs of service members as they transition from military to civilian life and study how service members are managing this transition. The resulting reports have yielded data-driven considerations for serving the military-connected population (Castro et al. 2015; Kidder et al. 2016; Kintzle et al. 2016). Commonly cited issues include difficulty scheduling an appointment (Castro et al. 2015; Kintzle et al. 2016), not knowing where to go to get help (Castro et al. 2015), and ineligibility for benefits (Castro et al. 2015). There are also other factors impacting engagement with services. As discussed above, LGBTQIA women tend to experience more challenges with discrimination and harassment when utilizing VHA services, which impacts their engagement with providers (Ruben et al. 2019; Cortes and Fletcher 2020; Shipherd et al. 2018). Race was also significantly associated with patient engagement and the working alliance with the provider (Eliacin et al. 2018). African-American veterans reported lower levels of engagement when compared to White counterparts (Eliacin et al. 2018).

Many studies cited the need for a holistic approach, the need to focus on prevention and early intervention, and the need for cross-sector collaboration so that services are organized and integrated in a way that enables and improves access. Several studies pointed specifically to the need for regional-level coordination (Kidder et al. 2016) or coalitions aimed at addressing challenges (Kinzle et al.), including issues with service navigation.

In response to widespread challenges with navigating services, there has been a call for solutions to help communities develop systematic ways to integrate services and help individuals traverse this resource-rich landscape by efficiently and effectively connecting them to the correct point of service (Copeland and Sutherland 2010). Exploring new delivery approaches, like tele-mental health, that can increase access to services, as well as strengthening the evidence for understanding the effectiveness of complementary and alternative therapies, were suggested strategies to advance the quality of mental health care for veterans (RAND Corporation 2019).

> ***These concerns with navigation and access were echoed by our study participants. Participants identified many of the same needs outlined in the literature and also emphasized the complex nature of co-occurring needs, citing that veterans commonly present with more than one need at a time and often present with multiple complex needs that can include housing, legal, and employment needs. Participants emphasized the need for providers to "work across silos" to better coordinate care. One participant advised, "Become a learning organization, collect knowledge, curate it and put it in motion so that we have a learning community of providers who are open to moving beyond their own boundaries, believing that what they're actually contributing to is not only their individual body of work but a collective community of work." Every community has its own unique set of needs, challenges, strengths, and assets along with its distinct history around collaborative efforts, norms, and values associated with working together. If communities can come together around serving military-connected community members better, there are many opportunities to be realized.***

Relationships. Social support can serve as a protective factor against suicide (Pietrzak et al. 2010a). Robert McDonald, former U.S. Secretary of Veterans Affairs, reported that seventeen of the twenty-two veterans who take their own lives every day are often disconnected from family and friends and are not receiving supportive services (Martin 2015). Studies have emphasized the positive relationship between social support and adjustment, particularly for veterans who may be dealing with symptoms of a psychiatric disorder (Larson and Norman 2014; Ozer et al. 2003; Sayers et al. 2009). Limited social support was also connected with a poorer response to therapy (Herman 1992; Sayers et al. 2009). Connection to support, including other veterans and professional services, could support a healthy transition and help to prevent suicide by reducing isolation, normalizing struggles, and providing hope for the future.

Connection to other veterans can be a strong source of support during transition. However, sustaining relationships with "military buddies" can be difficult, often because their homes are in different places. Relationships with other service members are identified as very important and a main source of support post-deployment (Caplin and Lewis 2011). These relationships are cemented by shared experiences and emotions that are unmatched by civilian counterparts (Olsen et al. 2014). Veterans typically form a strong military group identity early in their careers, an identity that is reinforced and strengthened through deployment, shared values, and emotional attachments, as well as grounded in a sense of individual sacrifice for the good of the nation (Caplin and Lewis 2011). Strain on relationships due to distance mean that the veteran loses a significant source of support. Continued connection to other service members can help to normalize the struggles of transitioning from military to civilian life and help veterans to persevere when confronted with challenges.

Military to Civilian Transition

Veterans who are transitioning from military to civilian life may experience difficult feelings including anxiety, frustration, fear, and loss, while at the same time questioning the meaning and purpose of their lives (Coll and Weiss 2013). This emotional impact is often ancillary to several tasks associated with transition from military to civilian life that all veterans must achieve (DeLucia 2016). Responsibilities associated with personal and

professional goals are often among veterans' top priorities upon their return to civilian life. Tasks and challenges associated with these goals include difficulty translating military experience to civilian job qualifications (Coll and Weiss 2013), finding and sustaining gainful employment (Adler et al. 2011), reentering college (Olsen et al. 2014), securing permanent housing (Coll and Weiss 2013), and attending to daily responsibilities such as money management (Caplin and Lewis 2011; Olsen et al. 2014). For many veterans, joining the military marked a transition into adulthood, and unlike the civilian sector, the military provided a highly structured environment that included medical care, stable income, housing, and educational benefits (Keeling 2018). Upon transitioning out of the military, some veterans can struggle to adapt to the unstructured civilian environment (Keeling 2018).

Transition has been conceptualized as interacting and overlapping phases that include interactions among multiple systems including individual, interpersonal, community, and organizational (Castro and Kintzel 2014). Some argue against theories that view military-to-civilian transition as an event that occurs at a fixed moment in time and instead promote an understanding of the differences among veterans' transition experiences (Higate 2001). There is agreement that military-to-civilian transition is a complex process that impacts several domains of functioning, including social, family, financial, occupational, and personal aspects of life (Blackburn 2017). In a study of post-9/11 veterans, 32% said it was somewhat difficult to transition and 16% said it was very difficult, compared to most pre-9/11 veterans who said it was easy for them to transition (Pederson et al. 2019).

Failure to successfully transition back into civilian personal and professional roles can exacerbate a veteran's problems. Adverse outcomes associated with failure to adjust include poorer social and family functioning (Khaylis et al. 2011; Vasterling et al. 2010), unemployment (Adler et al. 2011), financial issues (Vasterling et al. 2010), and homelessness (Caplin and Lewis 2011; Institute of Medicine 2010). Further, veterans who struggle with the transition may be more prone to isolate themselves from potential social supports (Larson and Norman 2014). All of these consequences put veterans at greater risk for developing mental health issues (Furukawa 1997; Lee et al. 2009), substance abuse problems (Seal et al. 2009), functional impairments across the lifespan (Larson and Norman 2014), and suicidal ideation (Mansfield et al. 2011b; Pietrzak et al. 2010a).

Lacking clarity in personal and professional goals and experiencing trouble finding adequate housing or meaningful employment can be potential causes of emotional distress. Though some veterans feel as though they gained invaluable life experience and confidence through their military service that supported achievements in civilian society (Olsen et al. 2014), others described their skills as nontransferable (Coll and Weiss 2013). Despite having had years of travel experience, leadership responsibilities, and the ability to work in highly pressurized situations, many veterans report difficulties in translating their military skills and experience to fit civilian jobs (Prudential 2012). Skill translation can sometimes be related to underemployment for veterans, where the level of work is below a veteran's education, experience, or compensation (Barrera and Carter 2017). Some research has indicated that underemployment affects more veterans than non-veterans and may indicate that veterans may be more likely to take jobs that are not the "best fit" just to find employment (Barrera and Carter 2017).

As part of the transition out of the service, veterans often need to reestablish intimacy with loved ones, including spouses and children, and reconnect with close civilian friends (Gewirtz et al. 2010; Pemberton et al. 2013; Sayers et al. 2009). Reestablishing close relationships may be complicated when family and friends expect returning veterans to be unchanged by their military experiences. On the other side of this exchange, veterans may have similar expectations of spouses, significant others, friends, and family members. Study participants identified this as a transition period for the entire family that may cause the veteran or service member to feel they lack a bond with their children or spouse. Roles often need to be renegotiated when the service member returns home, and this process can take time. Expectations surrounding the transition back to civilian life may contribute to psychosocial problems such as isolation, losing contact with friends, and a loss of camaraderie (Blackburn 2017).

Cultural Transition. One aspect of transition that presents challenges is the shift from military culture back to civilian culture. Scholarly publications in the field of social work have drawn attention to aspects of military culture that are in contrast with civilian culture (Coll et al. 2013; Pryce et al. 2012). The military's organizational structure and its cultural values emphasize strict discipline, loyalty, and self-sacrifice to maintain order in battle; rituals and ceremonies create a shared identity and intense connection among service members, reinforced by group cohesion and a common mission (Olsen et al. 2014; Pryce et al. 2012). These values and behaviors may conflict with U.S. mainstream culture in many ways. For example, U.S. civilian culture focuses on the goals and needs of the individual over those of a social group. This focus is in direct contrast to the military's focus on a shared mission and group identity (Coll et al. 2013). Military culture also carries its own laws, customs, and traditions that include several restrictions on behavior and personal freedoms that would not be acceptable in civilian society, including regulations regarding personal appearance (e.g., hair style) and personal conditioning (e.g., weight standards; Coll et al. 2013).

The sudden separation from military culture and immersion into civilian culture can be experienced as a cultural loss (DeLucia 2015). Veterans depart from the values, rules, traditions, and supports to which they have become accustomed. Veterans lose the sense of camaraderie that comes from the knowledge that fellow service members are looking out for their safety and well-being (Coll and Weiss 2013). This strong sense of group cohesion is not easily found in civilian society. In addition, the U.S. military community has a strong built-in support network. Military families often seek support from one another because of shared experiences and a common understanding of military life (Coll and Weiss 2013). When veterans return home, they may lack proximity to their military support network while simultaneously losing the familiarity and structure of military culture. Many veterans may need to reconfigure their identification with both civilian and military cultures as part of their transition process. Study participants talked about how identity is "commonly in flux" when service members transition out of the military. A service member's identity may have been tied to the individual's military role and culture. As the service member transitions out of the military this identity needs to be reconciled in the context of new civilian roles and responsibilities.

Transition can be further complicated when civilian citizens interacting with a veteran lack a complete understanding of the veteran's experience and military culture. A nationally representative survey among veterans with combat experiences in Iraq and Afghanistan found that 55% of respondents felt disconnected from civilian life and that roughly seven in ten veterans felt that the average U.S. citizen misunderstands their experiences (Chandrasekaran 2014). When civilian citizens set veterans apart from others by idealizing or disparaging their military service, they reveal a lack of detailed knowledge about what veterans' service entailed (Herman 1992). This reaction creates a social disconnection between veterans and the civilian communities in which they reside.

> ***These concerns were echoed by our study participants who identified that "being viewed as either a hero or victim" or the tendency to "aggrandize or pathologize" service members and veterans contributes to the military-civilian divide. Study participants also identified misconceptions and stereotypes that deepen the military-civilian gap, including incorrect assumptions about combat experience, personal and political values, mental health and PTSD, and tendency toward violence.***

Transitions for Women Veterans. Women veterans identify similar transition challenges to men including navigating available programs and services, finding employment, financial struggles, depression, acclimation to civilian culture, and skills translation (Maury et al. 2018). Research has identified that financial struggles and depression are significantly greater for female service members when compared to male service members. On average, it takes women veterans three months longer to secure employment after transition (Maury et al. 2018). Women veterans who recently separated from the military (40%) reported that it took over one year or that they were still looking for employment, compared to 19% of male veterans (Maury et al. 2020).

Women veterans encounter many similar challenges as their civilian counterparts including challenges associated with childcare, mental health issues, and sexual assault (Heineman 2017). Women veterans have reported feeling less prepared to navigate resources in their community than their male counterparts (Maury et al. 2020). Transition from military service to civilian life compounds these challenges with those commonly associated with transition such as financial concerns, employment, and relationship stressors (Hawkins and Crowe 2018; Heineman 2017). Other challenges include acclimating to civilian life while at the same time encountering gender-specific expectations within a civilian culture that misunderstands female veterans' military experiences (Hawkins and Crowe 2018). Women veterans report greater feelings of social isolation when compared with male veterans, and, with time, social isolation remained constant, whereas it declined for male veterans (Maury et al. 2020).

> ***Our study participants discussed some of the challenges unique to women service members and veterans. One of our study participants discussed identity challenges for female service members, noting that women in the service may feel pressure to conform to a largely male-dominated culture. Another study participant indicated that identity challenges associated with military-to-civilian transition may be further complicated for female veterans as gender-specific expectations add another layer that can complicate the process of military-to-civilian transition.***

Arts Programming: Overview of Programs and Considerations for Service Members and Veterans

There is an abundance of programs and community-based organizations that are eager to provide support and services to transitioning service members and veterans and their families. In 2015, Carter and Kidder identified 42,035 nonprofit organizations focused on serving this population—a remarkable number when you consider that these resources come alongside what is already available through the U.S. Department of Veterans Affairs and the U.S. Department of Defense (2017). Along with this "sea of goodwill" comes the challenge of navigating it (Copeland and Sutherland 2010). It has become increasingly complicated for military-connected community members to access the services that will address their needs in a holistic way. Existing resources and coordination among service providers are both important considerations for creative arts therapists and community-based arts providers serving veterans and service members.

Several experts interviewed for this study recommended that service providers research and develop an understanding of the needs and resources in their communities and build programming around these needs in a way that complements the existing resources. Creative arts therapists and community-based arts providers can examine their local service provider landscape, arts and non-arts programming alike, and consider how their programs can complement and enhance the resources already available in their community.

Our study surveyed current arts programming—grounded in creative arts therapy and/or community-based arts—that is available to service members and veterans. We interviewed seven experts working with veterans or service members, five of whom were arts providers. We found a wide range of programs and services available to veterans and service members in the arts, ranging across all disciplines, including music, drama, stand-up comedy and improv, visual arts, dance, and filmmaking. Participants shared perspectives on both creative arts therapy and community-based arts programming. One art therapist observed that art therapy removed barriers to healing by helping veterans and service members begin to talk about their concerns. This participant stated: "It was a way for therapists in our organization to get to know the people we were serving on their own terms—through their artwork."

Arts-based interventions provide an approach that reduces barriers to engagement, especially those related to stigma, as participant experts offer services that focus on strengths and resiliency. One participant emphasized the need for nonclinical approaches that move beyond a deficit-focused approach, stating: "Most of life's problems are quasi-clinical or not clinical at all." This mirrors the needs identified in the literature; although there has been a focus on PTSD, TBI, and depression, it has been well-documented that service members and veterans do not need to present with a formal diagnosis to benefit from supportive services to address the broad range of psychosocial concerns they identify. Creative arts providers reported that such nonclinical services, like offering a drop-in open art studio, promote wellness and support engagement in other services over time.

Community-based arts providers emphasized benefits of arts programming that included opportunities for self-expression, connection to other veterans and civilian community members that can build a sense of connection and camaraderie, and involvement in an engaging activity that can promote a sense of accomplishment and purpose. The ability of the arts to bring people together was significant; as one participant noted, arts engagement can help to reduce isolation and promote a sense of community and belonging. Participants explained that providing a physical space where veterans can engage in a meaningful activity, explore personal struggles and aspirations through their artwork, and take reasonable risks through art making in a safe environment often produced positive results. Veterans were able to "get lost in the process" and later look back on the results of their artwork and comment, "I didn't know that was possible."

A common recommendation among participants was for all creative arts therapists and community-based arts providers to collaborate in facilitating veterans' and service members' engagement with the arts. Coordination among arts providers can open more possibilities for engagement across the spectrum of creative arts therapies to community-based arts programming by facilitating connections between individuals and appropriate services, keeping in mind that the arts offer a range of benefits from addressing clinical needs to addressing the broad psychosocial needs associated with veterans' and service members' experiences of change and transition.

CHAPTER SUMMARY: SERVICE MEMBERS AND VETERANS

KEY CONSIDERATIONS FOR CREATIVE ARTS THERAPISTS

- **Work from a strengths-focused approach.**
- **Involve the full family.**
- **Develop opportunities for peer-to-peer mentorship.**
- **Use engagement with creative arts therapies to help break through barriers to treatment.**

KEY CONSIDERATIONS FOR COMMUNITY-BASED ARTS PROVIDERS

- **Help educate service members and veterans about the different programs available.**
- **Enable organizations to better create programs that combine seamlessly with other initiatives to offer comprehensive services.**
- **Develop programs and resources that meet the needs of veterans in the community in a way that complements existing resources.**
- **Work from a strengths-based approach.**
- **Establish group art sessions to foster connection and social support among service members and veterans.**
- **Use evidence-based practices and evaluate programs.**
- **Increase understanding of military culture.**
- **Collaborate with existing veteran or military serving organizations, and other community-based organizations.**
- **Conduct continuous outreach to military-connected participants and family members.**

CHAPTER SUMMARY: SERVICE MEMBERS AND VETERANS

COMMUNITY NEEDS

Identification and Connection

- Holistic approaches that focus on prevention and early intervention, and increased access to services, and early outreach help to promote a healthy and successful transition to civilian life.
- Engaging service members before and after they return from deployment.

Relationships

- Relationships are cemented by shared experiences and emotions that are unmatched by civilian counterparts.
- Connection to other veterans can be a strong source of social support during transition and post-deployment.

Military to Civilian Transition

- The military-to-civilian transition is a complex cultural transition that impacts several areas of a veteran's life: social, family, financial, housing, occupational, and personal.
- Shifting from military culture to civilian culture creates culture shock for many veterans.
- The cultural loss during transition creates feelings of anxiety, frustration, and fear, and raises questions about the meaning and purpose of their lives.
- Despite years of travel experience, leadership responsibilities, and the ability to work in highly pressurized situations, many veterans face difficulties translating their military skills and experience to fit civilian jobs creating under-employment, financial hardship, and stress.
- Transitioning to civilian life affects the entire family: parental and gender roles need to be renegotiated and family relationships must be re-established.

Transitions for Women Veterans

- Women veterans experience significantly greater financial struggles, depression, and feelings of social isolation compared to male service members.
- On average, it takes women veterans three months longer to secure employment after transition than male veterans.
- Women veterans face gender-specific expectations from a civilian culture that misunderstands their military experiences.

Service Member Spouses, Family Members, and Military Families

A military family member is defined as any person who is the spouse, partner, parent, sibling, or child of a service member (defined above as a current member of the U.S. Armed Forces, including those who are Active Duty, National Guard, and Reserve). In 2020, according to the demographic profile published by the Department of Defense, there were 4.7 million family members of U.S. service members across the total DoD force. The Department of Defense defined family members as spouses, dependent children, and dependent adults. Adult dependents include parents, grandparents, former spouses, siblings, and disabled older children. Nearly half of all service members were married in 2020. Roughly one-third (29.8%) of the total force was married to a civilian and had one or more children (military children are discussed in greater detail below).

Among DoD force dependents, 62.8% were children, 36.8% were spouses and 0.4 percent were adult dependents (U.S. Department of Defense 2020). Almost 18% percent of spouses of total DoD force service members (Active Duty and Selected Reserves) were 25 years old or younger, 22.2% were 26 to 30 years old, 22.5% were 31 to 35 years old, 17.7% were ages 36 to 40, and 19.8% were 41 years of age or older. Of spouses of active-duty service members, 9% were male and 91% were female, although these numbers vary by branch, with 3% of spouses of Marine Corps members being male versus 12% of spouses of Air Force members.

In the Selected Reserve, 14% of spouses were male and 86% were female. Again, this depends on the branch of service; less than 4% of spouses of Marine Corps Reserve members are male versus 13% of Air Force Reserves members' spouses. Roughly 64% percent of active-duty junior enlisted service members (E1-E4) are single with no children, compared with 40.5% of mid-level (E5-E6) and 67% of senior enlisted service members (E7-E9) are married with children (U.S. Department of Defense 2018). For active-duty officers, 69% of W1-W5, 27% of O1-O3, 69% of O4-O6, and 65% of O7-O10 are married with children. In 2018, the DoD reported that 14% of active-duty spouses were in the civilian labor force and seeking work, 39% were not in the labor force (not seeking work), and 47% were in the civilian labor force and were employed (U.S. Department of Defense 2018).

There is little information on the racial demographics of the dependents or family members of service members. As previously discussed, roughly a third of the total DoD force (Active Duty and Selected Reserve members) identify as a racial minority—17.2% Black or African American, 4.8% Asian, 3% multiracial, 1.1% American Indian or Alaska Native, and 1.2% Native Hawaiian or other Pacific Islander—and 16.1% of the total force report themselves as Hispanic or Latina/o, but the racial demographics of military families are not reported by DoD (U.S. Department of Defense 2020). For service members, racial demographics differ by branch of service, service member rank, age, and so forth. There are few studies on the experiences of racial minority families within the military, but studies by Lundquist and colleagues do report that certain racially based socioeconomic differences (e.g., higher rates of divorce for African American families) are reduced within the context of the military (Lundquist 2006; Lundquist et al. 2014). Additionally, there is a paucity of research on other types of minority families in the military, such as LGBTQIA families and immigrant families.

This portion of the report will focus primarily on dependent family members (spouses and children) and the immediate military family as a whole or unit. When possible, we will reference information on parents or siblings of service members, although the research on these types of family members is quite sparse (Cozza and Lerner 2013).

Dual-service military families. Dual-service families, where both spouses and/or parents are service members, are specific to the military (Clever and Segal 2013). In 2020, 2.1% of service members were in a dual-service military marriage with children and 3.1% of service members were in a dual-service military marriage with no children (U.S. Department of Defense 2020). Female service members are substantially more likely to be married to a fellow service member than are men (Clever and Segal 2013). Depending on branch of service and service member rank, dual-service military couples may be separated from each other for long periods of time (Huffman and Payne 2006; Clever and Segal 2013). Those who are parents must address decisions about where and with whom their children should live (Clever and Segal 2013). Additionally, dual-service military couples can experience stress related to deviation from traditional gender norms that are common within the military (Huffman and Payne 2006). Other types of work-family conflict also appear to be exacerbated in dual-service military families, which can lead to one spouse (typically female spouses in different-sex couples) leaving the military prior to retirement (Huffman and Payne 2006).

Single-parent military families. Approximately 3.9% of active-duty service members and 8.6% of Selected Reserve were single parents in 2020 (U.S. Department of Defense 2020) as are 11% of post-9/11 veteran families were single parents (70% of these single parents were divorced or separated; Hanson and Woods 2016). Considering the proportion of men and women active-duty service members, female service members are more likely to be single parents than their male counterparts (Clever and Segal 2013). Regardless of branch of service, enlisted service members are more likely to be single parents than officers (Clever and Segal 2013). There are few studies that examine the strengths, concerns, or needs of single parents in the military or their children (Kelley 2006). Extant research indicates that single parents in the military are likely to experience increased stress and decreased social support, particularly surrounding deployments (Kelley 2006; Vaughn-Coaxum et al. 2015). The lack of another parent or partner to compensate when military job demands are high may contribute to added work strain and parenting stress (Kelley 2006).

Veteran Family Members and Veteran Families

As of 2018, there were roughly twenty million veterans in the United States. It is unknown what proportion of these veterans were married and/or had children, however a 2010 report for the Department of Veterans Affairs reported that 70% of veterans were married (Westat 2010). Based on data from the 2013 and 2014 American Community Survey, Hanson and Woods found that 80% of post-9/11 veteran families are married couples and 82% are comprised of a male veteran and a civilian spouse. Seven percent of married couples are both veterans, though it is not clear if both are post-9/11 veterans (Hanson and Woods 2016). Hanson and Woods also reported that 61% of post-9/11 veteran families were white, though little else is known about the racial demographics of veteran families.

In 2018, 182,876 active-duty service members separated from military service. Following the deduction of Clever and Segal (2013), if there is an average of 1.3 dependent family members per active-duty service member in 2018, we can estimate that nearly 238,000 dependent family members separated from the military in 2018. This does not include any dependents of National Guard and Reserve members.

Population Needs

Military families are crucial to the success of the military. During their time affiliated with the military and afterward, most families have positive experiences and are satisfied with the military lifestyle (Blaisure et al. 2012; Shiffer et al. 2017). Generally, military and veteran families typically share strong family bonds; are adaptable to change; and value a sense of purpose, teamwork, and service (Park 2011). Many of these traits and strengths act as resilience factors to military-specific and more general challenges or stressors alike (Park 2011; Blaisure et al. 2012).

Still, as one study participant summarized, "Families can be strong and resilient, and still have needs and challenges that make life stressful."

Military-connected families are affected by both civilian and military contexts (Gewirtz and Youssef 2016). Military-connected families face typical or normative stressors such as parenting challenges and must also tackle challenges resulting from military life, such as deployments or exposure to trauma (Blaisure et al. 2012). These contexts and systems also interact with and influence each other. Therefore, the needs of military and veteran families change over time and vary greatly across families and individuals. Based on a literature review and interviews with subject matter experts, the following needs were identified for military and veteran families and family members.

General health and wellness. Extant literature indicates that military families are generally healthy (Blaisure et al. 2012). However, most health-related research concentrates on the mental health of military and veteran families, rather than their physical health. A recent paper using data from the Millennium Cohort Family Study examined health indicators, military experiences, and psychosocial factors in a large sample of military spouses (Corry et al. 2019). Most spouses met the measured health goals, but less than half met the health weight and strength training goals. Results also indicated that greater perceived family support was associated with better behavioral health outcomes. A study by Larson et al., compared the records of spouses of deployed soldiers with those of non-deployed soldiers to investigate differences in health-care utilization during times of deployment. Deployment was associated with an increased use of antidepressants, antianxiety medications, and specialist visits among spouses and children (Larson et al. 2012). Also, roughly one-third of families received care in the civilian sector (Larson et al. 2012). Studies of mental health diagnoses and doctor's visits for the children of service members revealed similar patterns during deployment. Another study investigated well-being and health behaviors in military spouses (Mailey et al. 2018). Many spouses of active-duty service members cited lack of time as a primary barrier for physical activity, social connection, and stress management, as well as the second most common barrier to a healthy diet. Financial worries were the most selected barrier to a healthy diet. Military spouses felt like the need to "do it all" took precedence over diet or exercise (Mailey et al. 2018). Focus groups revealed that lack of time was an even greater issue during deployment (Mailey et al. 2018).

Kimball and colleagues found varying degrees of satisfaction with health care received, access to appointments, and quality of providers among active-duty families, military retiree families, and veteran families. One-third of active-duty family respondents rated their ability to access general health care appointments as negative or very negative and 20% rated the quality of health care providers as negative or very negative, compared with 15% and 10% of veteran family respondents, respectively. Qualitative data indicated that many family members feel rushed, have difficulty obtaining referrals and do not feel listened to or acknowledged by providers.

It is important that clinicians and other service providers understand that health needs, like all needs, vary and change depending on a number of variables. For example, having a dependent family member with special health-care needs can greatly affect the experiences and challenges of military and veteran families, and in many cases, families have dependents with multiple special health-care needs (Aronson et al. 2016). Sonethavilay et al. reported that nearly half of survey respondents with a family member currently enrolled in the Exceptional Family Member Program were not able to receive a referral and be seen by a specialist in a reasonable amount of time after relocation to a new duty station. For these families, relocation and continuity of care were major issues, as were problems accessing extra services.

Mental health. Mental health within the military has been the topic of much research in recent years. A primary finding on mental health within military and veteran families relates to parenting and the role of parent mental health in family and child outcomes. For example, several studies have indicated that negative outcomes in children surrounding a deployment are the result of strained parent-child relationships due to increased stress and pathology in the non-deployed parent (Palmer 2008). Another study found that attachment bonds between civilian spouses and their children were negatively affected by longer deployments (Lowe et al. 2012). The added stress placed on at-home or civilian parents during the deployment of their spouses can drain their energy for parenting or positive interactions with their children. According to a study by Flake and colleagues, the most significant predictor of child psychosocial outcomes during deployment was parent stress and mental health. The at-home or non-deployed parent can also contribute to stress within the parent-child relationship through "parentification." In such instances, the boundaries between parent and child become less distinct and a parent may rely on a child in ways that surpass the child's developmental capacities (Hooper et al. 2014).

Post-traumatic stress or PTSD in veteran parents has been linked to family dysfunction and strained relationships, compromised parenting skills, and poor mental health outcomes in veteran children (Davidson and Mellor 2001; Ruscio et al. 2002; Creech and Misca 2017). Both spouses and children of service members or veterans are vulnerable to secondary traumatization or secondary traumatic stress (Bride and Figley 2009; Herzog et al. 2011). There even can be tertiary traumatic stress when trauma is transmitted from the secondary individual to a tertiary individual (Figley 1993, "War-Related Stress"). It is possible that if the non-serving parent experiences secondary traumatic stress (transmitted from the service member or veteran), a child could then experience tertiary traumatization. However, if one parent (such as the service member) has experienced trauma and the other parent has not, it is possible that the parent who has not been traumatized can serve as a buffer against poor mental health outcomes and even secondary traumatization for the children (Dinshtein et al. 2011)

Mental illness has also been linked to marital conflict, and, in extreme cases, intimate partner violence in military samples (Jones 2011). Research has also indicated that child maltreatment is more common in military families during periods of combat-related deployment and "large-scale military mobilizations" (Gibbs et al. 2007; McCarroll et al. 2008; Rentz et al. 2007). The primary explanation for the increase in maltreatment is the added stress placed on military families in times of deployment and war (Gibbs et al. 2007; Park 2011; Rentz et al. 2007). McCarthy and colleagues (2015) found that rates of maltreatment perpetrated by civilian parents during deployment increased by over 50% compared with pre-deployment levels.

In the limited research that exists on nondependent family members or nontraditional families, results demonstrate the need for increased identification and understanding of the needs of these families, as well as the need for quality mental health care. One study surveyed parents of veterans who had served in Iraq or Afghanistan (Doyle et al. 2017). Overall, the parent sample was resilient and tended to use positive coping strategies. However, the parents who identified as the primary caregiver for their veteran child reported symptoms of compassion fatigue and experienced more physical, behavioral, and mood problems than non-caregiver parents (Doyle et al. 2017). In a study of single military parents (service members), Vaughn-Coaxum and coauthors found that single parents received lower levels of social support during and after deployment and reported higher post-traumatic stress symptom severity than married or partnered parents (although not with respect to anxiety or depression symptoms). Health-care providers and clinicians should assess for and be aware of these types of factors.

Military-connected familial suicide. For the first time, the DoD reported military spouse and dependent suicides in their Annual Suicide Report (U.S. Department of Defense Under Secretary of Defense for Personnel and Readiness 2019). The DoD estimates there were 186 reported suicide deaths among military spouses (123) and

dependents (63) in 2017. Upon accounting for sex and age, the rates of suicide for these groups were fairly similar to the overall U.S population rates. The primary method of suicide death for military spouses and dependents was firearm and the rate for military spouses was 11.5 per 100,000 population (U.S. Department of Defense Under Secretary of Defense for Personnel and Readiness 2019). Sonethavilay and coauthors found that, in a sample of active-duty, National Guard, and Reserve family survey respondents, the most common reason for not seeking help after considering or attempting suicide was the fear of negative impacts on a service member's career. Both service member and their family members are concerned about the negative career repercussions associated with seeking mental health care related to suicide ideation or attempts. It is important to consider the lasting direct and indirect impacts of service member and veteran suicide on military and veteran family members, and to consider the unique and varying risk and protective factors across different types of families. For example, the report found that National Guard member suicide rates are higher than the U.S. population. It is important that military and civilian leadership, researchers, and providers further investigate this difference and the resulting implications for families.

Including family members in this report is an important step in addressing the mental health of military families, further understanding risk factors for spouses and children, and preventing military family member suicide. Several considerations and strategies resulted from the Annual Suicide Report that are relevant to this review, such as promoting connectedness through counseling for couples, families, and individuals and peer support programming, as well as teaching coping and problem-solving skills for service members and their families (U.S. Department of Defense Under Secretary of Defense for Personnel and Readiness 2019). Providers and programs should pay attention to families that may have particular risk factors, such as young and enlisted service members and families and National Guard members and their families. The report notes that for those in remote areas, such as some National Guard families, the DoD and VA will have to partner with one other and community-based providers to increase access to mental health care (U.S. Department of Defense Under Secretary of Defense for Personnel and Readiness 2019).

Strengths and resilience. Many have highlighted the need to focus on strengths and resilience, rather than emphasize vulnerabilities of military and veteran families. While there are service members and families that experience challenges related to mental health, physical health, finances, and employment, most families are coping well (Coppola et al. 2020). The absence or lack of understanding, awareness, and cultural competence among civilians, government officials, and providers can exacerbate stereotypes and incorrect information about military families. Common strengths of military families include the camaraderie and connection within the military community (particularly among military spouses), openness to change and "new adventures," and the values of service and selflessness. In families, shared experiences and vision, making meaning of challenges, and positive parenting (e.g., parents who are loving, set limits, and are involved in their children's life) can all improve family connection, communication, and resilience. Strong social support networks also can defend against stress and encourage resilience. The military community is skilled at forming communal bonds and these relationships can enhance resilience in individuals and families (Easterbrooks et al. 2013).

> ***All study participants agreed that military families have great strengths and encouraged the use of strengths-based perspectives and approaches. Additionally, several participants implied that resilience was a typical, common response to the challenges of military life. One remarked that "resilience is just the norm in the military."***

One study of military spouses reported that having more children, being a nonminority, greater social support, less work-family conflict, and better soldier mental health were associated with higher resilience (Sinclair et al. 2019). Future research should investigate the longitudinal impacts and pathways of military family resilience

and strengths. It is likely that some of the same factors, traits, and strengths that protect families from negative outcomes during service may benefit them during the transition to civilian status and throughout their life. Additionally, researchers should learn more about the factors that contribute to resilience in veteran families, dual-service military families, single-parent military families, and other family members (e.g., parents of service members and veterans).

Diversity. Programs and providers should treat families based on their family risk and promotive factors, but also consider the intersection of family members' individual risk and protective factors. There is little research on racial minority families within the military and the findings are sometimes inconclusive or contradictory. For example, a few studies have indicated that the military context reduces inequalities between racial minority families (Lundquist 2006; Lundquist et al. 2014). However, a small study of military spouses did find that being a nonminority was associated with higher resilience, which predicted improved health, sleep quality, and relationship functioning (Sinclair et al. 2019), indicating that military spouses who are racial and ethnic minorities may be at greater risk for decreased resilience and other negative outcomes. A separate and longitudinal study of military spouses found that spouses who identified as racial and ethnic minorities had higher odds of employment and that fewer depressive symptoms were associated with employment (Lara-Cinisomo et al. 2020). The authors mention that it is possible that White military spouses have a decreased need to seek employment; one related finding was that White spouses were more likely to be homeowners, which may indicate greater income and residential stability (Lara-Cinisomo et al. 2020).

There is also a need for additional research on LGBTQIA families, immigrant families, dual-service military families, single-parent military families, and families of National Guard and Reserve members. In one study of military and veteran families, nearly half of LGBTQIA respondents reported they do not feel supported by their military community (Kimball and Hurwitz 2020). In qualitative data, about one-quarter of LGBTQIA respondents reported experiencing discrimination and insensitive remarks in their community, and others shared experiences of loneliness and feeling unwelcome in their community. The most wanted support programming among these respondents was local support systems and networks, which included inclusive local environments (Kimball and Hurwitz 2020).

Many existing policies and programs are exclusive and do not include varying types of military and veteran families. Coppola and coauthors (2020) cite the definition used for Family Readiness programs which defines family as "group composed of one Service Member and spouse; Service member, spouse and such Service member's dependents; two married Service members; or two married Service members and such Service members' dependents" and discuss how this definition does not address or include unmarried partners, extended or multigenerational family members, or even sexual minority families. The National Academies of Sciences, Engineering and Medicine recently recommended that the DoD develop and implement a standardized military-specific definition of "family" and "family well-being" that incorporates service members' own definition of their family, which would be more inclusive and would better address the circumstances of families who are "currently invisible to the DoD and other organizations. The National Academies of Sciences, Engineering and Medicine (2019) report also recommended that the DoD take steps to gain a greater understanding of the diversity of modern military families and their needs, with particular focus on National Guard or Reserve status, membership in nontraditional families, socioeconomic status, race and ethnicity, faith and belief systems, and families who report medical conditions.

The majority of subject matter experts emphasized the heterogeneity within the military and veteran family populations and a few participants cited that diversity with regards to needs. One study participant aptly outlined future directions for research and programs by saying, "Since there is an increasingly diverse military, we need to have programming that is inclusive in engagement and the way we implement and design services. We also need to have a better understanding of the intersection of different kinds of diverse populations within military and veteran populations."

Community Needs

Identification and connection. A primary concern in the literature and across subject matter experts was that military and veteran families are anonymous in their communities.

Several experts recommended that providers identify (e.g., through an intake question at the start of treatment) if patients are the child, spouse, parent, sibling, or other family member of a veteran or service member.

Once military and veteran family members are identified within the community, it is vital that providers are familiar with military life. The combination of training and identification enables service providers to be aware of challenges that may be specific to that group or subset. It is of added importance that the families of National Guard and Reserve members, as well as veteran families, are identified in their communities. One study reported that nearly half of National Guard and Reserve family member respondents reported their local civilian support agencies are not effective in addressing and understanding their needs (Sonethavilay et al. 2020) and many respondents called for increased resources and access to Tricare and VA health care. The same study found that military (including Guard and Reserve families) and veteran family respondents perceived greater military family lifestyle cultural competence in their local communities, they also felt a greater sense of belonging to their community, which is associated with a host of positive outcomes.

Veteran families that are separating or have recently separated from service may require special attention since the military to civilian transition can include difficult changes across key areas such as community integration, health and health care, and employment for both veterans and their spouses. It is particularly important to identify the transitioning spouses of veterans since there are almost no resources, supports, or programs that target their experience (Keeling et al. 2020). Spouses that are transitioning alongside their veteran must navigate employment and education opportunities, find and access both-community based services and VA health care and benefits, and also experience the loss of connection to the military community and shift in identity (Keeling et al. 2020). It is important that both researchers and providers learn more about the experiences of these understudied and often underserved groups.

One subject matter expert said that if the VA could incorporate more tracking of veterans' family members (e.g., asking veterans how many children they have, what ages they are, etc.), that would hugely improve understandings of veteran family needs and experiences.

Another issue for military families is isolation, especially for spouses of active-duty service members. Isolation and loneliness can be disastrous for physical and mental health outcomes. As a result of the military lifestyle, active-duty military families typically live far away from their friends and family. Spouses of active-duty service members consider isolation from family and friends to be a major stressor in their military family (Shiffer et al. 2017). If military families then feel isolated within their community or feel they lack community connections, they are increasingly vulnerable to negative outcomes. For veterans, difficult transition experiences are associated with feelings of social isolation, particularly for female veterans who also identified as spouses of

active-duty service members (Sonethavilay et al. 2020). This is another population group and family structure that requires further support and understanding. Isolation and lack of community connection can be related to employment status for military spouses (Shiffer et al. 2017). Due to frequent moves, relocations, and service member job demands, it can be challenging for military spouses to find meaningful jobs, fill resume gaps, and foster career connections for networking (Sonethavilay et al. 2020). Employment is often an avenue through which military spouses can connect with and spend time with civilians in their community. Military spouse employment continues to be a top issue of concern for military spouses in the annual Military Family Lifestyle Survey, with the impacts of persistent underemployment continuing after transition for spouses of veterans (Sonethavilay et al. 2020). One study of military spouses found that fewer depressive symptoms were associated with employment (Lara-Cinisomo et al. 2020). Shiffer and colleagues found a significant difference in perceived sense of community between those active-duty spouses and service members who had interacted (had in-depth conversations) with civilians in the past month and those who had not.

Other studies have found that families that feel supported by their communities, the military, and outside organizations (religious organizations, businesses, etc.) experience less stress (Kudler and Porter 2013). Community connection is also closely tied to resilience at the individual and family level (Blaisure et al. 2012). Another study of military spouses reported that social support from friends predicted sense of community, which was associated with increased feelings of psychological well-being (Wang et al. 2015). It is possible that social isolation is a problem for the families of National Guard and Reserve members, as well as family members who are not recognized as dependents of service members or veterans (e.g., parents and unmarried partners) since there is often a lack of military cultural competency within civilian communities.

Programs. There are few programs that were specifically created to strengthen military families and address the challenges they face. Most programs are not based in evidence-based practice, nor are the programmatic impacts evaluated. This can make it difficult to identify effective programs (Creech et al. 2014).

> ***Study participants highlighted a handful of exemplary programs. Subject matter experts attributed the following to the efficacy of these programs: the programs are founded in evidence, are continuously evaluated, are flexible (offer online and telehealth options) include the whole family, and focus on skills and strengths. One interviewee commented that programs that come from a deficit perspective or a "fix you" approach are typically "non-starters for military families."***

Successful programs also focus on resilience, improving parenting and relationship skills, developing family coping skills, and enhancing family communication—and include children in the process. There are often many programs and trainings available to service members but few that target military spouses and/or children. Research by Corry and colleagues (2019) indicated that resources and programs which can assist military spouses in finding networks and support, both within and outside of the military, can improve their well-being, therefore improving the overall well-being and readiness of service members. Unfortunately, there are few programs for family members of veterans, and even fewer programs that address the veteran family as a unit. Similarly, there is an absence of validated interventions for the families of National Guard and Reserve members (Murphy and Fairbank 2013).

Subject matter experts called for more programs that address the unique needs of veteran families, as their military experiences continue to affect them after their service. In particular, programs and community providers should focus on those families that have recently transitioned to civilian life. One participant in the present study argued that "quality programs may be even more important for National Guard and Reserve families since they may lack the connections of active-duty families."

Relationships. Strong relationships are often at the core of family, service member, and veteran resilience (Park 2011). In fact, several subject matter experts highlighted the strength of military marriages as a protective factor for military families. Indeed, military couples are generally satisfied with their marriages (Karney and Crown 2011; Blaisure et al. 2012). Recent data on married military couples from the Millennium Cohort Study reported that over half of couples did exhibit high levels of strength and that increased spouse education level and higher service member rank were correlated with greater relationship strength (Pflieger et al.). However, most studies of military marriages examine relationships during phases of deployment or transition (Allen et al. 2010; Paley et al. 2013). Deployments can undoubtedly cause stress and strain for couples, but findings regarding the long-term impacts of deployments on military marriages are generally inconsistent. Karney and Crown (2011) determined that military deployment (or time deployed) does not predict divorce for military marriages. It has been hypothesized that military couples and families perceive deployment to be a normative military stressor and view the associated stressors as a necessary part of the military lifestyle. Karney and Crown (2011) equate deployment to new parenthood; extraordinarily challenging and stressful, but ultimately related to lower rates of relationship dissolution. In conclusion, it is important to consider timing when interpreting or assessing the effects of deployment on relationships. For example, one longitudinal study found that spouses' marital satisfaction dipped during deployment, significantly increased when the service member came home, and then gradually returned to pre-deployment levels over the following eight months (Meadows et al. 2016). Roughly 64% of military-affiliated respondents in one study reported they would recommend marriage to a service member (Kimball and Hurwitz 2020).

Research has found that deployments and separations can strain military relationships. However, many studies found that deployment in and of itself does not negatively affect marital satisfaction or other indicators of couples' well-being and marital outcomes can be moderated or mediated by other factors. Allen and colleagues did not find a difference in the marital satisfaction levels of spouses of Army service members who had been recently deployed and those who had not been deployed. However, when the Army service members reported higher levels of post-traumatic stress symptoms, both service members and spouses indicated lower levels of marital satisfaction. Allen and colleagues reported that the relationship between PTSD symptoms and marital satisfaction was mediated by lower levels of co-parenting, lack of positive bonding, and negative communication between spouses. Similarly, another study found that increased levels of parent distress were associated with weaker communication skills in marriages, not time away from home (Lowe et al. 2012). Pflieger and colleagues found that military couples with low relationship strength exhibited poorer mental health, marital quality, and less satisfaction with the military. Based on these findings, it is recommended that providers understand and address any underlying issues (e.g., poor parenting alliance or co-parenting, poor communication skills, dissatisfaction with the military, etc.) rather than reinforcing the stereotype that deployments or separations increase the risk of divorce (Karney and Crown 2011). Additional pathways between deployment, mental health, and relationship outcomes will be addressed below.

Some research indicates that veterans are more likely to be divorced than their civilian counterparts (Blaisure et al. 2012). When service members separate from service, it can be challenging for couples and families to adjust to their new lives and veteran family identity (Sayers et al. 2009). In a study by Sayers and colleagues, 41% of sampled veterans reported feeling like a guest in their own home and 37% felt unsure of their family role. In

transitioning, veteran families may lose access to the protective factors or institutions that had lessened their stress during service. Active-duty couples and families typically have access to health care, housing supports, and the support of fellow military families (Karney and Crown 2011; MacDermid Wadsworth and Riggs 2011).

> ***One study participant talked about veteran couples "actually having to be married" after separating and having to address issues that may have previously been ignored in order to maintain the marriage during difficult times, like deployments or moves.***

Following deployment and transition out of the military, roles may shift and these changes have to be addressed by the couple and within the family. These processes are often further complicated if the service member or veteran was injured or is experiencing post-traumatic stress, particularly when spouses assume a caregiver role (Renshaw et al. 2008; National Alliance for Caregiving and United Health Foundation 2010). The strains associated with caregiving can affect relationship quality, especially if caregivers feel their role as a caregiver has superseded their identity as a spouse or partner. The needs of military caregivers are discussed in great detail in the final section of this report. Finally, it is important that future research and programs consider other factors that likely affect the health and success of marital relationships in veteran and military families. Most of the research on military relationships and marriages is focused on heterosexual couples and female spouses. Research on the experiences of male spouses and same-sex couples—as well as couples where one or both members is a person of color—is required.

Arts Programming: Overview of Programs and Considerations for Military Spouses and Families

Five of the subject matter experts interviewed for this study research, serve, and/or work with military and veteran families. The majority provided services for military family members (spouses, children, and caregivers), as well as veterans and service members. Most focused more or specifically on active-duty families, rather than veteran families or veteran family members. The most common response regarding the needs of military and veteran families was that these families are so diverse and heterogeneous that it is essentially impossible to isolate primary needs. One expert said it was like "asking 'what are the most pressing needs of American families?'" Another participant said, "The veteran and military experience is as diverse as our country's experience." That said, participants outlined some central needs of military and veteran families, and provided valuable considerations for creative arts therapists, community-based arts providers, and other service providers.

Most experts discussed the importance of taking a family-based approach to resources and services. Many existing programs or organizations were often first created to serve service members or veterans and were then expanded to include these individuals' family members. However, it is necessary that service providers consider the individual needs of family members as well as the needs of the family as a whole. Participants seemed to agree that successful programs were ones that treated the family as a system. Creative arts therapy can be an "opportunity for the time and space to communicate with each other, express how roles have changed, and work through any conflict that might arise" as a family. The arts as a form of nonverbal communication is often "less threatening" and can help family members better empathize with and understand each other. Healthy and open communication strengthens family relationships and resilience (Blaisure et al. 2012). Programming for parents and children can be offered together or separately, with one expert arguing, "simply offering childcare is helpful." If there is no creative arts therapies or community-based arts programming available yet for military or veteran children, "you can still include the whole family and ensure that parents show up" if childcare is provided during parent appointments, particularly during times where the service member parent may be away due to deployments or training.

Researchers emphasized the critical need for and development of programs based in and informed by research. Organizations must determine if their programming has met goals, effected change, and encouraged participation. If arts providers can incorporate measurement and evaluation into their programs, this can inform future research, improve programming, and increase funding. Additionally, participants suggested that creative arts therapists focus on the strengths of military and veteran families. One interviewee stressed the importance of language and programs that build on existing skills or strengths. Military and veteran families are typically excited to try new things and/or improve their skills. Engaging in the arts can be a chance to be adventurous and take "safe risks" as individuals and as a family. It is also a way to monitor self-progress and improvement on a skill or craft, such as woodworking, playing a musical instrument, or stand-up comedy.

Creative arts therapists, community-based arts providers, and other service providers should all educate themselves and their staff about military culture and life for both active-duty and veteran families. Because stereotypes or biases can affect service and care, all service providers must be informed and up to date on issues affecting service members, veterans, their spouses or partners, and their children. Subject matter experts also recommend that organizations and service providers know about and partner with other organizations in their community. It can be helpful to partner with existing organizations that already know how to deliver their programs or already know how to interact with and recruit the military community. It is also vital that service providers be aware of other organizations and programs so they can better direct or refer military families to find the resources and support they need. Community connection can improve outcomes for all family members, particularly spouses, who may experience challenging periods of isolation.

Several participating experts listed a multidisciplinary approach to treatment and services as a goal or best practice. Multiple treatment options and multiple clinical providers can work together to address varying needs and issues (e.g., physical health, mental health, and community engagement) and to promote collaboration and coordination among clinical providers, including creative arts therapists. Lastly, two experts talked about the turnover in active-duty military communities and one summarized the issue by stating, "You're never done with outreach." It is important that outreach extends beyond service members to family members so that there is increased awareness of programs and resources. In addition to high rates of turnover, the needs of military and veteran families change greatly throughout time in the service, stages of deployment, rank, branch of service, and so on.

CHAPTER SUMMARY: SPOUSES AND FAMILIES

KEY CONSIDERATIONS FOR CREATIVE ARTS THERAPISTS

- **Offer a holistic approach in serving the whole family.**
- **Use a strengths-based approach.**
- **Embed evidence-based practice and evaluation in programming.**
- **Use a multidisciplinary approach.**

KEY CONSIDERATIONS FOR COMMUNITY-BASED ARTS PROVIDERS

- **Take a holistic family-based approach and use a strengths-based approach.**
- **Establish programs that focus on helping families make meaning of challenges, build social connections with other families and enhance family communication and reconnection after deployments.**
- **Establish programs that focus on military spouses, including veteran spouses, as well as spouses of service members, to increase social connections and support affirming and building self-identity.**
- **Use evidence-based practices and evaluate programs.**
- **Increase understanding of military culture.**
- **Collaborate with existing veteran or military serving organizations, and other community-based organizations.**
- **Conduct continuous outreach to military-connected participants and family members.**

CHAPTER SUMMARY: SPOUSES AND FAMILIES

COMMUNITY NEEDS

Identification and Connection

- Military and veteran families are often anonymous in their communities increasing service access issues, and a low sense of belonging to the community.
- Military spouses transitioning with alongside their veteran experience a cultural loss and a loss of services. There are very few resources, supports or programs to help them find employment, education, or navigate community-based health and other services.
- Military families face isolation and loneliness, especially spouses, because family and friends often live far away.
- Military spouse employment continues to be a top issue of concern for military spouses who face challenges finding meaningful jobs, fill resume gaps, and foster career connections for networking due to frequent moves, relocations, and service member job demands.

Programs

- The few programs specifically created to strengthen military families and address the challenges they face focus on resilience, improving parenting and relationship skills, developing family coping skills, and enhancing family communication—and include children in the process.
- There are often many programs and trainings available to service members but few that target military spouses and/or children.

Relationships

- Following deployment and transition out of the military, parental roles may shift and these changes have to be addressed by the couple and within the family and can be complicated if the veteran is injured or experiencing PTSD.

CHILDREN OF SERVICE MEMBERS AND VETERANS

Service members are not the only individuals impacted by their service. Children of service members and veterans face their own challenges and require programs dedicated explicitly to their unique needs. Nearly 1.7 million children of service members were reported in 2020 (U.S. Department of Defense 2020).

A report for the Department of Veterans Affairs in 2010 found that 31% of veterans (at that time there were nearly twenty-two million veterans in the United States) reported having dependent children (Westat 2010). Hanson and Woods analyzed data on post-9/11 veteran families and determined that there were 2.1 million children of post-9/11 veterans in the United States in 2014. Of post-9/11 veteran families, 58% have one or more dependent children, and 57% of these families have a child under the age of five (Hanson and Woods 2016).

While definitions and details vary by branch of service and by the administration of specific services and benefits, this report focuses on children already determined to be dependents of service members.

Children of Service Members

A military child is defined as the dependent child of a service member (defined above as a current member of the U.S. Armed Forces, including those who are Active Duty, National Guard, and Reserve). When referring to children, the military defines a dependent as an unmarried child who is under twenty-one years of age, is incapable of self-support due to mental or physical incapacity or is under twenty-three years of age and enrolled in an institution of higher education (National Military Family Association 2005). Additionally, the term child includes biological children, stepchildren, and any adopted child or children placed in the home by a placement agency (National Military Family Association 2005).

Nearly 80% of military children are school-age, and of the military children in school, nearly 80% attend public schools (U.S. Department of Defense 2020; U.S. Department of Defense Education Activity. n.d.). Most children of active-duty service members attend schools in the community where their family is stationed, with a large military presence (Clever and Segal 2013). However, military children whose families live far from base, in an area without a military installation, or whose parents serve in the National Guard or Reserve, may be among few military-connected individuals in their school and community. Lastly, a small percentage (roughly 11%) of school-age military children attend Department of Defense Education Activity schools, the majority of which are located outside the United States (U.S. Department of Defense Education Activity. n.d). For both active-duty service members and Selected Reserve members, the average number of children was two. Across active-duty service members, pay grades E7–E9 and W1–W5 had the highest percentage of members with children (82% and 80%, respectively). For the Selected Reserve, pay grades O4–O6 and E7–E9 had the highest percentage of members with children (74% and 72%, respectively). Thirty-eight percent of total DoD force children were between 0 and 5 years of age, 32% were between 6 and 11 years of age, 24% were between 12 and 18 years of age, and 7% were between 19 and 22 years of age (U.S. Department of Defense 2018).

While there is little information regarding the racial demographics of military children, as discussed previously, most service members are white, with approximately a third of service members identifying as racial minorities and nearly 17.2% of the total force reporting themselves as being Hispanic or Latina/o (U.S. Department of Defense 2020). As is the case with most variables, racial demographics vary by branch of service, service member rank, age, and so forth. As in civilian society, the military and veteran communities are becoming more diverse (Clever and Segal 2013). There is little known regarding the experiences of military children of color, but some research does indicate that race-based socioeconomic and health differences are diminished in the military when compared to civilian society (Lundquist 2006; Lundquist et al. 2014).

Children of Veterans

Within this report, a veteran child is defined as the biological child, stepchild, or adopted child of a military veteran (defined above as a person who has served in the U.S. Armed Forces for any length of time). The U.S. Department of Veterans Affairs defines a dependent veteran child as an unmarried child who is under eighteen years of age, is incapable of self-support due to mental or physical incapacity or is under twenty-three years of age and enrolled in an institution of higher education (Veterans Benefits Administration n.d.). Because there is limited research on children of veterans, this report includes research and information on veteran children of any age. There is more research on veterans and veteran families than on veteran children specifically. For further information on the experiences of veteran families, refer to the previous section of this report.

Population Needs

Most military children adjust well to the experiences and challenges associated with the military lifestyle (Park 2011; Blaisure et al. 2012). However, like all children, military-connected children and youth have specific and unique needs. It is important to note that military children encounter the same normative stressors as civilian children, including sibling relationships, academic challenges, and developmental changes (Blaisure et al. 2012; Stetz et al. 2012). The needs of military children vary and change over time; with age and maturity; by family structure, rank, and branch of service; and can be impacted by many additional factors (e.g., individual personality traits, disability or injury, financial difficulties, etc.; Blaisure et al. 2012; Clever and Segal 2013). Two of the defining features of military life are transitions (e.g., relocation and reintegration) and family separations (Park 2011; Clever and Segal 2013; Cozza 2015). The needs of military children as they pertain to transitions and separations will be discussed in greater detail below.

General health and wellness. Military children are typically healthy, though there is a dearth of information regarding their general health and well-being (Blaisure et al. 2012). A major benefit of military service is health care for dependent children (Blaisure et al. 2012). Like the civilian population, there are military children with medical issues and/or disabilities and these children may face certain difficulties (Russo and Fallon 2015). It is estimated that at least 20% of military children have special needs—some of which include physical health needs—that can lead to added challenges for children and their families (Eunice Kennedy Shriver National Institute of Child Health and Human Development 2014). As stated, most of the research on military children concentrates on service member deployment. This remains the case for findings relating to physical health (Johnson and Ling 2013; Siegel and Davis 2013; Rossiter et al. 2016).

The literature indicates that somatic symptoms, such as changes in appetite, an upset stomach, or headaches, often increase in military children when a parent is deployed (Johnson and Ling 2013). One small study followed children who experienced a combat deployment and the TBI of their service member parent and found that children experienced a decline in physical health and behavioral health following the TBI in the two years following the injury (Brickell et al. 2017). Sleep problems and nightmares are also common in children during deployment (Johnson and Ling 2013; Siegel and Davis 2013). A study of adolescent children of deployed service members found that they had significantly higher levels of stress, systolic blood pressure, and heart rates than their civilian counterparts (Davis and Trieber 2007). Very little is known about the long-term effects of service on the health of military and veteran children.

Mental health. Much of the existing research on the mental health of military children is focused on deployment experience. Many studies report that military children are at increased risk for mental health problems and behavior problems (Flake et al. 2009; Chandra et al. 2010; Park 2011). One scoping review of mental health in military-connected children reported that children in military families had more behavioral problems and greater emotional distress than children in civilian families (Cramm et al. 2019). Two studies found that military-

connected adolescents have a higher prevalence of depressive symptoms, sadness, suicidal ideation, and suicide attempts than their peers (Cederbaum et al. 2014; Gilreath et al. 2016). These risks are heightened during and after deployment, as the number and length of deployments increase, as the stress level of the at-home parent increases, and when a military parent has been mentally or physically injured in combat (Flake et al. 2009; Mansfield et al. 2011a; Siegel and Davis 2013; Hisle-Gorman et al. 2015; Rodriguez and Margolin 2015).

Research indicates that service member and/or civilian parents' psychological distress and symptoms are the top risk factors for worsened psychological distress, stress, and adjustment problems in military children (Lester et al. 2011; Lester et al. 2012; Link and Palinkas 2013). A study by Gorman and colleagues of military children ages three to eight years old found that mental and behavioral health visits increased by 11% when a military parent deployed. The authors also found that behavioral disorders increased by 19% and stress disorders increased by 18%. Some studies have reported that the risk of child mistreatment (particularly neglect) increases during deployment (Gibbs et al. 2007; McCarroll et al. 2008; Creech et al. 2019; MacDermid Wadsworth and Riggs 2011). There also are findings of increased risk behaviors (e.g., substance use, violence/harassment, etc.) in military adolescents that have experienced at least one deployment of a service member parent (MacDermid Wadsworth et al. 2016b). Again, it is important to consider the interaction between military-specific risk factors (e.g., deployment) and "normative" risk factors (e.g., family financial stress), as well as the accumulation of military and "normative" stressors (Lucier-Greer et al. 2014; MacDermid Wadsworth et al. 2016a). Lucier-Greer and colleagues actually found that exposure to parent deployment and school transitions alone were not significantly related to adolescent outcomes, but that an accumulation or pileup of stressors was associated with negative mental health outcomes.

Children of service members exposed to traumatic events are susceptible to the effects of that stress, sometimes resulting in secondary traumatization or secondary traumatic stress (Bride and Figley 2009; Herzog et al. 2011). There are multiple pathways through which this transmission of trauma can occur. Children may be traumatized directly by abusive or neglectful behavior that is a result of the parent's trauma (Galovski and Lyons 2004). Secondary traumatization also can occur if the child attempts to identify with the parent or if the parent tries to explain the trauma to the child (Galovski and Lyons 2004). The majority of research on veteran children is focused on veteran parent PTSD and the transmission of trauma. Previous research does indicate that there is intergenerational transmission of trauma between combat veterans and their children, and that children of veterans often display symptoms of post-traumatic stress (Dekel and Goldblatt 2008; Galovski and Lyons 2004; King and Smith 2016). Separate from secondary or tertiary traumatization, trauma experienced by a service member can affect the family in many ways (Chandra et al. 2011).

> ***One subject matter expert touched on the difference between "civilian trauma" and military trauma, saying, "Trauma from war and deployment is different from civilian trauma . . . [you're] not really able to talk about military trauma, but civilians can talk about the pain and fear of a car accident. Many parents try to shield their children from war, but then children know stuff is going on in [their] home and family, but don't understand why."***

There is little research on the children of veterans, particularly because the VA does not provide direct care for children of veterans (Creech et al. 2019). However, many researchers and clinicians believe that an increased emphasis on veteran parenting in trainings, programs, and treatment can improve outcomes for veterans and their children (Creech et al. 2019). Research by Zalta and colleagues (2018) found that veteran parent sense of competence was the most significant mediator in the relationship between veteran parent psychopathology and child psychopathology, indicating that parental competency and parenting skills could be useful targets for interventions and programs to improve veteran and child mental health outcomes. In one meta-analysis of international publications on children living with a veteran parent, most research indicated that the most

frequent mental health outcomes for children of veterans were internalizing and externalizing behaviors (Rayce et al. 2019). However, it is important to note that the meta-analysis did not distinguish between children who experienced combat deployments and those who did not (Rayce et al. 2019). A study of the adult children of Australian veterans (comparing deployed and non-deployed veterans) of the Vietnam War found that the adult children of deployed veterans were more likely to have been diagnosed with anxiety and depression and to have had thoughts of suicide or self-harm than the children of non-deployed veterans (Forrest 2018). Because it seems that there are enduring adverse effects for military children, it is important that providers consider and inquire about parent military status in both child and adult patients and clients.

Strengths and resilience. Easterbrooks and colleagues define resilience as "a product of the relationships between children and the people and resources around them" (99). Resilience also is defined as the process of adaptation in response to adversity (Blaisure et al. 2012). Individual, family, and community variables and characteristics all contribute to and promote resilient functioning. Easterbrooks, Ginsburg, and Lerner suggested that teachers can help children make meaning of their lives and experiences, encourage quality friendships and relationships at school and in their communities, and connect military children and families to community resources that can foster resilience.

> ***The need for strengths-based perspectives and approaches was the central theme of interviews with experts on military children and families. Subject matter experts emphasized the many strengths of military children and the fact that "most military children turn out just fine" (Easterbrooks et al. 2013 99). Participants highlighted adaptability, openness, kindness, and maturity as strengths of military children. One participant said that resilience was "the word" to describe military children. Subject matter experts recommend that programming focus on building skills (e.g., resilience, relationship, and communication skills) and enhancing strengths in military children and their families.***

While military children certainly encounter adversity and stress, study participants and researchers agree that the full story is neglected when the sole focus is on the negative effects of military life (Cozza and Lerner 2013). Researchers should examine the strengths and resilience of military children, how these strengths carry them through difficult experiences, and how their own strengths and their family strengths play a role in larger military and civilian communities (Cozza and Lerner 2013). Some research has found that parental mental health and adjustment are important to developing a child's resilience (Huebner 2019). Socialization with other military children during deployments has also been linked to better functioning in military-connected children (Huebner 2019). Russo and Fallon propose that improving understanding of promotive factors that contribute to resilience and positive long-term outcomes in military children could not only inform policies and programming for military children, but also high-risk civilian children (e.g., children from immigrant, migrant, and poor families). Research and programs that address the strengths of these populations will better engage and support military-connected children and their families (Cozza and Lerner 2013).

Diversity. A key theme within the literature and in our interviews was that military children and their families have diverse needs, experiences, and lives. Therefore, "there can be no single approach to serving our nation's military children" (Kudler and Porter 2013, 180). Community providers and organizations should focus on working together to provide complementary, cooperative, and connected services (Blaisure et al. 2012; Kudler and Porter 2013). Because there are countless factors that can impact outcomes for military children, providers should identify and respond to individual combinations of risk and protective factors (MacDermid Wadsworth et al. 2016a).

It is important to highlight that there is little research on the experiences of minority military children (e.g., children with disabilities, racial minorities, sexual minorities, etc.), so it is unclear if and how the experiences

of minority military children differ from those of minority civilian children. While some studies have found that certain inequities are reduced within the context of the military when compared to civilian society, that research has focused on service members of color (Lundquist 2006; Lundquist et al. 2014). Others argue that military children who are racial and ethnic minorities or sexual minorities, respectively, may be at a greater risk for negative psychological or mental health outcomes (Lucier-Greer et al. 2014; Gyura and McCauley 2015).

Gyura and McCauley explained that sexual minority youth in military families can be at greater risk for negative psychological outcomes. Sexual minority adolescents may experience minority stress (e.g., stress from experiencing homophobia or identity concealment), which can uniquely interact with the military context (e.g., feeling like the military is not supportive of LGBTQIA individuals or having to determine if it is safe to reveal their sexual orientation after moving to a new location). When added to existing military-specific as well as broader stressors, this minority stress could cause a pileup of stressors. Both the interaction between stressors and the culmination of stressors can place adolescents at greater risk for negative health outcomes (Gyura and McCauley 2015). In summary, it is vital that all service providers and researchers give greater consideration to the intersection, interaction, and accumulation of risk factors experienced by military children.

Community Needs

Identification and connection. The principal challenge in improving community care and connection for military children is that "at many times and in many places, military children and their families are essentially invisible" (Kudler and Porter 2013, 163).

> ***One study participant said, "It sounds silly, but one of the biggest issues is people knowing that military kids exist in their community."***

To meet the needs of military children, clinicians, creative arts therapists, community-based arts providers, and other service providers must first determine if children in their community have parents who are serving in the military. It is estimated that over half of providers outside of military treatment facilities do not ask about the military status of children or families (Huebner 2019). One campaign, called "I Serve 2," was created to encourage health-care providers to ask children, "Do you have a parent who has ever served in the military?" (Rossiter et al. 2016). Like the Military Student Identifier, asking about parent military status serves multiple purposes for providers. It establishes records of military children, which can be used for tracking and learning more about the longitudinal impacts of military service, and it also ensures that providers can monitor potential challenges associated with parental military service, determine any individual and family risk factors, and identify and treat physical, psychological, or behavioral health issues early (Johnson and Ling 2013; Rossiter et al. 2016).

Because there can be a lack of continuity in care and resources for military children, early identification of problems and challenges can protect against negative outcomes (Rossiter et al. 2016). For children of active-duty service members, social support within the military community, friendships with military-connected peers, and access to resources on bases for children of active-duty service members all contribute to increased resilience, yet children of National Guard and Reserve members may not have access to these protective factors (Kudler and Porter 2013). Similarly, children of veterans are often anonymous within their communities. Many researchers and study participants called for an increased emphasis on family involvement in veterans' care, with a recent study by Ridings and colleagues recommending a focus on parenting skills, psychoeducation, teaching affective and coping skills, and incorporating relaxation components into programs and care (Ridings et al. 2019).

Most study participants mentioned that it is particularly important that children of National Guard and Reserve members are identified within their communities, because they are often not identified within their school. One interviewee recommended that the VA, health care providers, and other service providers ask veterans if they have children, what ages their children are, and so forth.

Transitions. There are many transitions throughout military service, including relocations and frequent moves (sometimes overseas), adjusting to new schools and communities, family reintegration, and separation from the military (Ender 2006; Park 2011; Stetz et al. 2012). On average, children of active-duty service members move every two to three years and may attend six to nine different schools by the time they reach eighteen years of age (U.S. Department of Defense Education Activity. n.d). Relocations provide military children with opportunities to meet new people and friends, learn about different cultures, and live in exciting places (Park 2011). Though relocations can be positive and many children develop adaptive coping skills, that is not to say transitions are without stress. Financial difficulties, employment issues for civilian parents, navigating new schools and resources, finding childcare, disruptions in services, and managing logistical details are all part of moving for military families (Ender 2006).

Cramm and colleagues (2019) found that several studies have found military-related mobility impact child mental health, with the majority reporting negative impacts on mental health such as behavioral problems, anger, anxiety, poor adjustment, and increase in mental health service use. These stressors can then be compounded by other features of military life, such as deployment. For example, a family could receive orders to move shortly after a service member comes home from a training or deployment. When service members return from time away, the reintegration process can shift family dynamics and alter roles and routines (Siegel and Davis 2013). Infants and toddlers may not remember their parent, while older children sometimes feel strange getting reacquainted or struggle to relinquish their responsibilities or independence (Siegel and Davis 2013). These circumstances can lead to a pileup of stressors or cumulative stress, increasing the likelihood of negative outcomes (Link and Palinkas 2013; MacDermid Wadsworth et al. 2016a). Research has indicated that the number of risks or stressors may be more impactful than the individual risks themselves (Lucier-Greer et al. 2014).

It is necessary to consider these transitions and changes within the context of child development. The experiences and needs of military children during transitions vary depending on their age, maturity level, and familiarity with moves.

Several of the subject matter experts interviewed for this project stressed the importance of developmentally appropriate practice. Study participants called for programming to "meet military children where they are at" and remember that "not one size fits all kids."

Younger children may feel confused about the move or act out when their routine is altered (Osofsky and Chartrand 2013; Russo and Fallon 2015). Older children sometimes feel frustrated or angry about a lack of control in relocating, sad to leave their friends and peers, and nervous about starting at a new school (Russo and Fallon 2015). Being the "new kid" can be more difficult for younger children or children who have only known one school district. Older military children often develop the "know-how" to improve their adaptation to new environments, schools, and communities (Russo and Fallon 2015).

Subject matter experts agreed that transitions in military life can enhance positive skills and traits in military children, but a few participants highlighted the role of schools, communities, and other systems in affecting outcomes for military children. Several participants stressed that identification and awareness of military-connected students was the first step in improving the school climate for military children.

First, it is vital that military children are identified as such within their school systems. The Military Child Education Coalition (2017) has advocated for the Military Student Identifier (MSI) in state public school data systems as a part of the Every Student Succeeds Act of 2015. Several states now include the MSI in student enrollment procedures. Incorporating the MSI provides data on military children, allows for the tracking of their academic progress, and ensures that educators are informed of their military status and more likely to provide support in a timely manner (Military Child Education Coalition 2017). The MSI does not include children of National Guard and Reserve members and because these children do not typically live in military communities, it may be of added importance that they be identified within their school districts. Educators who know little about students from military families sometimes view military children from a deficit perspective (Russo and Fallon 2015). In addition to identifying military students, school professionals must learn about the culture, family life, needs, and strengths of military children.

> ***Subject matter experts encouraged educators to take a strengths-based approach, focus on building resilience-related skills, and address the individual and developmental needs of military-connected students.***

The military-to-civilian transition or service-member-to-veteran transition is generally fraught with change for service members, their families, and their children. As with other transitions during service, the process of separating from the military often includes moving, new schools, and new communities. However, these changes have a sense of permanence once their service has finished. There is little research on the specific experiences of children during the transition process. It is likely that children are affected by the difficulties their veteran parent experiences because of transition, including a loss of identity or sense of purpose (Coll and Weiss 2013). The veteran may be struggling to find meaningful employment or even housing (Adler et al. 2011; Coll and Weiss 2013). Children may also personally struggle with some of the same issues their parents encounter, such as the loss of their identity as a military child, lessened support (social support and access to resources) from the military community, and family difficulties. Just as educators and school professionals must be aware of risks or challenges surrounding separations and transitions for the children of active-duty personnel, they also should be familiar with the transition process and the experiences of the children of veterans.

Separations. Most children of service members have experienced separation from their service member parent(s). As with other features of military life, deployments do not guarantee maladaptive outcomes in military children (Park 2011; Russo and Fallon 2015).

> ***Several subject matters mentioned that separations can sometimes increase parent-child closeness, deepen pride in their parent's service, and encourage independence.***

Separations can happen because of trainings, schooling, or deployments (Flake et al. 2009). Both active-duty service members and National Guard and Reserve members are separated from their families for these reasons (Lester and Flake 2013). Since 2001, nearly 3 million service members have served in 5.4 million deployments; half of these deployed soldiers were married and roughly half had children (Wenger et al. 2018). Between 2001 and 2015, the average cumulative months deployed for active-duty service members ranged from ten months (Navy) to eighteen months (Army; Wenger et al. 2018). It is unclear how much total time military service members have been separated from their families and children (including separations due to training and schooling). In the most recent Blue Star Families Military Family Lifestyle Survey, one-third of the sample (active-duty service members and active-duty spouses) reported that the service member had experienced at least one-quarter of the previous sixteen years away from their family, and 40% had experienced more than six months of family separation in the previous eighteen months (Shiffer et al. 2017).

There is a great deal of research that centers around the difficulties and challenges associated with deployment (Creech et al. 2014; Trautmann et al. 2015). Most existing research on military children concentrates on the impacts of deployment and generally approaches deployment as a major stressor for military children and families (Creech et al. 2014; Trautmann et al. 2015). Several factors affect the impact of deployments, including the length of the deployments, the frequency of (and time between) deployments, service members' deployment experiences, demographic variables of the military family (e.g., younger families are at greater risk for negative deployment-related outcomes), and the mental health of the at-home parent (Flake et al. 2009; Chandra et al. 2011; Russo and Fallon 2015). When determining the effects of deployment on military children, it is again necessary to consider child development. The experiences, needs, and outcomes of military children surrounding deployment differ by age and developmental period (Siegel and Davis 2013; Meadows et al. 2016).

> ***Many subject matter experts again highlighted the need for developmentally appropriate practice and for parents, educators, and providers to understand how deployment and separation differentially affects military children across the lifespan (Alfano et al. 2016).***

Military children, especially younger children, may experience parental separation as a loss (Siegel and Davis 2013). One interviewee indicated that it may be important for future research to investigate the impact of all military-related separations on military children, rather than focusing solely on deployment. There is less known about the experiences of young children (younger than six years of age), but it seems that deployments and separations may be especially stressful for such young children, as they rely on their parents for all their needs (Osofsky and Chartrand 2013). In studies focusing on preschool age children, several of the cited studies reported increase in mental health service use, behavioral issues like internalizing behavior, attachment issues, regressions in sleep and toileting, crying, and developmental delays (Cramm et al. 2019). Osofsky and Chartrand referenced extant research on child attachment and suggested that parent-child attachment in infant and toddler military children could be affected by deployment. During deployment in a two-parent family, military children are separated from one parent and the remaining parent is under added stress, potentially affecting emotional availability and mental health (Flake et al. 2009; Link and Palinkas 2013; Osofsky and Chartrand 2013).

As children age, many express fears for the safety of their deployed parent and also worry about their non-deployed parent. In the absence of their service member parent, older military children might need to assume more responsibilities to help their at-home parent and may learn more about family stress involving finances, relationships, or caring for children (Park 2011).

> ***As one expert said, "Children sometimes worry more about their mom at home, because they see the stress and worry she is dealing with." Two subject matter experts mentioned that the parentification of older siblings in military families can lead to added strain throughout the stages of deployment.***

Parentification has been linked to negative outcomes for children and for families (Hooper et al. 2014). Parentification is especially common and stress inducing for children of wounded, ill, or injured service members or veterans and children of caregivers (Hooper et al. 2014). Additionally, children may feel anxiety regarding changes in routine or feel that peers or teachers don't understand their family's experiences during a deployment (Chandra et al. 2011). Many military children feel upset when their civilian classmates or friends inquire about their deployed parent; asking when their parent will return or if they will be present at special events such as holidays or sports games. A lack of knowledge and understanding may be worsened for children of National Guard and Reserve members. Several study participants expressed concern regarding the absence of research on and programs for families of National Guard and Reserve members. In a study conducted by Chandra and colleagues (2011) 35% of children of active-duty service members agreed that their teachers understood what it was like for them to be a military kid, compared with only 27% of children of National Guard and Reserve members.

One study participant said, "There are civilians that think the Guard and Reserve don't deploy."

Older military children might see graphic coverage of combat or negative attitudes toward the military and service members on television, social media, or the Internet, potentially exposing them to content beyond their developmental level (Siegel and Davis 2013). Resulting feelings of worry, anxiety, or depression can lead to distraction, sleeping programs, worsened grades, and socioemotional issues (Chandra et al. 2010). Older children are more likely to experience internalizing behaviors, whereas younger children may act out more during deployment. Additional mental health outcomes related to deployment will be discussed later in the report. There are mixed findings regarding deployment and academic outcomes for children, with some studies finding academic performance decreased and problem behaviors at school increased, and others reporting no change in academic variables (Link and Palinkas 2013; Meadows et al. 2016).

Education and understanding. In addition to identification, it is vital that community providers develop an understanding of military culture, deployment and transitions, and terminology (Creech et al. 2014). In cases of mental, physical, or behavioral health problems, having a foundational knowledge of military life can improve the efficiency and efficacy of treatment or care (Creech et al. 2014; Ohye et al. 2017). Huebner specifically calls for competency training in medical schools to develop an understanding of military history and military family experiences. Children are more resilient when they feel understood by those around them and can depend on others for help. To cultivate resilience and growth in response to hardship, children must have stable and positive relationships within their family, friends, and community groups (Boberiene and Hornback 2014).

One interviewee stressed that service providers must remember that, like their parents, children "are serving too."

When community members and providers are aware of military children and display military cultural competency, it closes the military-civilian gap, strengthens community connection, and increases community engagement (Boberiene and Hornback 2014; Ohye et al. 2017; O'Neal et al. 2018). Some participants indicated that, in addition to understanding military life, providers should be informed and aware of military and non-military programs and resources within their community. Military families are often unaware of available and existing resources, especially during times of transition (Shiffer et al. 2017). Community providers, neighbors, and educators can connect families and children to existing programs, facilitate the development of social networks, and increase access to quality care (Boberiene and Hornback 2014). In their recent report, the National Academies of Sciences, Engineering and Medicine (2019) recommended that the DoD play a role in better encouraging civilian understanding of the strengths, experiences, and needs of military-connected individuals and families. The authors requested that there be particular focus on addressing stereotypes and incorrect information. It is vital that teachers, doctors, and others involved in the lives of military learn about and understand their experiences, especially during deployments or other periods of transition (National Academies of Sciences, Engineering and Medicine, 2019).

Programs. As discussed earlier in this report, there are limited programs with the specific intent to strengthen military families and target the challenges faced by military families. Even fewer programs directly address the needs and strengths of military children. Previous studies have reviewed several programs for military families and children (Kudler and Porter 2013; Creech et al. 2014). Most programs are untested; therefore, the impact of their interventions is unknown (Creech et al. 2014). The National Academies of Sciences, Engineering and Medicine recently called for the DoD to enable greater access to effective, evidence-based, and evidence-informed programs for military families, as well as promote training in cultural competence for military family support providers. One study found that most community providers had little familiarity with military-informed and evidence-based services or treatment (Richards et al. 2017).

Subject matter experts, particularly researchers, stressed the need for programs based in and advised by research and evaluation. As one participant summarized, "Programs that sound good or feel good aren't enough; they have to work." It is also necessary for programs to attract participants and be engaging.

As previously referenced, the transition out of the military can be a particularly challenging time for service members and their families.

One study participant focused on the absence of programs for children of veterans, especially those who have recently transitioned to civilian life. This subject matter expert listed benefits, resources, and programs that are available to children of active-duty service members that are no longer accessible to those children when their service member parent separates from service. Some subject matter experts indicated that veteran families may rely more heavily on their communities for support and connection, as they are no longer a part of the active-duty military community. A few interviewees discussed the benefits of community programs that connect service members and veterans or newly transitioned veterans and veteran community leaders, as they allow for the sharing of experiences, leadership opportunities, and a sense of purpose for veterans.

Like their active-duty counterparts, the families and children of veterans are eager for engagement, have a strong sense of duty, and have much to add to their communities. One study of an intervention program that aimed to strengthen parenting in military families found that program resulted in improved peer adjustment for children, which research has connected to countless positive outcomes (Piehler et al. 2018). The same types of models can be likely applied to the children of veterans to enhance and highlight their strengths, foster friendships, encourage connections, and improve positive outcomes. In a study of youth from Army families, researchers found that while high levels of risk were associated with poor self-efficacy and greater symptoms of depression, youth that turned to their family members as a coping resource buffered the effects of risk on self-efficacy (Kaeppler and Lucier-Greer 2020). For all military-connected children, there is general agreement in the need to treat the family as a whole unit and involve children, family members, and service members or veterans in access to resources, treatment, and programming (Ridings et al. 2019).

Arts Programming: Overview of Programs and Considerations for Military Children

Five of the subject matter experts interviewed for this study research, serve, or otherwise work with military children. Some of these experts specifically focused on military children, while others provided resources or programs to military family members, veterans, and service members. Most services provided by interviewees are intended for children of service members, not for children of veterans. The predominant theme was the importance of taking a strengths-based approach. Many participants stressed that most military children are resilient and successful. Subject matter experts both within and outside of the arts agreed that art not only engages and benefits military children, but arts programs also focus on strengths. One interviewee commented, "Art can give voice to kids, give children a chance to express themselves or even make friends." Furthermore, engaging in the arts inherently can externalize problems or events for children, allowing them to explore alternate responses or solutions (Collie et al. 2006).

Connection with military and civilian peers, making friends, and group creative arts therapies were other common themes throughout the interviews. Military children generally work well in group settings, as military culture values teamwork. Military children benefit from participating in groups with other military-connected kids who may share their experiences or challenges. This is particularly significant for military children of veterans or service members who are wounded, ill, or injured. Group arts engagement also can foster friendship,

trust, and support among military and civilian children. Peer relationships are highly important for teenagers and pre-teenagers and team building or group work can promote friendships.

As previously mentioned, subject matter experts encouraged the use of developmentally appropriate practice. Creative arts therapies can certainly "meet children where they are." With children who are not able to talk about or express certain emotions or thoughts they are experiencing, "music [therapy] and art therapy can encourage processing and help kids learn to trust." Creative arts therapies and community-based arts programming also provide flexibility and choice for children of different ages. At any age, military children may crave a sense of control, so a setting where they are able to make choices can be empowering. Younger children may choose painting, while older children might be interested in songwriting, stand-up comedy, or filmmaking. Interviewees recommended being flexible in services and activities to accommodate children at varying levels of development.

Another primary theme named by many experts was the benefit of a family-based approach and services. Alfano and colleagues called for family-based approaches over individual child interventions (2016). Research reports that strong family support systems and positive parenting are primary protective factors for military families. Serving children and their families together can enhance parenting skills, encourage, and improve family communication, and facilitate close relationships. One subject matter expert shared stories about how veteran parents disclosed that taking children to programs and activities was actually what "got them out of the house" and helped them engage in civilian society. Lastly, taking a multidisciplinary approach was considered a best practice for working with children.

CHAPTER SUMMARY: CHILDREN OF SERVICE MEMBERS AND VETERANS

KEY CONSIDERATIONS FOR CREATIVE ARTS THERAPISTS

- Offer a holistic approach in serving the whole family.
- Use a strengths-based approach.
- Use a multidisciplinary approach.
- Use developmentally appropriate practice.

KEY CONSIDERATIONS FOR COMMUNITY-BASED ARTS PROVIDERS

- Design arts programs for military children that focus on their strengths, experiences, and challenges.
- Create a family-based approach that includes community members to increase familial and community ties.
- Provide flexibility and choice for children that is developmentally, or age, appropriate.
- Include activities that reinforce the military child's unique strengths while allowing them to interact with the broader community.
- Incorporate a group or team element to strengthen peer relationships.
- Use evidence-based practices and evaluate programs.
- Increase understanding of military culture.
- Collaborate with existing veteran or military serving organizations, and other community-based organizations.
- Conduct continuous outreach to military-connected participants and family members.

CHAPTER SUMMARY: CHILDREN OF SERVICE MEMBERS AND VETERANS

COMMUNITY NEEDS

Identification and Connection

- The primary challenge in improving community care and connection for military children is that most of the time military children are invisible.

Transitions

- On average, children of active-duty service members move every two to three years and may attend six to nine different schools by the time they reach eighteen years of age. Constantly being the "new kid" can be more difficult for younger children.
- Although relocations provide military children with adaptive coping skills, they also impact children's mental health leading to behavioral problems and poor adjustment. Younger children feel confused about the change in routine and older children feel frustrated about the lack of control in relocating.
- Family reintegration after deployment shifts family dynamics and routines. Younger children may not remember their service-member parent and older children find it difficult to relinquish independence creating cumulative stress.

Separations

- Separations happen because of training, deployment, or school and most military children experience multiple separations from their service member parent(s).
- Younger children may experience separation as a loss, creating stress and attachment issues for children.
- Older children express fears for the safety of the service-member parent, and many assume more responsibility at home such as caring for younger children. This parentification increases children's anxiety and stress.

Education and Understanding

- Children are more resilient when they feel understood by those around them and can depend on others for help. Community service providers need an understanding of military culture, deployment and transitions, and terminology to close the military-civilian gap.
- To cultivate resilience and growth in response to hardship, children need stable and positive relationships within their family, friends, and community groups.

Programs

- Few programs directly address the needs and strengths of military children and new programs need to treat the family as a whole unit involving children, family members, and service members or veterans.

Military Caregivers

A caregiver is defined in the literature as a person who provides assistance to and helps manage the care of a person with a disabling injury or condition—often a relative, friend, or neighbor of the individual (Tanielian et al. 2013; Ramchand et al. 2014). The literature also distinguishes several types of caregivers, including sandwich generation caregivers, defined as caregivers between the ages of 35 and 54 who are working to raise their own children while caring for another family member (Smith-Osborne and Felderhoff 2014). Military caregiver, as referenced throughout, is defined as a person who provides a broad range of unpaid care and assistance for, or manages the care of, a current service member or veteran with a disabling physical or mental injury or illness (Tanielian et al. 2013; Ramchand et al. 2014). Military caregivers may be a spouse, close relative, friend, or neighbor to the veteran or service member and in the role of caregiver they take on a set of care responsibilities that can include activities of daily living, health-care assistance, navigation and coordination of services, emotional support, financial planning, and advocacy on behalf of the care recipient (Tanielian et al. 2013).

In the United States, 9% of adults are caregivers and 5.5 million of those adults are military caregivers (Ramchand et al. 2014). Advances in battlefield treatment have led to more survivors from traumatic brain injury and amputation, causing veterans and their caregivers to adapt and respond to physical and mental conditions that are life-altering for the veteran, caregiver, and family (Conard et al. 2017; Tanielian et al. 2013). A typical caregiver of a veteran whose condition is service-related is female (96%) and the spouse or partner of the veteran (70%), whereas in the general U.S. population, 65% of caregivers are women and just 6% are a spouse or partner (National Alliance for Caregiving and United Health Foundation 2010). The relationship between caregiver and care recipient is a significant consideration when reflecting on the stressors, needs, and rewards associated with caregiving.

Veteran care recipients range in age from 18 to 75 years and older, with 41% of care recipients ranging in age from 18 to 54 and another 39% ranging from 55 to 74 (National Alliance for Caregiving and United Health Foundation 2010), and roughly 85% are male (Ramchand et al. 2014). Care recipients are receiving care for a range of conditions that include mental illness such as depression, anxiety, or PTSD, as well as traumatic brain injury, diabetes, and paralysis or spinal cord injury (National Alliance for Caregiving and United Health Foundation 2010). Post-9/11 care recipients commonly receive care for limiting back pain as well as mental health and substance abuse disorders (Ramchand et al. 2014). Eight in ten military caregivers report that they are caring for a veteran with two or more conditions (National Alliance for Caregiving and United Health Foundation 2010). Care recipient needs and caregiver responsibilities differ based on recipient age as well as the conditions that require care.

Service era is also a consideration, as caregiver demographics and needs differ among veterans who served before and after September 11, 2001 (Conard et al. 2017; Tanielian et al. 2013). Of the 5.5 million military caregivers, 4.4 million are caring for pre-9/11 veterans and 1.1 million are caring for post-9/11 veterans (Ramchand et al. 2014). There are some signature differences between pre- and post-9/11 caregivers. Pre-9/11 caregivers are more commonly the child of the veteran and post-9/11 caregivers are more commonly the spouse of the veteran. Of the growing generation of younger veterans from the Iraq and Afghanistan wars requiring care, one in four (26%) are cared for by their parents (National Alliance for Caregiving and United Health Foundation 2010). Younger veterans may require a transition of care to another caregiver as their parents age (National Alliance for Caregiving and United Health Foundation 2010), an important consideration as we look ahead to the needs of future generations of caregivers.

Other differences between pre- and post-9/11 veterans are important to note for the potential implications on caregiver needs. Notably, 71% of caregivers of veterans who served before 9/11 report having a support network, while just 47% of those caring for post-9/11 veterans report having a support network. Post-9/11 care recipients more commonly have a behavioral health condition—64% versus 36% in pre-9/11 veterans. VA disability ratings are also more common in the post-9/11 group, with 58% reporting a rating versus 30% in the pre-9/11 group. Post-9/11 caregivers may be caring for veterans with multiple or complex physical and mental health conditions and the caregiving role is often taken on at a younger age for both the caregiver and care recipient, and, as noted, with often less of a support network than those caring for post-9/11 veterans (National Alliance for Caregiving and United Health Foundation 2010; Ramchand et al. 2014).

Population Needs

General health and wellness. Common health concerns of caregivers that are related to caregiving include sleep disturbances, physical strain, increased blood pressure, and getting sick more often (National Alliance for Caregiving and United Health Foundation 2010; Ramchand et al. 2014). Military caregivers are at risk of neglecting their own physical and behavioral health needs as caregiving activities often take priority (Tanielian et al. 2013). This may include decreased attention to self-care, exercise, nutrition, sleep hygiene, and maintaining regular visits with health-care providers (Carlozzi et al. 2016; National Alliance for Caregiving and United Health Foundation 2010). Despite the health complaints of caregivers, many do not have medical coverage. Roughly one-third of caregivers of post-9/11 veterans lack health-care coverage, which is twice as high as the rates for pre-9/11 caregivers (Ramchand et al. 2014). Caregivers of pre-9/11 veterans have cited the cost of health care, lack of health problems, and postponing medical care as the top three reasons for lacking medical coverage (Ramchand et al. 2014). Preventive health care also is affected, as two-thirds of military caregivers spend less time exercising and more than half fall into poor eating habits after becoming caregivers (National Alliance for Caregiving and United Health Foundation 2010). Negative health effects have been shown to be more common when caregivers are caring for a veteran with TBI, PTSD, or a mental health condition, likely because of the emotional nature of these conditions and the high stress the caregiver may experience caring for the veteran (National Alliance for Caregiving and United Health Foundation 2010; Saban et al. 2016).

Mental health. Caregiving also can influence caregiver mental health. Caregivers report a higher prevalence of depression and anxiety than the civilian population (Ramchand et al. 2014). Caregivers also may deal with the effects of secondary traumatic stress (Bride and Figley 2009; Strong 2018). The stress and burden related to caregiving can be attributed to a number of factors including the physical demands of caregiving, such as the number of activities of daily living the caregiver supports and the amount of time spent caregiving (Ramchand et al. 2014).

> ***As one of our study participants stated: "As the care recipient's needs grow, so do the needs of the caregiver."***

Other factors that are associated with caregiver burden include the socioeconomic status of the caregiver and recipient, the recipient's disease progression, and perceived caregiver stress (Carolozzi et al.). Higher burdens and demands on the caregiver have been shown to predict increased rates of depression and other negative health outcomes (Ramchand et al. 2014). Greater physical and behavioral changes in functioning have been associated with greater care intensity and ultimately higher self-report of caregiver burden as well as poorer caregiver mental health (Griffin et al. 2017; Skomorovsky et al. 2020). Caregivers of veterans or service members following a TBI reported lack of time for their own needs, poor physical health, increased stress and anxiety, and feelings of isolation and loneliness (Brickell et al. 2017). Caregivers of service members with a moderate or severe TBI endured higher levels of stress anxiety, exhaustion and anger than caregivers to a service member or veteran with a mild TBI (Brickell et al. 2017).

Additional stressors related to veterans finding educational opportunities and healthcare providers, and veterans and spousal caregivers losing their military identity have also been attributed to higher levels of daily stress for caregivers (Skomorovsky et al. 2020). When compared to nonmilitary caregivers, military caregivers are typically younger, serve as caregivers for longer periods of time, have higher caregiver burden, as well as greater financial strain (National Alliance for Caregiving and United Health Foundation 2010; Ramchand et al. 2014).

> ***One of our study participants emphasized the impact, saying, "We see a lot of caregivers who are burned out, not because of any one single thing but from a conglomeration of issues."***

An area of consideration that is underrepresented in the literature is the association of race/ethnicity with caregiver burden and coping mechanisms. It has been noted in the literature and observed in our review that there is little research that explores how race and ethnicity may affect meaning in caregiving and caregiver burnout (Sodders et al.). This has been identified as an area for further research.

Caregivers have higher rates of depression and anxiety than non-caregivers (Ramchand et al. 2014; Stevens et al. 2015). Factors that have been shown to impact depression in caregivers include spousal relationship, gender, age, caregiver physical health, income, providing care to post-9/11 veterans, caregiver level of education, whether the caregiver is also caring for children, and the number of caregiver tasks (Ramchand et al. 2014; Bejjani et al. 2015; Griffin et al. 2017). Younger age and lower household income have been attributed to greater risk for depression, and the time spent caregiving and helping a veteran manage behavioral health problems were associated with increased stress and also depression (Ramchand et al. 2014). Further, grief and loss associated with cognitive changes in care recipients due to TBI have shown to increase perceived stress and depressive symptoms in caregivers (Saban et al. 2016). One study demonstrated that caregivers reported similar levels of grief related to loss of functioning from a TBI as those who lost a loved one to death (Saban et al. 2016).

Increased outreach resulting in professional psychiatric care would be a great benefit to this population. Not all caregivers who are dealing with probable depression seek treatment. A study of caregivers found that about two-thirds of caregivers with probable depression have received services in the past year and, notably, of those who did seek care 80% reported a positive outcome (Ramchand et al. 2014).

Secondary traumatic stress (STS) refers to experiences of caregivers who are caring for a person who has been directly exposed to some form of trauma or traumatic event. STS is also commonly referred to as compassion fatigue (Bride and Figley 2009; Strong 2018) and can cause symptoms that can mirror those of the care recipient or the person who was directly affected by the trauma (Bride and Figley 2009). These symptoms can include intrusive imagery, avoidance of reminders, hyperarousal, anxiety, distressing emotions, or functional impairment (Bride and Figley 2009).

Caregivers of veterans and service members often have no boundary between their personal experience and those of the person they are caring for, as they often live together and have close family bonds; this can cause the caregiver to be more susceptible to STS (Strong 2018). It is important for providers to recognize signs and symptoms of STS and to support caregivers in connecting with appropriate services and support to help address these symptoms.

Caregiver adjustment. In addition to the physical and mental health implications, caregivers often undergo a significant life adjustment when they take on the role of caregiver. Caregivers often change personal plans and adjust the amount of time they spend with friends and family to accommodate the needs of the care recipient (National Alliance for Caregiving and United Health Foundation 2010; Ramchand et al. 2014). Caregiving can impact social life, education plans, and retirement planning. One of the greatest areas impacted is time with

friends and family (National Alliance for Caregiving and United Health Foundation 2010). In a study conducted by the National Alliance on Caregiving, caregivers listed several reasons for spending less time with friends and family, including finding they no longer relate as well to non-caregivers, friends feeling less comfortable visiting, less interest in seeing friends if conversations tend to focus on the care recipient, the fact that planning outings requires more coordinating, and the fact that the care recipient's physical or mental health condition prohibit or are aggravated by social outings. Caregivers also commonly cited not having enough personal time. Adjusting to being more confined, particularly when caring for homebound veterans, can also cause feelings of isolation and contribute to increased stress and caregiver burden (National Alliance for Caregiving and United Health Foundation 2010).

The Military and Veteran Caregiver Experience Map (Elizabeth Dole Foundation and U.S. Department of Veterans Affairs Military n.d.) illustrates the caregiver journey as a cyclical process that starts with the caregiver becoming aware of and adjusting to the change; shifting personal and professional priorities and seeking help; and finding a rhythm that may include new daily routines, skills for addressing challenges, and increased confidence in their advocacy and outreach. This process may occur multiple times as caregivers face new challenges Map (Elizabeth Dole Foundation and U.S. Department of Veterans Affairs Military n.d.)

Employment status and financial hardship. Military caregivers also deal with employment and income-related challenges, as caregiving responsibilities may affect employment status. Caregivers are more likely than non-caregivers to leave the workforce due to their caregiver role (National Alliance for Caregiving and United Health Foundation 2010). Leaving the workforce or taking early retirement can affect a caregiver's income and lead to financial hardship (Tanielian et al. 2013). The majority (68%) of caregivers are employed at some point during their time as a caregiver; however, the longer a caregiver has been providing care and the more burden associated with caregiving, the more likely the caregiver is to change jobs, stop working, or take early retirement (National Alliance for Caregiving and United Health Foundation 2010). When employment responsibilities conflict with caregiving duties caregivers may make changes to their employment status in favor of their caregiving role (National Alliance for Caregiving and AARP Public Policy Institute 2015). A recent study found that twice as many caregivers of post-9/11 veterans reported the need to adjust their employment situation as a result of their caregiving role when compared to civilian caregivers or caregivers of pre-9/11 veterans, leading to a higher percentage of caregivers of post-9/11 veterans reporting financial strain (Ramchand et al. 2014). Lost wages and the cost of caregiving both affect the financial situation of caregivers (Ramchand et al. 2014). Employment factors can also impact retirement planning for caregivers, as leaving the workforce or working reduced hours may impact both employer contributions to retirement and the amount of social security received in retirement.

> ***One study participant talked about financial hardship and the influx of financial support that typically comes in when a service member is first injured. The expert noted that there were no services offered during that transition period to support long-term financial planning. Additionally, co-pays for services can create additional strain.***

Another aspect that is important to consider in the caregiving experience is the meaning that caregivers attribute to their caregiver role. The literature on caregiving defines this as positive beliefs caregivers have about themselves and their caregiving experiences (Noonan and Tennstedt 1997). Meaning associated with caregiving can be connected to caregiver gain (Kramer 1997), or personal or emotional benefits attributed the caregiving experience (Morano and King 2005). Meaning is consistently related to quality of life (Zika and Chamberlain 1992) and studies have demonstrated that positive beliefs and meaning attributed to caregiving are associated with lower rates of depression and higher self-esteem (Noonan and Tennstedt 1997). Caregiving can have a positive effect on caregivers, with many reporting feeling proud of the support they provide, experiencing

personal reward from the knowledge and skills they have gained from caregiving, and finding that caregiving is a fulfilling role (National Alliance for Caregiving and United Health Foundation 2010). Caregivers may gain an improved sense of strength for facing adversity, experience a sense of accomplishment, and develop a closer emotional relationship to the care recipient (Griffin et al. 2017).

> ***One study participant identified that providing support and mentorship to other caregivers was a way for caregivers find meaning and purpose in their caregiving role.***

Strengths and resilience. In the literature, there is a focus on adverse outcomes of caregiving, with less attention given to the moderating effects of resilient outcomes (Noonan and Tennstedt 1997; Smith-Osborne and Felderhoff 2014). Protective factors associated with caregiving, particularly for sandwich generation caregivers, include caregiver health, social support, caregiving networks that include extended family and friends, and religiosity (Smith-Osborne and Felderhoff 2014).

In a study conducted by Brickell et al. lower caregiver resilience was related to poor outcomes across a range of variables including physical and mental health, employment, finances, and social activities. Caregivers with low-moderate resilience were more likely to have greater financial burden associated with caregiving; greater impact in their employment status; less time for themselves; were more likely to also be caring for children; and were more likely to be caring for service member or veteran with irritability, anger or aggression (Brickell et al. 2018). Alternately, caregivers who measured higher on resilience were more likely to report being employed (Brickell et al. 2018). Authors highlighted that the impact on family life, given most caregivers who reported caring for children and caring for a service member or veteran with irritability, anger and aggression, were also more often living with the service member or veteran (Brickell et al. 2018). Though the study primarily demonstrated lower health related quality of life was associated with lower resilience, authors noted that many military caregivers report resilience at or above the normative sample, indicating that overall caregivers demonstrate adaptation and growth in their caregiving roles (Brickell et al. 2018).

> ***Study participants identified three common characteristics of military caregivers that reinforce or contribute to resilience: the ability to adapt to change, the strengthening of family connections, and enhanced advocacy skills. Participants described how military families often become stronger from their many experiences adapting to change through multiple deployments, moves, and adjustment to caregiving roles and responsibilities. The challenges military families tackle together can build an improved bond among family members and, as a result, the family can become more resilient in the face of adversity. Military caregivers often describe an improvement in their communication and advocacy skills as they advocate for the needs of their care recipient and family.***

Community Needs

Formal and informal social support networks can help to reduce isolation and improve satisfaction associated with caregiving. Improving resources and social supports for caregivers can help reduce caregiver burden and increase caregiver health (Griffin et al. 2017). Further, opportunities to connect with other military caregivers can help to reduce the isolation and create opportunities for them to share their experiences, coping strategies, and develop a post-military identity (Skomorovsky et al. 2020).

A caregiver network can be a group of family and friends who can provide caregiving assistance to the caregiver (Ramchand et al. 2014). Caregiver networks can be an important source of support for the caregiver. Informal networks of family and friends can provide both emotional support as well as practical support with caregiving responsibilities. A recent study conducted by the RAND Corporation found that 89% of caregivers reported that they relied on their family and friends to help with caregiving (Ramchand et al. 2014).

Other resources and networks for social support include organized caregiver groups and faith communities (Ramchand et al. 2014). Social support programs can include retreats designed to bring caregivers together, online support forums, and peer-to-peer mentoring programs (Tanielian et al. 2013; National Alliance for Caregiving and United Health Foundation 2010; Trail et al. 2020). Caregivers in these programs have expressed the significance of these connections (Tanielian et al. 2013).

> ***Participants in our study expressed the same, noting that peer-to-peer programs and other opportunities to connect with other caregivers helps to reduce isolation. Participants also described spiritual support and connection to spiritual communities as helpful in reducing isolation and improving community connectedness.***

Providing several options for caregivers interested in connecting with other caregivers can help with engagement, as there may be challenges with taking time away from being with their care recipient (Tanielian et al. 2013). Online support groups like those offered by the Military Veteran Caregiver Network and Hidden Heroes can provide flexible opportunities for caregivers to engage with one another (Trail et al. 2020). A recent study demonstrated that caregivers who joined an online community experienced less social isolation and loneliness over time (Trail et al. 2020).

> ***As one study participant stated: "Caregivers value freedom from their veteran and benefit from knowing they're not alone by connecting with others." When considering how to support caregivers in one's community, a recommendation is to begin with a survey of the resources currently available and talk with members of the community about the current needs. One expert highlighted the separation from other caregivers that typically occurs when the care recipient transitions from a long-term care facility back into the community and the sense of isolation this causes. The transition from long-term care can be a critical point for support. Arts providers can offer unique opportunities to bring military caregivers together through various community programs that center around building community connections and social support for caregivers.***

Relationships. Most caregivers are married or living with a partner (85%) and of those about three-quarters have reported that caregiving has placed a strain on their marriage (National Alliance for Caregiving and United Health Foundation 2010). The mental and physical health condition of the care recipient affects the amount of strain on the relationship; PTSD was strongly associated with relationship strain (National Alliance for Caregiving and United Health Foundation 2010). Changes that naturally occur in the relationship between the veteran and caregiver can be a source of stress. A shift may occur as the caregiver begins to adopt new ways of relating to the veteran in response to the caregiving plan that can include therapeutic physical or behavioral interventions (Conard et al. 2017). At times, the caregiver may need to be more assertive with the veteran than may have been typical in the past to accomplish care plan objectives (Conard et al. 2017).

Caregivers caring for a spouse or partner and those caring for a parent have reported feeling like they take on a parental role with the care recipient (National Alliance for Caregiving and United Health Foundation 2010). Secondary to taking on this new caregiver role, spousal caregivers reported a shift in friendship and intimacy with the care recipient (National Alliance for Caregiving and United Health Foundation 2010). Younger caregivers, typically those caring for post-9/11 veterans, tend to report poorer relationship quality than pre-9/11 veterans, which can partially be attributed to less time with their partner or spouse prior to taking on the caregiving role (Ramchand et al. 2014). Post-9/11 caregivers in strained relationships may be at greater risk for divorce than pre-9/11 caregivers (Ramchand et al. 2014). Caregivers supporting aging parents may not cohabitate, creating an additional strain as they often must travel in order to provide necessary support and coordination of services and care are often under their supervision while they are simultaneously managing the responsibilities of job, family,

and children (Conard et al. 2017). Caregiving for a family member of any type has been shown to increase the risk of depression and physical illness (Smith-Osborne and Felderhoff 2014).

In cases where intimate partner violence occurs in caregiver relationships it can be highly complex. Care recipients are often considered vulnerable, and caregivers may feel an obligation to remain in unhealthy relationships to fulfill their caregiving obligations (Hinton 2020). Additionally, caregivers may be inclined to distort or discount intimate partner violence, attributing the behavior to the care recipients' condition (Hinton 2020). Current statutes in many states dissuade caregivers from leaving abusive relationships, criminalizing the behavior by classifying it as abandonment (Hinton 2020). Caregivers may fear legal consequences if they leave the relationship. It is important that providers are aware that intimate partner violence may occur in caregiving relationships and that when it does it creates a significantly complex situation. It is recommended that providers connect with appropriate resources to help caregivers navigate these challenges.

Children. In addition to caregiver relationship changes, role modifications in the household can affect children. A 2010 study by the National Alliance for Caregiving found that three out of every ten caregivers of veterans had children under the age of eighteen living in their home. When providing care is stressful for the caregiver, it is likely to affect the parent-child relationship (Ramchand et al. 2014). Of note, caregivers of post-9/11 veterans have reported a burden on their family, specifically citing tension in the household and an impact on quality time spent with their children (Ramchand et al. 2014). Relationship changes may extend to children, who may become involved in veteran care or assume some responsibility for younger siblings (Conard et al. 2017). The caregiver may have less time to devote to activities with children (National Alliance for Caregiving and United Health Foundation 2010; Ramchand et al. 2014; Tanielian et al. 2013) and in the context of an overall shift in the household dynamic this can cause stress for young people. Notably, more than half of military caregivers with children have reported that their children are having emotional or school problems (National Alliance for Caregiving and United Health Foundation 2010; Brickell et al. 2018). Emotional and school problems were noted to be more common among children where the care recipient was a veteran with traumatic brain injury, depression, or anxiety (National Alliance for Caregiving and United Health Foundation 2010). In a study of caregivers to service members or veterans with a TBI, respondents described trying to protect their children from the care recipients' mood (Brickell et al. 2018). We describe the needs of children in greater detail above; however, as it relates to caregiving specifically, role changes within the family system have an impact on everyone in the household.

Programs

Caregiver training. Caregiver training has been well-documented to improve outcomes for caregivers and care recipients (Stevens et al. 2015). Training provides caregivers with practical skills and interventions that can help to improve outcomes for care recipients (Stevens et al. 2015) and help caregivers feel more effective and successful in their caregiver role (Easom et al. 2017). Studies have demonstrated that caregivers who receive training in how to support the physical and emotional needs of care recipients along with training on navigating systems of care report lower levels of depression, anxiety, and caregiver burden and higher rates of self-esteem (Stevens et al. 2015). The positive impact of training was especially relevant for spouses who became caregivers, more so than parents who were caring for an adult child, likely because of the major shift in relationship roles (Stevens et al. 2015).

Studies have demonstrated that military caregivers endorse the need for more information or help in making end of life decisions that their civilian counterparts (Rylee et al. 2019). This may be attributed to many variables such as care recipients with complex illnesses, post-traumatic stress, unresolved grief, or other mental health concerns at the end of life (Rylee et al. 2019). Caregiver training programs may consider how to address this gap in services and support for military caregivers.

Respite. Respite is defined as short-term temporary relief care that can reduce intensity for caregivers and have a positive effect on the burden of caregiving and caregivers' mental health (Griffin et al. 2017). Respite care can be provided in a care center or in the care recipient's home (Ramchand et al. 2014). A RAND Corporation study conducted in 2014 identified that 27% of military caregivers have used respite care; the authors also noted that the outcomes associated with respite care have not been well-demonstrated in the research (Ramchand et al. 2014). Furthermore, respite services and centers are few and far between and eligibility may present additional hurdles to accessing these services (Tanielian et al. 2013).

Participants in our study did not speak specifically about respite care or the benefits of respite care; however, several participants identified barriers to caregivers accessing services due to an inability to leave their care recipient. Childcare was also identified as a challenge for caregivers who were caring for dependent children in their home. Coordination of respite care alongside supportive services may facilitate engagement in programs offered to caregivers. There are some programs that currently offer respite care while providing services to the family (Ramchand et al. 2014); perhaps more coordination among community-based providers would support caregiver engagement and respite.

Wellness activities. Wellness activities for caregivers range from fitness classes to stress reduction workshops to outdoor activities targeting physical and emotional wellness (Ramchand et al. 2014). Activities that increase physical activity and healthy behavior can help to mitigate some of the effects of caregiver burden and stress. Providers interested in offering wellness activities for caregivers need to consider barriers to engagement. Typically, higher-burden caregiving situations complicate caregiver engagement in wellness activities (Ramchand et al. 2014); however, these caregivers are likely to benefit significantly from participation.

> ***Providers can identify barriers to engagement with their community of military caregivers and look for creative ways to partner with local organizations to reduce barriers, where possible.***

Mental health services. Caregivers can be parents, spouses, children, neighbors, close friends, or relatives. There are different challenges and needs associated with different relationships between the caregiver, care recipient, and other close family members.

> ***Participants in our study recognized that each member of the family needs access to high-quality mental health and supportive counseling services to address any mental health or psychosocial needs. The entire family system often needs to adapt to the change in roles and dynamics within the family. Caregiver, spouse, and/or child can benefit from psychoeducation to learn about the service member's injury or trauma, to understand and gain empathy for their family member, and to learn how to help the person during recovery. The whole family can benefit from the time and space to communicate, express how roles have changed, and work through any conflicts. Individual family members' responses and needs to stressors and trauma will be different. Each individual's distinct response will have an effect on the other family members and the family system as a whole. Supportive counseling can help to validate feelings, focus on developing and enhancing coping skills, and teach mindfulness, meditation, and relaxation techniques in order to promote self-care and enhance wellness.***

Caregivers often identify how their role as a caregiver has affected their emotional health. Common concerns include the burden of caregiving, feelings of loss, feelings of anger, depression, and anxiety (Carlozzi et al. 2016). A study conducted by the RAND Corporation identified that 30% of caregivers of post-9/11 veterans accessed mental health counseling, four times the rate of non-caregivers and twice the rate of civilian caregivers and caregivers of pre-9/11 veterans. Notably, about 80% of the study's participants found that mental health counseling was helpful (Ramchand et al. 2014), which is comparable to a previous study conducted in 2010 that

found that 77% of respondents identified mental health counseling as useful (National Alliance for Caregiving and United Health Foundation 2010).

Studies demonstrate that interventions that focus on positive attributes, including meaning and benefits gained from caregiving, along with interventions that support healthy family relationships, communication, social connection, and self-esteem, may protect against the burden of caregiving and caregiver burnout while enhancing mental health (Brickell et al. 2018). This is congruent with reports from many of our study participants, who emphasized the need for strengths-based approaches to treatment that build on resilience and help to reinforce and further develop protective factors. However, despite the identified gains associated with counseling, evidence points to an underutilization of mental health services by those who need them (Ramchand et al. 2014).

> ***Study participants cited common barriers to engagement as complications with scheduling and managing the needs of their care recipient.***

Arts Programming: Overview of Programs and Considerations for Military Caregivers

The RAND Corporation completed a survey of existing programs for military caregivers and found a range of programs that included periodic wellness activities and a handful of faith-based and helping-hand-type services that supported different aspects of family life. The researchers noted that caregivers used both governmental and nongovernmental programs; however, they indicated that utilization was not optimal and that caregivers cited difficulty finding information about services (Ramchand et al. 2014).

Our study surveyed current arts programming that is available to military caregivers and interviewed five experts working with military caregivers in some capacity. We found that most programs we encountered offered services to caregivers in addition to offering services to military family members, veterans, and service members more broadly. Many service providers talked about the benefits of serving the military-connected population holistically, stating that the opportunities for engagement and collaboration among professionals facilitated and, in some cases, enhanced the therapeutic benefits. Several interviewees also emphasized the need to be flexible with program offerings to help reduce barriers to access. Some examples of flexibility included offering services in different formats (e.g., online, in groups, and individually) and offering services at various times to facilitate scheduling (e.g., evenings and weekends). Online programming can be one of the more flexible options for caregivers and has been shown to effectively decrease isolation and loneliness (Trail et al. 2020).

Programs we researched offered creative arts therapy as well as group arts therapy to caregivers. Group arts therapy approaches were designed to promote social connections among caregivers and focused on self-care and stress reduction. Group interventions focused on self-care can be applied through a variety of arts therapy disciplines. Caregiver groups also supported caregivers in exploring their identity as a caregiver and offered directives that would empower caregivers. Another key aspect to consider is the exploration of a post-military identity, one that honors the social support and camaraderie of the military community and helps caregivers to strategize how to develop a post-military support network. A more arts-based approach through an open studio model was promoted by one interviewee, who felt that this model engaged caregivers who might be reluctant to engage in more clinically focused treatments. The open studio provided a venue for caregivers to come together around a meaningful activity and it promoted socialization and self-care.

Community collaboration and multidisciplinary approaches to treatment were other considerations highlighted by interviewees. Several interviewees talked about the potential for caregivers to feel isolated in their communities. Service providers can work to collaborate across arts and health and human services organizations.

Interviewees shared that as service providers it was important to be aware of the other resources available for caregivers in the community so that they could promote these programs and services to caregivers and make referrals on behalf of caregivers when needed. Two interviewees provided examples of collaboration between arts programming and community-based programing in the health and human services sector. It was evident that these collaborations promoted a sense of community while addressing caregivers' needs holistically. A multidisciplinary approach to treatment and colocation of services also promoted engagement of caregivers and their families, as multiple treatment options provided more opportunities for engagement and colocation of services promoted coordination among service providers.

Arts programs—utilizing both creative arts therapy and community-based arts—can address the self-care needs of caregivers, helping to mitigate the impact of stress and reduce the likelihood of compassion fatigue (Lambert et al. 2017). Creative arts therapies may also engage people who might be otherwise reluctant to seek treatment due to stigma associated with mental health, by offering a unique outlet for creating and expressing meaning associated with caregiving challenges and successes. Attending to the needs of caregivers can have a positive effect on the veteran and service member and the entire family system as the quality of care has a positive correlation with caregiver quality of life (Ebrahimzadeh et al. 2013).

CHAPTER SUMMARY: MILITARY CAREGIVERS

KEY CONSIDERATIONS FOR CREATIVE ARTS THERAPISTS

- Offer a holistic approach to serving the military-connected population by serving caregivers, spouses, and children.
- Utilize a multidisciplinary approach by including several different types of therapy (e.g., music therapy, dance therapy, and art therapy).
- Orient programming around opportunities for self-care and meaningful connection to other caregivers.
- Provide flexibility in appointment scheduling, hours of operation, and format of service delivery (e.g. online program delivery).

KEY CONSIDERATIONS FOR COMMUNITY-BASED ARTS PROVIDERS

- Focus arts programs on holistic health, ideally including the care recipient in the program when appropriate.
- Provide flexibility in scheduling, as caregivers might not be able to participate during traditional business hours.
- Offer programs in different formats to ease barriers to access including online programs, one-on-one classes (both on-line and in-person), and community classes with other caregivers to foster social connection, stress reduction and self-care.
- Use evidence-based practices and evaluate programs.
- Increase understanding of military culture.
- Collaborate with existing veteran or military serving organizations, and other community-based organizations.
- Conduct continuous outreach to military-connected participants and family members.

CHAPTER SUMMARY: MILITARY CAREGIVERS

COMMUNITY NEEDS

Identification and Connection

- Formal and informal social support networks can help to reduce isolation and improve satisfaction associated with caregiving.
- Improved resources and social supports for caregivers can help reduce caregiver burden and increase caregiver health.
- Opportunities to connect with other military caregivers helps to reduce isolation and create caregiver networks to share their experiences, coping strategies, and develop a post-military identity.
- Online support groups like the Military Veteran Caregiver Network and Hidden Heroes can provide flexible opportunities for caregivers to engage with one another.

Relationships

- Most caregivers are married or living with a partner and about three-quarters report caregiving placed a strain on their marriage.
- Caregivers caring for a spouse or partner and those caring for a parent have reported feeling like they take on a parental role with the care recipient. Caregiving for a family member of any type increases the risk of depression and physical illness for the caregiver.

Children

- When the caregiver faces stress, it is likely to affect the parent-child relationship, including children who assume caregiver roles or responsibility for younger siblings.
- More than half of military caregivers with children reported their children have emotional or school problems.

Caregiver Training

- Caregiver training improves outcomes for caregivers and care recipients by providing caregivers with practical skills and interventions that help them feel more effective and successful.
- Caregivers who receive training in how to support the physical and emotional needs of care recipients along with training on navigating systems of care report lower levels of depression, anxiety, and caregiver burden and higher rates of self-esteem.

Respite Care

- Respite care is short-term temporary relief care that can be provided in a care center or in the care recipient's home to reduce intensity for caregivers and improve caregivers' mental health.

Wellness Activities

- Activities that increase physical activity and healthy behavior can help to mitigate some of the effects of caregiver burden and stress.

Mental Health Services

- Programs that focus on the meaning and benefits gained from caregiving and support healthy family relationships, communication, social connection, and self-esteem, may protect against the burden of caregiving and caregiver burnout while enhancing mental health.

SUMMARY AND CONCLUSIONS

Our report has determined key needs for the four target population subgroups (service members and veterans, military families, military children, and military caregivers) and identified common gaps, opportunities, and approaches for all providers to consider. Overall, the leading theme was the heterogeneity of the military-connected population and the wide range of needs within it, calling for a variety of approaches. Service members and veterans and their families often face the same stressors and challenges as civilians and civilian families, in addition to military-specific experiences and stressors. It is important to consider the way that universal stressors and needs may change within the military context, as well as how civilian and military factors interact across individuals and families.

Although needs and experiences vary greatly throughout the four population subgroups in our study, several broad themes emerged that overlapped across all four. A central focus in the literature and interviews was the need for strengths-based perspectives and approaches. Programs often concentrate on deficits in the military-connected population, yet service members and veterans and their families have many strengths and skills. It is recommended that creative arts therapists focus on building resilience or enhancing skills, strengths, and relationships. Strengths-based programs are not only more engaging and more beneficial but also disprove the stereotype that stress or difficulty always cause negative outcomes.

Using a holistic approach to treat the entire family ensures that creative arts therapists can focus on crucial family dynamics, such as changing family roles, relationships, parenting, or caregiving. On a similar note, creative arts therapists are encouraged to consider a multidisciplinary approach to treatment, as well as colocation of services. Different types of therapies (e.g., music therapy, art therapy, and mental health counseling) and services (e.g., peer support groups and community engagement) can address multiple needs. A multidisciplinary approach and colocation of services promotes coordination among service providers and mitigates challenges for families. Lastly, there is a call for programs grounded in and informed by evidence-based practice. Programs should be evaluated to determine areas of improvement, engagement, and—most importantly—efficacy.

There were also universal considerations for community-based arts providers and service providers more broadly, as well as creative arts therapists. It is important for service providers to consider the needs in their local community as well as the needs of individual families. Service providers can customize services and programs to address and meet the specific needs of their local community. Needs vary greatly by age, branch of service, service member rank, region, and a host of other factors. Therefore, it is recommended that community-based arts providers (and all service providers in general) focus on needs and challenges at the individual, family, and community levels. Additionally, it is strongly recommended that service providers collaborate with and connect to local programs and resources and other community-based organizations. Both community-based arts providers and creative arts therapists must be able to connect and refer military family members to existing programs and resources within the community. Arts organizations and other organizations were encouraged to form partnerships to widen the range of available services.

The common thread in all considerations, across all population subgroups, for all service providers, was to acknowledge and appreciate the diversity of experiences and needs among the military-connected population. However, current research and literature do not adequately cover the diverse needs and subpopulations within the military. Much of the literature on military and veteran families reflects the experiences of white, heterosexual, married couples where the service member is male and the civilian spouse is female. Therefore, it is vital that future research and programs further examine the challenges, strengths, needs, and lives of minority

groups within the military. With more research and programming, specific considerations could be developed to address the unique needs and experiences of racial and ethnic minorities, LGBTQIA individuals and their families, female service members and veterans, single-parent families, and dual-service couples in the military. The military is becoming more diverse in multiple ways, so it is essential that research and programs are inclusive, welcoming, and culturally competent. Researchers and service providers alike must give greater consideration to the interaction and impacts of individual factors, such as race, gender, or family structure, within the context of the military.

There is no single approach in serving the military-connected population. Because there is such diversity in needs, strengths, and challenges across the military community, it is important that all service providers, including creative arts therapists and community-based arts providers, be informed and educated about military culture and life. A lack of knowledge and understanding can contribute to stereotypes, such as the assumption that service members are "broken" by their service. Military cultural competency is a necessary step to adequately address needs, create and implement effective programs, and bridge the military-civilian divide.

Creative arts therapists and community-based arts providers are uniquely positioned to address the needs of military-connected populations through arts engagement and creative arts therapy. Creative arts therapy can help to address the psychosocial and mental health needs of service members, veterans, and their families, while community-based arts providers can provide meaningful opportunities for community and peer connections. Both creative arts therapy and arts engagement offer outlets for self-expression that can support an increase in self-esteem and help to cultivate a sense of purpose. This report can be a foundation for creative arts therapists and community-based arts providers to develop a greater knowledge and understanding of the military and the needs of military-connected members. Building on this understanding, creative arts therapists and community-based arts providers can unite through collaborative and coordinated efforts to address the needs of their military-connected community members holistically.

APPENDIX A

Key Terms and Definitions

This report uses the following key terms as defined below.

Populations

Military-connected individual: Any veteran, service member, or military family member.

Veteran: A person who served in the military for any length of time.

Service members/service member: Service members are current members of the U.S. Armed Forces, including those who are Active Duty, National Guard, and Reserve. When referring to individuals, this report uses "service member."

Military family member: Any spouse, unmarried partner, parent, sibling, or child of a current service member.

Veteran family member: Any spouse, unmarried partner, parent, sibling, or child of a veteran.

Military child: A dependent child, stepchild, or adopted child of a service member.

Veteran child: A biological child, stepchild, or adopted child of a military veteran.

Military caregiver: A person who provides a broad range of unpaid care and assistance for, or manages the care of, a current service member or veteran with a disabling physical or mental injury or illness. For example, a military caregiver may schedule and coordinate a veteran's medical appointments (Tanielian et al. 2013).

Clinic-to-Community Spectrum

Arts: A physical expression of creativity through visual or performing modalities including visual art, photography, dance, theater, music, film, and writing.

Clinical setting: A setting where medical services are provided to assess, diagnose, and provide treatment for clinical mental health conditions such as post-traumatic stress disorder, depression, and traumatic brain injury. Examples of a clinical setting include a medical hospital or outpatient clinic where services are rendered by a multidisciplinary team of qualified health professionals (e.g., clinical psychiatrist; licensed clinical social worker; licensed mental health professional; credentialed, certified, and/or licensed art therapist, dance/movement therapist, drama therapist, or music therapist).

Community-based setting: Any public or nonprofit setting that offers services to members of the military-connected population within the community where they reside. Examples of a community-based setting include veteran-serving organizations, museums, community arts centers, and educational institutions.

Federal and government organizations: Entities operated under the U.S. Department of Veterans Affairs, the Veterans Health Administration, or the U.S. Department of Defense. Organizations operating under the Veterans Health Administration include hospitals (VA medical centers), clinics (community-based outpatient clinics), Vet Centers, and PTSD and specialty substance use disorder programs. Organizations operating under the Department of Defense include programs and services available to active-duty service members, National Guard, and Reserve (e.g., the Walter Reed National Military Medical Center).

Creative arts therapies: The distinct regulated health professions of art therapy, dance/movement therapy, drama therapy, music therapy, poetry therapy, and psychodrama. Board-certified professionals in these fields use their art form toward achieving clinical and therapeutic outcomes. Each of the professional disciplines possesses a definition of the profession, a legally defensible scope of practice, educational competencies, standards of practice, a code of ethics, and evidence-based research. Creative arts therapists share the feature of encouraging creative expression through a specific art form. However, each profession stands alone as distinct (Lambert et al. 2017).

Community arts programming: Community-based arts programs and therapeutic arts programs that promote the integration of healing arts practice as part of daily life (National Endowment for the Arts, 2018). Such programming is typically offered by someone with a background in the arts and in some cases by a professional credentialed creative arts therapist. Programming can be offered in community-based settings or clinical settings (e.g., an artist offering an arts engagement group in a hospital setting).

Creative arts therapy in community settings: Services provided by a creative arts therapist (a credentialed, certified, and/or licensed art therapist, dance/movement therapist, drama therapist, or music therapist) in a community-based setting as defined above.

Service provider: A person or organization that provides a service to an individual.

Intervention: The mechanism that is acting on a population, especially when an explicit population of interest experiences a change attributable to a mechanism that is assessed by an outcome measurement.

Resilience: Relative resistance to adversity or risk (Rutter 1999).

APPENDIX B

Summary of Interviews with Subject Matter Experts

Interviews with subject matter experts were structured using four separate interview instruments (specific to each population group), a recruitment e-mail, and a verbal consent form. Prior to starting the research, the Syracuse University institutional review board approved the protocol. The IVMF team created a matrix of subject matter experts, categorized by population served, type of programming, and type of arts programming (if applicable). Populations served were organized using four categories: veterans and service members, military and veteran families, military and veteran children, and military caregivers. The team contacted approximately thirty subject matter experts and conducted nineteen interviews in total. Experts were represented in the following professional roles: researcher, program director, creative arts therapist, and community-based arts provider. Some experts represented more than one professional role (e.g., program director and creative arts therapist).

Each interview included six to seven open-ended questions and lasted about one hour. The interviews were analyzed for themes and key findings. Primary themes and findings are presented below by population category and include considerations for creative arts therapists, considerations for community-based arts providers, challenges and stressors, population needs, and factors related to resilience and strengths. Many of the considerations for community-based arts providers have broad applications that may also apply to creative arts therapists or service providers more generally. An asterisk (*) has been used to identify considerations with broad applications. Interviews were considered for inclusion in multiple population categories when the expert or the organization the interviewee represented provided services to more than one population category and/or when the expert discussed information relevant to the needs of multiple populations during the interview.

1. Service Members and Veterans

Participants

We conducted four interviews with experts working with veterans and service members. In addition, three more interviews with experts working with military children, military families, or military caregivers in addition to veterans and service members were included. Experts in the following categories were represented: researcher (1), program director (4), creative arts therapist (2), and community-based arts provider (2).

Considerations for Creative Arts Therapists: Service Members and Veterans

1. **Use engagement with creative arts therapies to help break barriers** to healing. Engagement with creative arts therapies can help veterans and service members begin to talk about their experiences. “It was a way for therapists in our organization to get to know the people we were serving on their own terms—through their artwork.” “Most of life’s problems are quasi-clinical or not clinical at all.” Creative arts-based interventions can provide an approach to therapy that reduces barriers to engagement.

2. **Work from a strengths-focused approach** when working with veterans and service members. Engaging people in a strengths-focused approach can help to build upon existing successes and strengths.

3. **Involve the full family** whenever possible. Participants identified several reasons for full family engagement,

citing that the entire family is affected when a service member is preparing for deployment, is deployed, or transitions out of the military.

4. **Create opportunities for veterans to mentor** other veterans by giving back through advocacy, volunteering, and engaging in programming in support of other transitioning veterans.

Considerations for Community-Based Arts Providers: Service Members and Veterans

1. ***Become a learning organization,** collect knowledge, curate it, and put it in motion so that we have a learning community of providers who are open to moving beyond their own boundaries, believing that what they're actually contributing to is not only their individual body of work but a collective community of work."

2. ***Do research and develop an understanding** of the needs and resources in your community. Build your programming around these needs and in a way that complements existing resources.

3. ***Integrate and collaborate** with other programs in your community. Collaboration among programs supports veterans and service members in accessing additional resources and experiencing their community of providers as connected and centered on a common goal.

4. ***Develop programs that bring veterans or service members together** with one another around meaningful activities. Experts identified that arts making in groups involves a social component that can help to reduce isolation and promote a sense of community and belonging. The arts provide a range of opportunities for bringing groups of veterans or service members together.

Challenges and Stressors: Service Members and Veterans

1. **Co-occurrence of needs:** Many veterans and service members present with more than one need at a time (e.g., housing and employment). There is a need for providers to work across silos to coordinate care and better serve the population. Services to address basic needs such as finding stable employment, securing safe and permanent housing, and accessing transportation to and from work are commonly needed. Co-occurring needs that complicate these circumstances can include the need for legal and/or financial assistance.

2. **Idealizing and disparaging of military experience:** Perceiving and portraying veterans and service members as either heroes or victims contributes to a disconnect between veterans/service members and civilian citizens. One expert said there is a tendency to "aggrandize or pathologize" veterans and service members, adding that both responses contribute to a military-civilian divide.

3. **Military/civilian gap:** There is a contrast in values between military and civilian culture. Military culture places emphasis on group cohesion and a common mission and civilian culture puts emphasis on the needs and goals of the individual. This contrast can cause challenges for transitioning veterans. Misconceptions and stereotypes also exist and deepen the military/civilian gap. Some misconceptions identified by interviewees included assumptions about combat experience, personal and political values, mental health and PTSD, and tendency toward violence.

4. **Stigma:** Experts identified that more work needs to be done "at the ground level to overcome stigma and normalize challenges associated with transitions in the life cycle of service members and their families."

5. **Personal/professional identity:** Identity is commonly in flux when service members transition out of the

military. Service members' identity may have been tied to their military role and culture; during transition this identity needs to be reconciled in the context of new civilian roles and responsibilities. One expert talked about identity challenges of some women in the military, noting the pressure to fit into a largely male-dominated culture. Another expert indicated that identity challenges associated with transition may be further complicated for female veterans.

6. **Sense of purpose:** Lacking a sense of purpose can be tied to changes with identity upon transitioning from military to civilian life. Experts identified that developing a sense of purpose outside of one's role in the military was an important aspect of transition.

7. **Family transitions and relationships:** Families undergo a transition when a service member separates from the military. Veterans/service members may feel like they lack a bond with their children or spouse. Roles often need to be renegotiated when a service member returns home.

Population Needs: Service Members and Veterans

1. **Community connections:** Veterans and service members benefit from services that help build a meaningful connection to their community of residence and/or connect them with other veterans, service members, and/or military families.

2. **Navigation of benefits and services: T**here is a need to connect people to the right services quickly.

3. **Coordination among providers:** There is a need for providers to work across silos to coordinate care and better serve the population.

4. **Mental health services:** Veterans and service members may benefit from services that promote resilience and build on strengths. Some of the treatment approaches endorsed by interviewees included teaching grounding strategies, using guided imagery, teaching basic cognitive behavioral therapy skills like recognizing and tolerating emotions, and strategies, interventions, and programs that build community connections.

5. **Narrative approaches to therapy:** Services that explore dominant narratives can help veterans and service members examine strengths and resilience and build on those characteristics as they work to transition from military to civilian life. Narrative approaches to therapy also can support a shift from viewing circumstances through a deficit-focused lens to a strength-focused perspective, as veterans begin to tell their stories in a different light—moving toward a narrative that builds on feelings of being a strong, capable, and contributing citizen.

6. **Communication:** Veterans and service members benefit from programming that helps them to communicate their needs, feelings, and desires to the important people in their life.

7. **Peer-to-peer support and/or mentorship:** Services that center on peer relationships build on "the ethos crafted in the military of 'leave nobody behind.'"

Factors That Contribute to or Promote Resilience: Service Members and Veterans

1. **Mental and physical toughness**: Interviewees identified that mental and physical toughness developed during a person's military career can contribute to resilience.

2. **Self-sacrifice:** Veterans and service members often have a strong sense of self-sacrifice and selfless service. "An identity was formed by selflessly serving with others."

3. **Drive to be a productive and contributing citizen:** "When we finish want to be as productive in civilian society as we were in service."

2. Military and Veteran Spouses and Families

Participants

We conducted five interviews with experts working with family members of service members and veterans. Two additional interviews with experts working with caregivers, veterans, and service members also were included. Experts in the following categories were represented: researcher (4), program director (5), creative arts therapist (1), community-based arts provider (1), and other service provider (1).

Considerations for Creative Arts Therapists: Military and Veteran Spouses and Families

1. **Offer a holistic approach in serving the whole family.** In addition to serving veterans and service members, include spouses, children, and other family members in the services offered. Consider treating the family as a system, because veterans and service members "don't exist in a vacuum."

2. **Use a strengths-based approach**. Operating from a strengths-based perspective puts the focus on building or enhancing skills, strengths, and relationships, which is often more engaging and more beneficial. "So often what we are trying to do is guided by the wrong narrative, like the broken veteran."

3. **Embed evidence-based practice and evaluation in programming.** Researchers called for programs based in and informed by research. Additionally, they stressed the importance of evaluation. "Programs that sound good or feel good aren't enough; they have to work." Programs should be effective and engaging ("people have to like it and show up").

4. **Use a multidisciplinary approach.** Multiple treatment options and providers address varying needs and issues (e.g., physical health, mental health, and community engagement) and promote collaboration and coordination among service providers.

Considerations for Community-Based Arts Providers: Military and Veteran Spouses and Families

1. ***Develop training or education to enhance understanding of military culture.** A very common theme among all interviewees was the need for military cultural competency and understanding of the military lifestyle. It is important to learn about military service and recognize and unpack stereotypes.

2. ***Collaborate with existing community-based organizations.** It is helpful to partner with existing organizations that already know how to deliver programs to and/or how to interact with and recruit the military community. It is also vital that all service providers be aware of other community organizations, so they can better direct or refer military families to the resources and support they need. One participant summarized this with the motto "support, do not supplant."

3. ***Do continuous outreach.** There can be substantial turnover in military communities due to frequent relocations, promotions, and deployments. This means "you're never done with outreach."

Challenges and Stressors: Military and Veteran Spouses and Families

1. **Frequent transitions:** Due to frequent moves and relocations, deployments, and the ultimate transition from military to veteran status, there can be a lack of stability and consistency in the lives of military families. For families, this can mean changes in employment status, needing to find new childcare, shifts in family roles and identity, and navigating new schools and communities.

2. **Family separation:** Active-duty service members and National Guard and Reserve members are separated from their families due to trainings, schooling, and deployments. Deployments are typically associated with worry, fear, added stress, and changes in family roles. Family separations are more complicated for dual-service military couples and single-parent military families.

3. **Community isolation and lack of support:** Military families often report a lack of connection and belonging to their civilian communities and neighbors. Social isolation is particularly common in military spouses, families that live off-installation, and families of National Guard and Reserve members. It is likely that lack of community connection and lack of support are also problems for family members who are not recognized as dependents of service members or veterans (e.g., parents and unmarried partners).

4. **Chronic daily stressors:** Military families must deal with daily stressors or hassles that are specific to the military lifestyle. There are additional processes and paperwork involved in receiving medical care, moving, or enrolling in new schools and services. Additionally, there are long workdays for service members, and the unpredictable nature of military service can make it difficult to plan for the future of the family. One study participant added that stress can arise from conflicting identities and roles, reflecting, "the culture is fairly traditional but also requires nontraditional/flexible gender roles."

5. **Heightened risk:** Certain factors can make military families more vulnerable to the stressors and challenges of military life. Military parents who are younger, have children at younger ages, are not wealthy, live away from extended family members and support systems, and have difficult or draining jobs are at a greater risk for negative outcomes.

6. **Identity:** Spouses of service members and veterans sometimes feel they lack an identity or that their identity is ignored, as the focus of attention or services is typically on the service member or veteran. Spouse unemployment and underemployment also can affect issues with identity. Identity challenges also can arise for spouses and children during separation for military service and the transition from being a military family to being a veteran family.

7. **Spouse unemployment and underemployment:** Many military spouses often struggle with unemployment and underemployment because of frequent moves, lack of childcare, and gaps in their resumes. The effects of spouse unemployment and underemployment are far-reaching and affect both military and veteran spouses. As with civilian families, military and veteran families are stronger with two incomes. Additionally, meaningful employment can serve as a buffer for social isolation for military and veteran spouses.

Population Needs: Military and Veteran Spouses and Families

1. **Programs created for and/or specific to military families:** There are few programs that specifically cater to military families and their unique experiences, challenges, and strengths. A few experts commented on the gap in serving military families across community, clinic, and government programs. Programs that

currently involve military family members often are created for service members and/or veterans, and then expanded to include military family members (e.g., parents, spouses, and children) without addressing the individual and varying needs and experiences of different family members. Interviewees stressed the benefit of programs that serve the whole family and treat the family as a system. Additionally, many programs for veteran families are aimed at helping veteran caregivers or families of a wounded, ill, or injured veteran. There is a lack of programs that address more common issues in veteran families, particularly those surrounding transition. Even fewer military family programs and organizations are evidence-based and evaluative.

2. **Identification within the civilian community:** Unless military family members self-disclose as such, community systems, programs, and creative arts therapists may be unaware of their military status. It is important for military family members to be identified so they may be connected with the appropriate services and resources and treated by military-sensitive providers. Most interviewees mentioned that these issues are exacerbated for families of National Guard and Reserve members, particularly because children of National Guard and Reserve members are not identified within school systems.

3. **Social support, connection, and belonging: L**ike all families, military and veteran families should feel supported and experience a sense of connection and belonging within their local communities. However, many military families feel misunderstood by civilians and feel they don't belong within their civilian communities. Such experiences can contribute to detrimental outcomes related to isolation, loneliness, and stress. Experts in the arts especially stressed the importance of programs that foster community connection, involvement, and belonging for military families. Again, some respondents indicated that the need for connection and belonging may be heightened for families of National Guard and Reserve members, families living off-installation, and veteran families, all of whom may be missing or lacking connection to their military community.

4. **Connection to local programs and resources:** Some experts identified the need to connect military and veteran family members with existing programs and resources within their community. There may be a lack of awareness of certain programs or program administrators may be uncertain of how to reach military families and encourage participation.

5. **Access to quality mental health services:** Each member of the family needs access to quality mental health care. Needs vary across and within families, so military and veteran family members require care that will adapt to those needs.

6. **Childcare services:** As is the case with civilian families, military families often require childcare. Military family members are often living away from extended family and lack community connections, which can complicate finding suitable childcare.

7. **Military spouse employment:** Military spouses are often highly educated and motivated, yet often struggle to find employment due to frequent moves and gaps in their resumes. Military families benefit from two incomes, especially during periods of transition, and military spouses often benefit from meaningful employment.

The most common thematic response regarding the needs of military families was that military families are incredibly diverse and heterogeneous, making it difficult to identify primary needs. One expert said it was like "asking 'what are the most pressing needs of American families?'" Another respondent said, "The veteran and military experience is as diverse as our country's experience."

Factors That Contribute to or Promote Resilience: Military and Veteran Spouses and Families

1. **Bonds of military community:** Generally, military and veteran families are skilled at forming communal bonds and are often seeking to make tight connections, build camaraderie, and share a sense of belonging. Seeking out and forming these bonds and relationships within and outside of the military community can promote resilience in military family members.

2. **Effective and healthy communication:** Effective communication aids in building resilience and allows families to process experiences, negotiate, and problem solve. In particular, creative arts therapies and community-based arts programming can promote shared understanding and meaning and improve communication skills. "Art is really powerful because it is a form of nonverbal communication and is non-threatening . . . it can provide a place for all of them to sit down and be able to see or hear what each member of the family has to say."

3. **Desire to learn and master new skills:** Military families are often motivated, engaged, and eager to develop new skills. Subject matter experts in the arts highlighted the desire to learn and master new skills as a strength of military family members.

4. **Enhanced family connections and relationships:** Military families encounter challenges and experiences together that can enhance their family relationships and build a stronger family system. Similarly, building relationship skills can improve family connection. Resilience in children is more likely when parents set limits, are competent caregivers, and are loving and involved in their children's lives.

5. **Military lifestyle:** "Adaptability is our greatest skill." Many subject matter experts reported that resilience is ubiquitous among military families ("most military families are resilient") and is a necessary part of the military life.

6. **Individual characteristics:** As is the case with all families, individual traits (e.g., personality traits, genetic traits, etc.) can foster resilience. Intelligence, social competence, and kindness are all related to resilience.

3. Military and Veteran Children

Participants

We conducted five interviews with experts working with the children of service members and veterans. Two additional interviews with experts working with military and veteran families, caregivers, veterans, and service members also were included. Experts in the following categories were represented: program director (6), creative arts therapist (1), community-based arts provider (1), and other service provider (1).

Considerations for Creative Arts Therapists: Military and Veteran Children

1. **Offer a holistic approach in serving the whole family. I**n addition to serving the children of service members and veterans, include parents, grandparents, siblings, and other family members in activities, services, or events. Creative arts therapists should consider treating the family as a system in order to address and enhance parenting skills, parent-child relationships, sibling relationships, family dynamics, and other variables within the family context.

2. **Use a strengths-based approach.** Programs that focus on building or enhancing skills, strengths, and relationships are often more engaging and more beneficial. Creative arts therapies fit very well within a strengths-based approach. "Art can give voice to kids, give children a chance to express themselves and even

make friends." Children and youth may not be able to talk about or express certain emotions or thoughts they are experiencing, and "music and art therapy can encourage processing and help kids learn to trust." A few experts encouraged a greater focus on positive youth development.

3. **Use a multidisciplinary approach.** Multiple treatment options and providers address varying needs and issues (e.g., physical health, mental health, and community engagement) and promote collaboration and coordination among service providers. Additionally, a multidisciplinary approach is beneficial because it is not always clear which creative arts therapy will resonate with a particular child. A few study participants indicated that music and art therapy are popular with many children, but others prefer creative writing. In taking a multidisciplinary approach, creative arts therapists can determine what works best for each military child.

4. **Use developmentally appropriate practice.** The needs and experiences of military children vary widely by age and maturity of the child. Older children may display more emotional symptoms, while younger children may act out behaviorally. Creative arts therapists must "meet children where they are" and remember, "not one size fits all kids." Programs must take a developmental and contextual approach to caring for military-connected children and youth.

Considerations for Community-Based Arts Providers: Military and Veteran Children

1. ***Develop training or education to enhance understanding of military culture.** A common theme among all interviewees was the need for military cultural competency and understanding of the military lifestyle. It is important for all service providers and even civilian community members to learn about military service, unpack stereotypes, and improve understanding of the experiences of military children.

2. ***Focus on local community needs and individual family needs.** Both creative arts therapists and community-based arts providers can customize services and programs to the specific and individual needs of the local community. Needs differ so much across different age groups, branches of service, service member rank, geographical location, and so on that it is better to address needs at the lower systems level. It is vital that all service providers "meet people where they are." It is also important that all service providers be aware of other community organizations, so they can better direct or refer military and veteran families and children to the resources and support they need.

3. ***Provide flexibility and choice for children.** Create an environment for military children where they are able to make choices and feel in control, even "if it's just picking their art materials." Military children often feel as though they have little control of their life (due to moving schools, separation from parents, etc.). Additionally, being flexible in terms of the services and activities offered can accommodate children at varying levels of development and maintain and encourage engagement. "Maybe you have to get them moving, maybe you switch to writing, or use imagery . . . sometimes we sit under the table!"

4. ***Consider incorporating a team or group element.** Group settings work well for military children, because the military culture is focused on teamwork and selflessness. Additionally, groups or teams can foster trust, reliance, and support among children. Military children also benefit from participating in groups with other military families who have shared experiences and understand the military lifestyle. This is particularly significant for military children of veterans or service members who are wounded, ill, or injured. Peer relationships are highly important for teenagers and preteenagers and team building can develop or solidify relationships.

Challenges and Stressors: Military and Veteran Children

1. **Frequent transitions and school changes:** Military children often experience a lack of stability and consistency because of frequent moves and relocations, deployments, and other transitions. There are many transition challenges related to education and community engagement for military children. These challenges and stressors can be particularly difficult for military and veteran children with special needs.

2. **Family separation:** Most military and veteran children have experienced separation from their service member parent. During deployments, children must cope with the stress and anxiety of having their parent in danger. One subject matter expert said, "During deployment or separation, from a young child's perspective, that person is gone."

3. **Shifts in family dynamics:** During transitions, and particularly during times of family separation, there can be a change in family roles. Children may have to take on more chores or responsibilities. Sometimes there is a risk of parentification of children, and parents may rely on children in ways that surpass their developmental capacities. There also can be shifts in family dynamics when the family separates from the military or a service member or veteran returns home with a mental or physical injury.

4. **Community isolation and lack of support:** Military children sometimes feel lonely or singled out, especially if they are not in a community with other military kids or families. Lack of connection, belonging, and support, as well as social isolation, are of particular concern for children in military families that live off-installation, families of National Guard and Reserve members, and veteran families. One study participant commented on the absence of services and resources targeting and available to children of veterans.

5. **Secondary trauma:** Post-traumatic stress disorder in service members and veterans can be transmitted to their children. Even if children do not experience secondary traumatic stress, the effects of trauma experienced by a parent can greatly affect parenting, parent-child relationships, and family dynamics. "Trauma from war and deployment is different from civilian trauma . . . [service members are] not really able to talk about military trauma, but civilians can talk about the pain and fear of a car accident. Many parents try to shield their children from war, but then children know stuff is going on in home and family, but don't understand why."

6. **Deficit approach:** Much of the literature and programming targeting military children and youth concentrates on deficits. This can have a negative impact on the confidence, self-esteem, and resilience of military and veteran children. Programs tend to be developed around problems rather than strengths.

Population Needs: Military Children

1. **Recognition and awareness of military children needs:** Several respondents expressed concern that civilians, service providers, schools, and so forth don't consider or aren't aware of the needs and experiences of military children. One interviewee stated the following was a pressing need: "Keeping people aware that we have an all-volunteer force that is married with children." It's important that programs, research, and schools focus on and further investigate how children are affected by military service. "So often when we say 'military family,' we are really just referring to the adults in the family; we must focus on the children." "I know their parents are serving, but they're serving too."

2. **Improved school experiences and transitions:** Changing schools is challenging for military children and their families. It is important that school professionals are educated about military children and develop military cultural competency. There is a lack of consistency during school transitions, and military parents and their children are left to navigate changes in expectations and requirements, receiving the appropriate services,

continuing activities, making new friends, and so forth. Military parents also need help in guiding their children through these processes and gaining access to the necessary information.

3. **Programs created for and/or specific to military children, particularly children of veterans:** There are few programs that specifically cater to military children and their unique experiences, challenges, and strengths. A few experts commented on the gap in serving military families, especially military children, across community, clinic, and government programs. Programs that currently involve military family members often are created for service members and/or veterans and then expanded to include military family members (parents, spouses, and children) without addressing the individual and varying needs and experiences of different family members. Additionally, many programs for veteran families are aimed at helping veteran caregivers or families of wounded, ill, or injured veterans. There is a particular absence of programs that address issues relating to the transition from being a military family to being a veteran family. Children of veterans lose connection to the military and access to certain services, resources, and programs, and can face new challenges during transition, "yet there is almost no programming for them."

4. **Identification within the civilian community:** Unless parents identify their children as military-connected or children self-disclose, community systems, programs, and providers may be unaware of their military status. It is important for military children and youth to be identified so they may be connected with appropriate services and resources and be treated by military-sensitive providers. Most study participants mentioned that these issues are exacerbated for families of National Guard and Reserve members, particularly because children of National Guard and Reserve members are not identified within school systems. Additionally, children of veterans are frequently not identified within the community. One interviewee recommended that the VA, health-care providers, and other service providers ask veterans if they have children, what ages their children are, and so forth.

5. **Social support, connection, and belonging:** Like all children, military children should feel supported and experience a sense of connection and belonging within their local communities. However, many military children feel they stand out and/or don't belong within their civilian communities or schools. "If military parents are isolated, odds are children are isolated as well." Such experiences can contribute to detrimental outcomes related to isolation, loneliness, and stress. Some experts indicated that the need for connection and belonging may be heightened for children of National Guard and Reserve service members, children living off-installation, and children of veterans, all of whom may be missing or lacking connection to their military community.

Factors That Contribute to or Promote Resilience: Military Children

1. **Military community bonds and peer support:** Military families and military children are skilled at forming communal bonds. Seeking out and forming these bonds and relationships within and outside of the military community can promote resilience in military children. Support from peers (military and civilian) can greatly enhance resilience in military teens and preteens, in particular.

2. **Enhanced family connections and relationships:** Military families encounter challenges and experiences together that can enhance their family relationships and build a stronger family system. Similarly, building relationship skills can improve family connection. Resilience in children is more likely when parents set limits, are competent caregivers, and are loving and involved in their children's lives.

3. **Military lifestyle:** "Adaptability is our greatest skill." Many interviewees reported that resilience is ubiquitous among military families ("most military families are resilient") and is a necessary part of the military life. Military children "learn to be flexible and roll with change."

4. **Military children see selfless sacrifice:** Military children are often exposed to admirable qualities in military adults (including their parents), such as dedication to service, a sense of duty, and selfless sacrifice. Making meaning of challenges associated with the military lifestyle and focusing on positive strengths can both improve and foster resiliency in military-connected children and youth.

4. Military Caregivers

Participants

We conducted five interviews with experts working with military caregivers. One additional interview with an expert working with military families was also included. Experts in the following categories were represented: researcher (1), program director (3), creative arts therapist (2), and other service provider (1).

Considerations for Creative Arts Therapists: Military Caregivers

1. **Offer a holistic approach** to serving the military-connected population by serving caregivers, spouses, and children in addition to serving veterans and other military family members, when possible. Offering many services at one location makes the coordination of services and appointments easier for families and can promote the engagement of the whole family. Coordinating services at one location also can promote better collaboration among providers.

2. **Utilize a multidisciplinary approach** that can include several different types of therapies (e.g., music therapy, art therapy, and mental health counseling) and services (e.g., peer-to-peer support groups, activities, and engagement in the community). Multiple services and treatment options can promote engagement.

3. **Provide flexibility in appointment scheduling, hours of operation, and format of service delivery.** All experts interviewed cited flexibility as important when serving military caregivers. Interviewees identified that flexibility in scheduling appointments and expanded hours of operation (e.g., evenings and weekends) can help reduce barriers to engagement. In addition, offering services remotely (via online engagement) was recommended, particularly when offering peer-to-peer support services, as it was easier for caregivers to participate. Other considerations included offering caregiver groups that focus on wellness and offering these opportunities on an individual basis for caregivers who may not be able to make regularly scheduled group meetings. Finally, providing services or care to children and care recipients while services are being provided for caregivers (e.g., childcare offered concurrent with caregiver group sessions) can support engagement.

4. **Orient programming around opportunities for self-care, meaningful engagement, and connection to other caregivers.** Creative arts therapy services can address needs associated with mental health, identity, stress management, and the caregiver/care recipient relationship.

Considerations for Community-Based Arts Providers: Military Caregivers

1. ***Collaborate with other community-based organizations.** Collaboration is important because there is a need for providers to be able to refer quickly and efficiently to other services that meet needs that fall outside of the scope of the initial or primary provider. Partnerships between arts and non-arts organizations can promote services that address a range of needs.

2. ***Develop a basic understanding of military culture.** This is important for all providers working with the military-connected population. In addition, an understanding of the basic needs and challenges of caregivers is important. Caregivers may be sensitive to a lack of understanding and erroneous assumptions about their caregiver role or experiences.

Challenges and Stressors: Military Caregivers

1. **Demands of the caregiving role:** Caregiving can require around-the-clock care for some caregivers and caregiving can be burdensome at times. Caregivers may worry about the worsening health of their care recipient.

2. **Worries about the future:** Caregivers may worry about the long-term health of their care recipient and implications for the future that may include financial concerns (e.g., retirement) and personal concerns (e.g., isolation). "As the care recipient's needs grow so do the needs of the caregiver"

3. **Relationship issues:** Relationship challenges and stressors may emerge in the relationship between the caregiver and care recipient, as roles and responsibilities often shift when a friend, family member, or spouse takes on the caregiver role.

4. **Social issues:** Social issues can include social isolation. Caregivers may not be able to leave their care recipient alone and other medical and behavioral health issues may prevent or complicate the caregiver's ability to bring the care recipient to various places. Decreased socialization with friends and family may lead caregivers to feel isolated.

5. **Complex systems of care or lack of services:** Caregivers often express having a difficult time navigating systems of care or finding services to meet their needs. One expert talked about the lack of services available in some communities, noting that people sometimes travel long distances to receive specialized medical treatment.

6. **Caregiver burnout:** "We see a lot of caregivers who are burned out, not because of any one single thing but from a conglomeration of issues."

7. **Desire to leave the caregiver role:** Caregiver fatigue, loss of independence associated with time spent on caregiving responsibilities, and relationship stressors in the relationship with the care recipient are among some of the stressors that may cause caregivers to want to leave their caregiving role.

8. **Financial issues:** One study participant talked about financial hardship and the influx of financial support that typically comes in when a service member is first injured. The expert noted that there were no services offered during that transition period to support long-term financial planning. Additionally, co-pays for services can create additional strain on families.

9. **Mental health needs:** Caregivers may develop mental health needs associated with depression, anxiety, caregiver fatigue, and stress.

10. **Loss of personal identity:** Several experts talked about caregivers' personal identity being shadowed by their caregiver role. Caregivers have been identified as "hidden heroes," because the focus of attention is often on the care recipient. The caregiver may experience grief over the loss associated with life changes.

11. **Unpredictability:** There is an unpredictability to a caregiver's life that is often affected by the physical and emotional status of the care recipient. As one expert stated: "One day might be great, the next day might be terrible."

Population Needs: Military Caregivers

1. **Community-based resources:** Military families need resources and support in their community. Military families can move a lot and so wherever they end up they need to have resources that help them to feel like they are part of the community. "Providing services to caregivers is a great way to serve veterans—by caring for caregivers we are caring for veterans."

2. **Comprehensive caregiver services:** Experts recommended several types of programs and services to address caregiver needs, including:

    a. **Programs that help bolster the caregiver** role and engage caregivers in providing care by learning caregiving interventions and how to adapt to the caregiver role.

    b. **Programs that reduce isolation.** Caregivers value freedom from their care recipient and benefit from knowing they are not alone by connecting with others.

    c. **Case management service**s that help with service navigation and access. A key factor can be a caregiver support coordinator—a person who serves as a designee for a caregiver, conducts a needs assessment, and formulates a treatment plan especially set up to meet the needs of that caregiver (available through the VA comprehensive caregiver support program).

    d. **Financial literacy and assistance.** Often times there is a gap or decrease in income when a service member is injured and is medically retired. This occurs at the same time that families are often negotiating relocation and securing new housing. Additionally, spouses who become caregivers may leave employment in order to manage caregiving responsibilities.

    3. **Mental health services:** Caregivers can be parents, spouses, or children and there are different challenges and needs associated with these different relationships. Each member of the family benefits from access to high-quality mental health providers when needed. Every family is different and has unique needs, and families need care that will adapt to those needs. Clinics that have a multidisciplinary environment (e.g., offering creative arts therapies, peer-to-peer support services, and mental health counseling) where people have access to different kinds of treatment and providers can be beneficial.

4. **Childcare services:** Many caregivers—particularly those who are the spouse of the care recipient— are also caring for dependent children in the home, and may have childcare needs.

5. **Support with adjusting to change:** The whole family often needs to adapt to changes in roles and dynamics within the family when a family member takes on a caregiving role. The whole family can benefit from psychoeducation to learn about the veteran or service member's injury or trauma, to understand and to gain empathy for the injured family member, and to learn how to help the family member in the recovery process. The whole family also can benefit from the time and space to communicate with one another, to express how roles have changed, and to work through any conflicts. Individual family members' responses and needs to stressors and trauma will be different. Each person's distinct response will have an impact on the other family members and the family system as a whole. Supportive counseling can help to validate feelings; focus on developing and enhancing coping skills; and teach mindfulness, meditation, and relaxation techniques in order to promote self-care and enhance wellness.

6. **Opportunities to engage in self-care:** A military caregiver often has a bigger role to play in the family system (e.g., being a parent in addition to being a caregiver) that can result in additional stress. Caregivers may

benefit from psychoeducation on burnout, opportunities to engage in self-care, and access to self-care services such as yoga, art therapy, and mental health counseling.

7. **Social support:** Caregivers benefit from supportive networks that include other caregivers. Caregivers can support and understand one another, which may help to reduce isolation. Peer mentoring programs are one way to address this need.

8. **Spiritual support:** Spiritual support can promote a sense of inner peace. Spiritual networks may also help to reduce isolation.

Factors That Contribute to or Promote Resilience: Military Caregivers

1. **Ability to adapt to change:** Military families can become stronger after having adjusted to multiple moves or deployments. Empathy and communication may become stronger as military families build an enhanced ability to adapt to change. The family system itself also can become stronger because of experiences adapting to change.

2. **Enhanced family connections:** Military families deal with challenges that civilians may not understand. There is a cultural connection that develops from shared experiences and a common mission, which builds a common connection among members of military families.

3. **Advocacy:** Caregivers can develop strong communication and advocacy skills from their caregiving role.

APPENDIX C

Interview Instruments

The following instruments were used to conduct semi-structured interviews with the nineteen subject matter experts who participated:

Veterans and Service Members

1. Please tell {me/us} a little about your program/organization/department and your role at your program/organization OR tell me about your research. What types of programs and services does your program/organization/department offer to veterans and/or service members?

2. What do you perceive to be the most pressing needs of service members and/or veterans? What do you perceive to be the primary issues and challenges facing veterans and service members?

3. What are some common misconceptions about veterans and service members? What are the impacts of these misconceptions or stereotypes?

4. What are some factors that contribute to resilience in veterans and service members? What factors or traits do you think contribute to resilience in veterans and service members?

5. How does {your/this/"x"} program address such challenges and address the varying needs of veterans and/or service members? Can you describe the impacts of/related to {your/this/"x"} program for veterans and/or service members?

6. What do you believe are some best practices in serving veterans and service members? Can you speak to any notable best practices you are aware of in other programs, departments, or organizations that serve veterans and service members? Have you adopted any of these practices?

7. What do you believe are important considerations for arts providers?

Military Spouses and Families

1. Please tell {me/us} a little about your program/organization/department and your role at your program/organization OR tell me about your research. What types of programs and services does your program/organization/department offer to family members of veterans and service members?

2. What do you perceive to be the most pressing needs of military families? What do you perceive to be the primary issues and challenges for military families?

3. What background information do you believe is most important to fully understand and assess the needs of military families? What background information do you believe is most important to fully understand the dynamics impacting these families?

4. What are some inherent strengths of military families? What factors do you think contribute to resilience in military families? How are the needs and challenges of active-duty and veteran families similar and/or different?

5. How does {your/this/“x”} program address such challenges and address the varying needs of military families? Can you describe the impacts of/related to {your/this/“x”} program for military families?

6. What do you believe are some best practices in serving military families? Can you speak to any notable best practices you are aware of in other programs, departments, or organizations that serve military families?

7. What do you believe are important considerations for arts providers?

Military Children

1. Please tell {me/us} a little about your program/organization/department and your role at your program/organization OR tell me about your research. What types of programs and services does your program/organization/department offer to military children and youth?

2. What do you perceive to be the most pressing needs of military children and youth? What do you perceive to be the primary issues and challenges for military children and youth? How do these differ by age?

3. What are the challenges in providing services for military children and military youth?

4. What are some inherent strengths of military children? What factors or traits do you think contribute to resilience in military children and youth?

5. How are the needs of children of service members and children of veterans different or similar?

6. How does {your/this/“x”} program address such challenges and address the varying needs of military children? Can you describe the impacts of/related to {your/this/“x”} program for military children?

7. What do you believe are some best practices in serving military children and youth? Can you speak to any notable best practices you are aware of in other programs, departments, or organizations that serve military children and youth?

8. What do you believe are important considerations for arts providers?

Military Caregivers

1. Please tell {me/us} a little about your program/organization/department and your role at your program/organization OR tell me about your research. What types of programs and services does your program/organization/department offer to military caregivers?

2. What do you perceive to be the most pressing needs of military caregivers? What do you perceive to be the primary issues and challenges for military caregivers? What are the stressors that caregivers face?

3. Please describe the population of military caregivers that {your/this/“x”} program serves (e.g., primarily spouses, parents, children, friends). How do the needs and challenges of military caregivers differ across these groups?

4. What are some inherent strengths of military caregivers? What factors do you think contribute to resilience in military caregivers? How does {your/this/“x”} program employ those factors when working to address the needs of military caregivers?

5. How do the needs and challenges of military caregivers change based on service member needs?

6. How does {your/this/“x”} program address such challenges and address the varying needs of military caregivers? Can you describe the impacts of/related to {your/this/“x”} program for military caregivers?

7. What do you believe are some best practices in serving military caregivers? Can you speak to any notable best practices you are aware of in other programs, departments, or organizations that serve military caregivers?

8. What do you believe are important considerations for arts providers?

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