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Serving Military Families: Perceptions of Educational Counseling in a Virtual Environment

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by

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We hereby certify that this dissertation, submitted by Taryn Stevenson, conforms to acceptable standards and is fully adequate in scope and quality to fulfill the dissertation requirements for the degree of Doctor of Philosophy.

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The advances in communication technology over the past 20 years have significant implications for the delivery of psycho-educational therapeutic services to populations that have been historically underserved due to remote locations lacking trained providers. One such population is military families, who also suffer from a negative stigma of asking for outside help or education for personal growth. This population also faces increasing mental health needs due to military deployment in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). These operations have increased the number of returning service members who have been physically and mentally injured. The effect that these injuries have on the military family and children can be severe and damaging not only to the family unit but also to the morale of the military itself. Providing mental health services and psycho-educational counseling that meet the needs of the family as well as finding therapeutic approaches that are empirically sound has proven difficult. Recent success with the use of Solution Focused Brief Therapy (SFBT) with families in the civilian population holds promise in reducing emotional and behavioral disturbances in children as well as increasing the overall functioning of the individuals within the family. Providing services virtually through teleconferencing programs addresses many common barriers to treatment of military families. This study has examined the experience of military families during and after deployment, their perception of counseling and educational services as well as their recommendations for the use of technology. Numerous recommendations for future educational and counseling services via technology were found when the interventions were supported by and aligned with military culture and values.

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Chapter 1

Introduction

The events of September 11, 2001, have dramatically increased the demands of the United States Military in a way not seen since the conflicts in Vietnam. These changes have coincided with the changes in the make-up of enlisted military personnel. Today's armed forces, Army, Navy, Air Force, and Marines, consist of a volunteer force, many of whom are reserve soldiers with established families. The deployment, field action, and possible traumatic injury of these soldiers has negatively impacted their families, caregivers and morale of today's military (Drummet, Coleman & Cable, 2003; Eaton et al., 2008; Siegel et al., 2013).

The families of returning deployed military members face many unique challenges. The relief that often occurs at the return of loved ones can quickly be replaced by feelings of loss and grief for injuries or psychological disorders that will affect both the service members and their families. In most cases, spouses or significant others are the primary caretakers, both physically and emotionally, of these wounded warriors (Collins & Kennedy, 2008). This new role causes an increase in stress, anxiety, substance abuse, and depression as well as a general decline in the optimism and quality of life these caregivers, and subsequently their children, experience (Ahmadi & Green, 2011; Eaton et al., 2008; Galvoski & Lyons, 2004; Verdeli et al., 2011). These issues are more prevalent in military families for numerous reasons, including military culture, anxiety of reporting mental health issues, the lack of mental health services, and the remote locations of many military bases resulting in the lack of quality mental health services

(Bowen, Mancini, Martin, Ware, & Nelson, 2003; Hoshmand & Hoshmand, 2007; Warner et al., 2011).

During the past ten years new technologies that have the capacity to overcome physical and stigmatization barriers in providing mental health education have been developed. Providing psycho-educational counseling services remotely through web chat, video teleconferencing, or other virtual environments have shown promise in reducing emotional distance, increasing disinhibition and self-awareness, and providing more equality in the patient-practitioner relationship (Baker & Ray, 2011; Cohen & Kerr, 2008; Suler, 2004). Online counseling increases the feelings of anonymity or privacy and rapport that often inhibit the traditional relationship in face-to-face counseling sessions (Leibert, Archer, Munson & York, 2006). Video-counseling in particular gives patients and counselors the ability to increase the therapeutic alliance by introducing a visual element of proximity while still maintaining the client's sense of control and power (Simpson, 2009).

Another significant barrier to effectively educating these families is the lack of empirical evidence on a theoretical counseling approach that adequately addresses the unique needs of military families, specifically those dealing with the post-deployment needs of injured soldiers (Verdeli et al., 2011). The need for proactive planning for counseling and education with this specific population is highly recommended yet is not always addressed (Ahmadi & Green, 2011). The focus on preventative measures may hold promise for increasing the wellbeing of military families (Lara-Cinisomo, Chandra, Burns & Lau 2013; Smith, Chun, Michael, Schnieder, 2013). The purpose of this study is

to investigate the perceptions of technology based psycho-educational counseling by the families of military members who have been deployed during wartime.

Background

Since the beginning of military operations in Iraq, Operation Iraqi Freedom (OIF) and Afghanistan, Operation Enduring Freedom (OEF), more then two million service members have been deployed (DOD, 2011). These conflicts represent the most aggressive military operations since the establishment of America's all volunteer forces in 1973. Over half of current service members are married and have dependent children (DOD, 2011). This increase in demand for military personnel puts greater strain on the families through deployment and post-deployment, especially in coping with traumatic injuries and psychological stress (Collins & Kennedy, 2008; Cozza, Chun, & Polo, 2005).

The increase in insurgency warfare and improvised explosive devices (IED) combined with advancements in medical services and protective body armor has also affected the type of injuries returning soldiers have sustained (Collins & Kennedy, 2008). Collins and Kennedy found that injuries sustained by IEDs most frequently result in traumatic brain injury (TBI) and orthopedic or soft tissue injury that leads to amputation. Many of these service members would not have survived 30 years ago, but due to the increase in medical technology, the number of surviving war veterans with TBI and other physical injuries has increased significantly (Collins & Kennedy, 2008). In addition to physical injury, psychiatric illnesses related to wartime trauma are increasingly common. The Department of Defense (2011) reports that at least 9% of service members report Post Traumatic Stress Disorder (PTSD), 27% report signs of depression, and 19% return

with traumatic brain injury. These injuries and subsequent mental issues often lead to substance abuse, domestic violence, and divorce within the military family (Drummet, Coleman, & Cable, 2003; Gibson, Barnet, & Hickling, 2012).

The military spouse plays an essential role in maintaining the cohesion of the family and providing a stable and healthy home to the returning service member (Spera, 2009; Tanielian & Jaycox, 2008). Having an injured war veteran in the family places a large responsibility on the spouse to maintain a functional household, as nonspecific dysfunction have been linked to higher rates of aggressive behaviors, decreases in academic performance, and difficulty in peer relationships and affective regulation in their children (Galvoski & Lyons, 2004, Rosenheck & Fontana, 1998). The impact of emotional and physical injuries to the returning service member and the demands of military culture are often seen in increases in anxiety, depression, substance abuse, and in some cases even secondary symptoms of PTSD in the spouse or caregiver of the injured service member (Collins & Kennedy, 2008, Eaton et al., 2008). In many cases, these mental health issues have a negative effect on the caregiver's ability to assist the service member in treatment for PTSD or substance abuse or to bolster the resilience of the family (Palmer, 2008; Verdeli, et al., 2011).

The theory of ambiguous loss describes the mourning reaction that individuals go through when a family member is injured but still present in the lives of the family (Boss, 2006). According to this theory, negative symptoms such as depression and anxiety regarding an uncertain circumstance are alleviated by increasing the tolerance for an ambiguous future while increasing hope and meaning within the lives of the clients (Boss, 2006). The need for support systems and mental health education for the families

of injured service members to increase their tolerance for ambiguity, increase their hope for the future, and decrease negative emotions is essential in providing not only educational services to cope with their new roles, but parenting support, stress reduction, and a return to normal functioning for both the caregiver, the service member, and their children (Boss, 2006; Drummet et al., 2003; Galvoski & Lyons, 2004; Weiss et al., 2010).

The improvements in technology in the past fifteen years have the ability to provide services remotely to populations that have been historically underserved (Baker & Ray, 2011). It has been estimated that nearly 81% of Americans have access to the Internet (International Telecommunications Union, 2013). The Internet is also quickly becoming a viable choice for mental health services due to the accessibility from home, the privacy or anonymity of the session, the ability to edit or process communication in deeper levels, and the lower costs associated with web-based services (Cohen & Kerr, 2008; Leibert et al., 2006; Richards, 2009).

Computer based counseling or online counseling refers to a variety of types of services including emails, instant messaging, teleconferencing, and virtual reality applications. Remote video counseling in particular has shown promise in decreasing anxiety normally felt about the stigma of counseling and deepening the therapeutic relationship in a shorter amount of time, and it is more satisfactory to patients who are highly self-conscious about attending therapy (Hanley, 2009, Simpson, 2009). A sense of trust is quickly established due to a perception of anonymity and disinhibition that exists in online communication (Leibert et al., 2006; Suler, 2004). The importance of anonymity to the military family is also respected in online counseling, as the therapist

and client are located remotely, there is a lack of attending a physical office, and there is an increase in self-disclosure the client has in the communication with the counselor (Cohen & Kerr, 2008, Leibert, et al., 2006; Suler, 2004; Warner, et al., 2011).

An important aspect in computer-mediated counseling is that the clients have more perceived control over their encounter than they do in face-to face situations (Cohen & Kerr, 2008; Leibert et al., 2006). In particular, videoconferencing allows the client control over his or her space and reduces the power imbalance, and both client and therapist report feeling more relaxed after a session (McLaren, Blunder, Lipsedge, & Summerfield, 1996; Omodei & McLennan, 1998). The most studied therapeutic approaches in online counseling have been cognitive-behavioral or psychodynamic (Goss & Anthony, 2009; Simpson, 2009). The use of a more educational approach, such as Solution Focused Brief Therapy (SFBT), has the potential to reflect the strengths of both online counseling and the needs of the military family to be goal-directed, self-sufficient and solution-focused.

The use of SFBT holds promise in virtual counseling as well as with military families due to the emphasis on the clients' perceptions of their problems and creation of their own reality in the solutions, thus giving more control to the clients (Lee, 1997). The SFBT approach, as described by DeShazer (1994), relies on the assumption that individuals possess the necessary resources to resolve their own problems and be proactive in educating themselves about their circumstances. The attention is not on the past or the history of the problem, but on learning how the individuals can solve the problem and be proactive in their own control and power over the situation (DeJong and Berg, 2001; DeShazer et al., 1986). Due to the reliance on the individual's future,

solution focused therapy tends to be short term and cost effective (Corcoran & Pillai, 2009; Lee, 1997).

This approach is particularly effective in educating one part of the family on the dynamics surrounding their family system, increasing family resilience and self-esteem and has been proven to be an effective tool with military personnel in therapeutic rapport building, enhancing self-efficacy, as well as improving individual and family functioning and well-being (Kim & Franklin, 2009; Lee, 2007; Weiss et al., 2010). SFBT has the potential to increase positive emotional and behavioral reactions of children and their families in numerous ways as the approach has been effective in decreasing negative symptoms for the families when even one member participated (Lee, 1997). The educational components of SFBT align with the strengths of the military culture and provide the lens for understanding their needs and feelings regarding psycho-educational therapy in a virtual environment.

Problem Statement

The mental health needs of military families have traditionally been underserved, yet they form one of the largest areas of concern for the future of these institutions (DOD, 2011). The increase in deployment of active military members, wartime violence, and traumatic injury of veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have increased the stress, substance abuse, domestic violence, and overall dysfunction within military families (Collins & Kennedy, 2008; Drummet et al., 2003; Siegel, et al., 2013). The spouses or primary caregivers of these service members suffer from an increase in depression as well as a decrease in quality of life, both of

which have a negative cumulative effect on the household, including the children of these service members (APA, 2007; Spera, 2009; Verdeli et al., 2011). The increase in these family issues has also resulted in a negative morale of military family life and a decrease in enlistment over the past ten years (Drummet et al., 2003; Hoshmand & Hoshmand, 2007; Siegel, et al., 2013).

There have been several barriers identified in assisting with these family issues. There is a lack of available services for the mental health needs of these families; the services available are often not accessible due to physical and financial limitations as well as the military cultures' perceived stigma associated with seeking help for internal family issues (Cusac, 2004; Eaton et al., 2008; Gorman et al., 2011). Of these barriers, the stigma of help seeking by military families has proven to be a main concern for educating families on the potential stressors of deployment and return (Lincoln & Sweeten, 2011). These barriers to receiving services may however be met through virtual counseling and education. In this modality services are delivered online, eliminating barriers for availability and accessibility. In addition, the lack of scheduling a physical appointment leads to greater anonymity and self-disclosure that is needed due to the military community's negative perception toward mental health care (Warner et al., 2011). In order to better understand the possible effects of technology on psycho education for military families, the experiences and perceptions of these individuals were investigated. In addition, their attitude towards technology and self-disclosure was explored as a possible remedy to these barriers.

Goal

The goal of this study was to investigate the experiences of military families throughout deployment and return, their perception of educational and counseling services, as well as determine their opinions of the usefulness of technology to provide current or new services of this type. The goal was met through the use of a phenomenological qualitative methodology using a Solution Focused Brief Therapy perspective.

Research questions:

The study sought to answer the following research questions:

Research Question One:

What is the experience of military families during and after the deployment of a service member?

Research Question Two:

What is the perception of military families for seeking mental health services?

Research Question Three:

What is the potential of technology to be used in order to provide mental health counseling or education for military families?

Relevance and Significance

In 2011, there were approximately 700,000 military spouses and an additional 400,000 spouses of reserve service members (DOD, 2011). The significant change in the military in the past 30 years from mainly young single males to the volunteer force of today is that it now must compete with the corporate market that often offers better economic stability and greater family life satisfaction. This has put greater pressure on the recruitment and retention of the military in order to sustain a viable healthy organization (Drummet et al., 2003). The need for increased services to support military families has not, however, been addressed by a change in the system itself. This has caused a decrease in families' overall satisfaction with the military lifestyles and lower retention rates, which has yet to be fully addressed due to the unique demands of the military context (Drummet et al., 2003; Lara-Cinisomo et al, 2013; Verdeli et al., 2011).

Military spouses provide essential emotional, physical, and sometimes financial support for their children and the returning service members (Cusac, 2004; Verdeli et al., 2011). They play a role in the morale of deployed service members by ensuring family cohesion and maintaining a healthy environment during deployment (Spera, 2009). Children, in particular, have the tendency to react negatively, both emotionally and behaviorally, to having a deployed parent, and these symptoms are predicted by the non-deployed parent's mental health status (Drummet et al., 2003; Flake, Davis, Johnson, & Middleton, 2009). Upon the deployed parent's return, healthy spouses and caregivers provide a safe and nurturing environment in order to increase the resilience of the family and encourage healthy behavior, such as help seeking, of the service member (Palmer, 2008). Often, however, spouses or caregivers of injured soldiers suffer mental health

issues due to a lack of coping skills, role confusion, substance abuse, and secondary PTSD that prevent them from being the supportive caregivers needed to increase the well-being of the military family (Ahmadi & Green, 2011; Eaton, et al., 2008; Gibbons et al. 2012; Verdeli et al., 2011).

Awareness of the educational and emotional needs of injured service members has increased the services available to them to treat PTSD and other mental health issues such as depression and substance abuse (Gibbons et al., 2012). This increase in mental health care and services for returning service members, however, has decreased the availability for these same services for their families due to a shortage of uniformed mental health care professionals (Ahmadi & Green, 2011). Verdeli et al. (2011) point out that the emotional needs of these families are also underserved due to accessibility and acceptability issues. Specifically, the stigma of asking for help as well as the cost associated with receiving help are considered the two main reasons military families do not seek mental health services (Eaton et al., 2008; Greene-Shortridge, Brit, & Casto, 2007). In addition, interventions used for this population must also be adapted to their unique challenges, and there is still little scientific research to support novel approaches (Verdeli et al., 2011).

The remote location of many service members, specifically those in the Reserve Forces, also calls for the use of new technology in order to provide educational services and support (Beardslee et al., 2013). The potential use of technology for psycho-educational purposes with this population is an area that has not yet been fully explored, and outcomes have not yet been established (Beardslee, et al. 2013; Cozza, et al., 2013; Smith et al., 2013).

The potential for remote videoconferencing to provide counseling and education services essential to the mental health of military families due to their accessibility and anonymity, thus reducing the stigma of attending counseling sessions, is clear (Cohen & Kerr, 2008; Leibert et al., 2006). This can extend to the resilience of the family unit, as the spouse or caregiver's well-being directly affects the mental health status of military service members who are returning from war because the spouses or caregivers provide encouragement for veterans to seek help for their own depression and PTSD, and they supply the emotional support and consistency needed for children to adjust in a healthy manner to the changing family (Eaton et al., 2008; Flake et al., 2009; Palmer, 2008). The cost of providing mental health services online is also reduced as the need for child-care, transportation, or time off from work is reduced or eliminated (Baker & Ray, 2011). Looking at the perceptions within military families of educational and counseling services provided virtually may help improve the mental health status of these families and is an important step in establishing empirical evidence for an approach to helping this underserved population.

In order to best understand these issues and answer these questions this study will be conducted through an SFBT lens. SFBT has many proven benefits that align with the needs of the military families such as a strong focus on education, goal attainment, increasing psychosocial development, self-reliance, and future orientation (Corcoran & Pillai, 2009, Lee, 1997, Reiter, 2010). The viability of providing virtual therapy to military families will help to define potential interventions that can be adapted to their unique culture.

Barriers and Issues

The APA (2007) has identified a lack of systemic research investigating the emotional and psychological consequences of military action on service members and their families. Verdeli et al. (2011) specifically identify three treatment factors, availability, accessibility and acceptability, which prevent research on mental health status of military spouses. These spouses are often referred to civilian mental health care professionals due to lack of uniformed mental health care professionals. This often results in long wait times, lack of familiarity by counselors with the military lifestyle, and an increase in financial demand for the family. Referral also limits the access family members have to care due to the remote locations and difficulty getting time away from work, parental responsibilities, and higher costs that prevent these family members from seeking mental health care (Eaton et al., 2008; Gorman et al., 2011). The largest barrier to treatment, however, is the negative opinion of mental health services in particular within the military community, resulting in spouses not seeking mental health care for fear of the impact on the service member (Drummet et al., 2003; Warner et al., 2011). Finding effective treatment approaches that respect the unique demands of the military culture and making them widely available and accessible have proven to be significant issues in this population.

In addition to the physical barriers to providing effective treatment approaches for military spouses, the stigma of seeking help and education for mental issues is the largest barrier to this study. The negative association of admitting to mental health concerns has long been a barrier to discussion in civilian populations (Overton & Medina, 2008). The

military culture that emphasizes self-reliance and personal strength presents an additional obstacle to admitting the need for outside intervention (Lincoln & Sweeten, 2011). It is essential to use an educational framework, such as SFBT, in order to overcome the negative association that many of these families have with traditional mental health counseling.

These barriers to the population given their remote location and the approach of this study are significant and present concern for the outcome. The technology that was used such as phone and videoconferencing will allow for contact, but the failure of technology and delay that this can cause may present an additional obstacle to this study and this population. As previously mentioned, it was difficult to recruit study participants due to the embarrassment military families may feel at discussing personal family issues with someone outside of the military.

Assumptions

1. The participants were truthful during the interview regarding their experiences and their perception of counseling and technology.

Limitations

1. The reluctance of military family members to participate in an interview may have limited the generalizability of the results.
2. The availability of military families may have hindered the time allocated to complete a thorough interview regarding the research questions.

3. The limited dissemination of the research project solicitation may limit the population from which the interviews are conducted.

Delimitations

1. The focus on a very specific population, the family members of deployed soldiers, may limit the generalizability for the study to civilian populations.
2. Using the lens of SFBT will limit the applicability to other types of therapeutic approaches.
3. The small sample size may not reflect all branches of the military population.

Definitions of Terms

1. Service member: Any member of the armed services including the Army, Navy, Marines, Air Force, and the Reserve forces.
2. Family members: the immediate family that resides with the service member and can include spouses, parents, or significant others.
3. Solution-Focused Brief Therapy: "an approach to psychotherapy based on solution-building rather then problem-solving."(Iveson, 2002, p.149). This approach typically explores the current resources and future hopes of the client rather then present problems and typically last only three to five sessions (Iveson, 2002).
4. Depression: any mood disturbance characterized by feelings of hopelessness, helplessness, sadness, or grief. It will include DSM classifications of depressive

disorder, mood disorder, not otherwise specified (NOS), Adjustment disorder with depressive symptoms and adjustment disorder, NOS.

5. Post-Traumatic Stress Disorder: The Diagnostic and Statistical Manual of Mental Disorders V (APA, 2013) defines as a trauma or stress related anxiety that is caused by exposure to real or threatened death, injury or sexual violence. Symptoms occur within one month of the traumatic event and persist for at least one month and include intrusion symptoms, avoidance or numbing, and increased arousal (APA, 2013).
6. Videoconference: the holding of a conference among people at remote locations by means of transmitted audio and video signals (Merriam-Webster, n.d.)
7. Genogram: A pictorial display of family relationships including specific psychological and medical dynamics (Weiss e al., 2010) [Appendix C].

Summary

The acceptance of technology enhanced psycho-educational counseling services is a recent concern as computer-based services continue to grow and allow underserved populations to receive services not available in the past. The mental health needs of the United States Military families have dramatically increased as the wartime violence in two major military operations have occurred within the past 10 years. Military families historically have been underserved, although there is the potential to utilize the way in which technology can break the barriers of accessibility, availability and anonymity that often prevents families from receiving mental health support. This study examined the perspectives of military families on support services such as counseling and psycho-

education. In addition, the families thoughts on the use of technology to provide these services and their recommendations for future use were examined in order to suggest possible interventions that will be unique to the military community.

Chapter 2

Literature Review

The change in dynamic of the military family in the past thirty years as well as the increase in demand and stressors of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are well documented in the literature. The need to focus on early interventions and support for these families that overcome traditional barriers have been recently highlighted by the commitment of the military as well as the negative effect on enrollment and satisfaction with military life (DOD, 2011, Drummet et al., 2003). While there is a call to provide more services, a treatment approach that aligns closely with the military culture of resilience, independence, and strength has not been clearly identified (Verdeli et al., 2011). Using a strengths based educational problem solving approach such as Solution Focused Brief Therapy (SFBT) has been shown to effectively promote hope and resiliency and decrease family dysfunction in civilian populations (Reiter, 2010). In addition, the literature suggests that providing psycho educational counseling through an online service addresses the barriers of availability, accessibility, and stigma, which are prevalent in the military culture (Rivas, 2005).

Solution-Focused Brief Therapy

SFBT, as described by Iverson (2002), is a simple, all-purpose approach to psychotherapy based on establishing future goals, recognizing the strengths of the client, and emphasizing the current resources the client has. DeShazer et al. (1986) emphasize the evolution of SFBT as moving away from changing the neurotic symptoms to working towards the positive goals set by the clients themselves that make life satisfactory.

Complaints and solutions are all a part of the client's worldview, and they have it within themselves to change (DeShazer et al., 1986). This expectation of change is key to the implementation of SFBT because change is often the stressor, yet it is necessary and inevitable in creating solutions to the symptoms and finding hope for the future of the client (DeShazer et al., 1986).

According to Finley (2011) SFBT is extremely adaptable to the educational setting given the focus on goal-setting, future orientation as well as the power given the individual that differentiate this approach from other counseling approaches. The deliberate move away from the language of deficit to one of solution forming and educating the client is essential the SFBT lens (Finley, 2011). The educational nature of SFBT was also proven in a recent study on supporting the educational demands of at-risk students (McNaught, 2014). The use of a SFBT framework was used to educate terminated students through their re-entry into a college program. This study used a positive framework and educational process through the SFBT lens that resulted in an 80% improvement in retention and satisfaction for these remedial students (McNaught, 2014). This suggests that the SFBT framework is one that is highly adaptable to education and can be used to improve the retention of positive behavioral skills.

Much of the educational benefits from SFBT come from the instilling of hope and expectancy on the part of the client. The idea of hope for the future as a measure of well-being has been defined as the mental willpower combined with the waypower to achieve one's goals (Snyder, 2002). SFBT emphasizes a future where there is hope, and the client has the positive attributes to create this change when they use these attributes when focused on specific goals. Hope is also instilled during the beginning sessions of any type

of therapy, and SFBT relies heavily on instilling this hope quickly and effectively (Reiter, 2010). In this way, the hope of the client that things will improve for them, and the understanding that they can achieve their goals is a common factor in the positive outcome of SFBT, independent of the problem (Reiter, 2010). Given the common factor of hope as the agent of change, there is evidence to support the use of SFBT with a variety of different age groups, clinical diagnoses, and problems, such as family breakdown, homelessness, drug use, relationship problems, and the intractable psychiatric disorders, all with positive outcomes (Iverson, 2002).

Iverson (2002) finds that average time for completion of goals is between 3-5 sessions, and SFBT has even shown effectiveness in as little as one session. This is supported by Sundstrom's (1993) findings of a significant decrease in depression of college students after only one session of SFBT. In order to establish the relationship in SFBT, there are several techniques that differentiate it from other methods. Specifically, the use of the "miracle question" in the first session, the framework of scaling questions, use of compliments, exception questions as well as homework assignments are typical techniques associated with SFBT that are useful in focusing on the positive changes and the future (Iverson, 2002). Since SFBT focuses on solutions to the problem of the client, the emphasis on exceptions, or times when the problem was not present, is essential in helping to focus on how clients coped at a time without the problem. The use of genograms to find exceptions is a key technique to identifying with the past in order to recognize strengths the client possesses in the present (Weiss et al., 2010).

In early studies, DeShazer et al. (1986) found that an average of 72% of clients reported positive changes after six months of receiving care for an average of five to

seven sessions. This finding was reported even when goals for the client were vague. In a meta-analysis of effective outcomes of SFBT, Kim (2008) found that there is significant evidence of having a positive effect on internalized behavior problems such as depression, anxiety, self-concept, and self-esteem when using this approach. Kim also found that the setting in which SFBT takes place impacts the effectiveness, with real-world settings having smaller effect then clinical settings. These findings support the review of SFBT conducted by Corcoran and Pillai (2007) that found 50% of studies on SFBT show a moderate to high improvement in factors such as self-esteem, depression, parenting skills, and relationship satisfaction from SFBT interventions. It is important to note, however, the lack of standardized measures within the outcomes of SFBT that can lead to more generalizablilty about the effectivness of this treatment (Corcoran & Pillai, 2007; Kim, 2008).

Gingerich and Eisengart (2000) found that in analyzing the empirical evidence of several studies, SFBT has shown significantly positive outcomes for a variety of populations. In an experimental parenting group, Zimmerman, Jacobsen, MacIntyre, and Watson (1996) found that the scores of clients in the SFBT group were significantly higher in role image, rapport, communication, and limit setting in their parenting as compared to the group given no treatment. In comparing treatments for the rehabilitation of orthopedic patients, the return-to-work rates were significantly higher in the SFBT group than in the other three interventions (Cockburn, Thomas, & Cockburn, 1997). SFBT has also been shown to reduce recidivism in prison populations and antisocial adolescents (Gingerich & Eisengart, 2000).

There is some conflicting data however, on the long-term results of SFBT. Kneki et al. (2007), for example, found that SFBT had higher rates of success in treating depression and anxiety than long-term psychotherapy within six months; follow-up after three years did not show the same result. In fact, it was found that patients treated with either SFBT or short-term psychotherapy had higher rates of relapse after three years than did the patients in long-term psychotherapy. These findings suggest the need to determine the long-term effects of SFBT in treating specific disorders.

The use of SFBT in families has recently received attention because it has been used in a wide variety of populations with diverse backgrounds and presenting problems. One of the strongest indicators of success in family therapy using SFBT is the positive outcome for families independent of the member that attends the therapy (Lee, 1997). In a preliminary study of the use of SFBT with families, Lee (1997) found that two-thirds of the participants reported fewer family issues within five sessions. Kim and Franklin (2009) concluded after reviewing 14 studies that there is evidence of positive behavior change for children in school and at home when SFBT was utilized as the only intervention within the family for negative academic and behavioral problems. In addition, a review of 38 articles over the past 20 years has lead to evidence that SFBT used with children and families has yielded significant positive improvement of internalized and externalized problems of children when these problems are mild to moderate (Bond et al., 2013). This research suggests that SFBT has the potential to positively impact the family unit, independent of the family member that attends therapy.

Military Family Issues

Military families' lives have unique concerns, including mobile lifestyles, isolation from the civilian community and extended family, adjustment to the rules and regulations of military life, and frequent separations. This is compounded with daily stressors such as employment, child-rearing, and household duties. The post-deployment needs of service members suffering from PTSD, traumatic brain injuries, and physical injuries compound the stress on the family unit (Galvoski & Lyons, 2004). For these reasons, the needs of the military family have been recognized as one of the top priorities of the DOD (2011).

The stigma of counseling is a significant concern for military families as well. Overton and Medina (2008) define stigma towards mental illness as the feelings, attitudes and beliefs that admittance of having a mental health concern makes an individual "crazy, unstable, and unfit". The theory of reasoned action proposes that intentions are directly based on one's attitude toward a behavior, or self-stigma, and that, these attitudes are based on the expectations one has about the outcome of the behavior or social stigma. Consistent with this theory, Vogel, Wade and Hackler, (2007) suggest that one of the primary predictors of help seeking willingness is one's attitude toward the counseling and education process. These attitudes, in turn, are strongly associated with the degree of public and self-stigma one experiences (Vogel et. al, 2007). This public and self-stigma towards mental health, however, is amplified by the military culture of strength and independence, and unfortunately has resulted in negative side effects for spouses dealing with the stress of separation and re-unification caused by deployment.

The post-deployment phase of military families creates a unique circumstance and challenge. The reunion phase characterized by excitement and apprehension gives way to one of uncertainty and, often, increased stress for the entire family. During this time, family roles and routines are renegotiated and redefined (Drummet et al., 2003). In a survey of military families, the APA (2007) found that during this time spouses experience loneliness, confusion, and isolation as well as a loss of independence due to the needs of the returning veterans and their children. The return to co-parenting as well as coping with combat injuries often lead to depression, anxiety and substance abuse in the military spouse (Pincus, House, Christensen, & Adler, 2005).

The impact of physical and mental injuries sustained as a result of combat has proven to have a direct effect on the families and children of these service members. PTSD itself has been shown to cause reduced family cohesion, decreased interpersonal expressiveness, greater interpersonal conflict and reduced problem solving ability in families (Cozza et al., 2005). Sustaining injuries as a result of deployment affects the relationship between spouses as well as parental attachment (Galvoski & Lyons, 2008). There is growing evidence that the families of wounded soldiers experiencing PTSD are often victims of secondary traumatization due to anger and violence in the household, isolation from support systems, or over-identification with the veteran (Cozza, Holmes & VanOst, 2013; Institute of Medicine, 2013; Rosencheck & Fontana, 1998).

The Military Spouse

Due to this trauma, military spouses and their children often suffer from a higher rate of behavioral, emotional, and clinical diagnoses compared to those of civilian

populations. This issue is compounded due to the mobile lifestyle, remote location, and reluctance of the military to engage in mental health services (Verdeli et al., 2011). Military spouses also reported difficulty arranging child care, getting time off from work, getting appointments, covering the cost of visits, and knowing where to get help in addition to the embarrassment of receiving treatment (Eaton et al., 2008). In addition, the services available to military families lack empirical evidence of success within this population (Verdeli et al., 2011).

A survey conducted by Eaton et al. (2008) of military spouses found that over 20% report significant life stressors and family issues that detract from their quality of life. In fact, it was found that 19.5 % of spouses that report significant stressors and met the criteria for clinical depression or anxiety (Eaton et al., 2008). These numbers are very similar to the percentage of service members returning from combat experiencing mental health issues. Only 20% of spouses, however, report fear of reporting mental health issues as opposed to 44% of service members returning from combat (Eaton et al., 2008). This suggests a greater ability of the spouse to recognize the impact of mental health and combat related injuries on the family. The services available to them, however, are often primary care providers, not mental health services, which have increased for the veteran but decreased for the family itself (Eaton et al., 2008).

In civilian populations, studies consistently find that women are more likely to seek help for emotional issues (Moller-Leimkuhler, 2002) and possess more positive attitudes toward counseling than men (Fischer & Farina, 1995). This is not always the case in military families where men make-up 85% of the active military population and the majority of spouses are women. The culture of the military community unfortunately

greatly effects the perception of these spouses to receiving mental health counseling and education. In particular, women have expressed the need to remain strong and independent for their husband and they fear retribution from the authorities if they do not present a united front with their military spouse (Lincoln & Sweeten, 2011). The need to overcome this self-stigma of help-seeking behavior in the military spouse has been identified, but no clear theoretical lens has been shown to be effective in educating these spouses on mental health skills while at the same time valuing their independence and self-reliance within the military community (Lincoln & Sweeten, 2011, Verdeli et. al, 2011).

Another significant aspect of re-integration of the military spouse is the communication within the family itself. Hinojosa, Hinojosa and Hognas (2012) find that the selective disclosure and limited communication of the military spouse during deployment leads to contentious and stressful family relations during reintegration. Technology problems and the lack of physical presence also were noted as a disconnect in communication between the military service member and their families upon their return (Hinojosa et al., 2012). On a positive note, military spouses report a positive maintenance when they are receiving social support in the form of advice, reframing and the separation as a normal part of the relationship (Merolla, 2010).

Deployment and Military Children

In a review of presenting problems of children of deployed military members, it was found that the children suffer from higher attachment disturbances, depression, and anxiety than the general population (Chandra et al., 2010). There have even been reports

of increased child maltreatment observed in military families (Rentz et al., 2007). An outpatient study of children of deployed families supports this concern, finding children of active duty military personnel visits to mental health services for mental and behavioral problems increased by 11%, stress disorders increased by 18% and behavioral disorders increased by 18% when a parent is deployed (Gorman, Eide, & Hisle-Gorman, 2010). The impact of the non-deployed parent's mental health status is important in understanding the coping strategies of these children.

Flake et al. (2009) found a correlation between children's depression and internalizing and externalizing behavior and the non-deployed parent's mental health status. This is supported by previous studies on civilian populations documenting high rates of disruptive disorders, anxiety, and depression of children who have a parent suffering from depression (Verdeli et al., 2011). The impact of the returning veteran's health is also an important factor to consider in the overall health of the family, as 70% of veterans with PTSD or other injuries have reported moderate to severe relationship distress, including domestic violence and substance abuse (Galvoski & Lyons, 2004).

Strengths of the Military Family

While the literature finds numerous risks for the families of veterans returning from combat with mental and physical injuries, there is evidence that this unique population has many strengths that can be utilized to compensate for these risks. Palmer (2008) found that while there are significant risks for the military family, there are numerous factors that promote the resilience of these families. Protective factors such as social and financial support; stress management training; mental health screenings; and

fostering optimism, hope, and positive future outlook may be present and can be focused on to bring attention to the resilience of military families and formulate their own unique solution to daily problems (Palmer, 2008; Watson, 2006). In addition, factors such as improving functional family dynamics and positive psychology models have been found to significantly reduce the impact of PTSD on the family unit (Gibbons et al., 2012).

A significant finding is in the perception of technology and its ability to enhance communication within the military community. A study by Bush et al. (2012) on the usage and perception of technology by service members found that 87%-91% of deployed and returned service members feel extremely comfortable using the computer and do so on a daily basis. In addition, the preferred communication while deployed is video/voice conferencing, social networking and email over the telephone (Bush et al., 2012). This finding is consistent with the civilian population in a study by Yaroush and Abowd (2011) which found the majority of work-separated families preferred the visual contact that teleconferencing provided over the telephone. This suggests not only the ability to connect through technology, but the preference by which these families communicate virtually.

The services available to these families can provide protective factors, but they also represent the stigma of weakness by asking for help. The importance of anonymity when seeking mental health services for military families cannot be underestimated. The stigma of seeking mental health treatment for military service members and veterans is extremely high compared to that of non-military civilians (Green-Shortridge et al., 2007). A six-year study of returning soldiers finds that allowing anonymity, by lack of face-to-face contact, increases the self-report of mental health issues such as depression, anxiety

and PTSD by 73% (Warner, et. al, 2011). Eaton et al. (2008) also found that 45% of returning service members was embarrassed to seek mental health care. Anonymity is therefore essential for honest reporting and help seeking for the military family.

Interventions

Understanding the unique risks and protective factors of the military family makes it clear that the treatment approach for mental health issues needs to align with this community. There is, however, a lack of empirical evidence that such an approach has been identified (Verdeli et al., 2011). Recently, though, brief therapeutic approaches, community practice models, and SFBT techniques have been applied successfully to treat the military family. While studying military families coping with physical and mental injuries sustained in combat, Collins & Kennedy (2008) concluded that these families need a flexible, individualized, collaborative and systems-based intervention. Brief screening and interventions for substance abuse have been used successfully in early stages of alcohol and substance abuse by military spouses (Ahmadi & Green, 2011).

Recently, several interventions utilizing solution focused themes and a focus on family health have been introduced to the military community (Beardslee et al., 2013; Smith et al., 2013). Beardslee et al.(2013) determined several factors that are conducive to effective treatment of military families including introduction of family psychological well-being, the use of resilience skills including problem solving and identifying a family narrative similar to a genogram. In addition, a study on preclinical engagement of the military family by Smith et al. (2013) found that families that have been a victim of traumatic violence, such as wounded soldiers, benefit from a solution focused program

that built upon past successes and planning for future long-term issues. Weiss et al. (2010) also found success with the solution-focused techniques of creating a genogram (Appendix B) to emphasize the strengths and resilience that military families possess. These studies suggest that a strengths-based, positive approach to treatment holds promise for successfully treating the family system, aligns to the values and culture of the military, and addresses the risks and barriers to help seeking.

Virtual Mental Health Counseling

The increase in global access to the Internet, as well as the increase in social use and community connections through Web 2.0 tools, has opened a new realm of mental health treatment for a variety of clients. Online counseling, computer-mediated counseling, web-based counseling, and telecounseling are all terms that have been used to describe providing mental health counseling to clients remotely through the use of technology, either using telephone, video conference, email, or virtual reality (Hanley, 2009). The rapid adoption of Web 2.0 tools, social networking, and popular video conferencing programs, has increased the ease of use and familiarity of this medium for the majority of individuals and has opened opportunities to virtual counseling in order to serve historically marginalized groups (Goss & Anthony, 2009).

Early stages of virtual counseling consisted of text or voice based asynchronous or synchronous communication such as emails, text-chats, or telephone calls. It has been found that this communication reduces the cognitive load of both the therapist and client due to removing the concern with appearance, social cues, and motives such as self-presentation and social comparison (Walther, 1996). This can lead to greater self-

awareness through an increase in time to respond and more focus on message preparation then on social cues (Baker & Ray, 2011). This is considered a desired state when dealing with personal issues and self-exploration as it is assumed that this is often the driving force bringing the client to therapy.

In an early study, Cohen and Kerr (1999) compared rates of disclosure in one session of face-to-face counseling and one session of computer mediated counseling. They found a uniform decrease in anxiety and rated their counselors equally on expertness, attractiveness, and trustworthiness. The clients also experienced less agitation and reported feeling less anxious in computer mediated counseling during this study. Other studies have indicated the advantage of privacy and anonymity in virtual counseling leads to an increase in self-disclosure, lessening of the power differential in the relationship, and a decrease in the time necessary to trust the therapist (Rivas, 2005). For example, Suler (2004) found that in online support groups, individuals are much more likely to disclose personal information, act out inappropriately, and ask for assistance, a phenomenon termed "online disinhibition." Garcia-Palacios et al. (2001) found that 80% of clients presenting with anxiety preferred a virtual reality exposure therapy to traditional *in vivo* therapy due to the ability to create an environment in which the client can be challenged but feel secure. In addition, using a qualitative analysis of online counseling working with young adults, Hanley (2009) supports previous findings of increases in client power, anonymity, availability, and value of providing online counseling to college students.

One of the most critical questions in virtual counseling is whether an effective online relationship can be forged. The therapeutic alliance has been proven to be one of

the largest and most consistent factors predicting successful outcomes of therapy (Leibert et al., 2006). Preliminary studies have suggested that a therapeutic alliance can be created online and is equal to that of face-to-face counseling (Cook & Doyle, 2002). Leibert et al. (2006), however, compared the working alliance rating between face-to-face and online clients and found significantly higher ratings of working alliance in the face-to face group. During this same study, it was found that alliance scores were significantly associated with satisfaction with the outcome of online counseling (Leibert et al., 2006). This finding is significant and may be explained by the findings of Hanley (2009) in online counseling with young people that indicated the therapist's attitude toward online counseling affected the satisfaction of the client. This indicates that it is possible to establish a therapeutic alliance that is successful in the online environment, provided the therapist creates the necessary conditions of trust, intimacy and empathy.

The development of trust and intimacy is an essential part of the therapeutic alliance, and the lack of non-verbal cues in online counseling can present a barrier to treatment (Alleman, 2002). The use of video conferencing has potential to overcome this barrier. The improved availability of technology through Internet connections and video conferencing programs such as *GotoMeeting,* have increased the comfort levels of individuals as well as made the technology more available and accessible (Simpson et. al, 2006). An initial study by Simpson (2001) of 10 patients that took part in video therapy found that 81% of patients rated feeling comfortable in video counseling sessions and rated this medium less threatening and intimidating then face-to face counseling.

The use of videoconference as a mode for delivering counseling virtually has been shown to be as effective as the traditional face-to face counseling sessions. It has been

found with certain populations and diagnoses this modality may be preferred by the client (Simpson, 2009). Several case studies have found positive results using remote video therapy. Improvement in depression and anxiety was seen when using cognitive video therapy with one case over twelve weeks (Manchanda & McLaren, 1998). Cowain (2001) reports significant improvement in a patient with anxiety and agoraphobia as well as major depression after 12 sessions of video therapy. In addition, positive outcomes were reported for PTSD in combat veterans using a single session of video therapy (Deitsch, Freuh, & Santos, 2000).

There have also been larger studies looking at both outcomes as well as therapeutic satisfaction when using videoconferencing. Day and Scheidener (2002) compared outcomes of a sample of 80 clients with a variety of presenting problems that were randomly assigned to video counseling, audio only counseling, face-to face modality or no treatment. It was found that there was no significant difference in the positive outcomes of all three groups that received treatment. In a study comparing treatment of 119 depressed veterans with brief cognitive therapy via teleconference and face-to-face sessions, there was found to be no difference in satisfaction of the therapist between each group (Ruskin et. al, 2004). In addition, both groups of patients showed improvement in symptoms with no significant differences between the groups (Ruskin et. al, 2004). Simpson et. al (2006) also found the outcome of using cognitive therapy via videoconference with remote patients suffering from bulimia was equivalent to the outcome of face-to face studies. It is important to note however, there is a lack of evidence on the effectiveness of therapeutic approaches other then cognitive or

psychoanalytic and there is no evidence which population is best suited for this type of online counseling.

While online counseling has shown to be effective in providing services to populations, such as military families, that are traditionally underserved due to remote location, lack of qualified providers, or issues associated with cost, several studies have found that the clients comfort level with technology also drives their willingness to create a therapeutic alliance (Hanley, 2009). In addition, there is concern on the part of many clinicians about video counseling and being able to communicate effectively and create rapport (May, Gask, Atkinson, Ellis, Mair, & Esmail, 2001). The dramatic increase in technology for everyday life suggests the comfort level and trust in using these familiar tools to create a therapeutic relationship for both client and counselor has increased as well and may be more viable (Goss & Anthony, 2009). Having access to services in a medium the client is familiar with as well as having the availability of a counselor in a convenient and safe setting will theoretically increase the services for underserved populations.

Perhaps the most difficult barrier to treatment for many is the stigma associated with help-seeking behaviors and mental health counseling in particular (Green-Shortridge et al., 2007). Virtual counseling can provide a setting that is perceived to be anonymous and in the control of the client (Rivas, 2005). This is significant as previous studies found having control of client's own space and room helps clients to feel less intimidated and feel more powerful in a remote videoconference then in face-to-face sessions (Allen, Roman, Cox, & Cardwell, 1996). Cohen and Kerr (2008) have also found the online environment creates an illusion of privacy and decreases interpersonal risk, both factors

in decreasing the stigma the client may perceive by receiving treatment. Intimacy may also be developed in a shorter amount of time due to disinhibition (Suler, 2004). In fact, online counseling has been proven effective after only one session in reducing anxiety as well as forming a therapeutic alliance (Cohen & Kerr, 2008; Simpson, Doze, Urness, Hailey, & Jacobs, 2001). These findings support the use of brief therapeutic approaches, such as SFBT, that reduce the time in therapy and focus on the clients' control, which decrease the perceived stigma of counseling and are compatible with the strengths of the online environment.

Summary

It is clear that the mental health educational needs of the military family have increased due to the deployment and injury of service members in both OIF and OEF. These needs are often at odds with the military families culture of strength and independence. There have been several studies that indicate taking a proactive, strengths based approach to mental health and family systems have been successful at addressing the stress, anxiety, depression and other mental health concerns of family members of the military. In addition, there is evidence of successfully delivering mental health services to underserved populations through virtual teleconferencing programs. There is a lack of evidence however, on the attitudes and perceptions of SFBT delivered online through teleconferencing with the families of service members that have been deployed. This study will help to understand the perceptions of military families of mental health education as well as how services can be more accessible and available by utilizing technology.

Chapter 3

Methodology

Introduction

The research questions one through three were answered through a phenomenological research approach. The basic purpose of this type of study, according to Creswell (2015), was to reduce individuals' shared experience to a description of the essence of that common experience. It was suited to a study in which an understanding of several individuals' common experience of a specific phenomenon was essential. This research approach allowed for the description of the shared experience of military families during and after the deployment of their loved one as well as described their perceptions on help-seeking behavior and use of technology. This study was seeking to examine what all participants have in common as they experienced the deployment of their loved one and their subsequent return to the family unit. Accordingly, this study described the "what" and "how" of the participants shared experiences as well as their suggestions on how to better educate those going through similar circumstances (Creswell, 2015).

According to Creswell (2015), there are two types of phenomenological approaches to research, hermeneutic and transcendental. This study took the transcendental or psychological approach as described by Moustakas (1994). In this approach, the focus is not on the researchers interpretation of the experience, but on the description given by the participants themselves. Moustakas (1994) described this approach as a perspective in which all new information is perceived as if it has been

received for the first time. All research in this study has been analyzed as to reduce the information to significant statements and combining them into themes. In this manner those experiencing this event and their overall essence of the needed services in education and uses of technology for future research are conveyed within the structural description of the phenomena of military deployment and return.

Sampling Procedure

Gay, Mills and Airasian (2012) suggested a sample size between 10 and 15 participants in order to allow for the generalizability of the results and to control for sampling error and bias. This fell within the guidelines of looking at the essence of phenomena by collecting the data from 5 to 25 participants (Polkinghorne, 1989). In this case, in order to the answer research questions, a convenience sample of 12 family members of current and prior military service members had been recruited. This represented primarily family members from the Army and Marines, 83% female with an average age of 39. Participants were equally split between Hispanics and non-Hispanic white.

It is important to note that while 20 individuals were contacted, 8 declined to participate in the study. The main reason for non-participation was the reluctance to disclose personal information to individuals outside of the family.

After reviewing the consent form, a time and place for an interview was scheduled. Nine interviews were conducted over the phone, two interviews were conducted in person and one interview was conducted via the video-teleconferencing program *Skype*.

According to Moustakas (1994) there were two basic open-ended questions that served as the analysis of the interview statements by the participants'. They encompassed the following: "What have you experienced in terms of the phenomena (e.g. deployment and return of a military service member)" and "What context have influenced your experience of this phenomena (e.g. technology)?"

In keeping with this structure and for the purposes of this study the following open-ended questions were asked:

1. Tell me about your life since your loved one (husband, wife, etc.) returned from deployment? What if anything has changed?

2. How do you feel about talking to someone outside of the family to help you cope with these changes?

3. How could technology be used to facilitate these discussions?

Throughout the interview, notes were taken in order to gather specific statements on the participants' experience.

Analysis

Prior to beginning the actual analysis, the transcripts were read by the researcher for accuracy and understanding. Moustakas (1994) identified a technique known as *epoch*, or bracketing, in which the researcher set aside their experiences and focuses more on the description of the participants. Being sure to take this into account, care was taken

not to interject personal feelings or opinions (i.e. bracketing) during the entire analysis. Codes were identified as they related to (Creswell, 2015, p.243):

1. Setting and context
2. Perspective held by participants.
3. Participants' ways of thinking about people and objects.
4. Processes.
5. Activities.
6. Strategies.
7. Relationships and social structure.

The horizontalization, or significant statements, of how each interviewee experienced the phenomena was established and significant statements, or codes, were identified. Similar codes were grouped and reduced to approximately 12 unique codes, three major themes and an overarching theme labeled *reluctance.* In this step, clusters of meaning were established. From these structural and textural descriptions, the essence of the phenomena was analyzed to focus on the common experience of all participants.

Resources

The researcher was required to have access to the appropriate technology (e.g., a computer with video-conferencing capabilities or a telephone) to meet the needs of the interviewee.

Summary

A qualitative analysis of the anonymous interviews allowed for conclusions to be drawn for research questions one through three. This approach was conducted through a phenomenological approach based on the systematic steps outlined by Moustakas (1994). Throughout this process, formulated meanings were clustered into themes that allowed for a common understanding of a shared experience. This approach has allowed the researcher to focus on the experience of having a family member deployed and returned from a wartime military action. The importance of not only understanding this experience but in gaining insight into recommendations of educational services and the use of technology by this unique population was the focus of this study. The findings will be discussed in Chapter four.

Chapter 4

Results

Introduction

As noted in Chapter three, data were collected from a convenience sample in order to answer the three research questions within the study. Throughout the analysis the overarching theme of *reluctance* was noted as all families had a degree of fear and anxiety when discussing any type of self-disclosure. Throughout the analysis of the three research questions, main themes of experience for pre and post deployment were recognition of worry replaced by relief and then the fear of disruption of this relief by discussion of the time spent during deployment. The perception of counseling was positive for others outside of the family was clear although there is substantial reservations of personal disclosure due to self-stigma that was expressed. Most significant findings however, are in the discussion on the perception of technology to aid this stigma and the suggestions on appropriate solutions including mental health education to the anxiety surrounding reintegration of the military family member to the family unit upon return from wartime deployment.

Research Question One:

What is the experience of military families during and after the deployment of a service member?

In analyzing data from the field notes, distinct themes were developed for the time period during the deployment and after the service member returned home. As might be expected, family members expressed high levels of anxiety during the deployment, primarily due to feelings of worry for the safety of the family member. For example interviewees stated:

> *I don't like that stuff* (i.e. deployment) *because we cannot plan on anything including a family. I never know if he will come back. It is relief when he comes back.*

> *It was a difficult transition from him being home to one that you worry about him all the time.*

Others expressed a fear of the unexpected. For example, while stationed in Italy, the husband was deployed, and participant stated:

> *I am not prepared to live in a strange country by myself without my husband and don't know what will happen. I am scared.*

In another case where husband was deployed from Germany, a wife stated:

> *It was scary. But it was a matter of me taking care of business, so it was important to stay strong for the kids.*

Participants also expressed a sense of isolation, as indicated in the following examples:

In the Reserves, it was very isolating. I had no one to talk to.

It's hard because I am alone most of the time. I have to be very self-sufficient and even though I am married, I don't always feel like we have the close relationship we used to.

Most respondents expressed feelings of tension and anxiety (i.e., adjustment issues) upon the service member's return from deployment. Respondents stated:

There is a lot of tension and anxiety in the house when they return. No one knows what to say.

He is distant, a little more preoccupied. He missed some of the camaraderie and he didn't know how to relate to our girls.

This anxiety stemmed from an unwillingness of both parties to discuss the deployment. For example, participants stated:

No one talks about what happened; the family wants to pretend that nothing is changed and have a hard time accepting any difference.

He never talked about that time. You know, I hear little bits and pieces, but I think he wanted to protect me.

We never talk about his job. He doesn't say anything, and I never ask.

Other interviewees noticed changes in the household upon the service member's return from deployment:

When my husband comes back, it takes us a while to get used to each other again and for him to start helping around the house. Once we do, it seems that he has to leave again.

When my husband was gone, we would get into a routine. When he returned, it was hard to fit him in; he had to get to know the kids all over again.

In many instances, these adjustment issues resulted in bouts of anger on the part of the service member:

After he returned, we fought all the time. He never had a temper before, but now there is always screaming and yelling.

My father had PTSD and was very volatile growing up. Any little infraction and he would explode. This made my mother extremely irritable as well.

Summary of Research Question One

The interviews provide evidence that the deployment and return of a family member in the military causes stress and change within the family unit themselves. The worry about the well being of their family member while deployed during wartime appears to give way to a sense of relief that is quickly replaced with tension and anxiety upon their safe return. The experience of the service member during deployment, however, creates a barrier to communication within the family that makes it difficult to reintegrate into the family unit. The lack of communication has emerged as the largest concern within military families, and the causes should be an area of future research.

Research Question Two

What is the perception of military families toward seeking mental health services?

A small number of participants indicated they had sought, or had considered seeking, professional counseling. While denying a personal need, 11 of the 12 respondents stated they felt that other soldiers' family members as well as the service member themselves did need counseling related to deployment and return:

I know many girls who have a really hard time, and I don't know what to say to them. These people would need the help more than me.

I am very independent and have a strong personality; that is part of the military lifestyle. But the enlisted and lower ranking people need many more services. How they live, the money they make is tragic.

When asked why they did not seek professional counseling, respondents generally reported an overall perceived stigma in the military toward mental health issues, as evidenced in the following examples:

There is still a stigma in the military that asking for help, especially counseling, means that you have a problem you cannot handle on your own. You are not strong.

It was very hard to break the stigma and actually admit I needed help. The military looks down on these people, so you pretend the things that happened didn't because talking about it makes it real.

Others felt that counseling was a sign of weakness:

Talking to someone outside the family is a weakness. Families are not allowed to be weak.

It takes a strong person to be in this lifestyle. You have to be independent and not need other people to solve your problems.

Other participants expressed a negative reflection on the service members themselves, for example:

You always worry that it will look bad on your husband. That someone will find out and it will affect his career.

The stigma of getting help includes the family even more so. They aren't the ones doing the work, so if your family is complaining it looks very bad on the soldier.

Others felt that families must maintain normalcy and, because of their deployment, the soldiers deserved the attention, not the individual family members:

We often feel that families don't deserve the help; the soldier had the trauma. It is not our place to complain.

I never thought of bringing our problems up to anyone else. It is him (i.e. my son) *who is having the problems, not me.*

Several respondents stated a need for education and support but turned to non-professional resources such as their military chaplain and support groups:

I turned to my chaplain for advice when he was deployed. He was able to help me a lot.

I went to my priest when I was extremely stressed with the children for advice.

I had a support and education group of other military wives. This helped me the most because I knew what to expect.

When I was on the base the other wives' in the same situation were all there for each other. This was the most helpful because they understood what me and the children were going through.

Others relied on friends and family to support their emotional needs:

I speak to my friends back home a lot. They make me feel normal and help me to accept not being with him (i.e. my husband).

I have a lot of friends in the same situation and we all lean on each other when we need to. We understand the situation better than others who have not been in the military.

I spoke with my mother and father a lot. They helped me get through the separation.

I use my parents for support, especially with my son. They are always there to help.

Summary of Research Question Two

The main attitude the respondents in the previous interviews expressed is the concern for the stigma that seeking outside help has within the military community. While the need for counseling is acknowledged, the perception that the unique dynamic of the military community would be negative was a factor in seeking outside help. In addition, the perceived consequences that seeking counseling would have on the service members themselves was an obstacle to professional help-seeking that many family members articulated. There is a bit of a contradiction in the interviews perception of the need for counseling, which they support, to a fear of self-disclosure and self-imposed stigma of help-seeking behavior if they themselves admit to needing support during or after the deployment of their loved one.

Research Question Three:

To what extent do you believe technology could be used to offer counseling or education to families of military services members?

Analysis of the field notes resulted in the development of three themes; concerns about the use of technology, positive aspects of technology use, and suggestions for future use of technology for counseling, education and support. The primary concern related to the stigma of counseling in general, much as was the case in research question two:

I would never use counseling because I am strong enough. It won't look good for my husband, and I don't think it would be necessary.

I would be concerned with using technology because I wouldn't know who was on the other end and if they understood the military lifestyle. I wouldn't talk with someone who didn't understand the stigma of getting counseling.

While many of the respondents indicated that face-to-face therapy was preferable; this appeared to be a generational issue. The older participants felt a need for traditional face-to-face counseling, while younger family members agreed that counseling could be effective in a virtual environment as long as there was a face-to-face component:

There should be human contact. The families need a real person who understands the military lifestyle to provide a face-to-face contact.

It may be good for some of the younger families. They are familiar with all the technology and use them all the time. I know for myself I would need to see a real person.

The stigma of counseling also included concerns with privacy. For example it was stated:

I think the biggest thing is privacy. I would never want the other wives or husbands' superior to find out I was getting help. This is what makes families and wives nervous, anything could look bad for someone making a career.

One concern with online counseling is that you never know who might be in the next room listening.

In addition, a need for anonymity was expressed:

If it is an anonymous service, for something like a crisis situation, technology could be very useful for handling the stress of living with someone who is dealing with the issues of being at war.

Another concern was that of security of the technology used:

> *I think families would use it* (i.e. technology) *more if it is secure and HIPAA certified because it would reduce the stigma of walking into an office.*

> *I would want to be sure the person was qualified and I could see them. This would make me more confident and secure that I was talking to a professional.*

Participants also expressed positive perceptions of counseling in a virtual environment. Being physically removed from the counselor made several participants feel they had more control and power within the sessions, or example it was stated:

> *They would feel as if they have more power and control because they are in their own space and won't feel as challenged*.

Others felt they would be less inhibited and more likely to discuss feelings they would feel uncomfortable discussing in a face-to-face session:

> *It would make the family or person in counseling less inhibited because they don't have to walk into an office and more likely to be honest.*

Many participants felt that technology would afford them to be connected to the counselor more expeditiously:

I think is a great idea and very important to be able to reach out and get answers immediately as opposed to waiting six months.

I like being able to look up answers and connect with people when I need them, rather then waiting. This is useful.

The families' needs are not always considered. Using computers would be very helpful for families that are located remotely.

This same theme was expressed in the desire for continuity of services independent of location, indicated in the following examples:

It would help when relocating because you can keep a connection to your doctor or therapist, especially when they know your history and you have a bond.

Being remote, it would be helpful to have access to the same services that you have when on base. This is one way technology could improve services.

Family members had suggestions for the future use of a virtual counseling and educational environment. For example, many respondents felt that the technology would allow them to connect with other families in similar situations, thereby creating a sense of peer support:

I would have liked to have a support group of other military wives. Technology would be very useful for the Reserves families. Something like a Facebook for them would be very helpful.

I think most important is to connect with other families. I would like to see other people in the same situation. This is something I would use.

Several others expressed a need for online information dissemination in the form of tutorials and education:

Technology can be helpful with education. People can reach out and get immediate answers.

I have used technology to get education and to better understand what to expect when my husband was deployed as well as when he came home.

Others mentioned the value of a centralized way of remotely accessing services and crisis intervention for military families:

I also think that having a central list of services online for families should be available. That way you don't have to travel to the base to find the help you need.

It would be useful if there was a way to get information or services that you need. This way you wouldn't have to search different agencies.

I would use technology as a crisis intervention. To be able to contact help anonymously when dealing with an immediate situation would have been helpful.

Technology would be good for crisis. Like a support line when dealing with an immediate need.

Summary of Research Question Three

As previously noted, the stigma of counseling is a main concern within the military community; however, the respondents have noted the ability of technology to overcome this barrier in a significant manner. Other barriers such as availability and accessibility were mentioned as benefits of using technology in counseling for military families. Also suggested were other services such as education, information dissemination and crisis management. This suggests that there is a need to further investigate the ways in which technology can be used to benefit military families and overcome the barriers they perceive to seeking outside help and education.

Conclusion

Throughout this study, data were collected and effectively analyzed to answer the three research questions. As would be expected, feelings of apprehension and fear for the

service member's safety are replaced by an uncertainty and period of adjustment upon their return. The need for outside help is clearly expressed, although the perception of stigma and fear of negative consequences creates a significant barrier to seeking outside counseling or education. The use of technology however, was seen as having potential to overcome many barriers for military families in seeking help and many younger families expressed confident in technologies such as videoconferencing and live message boards.

Chapter 5

Conclusions, Implications, Recommendations, and Summary

Conclusions

This study investigated the experiences of military families during and after deployment of a family member. Additionally, their perception of mental health education and counseling in general, as well as their thoughts and beliefs towards using virtual technology-based counseling, was examined. In analyzing data from interviews of 12 family members, several distinct themes within each of these categories became apparent.

In discussing their lived experiences while their loved ones were deployed, issues that occurred both during the employment and when the service member returned were evident. As might be expected, during deployment, family members expressed feelings of worry, anxiety and isolation. Upon the return of their family member, tension and anxiety from an unwillingness to discuss events occurring both at home and during the service member's deployment were evident. Many family members stated that their unwillingness to discuss these issues arose from fear of the service member's frequent angry or volatile reaction.

As noted, a pervasive stigma toward mental health counseling, in general, was expressed. This was attributed to the perception that a service member's family needs to be strong, and a fear that personal counseling would reflect negatively on their loved one's career. At the same time, participants agreed that mental health services were valuable and needed for others, although they did not feel it was appropriate in their

personal case. In some cases, while hesitant to seek professional counseling, many participants said they had turned to self-initiated peer support groups, family members, other friends with loved ones in the military, or local military chaplains for education regarding the deployment and re-integration process.

In discussing the possible use of technology in education and counseling setting, participants expressed concerns, positive perceptions, and suggestions for future consideration. As alluded to in research question two, the stigma attached to counseling was evident; participants were wary of the possibility of being recorded, privacy issues, and anonymity. Others felt that the stigma could be lessened by not having to attend sessions at a specific physical location. Many felt that technology might lead to a participant having greater control and power in the counseling relationship. At the same time, the older participants felt that technology-based counseling would be ineffective in any situation for them personally. Finally, it was felt that the technology-based environment would allow for faster and more continuous service with a mental health provider available regardless of the provider's proximity since the lack of trained professionals was a consistent concern.

One of the more significant findings has been in the attitude of families towards counseling in general. They have expressed a positive view of other's needs to be met through receiving educational counseling services. This suggests that they have less of a social stigma and an increased self-stigma in regards to the counseling process. This is significant, because at the same time, they deny their own need for similar education when experiencing the same phenomena. This is an important barrier that needs to be addressed in the creation of educational services for military families.

In suggesting possible future uses of technology-based counseling, most respondents focused on the need for an educational platform. This would include a centralized source for information dissemination to include family and medical services, tutoring, counseling, and financial services. Based on observations of others in similar circumstances, several respondents stressed the need for crisis intervention and peer support. The attitude of all respondents towards technology was a positive one, and their experiences with connectivity through technology and the lack of services in their area led them to conclude that many educational and counseling services would be better served by creating a virtual application that centers around the military community.

Implications

The results of the study imply a need for counseling of family members, both during the deployment as well as when the service member returns. Despite that, a hesitancy to seek counseling is heightened by a stigma evident within the military culture toward mental health issues. This is consistent with previous findings (Drummet et al., 2003; Warner et al., 2011). Due to these issues not being addressed, the development of serious mental health issues is possible. For example, in one case, the family member of a returned veteran diagnosed with PTSD led to symptoms of clinical depression including rage, self-loathing, guilt, and the inability to maintain interpersonal relationships (APA, 2013). In another case, the explosive rage of the returning service member, a symptom of clinically defined PTSD (APA, 2013) led to the separation and divorce of the affected couple. Other respondents demonstrated symptoms of a variety of Adjustment Disorders

(APA, 2013). Each of these perceived disorders is consistent with reports of secondary trauma (Cozza, Holmes & VanOst, 2013; Institute of Medicine, 2013; Rosencheck & Fontana, 1998).

The evidence in this study points to an increase in self-stigma of military family members regarding help seeking behavior. In particular mental health education has a negative connotation and self-disclosure has caused anxiety and fear of retribution from the military establishment. However, the social stigma of mental health education is decreased as evidenced by statements of a positive attitude towards those, including family members, which participate in counseling. This implies that the need to provide psycho-education to reduce self-stigma to military families in particular as recommended by Vogel et. al (2007).

The results also seemed to indicate that families, when compared to the service members themselves, are less likely to seek mental health services due to this stigma. This is contrary to other published studies that found family members are more likely to seek counseling then the service members themselves (Eaton et al., 2008). This implies a need to further investigate the attitudes and help-seeking behavior of military families as well as a need to decrease the fear of negative consequences when looking to outside help.

Despite the self-stigma of mental health counseling, interviewees were somewhat supportive of the idea of using technology in order to overcome the anxiety regarding self-disclosure as well as negative issues arising from a reluctance of both the service member and family to seek services. This supports Alleman's (2002) and Suler's (2004) research that finds self-disclosure and disinhibition is increased when

communicating in an online medium. In addition, this study confirms Bush et. al (2012) conclusions that a decrease in stigma is felt within the military service members themselves when participating in remote counseling, however there is a perception of a lack of trained service providers. This implies that while there is a negative stigma associated with mental health counseling within the military community, it may be partially overcome with the use of technology.

In addition, the use of technology was perceived to create a seamless transition for services when coping with the mobile lifestyle that is part of military service or for those families living outside a military community but still needing support. The relocation of active service members as well as the remote location of the Reserve service and veterans has been identified as a major barrier to receiving consistent continuous care (APA, 2007; Spera, 2009; Verdeli et al., 2011). Consistent with these findings, several participants expressed the need or desire for education, peer support, and other health services that are designed for the military family, and many participants looked favorably on the use of technology to decrease this barrier. This implies a positive attitude toward technology and a void of services that could be filled through the development of programs for remote families.

It is important however to take into account the findings of Yarosh and Abowd (2011) that the technology available to the military community was viewed as unfavorable due a perceived lack of privacy and red tape needed to go through in order to use these programs as opposed to civilian families. This fear was also expressed by the several of the participants as one of the detractors from using technology for counseling purposes. This implies that the programs available to military families and the restrictions

that are placed upon their communication also affect the positive attitude many have toward technology used in mental health education.

The type of program that participants expressed a preference for was also significant when planning future studies. The main methods of preferred communication expressed were social networking message boards and video-teleconference. This is consistent with (Bush et. al, 2012) findings of time spent communicating is the highest in military families when using these types of services. The familiarity with popular video-teleconferencing programs such as *Skype* and the importance of having a social presence supports the further investigation of how *HIPPA*-approved counseling programs can be utilized by the military community. This also is consistent with Yarosh and Abowd (2011) and Hinojosa et. al (2012) findings that the need for a visual presence during communication is one of the most important factors in remote communication within the family. This supports the conclusion of Simpson (2009) that videoconferencing in particular can enhance the therapeutic alliance based upon the attitude of the individuals and their experience with the program itself. This finding in addition to the previous studies implies a need to develop technology that is both voice and video based and familiar to military families when designing computer facilitated educational counseling programs.

Consistent with other studies, the unique stressors and lifestyle of military families create an insistence on having interventions that are designed specifically for this population (Lara-Cinisomo et al., 2013; Verdeli et al., 2011). Most interviewees expressed their perception that any type of counseling would need to adapt to the military culture. As previously noted in Chapter 2, however, there has not been an empirically

tested theory or technique that would be acceptable to the military community. This is further supported by a stated need for interaction only with resources associated with the military. In addition, the conclusion of Verdeli et al. (2011) that educational and counseling approaches need to be aligned specifically with the military culture is strongly supported. The positive lens, focus of education and future orientation of the SFBT approach in this case appears to have value in this manner. The need to further investigate educational counseling approaches, such as SFBT, that build the resilience and strength of the military family was reinforced by the respondents throughout the study.

The willingness of family members to seek guidance and support from non-professional sources implies a willingness to seek help, but a wariness of disclosure. This is also consistent with the findings of Warner et al. (2011), which found distrust in traditional counseling services and a need for anonymity within the military community. This finding supports emerging technology-based programs such as information dissemination programs like the Families Overcoming Under Stress and preventative programs similar to Operation Building Resilience and Valuing Empowered Families (Beardslee et al., 2013; Smith et al., 2013). Both of these programs provide education or assessment and referral specific to the military family without the label of counseling, including virtual services. This implies the need to further investigate the enrollment and outcomes of these programs to determine if the stigma of help-seeking is as prevalent when services are provided virtually and not labeled as counseling.

Recommendations

Military leaders must understand the need for counseling of both returning military members and their families and the associated stigma of receiving services of this type. Suggestions for addressing this issue include informational training sessions and direct contact with the command structure. There also needs to be less red tape, more providers, and increased assurances of confidentiality. In addition, preventative educational programs for families should proactively be created and encouraged by leadership during the deployment of the service members. Negative symptoms caused by deployment and return need to be normalized by authority figures (Vogel et. al, 2007).

In addition to leadership accepting a more proactive educational role, the largest issue is the family member perception of mental health education as a weakness and not accepted. The family member themselves must accept the value of therapy and education associated with the deployment process. This can be accomplished by education that acknowledges the stress is not the family members fault, dysfunction is reversible and things will get better with treatment. This is supported by Overton and Medina (2008) findings that education is a necessary component to overcoming stigma regarding mental health. Education must be proactive for the family before deployment takes places, during the separation as well as upon re-unification.

As reported in the review of literature, there are specific approaches to counseling that align with the military culture (e.g., SFBT). Knowing that, a specific protocol based on this approach and designed to support military service members and their families is called for. Prior to educational counseling, the potential clients should understand that the approach has been specifically developed for their constituency.

Military families seem to be very comfortable and prefer the use, at times, of technological tools for social and communication contact. Technology designed to support education and mental health services should be developed within the structure of the military community. In addition, the encouragement of these types of technology for education has to come from the top echelon of the military community. Looking at technology programs that are social, educational and proactive in their approach will benefit the adaptation of these technologies to counseling services while at the same time combat the self-stigma many military families experience.

As noted, the use of technology may be effective in overcoming the stigma of counseling as well as the remote location and continuity of services due to relocation. The desire for trust as enabled by a visual presence suggests that video teleconference is the most effective use of technology in order to provide these services. Pilot programs using commonly available tools such as *Skype* or *GotoMeeting*, should be used to investigate this hypothesis.

Family members have been shown to accept self-developed or self-initiated support groups using social networking programs that eliminate the proximity barrier. The use of a professional trained in SFBT to guide the group, rather than offer specific counseling, would potentially decrease the stigma of counseling as well as offer opportunities for counseling or guidance as needed. It has also been noted that interventions should begin at the time of deployment, in order to offer preventative services to families upon the return of the service member.

Summary

The recent wars in Afghanistan and Iraq have created unprecedented tests for the resiliency of military families and the systems that support them. The increased rate of service members returning with physical injuries as well as PTSD often becomes disruptive to the familial relationships and family functioning. The need to support these families is apparent, and new interventions hold the promise to support the wellbeing of both adults and children in these families.

Evidence suggests that approaches to family health that focus on prevention and treatment and engage families early are more likely to be successful. However, the most significant finding of this study shows that the largest barrier to engaging these families remains the self-stigma associated with mental health counseling, the perception of weakness and the fear of negative consequences upon the careers of the service members themselves. It is also imperative that the approach to military families needs to align with the military culture and be educational, strength based and solution oriented. There is existing evidence that Solution-Focused Family Therapy is a viable framework when addressing the concerns of military families and should be further explored.

This study also finds that the use of technology has the potential to overcome this barrier of stigma when utilized in a proactive manner and is fully supported by military leaders. Since it is clear that services are most effective when families are engaged before significant pathology emerges within either the spouse or the children of the service member, future research should include an investigation of how technology can assist in interventions that would overcome the reluctance on the part of the family to

seek information and support services prior to the emergence of maladaptive behavior of the family members.

The need to support the families of military service members has become a priority and necessity to adapt to the changing nature of the military itself. It is clear from this study that there remains a reluctance of discussing the problems and stressors that exist, as would be expected, during the deployment and return of a loved one. In addition, there is mistrust within military families of the military establishment that their self-disclosure will be viewed as a negative upon their family member themselves. The familiarity and acceptance of technological communication systems within the military community is also evident. The need to overcome the self-stigma regarding mental health education as well as make services more available and accessible dictates that technology has the potential to be useful. It is important, however, to continue to investigate the uses of a framework that combines technology with an educational approach that is acceptable to the unique needs of the military community.

Appendix A – Informed Consent and Solicitation

Dear Potential Participant,

My name is Taryn Stevenson and I am working on a small scale university project, as a student in the PhD program Computing Technology in Education at Nova Southeastern University, with families of service members who have recently returned from overseas deployment. I am interesting in understanding the experience you have had during and after family members have returned from deployment. In addition, we are studying current available services and if technology can be utilized in order to better serve the military community.

It is anticipated that your participation in the program will take less then one hour.

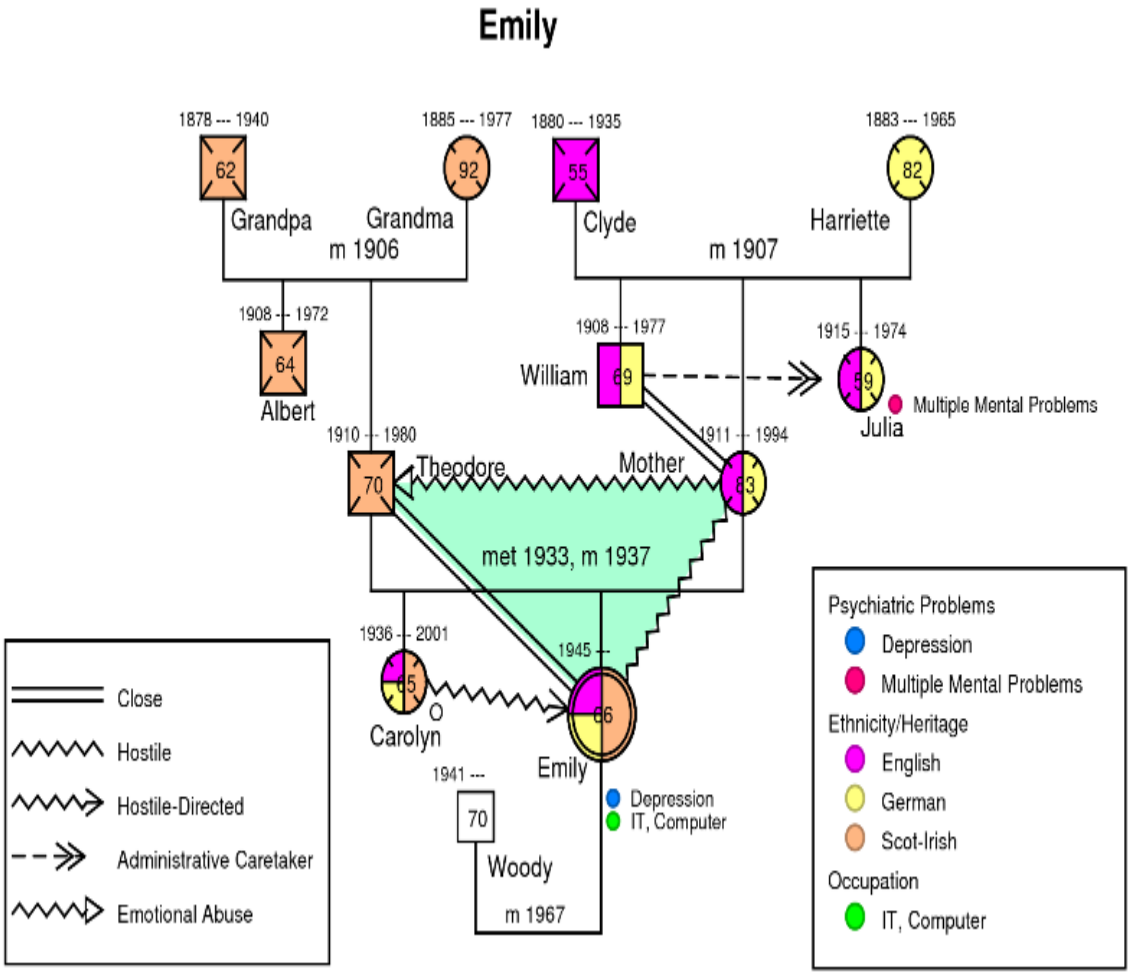
Before you agree to the interview I can confirm that:

- All information will remain confidential unless disclosure is required by law. No comments will be ascribed to you by name in any written document or verbal presentation. Nor will any data be used from the interview that might identify you to a third party.
- You will be free to withdraw from the project at any time.
- I will provide you a copy of my final report at the end of the project.

I sincerely hope that you will be able to help me with my research. If you have any queries concerning the nature of the research or are unclear about the extent of your involvement in it please contact email me at ts1085@nova.edu.
Thank you for considering my request; I look forward to your reply.

Yours sincerely,
Taryn Stevenson

Appendix B- Example Genogram



Appendix C- IRB Approval

NOVA SOUTHEASTERN UNIVERSITY

MEMORANDUM

To: Taryn Stevenson, M.A.
Graduate School of Computer and Information Sciences

From: David Thomas, M.D., J.D.
Chair, Institutional Review Board

Date: May 22, 2014

Re: *Serving Military Families: Using Solution-Focused Therapy in a Virtual Environment* – NSU IRB No. 04171418Exp.

I have reviewed the revisions to the above-referenced research protocol by an expedited procedure. On behalf of the Institutional Review Board of Nova Southeastern University, *Serving Military Families: Using Solution-Focused Therapy in a Virtual Environment* is approved in keeping with expedited review category # 6 and #7. Your study is approved on **May 22, 2014** and is approved until **May 21, 2015**. You are required to submit for continuing review by **April 21, 2015**. As principal investigator, you must adhere to the following requirements:

1) CONSENT: You must use the stamped (dated consent forms) attached when consenting subjects. The consent forms must indicate the approval and its date. The forms must be administered in such a manner that they are clearly understood by the subjects. The subjects must be given a copy of the signed consent document, and a copy must be placed with the subjects' confidential chart/file.

2) ADVERSE EVENTS/UNANTICIPATED PROBLEMS: The principal investigator is required to notify the IRB chair of any adverse reactions that may develop as a result of this study. Approval may be withdrawn if the problem is serious.

3) AMENDMENTS: Any changes in the study (e.g., procedures, consent forms, investigators, etc.) must be approved by the IRB prior to implementation.

4) CONTINUING REVIEWS: A continuing review (progress report) must be submitted by the continuing review date noted above. Please see the IRB web site for continuing review information.

5) FINAL REPORT: You are required to notify the IRB Office within 30 days of the conclusion of the research that the study has ended via the IRB Closing Report form.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed in Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991.

Cc: Dr. Ling Wang
Dr. Steven Terrell
Ms. Jennifer Dillon

Institutional Review Board
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