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Pepperdine University  
Graduate School of Education and Psychology

COPING AND PROTECTIVE FACTORS FOR ADULT CHILDREN OF MILITARY  
FAMILIES

A clinical dissertation submitted in partial satisfaction  
of the degree requirements for the degree of  
Doctor of Psychology

by

Maura K. Castellanos

July, 2019

Thema Bryant-Davis, Ph.D. - Dissertation Chairperson

This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

This paper assesses the adult children of traumatized military parents and their symptoms in the service of obtaining more information on the relationship with the other caregiver as a protective factor that possibly mitigated some of the intergenerational trauma transmission. Utilizing a qualitative retrospective design with an interpretive phenomenological inquiry strategy, participants engaged in reflection of their lived experiences in the context of being raised by a parent with a trauma diagnosis related to their military experience, major themes of protective factors include: Personal/psychological protective factors, Healthy Coping Strategies, Unhealthy Coping Strategies, Neutral Coping Strategies, and Positive Outcomes of Protective Factors. This study promotes the need for post-deployment psychological support services for veterans and their families in order to reduce intergenerational transmission of trauma. Services need to be provided to promote the development and enhancement of existing protective factors (e.g., understanding, other caregiver connection, and social support).

## Introduction

According to the United States Department of Veterans Affairs, the United States has been involved in at least 13 different wars, from the American Revolution starting in 1775 to the Global War on Terror (including Operation Enduring Freedom and Operation Iraqi Freedom) which started in 2001 (U. S. Department of Veterans Affairs, 2017). For more than 20 years, American troops have been deployed and engaged in conflicts overseas, such as Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) (U. S. Department of Veterans Affairs, 2014). The long-term nature of these conflicts has resulted in multiple deployments for United States military personnel. The personal impact of war on military members and their families can be seen across varying domains including, but not limited to, death of service members, both short-term and lifelong physical and emotional impairment, separation of families, and financial strains (U. S. Department of Veterans Affairs, 2017).

Posttraumatic Stress Disorder is one type of emotional impairment that impacts military members and their families. Statistics obtained from the National Institute of Mental Health reveal that in the past year 3.5% of the U. S. adult population met criteria for a diagnosis of Posttraumatic Stress Disorder, with 36.6% of those cases being classified as severe (1.3% of the U. S. adult population); they also reported that 4.0% of children between the ages of 13 and 18 would meet criteria for PTSD at some point in their life and that 1.4% of children between these ages satisfy criteria for the category of 'severe' (National Institute of Mental Health, 2015). These percentages increase significantly when looking at the prevalence rates of PTSD in military populations. The rates of PTSD among veterans vary depending on service era from approximately 11% to 20% (some estimates suggest the rates may be as high as 30% for

Vietnam era veterans), much higher than the rates found within the general U. S. population.

According to the Veterans Administration, it was found that approximately 11-20% of OIF and OEF, 12% of Gulf War (Desert Storm), and 15% of Vietnam War Veterans were diagnosed with Posttraumatic Stress Disorder (U. S. Department of Veteran Affairs, 2014). While there are events other than combat exposure that can create symptoms leading to a PTSD diagnosis (military sexual trauma) the focus of this project is on the effects of combat related PTSD.

Posttraumatic Stress disorder affects both children and adults in the general population as well as in more specific populations, such as the military. In the most recent edition of the DSM, criteria were added to account for the symptom presentation of PTSD in children under the age of 6. The majority of the criterion was the same for these children as they were for adults and children over the age of 6, however the key component added to this diagnosis was the child's awareness that a traumatic event was experienced by their parent or caregiver.

As more research has been conducted on the long-term effects of Post-Traumatic Stress Disorder, additional information has been revealed about the far-reaching impact of trauma. The effects of trauma are not limited to the individual who experienced the trauma, but can impact the lives and experiences of other people in their lives, such as their children, as seen in children and grandchildren of Holocaust survivors (Danieli, 1998; Lev-Wiesel, 2007; Steinberg, 1989; Wiseman, Metz, & Barber, 2006). Intergenerational trauma, also known as secondary traumatization, has been described as "the impact of trauma experienced by one family member on another family member of a younger generation, regardless of whether the younger family member was directly exposed to the traumatic event" (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009).

In children of individuals diagnosed with Posttraumatic Stress Disorder, intergenerational transmission of trauma can occur as a result of parental trauma leading to a diagnosis of PTSD, followed by the successive diffusion of the distressing symptoms of the disorder to their offspring without any direct exposure to the precipitating traumatic event (Dekel & Goldblatt, 2008). Secondary traumatization occurs as a result of those close to a traumatized individual (i.e., family members including spouses and children) developing behaviors and emotions in response to knowledge of a traumatic event and may result from a desire to want to help the traumatized individual (Figley, 2000, p. 7).

Approximately 5% of the United States' 80 million children are military-connected, meaning there are around four million military members currently in this country (Lester & Flake, 2013). While research has not identified one clear path as a direct mechanism for secondary trauma transmission through social learning or attachment, there appears to be increased correlation for development of trauma symptoms via parental exposure (Smith-Osbourne, Wilder, & Reep, 2013). This project focused on intergenerational trauma within the veteran population. Specifically, secondary traumatization in civilian offspring of veterans was studied.

### **Children of Veterans**

In recent years, as military deployments have increased in frequency and length of time due to long lasting political conflicts, such as OEF and OIF, subsequent diagnoses of Posttraumatic Stress Disorder have increased, more research and attention have been drawn towards the effects of these factors on the children of these veterans. In a 2010 report published by the Department of Defense, an estimated 2.1 million Americans (men and women) have been

deployed as part of either OEF or OIF and an estimated 44% (about 100,000) of those individuals are parents, and 48% of those deployed parents carried out at least two deployments (Department of Defense, 2010). As more information regarding the effects of PTSD and intergenerational trauma has been revealed in other familial contexts, such as with Holocaust survivors, it seems prudent to examine the impact of this phenomenon within military populations (Danieli, 1998; Lev-Wiesel, 2007; Steinberg, 1989; Wiseman, Metzler, & Barber, 2006).

In military families, secondary traumatization is seen as the transmission of the resulting distress from war experiences to offspring of veterans (Motta, Joseph, Rose, Souzzi, & Leiderman, 1997). Numerous studies have placed an emphasis on identifying the impacts of triggering events during combat in adults and the subsequent consequences observed in their children. Earlier research by Rosenheck and Fontana (1998) found that some overlap in endorsed symptomology between children and their father's in relation to their father's traumatic experience. Multiple clinical and empirical studies have reported the negative impact on family-functioning, emotional and psychiatric health, self-esteem, and overall distress levels of families, spouses and children, of veterans with PTSD (Davidson & Mellor, 2000; Dekel & Goldblatt, 2008). Research focusing on the impact of parental use of violence in the home, suggests a greater negative impact and effect on intergenerational transmission of trauma from the consequences of the diagnosis than the diagnosis itself as well as greater prediction of behavior problems, decreased school performance, and reduced social competence (Dekel & Goldblatt, 2008; Harkness, 1993). Beckham, Braxton, Kudler, Feldman, Lytle and Palmer (1997) found that children of Vietnam veterans were more likely to report using illegal drugs (more than 50%

of participants interviewed reported using illegal drugs) and were at increased risk for behavioral problems and PTSD.

According to the literature, measuring trauma symptoms in children of military members has been under-researched. Of particular underrepresentation has been research examining possible protective and resiliency factors that serve to mitigate trauma transmission. One study sought to identify pathways for transmission of intergenerational trauma through assessment of factors unique to military personnel and their families (Pearrow & Cosgrove, 2008, p. 77). The study recognized the damaging effects of PTSD and the impact on those around them including their spouses and children while acknowledging the lack of research that exists examining the experience of the female veteran in relation to PTSD and its subsequent impact on the family unit (Pearrow & Cosgrove, 2008). Existing studies have used various measures such as general demographic questionnaires, the CAGE, the HTQ-BH version, and measures designed specifically for the study designed to screen for neurotic, behavioral, and emotional problems. Results seem to indicate that questionnaires with more open-ended questions allow for broader and potentially novel information.

“If anything, the parallels between the recent wars in Iraq and Afghanistan and the war in Vietnam have helped to ensure Vietnam’s continued relevance, as soldiers in the Global War on Terror have looked to the culture of the Vietnam War in the hope that it would guide them in the struggle to define their own war,” (Ross, 2013, p. 342). War generations have their own culture, politics, and practices based upon their context and the unique experiences associated with growing up during a time of conflict and political unrest. Certain characteristics develop as part of the membership in a war generation regardless of personal or familial military status. In 2012,



Ail Hickey wrote about the hardiness, resourcefulness, and tenacity of war generations that develops through experiences such as standing in line for potato peels, watching the cruelty dealt to Jewish people by Nazis, and waiting for the next air raid to strike. These experiences are unfathomable to those existing outside of a war generation; they have not had to consider whether they were in support of the war and their country's military or against it. Those outside of a war generation have not kissed their children and spouses good-bye unsure if they would see them again or they would be lost to the fight, a martyr to the cause. War generations often have great political divides and can create a somewhat us versus them mentality between military/military supporters and those opposed to the war and not in support of the military.

The majority of the previous research was based on children of parents involved with military conflicts from the 90s and earlier, as those children were adults and available to participate in studies. As such, it proves more challenging to find research on children of veterans who served during Desert Storm, OEF, and IEF as those children are just now reaching adulthood and become able to participate in retrospective studies about their experiences as military children. In 2010, Weiss and colleagues set out to propose a military specific genogram to be used as part of the assessment process to allow for culturally appropriate interventions for military families (Weiss, Coll, Gerbauer, Smiley, & Carillo, 2010). Military children have unique needs that need to be addressed as part of services, including mental health, impacts of deployment, reintegration of the family post deployment, war-related trauma of the returning veteran parent, and experiences of reservist families (De Pedro et al., 2010). Wadsworth and colleagues, sought to identify frameworks and theoretical approaches to be used to fill in the

gaps in treatment and services to veterans in order to improve the support provided to military families (Wadsworth, Lester, Marini, Cozza, Sornborger, Strouse, & Beardslee, 2013).

## Review of Literature

### Intergenerational Trauma

**Definition.** Existing literature has demonstrated that the often long-standing negative impacts of traumatic experiences are not exclusively reserved for the individuals whom directly experienced the traumatic event and that the effects can be far-reaching and observed in their environment with family, friends, and caregivers (Dekel & Goldblatt, 2008; Figley 1995; Pearow & Cosgrove, 2008). This vicarious experiencing of trauma and associated negative consequences is often referred to as secondary traumatization or intergenerational trauma (Figley, 1995). Figley (1995) further identifies this phenomenon as the list of symptoms endorsed by people who have been exposed to traumatic events indirectly and secondarily.

### Psychological Responses to Intergenerational Trauma

**Symptoms.** The psychological symptoms and effects of secondary traumatization include several posttraumatic responses including difficulty trusting in relationships, intrusive unwanted images, increase feeling of vulnerability, and numbing of emotions causing stress and dysfunction in their lives (Danieli, 1998; Dekel & Goldblatt, 2008). Research has shown subsequent negative impacts on children's emotional, behavioral, social, and cognitive development including, but not limited to, anxiety, aggression, increased suicide rates, separation anxiety, regressive behaviors, poor social adjustment, attachment issues, and adjustment issues, following parental combat exposure resulting in diagnosis of Posttraumatic Stress Disorder (Ahmadzadeh & Malekian, 2004; Dias & Sales, 2009; Lev-Wiesel, 2007; Rosenheck & Fontana, 1998). Emotional problems (Parsons, Kehle, & Owen, 1990) and elevated endorsement and presentation of behavioral disturbances, as well as increased rates of depression are also

associated with children of fathers who have been exposed to traumatic events. Overall, children of combat Vietnam veterans reported an increased symptom list matching criterion associated with Posttraumatic Stress Disorder, including, but not limited to, reduced presence of social support, increased presence of suicidality, and higher experiences of guilt, in comparison with children of non-combat veterans and can replicate those presented by the individual that experienced the trauma (Figley, 1995; Rosenheck & Fontana, 1998). Furthermore, “Learning that the traumatic event(s) events occurred to a close family member or close friend” has been added to exposure diagnostic criteria of Posttraumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual- 5<sup>th</sup> Edition (DSM-V).

**Posttraumatic responses.** Secondary traumatization can include various posttraumatic responses including intrusive imagery, heightened sense of vulnerability, emotional numbing, and difficulty building trust in relationships (Dekel & Goldblatt, 2008). Previous clinical and empirical studies have revealed reduced levels of self-esteem, increased family distress, reduced family functioning, as well as emotional and psychiatric disturbances in both wives and children of Vietnam Veterans with PTSD, including but not limited to higher rates of anxiety, aggression, and depression (Ahmadzadeh & Malekian, 2004; Davidson & Mellor, 2000; Dekel & Goldblatt, 2008; Harkness, 1993; Lev-Wiesel, 2007; Parsons, Kehle, & Owen, 1990; Rosenheck & Fontana, 1998a). Additional research focusing on the children of Vietnam veterans found that the father’s combat exposure and resulting PTSD were positively correlated with development of maladaptive emotional, behavioral, social, and cognitive functioning including substance use problems and significant endorsement of PTSD (Beckham et al., 1997; Dias & Sales, 2009; Rosenheck & Fontana, 1998b). Furthermore, research has found that children of veterans raised

with fathers who were violent showed an increased likelihood to have behavior problems, lower school performance, and poorer social competence in comparison to children of veterans without reported violence displayed by their fathers (Harkness, 1993; Rosenheck & Fontana, 1998).

### **Parenting & Parent-Child Relationship**

**Impact of parental trauma exposure.** Research has also shown the impact of the parent's traumatic exposure on parent-child relationships. Studies suggest that these impacts may be observed in parents' ability to relate to their child and subsequently, in the attachment that is formed between parent and child (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009). Parental distress as a result of their own trauma experience can create a barrier to developing an awareness of their child's emotional dysregulation (Kaitz et al., 2009). The means in which information about the trauma is communicated to children can be another important component affecting the parent-child relationship. Dekel and Goldblatt (2008) identified communication between parents and children as a vital factor in the intergenerational transmission of trauma; Lack of appropriate dialogue about the parent's trauma history may create negative consequences for the child (Dekel & Goldblatt, 2008; Kaitz et al., 2009). Verbal and/or nonverbal communication about the traumatic event have both been shown effective in increasing the child's understanding of the parent's emotional experience; However, with or without communication about the traumatic event it appears the likelihood for intergenerational transmission of trauma remains constant (Danieli, 1998; Kaitz et al., 2009). In discussing the specifics of the trauma there is a risk that parents, due to the impact of their trauma fail to consider their child's perspective, relay the details of their trauma too vividly including frightening aspects that may not be appropriate to tell a child (Abrams, 1999; Ancharoff,

Munroe, & Fisher, 1998; Kaitz et al., 2009; Kosslyn, 2006). It should be noted that age appropriate communication about the parents' trauma is important for the child, without this disclosure the child may fill-in the gaps in the story with their own misinformed fears and distortions (Coates, Schechter, & Forst, 2003; Joshi & O'Donnell, 2003; Kaitz et al., 2009; Stuber et al., 2002).

Emerging literature on parental trauma history and its effects on parenting reveal noteworthy correlations. One study found that parents' own abuse histories increase negative consequences in the parenting role, including the use of more punitive, aggressive and physical discipline (Banyard, 1997). Banyard and colleagues (2003) found correlations between higher levels of trauma exposure and decreased levels of parental satisfaction, reports of child neglect, use of physical punishment. Furthermore, the impact of post combat PTSD symptoms on veterans' family life suggests that both male and female veterans' PTSD symptoms are associated with decreased levels of parenting satisfaction (Berz et al., 2008). Palmer (2008) found parental satisfaction and poorer attachment levels with their children, possibly resulting in secondary trauma and increased risk for mental health problems in a study of male Vietnam veteran's with PTSD. Additionally, research on PTSD suggests increased risks as a result of negative parent-child interactions, which appear to be related to some degree to the how parenting skills, attachment, hostility, and violence are impacted by PTSD symptoms and impairment for military children, in comparison to their non-military same-aged peers. The far-reaching consequences of parental PTSD symptoms include negative impacts on parent's functioning as well as reduced ability to parent effectively (Cohen et al., 2008).

## **Protective Factors/Resiliency**

**Definition.** The Child Welfare Information Gateway, a service of the U.S. Department of Health and Human Services defines protective factors as, “conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities that, when present, increase the health and well-being of children and families. Protective factors help parents to find resources, supports, or coping strategies that allow them to parent effectively, even under stress” (Child Welfare Information Gateway, 2017). Resilience, a prominent and well researched protective factor, has been described as the display of positive adaptive behavior in response to traumatic events (Agaibi & Wilson, 2005). Very few studies have assessed the development of resilience among children of veterans that may be result of adaptive coping, parenting style, and healthy attachment. Veterans and their families are known to be highly resilient and it would prove beneficial that further studies not only examine negative outcomes of having a parent with PTSD, but also the benefits and opportunities for Post Traumatic Growth, and how these might reduce the prevalence of PTSD among the children of veterans who also experience combat (Agaibi & Wilson, 2005).

Palmer (2008) reviewed literature on risk and resilience factors of military families in relation to various pertinent issues including frequent relocation, deployment, exposure to combat and PTSD, and post deployment reunion (p. 205). The article sought to examine the effects of parental stress and associated psychological diagnoses and their resulting impact on children to reveal resilience factors that may be utilized in future intervention efforts (Palmer, 2008, p. 205). Palmer suggests that parent-child interactions are a vital mechanism impacting military children. Furthermore, Pearrow and Cosgrove (2008) proposed that if protective factors

could be identified then preventative treatments could be enhanced in order to aid and support traumatized veteran parents to act as nurturing and effective parents in spite of the difficulties that they are experiencing as a result of their military service. While some resiliency factors have been considered, they have yet to be fully examined in an in-depth study that could reveal the extent to which these protective factors may prevent or ameliorate the impact of intergenerational transmission of Posttraumatic Stress Disorder in military populations (Palmer, 2008, p. 211).

**Posttraumatic growth.** Research of veterans and their families must also consider the potential positive gains associated with military service, war, and combat. This means not only considering resiliency, but also realizing that in some cases emotional growth can occur as a result of traumatic experiences. Tedeschi and Calhoun (1996) identified five factors that describe the primary domains of posttraumatic growth: greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or paths for one's life; and spiritual development. Elder's life-course perspective (1985) takes this possibility into account recognizing the growth that some veterans experience as a result of their combat exposure. This growth aids in dealing with difficult life circumstances as they arise and may prove to be a mitigating factor in the transmission of trauma to the next generation. Thus, it can be said the past can be used as a resource for coping.

## **Coping**

**Definition.** In defining coping, differences between developmental stages must be considered. The same standards and expectations used to define and evaluate coping



mechanisms in adulthood are different than developmentally appropriate coping in childhood and adolescence. Perhaps the most widely used definition of coping, “constantly changing cognitive and behavioral efforts to maintain specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984). The ability to successfully cope with and respond to stressful events and situations can be seen in individuals through emotion management, regulation of behavior, constructive thinking, and adaptive control of autonomic arousal (Compas, Connor-Smith, Saltzman, Harding, & Wadsworth, 2001).

**Adaptive coping.** Successful adaptive responses to traumatic events are more common than is often reported and discussed, the human capacity to positively respond to stress and cope effectively is not as rare as one might believe. Bonanno (2004) discussed this, “those who cope well with violent or life-threatening events are often viewed in terms of extreme heroism.” Bonanno and colleagues (2002), found strong evidence that many bereaved individuals will demonstrate little or no grief and these people are not cold and unfeeling but, instead, are adaptively coping with their stress.

**Factors that support adaptive coping.** Various factors have been identified and discussed in relation to adaptive coping including post deployment social support, the general process of self-regulation of emotion (emotion-focused coping), problem-focused coping and active task oriented coping, and the use of positive emotion and laughter (Bonanno, 2004; Compas et al., 2001; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Previously, use of positive emotion in response to traumatic and stressful events was dismissed as unhealthy and even worse so, a form of denial (Bowlby, 1980). Furthermore, the dynamic process of coping

involves continuous, purposeful responses aimed at resolving the negative impact of the stressful event or addressing the associated negative emotions experienced as a result of the event (Compas et al., 2001).

### **Military Cultural Context**

**Impact of deployment.** In 2014, Patricia Lester and Eric Flake used the deployment cycle in order to help explain the experiences of military families. The deployment cycle consists of five phases: pre-deployment, deployment, sustainment (period during deployment), redeployment, and post-deployment (Lester & Flake, 2013, p. 124). This cycle examined the range of emotions that children and spouses feel as the service member leaves, re-enters, and often must leave again. Lester and Flake set out to identify the impact of this process on children, what aspects of this process pose the most psychological risk to the child, and what resiliency related resources do these families possess (Lester & Flake, 2013, p. 121). When one parent is taken out of the system, the system must adjust to function without that member; this shift serves to maintain homeostasis within the system, but there may be difficulty when the missing member returns to take their position and the system must return to its previous state. Military families may be faced with challenges as a result of these changes in the system, “if boundaries change during deployment, the family may have trouble readjusting when the service member parent returns home, for example, a child may not want to give up newfound autonomy” (Lester & Flake, 2013, p. 127).

**Attachment theory.** Using attachment theory to further understand the effect of this absence on military children it is suggested the stronger belief in the parent’s ability to protect the child the more tolerable the experience will be for that child (Lester & Flake, 2013). The

strength of the parent-child relationship can be a major defining force as to whether the child views this cycle as unbearable or acceptable. Prior research focused on the impact the military family had on the veteran and their ability to assimilate back into the system, Vietnam era changed this approach and inspired a great deal of research about the family itself (Lester & Flake, 2013). Despite the stress, constant moves, and deployments military families consistently report high levels of strength and view their experience as rewarding (Lester & Flake, 2013). In order to continue serving this growing population, we must continue to study their needs in efforts to provide them with additional resources to further support the resiliency they have shown.

**Impact on perception of trauma.** Additionally, military culture is an important factor when interviewing military families. As discussed earlier, the way we identify culturally influences how individuals perceive their trauma as well as the impact they experience from that event or situation (De Pedro et al., 2011). Cultural identification is not limited to race or ethnic background. Military culture breeds a specific individual with a certain view of themselves and the world around them. In military families, “The family must learn to grow and adapt its natural growth and development to the rigidity, regimentation, and conformity that is required within the military system, as these characteristics often extend from the world of the service member into the structure of the home” (Hall, 2011, p. 8). As a result, the function and structure of the military family mirrors the structure of that system that it exists within. This type of existence can create various traits including secrecy, stoicism, and denial (Hall, 2011). These traits are housed in family unit with individuals who are proud of their service and may view

seeking treatment as weakness. This potential view of treatment seeking behavior as weakness can often lead to a delay or absence of services and support when they are needed (Hall, 2011).

**Honor.** However, we must not forget the importance of understanding honor and what that means to military members and their family members. In working with this population, “it is important to give due attention to the concept of ‘honor’ that is so central to the psychology of the military, and so central to male psychology” (Hall, 2011, p. 15). While asking questions and probing into the lives of these individuals, it is vital that one not imply that this person views their role in a military family as a burden; literature indicates that this is not likely true and they are proud of their service and sacrifice.

**Demographic differences.** Important factors such as age, birth order, and gender have been analyzed and found to impact one’s ability to cope with the trauma they experienced (Dekel & Goldblatt, 2008). In one study, researchers interviewed adult children of military members that developed trauma as a result of their military service and found that the effects of trauma they reported varied based on environmental factors apart from the relationship with the traumatized parent (Dekel & Goldblatt, 2008). The results indicated that the children were impacted by societal factors and their experience or lack of trauma symptoms was not solely a byproduct of the relationship with the traumatized caregiver. Literature indicates that often the relationship with the present caregiver is strengthened as a result of the often long and sometimes repeated absence of the military parent. The result of the tight bond that forms in the remaining family members may even be so solid that it keeps the military parent out (Hall, 2011, p. 11). In some cases, families, “may become so comfortable in their roles without the military parents that

when service members return, they simply put up with the intrusion, knowing that it won't be long before it ends" (Hall, 2011, p. 12).

**Negative impacts on family life.** While family is a priority in military culture, the culture itself can have negative impacts on family life. Deployments, relocation, frequently switching schools, and the stress of family separation can be detrimental to military families (Ruff & Keim, 2014). Spouses often spend great amounts of time apart, acting as single parents, and left to deal with all the financial, emotional, and other needs of the family members left behind while their loved one is deployed. This separation can put strain on intimate partner relationships and negatively impact the connection between the deployed parent and their child (Lester & Flake, 2013). Frequent entry and exit from the home can lead to insecure anxious attachments between parent and child. Children may be less trusting in their parents' ability to provide the necessary safety and security while their parent is also contending with their responsibilities as a military member during a time of war (Lester & Flake, 2013). There can also be a sense of separation or isolation experienced by military children who have been relocated to other countries or away from familiar base communities where they enjoyed community and connection (Wingo, 2002). While many children fondly remember their experience as "military brats," and report enjoying the somewhat nomadic adventure of moving to new places, meeting new people, and attending new schools, some adult children report feeling as though they are "recovering," from those experiences (Wingo, 2002).

**Minorities and subcultures.** Furthermore, ethnic minorities and persons who are impoverished are more likely to enlist and their cultural resources should be considered as potential protective factors and coping strategies. These subcultures within the military culture

present with their own unique factors. Closer familial, cultural, and religious supports that may be in place in minority and/or impoverished communities may serve as additional protective factors or means for coping (Weiss et al., 2010, p. 399).

### **Critique and Need for Further Study**

**Current study.** The goal for the current study was to assess the adult children of traumatized military parents and their symptoms in the service of attaining further insight into various contextual and protective factors, and factors related to resiliency that are associated with intergenerational transmission of trauma. These factors were explored through interviews with adults who were raised by parents that developed trauma symptoms as a result of their military service. It also examined the coping mechanisms that these individuals have adopted and practiced compensating for the stressors in their environments. Additionally, the current study will not only focus on the relationship with the traumatized parent, but the relationship with the other caregiver as well. This additional focus attempted to analyze the effect of the relationship with other caregivers as a source of support, resiliency, and possible preventative factor against the transmission of trauma. The research previously conducted has been focused on the negative impact on the child as a result of the relationship with the traumatized parent rather than possible protective and resiliency factors that may exist.

### **Focus and Scope of Project**

A retrospective qualitative analysis was performed in order to gather the information needed to complete this study. The researcher interviewed participants after brief self-disclosure is offered in an effort to foster a sense of safety and understanding to encourage more detailed participant disclosure. Questions pertaining to caregiver's military service, age at time of

caregiver service, length of caregiver deployment, details about caregiver past and current trauma symptoms and diagnosis, past and current coping skills, and past and current effects of subjective trauma exposure. Volunteers will be provided with resources and information for support groups for people living with trauma issues in the event that interviews are triggering.

**Research questions based on issues related to military families that were used.**

- Research Question 1: In what ways have experiences in this military family contributed to growth and/or lead them to feel a sense of resiliency?
- Research Question 2: What role did the non-military parent or caregiver play in the individual's development? How did the relationship with that person/s impact how the individual coped with and understood the military-related trauma his or her parent experienced?
- Research Question 3: What specific characteristics of the relationship with the non-traumatized caregiver do they feel were most impactful and protective?
- Research Question 4: In what ways have these characteristics possibly benefitted their self-concept or help them develop resiliency?

## Methods

### Research Design

Approval from Pepperdine University's Institutional Review Board was obtained prior to data collection. A qualitative, retrospective design was utilized for the purposes of this study with an interpretive phenomenological inquiry strategy. Interpretive phenomenological analysis (IPA) seeks to understand one's lived experience. Jonathan Smith started this approach in 1996, when he argued for an experiential approach that could be entered into mainstream psychology. Since then, this type of structured, qualitative approach has become more popular in both health care and psychotherapy. IPA understands that it is impossible for the researcher to gain access to a person's direct experience, but attempts to understand idiographic accounts of people's views and perceptions of how they make sense of their world. The idiographic approach is particularly effective for this study because it seeks to understand an individual's perspective in a context (Finlay, 2011).

The volunteers were interviewed one time only. Phenomenological research looks at the meaning of several individuals' life experiences of a concept or phenomenon. The idea is to review individual experiences and describe what individuals experienced in relation to a specific life event (Creswell, 2007). A convenience sampling method was employed for this study. A flyer was created to promote the study and gather volunteers. The experimenter requested permission from organizations providing services to veterans and their families to display flyers in the hopes of obtaining at least six volunteers. While other research methods may require larger sample sizes, phenomenological research yields a large amount of information from each participant and therefore requires fewer subjects in the study (Morse, 2000, p. 4). Additionally,



the flyer was posted online through social media platforms (i.e., Facebook, Instagram, & LinkedIn) to increase the likelihood of reaching potential participants. Due to the potential importance of identification and understanding of military culture, the experimenter disclosed background information regarding being part of a military family and personal motivation to conduct this study. Self-disclosure (Appendix E: Script for Self-Disclosure) was used in the hopes of increasing rapport with interviewees and allowing for a greater level of personal disclosure regarding sensitive material related to their membership as part of a military family.

### **Setting and Participants**

Interviews were conducted at the Pepperdine University Graduate School of Education and Psychology, Malibu Campus. Six adult volunteers, who were raised by a caregiver that suffered from trauma symptoms as a result of their military service, were interviewed. Inclusion criteria developed as requirements to participate in this study: (a) be a child of a military member that suffered from trauma symptoms as a result of their service, (b) be at least 18 years old, and (c) be a civilian. Exclusion criterion that would prevent participation in this study: (a) a person who is intoxicated at the time of interview or (b) is currently suicidal (as determined by suicide assessment to be performed prior to interview). Participants whom did not satisfy the criteria were not considered for the study.

### **Procedure**

Potential participants contacted the examiner via the email address listed on the flyer. The examiner responded via email and set up a phone interview. During the phone interview potential participants were screened to be sure that they met the inclusion criteria for the study. Once initial inclusion criteria were met, an appointment was set for the in-person interview.

Prior to beginning the face-to-face interview informed consent was obtained given, which included asking participants if they were sober; all participants confirmed that they were sober at the time of the interview. As part of the informed consent volunteers were informed that in the event they should become distressed they had the option of skipping a question, taking a break, or stopping the interview. The experimenter used clinical judgment throughout the interview to continually monitor for signs of distress. Specifically, if the participant became tearful, fidgety, began perspiring excessively, became pale, appeared to have trouble breathing, or appeared to have difficulty concentrating the experimenter asked the participant if they were able to continue the interview. Interviews were audio recorded. Volunteers were informed of this requirement and consent for audio recording was obtained. If for some reason, a volunteer objected to being recorded then their interview would stop, and they would no longer be a part of the study; no volunteers objected, and all interviews proceeded as planned.

Prior to the interview, participants were given a demographic measure (Appendix D). This measure was used for descriptive not predictive purposes to better understand the sample. Additionally, the researcher disclosed information about her own status as a member of a military family as well as motivation to increase services available to military families as a result of being raised by a veteran. Volunteers received a prepaid gift card in the amount of \$20.00 as compensation for their time, not to exceed 2 hours.

The interview consisted of questions about the participants' childhood experiences with special attention to their relationships with their caregivers. Specifically, questions related to their knowledge of their parents' military experience, any resulting trauma they sustained as a result, and impact of these factors. While these questions are sensitive and ask for private

information to be shared, they are important in order to gain increased understanding of the effects of parental military trauma on children.

In addition to questions related to knowledge of caregivers' trauma, demographic, and chronological are also relevant. Questions about their age at time of parents' deployments, their and place in birth order were asked in the form of a demographic measure that was given as part of the interview. Furthermore, questions were asked in order to assess volunteers' awareness of any non-military trauma exposure that their parents' might have experienced.

Initially, the questions started with more open-ended questions that allowed for a broader range of responses. This was done in hopes of revealing some new information that may not have been reported due to limiting of responses through more close-ended questions asked in previous studies. Specifically, the researcher asked a series of more open-ended questions related to the relationship with the other caregiver. Previous research has not fully explored the other parent as a possible protective factor for children coping with a parent that has been traumatized. This study aimed to fill in that gap seen in existing literature.

### **Data Recording and Analysis**

All interviews and were audio recorded and transcribed by the researcher. Participant data was protected and deidentified by assigning a numeric code for reference in all subsequent documentation. After all interviews were transcribed, the researcher reviewed transcripts and found pertinent information and themes born from the data. Two independent coders and an auditor were used in order to increase validity. Interrater reliability was evaluated once all coding and audits were completed. The interview questions were formulated to increase understanding of the participants' experience within their military family context.

The researcher analyzed each participant's experience separately and searched for common themes across cases. The IPA approach was utilized for this study because the researcher was attempting to better understand the protective factors of children in military families, particularly the relationship with the other caregiver that decreased the transmission of trauma to the next generation. However, the researcher did not want to over generalize the protective factors of these individuals, and therefore the researcher looked at each case individually first, and then searched for common themes among the participants. Analysis was performed this way to generate more hypotheses as to how this population has been able to mitigate the risk of intergenerational transmission of trauma. For these reasons, the IPA approach was used for this study.

The analytic process in IPA includes several steps. The analysis began with each individual case, with line-by-line coding, which looked at the understanding and concerns of each participant. Themes were then identified, emphasizing both convergence and divergence. Themes were identified across both individual and group cases. In order to qualify as a common theme more than one participant had to discuss the topic during their interview. A Psy.D. student coded two interviews with the primary researcher and compared results. The researcher's dissertation chair, Dr. Thema Bryant-Davis, audited the codes to ensure that they were valid. Neither party has a military background, but they both have experience with qualitative research and a background in trauma and family psychology. A dialogue between the researchers, their codes, and the knowledge concerning what the coded data meant for the participant was then conducted. That led to a development of an interpretative account as well as a structure that illustrated the relationships between the themes. The coded data was then

organized, and a narrative was developed so that the reader could trace the interpretation on a theme-by-theme basis. Lastly, a reflection was done on the researcher's own perceptions and conceptions (Larkin & Thompson, 2011). The researcher compared the protective factors that the volunteers utilized with the current research that has been published.

### **Ethical Considerations**

Engaging in a discussion about private family experiences, trauma, and lasting effects of that trauma can be stressful for both the researcher as well as the participant. With this in mind, prior to the delivery of any interview questions participants were informed that they can choose to stop the interview or take a break at any time in the event that the questions became too upsetting, as well assured that they were under no obligations to answer all of the questions. They were also provided with a list of local mental health providers (Appendix H) should they need to seek services after participation in the study. Adults, who were raised by a caregiver with trauma as a result of their military service, were interviewed, as it could pose ethical complications to interview minors currently struggling with the impact of their caregivers' trauma.

### **Researcher Reflexivity**

I am a 37-year-old, Caucasian, married, middle class, bisexual, English speaking, college educated, consumer of mental health services, born in the United States of America, who has never served in the military, but was raised in a military family in which most of the men are veterans. My personal characteristics and life circumstances have acted as sources of power and privilege and thus shaped my view point and dictated my life experiences. I do not know what it is like to be a minority or the experience of having less resources as a result of lower

socioeconomic standing. I hold a very positive view of the military and military culture as a result of the opportunities this life has provided my family. My father was a Vietnam era Marine and used his GI bill to finish his undergraduate degree and attend law school, becoming the first member of my family to attend college. This allowed my father to obtain a successful stable career as an assistant state attorney with an income that enabled him to provide myself and my two brothers with private school educations and college funds. My father is proud of his military service and his pride motivated my older brother to enlist in the Marine Corps after the events of September 11<sup>th</sup>, 2001. My brother has served both as an active duty Marine, being deployed multiple times during OIF/OEF, and a reservist. My older brother utilized the military's support to attend Law school and plans to divide his GI Bill benefits between his two children.

While their experience in the military had both positive and negative impacts on them, neither my brother nor my father have endured significant longstanding trauma; their experiences have not trickled down to their children in a negative or traumatic way. While there was some rigidity in my father's personality, that I attribute to his military experience, I believe this instilled strength, motivation, dedication, ambition, responsibility, and a duty to serve and protect others in myself and my brothers. I firmly believe that my father's military experience helped shape him into a parent that motivated me to reach for the stars and excel in all areas of my life. I do believe that with this duty also came a heavy pressure that made failure or anything less than perfection unacceptable. Given my perspective, I believe it can be difficult for me to see the possible negative impacts of military culture or detrimental effects on the family. My father's decision to join the military was the catalyst that shifted my family from blue collar, lower socioeconomic standing of a coal miner to the middle- class existence of an attorney, in one

generation. It is through this lens that I operate, and I must be aware of this as I process and digest the findings of the study. If I fail to consider my own characteristics, I risk misinterpreting someone else's experience as a result of my biases.

## Results

### Overview

Table 1.

*Major Themes / Subordinate Themes.*

Major themes	Subordinate Themes
Personal/psychological protective factors	Sense of Humor, Personal Strength, Compassion, Empathy, Forgiveness
Healthy Coping Strategies	Social Support, Help Seeking
Unhealthy Coping Strategies	Escape, Substance Use, Eating Disorder, Disconnection
Neutral Coping Strategies	Avoidance
Positive Outcomes of Protective Factors	Post-Traumatic Growth, Benefits of Non-Military Parental Support

### Personal/Psychological Protective Factors

The adult participants of this study reflected on their lived experiences in the context of being raised by a parent with a trauma diagnosis related to their military experience in order to identify protective factors. One major theme that emerged: *Personal/psychological protective factors* resonated as particularly important in how these participants conceptualized their traumatized parent and coped with their own experience. This major theme overarches four subordinate themes: (a) *Personal Strength*, (b) *Humor*, (c) *Compassion/Empathy*, and (d) *Forgiveness* (Table 1). Personal characteristics encompassed a sense of humor and personal strength that surfaced as a means of persevering through a tumultuous childhood with a parent coping with military-related trauma. These personal characteristics served as psychological protective factors which created a sense of understanding and shaped a perspective that allowed



for compassion, empathy, and forgiveness for the attitudes and actions of the traumatized parent rather than a stance of blame for either parent or child in the negative interactions.

Table 2.

*Personal / Psychological Protective Factors.*

Major themes	Subordinate Themes
Personal/psychological protective factors	Sense of Humor, Personal Strength, Compassion, Empathy, Forgiveness

Participants described and reflected upon the individual factors (See Table 2) they possessed and principles they utilized that aided them in persevering through their early childhood experiences and allowed them to view their traumatized parent in a less stigmatizing manner. Personal characteristics including, a sense of humor and a belief in their own personal strength provided participants with relief from the negative impacts of trauma in their home and instilled hope for a better future. A sense of understanding in the form of compassion, empathy, and forgiveness allowed for a less judgmental view of the traumatized parent to exist, free from blame and resentment.

**Sense of humor.** A sense of humor and a belief in one's own personal strength were identified by participants as key protective factors. Participants utilized humor to distract from negative emotions and experiences while coping with the negative impacts of their traumatized parent's actions.

I was always acting playful, so I think I was putting on a show, I would kind of make people laugh when there was conflict or try to minimize the conflict through laughter, being silly or making light of the situation. (1-9292018).

I make people laugh, it is my coping mechanism...My humor keeps me safe...You know laugh rather than cry. (5-02042019).

I would try to make things funny or try to lighten things up...I did always feel like I tried to make people laugh in a stressful situation. (6-02192019).

**Personal strength.** The belief that one had the strength to withstand the pressures present in their home environment was identified as an important protective factor that instilled hope. The journey was described as something that molded them into the adult they are today.

I remember thinking, like when I was younger like a teenager 13,14, 15, or 16, if I survive what I survived with my dad that I'm a very strong person. And I will be okay. (2-09292018).

I had to um go through that and it made me who I am today. I wouldn't take that back. (3-12182018).

**Compassion and empathy.** Participants felt that it was necessary to develop a sense of understanding for their parent's condition that allowed them to practice compassion, empathy, and forgiveness despite the negative situation they might have endured as a result of the parent's actions and/or attitudes. Practicing compassion and empathy towards their parent's rather than blame, anger, and resentment allowed for positive and warm feelings towards that parent to exist. As adults, they reflected on how they could help their parent.

I think there needs to be more support; well, in terms, of understanding what people who have been in combat have gone through and that impacts their sense of safety. (1-09292018).

I think we have to like remind the parents of the kids that they're not in a war zone anymore. (1-9292018).

I hold compassion for the challenges that he (Dad) experienced...I'm able to. I think, see people in their challenges in a way that is um deeply empathic. (1-09292018).

So just have to have some sort of compassion and forgiveness for where they are. (3-12182018).

**Forgiveness.** Participants reported that being able to forgive their parent for the negative and abusive, in some cases, interactions relieved them of harboring destructive feelings of resentment and created a space in which a new relationship with that parent could be created. Participants reflected on the relationships they were able to have with the traumatized parent later in life. A retrospective forgiveness was granted to the traumatized parent or the other caregiver.

So, I think, that I have been able to have forgiveness and be a bit more individuated. (1-09292018).

I am able to have forgiveness and I think that is a strength. (1-09292018).

And as much as I try to understand what it was like for my family, I'll never understand.

It is hard for them to let it go and I just need to be forgiving and remind them they are not in a war zone anymore. (2-09292018).

Forgiveness, the answer is forgiveness. I think had I not forgiven my Dad, I would not have had the relationship that had with him. (2-09292018).

I learned that my mother did the best she could with what she had. (4-011319).

But what I didn't realize was that he was just doing the best he could with the tools he was given. (5-02042019).

### Healthy Coping Strategies

Table 3.

*Healthy Coping Strategies.*

Subordinate themes	Subordinate themes
Social Support	Parental, Nonparental
Help Seeking	Support Groups, Psychotherapy

The second major theme that emerged: *Healthy Coping Strategies* were a vital component in their early years. This major theme overarches three subordinate themes: (1) *Social Support* and (2) *Help Seeking* (Table 3). Social Support, both parental and nonparental, in the form of family, friends, classmates, sports, and other activities allowed for support, escape from the stressful environment, and positive interpersonal interactions outside of home.

#### **Social support.**

**Parental.** Participants reflected upon the positive impact of strong relationships with other caregivers that reduced the negativity and potential trauma in their early childhood environments. These relationships provided a sense of normalcy that allowed for a recollection of their early experiences not solely routed in trauma. The closeness of other caregivers was described as that of another parent.

I'm very close with my mom. Um she's very sweet and warm and strong and um very protective and fun. I have a very close relationship with my mom. (1-09292018).

My nana is to me like she she is my mom...Oh I am like very attached to my nana. (3-12182018).

My relationship um we [she and her mom] were really really really really close, really close. (5-02042019).

My mom and I always had a connection, always a deep connection. (5-02042019).

**Nonparental.** Participants described friendships and relationships with peers outside the home as necessary parts of their childhood, allowing for less stressful interactions free from the entanglements of their tumultuous home environments. Positive interpersonal interactions provided an alternate experience which balanced the unfortunate negative interpersonal interactions occurring with the traumatized parent and within the impacted home.

I was always sleeping over at my girlfriends' houses. I always had friends like close girlfriends. I was always away. (1-9292018).

I was distracted by social relationships. (1-9292018).

I also had a lot of friends. Most of the neighbors on our block were all my age. So we just had a big group of friends that were always playing or doing something. (6-02192019).

I get along well with others and that is a gift. (6-02192019).

**Help seeking.** Participants reflected upon the impact of other relationships in their early years. The presence of other supportive relationships was identified as a fundamental component of their childhood that provided the nurturing, emotional intimacy, and sense of safety that their traumatized parent was not always able to deliver. Participants also recounted the positive

effects of social support that allowed for escape from the negative home environment and experience of positive interpersonal interactions.

***Support groups.*** A specific element of the recovery process was the use of support groups. Participants discussed the benefits gained through attendance and participation in 12-step groups.

I've done therapy and as you know, I'm part of a 12-step program. We work through some of those things because if we don't deal with those tragic things in our history we're doomed to keep using them as an excuse to go out and relapse. (3-12162018).

I built a new family within the program. (4-01132019).

Yes, I would find later in a 12-step fellowship that I was so resentful towards my father which I thought he like abandoned us and just left then he made another family. (5-02042019).

***Psychotherapy.*** Another important piece of the recovery puzzle that emerged was participation in some type of therapy. Participants both identified it as helpful for them and recommended it for other children of military families.

Encouraging veterans and their families to engage in therapy is vital. (1-09292018).

But this affects families. They need to get help. Don't be afraid to tell whatever it is. (4-01132019).

Seek help, get some type of therapy. (5-02042019).

### **Unhealthy Coping Strategies**

The next major theme identified by participants was *Unhealthy Coping Strategies*. As part of this theme, (1) *Escape*, (2) *Substance Use*, (3) *Eating Disorders*, and (4) *Disconnection*

were identified as ways in which participants handled the trauma and negativity in their lives (Table 4). Participants discussed the various maladaptive ways in which they dealt with the stressors in their environments before they learned and implemented healthy means of coping later in life. They reflected on their attempts to soothe themselves and regain a sense of control in a chaotic and stressful environment.

Table 4.

*Unhealthy Coping Strategies.*

Major themes	Subordinate Themes
Unhealthy Coping Strategies	Escape, Substance Use, Eating Disorder, Disconnection

**Escape.** Escape in various forms (sports, drama, art, music, other creative means) was reported to provide relief and a break from the intensity of negative situations at home. One participant describes the means she used to distract herself and escape the situation.

I would check out and use music to cope. (1-09292018).

I was always digging holes and hiding in holes. So digging and hiding, I'd always try to hide or run off. (4-01132019).

**Substance use.** Drug and alcohol addiction was identified as a temporary tool used by participants until they worked through the issues that plagued them from their earlier life experiences.

I was already sneaking out and doing drugs and drinking at that point. Basically doing anything to escape. (1-9292018).

Drugs became my solution to the fucked up feelings. (3-12182018).

Ya know because I became a heroin addict and sold myself, did everything ya know and until I was told there's a lot of people that have through what you've been through that aren't using drugs. (4-01132019).

**Eating disorder.** One participant's temporary means of managing her negative emotions in a chaotic home appeared in the form of an eating disorder. She described a need to find something she could control in an environment that felt out of control.

I developed an eating disorder when I was hmm like in the 8<sup>th</sup> grade...so I felt like food was something I could control. (1-09292018).

I remember starving myself and thinking how control I was, feeling relief because I could go days without eating. (3-12182018).

I would go on mini hunger strikes and think 'ha I will show you.' (1-09292018).

**Disconnection.** Participants identified the need to escape through disconnection prior to processing their feelings and developing more desirable coping tools.

...the ability to shut off and go somewhere else is what you call it. Like when my Dad would rage and I would cower in the corner. I would just go somewhere else. (2-09292018).

I think that something I learned when my Dad was doing what he was doing like, I learned to just close things out. (2-09292018).

I would go somewhere else mentally, disassociation. (4-01132019).

I do isolate a lot...Even here at work, I will try and hide out. (5-02042019).



## Neutral Coping Strategies

Another major theme identified by participants was that of *Neutral Coping Strategies* in the form of (1) *Avoidance* (Table 5). Participants reflected upon the various means they used to help avoid the distressing things in their environment.

Table 5.

*Neutral Coping Strategies.*

Major themes	Subordinate Themes
Neutral Coping Strategies	Avoidance

### **Avoidance.**

So I would just put on my headphones and listen to No Doubt or whatever music to calm me down. (1-9292018).

She (Mom) would use distractions...Engage us with activities. (1-9292018).

## **Positive Outcomes of Protective Factors**

The final major theme that was identified through participants' reflections on their lived experience was *Positive Outcomes of Protective Factors*. The subordinate themes for this final category are (1) *Post-Traumatic Growth/Resiliency* and (2) *Benefits of Non-Military Parental Support* (Table 6). Post-traumatic growth (PTG) is a theory that explains the transformation that some experience following trauma. It was developed as a result of the research of psychologists Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, in the mid-1990s (1996). The theory of PTG posits that people who undergo psychological struggle following adversity can often observe positive growth afterward.

Table 6.

*Positive Outcomes of Protective Factors.*

Subordinate themes	Subthemes
Post-traumatic Growth Benefits of Non-Military Parental Support	Helping Others/Meaning/Purpose Nurturing, Emotional Intimacy, Sense of Safety

**Post-traumatic growth/resiliency.** Participants attributed their growth and resiliency to the work they've done through their efforts to recover. Those recovery efforts took the form of self-helps groups (i.e., 12 step groups) and therapy.

**Helping others/meaning/purpose.** A common theme among participants was a sense of growth and desire to help others on their recovery journey. They reported an increased understanding of meaning in their lives and a deepened sense of purpose as their aspirations were realized. Participants who reported experiencing trauma, believed that actively working on their recovery was a major component of their post-traumatic growth and identity formation. A strong desire to help and care for others was identified by participants. They reported feeling a calling to protect and provide services to other people are coping with similar feelings and challenges as a result of their life experiences. There also seemed to be a sense of duty to protect others who were still struggling with negative emotions or unable to stand up for themselves. Several participants were inspired to seek careers in which they were able to help others recover from mental health issues and traumatic experiences.

Because of the 12 steps and the many years of therapy that I've had, yeah I've grown. (2-09292018).

I think that my eating disorder recovery is like a very big part of my identity. I think this is where I started to want to help others for a living. It kind of helped develop my own intuition and um my own emotional capacity to sense the feelings of others. (1-09292018).

I'm a very protective individual towards people who cannot protect themselves. (4-01132019).

Being able to take those experiences and have a career and be in a profession where I can help others who have had similar experiences...I am able to um take my own negative experiences and kind of push them in a direction where I can help people and that feels really good. (1-09292018).

I want to be an EMDR therapist. After I finished mine, I wanted to learn to do that. (4-01132019).

**Benefits of non-military parental support.** Participants reported emotional intimacy provided by another caregiver was a crucial part of their formative years and served as a protective factor in future relationships. Another caregiver being able to foster an emotional depth in a relationship provided modeling that was transferable to relationships to be developed later in life. The other caregiver often provided the nurturing that the traumatized parent was unable to provide. Furthermore, a sense of safety was identified as a vital factor in developing a sense of security and trust in themselves, others, and the world that helped mitigate the potentially damaging impacts of the perceived danger in their home environments.

***Nurturing.***

Throughout my life, she was very nurturing, very much attentive to my needs, my emotional needs specifically. (1-09292018).

My nana was the caring nurturing mother, I never had, but always wanted. She took care of me in every sense of the word. (3-12182018).

My biological mother decided that she couldn't raise me on her own, physically, emotionally, or financially. Nana provided all the nurturing that she couldn't or wouldn't. (3-12182018).

I do feel closer to my mom now. Like she is somehow able to show the nurturing that I always knew was there. (6-02192019).

***Emotional intimacy.***

Mom was really, is really, like a mother goose and she would um she was open with her feelings. (1-9292018).

Like anything that I ever needed [emotionally] at any time, my mom was always there. (2-09292018).

***Sense of safety.***

My mom was my protector...My mom will come pick me up and save me. (2-09292018).

I'm very close with my mom. Um she's um very sweet and warm and strong and um yeah very protective and fun. (1-09292018).

I have a very trusting attachment with my mother. I trust her. She was very reliable and consistent throughout my life. (1-09292018).

So that [forgiveness] allowed for a new relationship with her and to create new memories. (4-01132019).

## Discussion

### Contributions

This study provides a unique perspective into the lives of adults who were raised in military families. In particular, the goal of this study was to obtain more information on the relationship with the other caregiver as a protective factor that possibly mitigated some of the intergenerational trauma transmission. The research question formulated in order to obtain the desired information were (a) In what ways have experiences in this military family contributed to growth and/or lead them to feel a sense of resiliency? (b) What role did the non-military parent or caregiver play in the individual's development? How did the relationship with that person/s impact how the individual coped with and understood the military-related trauma his or her parent experienced? (c) What specific characteristics of the relationship with the non-traumatized caregiver do they feel were most impactful and protective? (d) In what ways have these characteristics possibly benefitted their self-concept or help them develop resiliency? Previous research has been conducted in which adults were interviewed about the trauma they experienced within their home and about their relationship with the traumatized military parent. However, there was little existing research on the protective factors identified in those individuals whom despite exposure to trauma through contact with a traumatized parent did not go on to develop trauma or were able to experience meaningful post-traumatic growth after recovery from traumatic early experiences; of particular interest are factors such as the relationship with other caregivers and timing of parental trauma. It was the hope that through this study, the researcher would obtain more specific knowledge regarding the impact of other caregiver relationships

these adults possessed as children and use this information to improve existing and/or create new resiliency programs for military families.

*(1) In what ways have experiences in this military family contributed to growth and/or lead them to feel a sense of resiliency?* Participants identified several ways in which their membership in a military contributed to their personal growth. Perhaps the most salient theme among participants was the notion that their experience provided them with an enhanced understanding of their purpose in life and ways in which they can find meaning. An intense desire to help others was important to participants and heavily influenced their career choices.

*(2) What role did the non-military parent or caregiver play in the individual's development? How did the relationship with that person/s impact how the individual coped with and understood the military-related trauma his or her parent experienced?* The role with the non-military caregiver emerged as possibly the most crucial factor in the lives of participants. Participants described their relationship with the other caregiver as vital in their early childhood years, providing them a sense of security that their military parent was not able to provide at that time.

*(3) What specific characteristics of the relationship with the non-traumatized caregiver do they feel were most impactful and protective?* The relationship with the non-military caregiver provided nurturing, emotional intimacy, and sense of safety. These proved to be protective factors that mitigated the damage or even prevented transmission of intergenerational trauma in some cases.

*(4) In what ways have these characteristics possibly benefitted their self-concept or help them develop resiliency?* Participants expressed a belief that they could survive any life

circumstance they encounter. They attributed this belief to the positive characteristics instilled in them by their military family as well as persevering through some difficult situations within their family system.

This study emphasizes the longstanding impacts of a childhood wrought with the presence of parental military related trauma and the resulting emotional and psychological issues that developed in the participants' lives. Previous research has proposed various types of child and adolescent coping, including but not limited to, problem solving, information seeking, cognitive restructuring, seeking understanding, catastrophizing, emotional release or ventilation, physical activities, acceptance, distraction, distancing, avoidance, self-criticism, blaming others, wishful thinking, humor, suppression, social withdrawal, resigned acceptance, denial, alcohol or drug use, seeking social support, seeking informational support, and use of religion (Compas et al., 2001). The information revealed from this study suggests, even with no actual exposure to the traumatic experiences, in some cases, and often without any specific knowledge of their parent's trauma, participants were negatively impacted.

The way children and adolescents manage stress in their lives is a central factor in psychological adjustment and symptomatic of both internalizing and externalizing issues (Compas et al., 2001). Participants identified the use of unhealthy coping strategies including, escape, substance use, eating disorders, and disconnection. The use of escape included, fantasy, running away, hiding, and maintaining busy social lives to avoid the negative emotions in their environment. Substance use was also identified by four out of the six participants as an early means of coping utilized to manage their emotions. Three participants revealed, to create a sense of control in an environment in which they felt powerless, they developed an eating disorder.



Additionally, escape through disconnection emerged as commonly used unhealthy coping strategies among participants. These unhealthy coping strategies have previously been identified by people as ways in which they have dealt with trauma (Compas et al., 2001).

The concept of control emerged during interviews with participants. In particular, the desire to gain some control in an environment that feels chaotic and out of control. In Palmer's 2008 research on risk and resilience, frequent relocation, deployment, exposure to combat and PTSD, and post deployment reunion were studied in order to understand the impacts on military families. Findings from this review revealed the perceived loss of control created through these frequent and repeated changes. One participant described her relationship with her eating disorder as her means to have control over something in her life as she felt such a lack of control otherwise. The absence of control can leave an individual feeling vulnerable and helpless; Perhaps developing a sense of learned helplessness in which they feel almost a victim to their circumstances rather than an active participant in determining their fate. In 2001, Compas et al. compared volitional coping responses and responses that are automatized and not under conscious control. In considering an eating disorder, as described by the participant, it could be construed as a conscious attempt to gain control when suffering from a lack of control in other areas of one's life.

On a more positive note, this study also revealed several protective factors and subsequent growth that participants attributed to their experience as a military child coping with a traumatized parent. Personal strength, compassion, forgiveness, and humor were all reported to be important principles that participants practiced in order to lessen the negative impact of the parental trauma in their home environments. Furthermore, several participants identified their

early experiences and recovery process are the catalyst for their desire to help others and work in a capacity in which they help others recover from emotional and psychological difficulties.

The ability to adapt to stress and adversity is a significant aspect of human development (Compas et al., 2001). Personal strength was identified as a protective factor which contributed to a belief that participants would be able to persevere through trying times, thus enabling them to manage stress in the face of adversity. Participants recounted experiences during which they could have given up, but their inner strength propelled them forward and did not allow them to give up hope for better times.

“The interaction of forgiveness and compassion is a two-person mechanism to help bring about reconciliation in close relationships following an altercation or disruption in connection,” (Gilbert, 2005, p. 68). Participants discussed the positive impact of holding a compassionate and forgiving attitude toward their traumatized parent as crucial in reducing negative feelings towards them. The ability to conceptualize their parent’s struggle as a shortcoming that resulted in a limited capacity to tolerate emotional discomfort or stress in the environment rather than as a characterological flaw reduced negative feelings towards their parent. As a result of this empathic stance, participants were able to forgive their parent for their limitations and reduce feelings of resentment. The most longstanding and impactful forgiveness paves the way for the repair of damaged connections that may be stronger than the initial relationship (Gilbert, 2005). With this perspective of acceptance, they were more likely to have a relationship with their traumatized parent without the presence of unrealistic expectations. Furthermore, humor emerged as a common thread among participants. Utilizing humor and making light of tense circumstances served as a method through which participants diffused stressful situations.

A strong connection with another caregiver and the presence of positive a social support system, Parental and Nonparental, were also identified as protective factors that mitigated the potential damage of their parental military trauma. Kaitz et al. (2009) examined the impact of the parent's traumatic exposure on parent-child relationships and found these impacts may be observed in parents' ability to relate to their child and subsequently, in the attachment that is formed between parent and child. This study further highlighted the necessity for a connection and dependence on something other than the traumatized military parent in order foster a secure and trusting attachment during their childhood. As suggested by previous research, parental distress can create a barrier to developing an awareness of their child's emotional dysregulation and make attachment more difficult (Kaitz et al., 2009). The current study identified a connection with another a strong social support system, either parental or nonparental, as a factor allows for more secure attachment thus reducing the negative impact of parental trauma and decreasing the likelihood of transmission of intergenerational trauma.

The emphasis on the importance of the relationship with another caregiver was a recurrent theme across most participants. The other caregiver did not have to be a parent, could be a grandparent, aunt, or uncle. The key component of this other caregiver relationship was the ability to provide those factors that the traumatized parent was unable to deliver. Nurturing, a sense of safety, and emotional intimacy surfaced repeatedly among participants as vital protective factors that their other caregivers contributed to their lives.

A common theme among participants was a belief in the benefits of seeking help to cope with mental health and emotional issues. Support groups, such as Alcoholics Anonymous and

Narcotics Anonymous, were identified as beneficial for participants in developing and maintaining healthier tools for coping. Furthermore, participants acknowledged the importance of psychotherapy in their healing and growth processes.

Additionally, this study confirmed information found in previous research regarding the benefits of Non-Military Parental Support whether that support be parental or nonparental. Nurturance, emotional intimacy, and a sense of safety were all key results of a healthy positive social support system. If an attachment figure is nearby, accessible, and attentive, an individual will perceive a sense of love and security (Ghafoori et al., 2017).

Positive outcomes of protective factors and coping strategies emerged in this study in the form of post-traumatic growth. In 1996, Tedeschi & Calhoun defined PTG as, “the experience of positive change that occurs as a result of the struggle with highly challenging life crises.” According to their research, PTG can be expressed in a multitude of ways, “including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life,” (Tedeschi & Calhoun, 1996). Results of this study demonstrate consistent findings with participants demonstrating a desire to help others, and identification of meaning and purpose in life, as results of their PTG. However, one must not forget that for PTG to occur there must be intense pain and struggle. As a byproduct of this struggle a strength emerges which stimulates growth and a capacity to endure struggle beyond what previously existed. So, while there are many positive results of PTG, it cannot exist without the presence of unfortunate negative events and resulting circumstances.

Additional negative impacts observed in this study agree with previous findings of destructive impact on family-functioning, emotional and psychiatric health, self-esteem, and overall distress levels of families, spouses and children, of veterans with PTSD (Davidson & Mellor, 2000; Dekel & Goldblatt, 2008). Additionally, parental use of violence in the home, increased reports of behavioral problems, decreased school performance, reduced social competence, and increased reports of illegal drug use were consistent with previous research findings (Beckham et al., 1997; Dekel & Goldblatt, 2008; Harkness, 1993).

The findings of this study have implications for clinicians providing treatment and services to children and families of traumatized veterans. They suggest the importance of strong support systems (family and friend networks), access to services (i.e., groups) that increase the presence of social support for military children and families, and enhancing those positive protective factors. As previous research has repeatedly demonstrated, military families are extremely resilient. Despite the stress, constant moves, and deployments military families consistently report high levels of strength and view their experience as rewarding (Lester & Flake, 2013). This positive view of their family experience as it related to military culture and their experience held true with most participants of the current study. Participants described themselves as strong, resilient, resourceful, organized, and ambitious; they attributed these characteristics directly towards their membership in a military family. Further, they also indicate the need for psychoeducation for military families regarding military trauma in order to promote a sense of understanding, allowing for a stance of compassion, rather than a sense of resentment towards a parent that may not be able to connect or be present to their trauma symptoms.

However, being mindful and cautious to not force forgiveness when the sentiment is not genuinely present or to assume that every military child's experience is the same.

### **Limitations**

Although this study may provide unique contributions, it is not without limitations. In particular, the researcher, who is a civilian, interviewed the volunteers. Although the researcher disclosed their familial military connections with the volunteers during the phone intake, to increase the likelihood that they were comfortable being a part of the research prior to the in-person interview, there was a possibility that volunteers may be hesitant to talk about their personal experiences with someone whose life experiences differ from theirs. It was the hope that through a thorough discussion of why this study was being conducted, the volunteers would feel more comfortable speaking about their personal experiences. It appears the self-disclosure and transparency regarding the purpose of the study were effective as participants were forthcoming with information and did not appear to be guarded during the interview process. Furthermore, the study is a retrospective study and therefore the researcher was obtaining information about the volunteers' life and experiences from childhood; they may be reluctant to share about this time period and might have had trouble recalling specific details.

Social media and the researcher's social media connections were another limiting factor. The researcher has many social media connections with those in the substance abuse recovery community and the mental health treatment field. As a result, three participants identified as being members of a 12-step recovery-based group and the other three identified as mental health workers. This was a limiting factor in that these participants had similar experiences that might be more related to their membership in the recovery community or their careers rather than a

result of being a child of a veteran with a trauma diagnosis. For example, participants might have experienced trauma while in their active addiction that impacted their adult functioning or experienced vicarious trauma through their work in mental health. These other similarities might account for the themes that emerged as common among participants more so than their membership in a military family. This needs to be taken into consideration when digesting the results of this study.

Further research is required in order to produce findings that would be generalizable to other populations. IPA is limited as a result of focus on a specific group's members and their unique lived experience. Furthermore, most of the research to date focuses on children of veterans who were involved in military conflicts prior to the 90s; In order to be more inclusive and generalize to more of the military rather than that limited time period, more current research needs to be conducted with children of veterans from more recent conflicts such as Desert Storm, OIF, and OEF. While interesting and informative, it does not allow for comparison to other populations without further study and inquiry of those groups.

Additionally, this study is a first step in what needs to be more in-depth research on attachment and the effect intergenerational trauma. Ghafoori et al. (2008) studied the impact of attachment on development of PTSD in veterans and found veterans with PTSD has higher rates of insecure adult attachment and lower rates of secure adult attachment in comparison to those veterans without PTSD. While the other caregiver relationship was identified as an important protective factor in this study, further research is needed to fully understand the role of attachment in this process.

## **Conclusion**

A retrospective qualitative analysis was performed in order to gather the information needed to complete this study. The researcher interviewed participants after brief self-disclosure was offered in an effort to foster a sense of safety and understanding to encourage more detailed participant disclosure. The researcher disclosed information about her own experiences as a member of a military family as well as her motivation to increase services available to military families as a result of being raised by a veteran. Interview questions pertained to caregiver's military service, age at time of caregiver's service, length of caregiver's deployment, details about caregiver's past and current trauma symptoms/diagnosis, past and current coping skills, and past and current effects of subjective trauma exposure. Volunteers were provided with resources and information for support groups for people living with trauma issues if interviews were triggering.

This study provided insights into the lived experiences of children of military families exposed to trauma in the form of a traumatized parent. These adult participants provided reflections about their childhood and young adult experiences in relation to their membership in a military family. They provided accounts of emotionally and psychologically distressing situations that occurred as a part of their interactions with a traumatized military parent. Participants also shared about the positive experiences, memories, and qualities that resulted from their membership in a military family. This study promotes the need for post-deployment psychological support services for veterans and their families in order to reduce the transmission of intergenerational trauma in military families. It is not enough to provide the veteran with services, the entire family unit needs access to psychological services. Services need to be



provided to promote the development and enhancement of existing protective factors (e.g., understanding, other caregiver connection, and social support). Bolstering these factors may reduce the negative impacts of trauma in military families.

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APPENDIX A

Extended Review of The Literature or Summary Table of Selected Literature

Authors	Year	Abbreviated Title	Focus
Abrams	1999	IGT of Terror	Recent Contributions from the Literature of Family Systems Approaches to Treatment
Agaibi, Wilson	2005	Trauma, PTSD, & Res.	PTSD, resilience, positive coping, resilient behaviors, interactional models
Ahmadzadeh, Malekian	2004	Agg, Anx, and SD in Adol	Aggression, Social Development, Anxiety, War Veterans, PTSD, Adolescent
Ancharoff, Munroe, Fisher	1998	Leg of Combat Trauma	Traumatic Stress Intergenerational Transmission Compassion Fatigue Vietnam Veteran Trauma Survivor
Banyard	1997	Imp of ch sa & ff	Parents, children, child abuse, mothers
Banyard, Williams, Siegel	2003	Imp of comp trauma & dep	Child maltreatment; parenting; trauma
Beckham, Braxton, Kudler, Feldman, Lytle, & Palmer	1997	MMPI Prof of Viet Vets	Veterans, Children of Veterans, MMPI
Berz, Taft, Watkins, Monson	2008	Ass b/t PTSD sxs & par. Loss,	PTSD, Female Veterans, Parenting
Bonanno	2004	Trauma, & Res	Loss, resilience, capacity to thrive
Bonanno, Wortman, Lehman, Tweed, Haring, Sonnega	2002	Res to Loss & Grief	Loss, resilience, capacity to thrive
Bowlby	1980	Attach and loss	Attachment
Coates, Schechter, First	2003	Brief Int w/ trauma child	Trauma, children, interventions
Cohen, Hien, Batchelder	2008	Imp of Com-ind Stress	Trauma; parenting; substance abuse; depression; child maltreatment

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Compas, Connor-Smith, Saltzman, Harding, Wadsworth	2001	Coping w/ stress dur child/adol	Childhood/adolescent coping
Davidson, Mellor	2000	Adj of Child of Aust Viet vets	PTSD, Children of Veterans, Fathers, Social and Emotional Functioning, Self- esteem
De Pedro, Astor, Benbenishty, Estrada, Gabrielle, Smith	2011	Child of Mil Serv Mem	Military families, children, mental health
Dekel, Goldblatt	2008	Is there IGT of trauma?	PTSD, war, fathers, secondary traumatization, intergenerational transmission
Dias, Sales	2009	War's Ment Hlth Leg	PTSD, Children of Veterans, Fathers, Social and Emotional Functioning, Self- esteem
Elder, Clipp	1989	Comb Exp & Emot Hlth	Combat experience, emotional health, resilience
Ghafoori, Hierholzer, Howsepian, Boardman	2008	Role of Adult Attach Comp,	PTSD, trauma, attachment
Gilbert	2005	Concept, Res, & Use in PT	Compassion, healing, therapeutic relationship
Hall	2011	Imp of Under Mil Cult	Military culture, worldview, deployment, dependents, change of station, honor, sacrifice
Hooper, Stockton, Krupnick, Green	2011	Dev, Use, & Psychomet Properties	THQ, Reliability/Validity
Joshi, O'Donnell	2003	Child Exp to War	War terrorism trauma child development
Kaitz, Levy, Ebstein, Farone, Mankuta	2009	Intl Eff of Trauma Ref	Parents, children, trauma, intergenerational transmission of trauma
Kosslyn	2006	Thinking & Ment Imag	Cognitive Development, Reflective Thinking
Larkin, Thompson	2011	Int Phen Anal in MH	IPA, Qualitative Research
Lazarus, Folkman	1984	Stress, App, & Cop	

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Lester, Flake	2013	How Wartime Mil Serv Aff Child	Military culture, worldview, deployment
Lev-Weisel	2007	IGT of Trauma	Intergenerational transmission, three family generation, trauma
Motta, Joseph, Rose, Souzzi, Leidermen	1997	Secondary Trauma	Veterans, Children of Veterans, MMPI
Palmer	2008	Theory of Risk & Res	Risk, Resilience, Military Families
Parsons, Kehle, Owens	1990	Incid of Bx Prob	PTSD, Children of Veterans, Fathers, Social and Emotional Functioning
Pearrow, Cosgrove	2008	Aftermath of Comb- Rel Trauma	
Pietrzak, Johnson, Goldstein, Malley, Southwick	2009	Psych Res & Post-dep Soc Sup Prac Guide	Veterans; combat; soldiers; posttraumatic stress disorder; resilience; social support
Pietkiewicz, Smith	2012	to Using IPA	IPA, Qualitative Research
Rosenheck, Fontana	1998	Transgen eff of abus viol PTGI: Meas	Children of Vietnam Combat Vets
Tedeschi, Calhoun	1996	Pos Leg of Traum	Posttraumatic Growth
Weiss, Coll, Gerbauer, Smiley, Carillo	2010	Military Genogram	Resiliency; Military families
Wiseman, Metz, Barber	2006	Ang, Guilt, and Intl Comm	Holocaust, emotional-trauma, parent-child communication, narratives, second generation
Wilder, Reep, Osborne- Smith	2013	Rev of Rev Exami Neuro Procc	Neurology; Military Children; Resilience

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APPENDIX B  
IRB Approval Notice



Pepperdine University  
24255 Pacific Coast Highway  
Malibu, CA 90263  
TEL: 310-506-4000

## NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: October 01, 2018

Protocol Investigator Name: Maura Castellanos

Protocol #: 18-07-826

Project Title: Coping and Protective Factors for Adult Children of Military Families

School: Graduate School of Education and Psychology

Dear Castellanos:

Thank you for submitting your amended expedited application to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today October 01, 2018, and expires on August 14, 2019.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond August 14, 2019, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at [community.pepperdine.edu/irb](http://community.pepperdine.edu/irb).

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.



Pepperdine University  
24255 Pacific Coast Highway  
Malibu, CA 90263  
TEL: 310-506-4000

Sincerely,

Judy Ho, IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist

APPENDIX C

Are you an adult who was raised by a military parent with PTSD?





APPENDIX D

Phone Prescreening Script

Thank you for your interest in our study. I need to ask you a few questions over the phone in order to determine whether you are eligible for the research. Before I begin, I would like to tell you a little bit about the research.

This research study is looking at the coping strategies and protective factors of those who are in families in which they have been affected by intergenerational military trauma. If you are eligible, your participation will consist of a 2-hour in person interview that will include a questionnaire to fill out, and an interview. At the conclusion of the interview you will be given a \$20.00 visa gift card for your time and participation in the study.

The screening will take approximately 10 minutes. Is this a good time for you? During the interview I will ask questions about how you coped with your caregiver's trauma, deployment, and associated factors. The goal is that by learning how you and others in similar situations coped with these experiences, we will learn which strategies may be helpful to others who are facing similar situations as the one you lived through. Several of the questions are about your personal experiences as a child in a military family before and after your caregivers' military service. If any of the questions make you uncomfortable, you do not have to answer them and you may stop the interview at any time. Your participation in this research is completely voluntary. Would you like to continue with the screening to find out if you can take part in the study?

*If yes, continue with the screening*

*If no, thank them for their time and hang up*

Your answers will be confidential. No one will know the answers except for the research team (Dr. Thema Bryant-Davis, my chair). If you do not qualify for the study your information will be destroyed. If you do qualify, your answers will be de-identified and your name will not be used on any published documents. Anything with your name on it will be kept in a locked cabinet to ensure your privacy.

Would you like to continue with the screening to find out if you qualify for the study?

*If yes, continue with the screening. If no, thank them for their time and hang up*

APPENDIX E

Phone Prescreening Questions

**Section A**

Are you 18 or older? *If yes, continue with the screening. If no, thank them for their time and hang up*

**Section B**

Were you raised in a military family affected by trauma of a caregiver? *If yes, continue with the screening. If no, thank them for their time and hang up*

How old were you caregivers' military trauma occurred?

**Section C**

Are you currently having thoughts of harming yourself or others? *If no then continue, if yes then thank them for their time, and give them a list of referrals over the phone. Inform the prospective participant that due to their disclosure it is recommended that they seek support services.*

*Referrals include Pepperdine Community Counseling Center in West LA, Encino, and Irvine*

*Pepperdine Encino: (818) 501-1678*

*Pepperdine West LA: (310) 568-5752*

*Pepperdine Irvine: (949) 223-2570*

Have you been hospitalized in the last 12 months for any mental health concerns? *If no then continue, if yes then thank them for their time and hang up*

Thank you for taking the time to answer these screening questions. *Indicate whether the participant is eligible or ineligible for the study*

Do you have any questions about the screening or the study? We can now schedule our in person interview (schedule when and where the interview will take place). If you have any questions about scheduling, or whether or not you want to continue with the study, you may contact me. Again my name is Maura Castellanos and my email is [Maura.castellanos@pepperdine.edu](mailto:Maura.castellanos@pepperdine.edu).

APPENDIX F

Demographic Information

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Race: \_\_\_\_\_

Ethnicity: \_\_ Caucasian \_\_ African-American \_\_\_ Latino \_\_\_\_\_ Asian-American \_\_\_\_\_ American

Indian/Alaska Native \_\_\_ Other \_\_\_\_\_

Educational Level: \_\_\_\_\_

Age at time of Parent Deployment(s)/Military Service: \_\_\_\_\_

Birth Order: \_\_\_\_\_

APPENDIX G

Script for Self-Disclosure



As a researcher, I would not normally share much about my personal life or my background. However, I think that given the nature of this study and my family history it is important that you know some relevant information about me. I am the child of a Vietnam veteran who was the sole surviving son of World War II veteran. I was raised in a family that believes in military service and this has certainly shaped my beliefs. Countless men in my family have chosen to serve our country including my father, both my grandfathers, my uncles, many cousins, and most recently my older brother. My older brother served over 10 years as active duty military, including two deployments to Iraq, and is now serving under a reserve status. As a result of this upbringing, I have a passion and desire to help veterans and their families. I believe that military families have many strengths and withstand great pressures and changes that most families are not faced with. It is this passion that motivates me to research protective factors of military families. I hope that my work can somehow benefit veterans and their families in the future and provide information that might inspire program develop to assist families that need support.

APPENDIX H

Qualitative Interview Questions

1. How much do you know about your parent's military/combat experience? How did you find out? How old were you? Where are you in birth order?
2. How do you believe your parent's combat experience affected the way they raised you as a child? How did it affect your relationship?
3. What do you remember most about this parent?
4. How much do you know about your parent's psychological symptoms that developed as a result of their service? Are you aware of any diagnoses that they may have had? Are you aware about any potential treatment that they may have had for these diagnoses?
5. What, if any, caregiver(s) were in the home in addition to your military parent? Describe your relationship with your other caregiver(s)? What was your experience like with these individuals? How was your experience with them while your military parent was deployed?
6. How would you describe your attachment to your non military caregiver/parent? Do you feel closer to them than to your military parent? How was your experience different with your parents when your military parent returned to the home?
7. How was conflict resolved in your home?
8. Who traditionally administered discipline in your home?
9. How was parenting different when your military parent was deployed? How did it change when they came back home?
10. Have you experienced potentially traumatic experiences? Please identify some of your personal characteristics (whether they may be positive, negative, mixed, or otherwise). What, if any, personal characteristics do you feel served as protective factors? Do you attribute these factors to your experience in your military family?
11. Have you experienced growth in the face of trauma? How so?
12. Do you have any advice for children of military families?

APPENDIX I

Mental Health Provider Referrals

**Pepperdine Community Counseling Center**

West Los Angeles  
6100 Center Drive  
Los Angeles, CA 90045  
(310) 568-5752

Encino  
16830 Ventura Blvd, Suite 216  
Encino, CA 91436  
(818) 501-1678

Irvine  
18111 Von Karman Avenue, Suite 401  
Irvine, CA 92612  
(949) 223-2570

**Hollywood Sunset Free Clinic**

3324 Sunset Blvd,  
Los Angeles, CA 90026  
(323) 660-2400

**Edelman Westside Mental Health**

11080 W Olympic Blvd,  
Los Angeles, CA 90064  
(310) 966-6500

**Exodus Eastside Urgent Care Center**

1920 Marengo St.  
Los Angeles, CA 90033  
(323) 276-6400