

Parenting Stress in Navy Families: The Importance of Spirituality and Social Support

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Abstract

The purpose of this study was to investigate social support and spirituality as potential mitigators of parenting stress in Navy families affected by deployment. Recent research has shown a relationship between increased levels of perceived threat and warfare exposure on recent deployments, and higher levels of parenting stress in Navy fathers within a year of return. Using a cross-sectional correlational design, questionnaire data was collected from a total of 193 military parents. Regression analyses were performed, using the Parenting Stress Index as the outcome variable, social support (measured with the Medical Outcomes Study Social Support Survey Instrument) and spirituality (measured with Underwood’s Daily Spiritual Experience Scale) as primary covariates, and adjusting for other factors such as PTSD and depression. As social support and spirituality scores increased, levels of parenting stress decreased for both fathers ($p < .001$, $p < .05$, respectively) and mothers ($p < .001$, $p < .001$, respectively). Spirituality and social support may be direct protective factors for parenting stress in military families.

Keywords: deployment; military families; parenting stress; mental health; social support; spirituality

Introduction

Deployments are challenging for active duty members (Booth-Kewley, Larson, Highfill-McRoy, Garland, & Gaskin, 2010; Tsai, Harpaz-Rotem, Pietrzak, & Southwick, 2012), and deployments are taxing on families (Huebner, Mancini, Wilcox, Grass, & Grass, 2007; Knobloch & Theiss, 2012). However, there is little information on how deployments affect parenting for both the active duty member and the home front spouse (Devoe & Ross, 2012; Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010; Palmer, 2008). A recent study found an association between increased length of deployment, increased sense of danger on deployment, and increased warfare exposure on deployment, with increased parenting stress in Navy active duty fathers who returned from a deployment within the past year (Yablonsky, Bullock, & Yan, 2016).

Because parenting stress can be increased by these deployment variables, the purpose of this study was to investigate if there are potential mitigators of parenting stress in Navy families affected by a deployment. The Operational Stress Model (Nash et al., 2010), developed for research utilization in military populations, guided the conceptual model for this study. As Nash et al. state: “Operational stress encompasses more than just combat; it occurs everywhere service members and their families live and work” (p. 1673). The Operational Stress Model defines three categories: stressor exposures, risk and resilience factors, and positive and negative stress outcomes. Stressor exposures can range from high-intensity stressor events, such as the death of a close friend during combat, to the accumulation of lower-intensity pressures that can lead to decreased adaptive capability over time (Nash et al. 2010). These military exposures can lead to stress-induced outcomes that are reflected in the physical, psychological, social and spiritual domains of wellness, ranging from mental health concerns to early-onset of physiologic disease (Boscarino, 1997; Currier, Drescher, & Harris, 2014; King, Taft, King, Hammond, & Stone, 2006; Nash, Silva, & Litz, 2009). The model developed by Nash and colleagues (2010)

identifies specific risk and resilience factors that are pertinent to operational stress: spiritual factors, social factors, and environmental factors. For the purposes of this study, the authors chose to incorporate guidance from the Operational Stress Model, operationalizing social support and spirituality as potential resilience factors.

Social Support and Stress

Increased levels of social support have consistently been shown to be associated with decreased levels of parenting stress in civilian populations (Cooklin, Giallo, & Rose, 2012; McConnell, Breitreuz, & Savage, 2011), as well as military populations (Flake, Davis, Johnson, & Middleton, 2009). According to Sherbourne and Stewart (1991), social support can be defined in either functional or structural terms. Structural social support is a concrete measure of the availability of support that a person has, and can be measured by number of relationships, type of relationships (e.g. school networks, family networks), and frequency of interactions (Hwang, Etchegaray, Sciamanna, Bernstam, & Thomas, 2011; Verheijden, Bakx, van Weel, Koelen, & van Staveren, 2005). Functional social support is a person's perception of the availability of potential social assistance and interaction (Sherbourne & Stewart, 1991). Various authors have noted a strong relationship between functional social support and measures of health (DiMatteo, 2004; Verheijden et al., 2005), and the current authors espoused the perspective that under stressful conditions "the perceived availability" of a social support network would be a more salient marker to a military family than the number and type of social networks (Sherbourne & Stewart, 1991, p. 705). Active duty members and their families are usually stationed far from the hometowns of their youth, and often are called upon to move from duty station to duty station every 2-4 years. This necessitates a change in their social support structures and living quarters on a fairly regular basis. Additionally, military families are regularly separated by deployment, which constitutes multiple layers of additional challenge. Much of the parenting stress and social support research has not been done in the military environment.

Studies in military families that include an aspect of social support as a variable have not included parenting stress in analytic models, and have mostly focused on one member of the family in the context of post-traumatic stress disorder (PTSD). Within military populations, PTSD has been linked with decreased parenting satisfaction in mothers and fathers (Berz, Taft, Watkins, & Monson, 2008; Samper, Taft, King, & King, 2004), decreased parenting alliance between partners (Allen, Rhoades, Stanley, & Markman, 2011), and more negatively valenced parenting practices (Gewirtz et al., 2010; Hayes et al., 2010). Research that has looked at the male veteran spouse has shown marriage and social support to be protective for suicide risk (Jakupcak et al., 2010), as well as for PTSD in male active duty spouses (Balderrama-Durbin et al., 2013; Carter et al., 2011). The marital relationship is a primary source of social support, and if this relationship is strong before deployment, post-deployment related stresses are lower (Allen et al., 2011) in addition to PTSD symptom severity (Carter et al., 2011).

However, the social support-PTSD relationship is complex. According to the erosion theory (King et al., 2006), chronic behavioral manifestations of PTSD (e.g. alienation, irritability, emotional numbing) tend to repel those who would offer social support. In addition, the cognitive theory posits that because of the way in which those with PTSD perceive the world (e.g. hypervigilant, avoidant), there is a tendency for them to perceive those who would offer social support as potentially threatening (Ehlers & Clark, 2000). Thus it can be difficult

for partners and family members to offer social support, and there is some evidence that social support is not as effective of a buffer in those with PTSD compared to those with other non-PTSD diagnoses (Brancu et al., 2014). In fact, King et al. found that “there is a stronger [negative] PTSD to social support effect than [positive] social support to PTSD effect” (p. 2985). It is important to note that there are no studies looking at social support pre-trauma, at time of trauma, and then longitudinally thereafter, thus it is impossible to know if higher levels of social support pre-trauma lead to lower PTSD symptoms post-trauma, or if lower levels of social support pre-trauma lead to higher levels of PTSD symptoms post-trauma.

Both King et al. (2006) and Price, Gros, Strachan, Ruggiero, and Acierio (2013) note that military populations may have risk for lower social support even prior to the trauma event. For military personnel prior to deployment, there is evidence that spousal partners emotionally withdraw as the time gets closer to separation (Lapp et al., 2010; Sahlstein, Maguire, & Timmerman, 2009; Willerton, E., Schwarz, Wadsworth, & Oglesby, 2011; Yablonsky, Barbero, & Richardson, 2016) which may make spousal social support even harder to re-engage upon return, when PTSD symptomatology emerges. However, one recent study showed that open communication about combat exposure with a spouse mediated the relationship between partner support and PTSD symptoms, with the result that active duty members with higher partner support experienced less PTSD symptom severity 6 to 9 months post-deployment (Balderrama et al., 2013). The authors reported that the reverse mediation model, where PTSD would lead to lower levels of combat disclosure and then to reduced partner support, was not supported by the study data.

Spouses with higher levels of marital satisfaction may provide higher levels of social support and alternately, spouses perceiving higher levels of social support may experience higher levels of marital satisfaction. Cobb, Davila, and Bradbury (2001) noted that positive social support behavior was associated with increased marital satisfaction in a sample of civilian newlywed couples followed over one year. Female civilian spouses married to male active duty members with PTSD have lower levels of marital satisfaction and family cohesion (and thus may provide lower levels of social support to their partners) than spouses married to active duty personnel without PTSD (Allen et al., 2010; Taft, Schumm, Panuzio, & Proctor, 2008). This is concerning, as spouses are a main source of support for military personnel with PTSD. In one study, wives' level of marital satisfaction decreased when they attributed their husbands' PTSD symptoms to “internal, characterological variables” (Renshaw, Allen, Carter, Markman, & Stanley, 2014, p. 194), but wives' marital satisfaction was not affected when they attributed the PTSD symptoms to traumatic events outside of a husband's control. In a study measuring spousal distress pre-, post-, and during their husband's deployment, psychological distress was the worst for spouses during the deployment (Andres, 2014). In the same study, higher levels of relationship satisfaction post-deployment were predicted by higher social support during deployment, as well as by higher pre-deployment relationship satisfaction.

Findings from a recent cross-sectional study (Balderrama et al., 2013) imply that partner social support may help attenuate PTSD symptomatology through the mediating effect of couple communication regarding combat exposure. However, in partners of Vietnam veterans with high levels of PTSD, communication about combat experiences led to psychological distress in the spouse (Campbell & Renshaw, 2012). It is unknown what the optimal frequency and content of disclosure should be regarding traumatic events, where disclosure will simultaneously aid the individual with PTSD, while also protecting the partner from a

secondary stress effect. However, there is preliminary evidence to indicate that different types of social support (e.g. emotional/informational, tangible, affectionate, social interaction) may have varying degrees of effect in the treatment of PTSD. In a study measuring functional social support in veterans pre-treatment and post-treatment, emotional/informational social support was “significantly related to the rate of change in PTSD symptoms such that increased emotional support was associated with better treatment response” (Price et al., 2013, p.96). According to Sherbourne and Stewart (1991), sources of emotional/informational support offer advice, guidance and feedback, and express “positive affect, and empathic understanding” (p. 707). Price and colleagues were not able to provide data on the strength of this social support effect across different sources (e.g. family, partner, peers, supervisors, community).

Recently, researchers have identified that male service members may benefit from, and be more comfortable with, peer support from other veterans (Smith et al., 2013; Tsai et al., 2012); “they can relate to what you’re going through” (Demers, 2011, p. 172). In a study looking specifically at National Guard fathers who had been deployed to Iraq ($N=468$), these men reported relatively high levels of social support on deployment, which may have been a result of unit camaraderie (Gewirtz et al., 2010). Service members with PTSD symptoms have difficulty retaining social support over time (King et al., 2006) and report more intimate partner relationship difficulty and stress (Laffaye, Cavella, Drescher, & Rosen, 2008; Tsai et al., 2012).

Several studies have incorporated data from more than one member of a military family (Allen et al., 2011; Faber, Willerton, Clymer, MacDermid, & Weiss, 2008; Gewirtz, Pinna, Hanson, & Brockberg, 2014). This data has supported that families tend to look for support from other families going through similar phases of deployment, and service members tend to look for support from other veterans after deployment (Faber et al., 2008; Yablonsky, Barbero, & Richardson, 2016). In a sample of married parents (86% mothers) experiencing the deployment of a spouse, feeling supported during the separation predicted better scores on measures of child psychosocial functioning (Flake et al., 2009). In a study of 300 married couples, 78% of whom were parents, and all of whom had experienced a deployment in the past year, a lack of perceived social support was associated with increased post-deployment stress in both husbands and wives (Allen et al., 2011). Focusing on family health and optimal communication is highly salient; a study of Marines who had deployed to Iraq and Afghanistan ($N=1,569$; sample 95% male) showed that deployment-related stressors were most associated with positive screens for PTSD, and the most oft-cited deployment stressor was “concerns or problems back home” (Booth-Kewley et al., 2010, p. 74).

Spirituality and Stress

In contrast to social support, there is little literature to date investigating the effect of spirituality on parenting stress within the specific context of military families. Whereas social support is a measure of support provided by others, spirituality can be framed as a measure of internal support. Spirituality is a difficult construct to define, and is often confused with religiosity. Religiosity is related to religious beliefs (e.g., doctrinal teachings), concrete religious actions (e.g., prayer, reading of devotional literature), and relationship with a community of faith (e.g., frequency of religious institutional attendance) (Cain, 2007). Religiosity has been positively related to social support in past research (Prado et al., 2004). Spirituality reflects an individual’s relational awareness of the transcendent, divine, or holy through feelings and sensations, separate from religious beliefs (Underwood, 2011). The more private construct

of spirituality may have a significant effect on parenting stress levels, and is distinct from the concept of social support.

Most of the ‘spirituality’ research that is extant in active duty and veteran military populations explores positive and negative religious coping (Cornish, Lannin, Wade, & Martinez 2017; Currier, Smith, & Kuhlman, 2017; Trevino, Archambault, Schuster, Richardson, & Moye, 2012; Witvliet, Phipps, Feldman, & Beckham, 2004), religious faith (Fontana & Rosenheck, 2004), or conflates religiosity and spirituality (Berg, 2011; Currier et al., 2014; Currier, Holland, & Drescher, 2015; Hourani et al., 2012; Park, Smith, Lee, Mazure, & McKee, 2017; Wachholtz, Pearce, & Koenig, 2007). Negative religious coping is defined as spiritual questioning, struggling, or anger with God or a Higher Power in regard to a difficult life event, and positive religious coping is defined as seeing God or a Higher Power as benevolent, caring, and collaborative (Currier et al., 2017; Pargament et al., 1998a). Research has shown a link between negative religious coping and increased levels of emotional distress (Cornish et al., 2017), suicidal ideation (Currier et al., 2017), anxiety and depression (Witvliet et al., 2004), and PTSD (Currier et al., 2014; Witvliet et al., 2004). Negative religious coping has also been linked with poorer physical health and quality of life in civilian samples (Pargament, Smith, Koenig, & Perez, 1998b), and poorer PTSD treatment outcomes in veteran populations (Currier et al., 2015).

Additionally, it is common in the literature for negative religious coping to have a small positive correlation (Cornish et al., 2017; Currier et al., 2017; Pargament et al., 1998b) or a moderate positive correlation (Trevino et al., 2011) with positive religious coping. This has been attributed to the “religious coping mobilization” (Pargament et al., 1998b, p. 721) of stressors, such that a significant enough stressor will mobilize all of an individual’s religious coping strategies, both positive and negative. In military populations, some research has found positive religious coping to be insignificant in decreasing suicidal ideation (Currier et al., 2017) or symptoms of PTSD, anxiety, and depression (Witvliet et al., 2004). Cornish et al. (2017) found that greater use of positive religious coping in active duty men at 10 months into a one year deployment predicted greater emotional distress one month later (.13, $p < .05$). However, a time lag of one month in a highly stressful deployment setting may have been too short to garner sufficient variability in the collected measures. Despite the significant positive predictive value of positive religious coping at time 1 to emotional distress at time 2, there was no cross-sectional relationship between religious coping and distress at 10 months into the deployment, or at 11 months into the deployment. In a recent cross-sectional study, Park et al. (2017) found that those with high levels of combat exposure and high levels of positive religious coping had higher levels of PTSD symptoms.

While religious coping is a very useful construct, it measures an adaptive “seeking” mechanism (Cornish et al., 2017; p. 307) rather than an individual’s outcome measure of personal connection to the divine. This element of seeking may be one reason why positive religious coping has shown insignificant and positive associations with negative mental health outcomes in military populations. Additionally, much of the research in civilian populations that suggests an inverse association between positive religious coping and mental health concerns comes from data in female majority samples (Bjorck & Thurman, 2007; Keefe et al., 2001; Pargament et al., 1998b). In fact, Trevino et al. (2011) note that veteran men in their study endorsed significantly lower rates ($p < .01$) of positive religious coping ($M = 10.48$) than women ($M = 20.33$). Currier et al. (2014) note that their work showing lower rates

of spirituality and religious coping in PTSD treatment-seeking veterans versus the general population was done with exclusively male samples, and may not reflect gender differences in these constructs. There may be gender differences in positive religious coping, or there may be a specific military interaction that makes positive religious coping less efficacious for mental health concerns in this population (Currier et al., 2017; Witvliet et al., 2004). The current authors sought to use a more specific construct designed to look at spirituality as distinct from religiosity, in the hopes that this more specific focus would show more robust resilient outcomes in military populations.

Again, the amount of research looking at spirituality as a distinct construct within military populations is scant. One study used a chaplain spiritual assessment instrument developed for clinical use to explore the self-reported spiritual health of veterans. Excellent or good self-reported spiritual health was associated with less suicidal ideation in treatment-seeking veterans, whereas veterans with suicidal ideation more often “described their spiritual health as fair, poor, or uncertain” (Kopacz, 2014, p. 354). Currier and colleagues (2014) found that Vietnam and Iraq/Afghanistan veterans beginning treatment for PTSD reported less daily spiritual experiences ($p < .001$) compared with a demographically similar civilian population. In another study, Currier et al. (2015) evaluated veterans at admission to, and discharge from, a residential PTSD treatment program. These authors noted that more daily spiritual experiences and more private spiritual practices at PTSD treatment baseline were linked to lower PTSD symptoms at discharge. Additionally, higher levels of negative religious coping at baseline predicted higher levels of PTSD symptomatology at discharge (Currier et al., 2015).

Investigation of spirituality in the context of military families is even more rare. In a qualitative study of 7 military couples, the majority utilized spirituality to help them cope during and after deployment (Hamlin-Glover, 2009). Other researchers (Blank, Adams, Kittelson, Connors, & Padden, 2012) found that spouses endorsed talking with someone else in a similar situation (social support), and praying or putting their trust in God (spiritual support) as the most effective ways of coping during their husband's deployment. The goal of this study was to examine whether individual spirituality and perceived social support were independent correlates of parenting stress levels even after accounting for the influence of deployment-related and other factors in both civilian mothers and active duty fathers.

Methods

Participants and Procedure

The sample consisted of 193 parents, including active duty U.S. Navy fathers who had recently returned from a deployment within the past year, and their civilian wives. The couples had at least one child in their home who was between 1 month of age and less than 6 years of age. Two fathers were excluded from the sample due to incomplete data, resulting in a final sample size of 111 fathers. After giving consent and finishing the questionnaire, these fathers were asked if their wives could be contacted. The spouses were contacted by phone, and 82 consented to be part of the study. The study used a cross-sectional correlational research design.

After institutional review board approval, recruitment occurred at a large military outpatient clinic, and informational materials, such as posters and brochures, were available in waiting rooms. In addition to active recruitment by the study investigator, informational

materials were also distributed on ships, and recruitment emails were sent via specific shipboard distribution lists. All eligible and interested participant fathers met with study personnel at the clinic to complete an online questionnaire in person. All eligible wives who consented to the study were sent an email link to complete the questionnaire on their own at a convenient time. Data collection occurred between the months of October 2013 and May 2014.

The psychosocial health measures included in the questionnaire were: the Parenting Stress Index, three subscales of the Deployment Risk and Resiliency Index-2, the Primary Care PTSD screen, the Patient Health Questionnaire-8, the Life Stress Scale, the Medical Outcomes Study Social Support Survey Instrument, and Underwood's Daily Spiritual Experience Scale.

Study Variables

Outcome Measure

Parenting stress. The construct of parenting stress is measured using the Parenting Stress Index (PSI), which assesses the parent-child system via 101 questions on two specific domains. The first domain is the child domain - six subscales measure a parent's perception of her child's characteristics. The instrument uses the assumption that a parent's perception of her child can increase that parent's stress, even if an outside observer does not perceive the child's behavior as being a cause for stress. The second domain is the parent domain - seven subscales measure a parent's perception of her own parenting characteristics. Each item is scored on a scale, ranging from "strongly disagree" to "strongly agree." The scores on the two domains are combined for a total PSI score ranging between 101 and 505; higher scores indicate higher levels of parenting stress. For interpretation, the scores on the PSI are converted to percentile ranks, which show where the individual scores fall in relation "to scores of the respondents in the normative sample" on which the PSI was based (Abidin, 2012, p. 13). The reliability coefficient for the total PSI score was .96 in a sample of 2,633 parents (Abidin, 2012); the Cronbach's alpha in this sample was also .96. In the study, if the score for the total PSI was above the 85th percentile, parents were contacted with this information within 3 days and given contact information for self-referral.

A defensive responding (DR) score is also calculated based on a subset of questions within the PSI, which may indicate invalid answers by the respondent (i.e., the parent is reporting abnormally low scores on multiple questions, which in the majority of respondents elicit a much higher range). A score lower than 25 is considered 'defensive.' The rate of defensive responding in the general population is between 5 and 8% (Parkes et al., 2011).

Primary Covariates

Social support. The Social Support Survey Instrument was used in the Medical Outcomes Study (Sherbourne & Stewart, 1991) to measure four domains of functional support: emotional/informational (e.g. "someone who understands your problems"), tangible support (e.g. "someone to help with daily chores if you were sick"), positive social interaction (e.g. "someone to have a good time with"), and affectionate support (e.g. "someone who hugs you"). There are 19 items rated on a 5 point Likert scale, which are summed for a total social support score. Higher scores indicate more perceived social support. This instrument has been widely used in diverse populations (Costa-Requena, Arnal, & Gil, 2013; Gjesfjeld, Greeno, & Kim, 2008; Southivong, Ichikawa, Nakahara, & Southivong, 2013), as well as in veteran populations

(Brancu et al., 2014; Price et al., 2013), and active duty military populations (Fleishman et al., 2000; King et al., 2006). A reliability coefficient of .97 has been reported (Sherbourne & Stewart, 1991), which was the same value obtained in this sample.

Spirituality. This construct was measured using Underwood's Daily Spiritual Experience Scale (DSES), which aims to quantify day-to-day experiences that reflect an "awareness of the divine or transcendent ... 'more than' what we can see or touch or hear" (Underwood, 2006). There are no subscales within the instrument, and the scale has shown a single factor structure, but the 16 questions capture various aspects of the construct such as connection, divine help, perceptions of divine love, awe, thankfulness, and compassionate love (Underwood & Teresi, 2002). Example questions include: "I feel God's love for me, directly," and "I am spiritually touched by the beauty of creation." Cronbach's alpha reliability coefficients have ranged from .94 to .96 in various samples (Ellison & Fan, 2008; Underwood & Teresi, 2002). In this sample of military parents, the reliability coefficient was .97.

Other Covariates

Deployment factors. Four deployment factors were examined: 1) Number of Deployments, 2) Time Away from home, 3) Perceived Threat, and 4) Warfare Exposure. For the first two deployment factors, each was measured over the preceding 5 years; this is familiar to Navy service members who deploy, as these two questions are asked immediately after deployment, and within six months thereafter (Department of the Navy, 2012).

Number of deployments. Fathers were asked how many deployments they had been on in the past 5 years.

Time away from home. Fathers were asked how many months they had been away from home related to deployments in the past five years.

Perceived threat. This construct was measured using the Deployment Concerns subscale of the Risk and Resiliency Index-2 (DRRI-2), which reflects fear for personal safety during deployment. An example question: "I was concerned that I might encounter an explosive device." Reliability coefficients for the subscale of Deployment Concerns in past studies have been .89 (Vogt, Proctor, King, King, & Vasterling, 2008). The Cronbach's alpha in this sample for the Deployment Concerns subscale was .90.

Warfare Exposure. The warfare exposure factor was measured by combining two subscales of the DRRI-2, the Combat Experiences Scale and the Post-Battle Experiences Scale. The scales have been aggregated in the same way in the past by the authors of the DRRI (Vogt & Tanner, 2007; Vogt et al., 2011). The current authors chose to follow this example, as warfare exposure can be experienced by combatants in battle (reflected in the Combat Experiences Scale – e.g. "I was exposed to hostile incoming fire"), as well as by combatants and non-combatants after active fighting ends (reflected in the Post-Battle Experiences Scale – e.g. "I took care of injured or dying people"). A reliability coefficient of .91 for this aggregate factor has been reported (Vogt & Tanner, 2007); in this sample, the Cronbach's alpha for the Warfare Exposure factor was .90. The variable of warfare exposure was positively skewed, and so was partitioned into low (29-34), medium (35-45) and high (≥ 46) categories; these scales have been categorized in prior research (Hourani et al., 2012; Park et al., 2017).

PTSD. The Primary Care PTSD Screen instrument consists of four questions to be answered either “yes” or “no.” If a person answers affirmatively to three out of the four questions, the screen is considered positive for probable PTSD (Prins et al., 2003). Previous research has shown that this instrument yields a sensitivity of .83 and a specificity of .85 (Calhoun et al., 2010). In this study, the Cronbach’s alpha coefficient was .78. A dichotomous indication of probable PTSD using the cutoff score of 3 was used as a descriptive variable (see Table 1). However, within the regression analyses, the aggregate continuous score for PTSD symptoms was used.

Depression. The Patient Health Questionnaire-8 (PHQ-8) screens for probable depression, and a score of 10 or above has 88% sensitivity and 88% specificity for major depression (Kroenke, Spitzer, & Williams, 2001). A dichotomous indication of probable depression using the cutoff score of 10 was used as a descriptive variable (see Table 1). However, within the regression analyses, the aggregate continuous score for depression symptoms was used. A Cronbach’s alpha of .86 is reported (Kroenke, Spitzer, Williams, & Lowe, 2010); in this sample, the reliability coefficient was also .86. If parents screened positive for probable depression, or for probable PTSD, they were called with this information within 3 days and given contact information for self-referral, and encouraged to contact a health care provider or mental health professional for follow up.

Life stress. The Life Stress Scale is an optional instrument that comes with the PSI, but is scored independently of the PSI (Abidin, 2012). It contains 19 items that assess possible family stressors within the past 12 months (e.g., financial difficulties, pregnancy, geographic relocation). Each stressor is assigned a score, with some stressors scoring higher than others (e.g. divorce = 7; moved to new location = 2). All endorsed items are summed for an aggregate score; higher values indicate “an intensification of the total stress that the parent is experiencing” (Abidin, 2012, p. 21). Multiple authors have discussed problems with psychometric properties of various life-event measurement scales (Blasco-Fontecilla et al., 2012; Brantley, Waggoner, Jones, & Rappaport, 1987; Lei & Skinner, 1980); the author of the Life Stress Scale did not provide psychometric data for this instrument (Abidin, 2012). In this sample, the Cronbach’s alpha coefficient was .54.

Data Analysis

Influence of Spirituality and Social Support on Parenting Stress

Two sets of regression analyses were performed, one for spirituality and one for social support, to investigate their possible mitigating effects on parenting stress. These regression analyses were performed separately for the 82 mothers and again for the 111 fathers. In all regression analyses, the dependent variable was the parenting stress score. Linear regression was first used to obtain the unadjusted association between spirituality and parenting stress scores (model 1). Subsequently, this association was examined with sequential adjustments for years of education, childcare arrangements, and years in the military (model 2); life stress, and PTSD symptoms (model 3); depression symptoms (model 4); and the four deployment factors (model 5). Childcare arrangements and years in the military were not significant in univariate regression for mothers ($p > .20$), and were excluded. The second set of regression models substituted the spirituality variable for the social support variable. Throughout the paper, these models will be referred to as “the comprehensive mitigator models.”

Sensitivity Analysis

The sample was modified, setting aside the results for the group of parents who scored 24 or below on the defensive responding scale of the PSI. Those parents whose scores were 25 and above were referred to as “the restricted sample” of responders. The two groups of fathers (the restricted sample and the defensive responders) and the two groups of mothers (the restricted sample and the defensive responders) were compared across demographic and study variables; categorical variables were analyzed using chi-squared testing, and continuous variables were analyzed using independent samples t-tests. The analysis plan described previously was performed on the restricted sample.

Assessing the Influence of Outliers

The study team evaluated the three continuous deployment factors (time away from home, number of deployments, and perceived threat) for outliers. Using the outlier labeling rule (Hoaglin & Iglewicz, 1987), three participants were removed from the full sample of fathers, and three participants were removed from the full sample of mothers. Data analysis was run with and without outliers, and differences noted were minor; within this paper, written interpretations and data presented include all outliers.

All data was analyzed and interpreted using SPSS Version 22 (IBM Statistics). The alpha value for statistical significance in all tests was 0.05 (two-tailed).

Results

Over 95% of parents in this study were biologically linked to their offspring; others were either step-parents or adoptive parents. Within this sample, mean PSI scores were roughly equivalent to a 50th percentile score (Abidin, 2012). Mean levels of spiritual experience were higher for mothers than for fathers. Table 1 shows characteristics of variables within the study for the 111 fathers and the 82 mothers who participated. Except for two instances, no differences were noted on any demographic, covariate, or outcome variables ($p > .05$), between those fathers whose wives completed the survey ($n = 82$) and those fathers whose wives did not complete the survey ($n = 29$). Those fathers whose wives did not complete the survey had significantly lower levels of social support than those fathers whose wives completed the survey ($M (SD) = 76.45 (\pm 17.49)$, $M (SD) = 82.43 (\pm 14.26)$, respectively; $p < .05$); a similar pattern held for spirituality ($M (SD) = 51.42 (\pm 24.48)$, $M (SD) = 60.14 (\pm 22.98)$, respectively; $p < .05$).

Bivariate correlations were examined between deployment factors, demographic variables, and spirituality and social support. Spirituality and social support showed a moderate negative correlation with both depression symptoms and parenting stress in mothers ($p < .001$). For fathers, there was a small negative correlation between spirituality and parenting stress, and between social support and depression symptoms ($p < .01$); there was also a moderate negative correlation between social support and parenting stress ($p < .001$). The full bivariate correlation matrices for mothers and for fathers can be seen in Tables 2 & 3, respectively.

Table 1. Descriptive Variables for Fathers (n=111) and Mothers (n=82)

	Fathers (M, SD)	Mothers (M, SD)
Demographic Variables		
Age	32.14 (±6.10)	30.48 (±5.06)
Years of Education	14.23 (±2.29)	15.18 (±2.56)
Years in the Military	10.03 (±5.33)	9.85 (±5.44)
Covariates		
Number of Deployments	2.39 (±1.27)	2.39 (±1.66)
Time Away from Home (months)	19.95 (±11.31)	18.33 (±11.25)
Perceived Threat	24.06 (±10.30)	24.33 (±10.17)
Social Support	80.76 (±15.39)	77.89 (±16.77)
Spirituality	57.70 (±23.62)	65.54 (±20.13)
Outcome Variable		
Parenting Stress	216.93 (±46.72)	218.11 (±46.50)
	Fathers (n, %)	Mothers (n, %)
Demographic Variables		
Race		
Caucasian	72 (64.86)	55 (67.07)
Afro-American	26 (23.42)	18 (21.95)
Other	13 (11.71)	9 (10.98)
Hispanic	19 (17.12)	16 (19.51)
Rank		
Junior enlisted	49 (44.14)	36 (43.90)
Senior enlisted	46 (41.44)	33 (40.24)
Junior officer	10 (9.01)	9 (10.98)
Senior officer	6 (5.41)	4 (4.88)
PTSD positive screens	19 (17.12)	11 (13.41)
Depression positive screens	19 (17.12)	12 (14.63)
Covariates		
Warfare Exposure		
Low	68 (61.26)	52 (63.41)
Medium	35 (31.53)	25 (30.49)
High	8 (7.21)	5 (6.10)

Table 2. Correlation Table for Demographic Variables, Covariates, and Outcome Variable for Mothers (*n*=82)

	1	2	3	4	5	6	7	8	9
1. Age	@								
2. Years of Education	.408***	@							
3. Number of Deployments	.056	.076	@						
4. Time Away	-.012	.090	.575***	@					
5. Social Support	-.028	.058	.004	-.092	@				
6. Spirituality	.071	.124	-.126	-.083	.236*	@			
7. PTSD	-.192	-.150	-.018	.123	-.208	-.126	@		
8. Depression	-.165	-.233*	.258*	.083	-.390**	-.350**	.481***	@	
9. Parenting Stress	-.106	-.193	.063	-.100	-.510***	-.500***	.385***	.614***	@

* *p* < .05
** *p* < .01
*** *p* < .001

Table 3. Correlation Table for Demographic Variables, Covariates, and Outcome Variable for Fathers (*n*=111)

	1	2	3	4	5	6	7	8	9	10	11	12
1. Age	@											
2. Years of Education	.348***	@										
3. Years in Military	.698***	.125	@									
4. No. of Deployments	.074	-.002	.112	@								
5. Time Away	-.025	-.045	.074	.610***	@							
6. Perceived Threat	-.129	.072	-.158	.034	.188*	@						
7. Warfare Exposure	.015	.275**	.036	.189*	.361***	.296**	@					
8. Social Support	.159	.026	.234*	.035	-.006	-.115	-.159	@				
9. Spirituality	.263**	.090	.206*	-.082	-.080	.010	-.089	.252**	@			
10. PTSD	-.230*	-.226*	-.160	.104	.154	.372***	.099	-.138	.030	@		
11. Depression	-.111	-.097	-.160	.045	.182	.335***	.260**	-.286**	-.117	.460***	@	
12. Parenting Stress	-.099	-.166	-.187*	.065	.080	.213*	.288**	-.529***	-.253**	.209*	.501***	@

* *p* < .05
** *p* < .01
*** *p* < .001

Influence of Spirituality and Social Support on Parenting Stress

The comprehensive mitigator model11s were analyzed for the full sample of 111 fathers and 82 mothers. The results of these analyses, including effect sizes (i.e. unstandardized regression coefficients (*B*) and *R*² values), are shown in Table 4 (for spirituality) and Table 5 (for social support). Spirituality was found to be a significant independent correlate of total parenting stress scores, although the magnitude of effect indicated by *R*² values across both unadjusted and adjusted models was higher for mothers than for fathers (unadjusted model: *R*² = .250, *R*² = .064, respectively). Social support was a significant independent correlate of total parenting stress scores as well, and within the unadjusted model, the magnitude of effect indicated by *R*² values was similar for both mothers and fathers (*R*² = .265, *R*² = .280, respectively).

Aside from two exceptions, the magnitude of effects (as indicated by the unstandardized regression coefficients) lessened for both spirituality and social support as more factors were introduced; however these effects remained significant across all models. The lower the levels of both spirituality and social support, the higher the levels of parenting stress for both fathers and mothers. Of interest, the magnitude of effect for social support in mothers for Model 4 (*B* (*SE*) = -0.88 (± 0.25)) actually increased in Model 5, where deployment factors were finally included (*B* (*SE*) = -1.03 (± 0.26)). There was a similar pattern for spirituality in mothers between Model 4 and Model 5 (*B* (*SE*) = -0.78 (± 0.20), *B* (*SE*) = -0.81 (± 0.21), respectively).

Table 4. Regression of Spirituality on Parenting Stress for Fathers and Mothers Across Multiple Models

<i>n</i> =111 fathers <i>n</i> =82 mothers	Model 1 (Unadjusted)	Model 2 (adjusted for years of education and family factors)	Model 3 (additionally adjusted for Life Stress & PTSD)	Model 4 (additionally adjusted for Depression)	Model 5 (additionally adjusted for Deployment Factors)
Fathers' Spirituality					
<i>B</i> (<i>SE</i>)	-0.50 (±0.18)	-0.45 (±0.18)	-0.49 (±0.17)	-0.39 (±0.16)	-0.37, (±0.16)
<i>p</i> value	.007	.016	.006	.016	.028
<i>R</i>²	.064	.151	.238	.379	.397
Mothers' Spirituality					
<i>B</i> (<i>SE</i>)	-1.15 (±0.22)	-1.12 (±0.22)	-1.06 (±0.22)	-0.78 (±0.20)	-0.81(±0.21)
<i>p</i> value	<.001	<.001	<.001	<.001	<.001
<i>R</i>²	.250	.267	.365	.491	.565

Table 5. Regression of Social Support on Parenting Stress for Fathers and Mothers Across Multiple Models

<i>n</i> =111 fathers <i>n</i> =82 mothers	Model 1 (Unadjusted)	Model 2 (adjusted for years of education and family factors)	Model 3 (additionally adjusted for Life Stress & PTSD)	Model 4 (additionally adjusted for Depression)	Model 5 (additionally adjusted for Deployment Factors)
Fathers' Social Support					
<i>B</i> (<i>SE</i>)	-1.61 (±0.25)	-1.51 (±0.26)	-1.41 (±0.26)	-1.19 (±0.24)	-1.14, (±0.25)
<i>p</i> value,	<.001	<.001	<.001	<.001	<.001
<i>R</i>²	.280	.324	.358	.466	.476
Mothers' Social Support					
<i>B</i> (<i>SE</i>)	-1.42 (±0.27)	-1.40 (±0.27)	-1.24 (±0.26)	-0.88 (±0.25)	-1.03 (±0.26)
<i>p</i> value,	<.001	<.001	<.001	.001	<.001
<i>R</i>²	.265	.287	.360	.479	.569

Sensitivity Analysis

There were 28 fathers and 11 mothers who met the criteria for defensive responding (25.2% of the fathers, and 13.4% of the mothers). As expected, parents classified as defensive responders had significantly lower mean parenting stress scores ($p < .001$) than the restricted sample of responders. Additionally, defensive responders (both fathers and mothers) endorsed significantly more time away from home related to deployment by active duty fathers in the past 5 years ($p = .013$), as compared to other parents (for fathers, mean rank 67.66 months compared to 52.07 months; for mothers, mean rank 54.32 months compared to 39.51 months). Mothers who were defensive responders also noted higher life stress scores than other parents (mean rank

of 54.31 compared to mean rank of 39.65; $p = .037$). Parents who were classified as defensive responders also had lower mean scores on depression symptoms (for mothers, mean rank of 21.73 compared to mean rank of 44.56 with $p = .001$; for fathers, mean rank of 37.95 compared to mean rank of 62.09 with $p < .001$). There were no other significant differences between the two groups.

Data analysis for the restricted sample (which did not include defensive responders) proceeded in the same way as for the full sample. The results from the restricted sample analysis of the comprehensive mitigator models mirrored those of the full sample: lower levels of spirituality and social support were associated with higher parenting stress scores.

Discussion

The direct effect of higher spirituality and higher social support scores was to independently predict lower parenting stress scores for both parents. Mean scores for social support were high within the range of the measure for both mothers and fathers, ranging in the upper quartile of the scale. Fathers' mean scores for spiritual experience were slightly above the midpoint for the scale; mother's mean scores were in the upper tertile of the instrument. This is consistent with prior research in a large nationally representative sample (Idler et al., 2003), in which women had higher ratings on measured DSES items as compared to men. Spirituality and social support may be direct protective factors for parenting stress, with spirituality perhaps being more salient to women. The resilience constructs of spirituality factors and social factors identified within the Operational Stress Model were operationalized as spirituality and social support within this cross-sectional study; this study data supports further scientific investigation of these factors. When designing effective interventions for military families, these factors should be considered for inclusion.

Spirituality as a Resilience Factor

Of note, the DSES instrument used in this study to measure spirituality was salient for both military fathers and their civilian wives. While these findings point to a positive effect of spirituality on parenting stress, other authors have shown potential negative effects of high levels of positive religious coping on distress outcomes for service members on deployment, and in those who have experienced particularly high levels of combat exposure (Cornish et al., 2017; Park et al., 2017). These findings are not intuitive, and more work needs to be done in this area, particularly with prior positively valenced aspects of religiosity and spirituality, such as positive religious coping, private religious practices, forgiveness, and daily spiritual experiences (Currier et al., 2015). These different aspects of religiosity and spirituality may have differential effects on stress outcomes, just as different aspects of social support have been found to have differential effects on PTSD treatment outcomes (Price et al., 2013). Research is needed looking at the longitudinal patterns seen in military members who concurrently endorse high levels of these religious and spiritual modalities, and who have experienced extreme stressors and stress outcomes, such as high levels of warfare exposure and high levels of parenting stress. As suggested by the Operational Stress Model (Nash et al., 2010), analysis of potential moderating effects of these religious and spiritual modalities on the relationship between stressor exposures and stressor outcomes is needed. Also, research including nested analysis of family members would be instructive and innovative.

Parenting Stress, PTSD Symptoms & Depression Symptoms in the Sample

To our knowledge, this is the first study to look at parenting stress for both parents after one of them has been in a potentially dangerous situation. Most often parenting stress has been studied when a child's health is in danger (An, Song, Sung, & Joung, 2011; Potterton, Stewart, & Cooper, 2007). Other studies have looked at parenting stress in the context of maternal HIV, where those mothers who were more anxious or distressed regarding their health, exhibited increased parenting stress (Murphy, Marelich, Armistead, Herbeck, & Payne, 2010; Oswalt & Biasini, 2012). Additionally, mothers recovering from addiction with lower levels of social support showed higher levels of parenting stress (Harmer, Sanderson, & Mertin, 1999). Across both parents within the study sample, mean PSI scores were roughly equivalent to a 50th percentile score (Abidin, 2012).

Mothers and fathers had similar rates of probable PTSD (13% and 17%, respectively), and similar rates of probable depression (14% and 17%, respectively). Fathers' rates of probable PTSD in this study were higher than prevalence estimates in other recent studies of male active duty personnel (Hoge, Auchterlonie, & Milliken, 2006; Warner et al., 2011), which ranged from 2.1 to 9.8% using the same instrument and scoring. Fathers' rates of probable depression in this study were also higher than those seen in other recent studies within male active duty samples (Kolkow, Spira, Morse, & Grieger, 2007; Warner et al., 2011), where the rates ranged from 5.2 to 7.0%. Rates of probable depression and probable PTSD for mothers in this study were similar to those found in other recent studies of military spouses which ranged from 13.1% to 30% for depression (Gorman, Blow, Ames, & Reed, 2011; Lester et al., 2010; Mansfield et al., 2010), and from 1.1 to 21% for PTSD (Gorman et al., 2011; Mansfield et al., 2010; Renshaw et al., 2011).

Limitations

Within the full study sample of mothers and fathers ($N=193$), 39 parents met the criteria for defensive responding (20.2%), which is much higher than the 5 to 8% rate reported in the general population (Parkes et al., 2011). This indicates that there may be privacy concerns and worries about disclosure in a military population. There are data that show that military members are more likely to answer questions without reservation if they are anonymous (McLay et al., 2008; Warner et al., 2011), but this study shows that civilian wives of military members may also be more guarded in their responses than a civilian sample unaffiliated with the military. This is a limitation of our study, and also may limit future understanding of parenting stress within the military family. In part, the differences in recruitment for mothers and fathers may help to explain the differences in defensive responding between the groups (13.4% for mothers, 25.2% for fathers). The strategy for fathers necessitated an in-person meeting with the researcher, whereas mothers were contacted on the phone, and were sent a link to the survey; these different levels of in-person contact may partly explain the differences in defensive responding between fathers and mothers.

There were very few participants within the study who had experienced high levels of warfare exposure. With only eight participants, it is difficult to make any definitive conclusions about the effect of spirituality and social support on parenting stress in those who have experienced high levels of warfare exposure. A larger study utilizing a longitudinal design would

be appropriate to explore these relationships. As this data was within a cross-sectional study, causal inferences cannot be made. Additionally, the use of mental health screening measures should not be conflated with the gold standard of clinical diagnoses.

Conclusion

It is vital that clinicians demonstrate empathetic, nonjudgmental concern for military families, as well as skillful and attentive family assessment skills. Military members with PTSD have great difficulty with family communication, cohesion, and closeness. It is important for clinicians to extend care and concern to family members as well. Rates of probable depression and probable PTSD in this study were higher than reported elsewhere, indicating a need to continue to address mental health as a component of quality health care.

The study's most striking findings showed that spirituality and social support were both significant independent correlates of parenting stress; as spirituality and social support increased, parenting stress scores decreased. Being a cross-sectional study, causality cannot be inferred, but the results do confirm and advance other research advocating social support as an appropriate intervention for at-risk families (Cooklin et al., 2012; McConnell et al., 2011). To our knowledge, this is the first study to specifically investigate spirituality in the context of parenting stress. These findings have the potential for translation to other high-risk families undergoing significant environmental stressors. The integration of spirituality may be a valuable addition to parenting support interventions; more research is needed in this area.

Within the military, there exists a Chaplain Corps whose members serve the spiritual needs of military members, no matter their religious background (Besterman-Dahan, Gibbons, Barnett, & Hickling, 2012; Morgan, Hourani, Lane, & Tueller, 2016). This resource could be highlighted and bolstered within the various services, and more focus given to assessing specific dimensions of spiritual experience for military service members (Berg, 2011; Cornish et al., 2017; Hourani et al., 2012). In addition, many authors have recommended better integration of chaplains with mental health providers within military health care (Currier et al., 2015; Hourani et al., 2012; Morgan et al., 2016; Nieuwsma et al., 2014). A recent study showed that service members are significantly more likely ($p < .001$) to discuss family problems with a military chaplain, as compared to mental health professionals, or medical health practitioners at military or civilian facilities (Morgan et al., 2016). This marked preference by active duty personnel to engage with military chaplains on highly personal family problems indicates that chaplains may also be a critical component of military family outreach.

With enhanced integration of services, interventions could be designed incorporating chaplains, psychologists, nurses, social workers, physicians, and others who could develop multi-dimensional programs to provide support to military families experiencing deployment. Such a program already exists for military personnel across the service branches – it is called the Combat and Operational Stress Control (COSC) program. The purpose of the COSC program is to “prevent, identify, and manage adverse combat and operational stress behavior” in military units (Brusher, 2011, p. 60). Similar programs are needed for military families; some have been developed for active duty families (Lester et al., 2012) as well as National Guard and Reserve military families (Gewirtz et al., 2014; Walsh et al., 2014), but are currently available only to limited subsets of the targeted populations.

Health is multi-faceted, encompassing physical, mental, social, and spiritual domains (World Health Organization, 1998). This study provides a small pocket of evidence for increased attention to the spiritual, social, and mental domains of health; all members of the military family will benefit when health care deploys a holistic framework for healing.



References

- Abidin, R. R. (2012). *Parenting Stress Index, fourth edition: Professional manual*. Odessa, FL: Psychological Assessment Resources.
- Allen, E., S., Rhoades, G., K., Stanley, S., M., & Markman, H., J. (2011). On the home front: Stress for recently deployed Army couples. *Family Process, 50*(2), 235-247.
- An, K. J., Song, M. S., Sung, K. W., & Joung, Y. S. (2011). Health-related quality of life, activities of daily living and parenting stress in children with brain tumors. *Psychiatry Investigation, 8*(3), 250-255.
- Andres, M. (2014). Distress, support, and relationship satisfaction during military-induced separations: A longitudinal study among spouses of Dutch deployed military personnel. *Psychological Services, 11*(1), 22-30. doi:10.1037/a0033750
- Aubuchon-Endsley, N. L., Kennedy, T. S., Gilchrist, M., Thomas, D. G., Grant, S. (2015). Relationships among socioeconomic status, dietary intake, and stress in breastfeeding women. *Journal of the Academy of Nutrition and Dietetics, 115*(6), 939-946. doi: 10.1016/j.jand.2014.12.017.
- Balderrama-Durbin, C., Snyder, D. K., Cigrang, J., Talcott, G. W., Tatum, J., Baker, M., ... Smith Slep, A. M. (2013). Combat disclosure in intimate relationships: Mediating the impact of partner support on posttraumatic stress. *Journal of Family Psychology, 27*(4), 560-568. doi:10.1037/a0033412
- Berg, G. (2011). The relationship between spiritual distress, PTSD and depression in Vietnam combat veterans. *The Journal of Pastoral Care and Counseling, 65*(1), 1-11.
- Berz, J. B., Taft, C. T., Watkins, L. E., & Monson, C. M. (2008). Associations between PTSD symptoms and parenting satisfaction in a female veteran sample. *Journal of Psychological Trauma, 7*(1), 37-45. doi: 10.1080/19322880802125969
- Besterman-Dahan, K., Gibbons, S. W., Barnett, S. D., & Hickling, E. J. (2012). The role of military chaplains in mental health care of the deployed service member. *Military Medicine, 177*(9), 1028-1033.
- Bjorck, J. P., & Thurman, J. W. (2007). Negative life events, patterns of positive and negative religious coping, and psychological functioning. *Journal for the Scientific Study of Religion, 46*(2), 159-167.
- Blank, C., Adams, L. A., Kittelson, B., Connors, R. A., & Padden, D. L. (2012). Coping behaviors used by Army wives during deployment separation and their perceived effectiveness. *Journal of the American Academy of Nurse Practitioners, 24*(11), 660-668. doi:10.1111/j.1745-7599.2012.00766.x

- Blasco-Fontecilla, H., Delgado-Gomez, D., Legido-Gil, T., de Leon, J., Perez-Rodriguez, M. M., & Baca-Garcia, E. (2012). Can the Holmes-Rahe Social Readjustment Rating Scale (SRRS) be used as a suicide risk scale? An exploratory study. *Archives of Suicide Research, 16*(1), 13-28. doi: 10.1080/13811118.2012.640616
- Booth-Kewley, S., Larson, G. E., Highfill-McRoy, R. M., Garland, C. F., & Gaskin, T. A. (2010). Correlates of posttraumatic stress disorder symptoms in Marines back from war. *Journal of Traumatic Stress, 23*(1), 69-77. doi:10.1002/jts.20485
- Boscarino, J. A. (1997). Diseases among men 20 years after exposure to severe stress: Implications for clinical research and medical care. *Psychosomatic Medicine, 59*(6), 605-614.
- Brancu, M., Thompson, N. L., Beckham, J. C., Green, K. T., Calhoun, P. S., Elbogen, E. B., Wagner, H. R. (2014). The impact of social support on psychological distress for U.S. Afghanistan/Iraq era veterans with PTSD and other psychiatric diagnoses. *Psychiatry Research, 217*(1), 86-92. doi: 10.1016/j.psychres.2014.02.025.
- Brantley, P. J., Waggoner, C. D., Jones, G. N., & Rappaport, N. B. (1987). A Daily Stress Inventory: Development, reliability, and validity. *Journal of Behavioral Medicine, 10*(1), 61-74.
- Brusher, E. A. (2011) Combat and operational stress control. In E. C. Ritchie (Ed.), *Combat and operational behavioral health* (pp.59 – 74). Fort Detrick, MD: Office of the Surgeon General.
- Cain, D.S. (2007). The effects of religiousness on parenting stress and practices in the African American family. *Families in Society, 88*(2), 263-272. doi:10.1606/1044-3894.3624
- Calhoun, P. S., McDonald, S. D., Guerra, V. S., Eggleston, A. M., Beckham, J. C., & Straits-Troster, K. (2010). Clinical utility of the Primary Care-PTSD Screen among U.S. veterans who served since September 11, 2001. *Psychiatry Research, 178*(2), 330-335. doi:10.1016/j.psychres.2009.11.009
- Campbell, S. B., & Renshaw, K. D. (2012). Distress in spouses of Vietnam veterans: Associations with communication about deployment experiences. *Journal of Family Psychology, 26*(1), 18-25. doi:10.1037/a0026680
- Carter, S., Loew, B., Allen, E., Stanley, S., Rhoades, G., & Markman, H. (2011). Relationships between soldiers' PTSD symptoms and spousal communication during deployment. *Journal of Traumatic Stress, 24*(3), 352-355. doi:10.1002/jts.20649
- Chalfin, S. R., Grus, C. L., & Tomaszewski, L. (2002). Caregivers's stress secondary to raising young children with HIV infection: A preliminary investigation. *Journal of Clinical Psychology in Medical Settings, 9*(3), 211-218.
- Cobb, R. J., Davila, J., & Bradbury, T. N. (2001). Attachment security and marital satisfaction: The role of positive perceptions and social support. *Personality and Social Psychology Bulletin, 27*(9), 1131-1143.

Articles

- Cooklin, A. R., Giallo, R., & Rose, N. (2012). Parental fatigue and parenting practices during early childhood: An Australian community survey. *Child: Care, Health and Development*, 38(5), 654-664. doi:10.1111/j.1365-2214.2011.01333.x
- Cornish, M. A., Lannin, D. G., Wade, N. G., Martinez, M. (2017). Can use of positive religious coping predict greater distress? An examination of Army soldiers on deployment. *Journal of Counseling Psychology*, 64(3), 302-309. doi: 10.1037/cou0000200
- Costa-Requena, G., Arnal, R. B., & Gil, F. (2013). Perceived social support in Spanish cancer outpatients with psychiatric disorder. *Stress and Health*, 29(5), 421-426. doi:10.1002/smi.2488
- Currier, J. M., Drescher, K. D., & Harris, J. I. (2014). Spiritual functioning among veterans seeking residential treatment for PTSD: A matched control group study. *Spirituality in Clinical Practice*, 1(1), 3-15. doi: 10.1037/scp0000004
- Currier, J. M., Holland, J. M., Drescher, K. D. (2015). Spirituality factors in the prediction of outcomes of PTSD treatment for U.S. military veterans. *Journal of Traumatic Stress*, 28, 57-64. doi: 10.1002/jts.21978
- Currier, J. M., Smith, P. N., Kuhlman, S. (2017). Assessing the unique role of religious coping in suicidal behavior among U.S. Iraq and Afghanistan veterans. *Psychology of Religion and Spirituality*, 9(1), 118-123. doi: 10.1037/rel0000055
- Demers, A. (2011). When veterans return: The role of community in reintegration. *Journal of Loss & Trauma*, 16(1-3), 160-179. doi:10.1080/15325024.2010.519281
- Department of the Navy (2012). Navy deployment health assessments. Retrieved from <http://www.public.navy.mil/ia/dha/Pages/default.aspx>
- DeVoe, E. R., & Ross, A. (2012). The parenting cycle of deployment. *Military Medicine*, 177(2), 184-190.
- DiMatteo, M. R. (2004). Social support and patient adherence to medical treatment: A meta-analysis. *Health Psychology*, 23(2), 207-218. doi: 10.1037/0278-6133.23.2.207
- Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319-345.
- Ellison, C. G., & Fan, D. (2008). Daily spiritual experiences and psychological well-being among US adults. *Social Indicators Research*, 88(2), 247-271. doi:10.1007/s11205-007-9187-2
- Faber, A. J., Willerton, E., Clymer, S. R., MacDermid, S. M., & Weiss, H. M. (2008). Ambiguous absence, ambiguous presence: A qualitative study of military reserve families in wartime. *Journal of Family Psychology*, 22(2), 222-230. doi:10.1037/0893-3200.22.2.222
- Fee, R. J., & Hinton, V. J. (2011). Resilience in children diagnosed with a chronic neuromuscular disorder. *Journal of Developmental and Behavioral Pediatrics*, 32(9), 644-650.

- Fick, M. N., & McMahon, C. A. (2009). Psychosocial correlates of parenting stress in Australian parents with a daughter adopted from China. *Australian Journal of Adoption*, 1(2), 1-30.
- Flake, E.M., Davis, B.E., Johnson, P.L., & Middleton, L. S. (2009). The psychosocial effects of deployment on military children. *Journal of Developmental & Behavioral Pediatrics*, 30(4), 271-278.
- Fleishman, J. A., Sherbourne, C. D., Crystal, S., Collins, R. L., Marshall, G. N., Kelly, M., ... Hays, R. D. (2000). Coping, conflictual social interactions, social support, and mood among HIV-infected persons. *American Journal of Community Psychology*, 28(4), 421-453.
- Fontana, A., & Rosenheck, R. (2004). Trauma, change in strength of religious faith, and mental health service use among veterans treated for PTSD. *Journal of Nervous and Mental Disease*, 192(9) 579-584. doi: 10.1097/01.nmd.0000138224.17375.55
- Gewirtz, A. H., Pinna, K. L. M., Hanson, S. K., & Brockberg, D. (2014). Promoting parenting to support reintegrating military families: After deployment, adaptive parenting tools. *Psychological Services*, 11(1), 31-40. doi:10.1037/a0034134
- Gewirtz, A. H., Polusny, M. A., DeGarmo, D. S., Khaylis, A., & Erbes, C. R. (2010). Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq: Associations with parenting behaviors and couple adjustment. *Journal of Consulting and Clinical Psychology*, 78(5), 599-610. doi:10.1037/a0020571
- Gjesfjeld, C. D., Greeno, C. G., & Kim, K. H. (2008). A confirmatory factor analysis of an abbreviated social support instrument: The MOS-SSS. *Research on Social Work Practice*, 18(3), 231-237. doi:10.1177/1049731507309830
- Golombok, S., Murray, C., Brinsden, P., & Abdalla, H. (1999). Social versus biological parenting: Family functioning and the socioemotional development of children conceived by egg or sperm donation. *Journal of Child Psychology and Psychiatry*, 40(4), 519-527.
- Glenn, S., Cunningham, C., Poole, H., Reeves, D., & Weindling, M. (2008). Maternal parenting stress and its correlates in families with a young child with cerebral palsy. *Child: Care, Health, and Development*, 35(1), 71-78. doi: 10.1111/j.1365-2214.2008.00891.x
- Gorman, L. A., Blow, A. J., Ames, B. D., & Reed, P. L. (2011). National Guard families after combat: Mental health, use of mental health services, and perceived treatment barriers. *Psychiatric Services*, 62(1), 28-34.
- Hamlin-Glover, D.L. (2009). *Spirituality, religion, and resilience among military families* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Order No. 3442121)
- Harmer, A. L., Sanderson, J., & Mertin, P. (1999). Influence of negative childhood experiences on psychological functioning, social support, and parenting for mothers recovering from addiction. *Child Abuse & Neglect*, 23(5), 421-433.

- Hayes, J., Wakefield, B., Andresen, E. M., Scherrer, J., Traylor, L., Wiegmann, P., ... Desouza, C. (2010). Identification of domains and measures for assessment battery to examine well-being of spouses of OIF/OEF veterans with PTSD. *Journal of Rehabilitation Research and Development*, 47(9), 825-840. doi:10.1682/JRRD.2009.04.0049
- Hoaglin, D. C., & Iglewicz, B. (1987). Fine-tuning some resistant rules for outlier labeling. *Journal of the American Statistical Association*, 82(400), 1147-1149. Retrieved from <http://www.jstor.org/stable/2289392>
- Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295(9), 1023-1032.
- Hourani, L. L., Williams, J., Forman-Hoffman, V., Lane, M. E., Weimer, B., & Bray, R. M. (2012). Influence of spirituality on depression, posttraumatic stress disorder, and suicidality in active duty military personnel. *Depression Research and Treatment*, 1-9. doi: 10.1155/2012/425463
- Huebner, A. J., Mancini, J. A., Wilcox, R. M., Grass, S. R., & Grass, G. A. (2007). Parental deployment and youth in military families: Exploring uncertainty and ambiguous loss. *Family Relations*, 56(2), 112-122.
- Hwang, K. O., Etchegaray, J. M., Sciamanna, C. N., Bernstam, E. V., & Thomas, E. J. (2011). Structural social support predicts functional social support in an online weight loss programme. *Health Expectations*, 17, 345-352. doi: 10.1111/j.1369-7625.2011.00759.x
- Idler, E. L., Musick, M. A., Ellison, C. G., George, L. K., Krause, N., Ory, M. G., ... Williams, D. R. (2003). Measuring multiple dimensions of religion and spirituality for health research: Conceptual background and findings from the 1998 General Social Survey. *Research on Aging*, 25(4), 327-365. doi:10.1177/0164027503252749
- Jakupcak, M., Vannoy, S., Imel, Z., Cook, J. W., Fontana, A., Rosenheck, R., & McFall, M. (2010). Does PTSD moderate the relationship between social support and suicide risk in Iraq and Afghanistan War Veterans seeking mental health treatment? *Depression and Anxiety*, 27(11), 1001-1005. doi:10.1002/da.20722
- Keefe, F. J., Affleck, G., Lefebvre, J., Underwood, L., Caldwell, D. S., Drew, J., ... Pargament, K. (2001). Living with rheumatoid arthritis: The role of daily spirituality and daily religious and spiritual coping. *The Journal of Pain*, 2(2), 101-110. doi: 10.1054/pai.2001.19296
- King, D. W., Taft, C., King, L. A., Hammond, C., & Stone, E. R. (2006). Directionality of the association between social support and posttraumatic stress disorder: A longitudinal investigation. *Journal of Applied Social Psychology*, 36(12), 2980-2992. doi:10.1111/j.0021-9029.2006.00138.x
- Knobloch, L. K., & Theiss, J. A. (2012). Experiences of U.S. military couples during the post-deployment transition: Applying the relational turbulence model. *Journal of Social and Personal Relationships*, 29(4), 423-450. doi:10.1177/0265407511431186

- Kolkow, T. T., Spira, J. L., Morse, J. S., & Grieger, T. A. (2007). Post-traumatic stress disorder and depression in health care providers returning from deployment to Iraq and Afghanistan. *Military Medicine*, 172(5), 451-455.
- Kopacz, M. S. (2014). The spiritual health of veterans with a history of suicide ideation. *Health Psychology and Behavioral Medicine*, 2(1), 349-358. doi: 10.1080/21642850.2014.881260
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606-613.
- Kroenke, K., Spitzer, R. L., Williams, J. B., & Lowe, B. (2010). The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: A systematic review. *General Hospital Psychiatry*, 32(4), 345-359. doi:10.1016/j.genhosppsych.2010.03.006
- Laffaye, C., Cavella, S., Drescher, K., & Rosen, C. (2008). Relationships among PTSD symptoms, social support, and support source in veterans with chronic PTSD. *Journal of Traumatic Stress*, 21(4), 394-401. doi:10.1002/jts.20348
- Lapp, C. A., Taft, L. B., Tollefson, T., Hoepner, A., Moore, K., & Divyak, K. (2010). Stress and coping on the home front: Guard and Reserve spouses searching for a new normal. *Journal of Family Nursing*, 16(1), 45-67. doi: 10.1177/1074840709357347
- Lei, H., & Skinner, H. A. (1980). A psychometric study of life events and social readjustment. *Journal of Psychosomatic Research*, 24(2), 57-65.
- Lester, P., Peterson, K., Reeves, J., Knauss, L., Glover, D., Mogil, C., Duan, N., Saltzman, W., Pynoos, R., Wilt, K., & Beardslee, W. (2010). The long war and parental combat deployment: Effects on military children and at-home spouses. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(4), 310-320.
- Lester, P., Saltzman, W. R., Woodward, K., Glover, D., Leskin, G. A., Bursch, B., Pynoos, R., & Beardslee, W. (2012). Evaluation of a family-centered prevention intervention for military children and families facing wartime deployments. *American Journal of Public Health*, 102 (Suppl. 1), S48-S54. doi:10.2105/AJPH.2010.300088
- Mansfield, A. J., Kaufman, J. S., Marshall, S. W., Gaynes, B. N., Morrissey, J. P., & Engel, C. C. (2010). Deployment and the use of mental health services among U.S. Army wives. *New England Journal of Medicine*, 362(2), 101-109.
- McConnell, D., Breitreuz, R., & Savage, A. (2011). From financial hardship to child difficulties: Main and moderating effects of perceived social support. *Child: Care, Health and Development*, 37(5), 679-691. doi:10.1111/j.1365-2214.2010.01185.x
- McLay, R. N., Deal, W. E., Murphy, J. A., Center, K. B., Kolkow, T. T., & Grieger, T. A. (2008). On-the-record screenings versus anonymous surveys in reporting PTSD. *The American Journal of Psychiatry*, 165(6), 775-776. doi:10.1176/appi.ajp.2008.07111710

- Morgan, J. K., Hourani, L., Lane, M. E., & Tueller, S. (2016). Help-seeking behaviors among active-duty military personnel: Utilization of chaplains and other mental health service providers. *Journal of Health Care Chaplaincy*, 22(3), 102-117. doi: 10.1080/08854726.2016.1171598
- Murphy, D. A., Marelich, W. D., Armistead, L., Herbeck, D. M., & Payne, D. L. (2010). Anxiety/stress among mothers living with HIV: Effects on parenting skills and child outcomes. *AIDS Care*, 22(12), 1449-1458. doi:10.1080/09540121.2010.487085
- Nash, W. P., Silva, C., Litz, B. (2009). The historic origins of military and veteran mental health stigma and the stress injury model as a means to reduce it. *Psychiatric Annals*, 39(8), 789-794. doi: 10.3928/00485713-20090728-05
- Nash, W. P., Vasterling, J., Ewing-Cobbs, L., Horn, S., Gaskin, T., Golden, J., ... Baker, D. G. (2010). Consensus recommendations for common data elements for operational stress research and surveillance: Report of a federal interagency working group. *Archives of Physical Medicine & Rehabilitation*, 91(11), 1673-1683. doi:10.1016/j.apmr.2010.06.035
- Nereo, N. E., Fee, R. J., & Hinton, V. J. (2003). Parental stress in mothers of boys with Duchenne muscular dystrophy. *Journal of Pediatric Psychology*, 28(7), 473-484. doi: 10.1093/jpepsy/jsg038
- Nieuwsma, J. A., Jackson, G. L., DeKraai, M. B., Bulling, D. J., Cantrell, W. C., Rhodes, J. E., ... Meador, K. G. (2014). Collaborating across the Departments of Veterans Affairs and Defense to integrate mental health and chaplaincy services. *Journal of General Internal Medicine*, 29(Suppl. 4), 885-894. doi:10.1007/s11606-014-3032-5
- Oswalt, K. L., & Biasini, F. J. (2012). Characteristics of HIV-infected mothers associated with increased risk of poor mother-infant interactions and infant outcomes. *Journal of Pediatric Health Care*, 26(2), 83-91. doi:10.1016/j.pedhc.2010.06.014
- Palmer, C. (2008). A theory of risk and resilience factors in military families. *Military Psychology*, 20(3), 205-217. doi:10.1080/08995600802118858
- Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998a). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37(4), 710-724.
- Pargament, K. I., Zinnbauer, B. J., Scott, A. B., Butter, E. M., Zerowin, J., & Stanik, P. (1998b). Red flags and religious coping: Identifying some religious warning signs among people in crisis. *Journal of Clinical Psychology*, 54(1), 77-89. doi: 10.1002/jclp.10225
- Park, C. L., Smith, P. H., Lee, S. Y., Mazure, C. M., & McKee, S. A. (2017). Positive and negative religious/spiritual coping and combat exposure as predictors of posttraumatic stress and perceived growth in Iraq and Afghanistan veterans. *Psychology of Religion and Spirituality*, 9(1), 13-20. doi: 10.1037/rel0000086

- Parkes, J., Caravale, B., Marcelli, M., Franco, F., & Colver, A. (2011). Parenting stress and children with cerebral palsy: A European cross-sectional survey. *Developmental Medicine & Child Neurology*, 53(9), 815-821. doi:10.1111/j.1469-8749.2011.04014.x
- Potterton, J., Stewart, A., & Cooper, P. (2007). Parenting stress of caregivers of young children who are HIV Positive. *Psychiatry Investigation*, 10(4), 210-214.
- Prado, G., Feaster, D.J., Schwartz, S.J., Pratt, I.A., Smith, L., & Szapocznik, J. (2004). Religious involvement, coping, social support, and psychological distress in HIV-seropositive African American mothers. *AIDS and Behavior*, 8(3), 221-235.
- Price, M., Gros, D. F., Strachan, M., Ruggiero, K. J., & Acierno, R. (2013). The role of social support in exposure therapy for Operation Iraqi Freedom/Operation Enduring Freedom veterans: A preliminary investigation. *Psychological Trauma*, 5(1), 93-100. doi: 10.1037/a0026244
- Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., ... Sheikh, J. I. (2003). The Primary Care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*, 9(1), 9-14.
- Renshaw, K. D., Allen, E. S., Carter, S. P., Markman, H. J., & Stanley, S. M. (2014). Partners' attributions for service members' symptoms of combat-related posttraumatic stress disorder. *Behavior Therapy*, 45(2), 187-198.
- Renshaw, K. D., Allen, E. S., Rhoades, G. K., Blais, R. K., Markman, H. J., & Stanley, S. M. (2011). Distress in spouses of service members with symptoms of combat-related PTSD: Secondary traumatic stress or general psychological distress? *Journal of Family Psychology*, 25(4), 461-469. doi:10.1037/a0023994
- Sahlstein, E., Maguire, K. C., & Timmerman, L. (2009). Contradictions and praxis contextualized by wartime deployment: Wives' perspectives revealed through relational dialectics. *Communication Monographs*, 76(4), 421-442. doi:10.1080/03637750903300239
- Samper, R. E., Taft, C. T., King, D. W., & King, L. A. (2004). Posttraumatic stress disorder symptoms and parenting satisfaction among a national sample of male Vietnam veterans. *Journal of Traumatic Stress*, 17(4), 311-315.
- Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social Science & Medicine*, 32(6), 705-714.
- Smith, B., Vaughn, R. A., Vogt, D., King, D. W., King, L. A., & Shipherd, J. C. (2013). Main and interactive effects of social support in predicting mental health symptoms in men and women following military stressor exposure. *Anxiety, Stress, & Coping*, 26(1), 52-69. doi:10.1080/10615806.2011.634001
- Soliday, E., Kool, E., & Lande, M. B. (2000). Psychosocial adjustment in children with kidney disease. *Journal of Pediatric Psychology*, 25(2), 93-103.

- Southivong, B., Ichikawa, M., Nakahara, S., & Southivong, C. (2013). A cross-sectional community study of post-traumatic stress disorder and social support in Lao People's Democratic Republic. *Bulletin of the World Health Organization*, 91(10), 765-772. doi:10.2471/BLT.12.115311
- Taft, C. T., Schumm, J. A., Panuzio, J., & Proctor, S. P. (2008). An examination of family adjustment among Operation Desert Storm veterans. *Journal of Consulting & Clinical Psychology*, 76(4), 648-656.
- Tang, C., Quinonez, R. B., Hallett, K., Lee, J. Y., & Whitt, J. K. (2005). Examining the association between parenting stress and the development of early childhood caries. *Community Dentistry and Oral Epidemiology*, 33, 454-460.
- Timmer, S. G., Ware, L. M., Urquiza, A. J., & Zebell, N. M. (2010). The effectiveness of parent-child interaction therapy for victims of interparental violence. *Violence and Victims*, 25 (4), 486-503. doi: 10.1891/0886-6708.25.4.486
- Trevino, K. M., Archambault, E., Schuster, J., Richardson, P. & Moye, J. (2012). Religious coping and psychological distress in military veteran cancer survivors. *Journal of Religion and Health*, 51, 87-98. doi: 10.1007/s10943-011-9526-0
- Tsai, J., Harpaz-Rotem, I., Pietrzak, R. H., & Southwick, S. M. (2012). The role of coping, resilience, and social support in mediating the relation between PTSD and social functioning in veterans returning from Iraq and Afghanistan. *Psychiatry*, 75(2), 135-149.
- Underwood, L. G. (2006). Ordinary spiritual experience: Qualitative research, interpretive guidelines, and population distribution for the Daily Spiritual Experience Scale. *Archive for the Psychology of Religion/Archiv für Religionspsychologie*, 28(1), 181-218.
- Underwood, L. G., & Teresi, J. A. (2002). The Daily Spiritual Experience Scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health-related data. *Annals of Behavioral Medicine*, 24(1), 22-33.
- Underwood, L.G. (2011). The Daily Spiritual Experience Scale: Overview and results. *Religions*, 2(1), 29-50. doi:10.3390/rel2010029
- Verheijden, M. W., Bakx, J. C., van Weel, C., Koelen, M. A., & van Staveren, W. A. (2005). Role of social support in lifestyle-focused weight management interventions. *European Journal of Clinical Nutrition*, 59, S179-S186.
- Vogt, D. S., Proctor, S. P., King, D. W., King, L. A., & Vasterling, J. (2008). Validation of scales from the Deployment Risk and Resilience Inventory in a sample of operation Iraqi Freedom veterans. *Assessment*, 15(4), 391-403. doi:10.1177/1073191108316030
- Vogt, D., Smith, B., Elwy, R., Martin, J., Schultz, M., Drainoni, M.-L., & Eisen, S. (2011). Predeployment, deployment, and postdeployment risk factors for posttraumatic stress symptomatology in female and male OEF/OIF veterans. *Journal of Abnormal Psychology*, 120(4), 819-831. doi:10.1037/a0024457

- Vogt, D. S., & Tanner, L. R. (2007). Risk and resilience factors for posttraumatic symptomatology in Gulf War I veterans. *Journal of Traumatic Stress, 20*(1), 27-38. doi: 10.1002/jts.20187
- Wachholtz, A. B., Pearce, M. J., & Koenig, H. (2007). Exploring the relationship between spirituality, coping, and pain. *Journal of Behavioral Medicine, 30*, 311-318. doi: 10.1007/s10865-007-9114-7
- Walsh, T. B., Dayton, C. J., Erwin, M. S., Muzik, M., Busuito, A., & Rosenblum, K. L. (2014). Fathering after military deployment: Parenting challenges and goals of fathers of young children. *Health & Social Work, 39*(1), 35-44. doi:10.1093/hsw/hlu005
- Warner, C. H., Appenzeller, G. N., Grieger, T., Belenkiy, S., Breitbach, J., Parker, J., ... Hoge, C. (2011). Importance of anonymity to encourage honest reporting in mental health screening after combat deployment. *Archives of General Psychiatry, 68*(10), 1065-1071.
- Willerton, E., Schwarz, R. L., Wadsworth, S. M. M., & Oglesby, M. S. (2011). Military fathers' perspectives on involvement. *Journal of Family Psychology, 25*(4), 521-530. doi:10.1037/a0024511
- Witvliet, C. V. O., Phipps, K. A., Feldman, M. E., Beckham, J. C. (2004). Posttraumatic mental and physical health correlates of forgiveness and religious coping in military veterans. *Journal of Traumatic Stress, 17*(3), 269-273.
- World Health Organization (1998). *Review of the constitution of the World Health Organization: Report of the executive board special group*. (EB101.R2). Retrieved from http://apps.who.int/gb/archive/pdf_files/EB101/pdfangl/eb1017.pdf
- Yablonsky, A. M., Barbero, E. D., & Richardson, J. W. (2016). Hard is normal: Military families' transitions within the process of deployment. *Research in Nursing and Health, 39*(1), 42-56. doi: 10.1002/nur.21701
- Yablonsky, A. M., Bullock, L., & Yan, G. (2016). Parenting stress after deployment in Navy active duty fathers. *Military Medicine, 181*(8), 854-862. doi: 10.7205/MILMED-D-15-00302