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Parents' Perspectives of their Children's Reactions to an Australian Military Deployment

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This article reports on a qualitative study of Australian parents' perceptions of their children's reactions to a military deployment as well as their help-seeking behaviours. Thirty-eight in-depth interviews were conducted with 34 Australian Defence Force (ADF) parents and 33 non-deployed parents (67 participants). Twenty-nine interviews were with couples and nine were with individuals. The findings revealed that this group of children generally fared poorly in terms of physical and mental health, and behavioural outcomes. Children and adolescents had a number of needs which were not identified, assessed or treated, and prevention programmes were reported to be limited. Factors that are associated with positive and negative outcomes from the families' perspective are outlined. The data showed how developing a deeper understanding of military families' needs, as well as positive worker–parent relationships, would enhance the therapeutic alliance between parents and service providers. Implications for prevention and intervention approaches in relation to both policy and service delivery are outlined.

■ **Keywords:** mental health, children, Australia, military family, social work, military deployment

Introduction

Research on military families has increased significantly in the past 15 years (Burrell, Adams, Durand, & Castro, 2006; Hall, 2011; Wiens & Boss, 2006). Research has been multidisciplinary, emanating from psychologists, social workers, sociologists, psychiatrists, anthropologists, political scientists, economists and historians. However, in the Australian setting, parents, children and adolescents who remain at home when their loved one deploys to war or peacekeeping missions have been entirely absent from research designs. Moreover, little is known about the experiences of parent's military deployment. If parents' and children's needs are not understood, how can effective policies and programmes be developed?

This article reports on a qualitative study of Australian parents' perceptions of their children's reactions to a military deployment. A brief overview of previous research on military children and adolescents is provided and is then followed by a description of the research method. The findings and a discussion ensue, which examine the policy and practice implications for social workers and other professionals who work with this unique population.

Previous Research on Children and Adolescents in Military Families

Despite the fact there are large numbers of children and adolescents who endure a parent's military deployment, surprisingly little has been published on this topic (Mmari, Roche, Sudhinaraset, & Blum, 2009; Siebler, 2009). Anna Freud and Dorothy Burlingham (1943) conducted a landmark observational study of children in nurseries in London during the Second World War, which noted that war inevitably caused enforced separations and anxiety in parents (mostly mothers), which was invariably reflected in children's behaviour. Inconsolable crying, bed-wetting, aggression and temper tantrums were observed. This early finding that the non-deployed parent's mental health predicted children's depression, internalising and externalising symptoms, mirrors consistent findings in contemporary military family research (Drummet, Coleman, & Cable, 2003; Flake, Davis, Johnson, & Middleton, 2009; Stafford & Grady, 2003; Verdeli et al., 2011) and a vast civilian literature (Glasheen, Richardson & Fabio, 2010; Nomura, Wickramaratne, Warner, Mufson, & Weissman, 2002; Tunnard, 2004; Weissman & Olfson, 2009). The civilian literature also notes that fathers' and grandparents' mental health may affect children's wellbeing (Pettit, Olino, Roberts, Seeley, & Lewinsohn, 2008; Weitzman, Rosenthal, & Liu, 2011; Wilson & Durbin, 2010).

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McFarlane (2009) noted a conspicuous lack of research in this area from countries other than the USA. Prior to the recent and ongoing deployments to Iraq and Afghanistan (2001–present), Verdeli et al. (2011) concluded that studies throughout the 1980s and 1990s indicated that children and spouses experienced symptoms of depression and anxiety during, and immediately after, the deployment. It was suggested that they managed these demands successfully. The authors cite studies over this period where mean scores on measures of psychopathology in spouses and children were below clinical cut-offs. However, it must be noted there were significant gaps in the research because the bulk of the military family research at that time used quantitative survey methods that did not enquire into the actual experiences of parents or their children. As Fraser (2004) suggests, research needs 'to delve beneath statistically driven generalisations' and validate the knowledge of "ordinary" people' (p. 184).

Stafford and Grady (2003) suggest that children and adolescents may exhibit a diverse range of reactions to deployment which are dependent on their age, stage of development, personality, special needs and external environment. Toddlers may display extremes of behaviours such as tantrums and difficulty with sleeping. Pre-schoolers may regress, losing mastery of behaviours and exhibiting such symptoms as bedwetting (enuresis). School-age children may complain constantly, and teenagers may exhibit irritability and other negative behaviours (Stafford & Grady, 2003). Children and adolescents who have underlying mental health problems or special needs also require special consideration as they are likely to have greater difficulty in adjusting to the deployment of their parent (Stafford & Grady, 2003). This is reflected in more recent studies in the USA that found children whose parents are deployed may have more emotional difficulties when compared to national samples (Chandra et al., 2011), and that 'prolonged or multiple deployments of active-duty personnel may contribute to mental health problems among their children' (Mansfield, Kaufman, Engel, & Gaynes, 2011, p. 1003).

Consistent with international findings, the prevalence of mental health problems in Australia is high in the general population (14%) with a high rate of comorbidity in all age and gender groups (Sawyer et al., 2000). Children aged 6–12 years are more likely to have a disorder than are adolescents aged 13–17 years (17% versus 12%), but both children and adolescents with behavioural and emotional problems have a lower quality of life than those with fewer problems. Parents who care for young people with a disorder experience greater levels of concern and worry, and less time for their personal needs (Sawyer et al., 2000). However, unlike the USA, there have been no studies of Australian military children to determine if their mental health status is any different from that of the general population. Given that an estimated 43% of Australian Defence Force (ADF) personnel have been deployed multiple times, and that there is a notable trend towards a greater level of traumatic symptomatology for ADF personnel with each deployment (Commonwealth of Australia, 2011), the dearth of research is surprising.

A number of authors argue that the military family needs to be better understood by helping professionals, in order to form a working alliance (Hall, 2011; Pryce & Pryce, 2006). Knox and Pryce (1999) argue that social workers require an ecological lens through which to consider culture as a crucial practice principle. They suggest that social workers must understand the military culture and environment in which the family lives, as well as the norms and social beliefs held by the military family regarding their lifestyle. Furthermore, for successful practice to occur, the military hierarchy and system in which the family fits need to be understood.

Purpose of the Present Study

The purpose of this study was broad, and sought to gain knowledge and understanding of the experiences of ADF personnel who deployed to East Timor as part of a peacekeeping operation, and of their families who remained in Australia. This article draws on a selection of the data that focuses on parents' perceptions of their children's and adolescents' reactions to all the phases of the deployment.

Method

Qualitative data were collected from a sample of Australian Defence Force peacekeepers who had been deployed to East Timor and/or their partners. The rationale for a qualitative approach was that most of the existing research had been undertaken via quantitative surveys, and qualitative research methods were judged to be more suited to answering the overall research question: What are the experiences of Australian Defence Force (ADF) peacekeepers and their families in relation to overseas deployment? Since little research had been conducted with this population, the researcher was not sure to what extent this military family population would respond. Thus, a flexible method was employed.

A non-probability sampling method was chosen for this study. Schutt (2005) stated that because this form of sampling does not use random selection procedures, samples are not representative of the population from which they are drawn. However, qualitative research designs often rely on this sampling method because qualitative research is not concerned with a large representative sample, since it seeks depth of information rather than breadth (Minichiello, Madison, Hays, & Parmenter, 2004). Hence, the sample was chosen for the purpose of gaining in-depth information from a wide group of participants across a spectrum of experiences.

A total of 38 interviews were conducted involving 67 participants. Of the sample, 34 parents had deployed and 33 parents were non-deployed. Twenty-nine interviews were undertaken with couples who had children residing with them, and nine with individuals whose partners elected not to participate in the research or were unavailable due to a work-related absence. The sample included Army, Navy

and Air Force personnel of different ranks and military occupations and their partners. Although children were not interviewed, this sample of families comprised a total of 75 children, from neonates to 18-year-olds. Approximately 30% of the sample of 75 children consisted of pre-schoolers (0–4 years), 40% were middle primary school children (5–9 years), and approximately 30% were adolescents. One child was born the day before a Navy member deployed.

A coding system was developed to analyse the participants' stories, reflecting the research question and the theoretical framework of an ecological understanding. The rationale for this was that the author's categories meshed well with an ecological understanding which considered the multiple levels or domains of an experience. In summary, all transcripts were coded and categorised, and compared and contrasted to integrate into themes. Data analysis thus led to the major themes and concepts of the study. The researcher used NVivo, a software program that assists in electronic storage, filing and retrieval of large amounts of text (Bazeley, 2007).

Ethics approval for the study was obtained from both the Department of Defence and Monash University.

Findings

All interviewees were forthcoming in describing their children's and adolescents' experiences of military family life, deployment and its consequences. Descriptions of their reactions to the deployment and how parents attempted to seek help were described. Note that pseudonyms are used throughout.

Descriptions of Children's and Adolescents' Reactions

Participants reported that all stages of the deployment had an impact on their children's and adolescents' physical and mental health, and a number sought help. Before deployment, children's reactions mirrored their parents' concerns. Sleeping and eating problems were reported as common for children, and these continued many months post-deployment. Parents reported that children's grief reactions were palpable. Major changes in behaviour that were reported for children included tantrums, enuresis, inconsolable crying and upsets, school refusal, difficulty getting to sleep, nightmares and "clingier behaviour than usual". When asked to reflect upon less obvious behaviours, a number of respondents commented that children were "invisible", "quiet" and "moodier and sullen". Interviewees described such changes in behaviour and how they attempted to manage as follows:

> "Screaming in the middle of the night, inconsolable crying . . . they continued . . . a real terror for him in the middle of the night so he was able to come into our bed or we would sleep with him . . . we've got a mattress under his bed where we can pull it out and sleep in the bedroom." (Katrina)

> ". . . the one behavioural trait that was completely new to him . . . this awful crying that he would do, and it was never over being hurt or something . . . almost hysterical crying when something didn't go quite right." (Melissa)

Madeline provided the backdrop to her family's experience prior to the East Timor deployment. Her partner was on continual short notice to deploy and had only been at home in her estimation 12 weeks in the past 13 months due to frequent, expected and unexpected deployments, both overseas and in Australia, for training exercises. She explained the effect on her son in his early years and the actions she took:

> ". . . at three and a half I had him at a psychologist's and paediatrician's because he was losing hair through stress because daddy would go away and we wouldn't hear from him for weeks and he thought his dad was dead . . . " (Madeline)

Madeline dramatically and viscerally recounted how the East Timor deployment was almost the "straw that broke the camel's back" as she dealt with her own and her children's sorrow during the separation:

> ". . . one night . . . the poor kids. They are sitting there [points] in pain and crying . . . and everybody's hurting so I sat down at the table . . . I said 'how do you feel about your daddy being away?' Let's just go for it. Let's just cut the wound right open and get rid of all the pus. And she just . . . it just started to flow . . . And we'd go and sit on the settee, get the blanket over and have a good cry . . . "

Like a number of respondents, Madeline said Tom was withdrawn throughout the time her partner was away but "exploded" at times:

> ". . . he bottles up in terms of he does not talk about it but it comes out in his behaviour. A lot of angry, irrational, tantrums, loads of tears and aggression against me."

Mental health, behaviour problems and physical health were concerns for some adolescents during deployment. Eve's son was aggressive towards her. Mitchell's daughter lived with an anxiety diagnosis and received psychological counselling. Another broke out in rashes when her father deployed, and she refused to speak with him by telephone throughout deployment. Adolescents were reported to have conversations regarding their parent's deployment and were also reported to express support and worries about the deployed parent. Adolescents were more likely to act as caregivers for the non-deployed parent than younger children. Several adolescents were reported to manage the separation better than their parents although some were reported to "look after" their parent. Some families reported that their older children's education actually fared better than previously, while others indicated negative behaviours at home, school and in the community. Typical responses regarding adolescents were as follows:

> "My kids were actually better behaved. As I said, I mean, I'm the one that looks after them . . . it was the other way around . . . And they were looking after me . . . " (Jillian)

> "He's not aggressive generally . . . He actually got picked up for shoplifting during that time . . . " (Nancy)

> ". . . she'd break out in rashes and all sorts of things . . . that's her way of dealing with it, by not talking to him because then she doesn't have to explain that she's feeling upset that he's not there." (Cara)

> ". . . it was just that he was aggressive and he lashed out . . . even at me a couple of times. He can get quite uptight but he's never been that way before." (Eve)

When her partner was deployed, Josie was hospitalised and required emergency surgery for an ectopic pregnancy. Her teenage daughter was required to care for her since her partner was not approved to return from East Timor. Josie felt her daughter "grew up suddenly".

Mitchell's teenage daughter had a history of suicidal behaviour prior to this deployment:

> "She slashed her wrists once, overdosed with sleeping pills and tried to poison herself. The sleeping pills were probably the closest she got . . . "

Throughout the East Timor deployment Mitchell indicated his daughter's mental health was stable, although she was unable to complete her final year of education:

> "She just couldn't handle the exam pressure . . . she'd put herself under so much stress. I mean, she'd panic and she'd go all anxious and that sort of thing."

Many parents came into contact with social workers employed by the Department of Defence before and after their partners deployed. However, no contact was reported at post-deployment, which was a surprising finding given that families were adjusting to homecoming.

Seeking Help

Concerns about children's mental health and behaviour were common throughout deployment. Social workers employed by the Department of Defence are the primary service providers, and some respondents contacted them for information, seeking professional assistance for their children and adolescents. Several weeks into the deployment Emily's 8-year-old son, Kevin, displayed aggressive behaviour:

> ". . . he must have been angry, he was getting a bit violent with me, just pushing . . . I know he kicked a girl in the back, and probably he might have been clowning around in school . . . "

Emily spoke with a social worker, although she was unsure of the worker's role:

> ". . . he was a counsellor or something, because I had seen him once before. I don't know what he did – counsel people . . . "

Emily explained Kevin's behaviour and that her partner had recently been deployed. Emily indicated that the social worker said the "situation was very serious" and that a referral to a child and adolescent mental health service was needed:

> ". . . probably the name put me right off. He suggested that I go to . . . it was something like children's mental health, and I thought this is too serious, I'm not going to go there, they'll probably lock him up . . . "

Emily told the worker she would "think about it". No offer to meet with Emily and Kevin was made, and Emily received no follow-up telephone call. Instead, Emily sought the assistance of Kevin's teacher and a couple she had met through her church, and over time Kevin's behaviour was reported to settle:

> "I spoke to his teachers about it saying what situation he was in and also I had an old couple that I was friendly with. He sort of took him under his wing . . . "

Ruth and Owen recounted how their son's suicidal behaviour led to Owen returning to Australia before his deployment was completed. Their middle child, Aaron, 8 years old, became "out of control" several months after Owen deployed. Ruth stated that Aaron became "unsettled" when Owen deployed in the past but not anywhere near the extent when Owen deployed to East Timor. Aaron was also reported to be "excellent and popular" at school and "mad keen on sport". He had never had any diagnosed mental health concerns prior to deployment according to his parents. Typical of others, Ruth called on her own informal social network for support initially. This had strained relationships:

> "I enlisted help from my family like my dad who'd come and stay over sometimes or my mum. My parents are divorced. And even Owen's mum would come and stay with me for periods of time to help out because I was working as well but she couldn't stand it."

Ruth had contacted her local Defence family support office but did not establish rapport with the social workers:

> "I just found that they were a little bit harsh . . . just the couple that I had spoken to. It depends on who you get, really. Some people are better social workers than others, have better skills with talking to people."

The experience with the social workers deterred Ruth from utilising Defence's formal support further. She was prepared to be placed on a waiting list for service through a non-Defence community family support organisation:

> "That's Why I'd got my own resources . . . gone through the community centres and found out about this person who could come out to my home and so I got on the waiting list . . . "

A family support worker assisted Ruth by visiting weekly and developing parenting strategies. As Ruth described it, "she was a mobile worker who came to me". Ruth's son was also referred to a child psychiatrist. Ruth described how the situation with Aaron came to a head one evening when the family support worker was present:

> ". . . he would just be running into his bedroom, running into the walls at full pelt . . . Sarah witnessed this episode with Aaron where basically he threatened to stab himself with a really sharp knife in the kitchen . . . And she rang the psychiatrist and said, 'look, this is getting to breaking point' . . . He said 'well I can put him in the psychiatric facility at the children's hospital or we can put him on some drugs or we can try and get the husband back'. And so obviously I said, 'I don't want 1 and 2'. . ."

Ultimately, the child psychiatrist provided a report for the Defence network, and Ruth contacted a social worker as well as Owen in East Timor to inform them of the psychiatrist's assessment. Ruth emphatically "told the social worker" she did not want Aaron placed in a psychiatric facility. Owen was returned to Australia within 48 hours of the event. Both Ruth and Owen stated they felt shattered by the experience. Ruth indicated she felt inadequate as a parent as a result of the experience. Owen believed he had let his unit down in East Timor by returning for a "family matter" over which he had little control.

Katrina had been diagnosed with post-natal depression prior to her partner's deployment. Katrina had been placed in a mother–baby unit after the birth of her first child, and her newborn was 4 months old when her partner was deployed. According to Katrina, the social worker was aware that Katrina had been diagnosed with post-natal depression, yet did not refer her to a social worker when she relocated to a new locality to be near her parents for support. Another non-social work staff member made a home visit:

> "I entertained her . . . I felt like really nothing came of it . . . And that I was better off doing it myself."

Katrina did not question the appropriateness of the visit because she thought information would be passed to a social worker, but no follow-up ensued. Katrina was familiar with the process for admission to a mother–baby centre and facilitated this herself. Katrina did not contact a Department of Defence social worker again and located support via a referral to a psychologist through her doctor.

Shona, an Air Force partner diagnosed with depression when her partner deployed, contacted a social worker for assistance with childcare. Shona did not disclose her diagnosis as she was getting assistance via her doctor. Shona was shocked and annoyed when her request for assistance with childcare was unable to be met:

> ". . . she said 'I'm your social worker for the East Timor deployment. I'll be looking after you while your husband is over in East Timor, anything you need please contact me . . . We're here to help' . . . I knew it was coming up and I asked them could they arrange for some childcare because I didn't know anyone in the area . . . I'd given them like nearly a month's notice and on the Wednesday I said 'what's going on?' and they said 'we can't supply you childcare' and I said 'well, thanks very much'."

Shona felt unsupported. When she contacted the worker near the end of the deployment to ask why she had not received ongoing contact and for the situation to be changed, Shona felt the social worker did not care and Shona "gave up".

A small number of respondents described positive experiences with social work interventions. In contrast to the findings cited above, in these instances a helping alliance was evident as well as knowledge and expertise which heightened meaningful engagement. One respondent whose partner, Doug, had been involved in contact with militia in East Timor, during which a number of militia were killed, sought counselling with a social worker. Robyn was unsure whether the couple should talk about this with their child when he was older. Robyn was also concerned about how to make sense of the incident and talk about it with her partner, family and friends:

> "I found it very hard saying, thinking that he'd done this and I understood what he had done, but do I ask him about it? Do I talk to him about it? Do we one day tell Justin what has happened? . . . I talked to her about that and she helped me get over that . . . "

Interestingly, when Robyn formed a working alliance with the worker, she described how she was able to disclose that her husband had had an affair when on deployment. Friends and family had implored her to leave her partner. Robyn felt family members did not understand, and she discussed this with a social worker:

> ". . . I just wanted someone to listen to me about how I feel . . . I knew I needed help if I wanted to get over it, and I wanted our marriage to work. Like I knew I had to get myself better or get over it before he came home . . . "

Robyn's experience of being listened to by the social worker led her to recommend the social worker to a friend:

> "I've got a girlfriend whose husband is away at the moment for five months and she's got two younger kids . . . and I talk to her and say look, 'why don't you go and talk to someone?'"

Discussion

The findings of this study of parents' perspectives of their children's and adolescents' reactions to all stages of the military deployment detail how their children fared in terms of physical and mental health and its consequences for these military parents. The findings regarding children's and adolescents' reactions to their parent's deployment were concerning. As reported by their parents, children and adolescents were very aware of, and worried about, their parent's military employment and deployment. A major theme was the enduring suffering before, during and after deployment, of a significant number of young children, in particular. Parents' descriptions of their children's and adolescents' symptoms were consistent with undiagnosed mental health conditions, including depression. The evidence that some

interviewees sought assistance from social workers for their children and reported that they did not receive adequate help was a significant cause for concern, as was the finding that many children's and adolescents' problems were not identified or treated. A further notable finding was the variability in quality and effectiveness of social work interventions. In previous research, negative opinions of the service system have been shown to be influenced by prior experiences, particularly with respect to the child protection system (Dale, 2004; Farmer & Owen, 1995) and social work practice in general (Cree & Davis, 2007). However, to the authors' knowledge, prior to this study no research had been conducted with military families to gain their perspective.

Children's reactions to deployment reflected that of their parents. A number of interviewees were struggling with additional parenting demands and their own significant physical and mental health concerns. This situation compounded their children's and adolescents' problems and posed risks to their development. Evidence of delays in development of a number of young children was apparent after deployment. Given that childhood and adolescence are critical periods of development that may predispose people to adverse experiences in later life (Rutter, 2000), these findings have a number of important policy and practice implications.

Previous studies have outlined how children's reactions to a deployment may reflect their mother's reactions. Drummet, Coleman and Cable (2003) suggested that if a parent's reaction to the partner's deployment is depression, then the child may mirror the depressive symptoms or behaviours. Mothers with depression are often less nurturing towards their children, may use more physical punishment, and there is an increased chance of delays in children's language, social, emotional and cognitive development (Barlow et al., 2010). In this sample, it is possible that a number of children's reactions mirrored their parent's reactions. Shona's, Madeline's and Katrina's situations provided evidence of this phenomenon and some evidence of delays in their children's development. Children's emotions of sadness, anxiety and fear in reaction to the separation of the deployed parent have been described as 'normal' behaviour (Black, 1993, p. 277) and predictable emotional responses (Stafford & Grady, 2003). However, it is simplistic to describe Shona's, Madeline's and Katrina's situations with respect to their children as a normal, predictable response to separation. It is suggested that these and other children's behaviours that endured throughout, and after deployment, are concerning and may have indicated a developing, undetected and untreated mental health condition.

According to their parents, adolescents were very aware of, and worried about, the dangers of deployment, which is consistent with previous research by Huebner, Mancini, Wilcox, Grass, & Grass (2007). There was some evidence of pre-existing mood and anxiety difficulties as well as changes that occurred throughout deployment. Pre-existing mental health conditions included suicidal behaviour and anxiety. Such was the case for Mitchell's daughter who had received counselling prior to and during the deployment period. Mitchell's daughter was unable to complete her second attempt at the final year of secondary education due to an anxiety and panic disorder.

Most respondents who sought help for their children described the assistance as inadequate and unhelpful. Three interviewees, comprising one couple, and Robyn, a partner, said their experience was helpful. One respondent, Katrina, gave a mixed response. Most respondents tended to manage alone, received limited assistance and suffered emotionally, which is likely to have also influenced their children's wellbeing. Some respondents stated that social workers provided counselling prior to and during deployment. However, post-deployment, no respondent stated that they had any involvement with a social worker. A telling finding was that social work or other professional interventions were sought infrequently despite the fact such a service existed for families and parents who wanted contact from social workers. It is suggested that a number of these families could have been better assisted if social workers made routine contact with families throughout all deployment stages, built trust and used sound assessment skills (Harms, 2007) to provide a pathway to care where required.

Inadequate child and family assessment by social workers was a common experience, as demonstrated by Katrina and Shona, who both had young children and their own diagnoses of depression. It is suggested that these very young children's needs were overlooked, which could have posed risks to their language, social, emotional and cognitive development. Emily was deterred by the social worker's suggestion that Kevin needed to see "Children's Mental Health" since Emily felt "they would lock him up". It is evident that a working alliance was not established since Emily dismissed the social work advice and sought the help of others. Emily and Kevin may have benefited from a range of options. For example, the social worker could have offered to meet with Emily and Kevin and make an initial assessment of the situation. Further information may have been elicited as to whether Kevin's behaviour was normal in the context of the deployment, or suggestive of further exploration. An explanation of how child and adolescent mental health services work with children and families may have tempered Emily's concerns.

Good practice strategies suggest that policy should enable referral to couple or family therapists as required, including post-deployment (Wiens & Boss, 2006). A number of respondents did not obtain the necessary assistance after deployment due to a lack of any follow-up by social workers. This suggests a significant policy practice gap on the part of the Department of Defence, given the findings of mental health concerns for this sample.

Limitations

Although interviewing couples yielded rich information, interviewing together may have constrained openness about some sensitive experiences, such as domestic violence or

child abuse. Respondents could have been interviewed separately and then a joint interview conducted, but this would have entailed an additional 90 interviews, which was beyond the scope of this study. Children and adolescents were not interviewed in this study. This study only elicited parents' views of their children's needs and behaviours. Thus, children's voices have been heard through their parents' descriptions, limiting the conclusions that can be drawn regarding children and adolescents. Parents may have under-reported or over-reported their children's experiences. Finally, social work perspectives would have yielded valuable information, but this was beyond the scope of this research.

Conclusion

The findings of this study suggest that children and adolescents struggle with many serious issues when their parent figures are involved in a military deployment, and they may not gain appropriate assistance. Since this study was completed, the Department of Defence has made deployment support a core policy practice priority. The first author's report to Defence in 2003 (Siebler, 2003) has made a contribution to this change. Family-sensitive practice is now articulated across Defence's family support and mental health organisations (Commonwealth of Australia, 2011; Department of Defence, 2011). Notwithstanding, further research is required with children and adolescents themselves about their experiences. The lack of research in this area is a glaring omission from Australian and international military family research and urgently needed, given the contemporary deployments to 'theatres of war' such as Afghanistan. Qualitative research would be well suited to interviewing children and adolescents. A child-centred approach (Mudaly & Goddard, 2006) would place children's voices as central to the research. It is important to gain a fuller understanding of their experiences. As silent sufferers, children are not at the front line of the Department's family support or mental health strategies and are likely to be a population at considerable risk.

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