Reunification: The Silent War of Families and Returning Troops

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Military families grapple with a host of stressors when service members are called to war—and others when these warriors return home and must adjust once more to family life. Yet few studies have examined these struggles and the effects they can have on the health of all involved. Here, a review of the existing literature that identifies specific areas in need of further research.

The image of a soldier returning home from war is a powerful one. When we imagine the event, most of us probably picture the soldier falling into the arms of loved ones—spouse, children, parents, siblings, and friends—in a joyous reunion. And while this scenario is the reality for many service members and their families, it usually is not the end of the story.

The truth is that, both during and after wartime military deployments, families of service members face different kinds of battles at home. While the service member is deployed, those at home must deal with logistic, emotional, social, and financial challenges related to this absence. After the family is reunited, an initial "honeymoon" period typically is followed by a period of adjustment, which may be complicated by mental or physical problems the deployment has caused or exacerbated for the service member or family members.[1] If the family unit is unable to cope with these challenges in healthy ways, the situation may begin to spiral downward.

Given the known interactions between an individual's health and his or her family situation, it is important for federal health care providers to possess a strong knowledge of the problems families face when service members go to and return from war. With this knowledge, providers can identify those families at greatest risk and implement appropriate screening and treatment measures.

To help foster such knowledge, this article will review recent research regarding how war impacts service members and their families. It will describe current data on deployment- and reunification-related problems; discuss some of the challenges inherent in screening for, treating, and preventing such problems; and point out areas in which more research is needed. First, though, it will review the resiliency perspective, a useful approach for describing a family's ability to respond to stressful situations.

A RESILIENCY PERSPECTIVE

The key concepts that comprise the resiliency perspective are stressors, resiliency, positive adaptation, and negative adaptation. Stressors are the increased demands placed upon families in difficult situations, including wartime deployments. The severity of a stressor is determined by the degree to which the stressor threatens the stability of the family unit or places demands on or depletes the family's resources and capabilities.[2–4] Resiliency is a family's ability, as determined by positive behavioral patterns and functional competence, to adapt to stressors. Through resiliency, a family can overcome stressors, maintain its integrity as a unit, and ensure or restore the well-being of family members.[5] Good family resiliency in the face of stressors reflects positive adaptation, and poor family resiliency in the face of stressors reflects negative adaptation.

Wartime deployments have been associated with increased stressors for all family members. Such deployments generally necessitate a family member's absence from the home and presence in a war zone for a period of one year or longer, which often requires a remaining family member to assume exclusive responsibility for child caretaking and discipline during this period.[2–4] Although modern communications are helping today's deployed service members to stay actively connected with their families, this connection can increase some types of stress even as it relieves others.[6]

After a deployment, reunification of the family also can involve a number of stressors, even in families with excellent relationships and track records of success. The reunification process, which includes the anticipation

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of the upcoming reunification, can have a major impact on relationships between partners, siblings, parents, and children and on the family's social contacts, goals, established patterns of functioning, and balance and harmony.[2–4] After the euphoria of their safe return from the war zone has worn off, returnees may face new—or old—problems on the home front and, in the case of reservists or guardsmen, at their places of employment.[7]

FAMILY PROBLEMS DURING DEPLOYMENT

Deployment can have a major detrimental impact on service members' spouses or significant others. Preliminary data from an ongoing investigation of the resiliency of military families in Hawaii during the reunification period (defined in the study as three months before through three months after the service member's return) provide some evidence of the stress these family members experience during deployment. In this study, of 136 spouses of deployed service members who responded to a survey sent at three months prior to the service member's return, 5.1% reported experiencing suicidal ideation between one and 45 times over the past three months (P. A. F. McNulty, unpublished data, 2008).

In addition, an increase in child maltreatment recently has been linked to combat-related deployment of enlisted service members.[8,9] A descriptive case series of substantiated incidents of parental child maltreatment (which included neglect, physical abuse, emotional abuse, and sexual abuse) in 1,771 families of enlisted U.S. Army soldiers who experienced at least one combat deployment between September 2001 and December 2004 showed that, overall, maltreatment occurred at higher rates during the times when the soldier-parent was deployed compared with the times when this parent was not deployed (relative risk [RR], 1.42).[8] The rates of moderate or severe maltreatment also were higher during deployments (RR, 1.61). Of the specific categories of maltreatment, child neglect occurred nearly twice as often during the deployment period (RR, 1.95), while physical abuse occurred less frequently (RR, 0.76). Among female civilian spouses, overall maltreatment incidents increased more than 300%, incidents of neglect increased almost 400%, and physical abuse increased almost 200% during deployments. Based on these findings, the authors identified a need for "supportive and preventive services for [U.S.] Army families during times of deployment."[8]

Another study, a time-series analysis of Texas child maltreatment data from 2000 to 2003, found similar results.[9] This analysis showed the rate of occurrence of substantiated child maltreatment in military families doubled in the period after October 2002 (one year after the U.S. military response to the September 11th terror attacks). Among military families with at least one child, each 1% increase in the percentage of active duty personnel departing to or returning from operation-related deployment corresponded to an approximate 30% increase in the rate of child maltreatment. Nonmilitary caretakers in military families were responsible for the majority of maltreatment reported from December 2002 to April 2003—a period that also saw an increase in the rate of maltreatment, the greatest percentage of service member departures, and the lowest percentage of service member returns. The authors of the study noted that this finding "further suggests that the stress of war extends beyond the soldier to the family left behind."[9]

While further research is needed to fully understand the problem of child maltreatment during deployment, the evidence thus far suggests that civilian spouses of deployed service members may require additional support resources, more effective and desired services, and greater outreach to connect them with these services.

FAMILY PROBLEMS AFTER REUNIFICATION

Mental health of returning service members

Mental health problems have been reported in 26% of service members returning from Operation Enduring Freedom and Operation Iraqi Freedom since 2003.[10] Hoge and colleagues found that, of 3,671 service members who were involved in combat in Iraq or Afghanistan, up to 17% reported symptoms consistent with major depression, generalized anxiety, or PTSD.[11] Alcohol and drug abuse also are common problems for returning service members. A possible contributor to this problem could be the accessibility of some substances in Iraq and Afghanistan. Clinicians in Iraq report that alcohol is easily accessible and black-market diazepam is cheap and readily available.[12] In Afghanistan, opium poppies and marijuana remain the two largest cash crops.[13] In surveys completed three to six months after their deployments to Iraq, 11.8% of active duty service members and 15% of national guard or reserve members reported problems with alcohol.[14]

PTSD is a particular problem for families of service members who have returned from war-related deployment, as it is a relatively common affliction of these service members and is known to cause difficulty in maintaining stable family relationships.[15] A recent study indicated that the preva-

lence of PTSD may be related to the extent of service members' combat experiences.[11] When 1,709 service members were surveyed upon returning from Iraq, PTSD was found to affect 4.5% of those who had experienced no firefights, 9.3% of those who had experienced one to two firefights, 12.7% of those who had experienced three to five firefights, and 19.3% of those who had experienced more than five firefights. Similarly, when 1,962 service members were surveyed after returning from Afghanistan, PTSD was found to affect 4.5% of those who had experienced no firefights, 8.2% of those who had experienced one to two firefights, 8.3% of those who had experienced three to five firefights, and 18.9% of those who had experienced more than five firefights. Authors of this study also found that rates of PTSD were significantly associated with having been wounded or injured in battle (odds ratio for service members returning from Iraq, 3.27; odds ratio for service members returning from Afghanistan, 2.49).[11]

Another study indicated possible links between PTSD and respondents' military branch and rank.[10] It found that, while 11% of respondents who had served in the U.S. Army or U.S. Marine Corps experienced PTSD, only 3% of those who had served in the U.S. Navy or U.S. Air Force experienced the disorder. In addition, the PTSD rate was 10% for enlisted respondents but only 5% for officer respondents. Respondents who had served in the U.S. Army Reserves or National Guard, however, were about as likely as active duty respondents to experience the disorder (10% versus 9%, respectively). Similarly, the proportion of patients with possible PTSD did not vary substantially according to sex, race, or age.[10]

To complicate the matter, many returning service members are grappling with multiple mental health disorders, which may be interacting with one another. Reports in the relevant literature suggest that 80% of individuals with PTSD—both civilian and military—also meet the diagnostic criteria for at least one other psychiatric disorder,[16] and PTSD may precipitate or worsen the effects of other disorders, such as depression.[14] Substance abuse, in particular, is a frequent comorbidity of PTSD.[17] Furthermore, many returning service members are at an age when first episodes of depression, mania, panic disorder, and schizophrenia often manifest. And, as Reeves and colleagues point out, "It is easily conceivable that in a person susceptible to a certain disorder, that disorder could be precipitated or exacerbated by the stress of war."[14]

PTSD and partner burden

A service member's PTSD can contribute greatly to the burden the spouse or partner bears,[18] leading to stress that is comparable to that brought about by a partner's chronic disease in later life.[19] Research has demonstrated strong associations between PTSD and low marital satisfaction and the likelihood of divorce.[20] A study of 89 cohabitating female partners of combat veterans with PTSD indicated that these partners had severe levels of overall psychological distress, depression, and suicidal ideation.[18] Approximately 15% of them reported recent suicidal ideation, over 60% reported that their veteran partner demonstrated a physical threat to their well-being, and 25% reported receiving some mental health treatment during the six months prior to the study's initiation.[18] Another study examined the intimate partners of Dutch peacekeepers who had participated in military actions.[21] The study found that the partners of peacekeepers with PTSD were more likely than other partners to exhibit posttraumatic stress symptoms themselves.[21] These findings were consistent with previous research indicating increased psychological symptoms among partners of war veterans with PTSD compared to partners of veterans without PTSD.[22,23]

Partner burden caused by PTSD, in turn, can hinder the treatment of the partner with PTSD.

Partner burden caused by PTSD, in turn, can hinder the treatment of the partner with PTSD, as stressful family environments have been shown to have a negative impact on PTSD treatment outcomes.[24] More research is needed, however, to understand exactly how distress in partners relates to treatment outcomes.[18]

Does combat make returning service members more violent at home?

Some reports in the literature have suggested that spousal and child abuse may be related to deployments and the increased stress that occurs before, during, and after them.[25,26] The two studies of child maltreatment in military families discussed earlier provide evi-

dence that some types of child abuse may increase while service members are deployed.[8,9] But the question of whether there is a rise in domestic violence linked to service members' return from combat-related deployment has yet to be illuminated fully.

Findings from one study comparing self-reports of a 15% random sample of 26,835 active duty U.S. Army soldiers who had deployed during peacetime deployments with active duty male soldiers who had not deployed indicated that the risk of severe domestic violence was related to the length of deployment, although this risk was small (1%).[27] Findings from two studies involving U.S. Army soldiers and their spouses have suggested, however, that deployment alone is not a significant predictor of domestic violence after family reunification.[28,29] In the first study, 1,025 active duty, male soldiers—313 of whom had been deployed to Bosnia for six months and 712 of whom had not been deployed—completed an anonymous survey about postdeployment domestic violence three to five months after the deployed soldiers returned.[28] The second study looked at anonymous surveys on domestic violence completed by 1,025 wives of soldiers—368 whose husbands had been deployed to Bosnia for six months and 528 whose husbands had not been deployed—about 10 months after the deployed soldiers returned.[29] Neither study found a relationship between deployment and risk of domestic violence, although both found that this risk was greater in soldiers who were younger or who had a history of predeployment domestic violence.[28,29]

The findings of these studies, while important, are limited to peacetime and peacekeeping missions. The impact of war on families since the terror attacks of September 11, 2001 is in the infant stages. In addition, the authors of the study that surveyed soldiers' wives suggested that future studies address postdeployment domestic violence in the longer term (beyond 10 months).[29] They also hypothesized that longer deployments or increased operational tempo in both deployed and nondeployed military units might have substantial effects on family conflict and domestic violence.[28]

A 2000 study of the prison system found that veteran prisoners were more likely than nonveteran prisoners to have been imprisoned because of violent incidents. Of the veteran prisoners in the study sample, 20% had been involved in combat.[30] As the number of combat veterans has increased dramatically since 2000, more research is needed to determine the current percentage of imprisoned veterans who have had combat exposure.

EFFECTS OF MULTIPLE AND EXTENDED DEPLOYMENTS

As Operations Iraqi Freedom and Enduring Freedom continue, many service members and their families are experiencing multiple deployments and reunifications—with some already having gone through five or more. Additionally, in April 2007, all active duty army troops assigned to one-year tours in Iraq and Afghanistan had those tours extended to 15 months, with one return trip home. Moreover, the reserve components of the army have been mobilized to the fullest extent to support both conflicts, which marks a utility strategy for these troops that is distinctly different from that employed in previous conflicts. Under these circumstances, more research is needed to compare the effects of single deployments with those of multiple deployments with regard to family stress and resiliency.

A study of Canadian families in which a family member had an oversea deployment lasting at least six months found no significant differences between families who had experienced a single deployment and those who experienced multiple deployments. Families of junior ranked soldiers, however, reported significantly more family-related stress than families of senior ranked soldiers.[31]

My own interactions with army families in Hawaii led me to observe how the news of the recent extension of army tours to 15 months, which came only weeks before the date some deployed soldiers were expected to return home, magnified existing stress for many spouses of these soldiers. The ongoing study of the resiliency of soldier families during the reunification period, mentioned earlier in this article, will report on family adaptation and stressors (including self reports of suicidal ideation, suicide attempts, and incidents of physical abuse in the family) and will take into account the effects of multiple and extended deployments.

RESERVIST AND GUARDSMEN VS. ACTIVE DUTY FAMILIES

Families of reservists and guardsmen are believed to have less social support than those of active duty service members, who usually live near or on the military base.[7] Since social support has been linked to better family adaptation and resiliency, one could hypothesize that reserve and guard families are at greater risk during the reunification process due to decreased resiliency.[2]

Indeed, preliminary data from the ongoing study of resiliency among military families provide some evidence that spouses of reservists have less support than spouses of active duty service members due to their isolation from existing army readiness groups and reserve centers—and that these families continue to receive relatively less support after the service

member's return from deployment (P. A. F. McNulty, unpublished data, 2008). In addition, these data indicate that spouses of reservists have a higher rate of suicidal ideation than spouses of active duty service members (P. A. F. McNulty, unpublished data, 2008). Moreover, these families appear to have a higher divorce rate (P. A. F. McNulty, unpublished data, 2008) when compared to that previously reported for families of navy personnel returning from non–war-related deployments in Okinawa, Japan.[32]

Reservists and guardsmen also may be at higher risk for PTSD than active duty military personnel—for several reasons.[33] Compared to active duty service members, reserve members have less training, belong to less cohesive units, receive less formal or informal postdeployment debriefing, and return to a community with fewer new veterans who can provide them with support. Studies of troops in the Persian Gulf War have provided evidence for an increased prevalence of PTSD and depression among reservists than among active duty personnel.[34,35] Data from the present conflicts, however, have indicated that reservists are no more likely than active duty service members to develop PTSD.[10] Clearly, more research is needed in this area.

CHALLENGES OF SCREENING, TREATMENT, AND PREVENTION

The DoD has implemented primary care practice guidelines for delivering postdeployment health care to service members and their families.[36] Even so, only 7.6% of service members seen in mental health clinics in their first year after returning from deployment were referred from the Post Deployment Health Assessment program initiated by the DoD for all returning service members.[37]

In screening for mental health problems, it is important to consider that prodromal symptoms may not evolve into a disorder for many years.[7] Traumatic stress response to war may be chronic and develop months to years after the traumatic event.[14] Service members are more than twice as likely to report mental health concerns three to four months after returning from deployment as they are to report them immediately upon return.[38] This makes identification and follow-up for treatment especially challenging, particularly when troops are being sent back to combat for repeat tours. With these factors in mind, the DoD now focuses on a second interview of returning active duty members three months after reunification.

It also has been reported that recent military returnees face a strong stigma against disclosure of PTSD and other psychiatric problems, which makes them less likely to seek assistance.[15] Many choose civilian counseling to ensure confidentiality. Moreover, the fear of stigmatization among active duty service members creates an environment of secrecy that often extends to all family members and inhibits identification of at-risk families. In the aforementioned study in which Hoge and colleagues surveyed 3,671 service members returning from Iraq and Afghanistan, only 38% to 45% of those whose responses met the criteria for a mental disorder according to strict case definition indicated an interest in receiving assistance.[15] Fears of stigmatization and barriers to accessing and receiving mental health services were cited as obstacles to treatment.[15]

Reservists who are not on active duty are eligible to receive five years of VA services for their combat-related conditions. By contrast, spouses of returning reservists are eligible for psychiatric services for only six months after the termination of their spouse's obligated service. For many spouses, this period of eligibility is not sufficient—especially when symptom manifestation is delayed—and only additional medical insurance can provide them with the services they require. Thus, support arrives too late or not at all for many spouses. Additional research is needed to determine the long-term burden (beyond one year after return from deployment) that the current conflicts will have on the psychiatric health care system.[20]

In addition to helping the current service members and veterans and their families cope with the difficulties of deployment and reunification, it is incumbent upon us, as federal health care professionals, to learn the lessons of this conflict and apply them in preparing preventive measures for future conflicts. To that end, it will be important for health care providers to identify predictors for the family problems that occur prior to, during, and after deployments and require intervention. Previous research has identified risk and protective profiles for family members of active duty service members deployed during peacetime operations[32] and for active duty navy personnel deployed to Iraq and Afghanistan on aircraft carriers.[39]

To fully assess service members or veterans and their families during the reunification period, providers should address a broad range of issues, including psychological and physical health, anxiety, resiliency, coping techniques, social support, communication, military coherence, self-reliance, well-being, and adaptation. Once risk and protective profiles are established, nurses and clinicians can develop appropriate programs of prevention for service members and their families who will be called upon in future war deployments.

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CONCLUSION

Today, service members' families are dealing with strains, limited resources, life events, military events, and repeated deployments to war. The adaptation of families to the challenges of both deployment and reunification—especially now that such deployments have been extended beyond 12 months—needs to be examined to allow appropriate programs of intervention to be initiated. Additional research is needed on these topics, particularly with regard to families of reservists and guard members and the dynamics of these families. ●

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