

Adaptability and Resiliency of Military Families During Reunification: Initial Results of a Longitudinal Study

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After the initial “honeymoon” period, the family’s readjustment to a service member’s return from war can be difficult, especially when the war has had lasting effects on the service member. This study attempts to identify factors that increase or decrease the risk of family problems.

With Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) ongoing, deployments to a theater of war currently are inherent in U.S. military service. Such deployments, the separation that goes along with them, and the readjustment and adaptation that must occur once the service member returns home are a source of stress for family members and can have a number of detrimental effects on the family unit.¹

Adjustment to family reunification is difficult, even following peacetime deployments. When the deployment is to a combat zone, however, additional strain on the family may result from the effects war has had on the service member. After OEF and OIF deployments, it’s been estimated that up to 17% of service members may experience symptoms consistent with major depression, generalized anxiety, or posttraumatic stress disorder (PTSD).² The latter disorder is associ-

ated with substance abuse,³ may precipitate or worsen the effects of other disorders,⁴ can contribute greatly to a spouse’s or partner’s burden,^{5,6} and can cause difficulty in maintaining stable family relationships.³

Other links have been proposed between war deployments and family problems. Some research suggests that service members’ children may be more likely to experience maltreatment during their parent’s deployment to a war zone than at other times.^{7,8} And, while studies investigating a possible link between deployment and domestic violence occurring up to 10 months after the service member’s return did not find such a link, no research has addressed postdeployment domestic violence in the longer term.⁹

Many variables have the potential to influence the impact that wartime deployments, and reunification after these deployments, have on service members’ families. A study of service members deployed in OEF and OIF found that members of the enlisted ranks had a 10% rate of PTSD—double the 5% rate found among officers.¹⁰ Furthermore, while the same study found that reserve and active

duty service members had similar rates of PTSD (10% and 9%, respectively),¹⁰ studies of troops in the Persian Gulf War found that PTSD and depression rates both were higher among members of the reserve forces than among active duty service members.^{11,12}

Additionally, many troops have been deployed to Afghanistan or Iraq for extended periods and many have been returned for second, third, or fourth deployments. Frequently, these redeployments have occurred within the year following a 15-month deployment, leaving minimal time at home for the service member to receive adequate care and heal from the effects of war. It is possible that these multiple and extended deployments could result in greater negative effects on the family than single or shorter deployments.

Major gaps remain, however, in our understanding of factors that put military families at risk for—or that protect them from—experiencing problems after the service member returns from a wartime deployment.¹³ In an attempt to fill in some of these gaps, this article describes initial results from a quantitative, longitudinal

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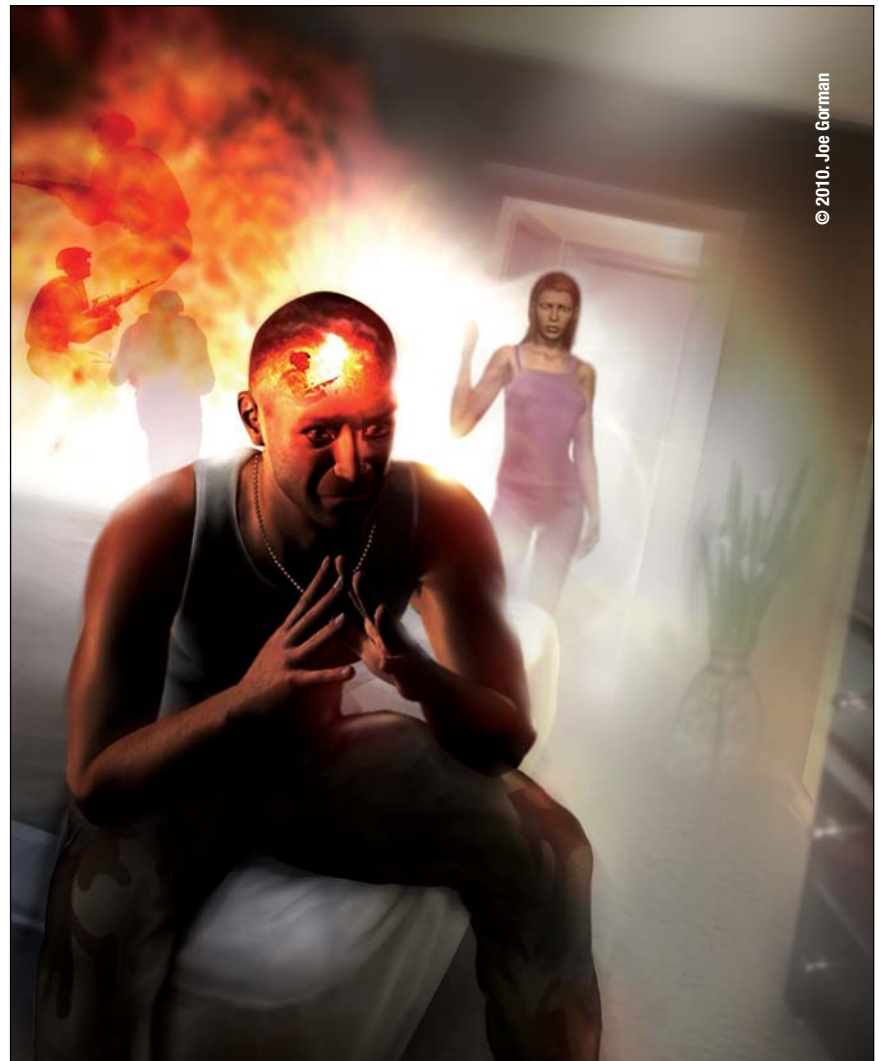
study, involving spouses of active duty army service members and army reserve members. The purpose of this study was to identify and describe the adaptability, resiliency, communication, functioning, well-being, and self-reliance of families of OIF/OEF service members—as reported by the spouses who remained at home—over an extended period from three months before to 12 months after reunification. Secondary objectives were to identify specific periods of time during the reunification process when the risk of poor adaptation is highest for families and to give spouses of deployed service members a chance to voice what they and their families are going through. The ultimate goal is to use knowledge gained from this study to construct risk and protective profiles that can help anticipate problems and guide interventions for families of future deploying active duty army and army reserve members.

This article presents results from analysis of the data collected during the first two phases of the study, from three months before to three months after reunification. Data from the last two phases (six months and 12 months after reunification) will be published separately.

METHODS

Design and participants

This quantitative, longitudinal study used a repeated measures design. At four points in the reunification process—three months before reunification (phase 1), three months after reunification (phase 2), six months after reunification (phase 3), and 12 months after reunification (phase 4)—the study participants completed a series of questionnaires designed to assess family adaptability, resilience, and well-being and the spouses' own levels of stress, anxiety, and psycho-



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logical health. The study protocol was reviewed and approved by the Institutional Review Boards of the University of Hawaii, Tripler Army Medical Center, and the Uniformed Services University of the Health Sciences' TriService Nursing Research.

Spouses of army active duty service members and army reserve members were enrolled by a sample of convenience. Active duty spouses were approached through attendance at Family Readiness Group meetings, which are conducted for spouses prior to service members' return, held at multiple locations throughout Hawaii.

Additional recruiting of army active duty spouses was conducted through booths set up in front of the Army Exchange store. Spouses of reserve members were recruited through the U.S. Army Reserve web site.

Assuming an alpha of 0.01, a power of 0.95, an effect size of 10%, four observations per participant, and an effect size variability of 0.1, the study required 47 participants to be adequately powered.¹⁴ Due to the large number of variables in the study, however, a larger sample was obtained for each group: A total of 455 participants—325 spouses of army

active duty service members and 130 spouses of army reserve members were enrolled.

Data collection

At each of the four assessment points, survey instruments were mailed to study participants. After completing the instruments, participants mailed them back using a self-addressed, prepaid envelope.

The phase 1 mailing included a demographic questionnaire, which asked participants to provide such information as their gender, age, level of education, history of psychological care or medication, duration of marriage, and parenting status. The questionnaire also included items about the service member to determine active duty or reserve status, officer or enlisted status, and number and duration of prior OIF or OEF deployments.

Instruments used at all four study phases included the following assessments of family resiliency and adaptability by McCubbin and colleagues: Family Changes and Strains (FCS), Family Problem Solving Communication (FPSC), Family Adaptation Checklist (FAC), Family Attachment and Changeability Index (FACI-8), Family Member Well Being (FMWB), and Self Reliance Index (SRI).¹⁵⁻²⁰ The State Trait Anxiety Index (STAI) by Spielberger also was used.²¹

The FCS measures self-reported levels of strains and changes in the family over the previous three months. FCS scores range from 0 to 3, with a score of 3 reflecting the ability to deal with multiple strains associated with separation of spouses in the military.

The FPSC measures the ability of families to discuss problems using good communication skills and respect. As with the FCS, scores for the FPSC range from 0 to 3.

The FAC measures the number of times a spouse or family member self-reports experiencing negative events, such as steps toward divorce, physical abuse, alcohol abuse, suicidal ideation or attempts, trouble with the law, accidents, financial hardships, deaths in the family, or hospitalizations. The tool was weighted, with the highest possible score being 100 (for no events). Depending on the event and the number of times the event occurred, negative scores (less than 0) were possible to achieve. For the purposes of this study, these negative scores were assigned a value of 0.

The FACI-8 measures family functioning using two subscales—attachment and changeability. Scoring intervals are used to classify the family functioning into one of several types: balanced family, indicated by a score of 6 to 6.5, moderate family, indicated by a score of 4 to 4.5, and poorly adjusted family or family in crisis, indicated by a score of 1 to 3.5. These scores were then calculated from each time point to determine if family functioning was improving, declining, or severely declining over time.

The FMWB measures participants' well-being by assessing their self-reported levels of energy, depression, fear, anger, sadness, and overconcern about the family's health. Scores range from 0 to 100, with 100 indicating the highest level of well-being.

The SRI measures the participant's ability to be self-reliant in the community. Scores range from 1 to 3, with scores of 2 and higher indicating positive adaptation and resiliency.

The STAI measures self-reported stress and anxiety over the previous three months. Scores range from 0 to 100, with lower scores indicating higher levels of stress and anxiety.

In addition to these instruments, the respondents were given the opportunity to write comments and remarks.

This feedback, as well as that obtained informally during calls with the principal investigator, were included in the study as qualitative results.

Data analysis

Cronbach alpha values of greater than 0.75 were recorded for all instruments in this military population. For each instrument, scores suggesting poor adaptation or resiliency were defined as follows: FCS, less than 2; FPSC, less than 2; FAC, 50 or lower; FACI-8, 5 or lower; FMWB, 50 or lower; and STAI, 50 or lower. For the purposes of this study, scores below these thresholds on two or more instruments indicated a family at risk for poor adaptation and poor resiliency. Additionally, a positive response on the FPSC item "we always yell and scream at each other" or any reported incident of physical abuse, extreme anger, depression, alcohol or drug use, or suicidal thoughts or attempts identified a family at risk even if overall scores on the instruments were above the designated thresholds.

Descriptive statistics, chi square, *t* test, and regression analysis were used to analyze the data gathered. When a family was identified as being at high risk for poor adaptation or resiliency according to the criteria described above, the participant was contacted to assess the risk, and intervention (including counseling and appointments for mental health evaluation, as needed) was arranged. Suicidal ideation was given high priority, and the families of respondents who indicated suicidal ideation were screened for appropriate referral immediately.

RESULTS

Respondents

Of the 455 participants enrolled in this study, 316 (69%) returned the

Table 1. Demographic characteristics of study participants and their families

Characteristic	Active duty group, % (n = 226)	Reserve group, % (n = 87)	P value
Participant demographics			
Educational level ≥ 15 years	27	49	.003
Ethnicity			< .001
White	60	85	
African American	14	1.5	
Hispanic	11	0	
Filipino	6	0	
Asian	4	5	
Hawaiian	1.5	3.5	
Pacific Islander	1.5	2.5	
American Indian	2	2.5	
Female gender	99	94	.009
Age			.002
19–25 years	21	17	
26–30 years	27	17	
31–35 years	24	13	
36–40 years	16	18	
41–45 years	8	9	
> 45 years	4	26	
Family characteristics			
Years married			< .001
< 5	31	31	
5–9	31	28	
10–15	27	13	
≥ 15	11	18	
> 25	0	10	
Weekly attendance at religious services	38	40	.614
Children living at home	83	64	.004
Military characteristics			
Officer rank	30	22	.151
Deployment duration			< .001
≤ 12 months	22	36	
> 12 and ≤ 18 months	78	64	
Duration of military affiliation ≥ 20 years	10	26	.100

mailed questionnaires for phase 1 and 225 (47%) did so for phase 2. Among the 325 participants in the active duty group, 226 (69%) returned the mailed questionnaires for phase 1 and 165 (58%) did so for

phase 2; among the 130 participants in the reserve group, the corresponding numbers were 87 (67%) and 58 (45%), respectively. After completing phase 1, six participants in the active duty group declined to continue

in the study, one participant's spouse was killed in Iraq, and 30 others moved without providing a forwarding address, leaving a total of 287 participants. In the reserve group, one participant declined to continue

Table 2. Rates of high risk scores^a on or responses to study instruments for active duty and reserve spouses, during phases 1 and 2 of the study

Instrument	Active duty group, %		Reserve group, %	
	Phase 1 (n = 226)	Phase 2 (n = 162)	Phase 1 (n = 87)	Phase 2 (n = 58)
STAI ^b	15	9	25	7
FCS ^c	23	16	26	23
FPSC ^d				
Overall high risk score	21	28	29	36
Positive response to “yelling and screaming” item	21	28	22	10
FAC ^e	3.5	5.6	9.7	18.6
FACI-8 ^f				
Overall high risk score	35	40	39	47
Overall decline in function	–	24	–	26
Severe decline in function ^g	–	8.6	–	3.7
FMWB ^h	41	27	52	38

^aHigh risk scores were defined as ≤ 50 on the STAI, FAC, and FMWB; < 2 on the FCS and the FPSC; and ≤ 5 on the FACI-8. ^bSTAI = State Trait Anxiety Index. ^cFCS = Family Changes and Strains. ^dFPSC = Family Problem Solving Communication. ^eFAC = Family Adaptation Checklist. ^fFACI-8 = Family Attachment and Changeability Index. ^gIndicated by a score of between 1 and 3.5 when scores from phase 1 were compared with those from phase 2. ^hFMWB = Family Member Well Being.

in the study after phase 1, leaving a total of 129 participants.

Demographics

Significantly more participants in the reserve group than in the active duty group had attained 15 years or more of education (49% versus 27%, respectively; $P = .003$) (Table 1). Ethnicity also was significantly different among the two populations, with a larger proportion of white spouses in the reserve group than in the active duty group (85% versus 60%, respectively; $P < .001$). While the vast majority of spouses in both groups were female, the percentage was significantly higher among active duty than reserve spouses (99% versus 94%; $P = .009$).

There were significant age differences between the groups ($P = .002$), with more active duty spouses in the younger age groups (25 to 30 years and 31 to 35 years), and more reserve spouses in the oldest age group

(older than 45 years). Similarly, more reserve spouses reported being married for 15 years or longer. Significantly more active duty spouses than reserve spouses reported having children living at home (83% versus 64%, respectively; $P = .004$). Similar proportions in both groups reported attending religious services weekly (38% of active duty spouses and 40% of reserve spouses; $P = .614$)

Military characteristics

Officers comprised similar proportions of service members in both groups (30% in the active duty group and 22% in the reserve group; $P = .151$). While a majority of both groups reported the duration of the most recent deployment to have been more than 12 (and up to 18) months, the percentage was significantly higher in the active duty group compared to the reserve group (78% versus 64%; $P < .001$).

There was a statistically nonsignificant trend toward reserve spouses having more experience with military life than active duty spouses, with a larger proportion of this group reporting affiliations of 20 years or more (26% versus 10%, respectively; $P = .1$).

Counseling and medication use

Active duty spouses reported a past history of family or individual counseling at a higher rate than did reserve spouses (41% versus 31%), although this difference was not significant ($P = .07$). Additionally, during phase 1 of the study, 16% of active duty and 8.2% of reserve spouses were receiving counseling for personal stress or anxiety ($P = .05$). During phase 2, these percentages increased in both groups (17.5% of active duty and 15.5% of reserve spouses; $P = .45$). Similarly, while neither group reported undergoing

marital counseling in phase 1, 9.7% of active duty spouses and 12.2% of reserve spouses reported seeking marital counseling (with or without their spouses) in phase 2 ($P = .37$). Furthermore, no respondents in either group reported that their children were in counseling during phase 1, but 9% of the active duty group and 7.3% of the reserve group indicated that their children were in counseling in phase 2 ($P = .49$).

Use of medications for stress or anxiety also increased in both groups between phase 1 and phase 2 of the study. In phase 1, 17% of active duty spouses and no reserve spouses used prescription medication for these indications, and no spouses in either group used over-the-counter stress or anxiety medication. By phase 2, however, 20% of active duty spouses and 14% of reserve spouses reported using prescription medication for stress or anxiety, and 2% of active duty spouses and 5% of reserve spouses had started using over-the-counter medications for these indications.

Scores on study instruments

The participants' overall scores on the FMWB, FCS, FPSC, FAC, and STAI indicated alarmingly high rates of poor family well-being, with no significant differences between the active duty and reserve groups (Table 2). On the STAI, FCS, and FMWB, there was some improvement between phases 1 and 2 in both groups. Although this finding was without statistical significance ($P = .65$), it suggests improvement at three months after reunification that could be clinically significant.

The FPSC scores reflected a slight (but statistically nonsignificant) decline in active duty and reserve spouses' scores for communication during phase 2 ($P = .26$ and $P = .1$,

Table 3. Comparison of high risk of poor adaptation and resiliency between officer and enlisted families

Phase	Officer, % (n = 73)	Enlisted, % (n = 177)	P value
1	23	41	.007
2	26	48	.001

Table 4. Demographic and military characteristics of families in which divorces occurred

Characteristic	% of all divorces (n = 24)
Active duty vs. reserve status	
Active duty	77
Reserve	23
Officer vs. enlisted rank	
Officer	18
Enlisted	82
Children living at home	
Yes	82
No	18
Marital duration	
< 5 years	40
< 10 years	80
No. of deployments	
1	60
2	30
3	10
Deployment lasting 12–18 months	73

respectively). This finding raises concern about a lack of proper problem solving communication after both active duty and reserve service members return home.

In phase 1, the percentage of spouses who had positive responses to the FPCS item that asked about "yelling and screaming" was similar for both groups (21% in the active duty group and 22% in the reserve group). During phase 2, this percentage increased to 28% among the active duty families ($P = .06$), while it dropped significantly to 10% among reserve families ($P = .02$). A positive response to this FPCS item was

highly correlated with being at high risk for poor adaptation and resiliency based on either overall low scores on at least two other instruments or reported incidents of physical abuse, extreme anger, depression, alcohol or drug use, or suicidal ideation or attempt.

FAC scores reflected a higher percentage of poor adaptation among reserve spouses compared with active duty spouses. The percentages of active duty families at high risk were 3.5% during phase 1 and 5.6% during phase 2; among reserve families, these percentages were 9.7% and 18.6%, respectively.

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Table 5. Rates of suicidal ideation and suicide attempts during phase 1 and phase 2

Event	Phase 1, no. (%)		Phase 2, no. (%)	
	Active duty (n = 161)	Reserve (n = 70)	Active duty (n = 159)	Reserve (n = 43)
Suicidal ideation				
Child	1 (0.7)	0 (0.0)	1 (0.6)	1 (2.8)
Service member	1 (0.6)	2 (3.0)	1 (0.6)	2 (4.7)
Spouse	6 (3.7)	5 (7.2)	4 (2.5)	3 (7.0)
Suicide attempt				
Child	0 (0.0)	0 (0.0)	0 (0.0)	1 (2.9)
Service member	1 (0.7)	0 (0.0)	0 (0.0)	1 (2.4)
Spouse	1 (0.7)	0 (0.0)	0 (0.0)	0 (0.0)
Total	10	7	6	8

Of particular concern were the results of family functional decline indicated by worsening scores on the FACI-8 between phases 1 and 2. In the active duty group, there was a 24% rate of overall decline between these two time points, with 8.6% showing a severe functional decline (which indicates a family in crisis). In the reserve group, there was a 26% rate of overall decline and a 3.7% rate of severe decline ($P = .05$ for the difference in severe decline between the active duty and reserve groups).

Scores on the SRI reflected differences between active duty and reserve spouses in self-reliance. Significantly more reserve spouses than active duty spouses scored 2 or less on this instrument during both phases ($P < .001$ for phase 1 and $P = .007$ for phase 2). In general, reserve spouses (living in various locations throughout the United States) reported a lack of support for self-reliance due to a scarcity of available military resources and an absence of other reserve families in their area.

Overall risk of poor adaptation and resiliency

Overall, in phase 1, participants' responses to the questionnaires in-

dicated risk of poor adaptation and poor resiliency at the rate of 65% among active duty families and 61% among reserve families ($P = .31$). In phase 2, this rate decreased slightly to 60% among active families and 54% among reserve families, with no statistical difference between groups ($P = .21$). Although this reflects a slight improvement in risk three months after the soldiers returned home, the rate is still alarmingly high for both groups. There was a significant difference between officer and enlisted families, with greater percentages of enlisted families at risk (Table 3).

Divorce

An overall divorce rate of 7.6% was reported through phase 2 of this study. These rates differed significantly according to various demographic and military characteristics (Table 4). Officer spouses who were older than 35 years, had been married over 10 years, had no children currently living at home, and were reunified with their service member spouse after two or more tours in Iraq or Afghanistan had the lowest risk of divorce. The reserve spouses had a lower rate of divorce than the

active duty spouses, which may be explained by the fact that reserve spouses generally were older, had longer marriages and periods of military service, and were more likely to have children living outside the home than active duty spouses.

Suicidal ideation or attempts

Based on the results of the FAC, there were a total of 31 reports of suicidal ideation or suicide attempts in the study's first two phases, with no significant differences between the active duty and reserve groups (Table 5). These were very serious findings. All respondents who reported these events were called immediately, and intervention with mental health professionals was arranged. There were no deaths as a result of these suicide attempts.

In phase 2, 1.6% of respondents who considered suicide were officer spouses and 4.3% were enlisted spouses. All of the adult suicide attempts that were reported in both phases were reported from enlisted families. In both phases, the children who considered or attempted suicide were children of officer service members. None of these differences were statistically significant.

Qualitative results

Pleas for more help for service members and other family members were a recurrent theme in respondents' open-ended survey comments and in telephone consultations with the principal investigator. These comments indicate that delays in PTSD diagnosis are leading to a lack of proper care for service members. In many cases, reserve spouses reported having to "fight" for their spouse to be recognized for treatment.

Spouses' comments also indicate that stigmas associated with seeking mental health care continue in the military. In many cases, spouses of active duty service members reported that the service member refused to get needed help. Other spouses reported that, when their service member spouse received counseling, they were not promoted or were punished with future job assignments.

Respondents also requested more information and education on how to live with a family member who has PTSD. Although spouses received information on how to identify symptoms of PTSD during military pre-reunification briefs and Family Readiness Group meetings, they did not receive education needed to live with a family member with PTSD. Some respondents voiced concerns that their spouses now lacked the ability to connect with their children and the patience they once possessed for dealing with issues at home. Many qualitative remarks reported dealing with spouses who appeared short-tempered and angry, became "couch potatoes," or drank to excess each evening. Road rage, short temperament, and lack of interest in sexual intimacy were recurrent themes, and many spouses said that their service member spouse wanted to go back to the war zone rather than be at home with their families. "Who is this

man who calls himself my spouse?" summed up the feelings and pain of many respondents.

Spouses of reserve members voiced concern that psychological treatment for the spouse and family members was available for only six months after the service member's military obligation ended. Many reserve spouses reported that their families lacked medical insurance following the deployment. Some spouses reported that the service member's loss of employment led to depleted finances that placed an immense burden on the family.

Active duty spouses in phase 2 referred to fears of the service member returning to the war zone and expressed concern that required training for the next deployment limited the service member's time with the family. "How many more times can he return to Iraq before he doesn't return at all?" was a major concern.

DISCUSSION

Many families will work out problems that have arisen during a service member's deployment to a combat zone once the service member returns home. Others will experience worsening issues that cause marriages to suffer and dissolve as PTSD and traumatic brain injury (TBI) symptoms manifest. Initial results from the first two phases of this study suggest that, once the initial "honeymoon phase" of reunification ends, spouses deal with increased stress. Unfortunately, for many families, resiliency and adaptation are showing signs of instability and deterioration early on in the reunification period. It is critical, therefore, to be able to identify families at high risk for poor adaptation and resiliency. Furthermore, for those families identified as being at risk, programs must be in place to provide them with the prompt coun-

seling and intervention that could help the family unit survive intact.

During phases 1 and 2 of this study, spouses who were younger than 35 years, had been married fewer than 10 years, had children living at home, and were married to enlisted service members who had been deployed only once to Iraq or Afghanistan were at greatest risk for poor family resiliency or adaptation and divorce. Targeting families with these characteristics through mandated, nonstigmatizing programs could benefit them greatly.

It is not hard to imagine that younger families, with less military experience, less marital experience, and less overall life experience, might have a harder time dealing with the stresses inherent in a service member's deployment and subsequent return. Additionally, the presence of young children or adolescents in the home likely adds to the stress experienced by the spouse and the complexity of the relationships the service member returns to following deployment.

In terms of military characteristics, the association between enlisted status and high risk of family problems may be related to the greater financial burdens experienced by most families of enlisted service members. Notably, there were no significant differences between active duty spouses and reserve spouses with regard to overall risk of poor adaptation and resiliency. This finding reflects other recent data suggesting similar rates of PTSD among both reserve and active duty OIF and OEF service members.

Study limitations

Although the samples for active duty and reserve spouses were adequate, with power above 0.8, they remain limited by the fact that they were samples of convenience. All active duty spouses enrolled in the study

Table 6. Internet resources for army service members and families

Site name	URL
Army Suicide Prevention Program	http://www.armyg1.army.mil/hr/suicide/
U.S. Army Center for Health Promotion and Preventive Medicine—Suicide Prevention	http://usachppm.amedd.army.mil/dhpw/readiness/suicide.aspx
U.S. Army Chaplain Corps	http://www.chapnet.army.mil/
Army Well-Being	http://www.armywell-being.org/skins/WBLO/home.aspx
Army Behavioral Health	http://www.behavioralhealth.army.mil/
Battlemind Training	http://www.battlemind.org/
National Suicide Prevention Lifeline ^a	http://www.suicidepreventionlifeline.org
American Association of Suicidology	http://www.suicidology.org/

^aThis lifeline also can be accessed with the following telephone number: 1-800-273-TALK (8255).

were living in Hawaii at the time of the study. Although reserve spouses, who were recruited through a web site, were not geographically limited in this way, their numbers were limited due to the timing of the study and the method of outreach. More research needs to be conducted among reserve spouses to tell their stories properly.

This study is also limited by the fact that all data were reported by the service members' spouses, thus all information provided about children and service members were subject to interpretation by the reporting spouse. Finally, conclusions that can be drawn from this study are limited to the period of three months before to three months after reunification. Longer-term conclusions can be made only after data from phases 2 and 3 of the study are analyzed and reported.

CONCLUSIONS AND FUTURE DIRECTIONS

Overall, the results of phases 1 and 2 of this study make it clear that families are suffering emotionally from deployments of spouses beyond what has been reported previously. The

study's respondents reported high divorce rates and troubling rates of suicidal ideation and suicide attempts. While this study is still in the process of data collection for phases 3 and 4, much has been learned already from the responses of these spouses.

For many families of service members who have deployed to Iraq or Afghanistan, the road ahead will be difficult. Proper intervention at the right time will be critical to the survival of service members' families after the war ends and a new battle begins at home. Several resources aimed at providing mental health support—and, in particular, suicide prevention—are available to army families on the internet (Table 6). More targeted programs, however, are needed to address the problems families like the ones surveyed in this study are grappling with.

Earlier recognition, diagnosis, and treatment of PTSD and TBI would go a long way toward giving families the chance to heal and survive. Data from this study, together with those of other recently published studies, suggest that PTSD and TBI are surfacing well after service members return home from war. Thus, it will be es-

sential to evaluate service members returning from OIF and OEF deployments during the first year after reunification beyond the immediate evaluation performed upon their return.

Commanders must take the responsibility and time to intervene with service members who appear to be in physical and emotional trouble. In addition, service members must not be penalized for getting the help they need for depression, anxiety, anger, PTSD, or TBI. Service members who show signs of anger, depression, hopelessness, road rage, poor concentration, or poor work performance must receive the proper diagnosis, intervention, treatment, and medication before redeployment occurs. Proper, comprehensive screening of all service members facing redeployment would prevent some of the poor outcomes revealed in this study.

Finally, support programs need to be established to assist spouses and children in dealing with the psychological impact of reunification. Families need continued educational and psychological assistance for successful adaptation and survival after war.

Our service members and their families deserve nothing less. ●

Author disclosures

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