

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

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This longitudinal study examines the impact of reunification on the adaptation and resiliency of soldier families after deployment to Iraq or Afghanistan.

The introduction and background of this study was described in McNulty, 2008, and McNulty, 2010.<sup>1,2</sup> These findings included the 3 months before reunification through 3 months after reunification occurred, indicating increased stress among families 3 months after the return of the spouse from Iraq. Many qualitative remarks summarized that the stigma of getting help kept many army soldiers from reaching out due to the real or perceived perception that their military careers would be adversely affected. An overall divorce rate of 7.6% was reported during this period. Active-duty spouses reported divorces at 8.6% compared with 4.7% in the reserve group. Those with children, those who were enlisted, and those married < 10 years were identified to be at risk for divorce.

There were no significant differences in the amount of suicidal ideation (SI) or suicide attempts (SA) between active-duty and reserve groups in phase 1 (3 months before reunification) of the study. Overall,

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enlisted spouses and soldiers considered suicide at 7.9% during phase 1 compared with only 1 officer soldier (1.5%) in phase 1 ( $P = .44$ ). In phase 2 (3 months after soldier reunification), 3.2% of those who considered suicide were officer spouses compared with 4.3% who were enlisted spouses with no significant difference ( $P = .88$ ).

High-risk families were identified during phases 1 and 2 of the study. High risk increased from phase 1 to phase 2, indicating poor family adaptation and resiliency during both phases among both active-duty and reserve families ( $P = .40$  in phase 1;  $P = .26$  in phase 2). Officer families were at high risk during phase 1 at 23% compared with enlisted families at 42% ( $P < .01$ ). During phase 2, officer families remained at high risk at 20% compared with 45.3% of enlisted families ( $P < .01$ ). There were no significant differences of high risk between families with children and those who were childless. During phase 1, 20% of childless and 23% of those with children showed decline and in phase 2, 18% of childless showed deterioration compared with 26% of those with children ( $P = .79$ ). Both were at high risk between 34% and 44% by

service (active duty/reserve) and between 36% and 42% by child status (with/without children) during the first 2 phases of the study.

Army spouses reported overall declination in function between phases 1 and 2 at 24% with severe declination reported at 8.6% when measured with the Family Attachment and Changeability Index (FACI-8) instrument. Reserve spouses reported an overall declination in function at 17.5% between phase 1 and phase 2 with no severe declination reported ( $P = .13$ ). Spouses with children reported no significant difference in declination when compared with childless spouses; however, severe declination occurred at 16.6% in families with children compared with 7.5% without children at +3 months into reunification.

The purpose of this current study was to identify and describe the psychological and physical health needs, anxiety, resiliency, communication, self-reliance, well-being, and subsequent adaptation and resiliency of the families of deployed troops over an extended reunification period during the final 2 phases of the study (+6 months and +12 months) between army active-duty families and reservists families as reported by fam-

ily caretaker spouse responders. Research was lacking on the long-term effects of war on reunification in regard to family health care needs and adaptation/resiliency. The knowledge gained will identify a risk and protective profile for the future deploying families in the army and army reserves.

The specific needs of families and the identified period of time when these needs were greatest required further study. With the new knowledge, programs of intervention can be implemented to the target audiences so that reunified families benefit from the services and assistance they deserve and need.

## METHODS AND DESIGN

This was a quantitative, longitudinal study with a repeated measures design. Descriptive statistics, chi square, analysis of covariance, and regression analysis were used. Spouses of active-duty and army reserve soldiers were enrolled by a sample of convenience. Assuming an alpha of 0.01, power of 0.95, effect size of 10%, 4 observations per subject, and an effect size variability of 0.1, subjects needed in each group were determined to be 47. Due to the large number of variables in the study, a larger sample was obtained. A total of 325 active-duty and 130 reserve spouses were enrolled. The statistics in this report were limited to the last 2 phases of the study: Phase 3 was the period of 6 months after reunification (+6) and phase 4, the period of 12 months after the soldier returned home (+12).

The tools used in this study included the following by McCubbin and colleagues for family resiliency and adaptation: Family Changes and Strains (FCS), Family Problem Solving Communication (FPSC), Family Adaptation Checklist (FAC), Fam-

ily Attachment and Changeability Index (FACI-8), Family Member Well Being (FMWB), and Self Reliance Index (SRI).<sup>3-8</sup> In addition, the State Trait Anxiety Index (STAI) by Spielberger was used to measure stress and anxiety.<sup>9</sup> Details of each tool can be found in McNulty 2008 and 2010.<sup>1,2</sup>

## STATISTICAL ANALYSIS

Of the 325 active-duty army spouses enrolled in the study, the response rate (RR) was 158 (49%) during phase 3 and 110 (34%) during phase 4. Of the 130 reserve spouses enrolled, the RR was 58 (45%) during phase 3 and 56 (43%) during phase 4. There was a significant difference seen in the educational level between groups. Chi square analysis revealed army spouses reported > 15 years of education at 27% compared with 49% in the reserve spouses ( $P = .003$ ). Reserve spouses were older with 29% aged > 45 years, whereas army active-duty spouses were younger with only 4% aged > 45 years ( $P < .01$ ). The total number of years married differed between the 2 groups ( $P < .01$ ). Only 14% of those in the army active-duty group were married > 15 years compared with 27% in the reserves. In addition, 10% of reserve spouses were married > 25 years.

## MILITARY DEMOGRAPHICS

Officers comprised 30% of those sampled in the army active-duty group compared with 22% in the army reserve group ( $P = .15$ ). Of army active-duty families, 83% had children living at home compared with reserve families at 64% ( $P < .01$ ). Reserve spouses had more experience with military life, reporting that 26% had been affiliated with the military for > 20 years, whereas army active-duty spouses reported that only 10% had been in the army for > 20 years.

## SPOUSE COUNSELING FOR STRESS

Counseling remained consistent during the entire study. Spouses were in counseling for stress-related issues at 13% during both +6 months and +12 months after reunification. Reserve spouses reported 0% counseling for personal stress during phase 1; however, 17% were in counseling during phase 2 (+3 months) for stress. This remained at 16% during phase 3 (+6 months) and at 13% during phase 4 (+12 months). Counseling for stress was sought more often by enlisted spouses than by officer spouses throughout the entire study. Six months after the soldier reunified, enlisted spouses sought counseling at 16% compared with 11.3% of officer spouses. During phase 4, 13.5% enlisted spouses compared with 7.5% officer spouses sought counseling. This was consistent with counseling sought at the +3-month phase of the study.

## MARITAL COUNSELING

Marital counseling was reported overall at 10.5% during phase 3 (+6 months) and at 9% during phase 4 (+12 months) after the soldier was home 12 months. This finding was consistent with findings during phase 2 (+3 months).

## CHILD COUNSELING

There were no children of active-duty or reserve families in counseling during phase 1. However, during the second phase, 9% of active-duty children and 5% of reserve children reported being in counseling. Counseling among active-duty children remained at 8% and 10% during phases 3 and 4 of the study. Reserve children remained in counseling at 6% throughout the remainder of the study (+6 months and +12 months postreunification) with no significant difference seen between these groups.

**Table 1. Length of time prescription medications were used during all phases of the total sample (%)**

Phases (mos)	1 (< 3)	2 (+3)	3 (+6)	4 (+12)
Medication used (mo)				
< 3	10.8	11.1	14.9	18.9
3-6	18.9	11.1	10.6	18.9
6-12	27.0	26.0	4.3	5.4
> 12	43.2	52.0	70.2	57.0

**MEDICATION USE**

Over time, it was hypothesized that stress would return to a normal state after the soldier had been home for an extended period of time. Statistics from phase 3 of the study indicated that this did not occur. Use of prescribed medication by the spouse for stress-related conditions remained at 21.1% at 6 months after reunification and at 20% at 12 months postreunification. This use among active-duty spouses was at 22% in phase 3 and at 20% during phase 4 of the study. Reserve spouses’ use continued at 20% and 21% during phase 3 and phase 4 of the study, respectively, with no significant differences seen between the 2 groups.

Table 1 provides the length of time medication was taken by the percentage of medication used during each phase. The lengths of time medications were taken were divided into 4 categories: (1) < 3 months; (2) +3 months; (3) +6 months; and (4) +12 months. This table indicates that the use of prescription medications for stress taken in excess of 12 months was between 43.2% and 70.2% during all phases of the study. During phase 3, 70.2% of those on medication were taking them in excess of 1 year. This use continued at a rate of 57% during phase 4. Those who responded during each phase of the study were not always the same responders. There were no differ-

ences between active-duty and reserve spouses who remained on medications after 1 year. This percentage range was from 19.7% to 22% in each group.

When medication use was studied with respect to children in the family, the following was reported: Childless spouses reported 0% use at +6 months compared with 6% use among spouses with children. It must be noted that the “n” size for spouses without children was only 44 compared with a much larger sample of those with children. This increased among childless spouses to 4.5% at +12 months compared with 5.3% use among spouses with children ( $P = .84$ ). There was no significant difference seen with prescription medication use for stress in these groups. Childless spouses were on prescription medications at 18% at +6 months and at 23% at +12 months compared with spouses with children who took prescription medications at 22% at +6 months and 25% at +12 months ( $P = .20$ ).

Prescription medication use for stress-related conditions among enlisted and officer spouses showed a significant difference during phase 1 with 29% enlisted spouses compared with 17% officer spouses taking prescription medication ( $P = .038$ ). Enlisted spouses continued prescription medication use at 26% during phase 2, 27% during phase 3, and 24% dur-

ing phase 4 compared with officer spouses at 16%, 17%, and 19%, respectively. Over-the-counter (OTC) medications for stress were reported by enlisted spouses at 5% at both +6 and +12 months. Officer spouses’ OTC medication use increased by more than double the rate in the last 6 months of reunification, from 4.3% at +6 months to 9.4% at +12 months of the study.

Soldier medication use was reported by the military spouse. During all phases, the OTC use was 1.5%, 2.3%, 2.8%, and 2.4%, respectively, for stress-related conditions. Prescription medication use was reported as 4.4%, 7.5%, 6%, and 9% during the 4 phases, indicating an increased use at the 1-year mark of reunification. These percentages might be low if soldiers did not share this information with their spouses.

**INSTRUMENTS**

**Family Member Well Being**

Analysis of covariance revealed that overall FMWB scores showed an improvement over time ( $P < .01$ ) until phase 4, when scores decreased in both the officer and enlisted groups. Officer spouses scored higher in all phases of the study, but scores were only between 56% and 65% compared with enlisted scores of between 52% and 58% ( $P < .01$ ). There was no difference between scores of spouses with children. Both spouses in this category had decreased scores at +12 months, from mean scores of 62% at +6 months to mean scores of 57% to 60% at the 1-year mark. Scores were higher among active-duty spouses (56%-63%) compared with reserve spouses (49%-59%) during the final 2 phases of the study ( $P = .05$ ). At +6 months, 20% of reserve spouses scored  $\leq 50\%$  compared with 6.3% of active-duty spouses ( $P = .63$ ). At +12 months,

10% of both active-duty and reserve spouses scored  $< 50\%$  ( $P = .53$ ). Regression analysis revealed that as  $< 3$  month scores on both SRI and FACI-8 increased, the FMWB scores at +6 months increased.

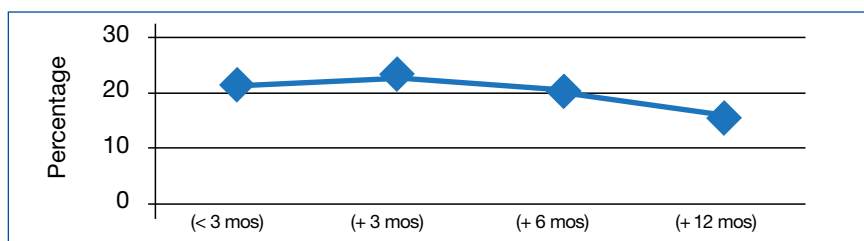
Qualitative statements added to this tool included the following:

*“My husband’s redeployment to Iraq will be his third rotation in 5 years. The fear is that we have been ‘lucky’ the first 2 times without injury or death and if we will be that lucky again. It’s nerve-racking! I am in constant worry. We just want out. And we still have 3 more years to go! This was supposed to be a career, but it’s time to go another route. Now we are struggling to come up with our plan B!”*

*“I fear that his posttraumatic stress disorder (PTSD) will get worse on the next tour. I’m not sure that I can deal with all the stress and emotions that will come our way—again.”*

### Family Problem-Solving Communication

Army active-duty spouses scoring 2 or below out of 3 on the FPSC continued to be between 25% and 32% among spouses with and without children during phases 3 and 4 without significant difference. What is clinically significant is that problem-solving communication remained poor among one-quarter to one-third of the sample at 1-year postreunification. In addition, a component of the FPCS, “usually or always yells and screams at each other,” remained between 20% and 22% of army active-duty spouses in phases 3 and 4. This compared with reserve spouses who reported the use of yelling and screaming as a form of communication during phase 3 at 17% and 9.3% during phase 4. Figure 1 depicts this percentage over the entire study period. When “sometimes yells and screams” was analyzed,



**Figure 1.** Percentage of those who “usually or always yells and screams at each other” during all phases of the study.

there was no significant difference seen between reserve spouses and active-duty spouses. Active-duty spouses reported sometimes yelling and screaming at 57.7% in phase 3 and at 19.4% in phase 4, indicating improvement at 1-year postreunification. Reserve spouses sometimes practiced yelling and screaming as a means of communicating at 53.3% during phase 3 and at 44.4% in phase 4 of the study.

There was a strong correlation between “yelling and screaming” as a means of problem solving and being at high risk during all phases of the study. Regression analysis indicated that as  $< 3$  months FPSC scores increased, +3 months FMWB scores increased ( $P = .04$ ); however, this had no effect on FMWB scores at +6 months or +12 months.

*“Our 13-year-old son who is bipolar is having lots of problems with his dad deploying again. He refuses to even talk to his father.”*

*“The communication between us is still lacking. My husband seems somewhat distant and is still having angry outbursts. I don’t know if what we are going through is normal.”*

*“What communication? We seriously need marriage counseling!”*

### State Trait Anxiety Inventory

During phase 3, STAI scores showed no significant difference among those with children and those without, but there was

an overall improvement of STAI scores over time ( $P < .01$ ). Those with children had mean scores of between 66% and 71% compared with childless spouses (63%-71%). Scores in both groups dropped at +12 months. Scores of  $\leq 50\%$  were reported at 10% in both groups during phase 3 and at 15.2% among spouses without children compared with 9.4% among those with children during phase 4. When STAI was analyzed among active-duty and reserve spouses, the following was reported: Active-duty spouses scored  $\leq 50$  at 11.8% compared with 8.3% of reserve spouses in phase 3 and at 10.9% compared with 11.3% of reserve spouses in phase 4 ( $P = .03$ ). These scores indicated higher anxiety in reserve spouses at +12 months postreunification when compared with previous phases of the study. Higher scores were measured among active-duty spouses during all phases of the study ( $P = .06$ ), which indicated lower anxiety in this group.

*“My spouse has emotionally distanced himself from myself and children. Will our problems be resolved before he deploys again?”*

*“I’m anxious to see if he will clear the HIV test. Our marriage seems to be strong enough (or I’m strong enough) to withstand his actions.”*

### Self Reliance Index

Scores on the SRI reflected dif-

ferences between active-duty and reserve spouses. Reserve spouses scored lower during all phases of the study and reported that the support for being self-reliant was lacking in most locations where reserve families reside. Scores of 2 or below indicating low self-reliance was reported at 5% in phase 3 and at 3.6% in phase 4 among active-duty spouses compared with 13.6% in phase 3 and 7.3% in phase 4 among reserve spouses. Regression analysis indicated that when SRI scores were increased at < 3, scores on the FAC at +3, the FMWB at +3 and +6 were also increased ( $P < .01$ ). When SRI scores at < 3 were decreased, counseling increased during +3 months ( $P < .01$ ) and at +6 months postreunification ( $P = .06$ ).

*"I'm focusing on my health, eating right, getting exercise, and spending time with my friends when I need to be away from him."*

*"Getting a job, keeping busy, and getting enough sleep will help me. I am preparing my family for his upcoming redeployment at the end of the year."*

### Family Adaptation Checklist

The FAC scores of  $\leq 50\%$  for active-duty spouses were reported at 3.5% during phase 1 and at 5.6% during phase 2 of the study. This increased to 6.3% in phase 3 and 9.4% during phase 4 of the study, indicating poorer adaptation as time at home progressed. Reserve spouses scored  $\leq 50\%$  at 9.7% during phase 1 and at 18.6% during phase 2. This continued at 20% in phase 3 and at 10.2% in phase 4. Reserve spouses recorded poorer adaptation during phases 2 and 3 compared with active-duty spouses; however, at +12 months, scores matched that of active-duty spouses. Overall, higher FAC scores

were seen in the active-duty population, but scores in this group decreased over time ( $P < .01$ ).

The FAC scores were higher among officer spouses compared with enlisted spouses ( $P = .02$ ); however, both groups' scores decreased over time. Spouse's adaptation with and without children remained constant over time. The FAC scores that decreased at the +12-month period, indicated equally poor adaptation at 1 year in both categories.

*"We are fighting a lot! My husband was diagnosed with PTSD after his deployment, and he is currently on antidepressant medication."*

*"We are stressed from the bills and constantly argue every day."*

*"My husband and I have 'some' disagreements, but we always manage to work things out. We as a couple have a strong faith and a good sense of humor."*

### Family Adaptation and Changeability

Army spouses reported overall declination in function between phases 1 and 2 at 24% with severe declination reported on the FACI-8 at 8.6%. This declination continued at 20.5% +6 months after reunification and 16.1% at +12 months. Severe declination remained at 4% for +6 months and +12 months. There was no significant difference in declination seen between reserve and active-duty groups. Reserve spouses reported an increase in overall declination from 17.5% to 22.4% between phases 2 and 3. Declination in function remained at 18% for the remainder of the study; however, no severe declination was reported in this group. Active duty declined in function at 26% during phase 3 and at 22% at +12 months postreunification with severe declination reported at 6% during both phases of the study.

Spouses with children declined at 27% during phase 3 and at 23% during phase 4 with severe declination reported at 4.5% during both phases. This compared with childless spouses who reported a decline at 18% during phase 3 and at 15% during phase 4 with a severe decline reported at 3% to 4% during both phases ( $P = .09$ ).

Officer spouses were significantly different from enlisted spouses regarding declination in function during the last 2 phases of the study ( $P < .01$ ). Officer spouse decline was reported at 19% and 11% during phases 3 and 4 with severe declination seen only during phase 3 at 1.4%. This compared with 28% declination in function at +6 months and 26% at +12 months among enlisted spouses. Severe declination of function in the enlisted category was reported at 5.6% at +6 months and at 6.3% at 1 year postreunification.

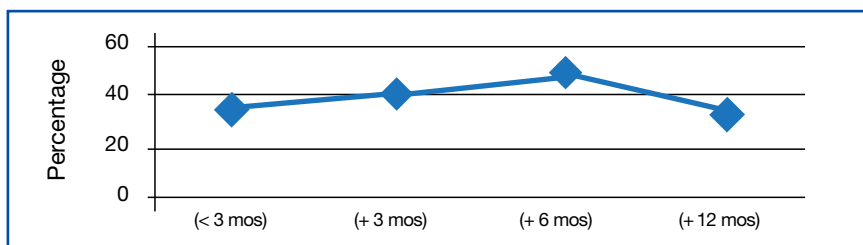
*"My family is falling apart! The stress of raising 2 teenage boys on my own is taking its toll, and these back-to-back deployments have torn us apart! My greatest concern is even though we love each other, we are headed for divorce. The boys don't even know their father anymore. It has been hell."*

### HIGH-RISK FAMILIES

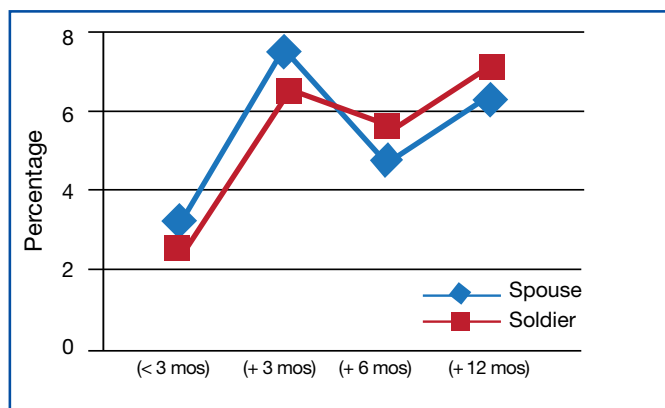
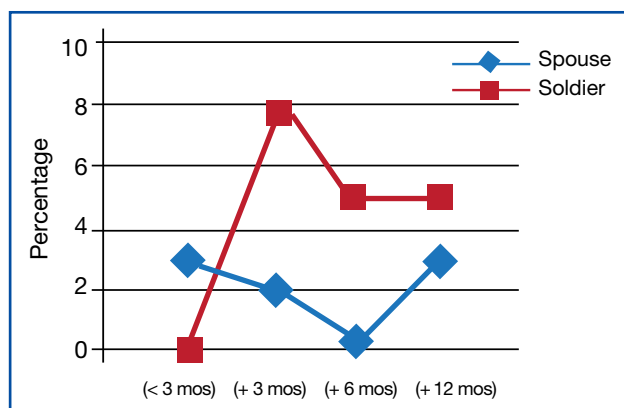
Overall, those considered high risk remained consistently high throughout the study. High risk is depicted in Figure 2 for all phases of the study. Army active-duty spouses were high risk during phase 1 at 34% and at 36% during phase 2. This risk rose to 45% at +6 months and remained high at 49% at +12 months. Reserve spouses were high risk at 37% during phase 1 and at 44% during phase 2 of this study. This risk rose to 45% in phase 3 and de-



**Figure 2.** Percentage of high-risk families during all phases.



**Figure 3.** Percentage of those who “had a problem with anger and physically abused another” among soldiers and spouses during all phases.



creased to 29% in phase 4. Of those in the high-risk group, 22% were officer spouses compared with 40% of enlisted spouses during phase 1. During phase 2, officer spouses were at high risk at 20% compared with 45.3% of enlisted spouses ( $P = .001$ ). In phase 3, officer spouses were high risk at 35% compared with enlisted spouses whose risk increased to 52%. In phase 4, officer risk decreased to 25%, whereas enlisted spouse risk remained high at 48%.

Figure 3 illustrates the percentage of spouses and soldiers who reported having a problem with anger and physically abusing another in all phases.

### DIVORCE

An overall divorce rate of 7.6% was reported by phase 2 of the study. At that time active-duty army spouses reported divorce at 8.6% compared with 4.7% in the reserve group. Officer rank represented 3.5% of all di-

vorces reported in phase 2 compared with a rate of 7.8% in the enlisted group. When data were analyzed in phase 4, the divorce rate increased to 10.2%. This reflects an additional 2.6% divorces having been filed between the third (phase 2) and the 12th-month postreunification (phase 4).

Of those with children, 7.3% reported getting a divorce compared with 4.3% of spouses without children during phase 2. This increased in phase 4 to 9.96% of those with children getting a divorce and 7% of spouses without children filing for divorce. Forty-one percent of those getting divorced were married for  $\leq 5$  years, and 81% of those getting divorced were married for  $\leq 10$  years. Of those getting divorced, 60% were serving their first tour in Iraq; 30% were in their second tour, and 10% were in their third tour to Iraq. Additionally, of those who were divorcing, 58% were aged  $< 30$  years and 10% were aged  $> 40$  years. Additionally, spouses who reported taking

**Figure 4.** Percentage of spouses who have taken steps for separations or divorce during all phases.

steps to separate or divorce are displayed in Figure 4.

### SEEKING HEALTH CARE Spouses

An important finding of this study suggests that health care was sought by soldier spouses numerous times during deployment for emergent and health maintenance opportunities. Three months prior to the soldier’s return, acute care visits to the primary care manager or emergency department were made by 72% of the responders: 39% by enlisted spouses and 33% by officer spouses. Visits were in the range of 1 to 20 per responder. During phase 2, +3 months after reunification, care was sought by 67%: 32% by enlisted spouses and 35% by officer spouses. Acute care

visits dropped to 27% by enlisted spouses and remained at 31% for officer spouses during phase 4, which was +6 months postreunification. At +12 months postreunification, visits were increased to 61% of all enlisted spouses and 60% by officer spouses alone.

### Children

Health care was sought for children in the acute setting at 46.9% 3 months prior to the return of their parent, 31% 3 months after his/her return, 35.8% 6 months after, and finally at 38% 1 year after reunification. Appointments for wellness that included immunizations and prevention programs for children remained between 38% and 56% throughout the entire study.

### Army Soldier

The use of health care was reported for the soldier by the spouse who was the responder in this study. Since e-mail correspondence was daily in most cases, the information for phase 1 should be accurate. The data for phases 2, 3, and 4 during postreunification were reported by the soldier spouse. Fifty-one percent to 67% of all soldiers used health care services from +3 months through +12 months after reunification. There was no difference in the amount of health care sought between enlisted and officer soldiers. Health care is often sought when psychological care is needed, but the stigma and risk of getting help from a mental health provider is too great. Additionally, soldiers sought counseling at low rates. Soldier spouses reported that during phase 1, while the soldier was still in Iraq, counseling was sought at 7%. Phase 2 reported counseling at 11.3%; phase 3 at 10.1%, and phase 4 at 9.8%. There are no data to distinguish those who self-sought counseling with those who

were ordered to counseling by their superiors.

### SUICIDAL IDEATION AND SUICIDAL ATTEMPT

There were no significant differences in the amount of SI or SA between groups (Tables 2 and 3). These were serious and tragic findings. All persons who reported these events were immediately called, and intervention for continued counseling and medication was implemented. Overall, reserve families considered suicide at 6.7% compared with officer families at 1.5% in phase 1 ( $P = .44$ ). In phase 2, 1.6% who considered suicide were officer spouses compared with 4.3% who were enlisted spouses ( $P = .77$ ) with no significant difference. The SA reported in both phase 1 and phase 2 were reported from enlisted families. Of interest was that in both phases, the children who considered or attempted suicide were officer children ( $P = .09$ ).

Spouses having SI were seen among those with children at 3% during phase 3 and at 5.4% in phase 4 compared with those without children during phases 3 and 4 at 0%. Suicidal ideation had improved among this group from phases 1 and 2 when 7.3% and 3.9%, respectively, had SI at 3 months prior to and 3 months postreunification. Of those who tried to commit suicide, only 1 spouse with children attempted during phase 1 of the study.

### DISCUSSION

#### Limitations

Although the sample for active-duty spouses and reservists was adequate with power above 0.80, it was a sample of convenience. Reserve spouses were limited to 130 due to the timing of the study and limited number of spouses available for enrollment.

More research needs to be conducted among reserve spouses to properly tell their story.

These findings on the impact of reunification on family adaptation and resiliency may be underestimated. Those who chose not to continue in all phases of the study (50%-65%) may have been the spouses who experienced the most difficulty with adaptation and, therefore, the most likely to drop out of the sample. Another possible scenario is that many of those who dropped from the survey were at high risk in the early phases of the study and once separated or divorced, chose not to continue in a family study. These data represent the tip of the iceberg with many more dysfunctional families missing data to complete this story.

For those who remained in the study, the outcome was dismal. The data indicated that once the initial honeymoon phase of reunification ended, spouses dealt with increased stress that did not rise to the surface on the immediate return of the soldier. Many families took a small blip upward in adaptation and resiliency at the +3-month mark, but this blip continued horizontally until taking a similar dip downward at the +12-month mark. This indicated that family resiliency and adaptation were poor with indications of deterioration in many families at the 1-year mark of reunification. Counseling increased during all phases, indicating a continued need for psychological support of soldier families. Medication use remained consistent over time among spouses. Stress had clearly increased among spouses with and without children at +12 months postreunification as indicated by the increased use of stress medications seen at this time for both groups. Even after 1 year at home, the situation for many families remained cha-

**Table 2. Suicidal ideation and attempt reported among active-duty families at all phases**

Phases (mos)	1 (< 3)	2 (+ 3)	3 (+ 6)	4 (+ 12)	(n)
Suicide ideation, No. (%)					
Child	1 (0.6)	1 (0.7)	2 (1.4)	1 (1.3)	5
Soldier	1 (0.6)	1 (0.6)	2 (1.3)	4 (4.5)	8
Spouse	6 (3.7)	5 (3.1)	4 (2.5)	4 (4.5)	19
Suicide attempt, No. (%)					
Child	0	0	1 (0.7)	0	1
Soldier	0	0	0	1 (1.1)	1
Spouse	1 (0.6)	0	0	0	1

**Table 3. Suicidal ideation and attempt reported among reserve families at all phases**

Phases (mos)	1 (< 3)	2 (+ 3)	3 (+ 6)	4 (+ 12)	(n)
Suicide ideation, No. (%)					
Child	0	1 (2.8)	0	0	1
Soldier	2 (3.0)	2 (4.7)	2 (3.4)	1 (2.3)	7
Spouse	5 (7.2)	4 (7.3)	1 (1.7)	1 (2.3)	1
Suicide attempt, No. (%)					
Child	0	1 (2.4)	0	0	1
Soldier	0	1 (2.4)	0	0	1
Spouse	0	0	0	0	0

otic and dysfunctional to the point of divorce in 10% of the sample.

It is clear from the results of this study that families are suffering emotionally from deployments of spouses beyond what is currently reported. Divorce rates are high. Suicidal ideation and SA are alarming. Qualitative remarks from spouses have revealed the great concerns regarding issues with soldiers who seem to have PTSD and their ability to survive in that environment. Spouses with children were con-

cerned whether the soldier would be able to reconnect with their children and have the patience they once possessed in dealing with issues at home. Others reported that “this man who calls himself my spouse is no longer the same.” Many qualitative remarks focused on dealing with spouses who seemed short tempered and angry and those who had symptoms of PTSD but refused treatment. Spouses of reserve soldiers were concerned due to limited psychological treatment availability for

themselves beyond 6 months after the soldier's obligation ended. For many, this was not enough, and many reserve families reported the lack of medical insurance once the soldier returns home. Many active-duty spouses referred to fears of the soldier returning to the war zone and expressed concern that there was limited time with families due to required training needed for the next deployment period.

During all phases of the study, high-risk families were identified as those who were younger, most of whom were also enlisted. This fact is not surprising given the financial restrictions of most enlisted households. There were no significant differences seen between active-duty army spouses and reserve spouses for high risk. Both groups were equally affected by the stressors of war and its impact on family adaptation and family resiliency.

## CONCLUSION

The identification of families at high risk must be immediately recognized if families are to be given the proper counseling and intervention that is so desperately needed. Once families are identified, implementation of a program for spouses and soldiers needs to be in place so that anger, abuse, SI, and divorce are not seen at the level indicated in this study. Soldier families need ongoing intervention and support throughout the reunification process. As the literature and data suggest, symptoms of PTSD and traumatic brain injury are surfacing well after the soldier returns. Soldiers need to be sent for proper diagnosis and intervention once symptoms begin so that families have the chance to heal and survive as a caring and loving unit. With the reported alcohol and drug use among soldiers, one would seriously question whether these soldiers are psy-



chologically and physically ready to redeploy 1 year after they reunify. These data suggest that they are not, yet many have already redeployed 1 to 2 times since this study ended.

Commanders must take the responsibility and time to intervene. Soldiers who are at risk for the development of PTSD and those showing signs of anger, depression, hopelessness, and poor concentration or poor work performance must receive the proper diagnosis, intervention, treatment, and medication before redeployment occurs. Proper, comprehensive screening of all soldiers facing redeployment would prevent some of the poor outcomes revealed in this study. Army soldiers and their families deserve nothing less. Intervention mandated for all in a caring environment with education and discussion will serve as the best preventive measure. The time

to help these soldiers and families is long overdue, but never too late. As one army spouse pleaded in her comments: "Take us away from this 'dreary marathon' and give us the tools that we need to 'sprint along' and remain 'Army Strong!'" ●

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