The impact of deployment on National Guard families

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Abstract
The National Guard was established as the original "well ordered militia" of the United States at a time when the country distrusted a standing army. Since that time the National Guard has been used to aid states during times of emergency and as an auxiliary force during times of war. Following the attack on the United States on September 11, 2001, the National Guard has been used extensively in the wars in Afghanistan and Iraq. At times, more National Guardsmen were in service than regular military due to the demands of these wars. Deployment duties for National Guardsmen have been increased from no more than one year of voluntary deployment during five years of service to more than two years of voluntary deployment during six years of service. Although supports have also increased, the specific needs of National Guardsmen and their families are not being met. This paper reviews how National Guard personnel differ from regular military personnel, the impact of war on National Guardsmen and their families, and available supports.

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THE IMPACT OF DEPLOYMENT ON NATIONAL GUARD FAMILIES

A THESIS

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

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BY

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IN PARTIAL FULFILLMENT OF THE

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OF

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Abstract

The National Guard was established as the original “well ordered militia” of the United States at a time when the country distrusted a standing army. Since that time the National Guard has been used to aid states during times of emergency and as an auxiliary force during times of war. Following the attack on the United States on September 11, 2001, the National Guard has been used extensively in the wars in Afghanistan and Iraq. At times, more National Guardsmen were in service than regular military due to the demands of these wars. Deployment duties for National Guardsmen have been increased from no more than one year of voluntary deployment during five years of service to more than two years of voluntary deployment during six years of service. Although supports have also increased, the specific needs of National Guardsmen and their families are not being met. This paper reviews how National Guard personnel differ from regular military personnel, the impact of war on National Guardsmen and their families, and available supports.

Keywords: National Guard, military families, deployment, spouses, partners, children
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Introduction

During Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), National Guard (NG) and Reserve (R) troops have been deployed in larger numbers than at any other time in recent history (Tanielian & Jaycox, 2008), and comprise approximately 40% of all U.S. troops across military branches (Shea, Vujanovic, Mansfield, Sevin, & Liu, 2010). As of 2005, two-thirds of all NG troops had served at least one deployment in either Iraq or Afghanistan (Bennis & Leaver, 2005). During the U.S. involvement in World War II and during the Vietnam War, military personnel typically served one to two tours of duty and NG/R troops were not deployed overseas. In contrast, during the wars in Iraq and Afghanistan multiple deployments (two, three, and sometimes four overseas stints of 12 to 15 months) for all U.S. military personnel became common, leading to increased exposure to combat for military personnel and increased uncertainty for military personnel and their families (Crary, 2008).

Originally treated as equivalent to regular active duty personnel in their experiences of deployment and reintegration, collected data and anecdotal information on the experiences of NG/R personnel brought to light a number of differences between the two groups. While NG/R personnel desire to serve their country, they are also often motivated to enlist for more practical reasons, such as to supplement income and pension benefits or procure education benefits (Lapp, et al., 2010). Due to the history of the reserve component of U.S. military forces pre-9/11, most NG/R members and their families never imagined deployments into combat settings, nor did they expect the possibility of extended or multiple deployments (Lapp et al., 2010; Wheeler & Stone, 2012). NG/R service members are typically “older, partnered with dependent children, and less prepared for prolonged separations from family” than active duty personnel (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). Other aspects of difference between NG/R service members and regular active duty personnel are related to the inherent lifestyle of their particular branch of
service. Due to the citizen-soldier model of the NG/R, they (a) train less frequently with fewer opportunities to reinforce skills—often leading to feelings of under-preparedness; (b) have greater nonmilitary responsibilities and stressors, while being less integrated into military life; and (c) are more likely to live in communities more isolated from other military families and services than their active duty counterparts (Kehle et al., 2010; Lemmon & Chartrand, 2009; Vogt, Samper, King, King, & Martin, 2008).

Perhaps due in part to these characteristics, NG/R have been shown to be at higher risk for mental health problems—especially posttraumatic stress disorder (PTSD)—and are referred to mental health services more frequently than active duty personnel following deployment (Hotopf, et al., 2006; Jacobsen et al., 2008; Milliken, Auchterlonie, & Hoge, 2007; Rundell, 2006; Schell & Marshall, 2008; Smith et al., 2008; Vasterling et al., 2010). Despite higher risk and referral rates, evidence that utilization rates are greater is lacking (Milliken et al, 2007).

The first wave of research on the reserve components of the U.S. military was focused on increasing combat readiness, enhancing integration with active duty personnel, and the mental health effects of OEF/OIF combat on NG/R personnel. Limited research exists which examines the impact of the deployment cycle on the spouses and families of the military reserve components. Although some aspects of the family experience of deployment between active and reserve components overlap, NG/R families are particularly at risk for family disruption and increased stress when compared to active duty peers due to multiple factors: families of NG/R personnel typically do not identify themselves as belonging to a military community, they have fewer support programs, and the geographical scatter of NG/R families leads to difficulties in gaining access to existing support programs (Lapp et al., 2010). In addition, after returning from deployment, NG/R veterans experience decreasing support due to their departure from active
duty and increasing emotional distress as they are expected to return to the responsibilities of civilian life, both of which have an impact on family stability (Miliken et al., 2007). NG/R families are also often under a significant financial strain: more than half of married or separated NG families reported a loss in income due to deployment (Booth et al., 2007). The downturn in the economy led some people to the NG/R as a source of income, but the economy has not recovered sufficiently to insure paid employment for these soldiers upon their return. In addition, NG/R veterans have shorter windows of time for government support than active duty personnel and are expected to return to the civilian workforce sooner (Burnett-Zeigler et al., 2011). Among those NG/R members who are pursuing schooling prior to deployment, many are forced to abandon educational pursuits midway through schooling and must then wait to resume them due to academic calendar scheduling. This pattern prolongs training for better-paying employment and lowers NG/R families’ income potential (Bauman, 2009).

The issues unique to NG/R service members need further consideration. To provide a fuller understanding of the impact of deployment on families, this paper will first review common mental health problems among NG/R service members (primarily PTSD and suicide) which are factors in readjusting to family and civilian life. To underscore the need for additional research on the impact of deployments of NG/R families, the current literature will be reviewed, including some examinations of the effects of the deployment cycle on the children and spouses of NG/R service members during deployment (Eskin, 2011; Lapp et al., 2010; Wheeler & Stone, 2012) and postdeployment, during reintegration (Gorman et al., 2011; Meis et al., 2010; Sherman & Bowling, 2011). Finally, this paper will offer recommendations, based on the literature, for better serving NG/R service members and their families.
Literature Review

The Impact on the Soldier: Posttraumatic Stress Disorder

PTSD is a widespread problem among service members returning from OEF/OIF across branches. Across studies, rates of PTSD range from 1.4 to 31% among active duty, National Guard (NG), and Reserve (R) military personnel, while in the Veterans Affairs Health Care System (VA), 22% of OEF/OIF veterans receive a diagnosis of PTSD (Hoyt & Candy, 2011). Tanielien and Jaycox (2008) found rates of both PTSD and depression to be at 14% in a large epidemiological study of 2000 OEF/OIF soldiers conducted by the RAND corporation. Furthermore, several studies have shown high rates of comorbidity of PTSD with other diagnoses, particularly substance abuse and depression (Rielage, Hoyt, & Reshaw, 2010; Erbes, Westermeyer, Engdahl, & Johnsen, 2007; Wells et al., 2010).

Milliken, Auchterlonie, and Hoge (2007) found that self-reports of mental health problems (including depression, PTSD, and relationship problems) among NG/R troops were more than double those of active duty personnel, at 42.4 and 20.3% respectively. In addition, positive screening rates of PTSD symptoms among NG/R service members increased at a much higher rate than for active duty personnel between immediate screening and a reevaluation six months later, indicating that NG/R are more likely than active duty military to develop PTSD after returning home from deployment. These findings are supported by the high rates of PTSD symptoms reported among National Guard troops returning from Iraq: 85% of respondents endorse at least one PTSD symptom, including endorsement rates of 56% for hypervigilance, 48% for exaggerated startle, 49% for difficulty falling or staying asleep, and 48% for irritability and anger (Shea et al., 2010).
Increased vulnerability for developing PTSD among NG/R troops has been speculated to be the result of many factors, including lower levels of predeployment training, increased stress due to dual civilian and soldier roles, and potential difficulties integrating with active duty combat troops (Renshaw, 2010). A number of studies have shown two additional factors to be at play in putting NG/R troops at greater risk: multiple deployments (Kline, Falca-Dodson, Sussner, Cicone, Chandler, Callahan, & Losonczy, 2010) and concerns about family and career disruptions (Browne et al., 2007; King, King, Vogt, Knight, & Samper, 2006; Renshaw, 2010; Vogt, Proctor, King, King, & Vasterling, 2008).

An additional source of vulnerability may be the increased exposure that OEF/OIF-era NG/R personnel have to potentially traumatizing situations over Operation Desert Storm-era NG/R troops (Renshaw, 2010). Combat experiences, postbattle experiences, and perceptions of threat are linked to PTSD, and a large majority of NG/R soldiers report substantial exposure to potentially traumatic war related events (Renshaw, 2010). In one recent study of over 400 OIF National Guard troops, 91% participated in combat missions or patrols, 94% reported that they or a unit member received incoming small arms fire, 55% reported being attacked by terrorists or civilians, 22% thought they killed someone in combat, and 10% were wounded or injured during deployment (Kehle et al., 2011).

Whatever the causes of increased rates of PTSD among NG/R service members, the impact of mental health concerns on the service members and their families likely plays a significant role in service members’ functioning when they return to daily life. PTSD has been found to be a key risk factor for family distress following deployment (Galovski & Lyons, 2004). Trauma affects not only the individual, but also their social/family context. Historically, parental psychopathology (primarily depression) has been found to impair marital adjustment, parenting
practices, and child adjustment. More recently, PTSD has also been linked with marital disruption, spousal abuse, reduced intimacy, sexual dysfunction, and decreased marital satisfaction (Gewirtz et al., 2010). The depth of the effect of PTSD on family life cannot be denied. Although Kehle and colleagues (2011) found NG personnel with any mental health diagnosis reported significant problems with social functioning and quality of life, PTSD was associated with the highest levels of impairment.

For combat veterans with PTSD, relationship and interpersonal problems are linked with “poorer prognosis, lower treatment engagement, and suicide risk” (Renshaw & Campbell, 2011). The link between PTSD in NG/R personnel and relationship satisfaction and functioning is an important one given that concerns about relationships increased at greater rates than any other concern among OIF veterans (Milliken et al., 2007). According to a 2008 report, more than 50% of OEF/OIF veterans referred to the Veterans Administration for mental health reasons reported intimate partner violence, and over 75% endorsed problems with their intimate partner or children (Sayers, Farrow, Ross, & Oslin, 2009).

Several recent studies have examined the relationship between PTSD and relationship functioning in OEF or OIF National Guard personnel. This is important research, as the link between PTSD symptoms and relationship issues in NG/R personnel has not kept pace with the same studies among regular active duty personnel, and the differences between NG/R service members and their active duty counterparts are well established.

Renshaw and Campbell (2011) surveyed 206 NG/R service members and their romantic partners. The vast majority of the service members studied were male and married (98.5%, each group), and non-Latino white (85.5%). The mean age was 34.91. Partners were primarily female, non-Latina white (85.4%), with a mean age of 32.84 years, and had been married to the
service members for a mean of 10.17 years. Renshaw and Campbell (2011) found that greater severity of PTSD symptoms in NG/R members was associated with greater distress in their partners. Of particular interest was their finding that the PTSD symptom of numbing/withdrawal was uniquely associated with psychological distress in the partner, as well as overall relationship distress. An inability to connect with intimate partners may lead to further isolation in both the service member and his/her partner than they may already experience due to feelings of distance from their military community and from civilian community concerns.

Typical relationship concerns experienced by military couples postdeployment may also be exacerbated by PTSD in combination with other factors. Meis, Erbes, Polusny, and Compton (2010) studied the relationship between PTSD, personality, and problem drinking with relationship quality in 308 NG soldiers recently returned from Iraq. The average respondent (277 male, 31 female NG service members) was 31 years old and white (95.8%). Most were currently employed (61.6%), married or living with a partner (64.8%), and half (50.6%) had at least one child. In their study, 15.8% of subjects screened positive for PTSD, 22.1% had relationship distress, and 30.5% screened positive for problem drinking. NG members who were positive for PTSD were more likely to report relationship distress (33.3% vs. 19.6%) and those who screened positive for problem drinking were more likely to also screen positive for PTSD (36.6% vs. 29.2%). However, those who had drinking problems were not more likely to screen positive for relationship distress than those without drinking problems. The authors were careful to point out that these were members who had recently returned from deployment, noting that drinking problems or PTSD symptoms could cause greater relationship distress over time, particularly without intervention.
In order to account for the possibility of this distress over time, Erbes, Meis, Polusny, and Compton (2011) assessed relationship adjustment and PTSD again, assessing at two points in time. A sample of 313 married or partnered NG soldiers was surveyed 2-3 months following their return from Iraq and one year later. The average soldier was 31 years of age (89% men, 11% women), deployed for 16 months, and primarily White and 86% were enlisted rank. As expected, findings showed that soldiers with PTSD reported poorer relationship adjustment than those who did not screen positive for PTSD. In this study, individual PTSD factors—reexperiencing, avoidance, dysphoria, and hyperarousal—were compared on relationship adjustment. Although all four factors were significantly correlated with poorer relational adjustment at Time 1, avoidance and dysphoria were correlated with relational adjustment at Time 2, and when further examined, dysphoria was the most important factor in relational adjustment in the six months following the soldiers’ return and predicted relational adjustment 1 year later. It is hypothesized that the effects of dysphoria result in relationship withdrawal from partners and decrease the soldiers’ capacity for emotional engagement.

In an effort to better understand which aspects of PTSD had the greatest effect on relationship adjustment, Erbes, Meis, Polusny, Compton, and Wadsworth (2012) examined the associations between overall PTSD, symptom clusters of PTSD, and relationship adjustment both cross-sectionally and longitudinally in a sample of OIF NG soldiers and their intimate partners. Forty-nine couples were included in the study; all soldiers were male and all partners were female. The majority of soldiers and partners were white, with mean age of soldiers being 34.71 and of partners 33.61. All but one couple was married, with a mean number of 9 years married. Data was collected from soldiers and their partners within the first year of the soldier’s return and again 6-9 months later. The Dyadic Adjustment Scale (DAS) was used to measure
relational adjustment and the PTSD Checklist-Military Version (PCL-M) was used to measure PTSD symptoms in soldiers. At Time 1, within the first year post deployment, soldier PTSD predicted decline in partner-endorsed relationship adjustment, but not soldier-endorsed relationship adjustment. This underscores the importance of looking not only at the soldier, but also at the partner, with regards to relationship adjustment, particularly because this may lead to “reduced support and increased conflict with soldiers suffering from higher levels of PTSD” (Erbes et al., 2012, p. 190). This could lead to long-term consequences for both service member and spouse.

The growing understanding of the effect of PTSD on service members’ and their spouses’ relational adjustment is important, but these findings also extend to the rest of the family. In 2010, Gerwirtz et al. conducted a one-year longitudinal study to examine the impact of change in PTSD symptoms following combat deployment on NG soldiers’ perceived parenting and couple adjustment one year after return from Iraq. Prior research (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008) had shown that family reintegration post deployment requires readjustment of roles as both a partner and a parent. Gerwirtz et al. (2010) surveyed 468 primarily white NG fathers with a mean age of 36. Participants completed a survey 1 month before returning home from deployment and 1 year after return. The PCL-M was administered both times. Two items assessing social support were gathered at Time 1. At Time 2, participants completed self-report instruments measuring parenting, couple adjustment (utilizing the DAS), parent-child relationship quality, alcohol use, and items regarding injuries sustained during deployment. Results of this study showed that increases in PTSD symptoms were associated with poorer couple adjustment and greater parenting challenges, and that couple adjustment did not mediate parenting. In addition, PTSD symptoms were predictive of parenting challenges
independent of their impact on couple adjustment. It is not possible through this study to
determine if parenting challenges and poor couple adjustment exacerbate PTSD symptoms,
though this is likely. One of the most important findings of this study may be in regards to social
supports: higher perceived social support measured in-theater predicted more effective
perceived parenting behaviors at follow up. The extent of social support was also negatively
associated with increases in PTSD symptoms.

The Impact on the Soldier: Suicide

Social supports and reintegration into family life postdeployment are important factors in
suicide prevention. Startling statistics about the rates of suicide among military personnel
underscore how crucial it is to understand the needs of all of our military populations. The rate
of military suicides increased by 80% between 2004 and 2008 and soared by another 18% in
2012. Deaths by suicide among military personnel have surpassed the number of deaths by road
accidents as the leading cause of noncombat deaths. Although veterans account for only 10% of
all adults in the U.S., they account for 20% of U.S. suicides (Thompson & Gibbs, 2012).

While some statistics regarding which service members are more likely to kill themselves
point to some factors less common to the NG/R soldier (e.g., 18-24 year olds are more likely to
kill themselves and NG/R soldiers tend to be older), others are more common to NG/R personnel
(e.g., a majority of cases are among married men). One possible factor in particular may be
more salient for NG/R troops: service members bond heavily with their units while in combat
and these units disperse once the troops return home. Another factor that may be more salient to
NG/R troops is that many who commit suicide report relationship issues prior to the act
(Thompson & Gibbs, 2012).
In a review of literature regarding suicide rates among NG soldiers, Griffith (2012a) noted that several studies indicated a correlation between PTSD and suicidal behavior (Ben-Ya’acov & Amir, 2004; Martin, Ghahramanlou-Holloway, Lou, & Tucciarone, 2009; Nye & Bell, 2007), the comorbidity of PTSD with depression (Lemaire & Graham, 2011), and the high prevalence of co-occurring major depressive disorder for completed suicides (Arsenault-Lapierre, Kim, & Turecki, 2004; Isometsa, 2001; Rihmer, 2007). Research on NG/R personnel found U.S. reserve personnel to be at greater risk for developing PTSD (Griffith, 2010, Griffith, 2011; Thomas et al., 2010) and they report higher rates of PTSD postdeployment than their active duty counterparts (Hoge, Auchterlonie, & Milliken, 2006; Schell & Marshall, 2008; Seal et al., 2009).

It is, therefore, not surprising that observed suicide rates among NG/R are higher than those of regular active duty personnel. In 2010, the U.S. Department of the Army reported that within the military services, Army and Marine troops (primarily ground troops) were found to be at higher risk than other military branches for suicide. Among those groups, Army NG troops were found to have the highest rate of suicide: 31.23 per 100,000 compared with 25 per 100,000 in active duty Army and 24 per 100,000 in the Army Reserve (U.S. Army, Office of the Chief of Public Affairs).

The reason for differences between regular active duty and NG/R military personnel regarding suicide rates is difficult to elucidate. Griffith (2012b) outlined several theories of suicide that may help explain the vulnerability of NG/R personnel. The stressor-strain model (Cohen & Willis, 1985; Department of the Army, 1994; Griffith, 2007) connects the number of deployments and exposure to combat experiences with increased vulnerability to suicide, PTSD, and depression. Another group of theories (Durkheim’s social control theory and Joiner’s
interpersonal-psychological theory) point to the relationship between social connections and suicide. According to Griffith (2012b), Durkheim explained suicide through a “lack of social integration and normative regulation of behavior” and Joiner explained suicide as resulting from “thwarted belongingness and perceived burdensomeness to others” (p. 105). Feeling disconnected from others and no longer feeling that one is contributing to a group to which one once belonged can lead to suicidal thoughts and behaviors. An additional theoretical perspective ties associated features of the most suicidal groups to their social contexts: white, male young adults and seniors are at highest risk of suicide in the civilian world, perhaps due to cultural features (Griffith, 2012b).

Griffith (2012b) analyzed the characteristics of NG soldiers who had, and had not, committed suicide. Suicides were found among predominantly male, young (17-29 years of age), White, single, and part-time military NG service members with no prior service. Suicides occurred among primarily part-time NG personnel in civilian (as opposed to active duty) status (81.4%, 80.0%, 82.3%, and 96.4% of suicides for years 2007, 2008, 2009, and 2010, respectively). “Careerists” tended to have lower rates of suicide, but members of this group who did commit suicide were more likely to report prior suicide attempts, interpersonal problems, PTSD, and access to firearms. “First-termers,” or those with no prior service, who committed suicide were characterized as having more suicidal thoughts and feeling isolated. Suicides from both of these groups had a history of behavioral health problems, substance abuse, loss of a significant other, and lack of income. Although some of these factors cannot be controlled, others may be mediated through increasing social supports and perceived belongingness. These same (and other) supports may also be of vital importance to NG/R service members’ families.
The Impact on Children

The scope of the potential effect of the wars in Iraq and Afghanistan on military families can be expressed through the sheer numbers of military personnel and their family members. Approximately 42% of active duty and NG/R personnel serving in the U.S. Armed Forces are parents (DeVoe & Ross, 2012). It is estimated that 1.5 million active duty service members have 1.8 million dependent family members—1.2 million of them children and youths up to 23 years of age. Among the nearly 900,000 NG/R forces, more than 1 million dependent family members are estimated, including 700,000 children (Pfefferbaum, Houston, Sherman, & Melson, 2010).

Children of all military personnel are vulnerable to emotional consequences of their parents’ involvement in military service (particularly deployment). These consequences include attention and behavior problems, somatic complaints, academic difficulties, and mental health concerns such as anxiety and depression (Chandra, Martin, Hawkins, & Richardson, 2010; Engel, Gallagher, & Lyle, 2010; Flake, Davis, Johnson, & Middleton, 2009; Kelley et al., 2001; Lester et al., 2010; Medway, Davis, Cafferty, Chappell, & O’Hearn, 1995). The extent of these problematic issues has been associated with two primary factors: length of deployment and emotional difficulties in the non-deployed parent (Chandra et al., 2010; Lester et al., 2010). The bulk of research on the effect of parental military service has focused on active duty military personnel to date, with relatively little research conducted specifically regarding NG children, despite the increased role of the NG since the beginning of OEF/OIF.

One recent study focused on NG service members and their families pertains to the first factor mentioned above: length of deployment. Pfefferbaum et al. (2010), studied NG children’s reactions to parental deployment and collected longitudinal data on NG children and their non-deployed parent before, during, and after deployment. A relatively small study with 13 non-
deployed spouses and the children of 10 of those spouses participating, all spouses were female, ranging in age from 24-53 years of age, 77% Caucasian, and 85% employed. Eighteen children participated, ranging in age from 6 to 17 years of age, 61% Caucasian, 61% boys and 31% girls. A written survey was conducted, except in the case of younger children who were read the survey by a researcher. Child emotional and behavioral problems and adjustment were measured using self-report measures and parent-report measures. The surveys also included children’s assessments of worry, perceived parent safety, perceived world safety, and perceptions of the future. The number of children scoring in the at-risk and clinically significant range and overall mean scores increased during the deployment period as compared to pre- and post-deployment periods. This indicates the increased risk for behavioral and emotional distress during deployment and supported the hypothesis found among active duty military families—that length of deployment is a factor. Perhaps more striking, however, was that assessments of worry indicated that children tended to worry about their non-deployed parents more post deployment. This suggests that the readjustment phase, the period of time after the deployed parent’s homecoming, may be an area where increased attention needs to be given. These results also speak to the second factor in child adjustment: mental health of the non-deployed parent.

Generally, military spouses have higher rates of somatic symptoms, psychiatric symptoms, and emotional distress than their civilian counterparts (Herzog, Everson, & Whitworth, 2011). For spouses of soldiers with PTSD, limited social support, marital relation problems (Dirkwzwager, Bramensen, Alder, & van der Ploeg, 2005), and poor relational adjustment (Dekel, Solomon, & Bleich, 2005) are common. Herzog et al. (2011) studied the impact of PTSD in NG soldiers on secondary trauma in their spouses and children. Fifty-four couples with dependent children completed surveys which included demographic information,
length and frequency of deployments, the PTSD Check List Military Version (PCL-M), the secondary trauma scale (STS), the hurt-insult-threaten-scream (HITS), the relax-alone-friends-family-trouble (RAFFTS), and the child behavior checklist (CBCL). The PCL-M was only completed by the soldier and the STS only by the spouse. Participants in the sample were primarily Caucasian, with a mean age of 37.8 among soldiers and 37 among spouses. The mean age of the oldest child in the household was 9.38 years with a standard deviation of 4.54.

Correlations between parent self-endorsed trauma symptoms and parentperceptions of problems for his or her child were moderate, with higher scores on the PCL-M and STS (measuring soldier and spouse trauma respectively) correlating to higher scores on the CBCL (measuring child behavioral and emotional difficulties). The overall implications of the study were that spouses and children of NG soldiers with PTSD tended to develop secondary trauma symptoms related to anxiety, depression, and PTSD-like symptoms, as well as somatic complaints in children. Again, these results indicate that care for returned service members and their families to cope with the emotional effects of war are of vital importance in maintaining family health.

A number of services have been designed to help NG personnel and their families cope with the stresses and demands of today’s military service, and these will be discussed later in this paper. Providing assistance to NG parents regarding the emotional cycle of deployment and, more recently, the “parenting cycle of deployment” is one way researchers suggest that military service branches and mental health professionals can help ease family transitions. DeVoe and Ross (2012) sought to characterize the impact of the “deployment life cycle on parenting roles among service members and at-home partners/caregivers of dependent children” (p. 184). Their model is based on Logan’s (1987) theory of “the emotional cycle of deployment,” which was later adapted (Pincus, House, Christensen, & Adler, 2001; Stafford & Grady, 2003). In the
model, the service member and partner go through five phases of adjustment: a) predeployment, b) deployment, c) sustainment, d) redeployment, and e) postdeployment (or reintegration). DeVoe and Ross (2012) asserted that parenting demands and intimate partner relationship demands differ significantly and that parenting competence is a significant component of the impact of deployment on children. Parenting competence can be impacted by several factors, most notably by parent characteristics, child development and temperament characteristics, and sources of contextual stress and support for both the parent and the child. Parenting competence and the parent-child relationship can provide a buffering effect to stress.

In light of these factors, DeVoe and Ross (2012) suggested logistical and emotional transitions for both service member and partner with regard to parenting. They distinguished between three primary phases (predeployment, deployment, and reintegration) and outline specific tasks within each phase. In predeployment, military parents must navigate when to inform partners and children and may have an uncertain window for departure. NG/R parents may be especially stressed by limited access to information, resources, and social supports that tend to be more readily available to families installed on a military base, and may feel less prepared for deployment to a war zone (MacDermid et al., 2005). In the first task of predeployment, service members must “look ahead” to their departure and navigate helping the non-deploying spouse to prepare logistically and emotionally for household tasks that lie ahead, while managing their own and the family’s emotional responses to both the separation and impending experiences of a war zone. They may be asked to increase training prior to departure which may conflict with their desire to spend as much time with family as possible. They must also navigate how to communicate the situation to children at appropriate development levels. The second task of predeployment is “saying goodbye.” Many service members may be pulled
to avoid goodbyes with children, leaving when their children are asleep or at school. Helping
them to understand the goodbye is important for them and for their children can be helpful as it
provides both the parent and the child the opportunity for reassurance that each will be missed
during the parent’s absence.

During deployment, non-deployed parents often experience emotional and sleep and
eating disturbances. Providing information about the normalcy of reactions to feeling distressed
over the absence of the partner and being overwhelmed by financial, household, and parenting
responsibilities can have a powerful impact (Pincus et al., 2001). Many non-deployed parents
develop new mastery, competence, and independence during the deployment period which
speaks to their resilience (DeVoe & Ross, 2012).

Deployed parents must manage the complexities of worrying about family at home while
fulfilling duties in the war zone (MacDermid et al., 2005; Renshaw, Rodrigues, & Jones, 2009).
Increased communication available in today’s wars may increase demands placed on the
deployed parent, both to respond to issues at home and in managing what information to provide
the at-home partner about their deployment experiences (MacDermid et al., 2005).

When deployment is nearing a close, deployed and non-deployed parents must manage
the excitement and apprehensions of the service member’s return. “Surviving the homestretch”
tasks include deciding when and how to inform the children of the service member’s return,
understanding the other partner’s reactions (the at-home parent may feel free to let their guard
down while the deployed parent must still meet the demands of combat situations and departure
preparations), and each partner helping the other with concerns about reunions with children
(DeVoe & Ross, 2012).
In the reintegration phase, parents have two primary task clusters: “facing reality” and “moving forward.” Facing reality includes dealing with the returning parent’s readjustment to civilian life following participation in a combat zone, including emotional and physical changes. Service members may be experiencing mental health challenges while at-home parents would like to return to “normal life” with their partners. At the same time, at-home partners may have developed new patterns for the family and new levels of independence that they do not wish to relinquish. Additionally, both parents may have to decide how to respond to any challenges their children face in the readjustment phase. After the initial honeymoon period is over, families may find that they are unprepared for difficulties of readjusting.

“Moving forward” tasks center on reestablishing the family’s equilibrium to a new center which may include the realities of a returned parent with on-going physical and mental health issues. New parenting routines and practices and integration of the new realities created during deployment must be integrated into the family’s vision for their future. These new realities are often unwanted, especially when the at-home parent and children expected a return to their former “normal.” Helping all members of the family to prepare for the extended length of this transition is critical (DeVoe & Ross, 2012).

The Impact on Partners

Since 2001, nearly 2 million service members have been deployed to support operations in OEF/OIF; more than half of all U.S. service members are married (Lara-Cinisomo et al., 2012). This suggests that many military spouses—and military families—have been affected by deployments.

Findings on the effects of deployment on military spouses suggested that partners of military personnel experience stress related to increased household responsibilities, decline in
emotional well-being, sleep and eating disturbances, communication stresses, relationship
distress, and worry about their partner’s safety during deployment (Huebner & Mancini, 2005;
Chandra, Burns, Tanielian, Jaycox, & Scott, 2008; Flake et al., 2009; Chartrand, Frank, White, &
Shope, 2008; Chandra et al., 2010; Eaton et al., 2008; Hinojosa, Hinojosa, & Hognas, 2012;
Mansfield et al., 2010; Steelfisher, Zaslavsky, & Blendon, 2008). This research has often been
limited to one branch of active duty military, leading to questions of whether data can be
generalized to other branches, and in particular, whether the information is generalizable to
NG/R partners (Lara-Cinisomo et al., 2012). Specific experiences of NG/R partners and spouses
have been more recently explored to a lesser degree (Caska & Renshaw, 2011; Lapp et al., 2010;
Wheeler & Stone, 2012), although they are perhaps more important given the unprecedented use
of NG/R in OEF/OIF. In addition, the greater number of NG/R service members who are
married compared to their active duty peers, the lack of centralized bases for NG/R families’
health care, and the lack of centralized support for many NG/R families underscore the need for
a better understanding of NG/R troops and their spouses.

In one attempt to further research from the perspective of NG/R spouses, Caska and
Renshaw (2011) explored the relationship of NG service members’ distress to their spouses’
distress through the lens of perceived burden in the spouse. Perceived burden has been defined
as spouses’ perceptions of negative life changes due to their partner’s mental health issues,
including increased household and childcare responsibilities, physical and psychological
concerns, financial difficulties, and interpersonal problems. The majority of research regarding
perceived burden has focused on those service members with diagnosable PTSD (Caska &
Renshaw, 2011). As mentioned in the previous sections of this paper, there has been much focus
on the relationship between PTSD and family and spousal distress, including secondary trauma
In their 2011 study, Caska and Renshaw surveyed 130 male NG/R service members currently deployed overseas and their spouses. Service members ranged in age from 20-58 ($M=33.63$), and 90.4% were Caucasian. Spouses’ ages ranged from 18-61 ($M=31.52$), and 92.2% were Caucasian. Ninety-eight percent of couples were married with a mean length of marriage of 8.94 years, and an average reported household income of $60,585.33. Spouses completed the Burden Interview to assess the perceived burden of the military service, the PTSD Checklist Civilian version (PCL-C) to assess PTSD symptoms, the General Self-Efficacy Scale to determine the spouses’ beliefs about their abilities to handle life problems, the Big Five Inventory to assess five factors of personality, and the Ways of Coping Questionnaire to assess strategies for dealing with stressful situations. Both spouses and service members completed the Depression Anxiety Stress Scale to assess for depression, anxiety, and stress, and the service members also completed the PTSD Checklist Military version (PCL-M).

Caska and Renshaw (2011) found that spouses’ perceived burden was significantly correlated with both severity of service members’ psychological symptoms (PTSD, depression, and anxiety) and their own higher levels of distress. The strength of the relationship between the service members’ symptoms and spouses’ burden was not moderated by whether the service members’ psychological symptoms met cutoffs for clinical levels of severity: even spouses of service members with subclinical symptoms reported elevated burden. Burden was also found to mediate the relationship between spousal distress and service member psychological symptoms,
was positively correlated with spousal neuroticism and avoidant coping, and negatively correlated to spousal self-efficacy. These results indicate that the spouses’ perceptions of burden were an important factor in how they managed their own distress in the service members’ absence and could be an important point of intervention.

Stress and coping strategies among NG/R spouses was further explored by two studies: Lapp et al. (2010) and Wheeler and Stone (2012). In each of these studies, the focus was on the spouse.

Lapp et al. (2010), conducted face-to-face interviews with 18 spouses of NG/R service members (16 women, two men) residing in a rural area of Wisconsin. NG/R service members were either currently deployed or had deployed within the past two years and all spouse participants stated that future deployment was possible. The average age of participants was 39; race and years of marriage were not reported. The researchers conducted interviews lasting an average of 60 minutes which consisted of interviewers asking participants to first “tell their story” and then followed up with five questions: (a) What are the stressors associated with your spouse’s deployment? (b) Tell me about the effect of the war on you—both physically and emotionally? (c) What do you do to help cope with the stress you’re under? (d) Is there anything the military has done to help decrease your stress or increase your ability to cope with this deployment? (e) Is there anything you would tell another spouse of a deploying soldier that you wish you would have known in the beginning? Interviews were audiotaped, transcribed, and examined for themes. Data were then placed in one of two categories: (a) sources of stress or (b) coping strategies.

With regard to sources of stress, Lapp et al. (2010) identified the following areas of stress: predeployment stress (planning for the service member’s absence, legal and financial
concerns, uncertainty about deployment timelines), during deployment stress (worry about safety and unknown changes to the relationship, waiting for communication, “going it alone” regarding finances and household duties, “pulling double duty” as a single parent, and loneliness), and postdeployment stress (getting to know their spouses again). Coping strategies included keeping busy, staying connected with the soldier and relevant others, managing personal needs (exercise, music, journaling, etc), buffering from too much information in the media, seeking support from others living through the same experience, and reunion briefing sessions provided by the NG/R. Participants indicated that the most valuable forms of support were connection with their service member, concrete acts of assistance (such as home repairs, shoveling snow, child care) or emotional support from other spouses who experienced deployment.

Wheeler and Stone (2012) also conducted a qualitative study to identify stressors and coping methods among spouses of Nebraska NG soldiers currently deployed or who had returned in the last two years. Only nine participants responded to requests for interviews, aged 21 to 46 years. Respondents were highly educated; eight of nine had jobs outside the home; all respondents had been married at least one year; five respondents had children. Participants were interviewed for a period of 45 to 120 minutes and asked seven open-ended questions prompting them to talk about the impact of deployment on (1) themselves, (2) their spouse, (3) their marital relationship, (4) their children, and to identify (5) what they found to be helpful in coping with deployment, (6) who they found to be helpful during deployment, and (7) any other factors that may have helped them cope with deployment. Findings were organized into stressors and coping strategies. Stressors included (1) problems with emotional, mental, and physical states; (2) difficulties with children; and (3) uncertainty about future involvement with the military (including wishes for their spouses to discontinue military service and disappointment with the
Coping strategies used consisted of (1) expressive activities (i.e. art, journaling), (2) support from family and friends, (3) spirituality, (4) communication with deployed spouse, and (5) avoidance of the situation. As in the previous study, talking with people who had been through similar situations was found to be very helpful, as was spending time with family and friends as a distraction. “Keeping busy” was another repeated theme. The authors found that the coping methods used by NG wives were similar to what they had found in studies of active duty military wives. A major difference between the two groups is the ready availability of people going through the same experience among active duty military versus NG wives.

The literature suggests that the difficulties unique to NG/R service members and their spouses do not stop after deployment ends—limited access to services, difficulty returning to jobs for NG/R members postdeployment, disconnection from the soldier’s combat unit, higher rates of relationship distress, immediate demands of the civilian world, disconnection from military monitoring, less structured postdeployment support networks, and a lack of understanding from the civilian environment (Gorman, Blow, Ames, & Reed, 2011; Renshaw, Rodrigues, & Jones, 2009; Sherman & Bowling, 2011).

**Avenues of Support**

To help NG/R families deal with difficulties during and after deployment, it is important to understand both barriers to support (such as those outlined above) and barriers to seeking support. One factor described is limited access to health care. Although all U.S. veterans of OEF/OIF, including NG personnel, are eligible for free health (which includes mental health) services from the Department of Veteran Affairs (VA) for five years following deployment (Kehle, 2010; Sherman & Bowling, 2011), not all NG veterans live within close proximity of VA centers. This exemplifies one of several factors identified by Kehle et al. (2010) that influence
treatment seeking behaviors among NG/R service members: practical barriers, such as inadequate transportation. Other factors which may keep NG soldiers from seeking care include stigma regarding the impact of mental health care on self-image and one’s military career, stigma regarding beliefs about those who seek mental health care, and negative and distrustful attitudes about the efficacy of mental health treatment. Treatment seeking behaviors were associated with receiving psychotherapy in-theater, higher levels of combat and perceived threat, injury in-theater, higher levels of PTSD and depression symptoms, poorer health, more extensive postdeployment stressors, and positive attitudes toward mental health treatment. These factors were also associated with postdeployment psychiatric medication use. Kehle et al. (2010) recommend providing education regarding treatment for PTSD and increasing availability to those treatments.

Another option for treatment postdeployment for NG service members is TRICARE, a military-based health insurance that can be used with a network of civilian based mental health care providers. In one study of TRICARE services, significant problems were found with accessing TRICARE outpatient provider networks (Avery & MacDermid Wadsworth, 2011). Doctoral-level psychologists in smaller markets with higher numbers of deployed NG soldiers were less likely to accept new TRICARE patients than in larger markets where active duty components were greater. This points to one barrier to care, which is particularly salient to more rural NG service members. While the NG has established services to assist with these issues (Family Assistance Centers and the Joint Support Services Portal presented in Table 2), need continues to outstrip services.

Many attempts have been made through military channels and outside of them to respond to the increased needs of NG/R personnel and their families. Mental health professionals can be
of assistance by helping guide family members to these resources and becoming familiar with the resources themselves. A number of online resources which have emerged to offer support across military branches are included in Table 1 below.

Table 1.

*Resources Available to All Military Personnel and Their Families*

1. Military One Source (www.militaryonesource.com) provides a clearinghouse of information for service members and their families, as well as time-limited free counseling
2. Give an Hour (www.giveanhour.org) allows mental health professionals to donate their time to provide services to military personnel and their families in their local area
3. Operation Homefront (www.operationhomefront.net) is a national nonprofit organization that provides emergency support and morale to military personnel and families and to wounded warriors postdeployment
4. The Military Spouse Career Center website (www.military.com/spouse) was developed and is operated by Monster and Military.com under contract on behalf of the Department of Defense to support to spouses and families by giving access to information about career opportunities, training information, and education options.
5. The Department of Veteran Affairs provides several guides to help military personnel, veterans, and their families cope during reintegration. These guides, and links to further information about PTSD-related topics, can be found on the VA website (www ptsd.va.gov/public/reintegration/returning_from_the_war_zone_guides.asp)

*Note:* Compiled from Lapp et al. (2008) and Sherman and Bowling (2011).

Recognizing the unique needs of National Guardsmen and their families and the increased strains placed on families by circumstances of deployment in the wars in Iraq and Afghanistan, the National Guard Bureau has made an attempt to further bolster support for NG personnel and their families. Additional support services are being offered specifically to National Guard personnel and their families. These services are presented in Table 2.
Table 2.

National Guard Resources and Programs

1. National Guard Youth ChalleNGe Program (NGYCP) (www.ng.mil/features/ngps) is a community-based program designed to lead, train, and mentor high school drop outs through a quasi-military residential training program followed by a one-year mentorship.

2. STARBASE (www.ng.mil/features/ngps) is an outreach program designed to engage fifth grade students in science, technology, engineering, and math fields.

3. Warrior Transition Units (WTUs)/Community-Based Warrior Transition Units (CBWTUs) provide support and transition services for wounded, ill, and injured soldiers including non-clinical support, case management, health-care, administrative processing, and transition assistance.

4. Yellow Ribbon Reintegration Program provides information, services, referrals, and outreach to service members, spouses, employers, and youth throughout the deployment cycle.

5. The Joint Services Support (JSS) Portal (www.JointServicesSupport.org) provides an online support community for NG service members and their families.

6. Family Assistance Centers (FACs) are designed to be “one stop shops” providing information and referral; assistance with identification cards and the Defense Enrollment Reporting System (DEERS); assistance with TRICARE and dental issues, legal and financial issues assistance, and referral to Employer Support of the Guard and Reserve (ESGR).

Note. Compiled from information in the National Guard Bureau 2012 Posture Statement. The JSS Portal is the starting point for most of the services listed.

The American Psychological Association (APA) has developed several informational brochures under the title “Resilience in a Time of War” to help family members navigate uncertainties during deployment and during the homecoming period. These brochures are tailored to helping parents and children at various stages better cope with these difficult time periods, and are also designed to help teachers learn to help children cope. These brochures are available for download on the APA website (www.apa.org). Links for numerous resources which serve the U.S. military, veterans, and their family members can also be found on the APA website (www.apa.org/about/gr/issues/military/resources.aspx).

Research has also supplied general recommendations for health and mental health practitioners who serve NG/R service members and their families. In one example of these
recommendations, Lapp et al. (2010) outlined several recommendations for family nurses which can be applied to all caregivers. These recommendations include the following:

(a) connect clients to appropriate support systems tailored to their own needs (community/professional/online), (b) encourage exploration of military resources such as other spouses or military-supported groups, (c) refer to appropriate medical professionals for physical and psychological symptoms, (d) view clients in the context the family and the military family, (e) empower families through caring and commendation for strengths and competencies, (f) witness and validate family members’ experience, (g) create a trusting environment that acknowledges and legitimizes intense emotion and family suffering, (h) intentionally engage with families in helping them to make sense of their circumstances and to move beyond it, and (i) provide family members with a context for change in shaping a direction for health and healing their own new normal. (p. 65)

Sherman and Bowling (2011) provided four psychoeducation intervention program recommendations for couples affected by trauma. Operation Enduring Families is a 5-session curriculum adapted from the SAFE program to target the needs of OEF/OIF veterans and their adult family members during the reintegration process (see www.ouhsc.edu/oef for a free download). The Veteran Parenting Toolkit is a set of 5 age-based toolkits for OEF/OIF veterans and their partners to support parents reconnecting with children postdeployment (see www.ouhsc.edu/VetParenting for a free download). For higher levels of PTSD and trauma exposure, the following programs may be more appropriate: the Support and Family Education (SAFE) Program and the Reaching out to Educate and Assist Caring, Healthy Families (REACH) Program. SAFE is an 18-session curriculum written for mental health professionals to give information and support to adults who “care about someone living with PTSD or mental illness” (p. 213). The curriculum is considered a best practice by the VA (see www.ouhsc.edu/safeprogram for free download). REACH is an adaptation of the evidence-based Multifamily Group Model and a 9-month intervention for veterans with PTSD and their
support persons. It is a combination of single family assessment sessions and multifamily group skills sessions.

Sherman and Bowling (2011) also review a number of couples therapy techniques which show promise for treating trauma affected couples which have limited empirical support to date and include the following: Cognitive-Behavioral Conjoint Therapy for Posttraumatic Stress Disorder, Strategic Approach Therapy, Emotion-Focused Therapy, Integrative Behavioral Couples Therapy, and a pilot program called Strength at Home (see Sherman & Bowling, 2011 for descriptions and sources for these programs).

Another way that mental health providers can be helpful is to familiarize themselves with the phases of deployment and the effects of those phases on both relationship adjustment and parenting. DeVoe and Ross (2012), whose work was more thoroughly outlined earlier in the paper, described the tasks that occur for NG/R personnel and their partners in each phase of deployment—from predeployment tasks through reintegration tasks.

Research on which resources and supports are most effective is needed to further enhance the support systems for NG/R service members and their families. In addition, increased numbers of practitioners who are willing to develop their understanding of the challenges faced by military families and resources available to them are needed. Continued commitment from professional organizations like the American Psychological Association can help to further the cause of NG/R service members and their families, but it will be largely up to individual providers and local agencies to reach the people most in need.

Conclusion

NG/R service members face demands as citizen soldiers (including high family demands, civilian employment demands following deployment, limited training, limited access to support...
services, and less military group cohesion) which their active duty counterparts either do not encounter or encounter to a lesser degree (Kehle, Polousny, Murdoch, Erbes, Arbisi, Thuras, & Meis, 2010; Lemmon & Chartrand, 2009; Vogt, Samper, King, King, & Martin, 2008). These demands may contribute to higher rates of mental health problems, including PTSD and suicide, among NG/R troops over active duty personnel (Hotopf, Hull, Fear, Browne, Horn, Iversen, et al, 2006; Jacobsen, Ryan, Hooper, Smith, Amoroso, Boyko, et al, 2008; Milliken, Auchterlonie, & Hoge, 2007; Rundell, 2006; Schell & Marshall, 2008; Smith, Ryan, Wingard, Slymen, Sallis, & Kritz-Silverstein, 2008; Vasterling, Proctor, Friedman, Hoge, Heren, King, et al, 2010).

Recent work has sought to clarify why NG/R troops suffer mental health problems at a higher rate (Griffith, 2012b), but more study is needed.

Regardless of the reasons for the high rates of mental health difficulties, it is clear that a better understanding of the impact of these issues on NG/R families is needed, particularly given the increased use of NG/R personnel. Studies have examined the effects of service members’ mental health difficulties on their families (Renshaw & Campbell, 2011; Sayers et al, 2009), but research specific to NG/R families in light of the differences between NG/R and active duty components of the military has only just begun (Gewirtz et al, 2010; Herzog et al, 2011; Kehle et al, 2011; Pfefferbaum et al, 2010). One aspect of family health is the perceived quality of intimate partner relationships. Spousal relationship patterns among NG/R families have begun to be studied (Caska & Renshaw, 2011; Lapp et al, 2010; Wheeler & Stone, 2012), but additional investigation is needed to improve understanding of how the military and health and mental health practitioners can better serve spouses of NG/R service members to sustain or improve NG/R family health.
Many services have been developed since the beginning of OEF/OIF. The extent to which those services are helpful to NG/R families is largely unknown (Lapp et al, 2010). Gathering qualitative data from NG/R family members is an important area of research given the current and likely future use of reserve components of the U.S. military in conflicts over seas. Examination of additional data on “what works” can help service providers to be more effective in meeting the needs of our nation’s citizen-soldiers and their families.
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