
Theses, Dissertations, and Projects

2009

Having our say : stressors and readjustment issues of veterans of the wars in Iraq and Afghanistan from the perspective of loved ones

Karen Davis McGinty
Smith College

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

McGinty, Karen Davis, "Having our say : stressors and readjustment issues of veterans of the wars in Iraq and Afghanistan from the perspective of loved ones" (2009). Masters Thesis, Smith College, Northampton, MA.

<https://scholarworks.smith.edu/theses/1218>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Karen Davis McGinty
Having our Say: Stressors
and Readjustment Issues of
Veterans of the Wars in Iraq
and Afghanistan from the
Perspective of Loved Ones

ABSTRACT

This qualitative study explores the stressors and readjustment issues experienced by veterans of the wars in Iraq and Afghanistan, from the perspective of loved ones. A review of the literature on veterans' experiences is vast; however there is little literature that discusses the stressors from the perspective of a loved one. This study examines the "common" post-combat stressors, psychosocial issues, and mental illnesses impacting combat veterans in the words and observations of those closest to them.

Twelve loved ones of veterans of the current wars in Iraq and Afghanistan participated in this study, providing narrative data based on their veterans' deployment experiences. Open-ended interviews were conducted to better gain access to loved ones' emotions, memories and thoughts, which often added illuminating insight to the study's findings.

Findings from the study reveal an equal split between those veterans who have experienced stressors and readjustment issues and those who have not; the impact of these concerns on veterans' families is also explored. Specifically, study participants mentioned issues related to mental illness (including PTSD, depression and anxiety) and their ongoing stigma, relationship problems, unemployment, financial concerns, problems with the military (including command leadership and inadequate training), and problems navigating the VA and its services. Those who did not experience readjustment issues

mentioned family, religion, friends and school as sources of strength. Suggestions for further research are discussed as a means to ease the adjustments for service members and their families – particularly National Guard and Reserve members – throughout the entire deployment process.

HAVING OUR SAY: STRESSORS AND READJUSTMENT ISSUES OF VETERANS
OF THE WARS IN IRAQ AND AFGHANISTAN FROM THE PERSPECTIVE OF
LOVED ONES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Karen Davis McGinty

Smith College School for Social Work
Northampton, Massachusetts 01063

2009

ACKNOWLEDGEMENTS

This thesis and all that it entailed could not have been accomplished without the assistance of many people.

To my thesis advisor, Dr. Nora Padykula, for your time, wise attention to content, detail and organization, and for making me a better academic writer. To the loved ones of the troops and veterans who shared their experiences with me – this project could not have existed without your bravery in revisiting the difficult days prior to, during and post-deployment. May peace be with you as you prepare for deployments to Afghanistan and/or continue your battles to heal on the home front.

To my mom, for housing and feeding me during the summers, and for always managing to lighten my load so I could focus on my studies – it means more than you'll ever know. To my father, the first social worker I ever met, whose concern about poor and otherwise-ignored people is surely a deep part of who I am. To my brother Jim, you're the best big brother a girl could ever have, and to Kathy (my social worker sister-in-law), thanks for your smart insight about school and the "real world" of social work.

To the McGinty family, for your continued encouragement, good humor and understanding. I should have more time to see you all now! To my darling cats Norma Rae and Lefty, one in my lap and one on my desk, these two watched over the whole thesis process and let me know when it was time to turn off the computer. And most of all, to my husband Kevin, without your never-ending support, patience and love, I don't know if I could have completed this entire journey in the first place.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES.....	iv
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	6
III METHODOLOGY.....	43
IV FINDINGS.....	50
V DISCUSSION.....	81
REFERENCES.....	94
APPENDICES	
Appendix A: Consent Form ..	101
Appendix B: Interview Guide ..	103
Appendix C: Resource Lists ..	106
Appendix D: HSR Approval Letter ..	112

LIST OF TABLES

Table

1. Demographic Characteristics of Loved Ones and Veterans 54

CHAPTER I

INTRODUCTION

When troops return home from the battlefield, they must readjust to life as civilians; re-integrating into the lives of their families, workplaces and communities. After the shock of combat, readjusting to life following deployment can be a daunting task. For many, surviving the challenges of war can be rewarding, maturing and growth-promoting (Litz & Orsillo, 2004). For others, coping with the effects of combat trauma may mean facing a host of post-deployment stressors, psychosocial issues, and mental health concerns.

Basham (2008) calls combat exposure “one of the greatest stressors a person can experience in life” (p.87). No matter what the specific effect of war is on its veterans, *all* combat veterans are affected by their experiences (Kudler, 2007). This belief is shared by military and Veterans Affairs (VA) psychiatrists, and affirmed by veterans and their families. The United States is obligated to assist its troops when they return from combat as they struggle with readjusting back to the civilian world. It is important to better understand how combat experiences manifested in the readjustment challenges of veterans and how those challenges impact veterans’ family members. To that end, this study asks the question: What are the stressors and readjustment issues faced by veterans of the wars in Iraq and Afghanistan from the perspective of loved ones?

A review of the literature on veterans’ experiences is vast; however there is little literature that discusses them from the perspective of a loved one. Much of the existing

research regarding combat veterans focuses on those coping with PTSD and other mental disorders (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004; Rivera, 2008, Prigerson, Maciejewski, & Rosenheck, 2002). The literature does not include the observations of family members, who are typically very familiar with their veterans' issues throughout the deployment process. Many articles focus specifically on the many psychosocial stressors veterans are battling post-deployment, including problems with the law, substance abuse, unemployment and other social concerns (Alvarez & Sontag, 2008; Friedman, 2005; Hoge et al, 2004; Jacobson, Ryan & Hooper, 2008; Winerip, 2008).

More recent articles highlight common post-deployment stressors that the military anticipates its service members may face as an expected byproduct of living through combat. The VA's Iraq War Clinician Guide (2008) identified these "common stress reactions" as:

- 1) Bad dreams, nightmares; 2) Flashbacks or frequent unwanted memories, 3) Anger; 4) Feeling nervous, helpless or fearful;
- 5) Feeling guilt, self-blame, shame; 6) Feeling sad, rejected or abandoned; 7) [Feeling] agitated, easily upset, irritated or annoyed;
- 8) Feeling hopeless about the future" (p. 17).

When veterans return home, in many ways they are changed individuals. In the current wars in Iraq and Afghanistan, (also know as Operation Iraqi Freedom, or OIF, and Operation Enduring Freedom, or OEF), troops have likely experienced continuous encounters with roadside improvised explosive devices (IEDs), suicide bombers, sniper fire, and an indistinguishable insurgency (Basham, 2008). The transition back to civilian

life is so jolting it is not surprising that the journey might involve readjustment issues for veterans and their families.

The purpose of this study is to examine the readjustment issues U.S. troops have faced following deployment to Iraq and Afghanistan from the perspective of loved ones. The study will look at the psychosocial and common stressors, mental illness and other issues impacting combat veterans in the words and observations of those closest to them. Throughout the study, the experiences of veterans and their families will be shown across the deployment process, including pre-deployment, deployment, post-deployment/homecoming and post-deployment/adjustment to home. The study will also look at veterans who have been deployed multiple times, as they and their loved ones may experience different readjustment concerns. This study also examines the unprecedented participation of National Guard and Reserve troops in deployments to Iraq and Afghanistan, and attempts to gain an understanding of the resiliency and vulnerability factors that may be comparable to or different from their Active-Duty counterparts.

This research study employs a qualitative design with open-ended interview questions to gather narrative data from 12 loved ones of veterans of the wars in Iraq and Afghanistan. The study considers the stressors and readjustment issues of veterans of the two wars from the perspectives of those loved ones. The semi-structured interview was selected to meet the researcher's interest in gaining information in the words of family members, who are not often represented in the literature regarding veterans' experiences throughout the deployment process. This first-person perspective illuminates the findings from this study and provides clarity and breadth to the literature.

In reviewing the narratives of the study's participants, several themes emerged which are discussed in relation to the literature reviewed. Literature from Rabb, Baumer & Wiesler (1993) stated that "service members are trained to be effective soldiers, but very little training is provided to service members or their families on the wartime stresses they face" (p. 441). Emotional withdrawal is mentioned in literature from McNulty (2005) and Hochlan (2004), who noted that communications problems often impacted veterans' mental health and increased their psychosocial stressors. However, this study advances the discussion by highlighting the profound effect of a veteran's withdrawal from a loved one and the damage it may cause to his/her relationships with a partner, children, in the work place and within the larger community.

The study also found that the stigma of PTSD and other mental disorders continues to be prevalent in the military today. This stigma can be a detrimental factor in veterans' acknowledging their mental illness and in seeking treatment for it, as noted in literature from Kudler & Straits-Tröster (2009), Warner, C.H., Appenzeller, Warner, C.M. & Grieger, (2009), and the VA National Center for PTSD (2008). Although the military has been making efforts to help remove the stigma of mental illness, this study's findings show that these efforts have not trickled down effectively to the veterans of OIF and OEF. As a result, many of the veterans in this study had neglected mental health treatment for their PTSD and were experiencing chronic suffering, worse outcomes and increased stressors impacting not only themselves, but their family members.

The study's findings also showed that some veterans had mixed feelings about leaving the adrenaline of battle and the camaraderie of their units to return home. Buck (2009) describes soldiers returning from combat with hair-trigger emotions and an

inability to cope with the everyday challenges of civilian life. Through firsthand accounts, study participants described the emotional re-integration of their soldiers back into the family fold, a process which could not be replicated in the literature.

This study will make a contribution to the field of social work because, unlike the large amount of literature on veterans' experiences, there is very little that discusses them from the perspective of loved ones. Also, much of the existing research on combat veterans examines those coping with PTSD or other mental illnesses. Given the complexity of the demands on returning soldiers, this study provide clinicians with a more complete picture of veterans of OIF and OEF in the eyes of those who know them best, their loved ones. By exploring combat veterans from a perspective that is rarely employed, it is hoped that clinicians will gain a deeper understanding of the mental health and psychosocial stressors of the military population. With this knowledge, civilian clinicians in particular, might better “meet their military clients and family members where they’re at” in treatment relationships, easing boundaries that might otherwise exist.

It is also hoped that this examination will enable social workers, students and society at large, to recognize the impact of the many stressors and strains troops, veterans and military families endure on behalf of their country. With the ongoing wars in Iraq and Afghanistan, the number of veterans coping with mental, physical and psychosocial issues will continue for years to come. The greatest honor America could give its troops is the full assistance each family member requires – whether National Guard, Reserve or Active Duty – to ensure smoother deployment transitions and alleviate mental, physical and psychosocial stressors.

CHAPTER II

LITERATURE REVIEW

This literature review explores the readjustment issues and stressors experienced by veterans of the wars in Iraq and Afghanistan from a loved one's perspective. It begins with an overview of the military's size and the changes it has implemented as a result of the ongoing conflicts in Iraq and Afghanistan; Operations Iraqi Freedom and Enduring Freedom (OIF/OEF). Next, there is a look at the various stages of the deployment process for the veteran and his/her loved ones, including Pre-Deployment, Deployment, Post-Deployment/Homecoming, Post-Deployment/Adjustment to Home, and the Impact of Multiple Deployments. For each section, the experiences, processes, stressors and readjustment factors are examined for soldiers and their loved ones.

The soldier and his/her family members experience a multitude of emotions prior to deployment, including fear, sadness and anxiety; as well as practical issues that must be determined, such as how families will communicate with their soldier and how household responsibilities will be handled in their absence. During deployment soldiers are fighting two wars with no clearly defined front lines, meaning that all soldiers, whether in combat or support roles, are exposed to the stressors of combat trauma (Hoge, Clark & Castro, 2007). Their loved ones live with constant worry and fear, never knowing if their soldiers are safe and alive. Many soldiers return home post-deployment and experience a brief "honeymoon" period, followed by a readjustment marked by flashbacks, sleeplessness, irritability, and sadness (U.S. Department of Veterans Affairs,

Guide for Military Personnel, 2008). This study attempts to provide additional research on soldiers at all stages of the deployment process from the perspective of their loved ones.

A Brief History of the Military

The Sheer Numbers

According to the Iraq War Clinician Guide (U.S. Department of Veterans Affairs (VA) National Center for PTSD, 2008), the size of the combined US Armed Forces reached an all time high of 8.3 million during World War II. Through the Vietnam War, military members were conscripted through the Selective Service Act of 1948 in order to achieve necessary force strength. In 1973 at the end of the Vietnam War, the all-male draft was ended and since that time the military has been comprised of an all-volunteer force. During Operation Desert Storm in 1991, the US Army totaled approximately 750,000 service members.

Since 2001, an estimated 1.6 million U.S. troops have deployed at least once to Iraq or Afghanistan (Kudler & Straits-Tröster, 2009), followed by a steady increase or surge in troop deployment in recent months (Basham, 2008). Some statistics obtained from a VA pamphlet (2008, p. 6), further describe veterans of the wars in Iraq and Afghanistan as follows:

- 48% Active Duty, 52% Reserve/National Guard
- 88% men, 12% women
- 65% Army; 12% Air Force; 12% Navy; 12% Marine
- 34% have been deployed multiple times
- 52%, the largest age group, is 20-29 years old

With more than a million troops having served in OEF and OIF, a great many relatives, friends, and coworkers have been left behind. The organization SOFAR (Strategic Outreach for all Families of Reservists) works with some of those loved ones by connecting military families with clinicians who provide free mental health services (Kubetin, 2008). SOFAR estimates that with each soldier leaving behind a support system of friends and family, “there may be between 73 million and 95 million people who are affected by the wars in Iraq and Afghanistan” (Kubetin, 2008, p. 3).

The military fighting in Iraq and Afghanistan “has a greater percentage of ‘moms and dads’ than it has had in any other conflict” (Glod, 2008, para 4). This is in part because of the greater reliance on the National Guard and Reserves, and in part because of the growing number of women in uniform. Of approximately 263, 000 people deployed overseas at present, mostly in Iraq and Afghanistan, about 43 percent are parents (Glod, 2008, para 4).

Among the most significant changes the U.S. military has experienced during OIF/OEF is the deployment to combat of an unprecedented number of National Guard and Reserve component troops. These part-time soldiers have typically not made the military their careers, and have full-time jobs, families and ties to communities outside army bases. It is important to look briefly at this contingent of America’s fighting force, as National Guard and Reserve members currently represent more than 50 percent of those fighting in the wars in Iraq and Afghanistan (U.S. Department of Veterans Affairs, National Center for PTSD, Iraq War Clinician Guide, 2008, p. 6).

National Guard and Reserve Troops

Congress officially designated the National Guard in 1916, establishing procedures for training and equipping these units to active duty military standards. In so doing, Congress made these state defense National Guard units available in times of national crisis or war. In times other than Congressional or Presidential call-up, the National Guard falls under the Governor of the State to which it is assigned. (U.S. Department of Veterans Affairs, National Center for PTSD, Iraq War Clinician Guide, 2008, p. 5)

As a result of the downsizing of the active duty military force in the 1990s, Guard and Reserve troops now play a central role in combat, which results in more frequent and lengthier deployments (Faber, Willerton, Clymer, MacDermid & Weiss, 2008). For the first time, an all-volunteer force is being deployed to the region, including over 378,000 Reserve and National Guard members (Batten & Pollack, 2008, p. 929).

There has never been a time in history when the military has had to rely so heavily on National Guard and Reserve troops. The unprecedented number of Reserve and National Guard troops deployed to Iraq and Afghanistan – who were formerly considered “weekend warriors” – now find themselves in combat alongside their full-time active duty brethren. According to a 2006 report by the Army’s Mental Health Advisory Team, many reservists and National Guard members may possess protective factors like being older and having a more stable income when leaving for battle, both shown to help in coping with combat. Alternately, the Reserve troops may lack crucial protective factors such as intensive Battlemind training, close unit camaraderie and strong combat leadership from non-active duty commanders (Mental Health Advisory Team,

2006). As a result, they may face heightened risk for mental health outcomes post-deployment regardless of how resilient they were prior to deployment (Basham, 2008).

No matter what branch of the military or whether active duty, Guard or Reserve, all troop members and their loved ones must learn to prepare for a deployment. Many troops will be deployed multiple times. In each case, the soldier and his loved ones must be ready both mentally and logistically to deal with the various tasks that accompany a call to service. That process begins with pre-deployment, typically starting from the time a soldier is informed of a deployment date.

Pre-Deployment

The Soldier's Experience

Preparing for deployment is the beginning of a highly stressful period for the soldier shipping out. The soldier must train for long hours and is usually away from his/her family multiple times during this training period (Warner, C.H., Appenzeller, Warner, C.M. & Grieger, 2009). Troops must resolve financial, health and household related issues; those who are parents must also transition responsibility for child care and discipline. All soldiers preparing for deployment must do these things with the anticipation of being away from loved ones for more than one year, in a distant and dangerous place. The intense stress of preparing for a deployment is increased when the mobilization is sudden, rapid and dangerous (Rabb, Baumer, Wieseler, 1993).

With all of the logistical planning soldiers and their families must accomplish pre-deployment, there is also a great deal of uncertainty and ambiguity for soldiers. No matter how much training a soldier has received, he/she has no clear idea of what lies

ahead in a combat zone. In a Mental Health Advisory Team report (2006) from the Army, it was noted that National Guard and Reserve troops “had lower perceptions of combat readiness and training than Soldiers in other units” (p. 3). Once a service member and his/her family are informed of an impending deployment, they may experience a short period of intense emotions, such as fear and anger (Whealin & Pivar, 2004). As the deployment date nears, the soldier may “engage in detachment and withdrawal, often unconsciously, as a way to cope with the ensuing separation” (McNulty, 2005, p. 530).

Screening for mental health problems is now routine both before and after deployment and is encouraged in primary care settings (Wright, Huffman, Adler & Castro, 2002; Veterans Health Administration, 2000). It has been suggested that by broadening the use of psychoeducational intervention prior to deployment and assuming a systematic perspective, predeployment counseling could involve partners (Fals-Stewart & Kelley, 2005). This venue would enable the soldiers and their spouses to recognize potential issues that may result from deployment, and would provide an opportunity to describe resources available following deployment.

Some troops are leaving for combat with risk factors for mental health problems. Research conducted in 2004 found that as many as 9 percent of soldiers were found to be at risk for mental disorders before combat deployment (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004). The participants identified depression, PTSD and anxiety as their primary mental health problems, and many indicated concerns with use of alcohol (Hoge, Castro et al, 2004). A 2005 study of active duty Navy personnel over the course

of a deployment to Iraq found that participants reported a 2.4 percent rate of suicidal ideation during pre-deployment (McNulty, 2005).

For soldiers preparing for deployment, there may be however, a big difference in some of the mental preparation they receive prior to shipping out, based on whether they are active duty or Guard or Reserve troops. For the time being, active duty soldiers have made the military their full-time careers, and thus have been preparing for possible deployment since they enlisted. Typically, they have spent months training with their units in combat exercises and have been heavily steeped in the service's "Battlemind" training. The goal of this training is to develop a realistic preview, in the form of several briefings, of the stresses and strains of deployment on soldiers. This training is based on the definition of "Battlemind" as "the Soldier's inner strength to face fear and adversity in combat with courage" (Walter Reed Army Institute of Research 2009, para 1). The training has not been universally available to all troops, particularly Guard and Reserve members who have trained once a month and two weeks a year. As mentioned earlier in this literature review, Guard and Reserve members currently make up more than 50% of those troops who have been deployed to Iraq and Afghanistan (VA, 2008). It is imperative that all of these soldiers receive "Battlemind" training so that they might have some assurance of the same mental preparation as active duty troops.

Although some National Guard and Reserve members may have protective factors including more stable income and older age, they may lack intensive "Battlemind" training and cohesiveness with their unit (Mental Health Advisory Team, 2006). This may put them at increased risk for the development of mental health problems regardless of their resilience prior to deployment (Basham, 2008). On top of all of the mental and

physical preparation for a deployment, soldiers must also assist in preparing loved ones for their absence. Family adjustment to preparation for deployment has been said to directly influence active-duty troops' combat readiness, retention and overall effectiveness (Steiner & Neuman, 1978; Nice, 1981; Wickham, 1983).

The Family's Experience

When a family member goes to war, both the soldier and those left behind must prepare for what is typically a daunting experience. There is often tremendous uncertainty about the dangers that are ahead for their soldier, where the soldier will be located on the deployment and speculation about when he/she will return (Whealin & Pivar, 2004). In addition to these concerns, loved ones preparing for deployment will want to know how often they can communicate with their deployed soldier, knowing that they will be worrying constantly about his/her safety. Preparing for this uncertainty would seem to be a difficult task for loved ones, particularly when they are providing necessary support to their soldier before a deployment.

The "Emotional Cycle of Deployment," from the National Center for PTSD, states that when a loved one is called for deployment, "fluctuating emotions such as pride, anger, fear and bitterness can add to the distress of uncertainty" (Whealin & Pivar, 2004, para 2). As described by Jennifer Hochlan in "The 7 Stages of the Emotional Cycle of Deployment"(2004): Pre-deployment can make soldiers' spouses moody, stressed, depressed and anxious, all emotions that may cause friction with their partners who are preparing for deployment in their own ways. Hochlan refers to a period of "Detachment and Withdrawal" that may arrive the final week before deployment. This is when Hochlan says that often all the emotions spouses have had for the past weeks rise

to their peak; that's when "you can think of a million and one final things to do before the deployment, but can find neither the time nor energy to complete even the smallest tasks" (para 3). Hochlan also notes that many times the stress and arguments preceding a deployment takes a "toll on your level of intimacy...you distance yourself from your spouse without consciously knowing it" (para 4).

Hochlan advises spouses and other loved ones to seek services on base if their emotions become overwhelming before deployment; she specifically mentions reaching out to a unit chaplain for guidance and support. Although Hochlan's advise is valid, it is best aimed at active duty service members who live on or near a base; for the families of the one-half of National Guard and Reserve troops fighting in OEF and OIF who live nowhere near bases, finding help isn't as easy. Greater availability of pre-deployment counseling might help these families better prepare emotionally.

The adult loved ones of a deployed soldier must not only prepare themselves mentally but simultaneously help orient their children toward the deployment date. It has been suggested that a good way to help ease children's minds is to assure them that their deploying family member has been trained to the best of his/her ability, and has the skills to handle their mission (Uniformed Services University of the Health Sciences, 2008). Researchers at the Uniformed Services University of the Health Sciences (USUHS) also advise loved ones awaiting their soldier's deployment to be careful about what they communicate with children; only providing certain details about the deployment and its timing based on each child's age.

The soldier and his loved ones preparing for deployment are faced with a myriad of challenges as they ready themselves for an uncertain and often anxiety-provoking time

apart. There are a range of emotions that confront everyone involved and that typically begin when the soldier learns of his/her deployment. Much of this preparation differs for each family member, and for some soldiers, they may not have been fully trained in the military's Battlemind program. Some soldiers may also be experiencing mental health issues prior to deploying. This mental preparation comes on top of the logistical planning that is necessary during pre-deployment, such as how often and by what means will the deployed soldier and his loved ones communicate, and who will take responsibility for household tasks that the service member handled. With the absence of a service member, responsibilities and dynamics in a family are changed, and loved ones must take time to account for these changes.

Deployment

The Soldier's Experience

According to a report on Army Reservists and their families regarding various stages of deployment during Operation Desert Storm, "service members are trained to be effective soldiers, but very little training is provided to service members or their families on the wartime stresses they face" (Rabb, Baumer & Wiesler, 1993, p. 441). Soldiers deployed to OEF and OIF first train at a base in the United States, followed by departure for the war zone, often with a stop in Kuwait. Deployments to OEF and OIF are unlike any in which the U.S. military has ever been involved in terms of the weapons used, the enemy's tactics and the location of battle. With all this in mind, prior to leaving for combat, troops are often able to visit their loved ones just once before leaving for Iraq or Afghanistan (VA National Center for PTSD, 2008).

First, there is no defined “front line” for the conflicts, meaning that those who are in non-combat or combat support roles are routinely being exposed to combat and its stressors (Hoge, Clark & Castro, 2007). The all-volunteer force deployed to Iraq and Afghanistan and the type of warfare conducted in these regions (including suicide bombers, rocket propelled grenades and improvised explosive devices) is also very different from that of past wars (Hoge, Castro et al, 2004). During deployment troops are “routinely shot at, see the deaths or injuries of others (including friends and civilians) and adapt to living in constant danger” (VA National Center for PTSD, 2008, p. 3). A sober statistic puts the ratio of wounded in action (WIA) to killed in action (KIA) in OIF operations at approximately 7:1; in World War II, the ratio was about 3:1 (Ginzburg & Holm, 2009). However, the authors also state that the intensity of combat, its random attacks and multiple deployments lead researchers to predict that the psychiatric toll of OIF and OEF will exceed that of physical injuries. The military expects that combat troops will be impacted in a significant way by their service in a war zone, as exemplified by the following statement from the VA’s National Center for PTSD Iraq War Clinician Guide (2004):

The destructive force of war creates an atmosphere of chaos and compels service members to face the terror of unexpected injury, loss, and death. The combat environment (austere living conditions, heavy physical demands, sleep deprivation, periods of intense violence followed by unpredictable periods of relative inactivity, separation from loved ones, etc.) is itself a psychological stressor that may precipitate a wide range of emotional distress and/or psychiatric disorders (p. 11).

Basham (2008) further describes combat trauma as a unique brand of horror that involves exposure to terrifying violent events along with a mixture of fear, anxiety, and

despair, as well as pride, excitement, loyalty, and patriotism. The demands, stressors, and conflicts of participation in war can also be traumatizing to one's spiritual belief system and sense of morality. In essence, it is transformative in potentially dangerous ways, the impact of which can be manifest across the lifespan (Litz & Orsillo, 2004).

Active-duty Navy service members deployed to OEF and OIF in 2002-2003 were the focus of a 2005 study to evaluate well being, adaptation, coping, anxiety, stress and health care needs during three phases of deployment (McNulty, 2005). The study concluded that during deployment "the immediate stress of the family becomes the immediate stress of the active duty member" (McNulty, 2005, p. 534). This is due in great part because – unlike past wars – soldiers and their loved ones now often have the immediate ability to reach each other via email or phone through much of the deployment. Some loved ones may hold back troubling information happening at home, but others may not, transferring those worries onto their soldier.

Studies from a team at the Walter Reed Army Institute of Research said that financial problems during deployment are a big cause of emotional pain for National Guard soldiers; money issues raised the odds six-fold that a National Guard soldier would have mental-health problems after leaving the war zone (Elias, 2009). The team concludes that these results may be caused by a variety of factors: many National Guard members are older and more likely to be married, and therefore may experience more family problems related to deployment. There may also be more National Guard members with mental health disorders prior to going to war.

Additionally, it has been shown that the emotional worries of family members – including anger, depression and hopelessness – often impact their soldiers negatively.

(McNulty, 2005). It is hypothesized that if these emotions impact a loved one's soldier in combat, it can jeopardize his/her safety along with that of the soldier's unit. In a study that looked at active duty Navy personnel during three phases of deployment to OIF, participants reported a nearly 5 percent rate of suicidal ideation during mid-deployment (McNulty, 2005).

The Family's Experience

After a family member deploys, The National Center for PTSD advises loved ones: A period of sadness, loneliness, and tension begins at the time of departure that can last several weeks or longer. Following the first weeks of deployment, families begin to adjust to a new routine without the deployed service member (Whealin & Pivar, 2004). The families of National Guard and Reserve troops are often at a disadvantage during deployment though, as they don't get to share in the camaraderie and social support available to active duty families living on a base. Active duty families also have access to day care, a chaplain, mental health services, family service centers and the Red Cross (Rabb, Baumer & Wieseler, 1993). This is a problematic disparity when so many of the service members deployed in OEF and OIF are not active duty soldiers.

A study by Wexler and McGrath (1991) indicated that loved ones experience the most stress (referred to as "the peak stress") between one and three weeks after their service member has been deployed, and this stress decreases after the third week. The study's participants were a group of primarily military wives, 68% of whom had been away from their husbands for one to three weeks at the time of the study. At that point in the study, many of the participants were experiencing a range of emotional and physical reactions to separation. The majority had feelings of loneliness and anxiety, but of

importance is that a majority also had strong feelings of pride and patriotism (Wexler & McGrath, 1991, p. 516).

“Military induced separations create stress due to commotion accompanying departure, increased caretaking and household responsibilities, disconnected relationships, loss of emotional support, and readjustment of roles upon reunion”(Kelley, 1994, p. 103). Although the departing soldier and his/her family may be aware of these factors, they may be at a loss about adequately preparing for them. There is some evidence suggesting that “indicators of a solid dyadic relationship (e.g., a long marriage), strong social support, and a lack of circumstantial stressors (e.g., financial or legal problems) may serve as protective factors against marital problems and secondary trauma once a soldier returns home” (Fals-Stewart & Kelley, 2005, p. 234).

In the current economic climate, the loss of a primary bread winner to deployment will surely impact U.S. military families negatively. Guard and Reserve members are leaving full-time jobs behind to receive military pay for a year or more. Many worry about whether their old jobs will still be around at the end of their deployment. To make matters worse, Army National Guard members called to active duty experienced problems in the processing of their paychecks, according to a General Accounting Office report (Ballard, 2003).

Research has shown that during separation, adult spouses of those deployed most often present to doctors with a laundry list of symptoms including: depression, sleep disturbances, boredom, helplessness, fatigue, headaches, low self esteem, poor concentration, hopelessness, anxiety and suicidal ideation (McNulty, 2005; Jensen, Martin & Watanabe, 1996; Amen, Jellen, Merves & Lee, 1988; McCubbin & Dahl,

1976). These same researchers have found that military spouses complain of increased anger, intolerance for their children, fears for their deployed spouse and fears of his/her infidelity.

Loved ones of military members indeed have a set of concerns unlike other Americans. Among the major issues for active duty military families are: adjustment to a mobile lifestyle, isolation from the civilian community and extended family, adjustment to the rules and regulations of military life, and frequent family separations (Ursano, Holloway, Jones & Rodriguez, 1989; Paulus, Nagar, Larey & Camacho, 1996; Rosen & Moghadam, 1988; Martin & Ickovics, 1987; Durand, 2006). In addition, worries such as jobs, childrearing and household duties compound these stressors (Martin, 1984; Rosen, Moghadam & Vaitkus, 1989; Martin & Ickovics, 1987). All of these stressors may have an adverse effect on the physical and mental health of loved ones leading up to and during deployment (Eaton, Hoge, Messer, Whitt, Cabrera, McGurk et al, 2008).

For active duty members who deploy with the units with whom they train and who leave families behind within established military communities (bases, posts), the impact of deployment may be less than for Guard and Reserve members. For those service members in the latter groups, deployment may result in loss of civilian employment, financial penalty, or separation from family who may be left far from any military base or resources (VA National Center for PTSD, 2004, p. 7).

One military couple preparing for the husband's second deployment said in a New York Times article (Winerip, 2008) they will "start lying to each other again, just as they lied their way through his first Iraq tour" (p.1). For this couple, it is easier to lie about how things are going on the homefront and how much danger is within the soldier's reach than upset or worry the other. Another couple differs on how they look at the war in Iraq,

with the wife in opposition to it and her husband saying “I have a job to do, I signed up knowing this could happen, so I’ll deal with it.” (Winerip, 2008, p.3).

For children, “having a parent sent to an active combat zone with an undetermined return date may rank as one of the most stressful events of childhood” (Lincoln, Swift & Shorteno-Fraser, 2008,p. 984). Maj. Keith Lemmon, an Army pediatrician, saw young patients at Fort Bragg, N.C., with headaches, stomachaches and other symptoms he attributed to stress (Glod, 2008, p. A01). The American Academy of Pediatrics has even called on civilian pediatricians to be aware of emotional needs of children from military families (Glod, 2008, p. A01).

Research has shown that spouses and children often exhibit greater symptoms of depression and anxiety, as well as increased use of medical and mental health clinics during and shortly after separation (Ursano et al, 1989; McNulty, 2003; Knapp & Newman, 1993; Kelley, 1994). Additionally, literature on trauma separations and certain aspects of PTSD suggest that separation for these military families and deployment into a potential combat zone may produce symptoms of stress similar to PTSD (Fairbank, Keane & Molloy, 1983; Fairbank, McCaffrey & Keane, 1985).

The American Academy of Child and Adolescent Psychiatry (2004) provides the following suggestions to ease the stress of the deployment:

- Talk as a family before the reassignment, sharing information, feelings, worries and plans for the future. Let your child know that the family member is making a valuable contribution to their country and the world.
- Emphasize the need for the family to pull together during the parent’s absence with everyone sharing in family responsibilities.
- Continue family traditions, structure and discipline. This is reassuring and stabilizing to children.
- Utilize available means (e.g. letters, email, phone) for the family members to communicate with the deployed parent.

- Share information with children based upon their developmental level and ability to understand. No news is usually more stressful and difficult to deal with than bad news.
- Monitor children's exposure to TV coverage of war events and political discussions of the war.
- Encourage the open and honest expression of worries, feelings, and questions.
- Consider having children participate in a project associated with their parent's deployment (e.g. classroom letter writing project, keeping a journal or scrapbook).
- Don't make promises that you can't keep.
- Initiate and maintain a close relationship and communication with your child's teachers and school.
- Utilize extended family, community and spiritual resources and other natural supports that are available both within and outside the military.
- As a single parent at home, make sure that you also take care of yourself so that you can be available to your children. (p.204)

As mentioned above, many active duty troops live on or near an established military base and they and their families have support within the military community. Without these support systems, it is often more difficult for military families to prepare for deployment. "National Guard and Reserve families are largely invisible, scattered throughout the country, surrounded by civilians who are often oblivious to the war, and certainly don't fret daily about the next phone call from Iraq" (Winerip, 2008, p. 2).

It is clear that the deployment process for the soldier and his/her loved ones can be a time of great stress for everyone involved. Family members worry for the safety of their soldier and juggle new roles, responsibilities and sometimes financial difficulties in the absence of their service member. Parents must take care of children alone and be careful to guard against their own feelings of sadness and loneliness. This is increased for National Guard and Reserve forces who lack the supportive resources and sense of community that is available to the families of active duty troops.

Post-Deployment: Homecoming

The Soldier's Experience

Troops returning from combat are first sent for one to two weeks to their home station or demobilization station, during which time they cannot yet see their loved ones. There they have debriefings that include sessions with military doctors and therapists, tips on coping with the civilian world post-deployment and practical matters like getting in last goodbyes to unit buddies and returning combat gear. The Department of Veterans Affairs reminds returning troops that they may experience adverse effects from their combat trauma, including flashbacks, agitation, sadness and anger (U.S. Department of Veterans Affairs, Iraq War Clinician's Guide, 2008).

The Army is developing additional material in its Battlemind training that includes realistic information on what soldiers should expect and how to cope with life once they are home. Two training modules are currently being developed to address how soldiers can bridge their combat skills to cope with stress at home. One of the modules will be given as soon as Soldiers return from the combat zone, and the other module will be given 3 months after Soldiers return home (Walter Reed Army Institute of Research, 2009, para 3).

Troops returning from a deployment are normally relieved to be home, but some find that the adjustment to life and family is more difficult than they had imagined. Returning troops from the wars in Iraq and Afghanistan face many challenges, including mental health concerns and psychosocial stressors. It is for this reason that the VA recommends that clinicians begin their assessments of OEF/OIF veterans not with an overview of combat trauma exposure but of current psychosocial functioning.

Work-related difficulties can have a significant impact on self-efficacy, self-worth and financial stability and are likely to be a major focus among veterans of the Iraq War. In terms of returning to their families, it's not uncommon to first experience a "honeymoon" phase of reconnection marked by euphoria, excitement and relief. However, this can be followed by a period of discomfort, role confusion and renegotiation of relationship(s) and roles can follow this initial phase. (U.S. Department of Veterans Affairs, National Center for PTSD, Iraq War Clinician Guide, 2008, p. 27).

Troops returning to work post-deployment may find the jobs they had before deployment boring compared to the thrill of combat (U.S. Department of Veterans Affairs, VA National Center for PTSD, Iraq War Clinician Guide, 2008, p. 4). Those who are coping with stress reactions or PTSD "may feel irritable, have sleeping problems and have difficulty getting along with co-workers; this may ultimately make it harder to go to work everyday or make common tasks seem impossible" (U.S. Department of Veterans Affairs, National Center for PTSD, Iraq War Clinician Guide, 2008, p. 4).

The National Center for PTSD also advises troops returning from deployment that they may feel mistrusting of others, and have a difficult time confiding in family members; they may be over-controlling or overprotective, after being in such a rigid environment; and they may be short-tempered due to poor communication and/or unreasonable expectations (U.S. Department of Veterans Affairs, National Center for PTSD, Iraq War Clinician Guide, 2008). Many of the things that help keep soldiers alive in a war zone are the most difficult to set aside at home, such as the avoidance of emotions, the rigidity of thought and action, and having the constant companionship of a combat unit.

The VA's Iraq War Clinician Guide (2008) has identified some Common Stress Reactions, including physical, mental/emotional, and behavioral reactions that troops might experience once they return home. The mental and emotional reactions include:

- 1) Bad dreams, nightmares; 2) Flashbacks or frequent unwanted memories, 3) Anger; 4) Feeling nervous, helpless or fearful; 5) Feeling guilt, self-blame, shame; 6) Feeling sad, rejected or abandoned;
- 7) Agitated, easily upset, irritated or annoyed; 8) Feeling hopeless about the future (p. 17).

It has been noted that between 20 and 30% of U.S. military personnel returning from combat report significant psychological symptoms (Hoge, Castro et al, 2004). Some of the deployment stressors and exposure to combat result in considerable risks of mental health problems, including PTSD, major depression, substance abuse, impairment in social functioning and in the ability to work, and the increased use of health care services (Helzer, Robbins & McEvoy, 1987; Jordan, Schlenger, Hough, Kulka, Weiss, Fairbank et al, 1991; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Prigerson, Maciejewski & Rosenheck, 2002).

A cohort of 88,235 U.S. soldiers returning from Iraq was studied, including both active duty and reserve component troops. Of the cohort, 20.4% of active duty and 42.4% of reserve forces required mental health treatment post-deployment (Miliken, Auchterlonie & Hoge, 2007). This sharp difference in mental health results demonstrates just one area where former "weekend warriors" are suffering in greater proportion than active duty troops.

In a 2007 study (Browne, Hull, Horn, Jones, Murphy, Fear et al, 2007.) that examined Reserve troops from the United Kingdom sent to Iraq , it was found that deployed reservists have worse health outcomes and more mental health disorders than both regular military personnel who are deployed and non-deployed reservists. Furthermore, the researchers found that study participants were 50% more likely than regular military personnel to be categorized as having PTSD, and reported more problems at home during and after deployment. Hoge, Castro et al (2004) state that most combat veterans do not suffer from a diagnosable mental disorder, although many veterans may experience significant functional problems that include: suicidal thoughts and acts, job loss, family stress/dissolution, homelessness, violence toward self and others, and problems with the criminal justice system.

PTSD and other Mental Health Concerns

Before a diagnosis for PTSD came into being in 1980, war-related psychiatric syndromes were known under a variety of names, including shell shock, traumatic war neurosis, and combat exhaustion (Friedman, Schnurr & McDonough-Coyle, 1994). In their 1947 book *War Stress and Neurotic Illness*, Kardiner and Spiegel described a chronic trauma war neurosis that involved preoccupation with the traumatic stressor, nightmares, irritability, increased startle responsiveness, a tendency to have angry outbursts, and general impairment of functioning. No matter what terminology was used, it was clear these names referred to what we now recognize as PTSD.

According to a RAND Corporation report, some 300,000 returning combat troops are currently estimated to be suffering from major depression or PTSD (Rivera, 2008).

SOFAR reports that “of the 50 percent of Army National Guard and Reserve soldiers who will return from service with a diagnosable mental health disorder, in some cases symptoms may not manifest themselves for 6-24 months” (Kubetin, 2008, p. 3). Veterans with diagnoses of PTSD, anxiety and depression must not only cope with the symptoms of their disorders but simultaneously readjust to life among their families, friends and other connections.

Mental health specialists at the Veterans Affairs Medical Center in White River Junction, Vermont use a testing method to determine PTSD that is a standard across the VA healthcare system. Veterans are referred by a provider at the VA or visit the Primary Mental Health Clinic and are screened for PTSD in a brief test that asks questions regarding levels of depression, anger, anxiety and suicide. If deemed to be within the possible or likely range for a PTSD diagnosis, the veteran is then called back for a two-hour written assessment. This assessment consists of the following tests: Traumatic Life Events Questionnaire, Distressing Event Questionnaire, Beck Depression Inventory II, Beck Anxiety Inventory, and the Alcohol Use Disorders Identification Test - Condensed Version (White River Junction VA, 2008).

On the Traumatic Life Events Questionnaire, veterans are measured on whether they've been exposed to trauma, how many traumatic events they have experienced, and if they perceived a threat to their life or someone close to them. This test also enables veterans to indicate whether they endorse experiencing intense fear, helplessness, or horror now or at another time. The Distressing Event Questionnaire measures PTSD symptomatology as reported by the veteran. The Beck Anxiety Inventory and Beck Depression Inventory II measures veterans for symptoms of those two disorders on a

Likert-type scale of responses from 'none' to 'severe.' Lastly, the Alcohol Use Disorders Test (or AUDIT-C) asks veterans to identify how many drinks they had on any occasion in the past month and year (White River Junction VA, 2008).

If veterans are determined to have PTSD or other mental health disorders, they may choose a variety of treatment options, ranging from individual psychotherapy, couples or family therapy visiting the Primary Mental Health Clinic as needed, or being referred to a Vet Center or Community Based Outpatient Clinic (CBOC). Vet Centers and CBOCs are affiliated with Veterans Affairs and are scattered across every state in America. Most have mental health specialists and prescribers, nurses and other medical personnel, depending on the size and location of the facility (U.S. Department of Veterans Affairs, Vet Center Home Page, 2008). Some veterans may be referred for more comprehensive assessment for PTSD, military sexual trauma, traumatic brain injury or other concerns (U.S. Department of Veterans Affairs, VA PTSD Services, 2008). There are also support groups at most VA facilities; at the VA Hospital in White River Junction, Vermont, there are several groups focused on PTSD including: PTSD Skills, Seeking Safety, Yoga for PTSD and a PTSD Partner Support Group.

Forty percent of soldiers who had served in Iraq and had mental health problems, including PTSD, said they were interested in getting help (U.S. Department of Veterans Affairs, National Center for PTSD, 2008). This same study asserts that soldiers hesitate to receive mental health treatment fearing that it will damage their reputations or ruin their military careers (U.S. Department of Veterans Affairs, VA National Center for PTSD, 2008). The military has recognized the big problem that stigma creates when attempting to reach out to soldiers who may be in trouble or at risk.

The Department of Veterans Affairs is attempting to reach more troops following deployment by hiring mental health specialists who are also veterans of the wars in Iraq and Afghanistan (Buck, 2009). The thinking is that veterans will feel more comfortable talking about their problems with someone who's been deployed themselves. These mental health specialists also address police departments, college administrators and social service agencies:

...on the hazards of post-traumatic stress disorder; and what can happen when society fails to recognize the symptoms of soldiers returning from combat with hair-trigger emotions and an inability to cope with the everyday challenges of civilian life “(Buck, 2009, para 5).

Psychosocial Stressors

Social support has long been known to be a central protective factor in mediating the long-term adverse effects of combat trauma (Basham, 2007). Strong social support from family and friends has been shown to lower the risk of PTSD (Kudler & Straits-Tröster, 2009). Soldiers who have trained for war have been required to adapt to a warrior mindset, a mindset that is not adaptive on the home front. The switch to a “civilian mindset” where danger doesn't lurk around every corner and cars aren't exploding unexpectedly takes time, and as a result, many service members feel disconnected or detached from their partner and/or family when they return from combat (VA National Center for PTSD, 2008). A recent New York Times article quoted a retired marine as saying, “Can you imagine being in an environment for eight months, not knowing whether you're going to come home or not, and then having to flip a magic switch?”(Richards, 2008, p A1). In the same article, the author reports that many troops find coming home from combat even harder than going to war.

Advocates for veterans have reported an increase in the number of veterans of OEF and OIF who are facing charges for crimes such as domestic violence, firearms violations, breach of peace and drunken driving (Somma, 2009, p. A7). Many of these crimes have been a result of the psychological issues veterans are facing post-deployment and might better be mediated outside the court system (Somma, 2009, pA7). As a result, some states are setting up veterans' courts or enacting laws to deal with veteran offenders.

It is not surprising then that research about returning veterans of the Persian Gulf War often listed family adjustment problems as their primary concern (Rosenheck et al., 1992). Studies of war-zone deployments are associated with less family cohesion and nurturance, more spousal emotional distress and depression, and more child behavior problems (Jensen, Martin, & Watanabe, 1996; Kelley, 1994; Medway, Davis, Cafferty, Chappell & O'Hearn, 1995; Pierce, Vinokur, & Buck, 1998). Many soldiers have reported that it is stressful to renegotiate roles, responsibilities and boundaries with their spouse (Faber et al, 2008).

Civilian soldiers must also return to full-time employment outside the military when they finish a deployment, a transition that is not always smooth.

Employers vary significantly in the amount of emotional and financial support they offer their reservist employees. Some veterans will inevitably have to confront the advancement of their co-workers while their own civilian career has stalled during their military service. While some supportive employers supplement reservists' reduced military salaries for longer than required, the majority does not, leaving many returning soldiers in dire financial situations (U.S. Department of Veterans Affairs, VA National Center for PTSD, Iraq War Clinician Guide, 2008, pp. 27-28).

Readjusting to life following a deployment can be difficult both emotionally and physically, as the service member adapts to new roles and relationships at home and in the workplace. The immediate return may be wonderful, followed by a time of transition when a host of conflicting emotions could result in a mental health diagnosis. This is one of the reasons that the first few months home for a soldier can often be a far more trying time than the soldier and his loved ones have imagined.

The Family's Experience

The deployment of the family members creates a painful void within the family system...The family assumes that their experiences at home and the soldier's activities on the battlefield will be easily assimilated by each other at the time of reunion and that the pre-war roles will be resumed. The fact that new roles and responsibilities may not be given up quickly upon homecoming is not anticipated (Yerkes & Holloway, 1996, p. 31).

Deployment to war, with its long separations, can put serious stress on military families. "Trauma, specifically combat or other military-related traumatic experiences, may be particularly detrimental to marriage," (Goff, Crow, Reisberg & Hamilton, 2007, p. 344). A study of soldiers returning from Iraq and Afghanistan showed that "increasing levels of trauma symptoms among the troops predicted lower marital and relationship satisfaction for both soldiers and their partners" (Warner, C.H., Appenzeller, Warner, C.M. & Grieger, 2009, p. 57). Much of this is related to the high number of troops whose trauma turns into PTSD, putting additional strain on the spouse and loved ones in adapting to the veteran's symptoms.

In 2004, divorce rates spiked among the officer corps of the Army resulting in the implementation of a "Strong Bonds" program to address the issue of marital stress

following long tours of duty (Kaufman, 2008, p. 2). It has been noted that families that have had counseling in the past have managed better physically and emotionally both during and post-deployment (McNulty, 2002).

It is believed that normal combat stressors like irritability, anger and insomnia contribute to soldiers' striking out at their loved ones. In extreme cases domestic violence among the military has exploded onto the front pages of daily newspapers. At Fort Bragg in North Carolina, within a six-week period in 2002, three Special Forces sergeants murdered their wives after returning from deployments to Afghanistan (Alvarez & Sontag, 2008). All three officers then committed suicide. This is an extreme example of how the stress of combat and its resulting mental anguish and psychosocial strains can impact families in extremely negative ways.

A factor adding to the stressors for family members seeking mental health care post-deployment is that military medical coverage is often time-limited following soldiers' separation from military service, whether active-duty, National Guard or Reserves (Kudler & Straits-Tröster, 2009). According to Kudler and Straits-Tröster, for National Guard and Reserve families, military TRICARE medical insurance eligibility usually ends within a few months of their soldier's return home from deployment. Unfortunately, soldiers' families are often still grappling with mental and physical health concerns long after their eligibility has run out. Even if family members do seek out assistance, the authors note that many primary care physicians do not accept TRICARE and if they do, they may be harder to find in the non-military communities where most National Guard and Reserve troops live.

It is important to recognize that children may be slow to warm up to their returning parents following deployment. While some children may respond excitedly, others may be more aloof and require more time. Children may have many questions of the returning parent about his/her experiences. These questions need to be respected and answered truthfully, but with the level of information that is appropriate to the children's age and developmental level (Uniformed Services University of the Health Sciences, 2008).

Reminding parents to be “in tune” with their children and to listen to their concerns when they are ready to express them; limiting television (especially of war coverage) to help reduce anxiety and worries; letting parents know it is okay to accept assistance from family members and friends, and that accepting help is also a way of contributing to the health of their families—all are important points to reinforce in healthcare settings (Uniformed Services University of the Health Sciences, 2008, p. 1)

Post-Deployment: Adjustment to Home

The Soldier's Experience

As troops settle back in at home, the transition is often longer and more difficult than they may have assumed, particularly for those who do not live on bases around the United States. Once soldiers have been home for a few months, they may begin to feel that they should be well adjusted again. Yet it can take anywhere from three months up to 24 months for soldiers post-deployment to manifest symptoms of a diagnosable mental health disorder (Kubetin, 2008, p. 3). Ninety to 120 days post-deployment, 38% of soldiers, 31% of Marines and 49% of National Guard members report psychological symptoms, according to data from the Post-Deployment Health Re-assessment (PDHRA) study (Ginszburg & Holm, 2009).

Those who are dealing with PTSD or other mental health disorders may choose not to seek treatment for many reasons, such as difficulty getting off work for appointments or finding childcare after hours. Many troops however, talk about the stigma they feel about seeking help, which often exacerbates their symptoms. Veterans of OEF and OIF have reported that they may not seek mental health care because it could interfere with their career or other aspects of their relationships with peers and supervisors (C.H. Warner et al., 2009).

They often express concern that their commanding officers will gain access to their medical records. They fear that any mention of a mental health problem in their VA chart might have an adverse affect on their military careers, their units, the mission, and their families. This concern is especially prevalent among those who are currently in veteran status but who continue as members of the Reserve Component (Kudler & Straits-Tröster, 2009, p. 65)

Veterans of OEF and OIF must also face military and government requirements if they are attempting to receive disability ratings for their injuries. Physical and mental/emotional disabilities are generally determined by healthcare providers; disability ratings are usually not (Ginzburg & Holm, 2009). According to the authors,

“veterans who’ve been diagnosed with PTSD and traumatic brain injuries (TBIs) are entitled to monetary benefits as set forth in the Veterans Judicial Review Act (Public Law 100-687, 1988); due to the influx of OEF and OIF veterans with PTSD many are not receiving benefits, care or services” (p. 71).

This means that veterans of OEF and OIF who may need help, particularly during an economic downturn, can’t get it from the country they’ve only recently served so heroically. In response, according to Ginzburg and Holm, on October 18, 2008, the Department of Defense issued a directive ordering the Army to assign a 50% rating to all

soldiers discharged from active duty with PTSD; unfortunately, many soldiers have not received the 50% rating since then, directly impacting their monetary disbursements from the military. All of these factors are occurring at a time when soldiers may be very emotionally vulnerable and not as able to juggle administrative red tape.

In the interim many soldiers are turning to drugs and alcohol to cope with their problems. Jacobson, Ryan & Hooper (2008) acknowledge the link between combat trauma and substance use in a study noting “substance use is highly correlated with PTSD and other psychological disorders that may occur after stressful and traumatic events such as those associated with war” (p. 663). The military study points specifically to the National Guard and Reserve combat troops in Iraq and Afghanistan as being more likely to develop drinking problems than active-duty soldiers (Jacobson et al, 2008, p. 663). The authors speculate that active-duty soldiers may be better able to cope with the stressors of combat trauma for a variety of reasons; among them: Longer and more focused preparation for combat, a sharper focus on Battlemind training, greater unit camaraderie, community and social support, and resources on base (Jacobson et al, 2008). With an unprecedented number of Reserve and Guard soldiers fighting in the two current wars, this study sounds an alarm about the need to address alcohol use and abuse among returning troops from Iraq and Afghanistan.

There has also been a rise in suicides among troops who have served in Iraq and Afghanistan. Suicides among Army soldiers in 2008 rose to their highest level since record keeping began in 1980; at least 128 soldiers killed themselves in 2008, and 41 Marines committed suicide (Jelinek, 2009). When the Army looked at individual cases,

they found that the most common factors for suicides were problems with personal relationships, legal or financial issues, and problems on the job (Jelinek, 2009).

The Army responded to the increase in suicides with a two- to four-hour “stand down” from mid-February through mid-March of 2009 when soldiers were trained to recognize a troubled colleague and effectively intervene (Kauffman, 2009, p. A5). Army officials said that because it is nearly impossible to identify all the soldiers at risk for suicide, they will adopt a multi-faceted approach to dealing with it, from improving soldiers’ mental resilience to enhancing family therapy (Kauffman, 2009, p. A5).

There are many psychosocial stressors impacting a soldier’s return to the civilian world, including potential substance abuse, relationship issues and financial problems. In the current economic downturn, (2008-2009), many troops are experiencing difficult choices about jobs, housing, food and other necessities. National Guard and Reserve service members may have lost jobs sometime during deployment; they may now have an even tougher time finding new ones. Both active duty and Reserve members may re-enlist for urgent financial reasons so that they can take care of their families both financially and with military health coverage.

Through a downward spiral similar to that of their Vietnam War counterparts, some OEF and OIF veterans are losing their families and homes, ending up in shelters and on the streets. For veterans coping with homelessness, “the problem is often compounded by inadequate mental health care, high unemployment, alcoholism and above all, a shortage of affordable housing” (Gore, 1990, p. 960). In a 1995 study, Humphreys & Rosenheck identified four categories of homeless veterans from a research group of 745 homeless veterans.

These included the “alcoholic” cluster (28.2%), a group with longstanding and serious alcohol problems, severe financial problems, and somewhat elevated psychiatric problems. Those assigned to the “psychiatrically impaired” cluster (29.4%) had a history of severe psychiatric problems and extensive inpatient psychiatric treatment, and were highly socially isolated. The largest cluster (42%) was termed “best functioning” because of its higher social engagement and lower intrinsic impairments than the other clusters. Finally, a small proportion of the sample (10.3%) comprised the “multiproblem” cluster, which had severe problems with both alcohol and other drugs, as well as significant psychiatric and legal problems. (Humphreys & Rosenheck, 1998, p. 286).

It is interesting to note that the “best functioning” homeless veterans were the largest group in this study. It is likely that these vets are challenged by a range of psychosocial stressors that inhibit their ability to find housing. New veterans of the wars in Iraq and Afghanistan may be reflected in the authors’ research clusters, a warning sign to clinicians working with returning combat troops from today’s wars. All of these factors demonstrate the ripple effect that mental illness and psychosocial stressors can have on the soldier who’s returned from Iraq or Afghanistan, his/her family and community.

The Family’s Experience

The soldier’s readjustment to home has a great impact on how his/her family will adjust as well. If a soldier develops PTSD or another mental illness, the family will necessarily be exposed to their veteran’s symptoms, possibly including “angry outbursts, flashbacks, sadness, hopelessness and suicidal thoughts” (U.S. Department of Veterans Affairs, National Center for PTSD, Guide for Families of Military Members, 2008, p. 3). The VA recommends that loved ones encourage their service member to get help if needed, but to be careful about pushing them too hard too soon. The VA also recommends that family members “give their service members opportunities to talk about

the war and their reactions and feelings whenever they are comfortable doing so,” and to realize they may be more comfortable talking to unit buddies instead of loved ones (U.S. Department of Veterans Affairs, VA National Center for PTSD, Guide for Families of Military Members, 2008, p. 6).

The National Center for PTSD (2008) has listed the following distress signals indicating a returning veteran may need mental health assistance:

Family and social relationship troubles – frequent and intense conflicts, poor communication, inability to meet responsibilities; Work, school or community issues – frequent absences, conflicts, inability to meet deadlines, poor performance, or; Depressed or angry moods – possibility that he/she is going to hurt someone or him/herself (U.S. Department of Veterans Affairs, VA National Center for PTSD, Guide for Families of Military Members, 2008, p. 8).

The process of adapting to a soldier’s readjustment can be exhausting for families who hoped their soldier would return unchanged. Family members are encouraged to have their veteran interact with others, rather than isolate themselves. It has been shown that social support is a key factor in mediating the long-term adverse effects of combat trauma (Basham, 2008). This is where loved ones are most important for soldiers following deployment – having consistent love and support from family and friends may be crucial medicine to smooth the transition back home.

Multiple Deployments

The Soldier’s Experience

Throughout the current conflicts in Iraq and Afghanistan, military forces have experienced repeat deployments, which are anticipated to continue as the course of the wars change. Of the 1.6 million troops that have been deployed in support of OEF and

OIF, almost half (449,261) have been deployed more than once (Kudler & Straits-Tröster, 2009). Studies have shown that multiple deployments increase the likelihood of soldiers suffering from combat trauma (Alvarez & Sontag, 2008; Amen, Jellen, Merves, 1988; Basham, 2008; Eaton, Hoge, Messer, Whitt, Cabrera, McGurk et al, 2008). It would follow that repeated deployments also increase the chance of a soldier being injured, killed or psychologically wounded in some way. “The longer troops are deployed in combat environments, the greater the number of troops exposed to combat-related stress and, concomitantly, the number of service members who can be expected to develop dysfunctional psychiatric ailments increase” (Kudler & Straits-Tröster, 2009).

Multiple deployments to OEF and OIF are now happening at faster rates than re-deployments in previous wars. Earlier, service members may have had 18 months to 2 years between deployments; today some service members and their families are facing re-deployment within 9 to 12 months of a return from combat (Family Readiness Through Education on Deployment, 2008).

For parents called to serve multiple times, maintaining relationships with their children can be difficult. Morten Ender, a sociology professor at the U.S. Military Academy at West Point provides insight on this repeated absence for service members: “Soldiers are missing graduations. They are missing birthdays. They are missing first steps. Now they are missing things multiple times. We don’t know what kind of long-term impact that’s going to have” (Glod, 2008, para 19).

For spouses of troops, multiple deployments may also wreak havoc on marriages, sometimes in violent ways. It has been reported that domestic violence in the military is linked to multiple deployments to Iraq and Afghanistan (Alvarez & Sontag, 2008, p. A1).

Crime levels are also up for members of the military who have been deployed multiple times, necessitating the addition of new treatment courts across the country that focus solely on OEF and OIF veterans (Thompson, 2008, para 6). Soldiers at these courts typically have been arrested on a drug, alcohol or other minor offense and are offered a strict treatment regimen rather than jail time.

With the never-ending reality of multiple deployments, soldiers and their family members are being asked to repeatedly put their lives on hold to return to the war zone. These re-deployments only heighten the level of stress and uncertainty with which service members and their family members must live.

The Family's Experience

For soldiers and families who have experienced previous deployments, it might seem that the emotional cycle will be less difficult as they prepare for another deployment; this however, might not be the case. This is particularly true if there are unresolved issues from prior deployments and reunions, and because each deployment experience is different from the last (U.S. Department of Veterans Affairs, National Center for PTSD, 2008).

A recent study examined spouses of one Army Brigade Combat Team (BCT) as their service members prepared and left for their fourth deployment to Iraq. At the time of deployment, the spouses had similar emotions of others facing separation from a loved one: anticipation of loneliness, fear for the safety of their soldier, concerns about raising children and handling day-to-day work and family matters (Warner et al., 2009).

During deployment, nearly half of the spouses (43.7%) met criteria for depression and just as alarming, more than one of 10 spouses endorsed symptoms of severe

depression (Warner et al., 2009). The authors measured spouses' depression levels based on a self-administered Patient Health Questionnaire (PHQ), the depression module of the Primary Care Evaluation of Mental Disorders. One finding from the study that presents a challenge to mental health providers is that although these spouses expressed openness to receiving mental health care, they listed several stressors associated with getting to appointments, including getting time off work or getting away from their children. Additionally, nearly 30% of the spouses endorsed concern that obtaining mental health treatment for themselves might have a negative impact on their partner's careers (Warner et al, 2009). It is alarming that such a significant portion of the U.S. military family also shares soldiers' concerns about the stigma attached to receiving mental health care. The authors also noted that this concern rose with each subsequent deployment of the unit.

In the same study of spouses of an Army BCT, the study's authors noted:

Although it has been anecdotally reported that multiple deployments increase family stress, in this sample, repeated prior deployments were not associated with depression at the time of deployment. It could be that those families with prior difficulties during or following deployment may have chosen to leave service or were not included in this sample (Warner, et al., p. 62).

It has been noted that among career military families, prior deployment experience may be a protective factor, as families can more accurately predict certain issues that may come up during an extended absence (Warner et al, 2009). Unfortunately this is not the case for families of National Guard and Reserve families whose soldiers were only away for training for two weeks a year before the wars in Iraq and Afghanistan.

Lynne Michael Blum, the author of “Building Resilient Kids,” an on-line course for educators to help military children says the following about the effect of multiple deployments on children:

You’re talking about a generation of kids who are hurt from the impact of multiple deployments. The first deployment can be hard, but parents report their kids bounce back. But now as families are facing multiple deployments, the research shows that families never have the chance to readjust back to normal. When they’re supposed to be focused on just being kids, they are focused on when Dad or Mom are [sic] going back into danger again (Glod, 2008, para 6).

Whether active-duty, National Guard or Reserve troops, current research seems to indicate that multiple deployments to Iraq and Afghanistan can be detrimental to both service members and their loved ones. This is a consequence that, like many outcomes of war, may not be fully understood for years to come. It is hoped that we as a nation are able to accept the mental and physical outcomes suffered by our soldiers and provide the support and health care they deserve.

The following section contains Findings from qualitative interviews with loved ones of troops who have been deployed to Iraq or Afghanistan. Their responses are helpful in bringing much of the research from the literature review to life as respondents talk about the multitude of emotions, stressors and readjustments they and their veterans of OIF and OEF have experienced.

CHAPTER III

METHODOLOGY

The existing literature makes a strong correlation between combat deployment and diagnoses of PTSD and other psychological disorders (Basham, 2008; Friedman, Schnurr & McDonough-Coyle, 1994; Hoge, 2004; Kardiner & Spiegel, 1947; Litz & Orsillo, 2004; Rivera, 2008; U.S. Department of Veterans Affairs, 2004). Although some research addresses psychosocial stressors (e.g., homelessness, unemployment, relationship and financial difficulties) (Alvarez & Sontag, 2008; Faber et al, 2008; Goff et al, 2007; Gore, 1990; Hoge, 2004; Humphreys & Rosenheck, 1998; Jacobson et al, 2008; Jensen et al, 1996; Kelley, 1994; Kudler, 2007; Medway et al, 1995; Pierce et al, 1998; Rosenheck et al, 1992; U.S. Department of Veterans Affairs, 2004), it is primarily examined in the context of veterans with PTSD. Therefore, the research question for this study was: From the perspective of a loved one, how has the deployment experience impacted veterans of the wars in Iraq and Afghanistan (known as Operation Iraqi Freedom or OIF and Operation Enduring Freedom or OEF, respectively)? The researcher attempted to gain an understanding of the specific psychosocial stressors combat veterans experienced across the deployment process and how their lives have been impacted since returning home following deployment.

The study employed a qualitative design with open-ended interview questions to gather narrative data as a means to better understand the subjective experience. A semi-

structured interview process was selected to meet the researcher's interest in gaining information in the words of loved ones of those who served in OIF and OEF, not solely through available literature. Semi-structured interviews are helpful in gaining subjective experiences, such as motivations, feelings, meanings and interpretations, and memories of events from the past as it allows interviewees to elaborate on their responses (Anastas, 1999).

While the study was exploratory, the researcher's assumptions influenced the nature of the questions. Based on the literature review, the researcher made the assumption that all veterans are changed in some way when they return from combat, some more deeply than others. The researcher also assumed from the literature review and from her work at a VA hospital that OIF and OEF veterans were dealing with many psychological and psychosocial issues, as had their counterparts from previous wars. The field of social work stands to benefit from a study that collected and summarized information on veterans from Iraq and Afghanistan regarding the particular psychosocial stressors they faced and how their lives have been impacted since returning home from deployment. This is especially timely in light of the two wars' continuation through the present.

Sample

Criteria for participation in this study were loved ones of troops or veterans who had deployed at least once to Iraq or Afghanistan. Additionally, the participants had to be over the age of 18 and speak English. Participants who met these requirements were not excluded for any other reasons.

Participants were recruited through an article in a monthly newsletter mailed to 6,000 Army National Guard members and their families in Vermont by the Guard's family outreach office. The researcher also implemented a snowball sampling technique by informing Vermont Guard Family Advocacy Outreach Managers about the study and inviting referrals from them. This technique was also implemented with a Family Advocacy Outreach Manager at Langley Air Force Base in Virginia via email. The researcher also posted notice of the study on the Military.com and ArmyWives.com blog sites.

Ethics and Safeguards

The purpose of the study was clearly stated to any potential participants in advance. Before gathering data, a proposal to protect participants' confidentiality and rights was submitted to the Human Subjects Review Board at Smith College School for Social Work. Once the study was approved, the researcher initiated participant recruitment. Prior to participation in the study each veteran signed an Informed Consent (see Appendix A) that described the study and participant rights. Participants were informed that their personal information will not be used for any purposes outside of this study and will be kept strictly confidential apart from myself and to a limited extent, my research advisor. Interviews were tape recorded with participants' consent. All names and identifying information were not included in the transcribed interviews; instead each participant was given a number that coincided with their identity in case they would like to withdraw from the study. All safeguards were consistent with federal regulations and the mandates of the social work profession. The data from the study will be stored for three years and then destroyed.

The potential risk of participating in the study was that some interview questions could prompt uncomfortable feelings for respondents. Participants were advised that they could stop the interview at any time and choose not to continue. Participants were also offered a resource list of mental health organizations, including: the VA's Vermont Vet Centers and Community Based Outpatient Clinics (CBOCs), the walk-in mental health clinic at the VA hospital in White River Junction, Vermont, and military and civilian mental health hotlines and community mental health organizations (See Appendix C).

Participants received no financial benefit for taking part in the study. However, they may have benefited from knowing they contributed to the increased knowledge of the psychosocial stressors that impact veterans of the wars in Iraq and Afghanistan. Participant cooperation was completely voluntary and each participant was given the researcher's contact information to ask questions or to withdraw from the study if they chose. Participants had the right to withdraw from the study before, during or after the interview until April 15, 2009. If participants withdrew from the study, all data and information collected pertaining to them was exempt from the study and immediately destroyed.

Data Collection

For this study, a qualitative design was used, consisting of open-ended interview questions to gather narrative data. Participants were recruited through an article in a monthly newsletter mailed to 6,000 Army National Guard members and their families in Vermont by the Guard's family outreach office. The researcher also implemented a snowball sampling technique by informing Vermont Guard Family Advocacy Outreach Managers about the study and inviting referrals from them; this technique was also

implemented with a Family Advocacy Outreach Manager at Langley Air Force Base in Virginia via email. The researcher also posted notice of the study in the Research sections of the Military.com and ArmyWives.com blog sites. In all cases, potential participants were instructed to contact me directly through phone or email to communicate their interest in participating in the study.

Once the participants expressed an interest to the researcher via phone or email, an interview appointment was scheduled for each loved one. The researcher gave each participant the option of having a face-to-face interview, doing the interview by phone or filling out the survey on the computer and returning it to the researcher via email or regular mail. To ensure confidentiality, the researcher conducted in-person interviews behind closed doors at a public place that ensured safety and privacy (e.g., a coffee shop or public library).

At the beginning of each interview the participant was reminded of the study's purpose and intent, and each read and signed an Informed Consent Form (Appendix A). The researcher then gave the participant a copy of the informed consent, the researcher's contact information, and a Resource list (Appendix C). The researcher then asked each participant the open-ended interview questions (Appendix B). During the interviews the researcher clarified questions and asked participants to expand on certain ideas when necessary. Generally however, participants were allowed to answer questions freely. The interviews were tape recorded with prior permission of the participants (included in the Informed Consent Form in Appendix A). The interviews took place between March and April 2009 and ranged from approximately 40 minutes to 75 minutes in duration. The resulting audio tapes were later transcribed onto the researcher's computer.

An interview guide was developed to gain data on veterans' experiences with psychosocial stressors post-deployment, and the resiliency and vulnerability factors that impacted their progress. The researcher selected this data collection method based on the belief that there are aspects of another person's thoughts and emotions that are better and more freely expressed through their own verbal descriptions (Anastas, 1999). This method is also useful in that open-ended questions enable the researcher to "interpret, explain, repeat or redirect an interview question on the spot to obtain the information that the question was designed to elicit" (Anastas, 1999, p. 351).

To safeguard participants' confidentiality, demographic information and signed consent forms were stored separately from the interview notes and responses. All names and identifiable information were not included in the transcribed interviews and the researcher was the only person to transcribe the interviews. All interviews were conducted in a place that provided privacy and only the researcher and the participant were privy to the conversation.

Data Analysis

The study's data was analyzed through a qualitative approach and examined using thematic content analysis. This enabled the researcher to focus on richer narrative data. Due to its flexible nature, the open-ended interview method used in the qualitative portion of the study focused on emerging themes.

Each participant's responses along with the corresponding questions were saved as PDF files, printed, and analyzed manually (e.g. cut and pasted into categories). Responses were separated from questions and each response was given one number to indicate which question was being answered. Categories were made with regard to this

researcher's original hypothesis of expected themes. In addition, sub-themes emerged and additional categories were added as they emerged. The original questions were then re-attached to responses and analyzed for commonalities.

The information was coded into conceptual categories where parts of the responses could be grouped. This coding was an ongoing process through the data collection as themes were identified from the interview responses. The code naming process (Boyatzis, 1998) included:

1. A label (i.e., a name)
2. A definition of what the theme contains (i.e., the characteristic or issue constituting the theme)
3. A description of how to know when the theme occurs (i.e., indicators on how to "flag" the theme)
4. A description of any qualifications or exclusions to the identification of the theme
5. Examples, both positive and negative, to eliminate possible confusion when looking for the theme (p. 31)

With regards to future use of data analysis, due to the small sample size of this research design, the results of this study will not hold strong transferability outside that of the sample's experience. However, through this study it should be determinable whether further study of the research question within a larger and more representative sample would be a valid direction for future studies.

CHAPTER IV

FINDINGS

Introduction

This chapter contains the findings from interviews with 12 loved ones of veterans who have been deployed to the wars in Iraq and Afghanistan. For the sake of clarity, these two conflicts may be referred to in this section by their military names, Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

The interview questions were designed to gain loved ones' perspectives on the stressors and readjustment issues faced by their troops during the deployment process. The deployment process includes pre-deployment, deployment, post-deployment/return home and post-deployment/adjustment to home. Interview questions were divided into sections based on each stage of the deployment process, although more of the questions were focused on the post-deployment/return home period. After talking to participants it became apparent that certain stressors occurred over two or more deployment stages. The researcher will note these deployment phases throughout this chapter.

The interviews began with a demographic section, which included brief questions about the soldier's immediate family, branch of military, Active Duty versus National Guard/Reserve status, and length and frequency of deployment(s). The questions in the next section focused on how troops prepared mentally during pre-deployment. (Pre-deployment typically starts the day a soldier is informed of an impending service call-up).

The third section was based on the deployment period and asked about stressors and adjustments troops experienced during combat. The last section of the interview contained open-ended questions about the difficulties, changes and readjustment issues the veterans faced after returning home post-deployment. This section included inquiries regarding psychosocial, mental and physical issues with which veterans were coping after leaving combat. The final question on the interview allowed participants to mention anything that hadn't already been asked or discussed.

The interviews were conducted per the participants' convenience; therefore not all of the interviews took place face-to-face. Of the 12 interviews, 4 were conducted in-person, 3 were held over the phone, and 5 were completed by the participant and emailed to the researcher. In-person interviews provided the immediacy of facial expressions and emotion that the other two methods lacked, sometimes bringing greater clarity to the process and participants' responses.

Presentation of the interview data begins with demographic information on loved ones and their veterans of OIF and OEF. This is followed by four sections representing the following themes that were drawn from the data analysis: The Communications of War, Dilemmas with the Military, War and the Family, and The Consequences of War. Some of the themes are further divided into sub-themes, which will be identified in that theme's introduction. As mentioned, the stages of the deployment process will also be noted throughout the findings.

Demographic Data

Demographics of Participants

This study was made up of 12 loved ones of veterans of the wars in Iraq and Afghanistan: 10 were women and 1 was a man. Another woman completed the questionnaire with her veteran, so both people may be quoted in this chapter. Seven loved ones were female spouses whose husbands had deployed with OIF or OEF; as stated above, one additional husband and wife filled out the questionnaire together based on his deployment. One participant reported information on both her husband and daughter who were deployed at different times during OIF. Three of the participants were mothers of daughters who had been deployed; the ex-husband of one of these women was also a participant, completing the questionnaire based on his perspective as the father of a soldier.

The majority (n=9) of the participants lived in Vermont, with one each living in New Hampshire, Pennsylvania and Oklahoma. All of the loved ones were identified by the researcher as Caucasian. The researcher did not ask the age of participants.

Demographics of Veterans of the Wars in Iraq and Afghanistan

One of this study's requirements was that loved ones' troops had to have deployed at least once to Iraq or Afghanistan. In the study, all of the veterans of OIF and OEF were current or former members of the Army. Seventy five percent of the veterans served with the National Guard, one was a Reserve member and one was an Active Duty officer. Demographic data on a final veteran was collected from both of her divorced parents, so one of the duplicate sets was not used in this section. Eight of the veterans were deployed to Iraq; four veterans were posted to Kuwait and made missions into Iraq

during their deployments. The deployments lasted between 4 months and 18 months, with an average deployment length of 13.7 months. The Active Duty Army officer was deployed to Iraq three times. One quarter of the troops was preparing for second deployments at the time of the study; they are all heading to Afghanistan.

Additionally, two thirds of the veterans in this study have children – a total of 20 between them. The children range in age from 10 to 35: three are between the ages of 10 and 19; 12 are aged 20 to 29, and; four are 30 to 35 years old. Many of the loved ones mentioned that their veterans have grandchildren, though no exact count was taken.

Table 1: Demographic Characteristics of Loved One's & Veterans

	Veteran's Duty Status					
	National Guard	10	Reserves	1	Active Duty	1
Loved One's Gender						
Female	10		1		1	
Male	---		1		---	
Loved One's Ethnicity						
Caucasian	10		1		1	
Other	---		---		---	
Loved One's Location						
VT	8		---		1	
NH	1		---		---	
PA	---		1		---	
OK	---		1		---	
Loved One's Relationship to Veteran						
Wife	8		---		---	
Mother	1		1		1	
Father	---		1		---	
Veterans' Military Branch						
Army	10		1		1	
Other	---		---		---	
Deployment Location						
Iraq	6		1		1	
Afghanistan	---		---		---	
Kuwait*	4		---		---	
Veterans with Children						
	7		---		1	
Veterans' Total Number of Children						
	19		---		1	

* Four veterans were deployed to and based in Kuwait, with mission into Iraq.

The Communications of War

The theme “The Communications of War” addresses the method, content and mood of the communications between the troops and their families during war time. There are many transitions and complications that every soldier and his/her family must adapt to related to communications. This starts during pre-deployment when soldiers are gearing up for battle and have a multitude of thoughts about what awaits them in a combat zone. Troops may or may not share these thoughts with loved ones. An inability or unwillingness to communicate with loved ones at this time can sometimes lead to stress for the soldier and disharmony in the family system.

During the deployment phase, the military mandates a communications policy for its troops, and by extension, the loved ones of those troops. According to one participant, whose Army National-Guard husband deployed to Iraq:

When he was deployed they (the military) told us wives and girlfriends, Don't upset the soldiers. Don't tell them anything bad. Don't let them know anything that's going on at home. Everything's *wonderful* at home. Don't distract them. Don't stress the soldiers, because it takes away from their focus.

The double-edged sword of this strict protocol is that not only do loved ones need to be cautious in their communications with their troops, but troops are not free to share the details of their day-to-day lives in Iraq. This communications firewall can cause anxiety for both soldiers and their families during the most difficult part of the deployment process.

During post-deployment, troops must rejoin their loved ones by re-integrating back into old communications patterns. In the best case, some troops adapt to life at

home within the first few months back, though this period often includes the realization that some old patterns must be altered for the sake of the soldier. For some troops though, the re-entry post-deployment is full of communication snags, silences and harsh words, as they attempt to communicate anew with their loved ones. For those soldiers, it is a worrisome process to reconnect with family members; in turn, it may be equally as difficult for loved ones to cope with the changes in their veteran.

Therefore, this theme's section is further divided into two sub-themes: Protective Communication and Emotional Withdrawal. Protective communication is defined by the soldier's inhibition of specific information from his/her loved ones as a means of protecting them. Emotional withdrawal is related to troops' distancing themselves from family because of an inability or unwillingness to share what are typically painful, frightening and/or uncomfortable feelings. Protective Communication and Emotional Withdrawal are prevalent throughout the entire deployment process.

Protective Communication & Emotional Withdrawal

Participants were asked five questions pertaining to their troops' mental preparation for war, adjustment to the war zone, stressors during deployment and readjustment to civilian life. In discussing the questions, half of the loved ones in the study (n=6) mentioned the impact of communications issues on their troops throughout the deployment process. These problems often began during pre-deployment, shortly after soldiers were informed of pending service call-ups.

One respondent – the wife of a Guardsman who was notified of his deployment just 11 days before leaving – noted a change in her husband almost immediately. During a trip the two took alone before her husband left for Iraq, his wife noted, “He was getting

quieter and quieter and a little moody at times...put a little bit more of a wall up.” In hindsight she explained that she thought it was her husband’s “way of just letting go... knowing he had to do it.” This Army wife added that her husband wouldn’t talk about it when she asked what was on his mind. The two are now preparing for the husband’s second deployment, this time to Afghanistan.

Another participant, whose husband was deployed to Iraq with the Army National Guard, shared that each of them shied away from difficult communications prior to deployment. This wife stated that she “figured [my] husband didn’t want to talk about the possibilities” of war and she took her conversation cues from him:

We didn’t talk about whether he was going to get killed, whether he was going to come back; we didn’t talk about those types of things. We just didn’t want to go there. We just thought, ‘Okay, you’re going to go there, you’re going to come back, you’re going to be okay’...And that’s how we handled it.

This same participant also reported that without a formal discussion, she and her husband withdrew from each other prior to his deployment:

I didn’t want to burden him with my part. I don’t think he wanted to burden me with his part. I think we went into our separate...okay I gotta get ready for this. I have things I’ve got to do and he has things he’s got to do so we kinda took our own gearing up for it...But then again, he was very closed up; withdrawn a little bit. We didn’t talk about it a lot, other than the things that we had to prepare at the house.

Once troops were deployed, the rules of the military regarding communications became the order of the day. It was during this period that respondents reported the most stress for their troops related to communications with their loved ones; one-third (n = 4) of participants mentioned these issues during deployment. Soldiers were unable to share

the traumatic realities of war with their families, and also realized that their loved ones couldn't reveal certain news from the home front.

The respondent who prepared for her husband's deployment in 11 days, said she could often pick up on his feelings over the phone once he was in Iraq. "There were times when he'd break down... but he wouldn't admit to it. I could hear his voice was cracking." She said that her husband was always worried about her and often told her to ignore alarming noises from his end of the line: "I would hear noises in the background, like explosions and I finally said, 'What is that that I'm hearing?'" and he said, "I want you to tune that out. It's like half a mile away."

Another wife noticed in hindsight that her Army National Guard husband called her prior to convoys to certain cities in Iraq. She said that her husband didn't indicate his apprehension directly to his wife, so instead, she began to listen for names of particular cities and how her husband talked about them: "He would say, 'Oh, I got a Karsh run today. I really don't like going to Karsh.' But he never told me to the extreme of how he felt about it."

One participant's daughter is an active-duty Army officer who has been deployed to Iraq three times. This mother reported that her daughter worried about her family during deployments and "one of her biggest concerns was about me." The respondent laughed during the interview when describing the lengths to which her daughter went to keep information about her third deployment from her mother (the respondent): "She told me she was going to Kuwait...that she would be in Kuwait the whole time...and she was in Iraq! And I fortunately did not know that the whole time. I didn't know until right before she came back..."

Another respondent, whose husband recently retired from the Army National Guard after 25 years, said her husband didn't say much about things when he was deployed. "There was a lot he couldn't talk about so he went to something he could talk about." Yet the thing that was most difficult for this participant to handle was the lack of information she received from her husband about an injury he received in combat:

And there were some things in this process that I was not aware had happened. There were a few things he had talked about very briefly. Well, the worst thing happened during his last little bit over there...I didn't know about it then. There was a roadside explosion and he didn't get hit but there was a wave that rolled over them. He said he was "out" for a couple of days (unconscious) and he thought they'd take him to Germany but they didn't. When he came to they took him back to Kuwait.

Loved ones reported that their troops' problems with communication and emotional withdrawal did not end when they returned home post-deployment. In fact, of the 50 percent of respondents who identified communications concerns as stressors for their soldiers, all reported that these problems occurred or continued during post-deployment

When one participant's husband returned from Iraq to his family, she noticed his emotional withdrawal and the frustrations he faced because of it:

...He shut down and wouldn't talk...for him he was frustrated by it, that he couldn't do it...and tell us why he was feeling the way that he was. And I think for him that was the most difficult part...I would find him with tears in his eyes and I knew something was bothering him and something happened over there.

The wife of an Army National Guardsman mentioned how her husband doesn't talk about nightmares he still suffers after returning from his deployment four years ago. "He'd say, 'I just can't talk about it.' And he still can't." This respondent, whose

husband was 54 years old when he deployed to Iraq, knows that her husband's nightmares are terrible and senses he wants to shield her from their horror. "He never says anything during the dreams but I can tell by the look on his face and his action that, "Oh my God, it was awful."

The mother of the Active Duty soldier/daughter was upset when her daughter returned from her third deployment and seemed immediately alienated from her husband. This was the first deployment when her daughter had to leave soldiers behind whom she had trained; her attachment to her unit was strong and when she arrived home she was angry.

And the day she came home to the house she told her husband she wasn't happy. I know if I hadn't talked her out of it she was going to get a divorce....she had a real difficult time getting adjusted to her family...because she had that "block"...

Dilemmas with the Military

The theme "Dilemmas with the Military" focuses on the impact of several institutionalized aspects of the military on the troops who've fought in OIF and OEF. The regimentation of the military during war and the reality of being on the battlefield require troops to readjust to new circumstances and life-or-death consequences. These new rules can impact troops at critical periods during the deployment process and cause increased stress and anxiety.

Participants were asked four questions related to stressors their troops experienced during deployment and post-deployment. It is during this time that participants mentioned the most difficulties with different branches of the military, including command leadership, military resources and institutionalized attitudes regarding PTSD.

This theme's section is divided into the following sub-themes: Issues with Training and Command Leadership, Red Tape with Military Resources, and The Stigma of PTSD. Issues with training include concerns regarding length of training, type of training and troops' perceived preparedness for war. Problems with command leadership typically involved the immediate chain of command and usually occurred during deployment. Red tape with military resources involves a range of issues that most often impact the smooth transition for soldiers from deployment to post-deployment. Unfortunately, this red tape also effects those soldiers who have been physically or mentally injured fighting in OIF and OEF. The stigma of PTSD is a sub-theme characterized by its longevity in military culture. It is discussed here as a reminder of its continued presence, and as an ongoing influence in the apprehension of troops and veterans seeking mental health treatment.

Issues with Training & Command Leadership

Seven of the 12 participants identified issues with training and command leadership as increasing tension for their troops during the deployment process.

One spouse stated that she knew there were problems with her husband's command and reported that these issues made it more stressful for the soldiers in the entire unit:

I know that their command was horrible...the guys...had a really rough mission because of that. The command was more of a sit-in-the-office...than getting out with the troops, and very partial to certain troops...so that was a whole boatload of stress on those soldiers in and of itself with the stress they were already under.

A mother of a soldier in the Army National Guard indicated similar issues during her daughter's deployment. Her daughter was based in Kuwait but took regular missions into Iraq, as did three other troops represented in this study. This participant described her daughter's thoughts regarding her immediate leadership this way:

The command of the TF was awful, showing favoritism and bad leadership. So it was hard to work on a deployment in which most of the soldiers were "guarding dirt" and told that they weren't really soldiers because they were not fighting in Iraq.

The mother whose daughter has been deployed three times described her daughter's perspective about "life and death" in a combat command situation. As an officer, this woman's daughter sometimes had problems with sergeants under her command who didn't seem to understand the urgency required in a combat environment. This Army mother mentioned her daughter's problems with a particular sergeant during one of her deployments. "The sergeant "wasn't doing what she [her daughter] wanted her to do and peoples' lives were on the line...The sergeant was not paying attention to her surroundings...and that's how you get killed."

The participant who completed the questionnaire with her husband, a recently retired Army National Guard soldier, allowed her husband to describe his stress in coping with his much younger unit mates. Her husband felt these troops hadn't received proper training regarding war and cultural differences. According to her husband:

I was assigned to a section with the oldest soldier being about 25 and not much time away from home before. So for a 50+ year old, that in itself was quite stressful. I thought I had raised all my kids! Dealing with their stresses and quirks consumed quite a lot of time. And when not busy doing that, I was trying to mentor them in surviving, politics of the new democracy, and showing enough respect to the locals to keep them friendly.

The idea of training seen from both sides of the aisle was also evidenced in comments made by the mother of the active duty officer. She reported that knowing how well her daughter was trained was comforting when her daughter was away on deployments:

...I always think this is her career because she is trained to the max and she takes that very seriously. That makes me feel better. She's out on the rifle range before she goes [on deployment]...She learned as much of the language as she could.

This same military mother expressed concern about what she feels is a lack of training for National Guard and Reserve members in comparison to active-duty troops:

...one day they're sitting in an office and the next day they're sitting over there. Especially when the war first started. They didn't get any training...they were just over there. And I used to always think, thank God my kid is full-time military because she's trained.

One mother noted that the only preparation her daughter received prior to deploying to Kuwait was "wondering if and when she would be called up." A wife whose husband was in OIF with a Vermont Guard unit, was concerned about her husband's preparation for battle: "He didn't get the right amount of training. It was 45 days of training and then he was rushed over there...what can you learn in 45 days about fighting in a war?!" This same participant added that problems with training continued once her husband got to Iraq: "He was 'trained' to do one thing, then when he got over there he had to do something else entirely different."

Two of the respondents also mentioned concerns about their troops' preparation to return home post-deployment. One participant said that there "is no exit plan from war to the civilian world" from the Army. Another respondent, whose husband returned from

a deployment to Iraq four years ago, talked about specific issues with the Army's de-briefing process. (This process takes place immediately following the troops' return from deployment; for Vermont National Guard soldiers the de-briefing is at Fort Dix, New Jersey over a two-week period). This respondent noted some of the ways in which she felt the de-briefing was not helpful to soldiers:

I don't believe that they [the Army] actually give them [soldiers] the correct information...I think they allow them too much time, or not enough time in some cases, to readjust. Because who's to say what's right for one person is right for the other?"

This same participant questioned how much information soldiers actually absorbed at a de-briefing immediately after a deployment. She shared the thought that any soldier's natural instinct would be to get home right away after being away for so long. "...A lot of guys, I assume, when they're down in New Jersey...they're just like, 'Let's take care of this paperwork and get home.' I don't think they realize the impact this is going to physically have on them when they get home..."

Later in the interview this same spouse said she "realizes families have expectations that their soldier will be the same as when they left," but reports that "the military doesn't prepare you for the bad. They don't prepare you for the withdrawn...they don't prepare you for a lot of things."

Red Tape with Military Resources

Half of the respondents in this study indicated they had no problems accessing military resources throughout the deployment process. The retired Guardsmen, who completed the interview with his wife noted: "I was astounded by the magnitude of

resources available for returning veterans. I can remember over the past 35 years that a lot of veterans returning from conflicts were not given that service.”

For the other 50 percent of the respondents though, many mentioned paperwork and other problems with the military or VA system as the cause of greater strain for their veterans. This was particularly the case during post-deployment. One participant said, in regard to the amount of paperwork she continues to complete based on her husband’s various injuries, “We feel like we fought a war and we’re fighting still.”

Another spouse indicated how difficult it was for her husband to wait in Army Med Hold (Medical Hold) in Georgia before coming home. (Many Vermont National Guard soldiers who are physically injured are brought to Med Hold in Georgia). She said that her husband was in Med Hold for five months and that during that time “he was depressed; he just wanted to come home.”

There’s a lot of waiting in Med Hold...a lot of ‘hurry up and wait.’
So they [the soldiers] would see a doctor and their next appointment
is four weeks later, so they’re just trying to wait...And you can’t
leave there without all this paperwork done.

This participant was eventually asked to come to Georgia by her husband’s therapist, due to her husband’s rising level of depression.

When her husband’s belongings were shipped home, this woman said, “his personal belongings have never shown up. He had flags flown over his camp for each of our daughters when he was there...they didn’t come home with him...” The anguish this caused her husband, coupled with his other ongoing injuries led him to suffer a nervous breakdown some time after returning home.

One participant, who tried for three years to get her National Guard husband to attend therapy, was frustrated about the lag-time at the VA after he finally had a PTSD assessment: "...It took the VA forever to call me back. I had to keep calling to tell them how urgent I thought my husband's PTSD was. Then you get a different person every time you call..."

Another respondent discussed her husband's confusion with various stages of the VA process: "When he re-established his claim it took them [the VA] from August of 2007 until March of 2008 to get it done."

On the subject of disability insurance and other paperwork, another respondent said: "I haven't had time for the challenge of it yet." One spouse, whose 38 year-old veteran husband has cognitive deficits post-deployment said, "People have been pushing TBI and mild traumatic injury forms at me. Someone was helping me at one point but he got fired and no one else has picked up our case." This wife talks about "bringing information to the Guard that they've misplaced," and feels that her husband has gotten "a lot of broken promises from the Guard and the VA."

The Stigma of PTSD

Although the military has made a big effort to stamp out the stigma of PTSD and other mental illnesses, many soldiers still consider it shameful to have PTSD. This shame is often tied to messages they have consciously heard (e.g., "Be Army Strong"), seen in the lives of others, or believe from the long legacy of stigma attached to PTSD in the military. Stigmatization posed problems for one third (n=4) of this study's

respondents. In most cases, it delayed or prevented veterans from seeking therapy and/or medication.

One participant, who noticed her husband's PTSD-like symptoms for three years before she could convince him to seek therapy said:

...Because of the PTSD...it's a stigma to him. If you have it or I have it it's okay. But for military...to be labeled PTSD or to be labeled anxiety...is NOT okay...He considers [it] a weakness, and men aren't supposed to have weaknesses...men aren't supposed to cry...

The wife of an injured National Guard veteran sighed as she talked about how difficult it is for veterans like her husband to admit they are having mental health problems, only saying, "For troops to show a weakness, to ask for help..." and then not finishing her sentence. Another National Guard wife said her husband avoided therapy until she made an appointment for him. She shared the fact that her marriage was on the brink of separation at that point, and getting her husband to therapy was her final hope.

Another participant, whose daughter has had a difficult return from a third deployment, was so worried about her daughter's mental state that she offered to pay out-of-pocket for her daughter's therapy. She explained that "they [soldiers] don't feel comfortable going to get help if they're Active Duty. I think if she were out of the military she'd go." This mother reported that the message she's received from her daughter is that going to therapy can still be detrimental to your military career:

I don't care what anybody tells you, if it's your career you don't go see somebody. They say, 'Ah yes, we'll help you,' but if someone is looking for someone to promote to major, they're not going to pick the one that went to counseling...That's just how it is, at least in her [her daughter's] mind...

War and the Family

The theme “War and the Family” encompasses daily life for the loved ones of troops deployed to OIF and OEF, and how these activities impact their soldiers. Prior to deployment, loved ones may assist their troops in preparing for departure, but it is the emotional preparation that is the most anxiety-provoking. During deployment, family members turn to the task of providing ongoing support to their soldiers through loving words and gestures (e.g., care packages, letters, family photos, etc.). The military recognizes that family support is an integral element for the cohesion of troops within their units. For troops and their loved ones though, this process is often made more difficult by the military’s limitations on communication during deployment, as mentioned earlier in this chapter. Post-deployment, family members must readjust to life with their veterans, some of whom have changed dramatically since leaving home for combat.

In this section, participants were asked four questions about their troops including, 1) What’s been most helpful to your loved one during the transition to deployment? 2) What was the most difficult thing for your loved one to adjust to when he or she left for OIF/OEF? 3) Did your loved ones have any problems readjusting to civilian life post-deployment? If so, what were some of those problems? If not, what helped him/her to adjust? 4) Please describe any stressors experienced by your loved one in the following areas of his/her life (one of the areas mentioned was family relationships). Seventy five percent (n =9) of the participants in this study mentioned the importance of friends and family to their troops, and the impact of those relationships throughout the deployment process.

This theme's section is divided into two sub-themes: Support from the Home Front, and Re-integration of the Soldier into Family Life.

Support from the Home Front

The wife of a Guard soldier talked about how challenging it was to prepare for her husband's deployment with just 11 days' notice: "It wasn't even sinking in. We had a lot of friends surround us, a lot of family surround us." In the end though, this woman said "the family became almost a nuisance, because it became like too much family." Another respondent, the mother of a daughter in the Army Reserves, said that one of the most helpful things for her daughter during her transition to deployment was the "connect[ion]s and support she received from family, current classmates and friends from the military." Yet another wife and mother, whose husband and daughter have both been deployed, said of her daughter: "She and her siblings are close, and she and her dad drill together... We are a supportive family and I think that made a big difference all around."

One father mentioned his daughter's regret at "leaving her nephews and not being able to see them grow." The retired National Guard member who completed the interview with his wife said: "No matter how many times you are separated from family and friends, it still remained the most difficult adjustment for us."

The wife of a Guardsman shared a particularly painful experience for her husband during the troops' send-off to Iraq. At the time the couple's youngest daughter was 11 years old and was described by her mother as "very much a daddy's girl:"

When they [the troops] go into formation they can't come out of formation again...and they can just look at you from a distance. And he always said that it just ripped his heart out that he could see her [his daughter] crying and he couldn't get to her.

This same wife and mother spoke about the huge task of raising their daughter alone when her husband deployed, saying their daughter was “just entering those pre-teen years.”

...And she was already starting with the, ‘Oh Mom, you don’t know anything,’ and fighting with me. I mean, when he left, we had to figure out a way to reconnect. So it bonded her and I in a way that helped us go through those years that could have been very different.

Two of the respondents talked about notable ways they handled their soldiers’ deployments, each involving planning and activity. One of the women, an Army mom, and the other, the wife of a National Guard member, considered it important to stick to their missions during deployment.

The Army mom said throughout her daughter’s three OIF deployments “I sent packages constantly....bundles and bundles of cookies so she could share them.” This mother laughed as she talked about finding out her daughter and her unit didn’t have enough toilet paper:

I got the word out to family, (and I have a big family), so she ended up with 120 rolls of toilet paper...and she actually had somebody do a little video of her tent and how high [the toilet paper was].

This Army mom acknowledged that seeing the video, including shots of soldiers eating the cookies she’d baked, “kept me going.” She even convinced a local candle company to send free candles to her daughter’s troops when she heard about the “unbelievable smell” in their building after water supplies were blown up.

Another participant prepared for her husband’s deployment in a way not mentioned by any other respondents; she decided to put her own mission on paper.

And the same thing as when he was deployed, I took on a mission. I took on, how did I get through these 13 months... So what I did is I made a list, and I said, '...these are the things I want to accomplish when you're gone.' I gave *myself* a mission each day, each month, each time.

This same participant said that she and her husband still went through a complete list of items that needed to be taken care of in his absence, including "how often to clean the woodstove and the chimney:"

...we talked about a lot of things...he needed to pass on to me. Like all the oils have to be changed, the equipment has to be done, all these things I needed to tend to while he was gone. So he started pushing some of that responsibility on me right away...and there are things we had to gear up for, like how are things going to get paid for? How much money to put aside? We opened up a separate account for him at the bank so, how much money are you going to need? How do we get this money to you? There's certain things we had to address, but other than that it was like, okay we're preparing for this day.

The National Guard daughter of one study participant was forced to leave art school just before midterms when she received her orders to leave for Kuwait. Her mother was left to battle the college regarding her daughter's absence from school, course status, tuition and other concerns. "I spent many hours explaining to them that even though there was an institutional policy, this was something that needed an exception."

Re-integration of the Soldier into Family Life

Family and friends of troops deployed to OIF or OEF hope that their soldiers will return home unharmed. Whether they are injured or whole, loved ones play a big role in re-integrating veterans back into their families, a job that is harder for some families than others. Of the 12 participants in this study, 50 percent talked about readjustment

problems for their troops that were related to family life. The respondents who indicated that their veterans had not suffered readjustment issues during post-deployment mentioned family, religion, education and marriage, and friends and new classmates, as being helpful factors in the transition back home. One participant said her daughter and husband both deployed with the National Guard at different times, giving them unique, ready-made support: “She [my daughter] told him a lot more than she told me. But she told me when she got home.”

The participant with her own “mission” said that when her husband came back from Iraq “his mission stopped and mine kept going. So he had to get back into a mission, like going to work, fitting into the family...where before, he had a mission regardless.”

This respondent noted that the military has a belief that troops should take their time getting back into the rhythm of family life after getting home from a deployment. She commented that this policy doesn’t always match the reality on the homefront:

They tell the guys just sit back, don’t try to force yourself in. Your wife or your husband... has been in charge for this deployment time ...has had to make these critical decisions without you. And they told them to just sit back and ease into things ...It just prolongs them getting back into the routine of things.

Another respondent noted her husband’s initial awkwardness around household responsibilities after he returned from Iraq:

He was very cautious about it, like the first time he mowed the lawn he said, ‘Would you mind if I mowed the lawn?’ Because he knew I had been mowing it for two years. I was like, ‘Are you kidding me? Take it all. I don’t even want to even see the lawn mower again!’

One wife related how sometimes, even though her husband has been home from Kuwait for 2 ½ years, they still go back and forth about household chores:

...He'll say, 'What did you do while I was gone?' A couple of months ago we shoveled the snow and I told him I did it [when he was gone]... He's been home 2 ½ years and sometimes when he says things like that it feels like he just got back.

The wife of an Army Guardsmen discussed how deeply ingrained her sense of independence became during her husband's deployment, and how difficult it was to reconcile it with his return home post-deployment. She states that with him [her husband] and I, it was just the coming back together as a couple, because I was so independent then." This woman also shared an incident that caught them both off guard after her husband got back from Iraq:

I remember one time I left the house and went somewhere and he called me on the phone and said, 'Where are you?' And I went, Oh my God, I forgot you were home! I was so used to going [out alone] that I forgot to tell him I was going to be gone for awhile. It's one of those deals because you just get used to a different life.

Another respondent, whose husband was with an Army National Guard unit, said her new-found independence caused different issues in their household: "He has the, I'm the man and I'm the king of this castle, thing going on. You're used to doing it yourself and he's been gone. You want to do it and that's a battle." For this wife the situation is compounded by her husband's traumatic brain injury, unemployment, and the impending foreclosure on the family's home.

For half the participants (n=6), their soldier's return to the family following deployment was a time of stress for everyone. In some cases this was related to the tasks

of family members and the independence that spouses gained. These challenges were made more difficult if troops returned from OIF or OEF with physical or mental injuries.

The Consequences of War

The theme “The Consequences of War,” focuses on the outcomes of a deployment to Iraq or Afghanistan. Some loved ones have troops who came home with physical injuries; others greeted veterans who were impacted mentally by the horrors of combat. There are also soldiers who were deployed and transitioned back home fairly unscathed. Yet for most veterans there is a part of battle that remains with them and may have a lasting impression on how they live the remainder of their lives.

The retired Guardsmen who finished his military career with a deployment to Iraq summed up the feelings of others when he said:

You can't go to a country like Iraq and not return without being changed in some way. You are exposed to another culture, currently in the infancy of democracy, previously a dictatorship. You have the opportunity to experience good, bad and indifferent.

Although this veteran talked about the changes one experiences during service in Iraq, on a personal level, he reported few issues while re-adjusting to life post-deployment. He said he had “no problems after a month or so and started to relax more.” He also reported that by that time he was “not startled by loud noises, started driving civilized again, and didn't have to time the showers.” Of the other 11 respondents to the study, three also indicated that their troops did not have much difficulty readjusting post-deployment.

Many soldiers who returned from the wars in Iraq and Afghanistan experience stressors related to combat that the military considers common. Some troops express

anger, irritability, sleeplessness, nightmares and other symptoms that may indicate these common stressors; others though, may be exhibiting symptoms of PTSD or another mental illness.

Two thirds of the loved ones in this study indicated that their veterans returned from Iraq or Kuwait with mental illnesses. Additionally, half of the participants mentioned that their troops have experienced psychosocial stressors, and one third of the loved ones said their veterans came home with physical injuries. In far too many cases these issues overlap, making it difficult to split participants' responses into sub-themes; instead, the final theme is described broadly under Mental, Psychosocial & Physical Issues Post-Deployment.

Mental, Psychosocial & Physical Issues Post-Deployment

A spouse in the study said her husband's "anger wavers back and forth...but there's a huge fear of it constantly for him (and for me)." This same participant discussed her husband's paranoia and "huge distrust issues." Another respondent said with her husband's PTSD diagnosis there was a "total lack of emotion or involvement in discussion... He is emotionally distant from family and avoids them...He did a lot of defensive driving, and he wouldn't pick up anything, because he was always thinking an IED would be under it."

One woman was not prepared for the hyper-vigilance her National Guard husband demonstrated both prior to his deployment and more acutely when he returned from combat. This respondent discussed how things seemed okay with her husband when he initially got home from Iraq, but that they've slowly deteriorated. "On the way back

from a drill he had a major panic attack. He started having problems in the night, flashback episodes.” Later, she said that his symptoms worsened and he had to stop working. “He tried to go back to work but he felt there weren’t positions he could do. He tried doing odd jobs but there were some days he couldn’t get up and go.” Now this veteran has been diagnosed with PTSD and depression; he has no feeling in his right leg and has balance problems; he has also been issued hearing aids. This respondent worries more about her husband’s ongoing headaches, which she feels are the result of a blast injury in Iraq that may now indicate a traumatic brain injury (TBI).

A National Guard spouse talked about the differences in her husband upon his return home following deployment:

...Everything was different. Like when you go on vacation, it’s the same but it’s not the same...we went into our bedroom and he said, ‘Where would you like me to put my stuff?’ And I was like, You live here! This is your home! But he was acting like a visitor. It was the strangest thing...It was just really bizarre to me, how he was acting.

This spouse said that after her husband’s many months of counseling and with a lot of work on their marriage, things are improving: “Slowly...he started coming back. Slowly you could see pieces of him coming back.”

One participant, whose husband deployed once to Iraq and earlier with Desert Storm, talked about how her husband has not been able to return to work since he got home. She said “I have a good job and our finances are fine,” still, she shows the stress of someone who is now the sole breadwinner tending to a disabled spouse. Her husband’s former life as a nurse has been interrupted by a brain injury that has been upgraded to “moderate,” from an earlier “mild” diagnosis.” This woman says her

husband now “usually spends his day organizing something that used to take him no time...This is a man with two bachelor’s degrees and an associates!”

Another respondent watched as her husband jumped from job to job when he returned from Iraq. At one point she said she wondered, “How do you deal with somebody who’s changed so much?” She watched as her husband went through five or six jobs in one year before she was able to get him into counseling at the VA for PTSD:

...When he did go back to work he ended up quitting his job. He was there...9 or 11 years...and he ended up quitting...a really good job. He said too much had changed and he didn’t fit in...his friends had moved on... and the work had moved on and things had changed ...He was just so bitter. And it was just like, ‘Where did this bitterness come from?’ I still don’t know.

This same respondent said that her husband has now been home from Iraq for four years and, “He will never be the same as he was before...And I don’t expect him to be the same...but I expect him to be as close as he can.”

One participant reported on her husband’s many physical injuries and plunging mental health condition, which ended in a nervous breakdown:

He came home...he has a titanium plate in his neck and while he was home it got infected. And we had to go back to Georgia because that’s where they did the surgery, and he was really upset then...He can’t work; he can’t go to work ever. And that’s a big part of it because he’s told me he feels like a worthless piece of shit because he can’t go back to work. He’s all but in a wheelchair permanently.

Another participant, whose husband returned from Iraq at age 35 with cognitive and mental disorders, said he is currently being tested for a TBI. This wife says her husband had to retire from the military because of his injuries, and he is unable to work in the civilian sector. She mentioned during the interview that she and her husband were

going to a VA Hospital in Pennsylvania the following day in search of health-related answers and relief; they still do not know the extent of his injuries. This spouse added that her husband's disabilities often made him "do things like when he was younger." Their two kids say that it's like their father is "walking through a dream," and have commented that "Dad was looking through me" or "talking to someone else who wasn't there" What has also been devastating for this young couple is the impact of the husband's various injuries on their marriage. The wife reports:

In the last four years my husband and I have wanted to part ways many times. With the disability you end up falling into it yourself. You don't know what's real and what's not. You can't see his injury [TBI], but it's there and it's so hard to tell what's going on.

Another spouse, whose husband served as chaplain with an Army National Guard unit, shared some of his experiences during war time:

As the Chaplain for the Task Force that saw the highest numbers of casualties – and six from our small state – he said it was like watching his children die. He spent a lot of time in the surgical unit and became an official member of the Mortuary Affairs Unit. He watched the soldiers die, and did their memorial services, and cared for their units, and watched the angel flights leave carrying the remains home.

This spouse did not indicate whether her husband's military responsibilities have lead to long-lasting consequences, but she did report that "there is a sadness within him now."

The mother of the Active-Duty soldier was disappointed when her daughter came back from war questioning her faith. This Army mom said "the one thing that breaks my heart is that my daughter lost her faith in Iraq. She was a very strong Catholic and now she doesn't know if she believes in God."

Summary

This chapter has presented the findings from 20 questions asked to 12 loved ones of troops deployed to Iraq or Afghanistan. In many cases there was common ground on the issues related to stressors and readjustment during the deployment process. Some respondents (n=4) noted that their veterans did not experience much difficulty with the transitions involved in a deployment. One of those respondents was the wife of a 51 year-old Army National Guardsman, whose husband recently retired after 26 years in the military. He completed the interview with her, referring to his deployment to Iraq as “old hat,” in light of the multiple deployments he’s had throughout his military career. This veteran indicated strongly that those prior deployments gave him the confidence and training to succeed in Iraq. Two other respondents mentioned “religion,” “supportive family,” “family and friends,” and “returning to school” as factors in their daughters’ relatively smooth readjustments home post-deployment.

Half of the participants (n=6) agreed that protective communications and emotional withdrawal were very stressful for them and their soldiers. This was particularly true during deployment and post-deployment. Though spouses of soldiers said they understood why they weren’t supposed to share any bad news with their husbands, most said it was still difficult to hide information. Loved ones also had trouble when their troops returned from service and were emotionally distant.

Many participants in this study also reported problems with the military that contributed to the stressors their soldiers experienced. The areas that were noted most often were problems with training and command leadership, red tape with military resources and the sense that PTSD is still stigmatized by the military.

The majority (75 percent) of the study's participants mentioned family as a source of support or tension for their veterans. Most respondents noted how hard it was to see their soldiers struggle at some point during the deployment process, and how difficult it often was to handle the changes in their veterans.

The final section of this chapter discussed the consequences of war related to mental illness, physical injuries and psychosocial stressors experienced by OIF and OEF veterans. Participants noted ways in which their soldiers' lives have been altered since deployment. In many cases, medical problems experienced by the participants' troops evolved into other concerns in their lives. Some veterans can no longer work because of cognitive deficits, others have PTSD and/or other mental illnesses, and at least one veteran now spends most of his time in a wheelchair.

Some veterans whose loved ones participated in this interview have suffered the "common stressors" the military anticipates post-deployment, including anger, irritability, flashback and sleeplessness. In these cases participants stated that although often their troops end up without long-term readjustment issues, in the short-term, those common psychosocial stressors can be equally as devastating (e.g., relationships issues, substance abuse, financial problems, etc.).

The findings from this study were organized into four themes and presented above. The following chapter will discuss the relevance of the study's findings to the previously reviewed literature and how those findings might impact social work practice.

CHAPTER V

DISCUSSION

This qualitative study explores the readjustment issues and stressors experienced by veterans of the wars in Iraq and Afghanistan from the perspective of loved ones. A review of the literature on veterans' experiences is vast; however there is little literature that discusses the stressors from the perspective of a loved one. In this study, several issues faced by veterans throughout the entire deployment process were continually noted. These included the "common" stress reactions outlined in the VA's Iraq War Clinician Guide (2004): nightmares, flashbacks, anger, nervousness, feelings of guilt or shame, sadness, agitation/irritability, hopelessness, mental illnesses, and the stigma that surround these disorders.

This chapter will relate the findings of the research study to the literature reviewed. Many of the key findings support the literature, some do not, but most all of the narrative data was illuminated by the open-ended interview design. Four separate themes emerged, and in some cases, were further divided into sub-themes. These themes were: (a) The Communications of War, (b) Dilemmas with the Military, (c) War and the Family, and (d) The Consequences of War. The findings will be discussed throughout the following sections of this chapter: 1) Major Findings, 2) Social Work Practice Implications, 3) Limitations, and 4) Research Implications.

Major Findings

Loved ones in this study continually shared that their veterans of the wars in Iraq and Afghanistan are experiencing or have experienced, stressors and readjustment issues throughout the deployment process. Specifically, issues related to mental illness (including PTSD, depression and anxiety) and their stigma, relationship problems, unemployment, financial concerns, problems with the military (including command leadership and inadequate training), and red tape with the VA were mentioned. A discussion of these findings follows.

The Communications of War

There are many complicated communications adjustments that troops and their loved ones must adapt to during war time. The study supported the theory that the content and emotion of communications between troops and their loved ones prior to, during and following deployments causes disquietude and heartache on both sides. This was supported in the writings of McNulty (2005) and Hochlan (2004), which mentioned that troops' emotional withdrawal and inability or unwillingness to communicate often impacted their mental health and increased psychosocial stressors (e.g., relationship problems, substance use and unemployment).

Another finding from the study was related to troops and family members sharing stressful news during a deployment. A 2005 study by McNulty with Active-Duty Navy service members concluded that during deployment "the immediate stress of the family becomes the immediate stress of the active duty member" (p. 534). The author attributed this stress to the immediacy and availability of email and phone service in Iraq and Afghanistan, enabling troops to be in closer touch with loved ones. In this particular

study however, findings indicated that participants adhered to the military's request to keep bad news from their soldiers, and as a result loved ones mentioned how difficult it was not to share the "full" stories of what was happening at home. Study participants also said that though their troops did not generally tell their loved ones upsetting news during deployment, the soldiers still worried about what was happening at home and were anxious about their families.

Dilemmas with the Military

Though the emotions that accompanied issues related to inadequate training and command leadership were studied by the Mental Health Advisory Team report (2005), there was little other mention of them in the literature. This study's findings though, clearly highlighted the anger, uncertainty and fear experienced by troops due to their concerns about a lack of leadership and preparedness in battle. These feelings added stress to the troops' already high anxiety levels from being in a combat environment.

Because all but one of the study's participants discussed a veteran who was a National Guard or Reserve member, these findings need to be understood within the context of this population. However, considering that half of the troops deployed to OIF and OEF are Reserve component service members, the study's findings indicate a level of anxiety that could be better controlled by the military if all troops (National Guard, Reserve and Active Duty), as well as command leadership, were adequately trained for missions.

This study's findings indicate that the stigma of PTSD and other mental disorders continue to be a detrimental factor in veterans' acknowledging their mental illness and in seeking treatment for it. These findings correspond with the perception that receiving

treatment for PTSD will negatively impact both interactions with troops and the veterans' careers cited in literature from Kudler & Straits-Tröster (2009), C.H. Warner et al (2009), and the VA National Center for PTSD (2008). Although the military has been making efforts to help remove the stigma of mental illness, this study's findings show that these efforts have not trickled down effectively to the veterans of OIF and OEF. This is concerning as it indicates that a segment of troops and veterans who might benefit from mental health treatment are not receiving it for fear of negative consequences. This neglected treatment could lead to prolonged suffering, worse outcomes and increased psychosocial stressors that impact both veterans and their family members.

Kudler & Straits-Tröster (2009) and Ginzburg & Holm (200) addressed the difficulties troops have experienced trying to secure medical insurance coverage and disability benefits, and in filing medical claims. The study's findings though, demonstrated the human toll suffered by loved ones and their veterans as they tried to navigate the VA's paperwork and regulations. The findings also highlighted how a delay in receiving a medical benefit like disability can negatively impact a veteran and his family in terms of physical and mental health, psychosocial issues (e.g., financial problems, marital issues, substance use, unemployment, etc.).

Another finding from the study that was not found in the literature concerned veterans' and participants' mistrust of certain medical examinations and testing routines at the VA, particularly for traumatic brain injuries. In most cases the study participants were the caretakers for their veterans and had firsthand experience with the VA in seeking services post-deployment. Many of the participants indicated that they did not know the extent of their veterans' injuries or did not trust the VA's diagnoses months

(and sometimes years) post-deployment. Often this was either because the participants had disagreements with the VA regarding their veterans' injuries; the subject matter was almost always whether their veteran was actually suffering from a TBI or "only" the PTSD with which they had been diagnosed. In any case, the confusion and concerns about the VA that participants mentioned in the study's findings were another cause of ongoing stress for veterans and their loved ones. This indicates a need for the VA to streamline paperwork for returning troops of OIF and OEF and simplify the language and processes for caregivers and veterans; without this consideration, troops will continue to face the added stress that accompanies their physical, mental and psychosocial concerns.

War and the Family

Literature from Rabb, Baumer & Wiesler (1993) stated that "service members are trained to be effective soldiers, but very little training is provided to service members or their families on the wartime stresses they face" (p. 441). This study's findings concurred with this observation as many participants mentioned how challenging and anxiety-provoking deployment and post-deployment were for them and their veterans. Literature from Jensen, Martin & Watanabe (1996), Kelley (1994), Medway, Davis, Cafferty, Chappell et al (1995), and Pierce, Vinokur & Buck (1998) on families, noted that deployments are associated with less family cohesion and nurturance, more spousal emotional distress and depression and more child behavior problems.

The study's findings showed that veterans were usually happy to return home but often had mixed feelings about leaving the adrenaline of battle and the camaraderie of their units. Buck (2009) describes soldiers returning from combat with hair-trigger emotions and an inability to cope with the everyday challenges of civilian life.

Participants in the study spelled out what these emotions meant to them and their families: Months of arguments, silences, emotional withdrawal and in some cases, diagnosable mental illnesses that were left untreated. Though the literature mentioned these issues, the volatile dynamics of re-integrating a soldier back into the family fold were more clearly defined in the words and emotions of this study's participants who lived through the experience with their veterans. This human emotion was not represented in the literature, but might better point to what resources should be available for all military families (particularly National Guard and Reserve members) during and post-deployment to address problems quickly and ensure that they do not become chronic.

Although the VA National Center for PTSD (2004) mentioned that returning service members may feel disconnected or detached from their partners or families post-deployment, findings from the study's participants further demonstrated the impact of this detachment on personal relationships. In many cases, wives in the study expressed surprise at how negatively their marriages were impacted by their husbands' combat experiences, and grew troubled about how to cope with the distance and tension in their lives. These women also shared that their husbands' detachment caused heartache for their children, as the kids often did not understand the circumstances of their fathers' silences or stormy moods.

Although the government acknowledges the sacrifices made by its military families, and it is covered in the literature, neither adequately demonstrates the sadness expressed by the loved ones in this study regarding their troops' readjustment home post-deployment. The findings help to further describe what may be the unexpected part of a

soldier's welcome home, which may help other military families who anticipated only happy returns. This study's participants – nearly all loved ones of National Guard and Reserve members – represent the 50 percent of families whose troops are also serving in OIF and OEF, which signals the need for more services for these families to address the stressors of post-deployment.

Consequences of War

Most of the participants in the study indicated that their veterans were suffering from mental illnesses, particularly PTSD and depression. This finding echoes a great deal of literature, but in particular data from Hoge, Castro et al (2004) indicating that between 20% and 30% of U.S. military personnel returning from Iraq report significant psychological symptoms, and findings from a RAND Corporation report (Rivera, 2008) stating that 300,000 returning troops are estimated to be suffering from major depression or PTSD. Because nearly all of the loved ones in the study discussed veterans who were members of the National Guard and Reserves, it also bears noting literature from Miliken, Auchterlonie & Hoge (2007) on the mental health outcomes of a cohort of these troops compared to Active Duty soldiers. In the study, nearly 43% of Reserve component troops required mental health treatment after returning from Iraq compared to 20% of their Active Duty counterparts.

The literature also addresses some of the psychosocial stressors faced by veterans post-deployment, but findings from this study demonstrate how deeply issues such as unemployment, substance use and financial problems can impact troops and their loved ones. One participant's husband returned from Iraq with a titanium plate in his neck, and is wheelchair bound and unable to work. Because of his circumstances, her husband has

descended into a deep depression that has not been alleviated by any medical interventions; he considers his life meaningless because he can't provide for his family. The range of issues involved in this one participant's story, including physical and mental health issues and a range of psychosocial concerns, has upended life for the entire family. These findings demonstrate how all-encompassing the stressors and injuries of combat can be post-deployment, and how long they can impact everyone involved. It would follow that the VA's focus on early and continued intervention with veterans following deployment might catch some of these concerns before they seep into other aspects of veterans' personal and public lives.

Literature from Jacobson et al (2008) acknowledges the link between combat trauma and substance use and further identifies National Guard and Reserve combat troops in OIF and OEF as being more likely to develop drinking problems than Active Duty soldiers (p. 663). This study's findings did not back up the literature on this subject as none of the participants noted substance abuse as an issue for their veterans. Several of the participants did mention though, that had they not interceded and asked their spouse to see a therapist, they felt their veterans would have turned to alcohol or drugs.

Social Work Practice Implications

Nearly all of the participants in this study reported that their veterans experienced stressors and readjustment issues at some point during the deployment process. These problems were often psychological or psychosocial in nature, although some veterans had physical injuries that compounded these concerns. The research from this study pointed to some practical applications for civilian social workers who provide services to military service members and their families. Like any other population with whom clinicians

work, this study demonstrated that if clinicians work with members of the military and their families, it is imperative to learn about the particular concerns of the community. This involves not only gaining an understanding of how the military “works,” but how its red tape and delays impact the lives of veterans emotionally and physically. The study’s findings also provide data regarding the ongoing stigma of PTSD and other mental illnesses in the military, which civilian social workers should be aware of prior to working with this population.

Findings from this research also indicate that civilian social workers could play a role in assisting OIF and OEF veterans and their loved ones, particularly for National Guard and Reserve families, who often live far away from military bases and their health resources. Much like Jaine Darwin has done through her SOFAR network of clinicians, there are many families who still need outside assistance from civilian social workers. In part, this is because many troops and veterans who may want or need mental health care may not wish to seek it through the military due to the stigma surrounding PTSD, depression and other mental health disorders.

Also, because this study was conducted in Vermont, the researcher noted that providing individual, couples and family therapy, along with support groups in similarly rural states (where a high percentage of National Guard and Reserve members live), is an opportunity for social workers to help military members and their loved ones. As a rule, children of Guard and Reserve members have few peers with deployed parents (unlike those of Active Duty members who live on or near bases), so children might also benefit from support groups or activities run by civilian social workers.

Limitations

The aim of this research project was to explore and document the stressors and readjustments of veterans of the wars in Iraq and Afghanistan, from their loved ones' perspective. It was hoped that this research might be of use in future studies on veterans of OIF and OEF, as the two current wars continue unabated. In order to gather narrative data, this study employed a qualitative design with open-ended interview questions as a means to better understand the participants' subjective experiences. This method was chosen to gain information in the words of loved ones regarding their veterans, and not solely through the available literature.

The limitations of this research were that the sample size was small (n=12), racially homogenous (all participants were Caucasian), geographically centered in Vermont, and participants were almost exclusively the loved ones of Army National Guard members. Future research would benefit from a larger and more diverse sample, and a younger participant pool. Future research that also examines a larger group of loved ones of Active Duty military versus National Guard and Reserve troops would also be of interest, as current literature suggests the two groups may differ markedly in their rates of mental illness and resilience in battle. This is evidenced in articles by Miliken, Auchterlonie & Hoge (2007), The Mental Health Advisory Team (2006), and Hoge, Castro, Messer, McGurk, Cotting, & Koffman (2004). Additionally, research on loved ones whose veterans have experienced few readjustment issues post-deployment might provide further data on how those veterans have gained resilience.

All but one of the participants in this study has a veteran who is or was a National Guard or Reserve member; this fact eliminated any meaningful analysis between these

troops and Active Duty soldiers. Also, many of the participants in the study discussed veterans who are middle-aged; therefore, the study's findings might not be reflected in outcomes for younger troops.

Also, it is not known what compelled loved ones to participate in this study and how their motivations may have differed from those who chose not to take part.

Participants may have been drawn to the study because their veterans had a difficult deployment and transition home post-deployment, and they wanted to express their feelings toward the VA or the military by speaking up. Other potential participants whose veterans had less difficult deployments followed by relatively easy adjustments might not have felt compelled to participate in a study of this kind.

Additionally, at the time of this study, the researcher was a graduate intern in social work and mental health at the VA in Vermont, which may have created some biases regarding the data analysis of psychosocial and psychological stressors of veterans. The researcher took precautions as required to maintain neutrality throughout the study.

Research Implications

The researcher's use of a qualitative design with open-ended interview questions in this study provides insight from 12 loved ones of veterans of the wars in Iraq and Afghanistan. Though there is a great deal of literature on the experiences of war veterans, there is very little on them from their loved ones' perspectives. The research methodology added depth to the study and illuminated the quantitative results explored through the literature review. This allowed the participants and their veterans to "come to life" in a way not possible through the literature alone. Social work researchers may benefit from the "real-world" findings garnered from this study's interviews, a

methodology of which Anastas (1999) noted is “helpful in gaining subjective experiences, such as motivations, feelings, meanings and interpretations, and memories of events from the past...(p. 351).”

The research also strongly indicates that loved ones of veterans possess important information about issues related to the deployment process, particularly related to the mental and physical health of their troops and the often difficult path through VA medical and disability services. This study’s data would suggest that loved ones are a key point of entry for the VA (for mental, physical and psychosocial treatment and services, and medical benefits), particularly when their veterans are faced with complicated readjustments post-deployment. Findings from this study may lead to further research on the ease of veterans’ access to VA facilities across the country.

Conclusion

Although its sample size is small (n=12), this study provides useful data regarding the stressors and readjustment issues experienced by veterans of the wars in Iraq and Afghanistan from their loved ones’ perspectives. Through the narratives of wives, mothers and fathers of the troops, the deployment experiences of soldiers and their families are revealed. As a result, social workers may gain a greater understanding of the impact of the ongoing wars on the veterans of its battlefields.

Through this study, it was learned that members of the military and their families speak a secret language during deployments that is devoid of bad news from either side. This communications vacuum is often difficult to fill when troops return home to spouses and children, sometimes leading to relationship problems. The study’s findings also showed that while some veterans are grappling with psychosocial issues like

unemployment, financial concerns and relationship problems, they and their loved ones are often stymied by the inaccessibility of many of the VA's benefits and programs. The study revealed the continuing stigma of PTSD in the military and how its members fear being labeled weak; they also consider seeking treatment a risk to their military careers and relationships.

In addition to sharing their perspectives on their veterans, loved ones in this study discussed their own stressors and readjustment issues throughout the deployment process. This data was important in understanding the role of partners and families when a soldier is at war. The open-ended questions allowed the researcher to gain greater clarification from participants and to observe their emotions during the interviews. In this way, much of the literature was more fully realized and additional concerns of the loved ones could be noted.

Due to the ongoing mental and psychosocial stressors faced by the veterans of the wars in Iraq and Afghanistan, this study indicates a role for civilian social workers in assisting these troops and their families. And though we owe our experience as social workers to all members of the military, in particular it is important to remember and reach out to the National Guard and Reserve soldiers who make up half of the troops deployed with OIF and OEF. This study's findings demonstrate that it is this group who may suffer just as much or more than their Active-Duty counterparts but lack the preparedness or resources to overcome their difficulties. We as a nation owe all of our veterans and their families – whether Reserve component or Active Duty – every resource available to counteract the stressors and readjustment issues resulting from deployment to a war zone.

References

- Alvarez, L. & Sontag, D. (2008, February 15). When strains on military families turn deadly. *The New York Times*. Downloaded October 10, 2008 from www.nytimes.com.
- Amen, D., Jellen, I., Merves, E. & Lee, R. (1988). Minimizing the impact of deployment separation on military children: stages, current preventative efforts, and system recommendations. *Military Medicine*, 153, pp. 441-446.
- American Academy of Child and Adolescent Psychiatry. (2004). Families in the military. Downloaded March 19, 2009 from http://www.aacap.org/cs/root/facts_for_families/families_in_the_military.
- Anastas, J. (1999). *Research Design for Social Work and the Human Services*. New York: Columbia University Press.
- Basham, K. (2008). Homecoming as a safe haven or the new front: Attachment and detachment in military couples. *Clinical Social Work Journal Issue on Attachment* 36(1), pp. 83-96.
- Basham, K. (2008). Trauma theories. In J. Berzoff, L.M. Flanagan & P. Hertz (Eds.), *Inside Out and Outside In: Psychodynamic Clinical Theory and Psychopathology in Contemporary Multi-Cultural Contexts* (pp. 411-441). Lanham, MD: Jason Aronson.
- Batten, S. & Pollack, S. (2008). Integrative outpatient treatment for returning service members. *Journal of Clinical Psychology*, 64(8), pp. 928-939.
- Boyatzis, R.E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, CA: Sage.
- Browne, T., Hull, L., Horn, O., Jones, M., Murphy, D., Fear, N. et al (2007). Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *British Journal of Psychiatry*, 190, pp. 484-489.
- Buck, R. (2009). Healing vets: A new breed of counselor. *The Hartford Courant*, February 22, 2009, pp. A1 and A6.
- Durand, D. (2006). Army wife, army mother. In C. Castro, A. Adler & B. Thomas (Eds.), *Military Life: The Psychology of Serving in Peace and Combat* (pp. 3-10). Westport, CT: Praeger Security International.

- Eaton, K., Hoge, C., Messer, S., Whitt, A., Cabrera, O., McGurk, D. et al. (2008). Prevalence of mental health problems, treatment need, and barriers to care among primary care-seeking spouses of military service members involved in Iraq and Afghanistan deployments. *Military Medicine*, 173(11), pp. 1051-1056.
- Elias, M. (2009). Iraq war takes toll on National Guard. Downloaded from *USA Today* February 1, 2009 from <http://usatoday.com>.
- Faber, A.J., Willerton, E., Clymer, S.R., MacDermid, S.M. & Weiss, H.M. (2008). Ambiguous absence, ambiguous presence: A qualitative study of military reserve families in wartime. *Journal of Family Psychiatry*, 22(2), pp. 222-230.
- Fairbank, J., McCaffrey, R. & Keane, T. (1985). Psychometric detection of fabricated symptoms of posttraumatic stress disorder. *American Journal of Psychiatry*, 142(4), pp. 501-503.
- Fairbank, J., Keane, T. & Molloy, P. (1983). Some preliminary data on the psychological characteristics of Vietnam veterans with posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology*, 51(6), pp. 912-919.
- Fals-Stewart, W. & Kelley, M. (2005). When family members go to war – A systemic perspective on harm and healing: Comment on Dirkwager, Bramsen, Adèr and van der Ploeg (2005). *Journal of Family Psychology*, 19(2), pp. 233-236.
- Family Readiness Through Education on Deployment. (2008). New emotional cycles of deployment: For service members and their families. Downloaded March 30, 2009 from <http://deploymenthealthlibrary.com>.
- Friedman, M., Schnurr, P. & McDonagh-Coyle, A. (1994). Post-traumatic stress disorder in the military veteran. *Post-Traumatic Stress Disorder*, 17(2).
- Ginzburg, H. & Holm, C. (2009). The struggle for DoD/VA benefits. *Psychiatric Annals*, 39(2), pp. 71-77.
- Glod, M. (2008). Coping with their parents' war. *Washingtonpost.com*. Downloaded October 5, 2008 from <http://www.giveanhour.org/skins/gah/display.aspx>
- Goff, B., Crow, J., Reisberg, A. & Hamilton, S. (2007). The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *Journal of Family Psychiatry*, 21(3), pp. 344-353.
- Gore, A. (1990). Public policy and the homeless. *American Psychologist*, 45(8), pp. 960-962.

- Green, B., Grace, M., Lindy, J., et al (1990). Risk factors for PTSD and other diagnoses in a general sample of Vietnam veterans. *American Journal of Psychiatry*, 147(6), pp. 729-733.
- Helzer, Robbins & McEvoy. (1987). Post-traumatic stress disorder in the general population: Findings of the epidemiologic catchment survey. *New England Journal of Medicine*, 317(26), pp. 1630-1634.
- Hochlan, J. (2004). The 7 stages of the emotional cycle of deployment. *LIFELines*, December 21, 2004. Downloaded March 12, 2009 from <http://www.armywivesforums.com/forumsshowthread.php?t=43910>.
- Hoge, C., Clark, J. & Castro, C. (2007). Commentary: Women in combat and the risk of posttraumatic stress disorder and depression. *International Journal of Epidemiology*, 36, pp. 327-329.
- Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D. & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems and barriers to care. *New England Journal of Medicine*, 35, pp 13-22.
- Humphreys, K. & Rosenheck, R. (1998). Treatment involvement and outcomes for four subtypes of homeless veterans. *American Journal of Orthopsychiatry*, 68(2), pp. 285-294.
- Jacobson, I., Ryan, M. & Hooper, T. (2008). Alcohol use and alcohol-related problems before and after military combat deployment. *JAMA*, 300(6), pp. 663-675.
- Jelinek, P. (2009). Officials: Army suicides at 3-decade high. Downloaded January 29, 2009 from http://www.militarytimes.com/news/2009/01/ap_army_suicides_012909/.
- Jensen, P., Martin, D. & Watanabe, H. (1996). Children's response to parental separation during Operation Desert Storm. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, pp. 433-441.
- Jordan, K., Schlenger, W., Hough, R., Kulka, R., Weiss, D., Fairbank, J., et al. (1991). Lifetime and current prevalence of specific psychiatric disorders among Vietnam veterans and controls. *Archives of General Psychiatry*, 48(3), pp. 207-215.
- Kardiner, A. & Spiegel, H. (1947). *War Stress and Neurotic Illness*. New York, Paul Hoeber.
- Kaufman, L. (2008, April, 6). After war, love can be a battlefield. *The New York Times*. Downloaded October 8, 2008 from <http://www.nytimes.com/2008/04/06/fashion/06marriage.html?>

- Kelley, M. (1994). The effects of military-induced separation on family factors of child behavior. *American Journal of Orthopsychiatry*, 64(1), pp. 103-111.
- Kessler, R., Sonnega, A., Bromet, E., Hughes, M. & et al. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52(12), pp. 1048-1060.
- Knapp, T. & Newman, S. (1993). Variables related to the psychological well being of Army wives during the stress of an extended military separation. *Military Medicine*, 158(2), pp. 77-80.
- Kubetin, A. (2008). SOFAR focuses on military families. *Clinical Psychiatry News*, 36(8), pp. 1-3.
- Kudler, H. & Straits-Tröster, K. (2009). Partnering in support of war zone veterans and their families. *Psychiatric Annals*, 39(2), pp. 64-70.
- Lincoln, A., Swift, E. & Shorteno-Fraser, M. (2008). Psychological adjustment and treatment of children and families with parents deployed in military combat. *Journal of Clinical Psychology*, 64(8), pp. 984-992.
- Litz, B. & Orsillo, S. (2004). The returning veteran of the Iraq War: Background issues and assessment guidelines. *Iraq War Clinician Guide*. National Center for PTSD, Department of Veterans Affairs.
- Martin, J. & Ickovics, J. (1987). The effects of stress on the psychological well-being of army wives: The initial findings from a longitudinal study. *Journal of Human Stress*, 13(3), pp. 108-115.
- McCubbin, H. & Dahl, B. (1976). Prolonged family separation in the military: A longitudinal study. *Families in the Military System*, pp. 112-144. Newbury Park, CA: Sage Publications.
- McNulty, P. (2005). Reported stressors and health care needs of active duty navy personnel during three phases of deployment in support of the war in Iraq. *Military Medicine*, 170(6), pp. 530-535.
- McNulty, P. (2003). Does deployment impact the health care use of military families stationed in Okinawa, Japan? *Military Medicine*, 168(6), pp. 465-470.
- Medway, F., Davis, K., Cafferty, T., Chappell, K., et al. (1995). Family disruption and adult attachment correlates of spouse and child reactions to separation and reunion due to Operation Desert Storm. *Journal of Social and Clinical Psychology*, 14(2), pp. 97-118.

- Mental Health Advisory Team. (2006, November 17). *Report from Operation Iraqi Freedom*. Downloaded February 7, 2009 from <http://www.armymedicine.army.mil>.
- Milliken, C., Auchterlonie, J. & Hoge, C. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. *JAMA*, 298(18), pp. 2141-2148.
- Nice, S., McDonald, B. & McMillian, T. (1981). The families of U.S. Navy prisoners of war from Vietnam five years after reunion. *Journal of Marriage & the Family*, 43(2), pp. 431-437.
- Paulus, P., Nagar, D., Larey, T. & Camacho, L. (1996). Environmental, lifestyle, and psychological factors in the health and well-being of military families. *Journal of Applied Social Psychology*, 26(23), pp. 2053-2075.
- Pierce, P., Vinokur, A. & Buck, C. (1998). Effects of war-induced maternal separation on children's adjustment during the Gulf War and two years later. *Journal of Applied Social Psychology*, 28(14), pp. 1286-1311.
- Prigerson, H., Maciejewski, P. & Rosenheck, R. (2002). Population attributable fractions of psychiatric disorders and behavior outcomes with combat exposure among U.S. men. *American Journal of Public Health*, 92(1), pp. 59-63.
- Rabb, D., Baumer, R. & Wieseler. (1993). Counseling army reservists and their families during Operation Desert Shield/Storm. *Community Mental Health Journal*, 29(5), pp. 441-447.
- Richards, S.M. (2008, October 26). For some in the military, danger is seen off duty, too. *The New York Times*, pp. A1 and A18.
- Rivera, P. (2008). State must provide treatment for post-traumatic stress. *Buffalo News*. Downloaded July 19, 2008 from <http://www.buffalonews.com/149/story/395068.html#>
- Rosen, L., Moghadam, L. & Vaitkus, M. (1989). The military family's influence on soldiers' personal morale: A path analytic model. *Military Psychology*, 1(4), pp. 201-213.
- Rosen, L. & Moghadam, L. (1988). Social support, family separation, and well-being among military wives. *Behavioral Medicine*, 14(2), pp. 64-70.

- Rosenheck, R., Becnel, H., Blank, A., Farley, F., Fontana, A., Friedman, M., et al. (1992). *Returning Persian Gulf troops: First year findings*, VA Northeast Program Evaluation Center (NEPEC), The Evaluation Division of the National Center for PTSD. West Haven, CT: Veterans Affairs Medical Center.
- Thompson, C. (2008, July 7). Special court for veterans addresses more than crime. *The Boston Globe*, *The Nation*, p. A7.
- Uniformed Services University of the Health Sciences. (2008). Advancing the health of the family left behind. Courage to Care fact sheet. Downloaded from USUHS on March 1, 2009 at www.usuhs.mil.
- United States Department of Veterans Affairs. Vet Center Home Page. Downloaded October 26, 2008 from http://www.vetcenter.va.gov/Vet_Center_Services.asp.
- United States Department of Veterans Affairs, National Center for PTSD. (2008). Returning from the war zone: A guide for military personnel. Retrieved October 10, 2008 from www.ncptsd.va.gov.
- United States Department of Veterans Affairs, National Center for PTSD. (2008). Returning from the war zone: A guide for families of military members, pp. 1-11.
- United States Department of Veterans Affairs, National Center for PTSD. (2008). *Iraq War Clinician Guide*. Retrieved November 15, 2008 from http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/iraq_clinician_guide_v2.pdf.
- United States Department of Veteran Affairs. (2008). OEF/OIF veterans' statistics. *Strategic Goals pamphlet*, February, 2008.
- Ursano, R., Holloway, H., Jones, D., Rodriguez, A. (1989). Psychiatric care in the military community: Family and military stressors. *Hospital & Community Psychiatry*, 40(12), pp. 1284-1289.
- Walter Reed Army Institute of Research. (2009). WRAIR – Department of Military Psychiatry Training Opportunities. Downloaded on March 30, 2009 from http://wrair-www.army.mil/Psychiatry-and-Neuroscience/wrair_domp_train.htm
- Warner, C.H., Appenzeller, G., Warner, C.M. & Grieger, T. (2009). Psychological effects of deployment on military families. *Psychiatric Annals*, 39(2), pp. 56-63.
- Wexler, H. & McGrath, E. (1991). Family member stress reactions to military involvement separation. *Psychotherapy*. 28(3), pp. 515-519.

- Whealin, J. & Pivar, I. (2004). Coping when a family member has been called to war. *National Center for PTSD Fact Sheet*. Downloaded March 7, 2009 from http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/familycoping.html?opm=1&rr=rr116&srt=d&echorr=true
- Winerip, M. (2008). Guard families fight war of their own. *The New York Times*. Retrieved October 2, 2008 from <http://www.nytimes.com/2008/10/05/nyregion/new-jersey/05parent.html>.
- Wright, K.M., Huffman, A.H., Adler, A.B., & Castro, C.A. (2002). Psychological screening program overview. *Military Medicine*, 167(10), pp. 853-861.
- Yerkes, S. & Holloway, H. (1996). War and homecomings: The stressors of war and returning from war. In R. Uranso & A. Norwood (Eds.), *Emotional aftermath of the Persian Gulf War*, (pp. 25-42). Washington, DC: American Psychiatric Press.

APPENDIX A

INFORMED CONSENT FORM

Dear Loved One of a Veteran of the Wars in Iraq and Afghanistan:

My name is Karen McGinty, and I am an MSW candidate at Smith College School for Social Work. I am conducting a research study as part of my thesis project and for possible future presentation and publication. The focus of my research is to explore the deployment and readjustment process of veterans of the wars in Iraq or Afghanistan from your perspective, as that of a loved one.

Participation involves completing a confidential questionnaire. To participate, you must be 18 years old or above, be fluent in English and have a loved one who has been deployed at least once to Iraq or Afghanistan. The questionnaire will take approximately 30 – 60 minutes to complete. Participants can choose to complete the questionnaire through email, by a phone interview, or face-to-face at a public place convenient to you and I.

Possible risks from participating in this study may include some uncomfortable feelings in response to some of the interview questions. In the event that this occurs, I recommend that you consult the enclosed referral list that includes supportive resources specific to the needs of being a loved one of a veteran of the Iraq and Afghanistan wars.

Your participation in this study would add knowledge to the field of social work about the stressors experienced by soldiers and veterans, but from your unique vantage point of being a loved one. Your efforts would allow many professionals to better understand their clients and to provide more effective therapy for troops and their families. You may also gain a different perspective on what your loved one has experienced which could help you cope through having a loved one who has served in the military during a time of conflict. Compensation will not be provided in exchange for participation in this study.

The information that you provide will be handled with sensitivity and the highest level of confidentiality. Those who have access to the interview data are my research advisor and I. All identifying material will be carefully disguised or omitted. Confidentiality will also be maintained in any publications that may result from this research. If brief quotes or vignettes are used, they will be carefully disguised. All electronic data will be put into hard copies then destroyed. All of the actual hard copy data will be safeguarded in a locked environment for a period of three years, as required by Federal guidelines. After the three years, all data will be destroyed when no longer needed.

Your participation in this study is voluntary and you may refuse to answer any of the questions. You may also choose to withdraw your involvement in this study at any

point prior to April 20, 2009. If you choose to withdraw, please let me know, and all materials pertaining to you will be immediately destroyed. Please feel free to contact me with any questions. I am best reached by email at kmcginty@smith.edu or by phone at (802) 728-4777. If you have any concerns about your rights or about any aspect of the study, you are encouraged to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. ADDITIONALLY, I SUGGEST THAT YOU KEEP A COPY OF THIS CONSENT LETTER FOR YOUR PERSONAL FILES.

Sincerely,

Karen McGinty

Signature of Participant: _____

Date: _____

Signature of Researcher: _____

Date: _____

APPENDIX B
INTERVIEW GUIDE

General Questions:

1. Does your loved one have children? Yes _____ No _____. If yes, how many and what are their ages?
2. What branch of the military is/was your loved one in? Are/were they Active Duty or National Guard or Reserve troops?
3. To which country was your loved one deployed? Iraq _____ Afghanistan _____ Both _____.
4. How many times has your loved one been deployed? 1, 2, 3, 4+
5. How long were each of your loved one's deployments? 0 – 3 months, 4-6 months, 7 – 9 months, 10 – 12 months, 13 – 18 months, 19 – 24 months, over 24 months?

Pre-Deployment:

6. How did your loved one prepare mentally for his or her deployment(s)?
7. What was most helpful to your loved one during the transition to deployment? (e.g., other family and friends, other military spouses, VA resources, religion, etc.)

Deployment:

8. What was the most difficult thing for your loved one to adjust to when he or she left for Iraq/Afghanistan?
9. What types of stressors do you believe that he or she experienced while in Iraq/Afghanistan?

10. What types of stressors did he or she share with you during the time of deployment to Iraq/Afghanistan?

Post-Deployment:

11. How did your loved one prepare mentally to return home following deployment?

12. What was the most difficult thing for your loved one to adjust to after finding out he or she would be returning home?

Returning Home:

13. Did your loved one have any problems readjusting to civilian life post-deployment? If so, what were some of those problems? If not, what helped him/her to readjust?

14. What was most difficult thing about your loved one's readjustment back to the civilian world?

15. Do you feel like your loved one was changed in some way because of his/her experience during deployment? If so, how?

16. Please describe any stressors experienced by your loved one in the following areas of his or her life:

- Family relationships (spouse/partner, children, parents, siblings, etc)?
- Education or Employment?
- Finances?
- Legal Issues?
- Accessing Military Resources?
- Physical Health?
- Mental Health?

- Substance Use?

17. How has your loved one coped with returning home? What has helped? Is there anything that he or she has used to cope that has not helped?

18. Has your loved one been diagnosed with (check all that apply):

PTSD, Depression, Substance Abuse/Dependence,

TBI, Physical Disability If so, is he/she receiving mental or physical health care for those conditions?

19. On a scale of 0 – 5 with **5** being the MOST stressful, how stressful was your loved ones return from deployment and his/her readjustment back to you and your family?

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

20. If there is anything you would like to mention that hasn't already been asked or discussed, please feel free to do so.

APPENDIX C.1
RESOURCE LIST
VERMONT PARTICIPANTS

VA 24/7 Toll Free Hotline
Toll Free 866-687-8387
(866-OUR-VETS)
Local Phone: (802) 295-9363

Veterans Affairs Medical Center
215 North Main Street
White River Junction, VT 05009-0001
Toll-Free: (866) OUR-VETS
Phone: (802) 295-9363

South Burlington Vet Center
359 Dorset St.
South Burlington, VT 05403
Phone: (802) 862-1806

White River Junction Vet Center
Gilman Office Building #2
222 Holiday Inn Drive
White River Junction, VT 05001
Phone: (802) 295-2908

VA Outpatient Clinic at Fort Ethan Allen
162 Hegeman Ave., Unit 100
Colchester, VT 05446
Phone: (802) 655-1356

VA Bennington CBOC
186 North Street
Bennington, VT 05201
Phone:(802) 447-6913

VA Rutland CBOC
215 Stratton Road
Rutland, VT 05702
Phone:(802) 770-6713

Behavioral Health Network of Vermont
155 Elm Street
Montpelier, VT 05602
Phone: (802) 262-6124

Clara Martin Center
Covering Randolph, Chelsea, Bradford & Wilder, VT
11 Main Street
Randolph, VT 05060
Phone: (802) 728-4466
Emergency: (800) 639-6360

Counseling Service of Addison County
10 Main Street
Middlebury, VT 05753
Phone: (802) 388-7641 (24-hour emergency services)

Health Care & Rehabilitation Services
Locations in Springfield, Brattleboro, Bellows Falls, Windsor & Hartford, VT
HCRS Connection (for service or information)
Phone: (888)-888-5144
Connection@hcrs.org
Crisis/Emergency 24-Hour Hotline: (800)-622-4235

Howard Center
855 Pine Street
Burlington, VT 05401
Phone: 802-488-6000

Lamoille County Mental Health
520 Washington Highway
Morrisville, VT 05661
Phone: (802) 888-6627
Emergency Services: (802) 888-6627
After Hours Phone: (802) 283-0957

NAMI Vermont (National Alliance on Mental Illness)
132 South Main Street
Waterbury, VT 05676-1519
Phone: 802-244-1396
Toll-free: 800-639-6480 (Statewide)

North American Family Institute
(Programs focused on children and families throughout Vermont)
30 Airport Road
South Burlington, VT 05403
chuckmyers@nafi.com
Phone: (802) 658-3924

Northeast Kingdom Human Services (Newport)
154 Duchess Avenue
P.O. Box 724
Newport, VT 05855
Phone: (802) 334-6744
Phone: (800) 696-4979

Northeast Kingdom Human Services (St. Johnsbury)
2225 Portland Street
P.O. Box 368
St. Johnsbury, Vt. 05819
(802) 748-3181
(800) 649-0118

Northshire United Counseling Services
Stephen C. Lundy Building
5312 Main Street
Manchester, VT 05255
Phone: (802) 362-3950

Northwestern Counseling & Support Services
107 Fisher Pond Road
St. Albans, VT 05478
Phone: (802) 524-6554

Rutland Mental Health Services
Phone: (802)-775-2381
Emergency Services: (802)-775-1000

United Counseling Services of Bennington County
100 Ledge Hill Drive
Bennington, VT 05201
Phone: (802) 442-5491

Vermont Association for Mental Health (VAMH)
P.O. Box 165
Montpelier, VT 05601

Phone: 802-223-6263
Toll-free: 800-639-4052

Washington County Mental Health Services
P.O. Box 647
Montpelier, VT 05601-0647
(802) 229-0591

Give an Hour
Barbara V. Romberg, Ph.D
Founder and President
PO Box 5918
Bethesda, MD USA 20824-5918
info@giveanhour.org

SOFAR Strategic Outreach to Families of All Reservists
A Program of the Psychoanalytic Couple and Family Institute of New England (PCFINE)

PCFINE
P.O. Box 920781, Needham, MA 02492
Tel: 617-266-2611
Fax: 781-433-0510
E-mail: help@SOFARUSA.org
Website: www.sofarusa.org

SOFARUSA information: 1 888 278-0041
PO Box 380766
Cambridge, MA 02238
SOFARMichigan: 1-877-54 SOFAR
SOFARNY 212-561-6702 | SOFARNY@gmail.com
SOFAR Massachusetts 617 266-2611 | help@sofarusa.org

APPENDIX C.2

RESOURCE LIST

OUT-OF-STATE PARTICIPANTS

Army Reserve Family Programs
Phone: (866) 345-8248 (Continental U.S.)
Phone: DSN 312-367-9701
Email: usarc_wfac@usar.army.mil
Website: <http://www.arfp.org/skins>

The Coming Home Project
1801 Bush Street, Suite 213
San Francisco, CA 94109
Phone: (415) 353-5363
Website: <http://www.cominghomeproject.net/ComingHome/>

Deployment Health Clinical Center
<http://www.pdhealth.mil/hss/smfss.asp>
Military.com
<http://www.military.com/>

Give an Hour
Barbara V. Romberg, Ph.D
Founder and President
PO Box 5918
Bethesda, MD USA 20824-5918
info@giveanhour.org

The Military Family Network
P.O. Box 16366
Pittsburgh, PA 15242
Phone: 1-866-205-2850
Website: <http://www.emilitary.org/index.html>

MilitaryOneSource.com
24/7 Response for Military Members, Spouses & Families
Phone: (800) 342-9647
Website: <http://www.militaryonesource.com/skins/MOS/home.aspx>

National Military Family Association (NMFA)
2500 North Van Dorn Street, Suite 102
Alexandria, VA 22302-1601

Phone: (800) 260-0218

Website: <http://www.nmfa.org/site/PageServer>

SOFAR Strategic Outreach to Families of All Reservists

A Program of the Psychoanalytic Couple and Family Institute of New England (PCFINE)

PCFINE

P.O. Box 920781, Needham, MA 02492

Tel: 617-266-2611

Fax: 781-433-0510

E-mail: help@SOFARUSA.org

Website: www.sofarusa.org

SOFARUSA information: 1 888 278-0041

PO Box 380766

Cambridge, MA 02238

SOFARMichigan: 1-877-54 SOFAR

SOFARNY 212-561-6702 | SOFARNY@gmail.com

SOFAR Massachusetts 617 266-2611 | help@sofarusa.org

Strong Bonds

<http://www.strongbonds.org/skins/strongbonds/display.aspx>

Veterans & Families Coming Home

Bobbi Park

Executive Director Volunteer

395 South Highway 65, Suite A #167

Lincoln, CA 95648

Phone: (916) 409-0462

Cell: (530) 388-8074

Email: bobbi@veteransandfamilies.org

Website: <http://www.veteransandfamilies.org/home.html>

U.S. Department of Veterans Affairs

National Center for PTSD

<http://www.ncptsd.va.gov/ncmain/index.jsp>

APPENDIX D

HSR APPROVAL LETTER

March 7, 2009

Karen McGinty

Dear Karen,

Your revised materials have been reviewed. You have done a very good job with what has really been a major task. We think you are very wise to focus on the loved ones. It will be very interesting to see what they think. One question: Do you think they will want to have something to say about how all this has been for them? You might want to add a couple of questions that give them a chance to talk about themselves. That, of course, is up to you. It is just a thought.

There are two things we are concerned about. First, we strongly advise students not to interview people in their homes. You have no idea what kind of situations you might find yourself in. Also, privacy and interruptions are problems. And you're on their turf. It's not neutral. Could you think of some other options?

The other change involves the Informed Consent. When you discuss risks, please delete the word "mildly." Talking about what their loved one has been through may well be a good deal more than mildly "uncomfortable"!

We are glad to give final approval to your study with the understanding that you will delete "mildly" and the offer of in home interviews. Just send the revised Consent to Laurie Wyman for your permanent file and she'll let me know.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting and timely project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Nora Padykula, Research Advisor