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Article 15

Military Spouses: The Overlooked, Underpaid, and Stressed-Out Casualties of War

Paper based on a program to be presented at the 2011 American Counseling Association Conference and Exposition, March 23-27, 2011, New Orleans, LA.

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When the average, non-military American thinks about the United States' conflicts in Iraq and Afghanistan, he or she generally associates the stressors and casualties of the wars with the active-duty service members. Rarely the spouses of those soldiers are taken into account when it comes to documenting the costs of military wartime service. There are almost 1.4 million Active Duty service members and 750,320 are married, which is more than half. As well as Active Duty service members, the military has Selected Reserve members, and of the nearly 900,000 Selected Military Reserve population, 426,296 are married as well. For the duration of this paper, the term military spouse is defined as a non-military female spouse due to the majority of spouses being female as well as the majority of the research completed on this topic also denotes military spouse as female. The effects of war are everlasting for military spouses.

Mounting responsibilities are thrust upon the spouses before the soldiers even deploy for war and do not end until well after their return. Even then, the spouse is unsure of the mental, emotional, or physical conditions in which her husband will return home, or if he will be the same man with whom she fell in love. Military spouses themselves are often beleaguered with mental health issues including anxiety disorders, depressive

disorders, and sleep disorders, to name a few. The majority of the mental health treatment services are focused on returning veterans. Spouses are frequently overlooked by the general public, possibly even the medical community, when it comes to receiving similar services for their issues that develop as a result of their husbands' deployment or uncertain future (Mansfield et al., 2010).

In a study of the frequency of mental health disorders, treatment of care, and barriers to care of spouses of deployed soldiers, Eaton et al. (2008) reported a mere 130 of 940 (13.8%) spouses surveyed received treatment from a mental health professional. Spouses of deployed soldiers reported barriers in seeking mental health care, including: "not knowing where to seek help, difficulty scheduling appointments, difficulty taking time off work or finding childcare, and the cost of mental health care" (p. 1054). Additionally, the stigma that soldier's face in seeking mental health services is shared by the spouse. It was reported that spouses perceive there to be a stigma regarding seeking mental health care because it would be "too embarrassing, it would harm their soldier's career, and it would be seen as weak" (p. 1054).

The United States military is primarily concerned with providing care to the soldier, and the soldier's family is considered secondary. The Department of Defense indicated in a June 2007 Mental Health Task Force report that TRICARE (the insurance provider for all military personnel) does not adequately provide for spouses or family members of soldiers (Eaton et al., 2008). Obtaining services is more challenging for the soldier's family members. In most cases, spouses must first seek treatment from their primary care doctor, which is typically on the military installation, and their doctor in turn refers them to a specialty treatment provider to address their mental health needs. In recent times, however, mental health providers are pushing for support services to be more readily offered to military spouses on military installations as well as in private organizations, because they are, after all, representing their soldiers here on the home front.

The family members of Selected Reserve soldiers have an even more difficult time obtaining services because they are frequently more isolated and lack the same sense of belonging and community that Active Duty service members encompass. Often times, Selected Reserve soldiers do not live on or near a military installation where treatment services can be rendered due to the fact that Reserve soldiers hold civilian jobs for the majority of the year and fulfill their duty to the military once a month. Many Reserve soldiers are activated for a deployment individually, instead of an entire unit, and the activation happens without prior notice, placing great stress on their families (Lapp et al., 2010).

The challenge in spouses receiving services is exacerbated by an increasing number of spouses needing mental health services. Recently, Mansfield et al. (2010) conducted a study regarding the mental health diagnoses of active-duty spouses of deployed soldiers; the results are alarming. The study examined the medical records of 250,626 spouses of soldiers who were deployed between 2003 and 2006. The records were obtained from both civilian outpatient and military treatment facilities. Nearly one-third (31.3%) of spouses of soldiers deployed 1 to 11 months had at least one mental health diagnosis, with the percentage increasing to 60.7% of those whose husbands had been deployed for more than 11 months (Mansfield et al., 2010).

The study concluded that spouses of deployed soldiers, no matter the length of the deployment, had received diagnoses of alcohol use, bipolar disorder, cognitive disorder, dissociative disorder, drug use, impulse control disorder, personality disorder, psychotic disorder, somatoform disorder, stress disorders; and the most prevalent diagnoses being: depressive disorders (23.7 %), sleep disorders (8.5 %), anxiety (13.6%), and stress disorders (11.5%). These findings should be significant enough to elicit mental health services and support on behalf of the spouses of deployed soldiers because the numbers are staggering. The war is not ending anytime soon, and the majority of deployments are 12 months, which means more deployments, increased stressors, and increased level of mental health diagnosis for spouses. In 2004, 38% of spouses of deployed soldiers reported they felt they could cope with a deployment of 7 months to a year; while only 24% of spouses reported they could cope with a deployment of more than a year (U.S. Army Community and Family Support Center, 2005, p. 4).

The importance of the spouse's mental health is well-documented. Eaton et al. (2008) state that the "health and well-being of military spouses is important, both to the individual family unit and the operational unit... and is relevant to the retention of a robust and experienced force" and "providing military spouses with the appropriate level of on-post specialty mental health services may serve to improve the health of the family unit, and in turn, better support soldiers' military careers, satisfaction, and retention" (p. 1052). Based on the direct correlation of the functionality of the soldiers and the well-being of their spouses, the military must stop overlooking the mental health and overall well-being of the spouses. Eaton et al. (2008) reported that more than 20% of spouses declared that "stress and emotional problems" were a constant threat to their everyday lives, and that 70% of spouses were more likely to seek mental health services than were their soldiers; even though mental health services are more readily available and treatment is highly encouraged for soldiers returning home from deployment.

To complicate matters, many soldiers have young children and their spouses also work outside the home. Of the Active Duty Officers, 41% of their spouses are employed in the civilian labor force, while 46% of Active Duty Enlisted spouses are employed. Forty-three percent of Active Duty soldiers report having one or more children; 79 % of all spouses say they and their soldier spouse have dependent children living with them. Of those who have dependent children living with them, 67% have children age 2 and under, 62% have children ages 3 to 5, 65% have children ages 6 to 10, 37% have children ages 11 to 12, 38% have children ages 13 to 15, 27% have children ages 16 to 18, and 13% have children age 19 and older" (U.S. Army Community and Family Support Center, 2005, p. 6). When the military member deploys, the spouse is left to care for the children, maintain the household, pay the bills, and still continue to foster her career. In short, the spouse is left to tend to the needs of the family while at the same time be fit and able to work.

While there may be financial need for the spouse to work outside the home, there is pressure on the military spouse to be successful at maintaining the home for the soldier. Hall (2008) reported the goal of the spouse is "to keep a positive attitude toward the military, to always maintain an interest in his duty, and to be very flexible and adaptable" (p. 77). Another spouse quoted the military career to be a "two-person career" but only the active-duty service member gets paid and the wife is supposed to maintain everything

at home (Hall, 2008, p. 77). Generally, enlisted active-duty service members are paid slightly above minimum wage for the work that is done by two people.

The regular moves, short durations of stay in one location, and dual parenting roles that are projected onto the spouse, make it hard for the spouse to obtain and maintain a career. A military spouse has various roles to play, and does so with a smile on her face because it is expected that she supports her husband and knows that her life is secondary to the function of the military. Many spouses recognize that the military is expected to be their primary interest and their husbands' careers should be reciprocated in some fashion, but frequently are not. SteelFisher, Zaslavsky, and Blendon (2008) indicated that few spouses view deployments as a positive situation, allowing them to explore their newly found independence, cultivate new friendships, and have a sense of accomplishment for maintaining the structure and routine at home while their soldiers are away. But the greater effects of deployment are negative, impacting mental and physical health, and job-related tasks of the spouse (SteelFisher et al., 2008).

What are the implications for mental health providers? Specifically, mental health professionals need to find alternative ways to support the spouses of our deployed soldiers. The Army has implemented a network of spouses for each deployed unit called the family readiness group (FRG) that is sustained by volunteers. The FRG's main purpose is to provide education and support to the spouses and families of deployed soldiers. However, many spouses choose not participate because of the personal history spouses have with each other and the diversity of the deployed soldiers' rank within the groups (Hall, 2008). The FRG represents the extent to which the Army provides support and therapeutic care for spouses, and the number of spouses who even participate or know about the FRG is dismal. Only 53% of all spouses reported that the FRG in the soldier's unit as being active, and 34% were not aware whether the FRG was active or not. Of those spouses who reported an active FRG, 72% participated by attending FRG meetings (U.S. Army Community and Family Support Center, 2005, p. 5). Additionally, the FRG's services are not made available to spouses of reserve soldiers.

Spouses of deployed soldiers need continuous support during the deployment, not only from other spouses, but from support groups that can develop strategies for alleviating loneliness, anxiety, and depression. Support groups that teach spouses about the deployment cycle, discuss the challenges of deployment, and give the spouse specific interventions on how to maintain their life without their soldier can be beneficial in reducing stress and creating a foundation on which the spouse can stand when the deployment cycle seems interminable.

There are three distinct phases to the deployment cycle: pre-deployment, deployment, and post-deployment. The pre-deployment phase for the Active Duty soldier consists of rigorous training and countless nights away from family in order to prepare for the real-life situations they will encounter during war. The deployment phase consists of actual time in theater during which soldiers are continually exposed to the dangers of warfare over a period in excess of 12 months and may be allowed a brief two-week respite to come home.

The post-deployment phase consists of soldiers returning home and having to adjust to family life and life in the United States again. This phase also includes reintegration training and psychological and physical assessments to determine whether the soldier's overall health has been affected by his time in combat. The pre- and post-

deployment phases are often fluid and sometimes it is hard to ascertain where one ends and the other begins as the cycle repeats itself. Active Duty soldiers are constantly in training mode; training for the next deployment, training new recruits, and training on new equipment. To the spouse it feels as if it is a never-ending cycle that is continually on repeat.

Spouses describe all phases of the deployment cycle as being stressful, but in vastly different ways. During the pre-deployment phase, spouses stated the biggest stressor was that their lives were on hold. They could not make vacation plans because of the daily, weekly, and monthly training schedules the soldiers must maintain. At times soldiers do not receive orders to deploy until two weeks before they are scheduled to leave. During the pre-deployment phase, a family care plan must be created in case of emergencies; a power of attorney needs to be authorized; and money issues need to be resolved. The car, household, children, animals, career, and extended family all need to be taken into account before the soldier deploys (Lapp et al., 2010).

The most difficult phase of the deployment cycle is deployment itself. Spouses are overwhelmed with the burden of having to maintain a home, being a single parent, working, worrying about their soldier, finances, and much more. “The deployment experience can be summarized with five stressors: worrying, waiting, going it alone, pulling double duty, and loneliness” (Lapp et al., 2010, p. 51). Too often the military spouse worries about the safety and well-being of the soldier, of the changes that will occur in their relationship, and of the unknown variables of war - death, injury, and mental health of her soldier that looms over her head.

The spouse that is left behind worries and waits a year of her life away; anxiously awaiting a phone call, a text message, an instant message, or an email not knowing whether the content bodes good or ill. Many spouses become tethered to the technological devices and feel angered, discouraged, upset, or hurt if they miss a call. However, when their soldier finally does call, nothing else matters except for the five minute conversation that makes up for a month of anxiety and apprehension. During the deployment phase, spouses go from being part of a couple to being a single, and the impact of essentially becoming a single person in a dual relationship is harsh. The spouses left behind soon realize that everything they could count on their soldiers for now falls onto them. If the spouse has to work late and the kids need to be picked up or the dog needs to be let out, the spouse has to figure it out herself.

The overwhelming stress of the spouses’ newfound responsibilities and lonely state of being “single” can be debilitating, which is why there is an increase in overall mental health disorders, but most significantly in depressive, anxiety, and stress disorders. “The nonmilitary spouse, usually a woman, spends a lot of time crying and keeping busy but also often experiences changes in sleeping and eating patterns” (Hall, 2008, p. 163). Rarely do spouses receive the information and support they need to effectively maintain and handle the lifestyle change which they face. FRG’s try to prepare soldiers and their families for deployment, but if only half of the spouses participate in the FRG, or are even aware of the benefits of the FRG, then the information disseminated misses far too many.

Spouses described an experience of extreme aloneness, bordering on abandonment... even if professional help were sought, it could feel inadequate because as one wife explained „they say you can go to counseling, yeah, but you

know, counselors here don't know anything about deployment, most of them. They've never had to deal with that. They don't know how to support these people through a deployment besides what they read in a book." (Lapp, 2010, p. 53)

Post-deployment stressors for the spouse include re-familiarizing herself with her soldier and focusing on attaining a normal life. During this phase, both the soldier and the spouse have to readjust to life with each other again and create a new balance that fits their lifestyle. The spouse also may be concerned with mental health issues her soldier might face currently and in the future, such as traumatic brain injury and post traumatic stress disorder (Lapp et al., 2010). Once the reunited couple becomes relatively adjusted to their life again and everyday starts to appear normal, they have to begin preparing for the pre-deployment phase and the cycle repeats itself. Chronic stress of repeated deployments can lead to a decreased immune system and physical sickness as well as emotional and mental instability.

In addition to understanding the deployment cycle, it is important for mental health professionals to be aware of ambiguous loss theory, the stages of grief, and how they pertain to the deployment cycle. Military spouses harbor the uncertainty of not knowing when or if they will ever see their husband again and they regularly become isolated after their husbands deploy, which makes it even more difficult to persevere and navigate their way through the anxiety, depression, worry, and loneliness that they may be experiencing. Rossetto (2010) describes in her dissertation that military spouses are subjected to ambiguous loss where "there may be physical absence with psychological presence or psychological absence with physical presence" (p. 10). The soldiers may be physically removed from everyday life, but their presence remains in the form of letters, emails, late night phone calls, webcam, and the queen-size bed that the spouse left behind. In essence, spouses of deployed soldiers are mourning the loss of their husbands, albeit a non-death loss, but a significant loss nonetheless, and a period of bereavement, mourning, and grief follows such an occasion.

Servaty-Seib (2004) specifies definitions of bereavement, mourning, and grief. The words are often used interchangeably though, in fact, represent quite different states. "Bereavement is the state in having experienced a loss. Grief is the generally passive and involuntary reaction to the state of bereavement... responses associated with grief span the affective, cognitive, physical, behavioral, social, and spiritual domains of human functioning. Mourning involves the active processes of coping with grief and bereavement" (p. 126). When working with a military spouse who is entering into, or is fully engaged in, the deployment phase of the deployment cycle, it would be of great benefit to the client if the mental health professional recognized, acknowledged, and addressed the significance of experiencing the physical loss of her husband to the war.

As well as using the ambiguous loss theory as a model for treating military spouses during the deployment phase, the stages of grief theory presents a valuable scheme to incorporate during treatment. According to Kubler-Ross (1969), there are five stages of grief: denial, anger, bargaining, depression, and acceptance. Although Kubler-Ross' theory is normally associated with the dying process in patients who have a terminal illness, applying those stages to the deployment cycle can be beneficial in helping spouses to identify and cope with their emotions.

For example, during the pre- and post-deployment denial stage a spouse might think, *“My soldier isn’t going to go back to war! We are moving and the Army can’t possibly send him over there again.”* During the end of the pre-deployment phase, a spouse might feel anger and think, *“I am so mad at my soldier! I can’t stand to be around him if he is choosing the Army and going to war over his family!”* A spouse in the deployment phase and bargaining stage might think, *“God, please, if you let him live I’ll quit smoking/never cuss again/never argue with him again.”* Deployment depression is finally realizing that he/she is gone and spiraling into a cycle of feeling hopeless, pessimistic, and guilty, as well as having physical manifestations of depression such as fatigue and changes in weight. Deployment and post-deployment acceptance is reflected in the spouse thinking, *“I can’t change what is happening right now, so I might as well make the best of it and try to find a way to move forward during the next year.”* Military spouses’ specific responses to the cycle of deployment will be unique and vary with each person, thus being able to recognize and identify the client’s individual stages of grief could be therapeutically beneficial.

How can mental health professionals help spouses of deployed soldiers even when we have not endured a deployment ourselves? It is an extremely sensitive subject to talk about the effects of a deployment with a spouse when you, yourself have not experienced one. *“The most effective resources identified by spouses were people living the same experience. Those who also were experiencing a similar military separation were seen as trusted sources of friendship”* (Lapp et al., 2010, p. 57). Individual counseling can be effective, but the therapeutic factors of group therapy have been well documented. Specifically, the instillation of hope, universality, imparting information, altruism, group cohesiveness, catharsis, and existential factors are all benefits of group counseling (Yalom, 2005).

A support group for spouses of deployed soldiers encourages spouses to attend a group that is not only therapeutically beneficial, but that involves other spouses who are living, breathing, and experiencing the same daily struggles of deployment. *“Seeking support from others, in many forms, was one of the most prominent coping strategies women introduced”* (Rosetto, 2010, p. 111). Spouses need support; in the form of friends, family, other spouses who are going through the same situation, their soldier, and in the area of mental health. As previously stated, the functionality of the soldier directly correlates with the overall well-being of the spouse, so if the spouse is asking for support, then ask and ye shall receive.

Spouses Supporting Spouses is a support group for spouses of deployed soldiers. The aim of this group is to support and educate military spouses whose husbands are currently deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom in Iraq and Afghanistan. The group is designed to meet once a month for 90 to 120 minutes for 12 months or the duration of the deployment with optional sessions right before the soldier deploys and a month after the soldier returns. The prerequisites of the group are: must be a spouse of an Active Duty or Selected Reserve soldier and soldier must be deployed or deploying within three months of commencement of group. Each session has a topic of discussion and members of the group are assigned homework, usually journaling, to bring to the next session.

The 12 topics include: introduction of group members, stages of grief and how it pertains to the deployment cycle, community resources and coping strategies, how to

maintain structure without the soldier, self-care, handling crisis, how to get through the holidays, birthdays, and anniversaries (session should be scheduled during month of November or December), halfway there, and memories of soldier (session should be scheduled at the halfway mark of deployment), positive experiences of deployment, exploring who the spouse is without her soldier, telling her own story of the deployment journey, anticipation of soldier return, soldier homecoming and termination of group, and optional follow-up session.

The Spouses Supporting Spouses group is a place where spouses can foster intimate relationships with other spouses who are experiencing the same thing and can learn about coping strategies they can utilize during the deployment phase. A support group like this during a time of need is crucial for spouses of deployed soldiers. Not only will it benefit the overall well-being of military spouses, but it will also decrease the prevalence of mental health disorders such as depressive, anxiety, and stress disorders, and it will allow spouses to better carry the burden of their husbands' careers, which will in-turn enable the military family unit to function as a whole.

In conclusion, it is imperative for the needs of spouses of deployed soldiers to be recognized, and for mental health services to become less stigmatized and more accepted as a prevention and maintenance tool for overall well-being. Frequently, a soldier whose spouse is proactively seeking mental health services is more apt to inquire about his own mental health care than a soldier whose spouse is not actively involved or inquiring about therapy. Military spouses have many expectations and stressors placed on them due to the upheaval of their lives that deployments cause, which could ultimately lead them to feel resentment toward their soldier, the military, and the war. In order to have the men who are fighting for our country return home safely and unscathed, we need to nurture the military spouses that stand behind them and fight for our country too. Spouses are the silent ranks; the unseen gateway to the prosperity of the war; and the brick wall that faithfully supports their soldiers, no matter the tasks that confront them. Therefore, they need support from not only the military community, but from the nation at large, especially during deployment.

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