



Supporting Military Families Through
Research and Outreach

The Experience of Reintegration for Military Families and Implications for Yellow Ribbon Reintegration Programming

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Military REACH, a project of the DoD-USDA Partnership for Military Families, utilizes a multi-disciplinary approach integrating both Research and Outreach to support those who work with and on behalf of military families. Through our three-fold approach, we provide empirical research that identifies and addresses key issues impacting military families and the programs that serve them, offer outreach and professional development through online resources, and host a Live Learning Lab for program staff seeking constructive professional development feedback for their programs.

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Executive Summary

Over 2.6 million members of the United States military have deployed in support of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND); 40% have deployed more than once (Institute of Medicine, 2012, 2014). These deployments affect not only the Service members, but also their spouses/partners, children, parents, and extended family.

Supporting military families across all phases of the deployment cycle is important, and attention to the reintegration phase is especially relevant during this time of drawdown from the Middle East. Although a growing literature is addressing the reintegration experiences and needs of Service members, relatively less research exists regarding their family members. Examination of the strengths, challenges, and needs of Service members, their spouses, and children can guide prevention, intervention, and outreach efforts.

Examination of the strengths, challenges, and needs of Service members, their spouses, and children can guide prevention, intervention, and outreach efforts.

This report provides a comprehensive summary of the research on the reintegration experiences of Service members, military spouses, and military children. It examines Service member and spouse experiences across six domains, including mental health, social functioning, relationship functioning, spiritual functioning, physical health, and financial well-being. Children's experiences are organized into the categories of mental health, academic functioning, family relationships, and parenting.

Most military personnel and their family members experience some turbulence during the reintegration period, but, ultimately, adjust quite well. Some, however, have more difficulty with the transition and may need targeted support to resume full functioning in their daily lives. For those families dealing with posttraumatic stress disorder (PTSD) or combat-related injury, reintegration can be especially challenging.

Because the timeline for the onset and development of reintegration issues is important when designing prevention, intervention, and outreach programs, the report specifies the timing of emergence of problems over time when such information is available. Overall, Service members and their spouses report few problems during the first 1-2 months after homecoming, but difficulties increase between 3 and 6 months. Longitudinal studies that follow participants over many years (such as the Millennium Cohort Study) will be helpful as researchers work to understand reintegration trajectories beyond 6 months.

In light of the findings from the reintegration literature, the report reviews current Yellow Ribbon Reintegration Program (YRRP) offerings and proposes potential enhancements to program content, format, modes of delivery, and partnerships. Overall, the YRRP covers many of the key challenges faced by Service members during the reintegration phase, including issues related to mental health, parenting, employment, finances, education, and health care. Programming and services available to military spouses and children appear to differ considerably across sites and are often focused on understanding and supporting the returning Service member. Expanded programming that focuses on spouses' and children's unique needs (e.g., related to mental health or academic performance) could strengthen existing YRRP offerings.

This report offers several content areas that could be addressed in YRRP programming. With respect to Service members, further attention to spiritual well-being may be useful, as well as continued collaboration with military chaplains. For spouses, programming related to spouse-specific mental health, caregiving, self-care, and family relationships in the context of PTSD could be beneficial. Regarding children, research has found elevated rates of mental health concerns among children who have experienced parental combat deployment; children whose parent has PTSD or other mental health concerns may be at greater risk. Programs aimed at prevention and early intervention may be useful to minimize the negative impact on children.

Regarding program format, YRRP may consider:

- Increasing offerings for spouses and children at events.
- Including workshop programs targeted at the dyadic (for the couple together), individual (separate programs for Service members, partners, and children), and family levels, possibly via distinct tracks in programming.
- Expanding events to include other people that are important to the reintegrating Service member, including parents, unmarried partners, and siblings.
- Maintaining contact for a longer period of time after homecoming, thereby potentially enhancing social support and awareness of resources.

With respect to the mode of delivery, YRRP may consider:

- Continuing flexible programming and offerings in various formats, including both in-person and online modalities.
- Increasing the accessibility and interactivity of online formats via a portal interface where Service members, spouses, and children could consolidate resources and information.
- Developing smartphone applications (apps) to facilitate access to information, resources, and support.
- Further developing opportunities for peer support for Service members, spouses, and children, both in person and via the internet such as via social media.

The YRRP already benefits from partnerships with many organizations, and may wish to continue to inform families about the numerous online support resources. In expanding its programming, YRRP may consider partnering with community providers who can offer spouses and children evidence-based programs to prevent and effectively cope with reintegration-related mental health challenges. YRRP may also continue to partner with community- and faith-based organizations to expand its scope and reach of programming for Service members, spouses, children, and families.

In sum, YRRP provides a broad array of preventive and supportive services to National Guard and Reserve Service members and their families. Its offerings for Service members align well with the research literature. New research on the experiences of military spouses and children during reintegration highlights potential targets for additional programming. The YRRP's continued commitment to the entire family throughout the deployment cycle has the potential to enhance resilience, bolster wellness, improve family functioning, and, ultimately, strengthen the readiness of the entire National Guard and Reserve force.

The Experience of Reintegration for Military Families and Implications for Yellow Ribbon Reintegration Programming

Over 2.6 million members of the United States military have deployed in support of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), 40% of whom have deployed more than once (Institute of Medicine, 2012, 2014). These deployments involve not only the Service members but also their spouses/partners, children, parents, and extended family. Nearly two million children in the United States have been affected by parental deployment to OEF/OIF, approximately 900,000 of whom have experienced multiple parental deployments (Flake, Davis, Johnson, & Middleton, 2009; Lester et al., 2012).

Although a growing literature is addressing the experiences and needs of Service members, relatively less research exists regarding their family members. Supporting military families across all phases of the deployment cycle is important, and attention to the reintegration phase is especially relevant during this time of drawdown from the Middle East. Focused examination of the strengths, challenges, and needs of Service members and all family members can guide prevention, intervention, and outreach efforts.

In response to a request from the Department of Defense's Reserve Forces Program for Psychological Health, the University of Minnesota's Center for Research and Outreach (REACH) team conducted a review of both Congressionally-mandated reports and the scientific literature (2012-2015) regarding reintegration experiences of Service members, military spouses, and military children after deployment. The review focused on both short- and long-term reintegration issues faced by military personnel and their families. Based on this review of the research and close examination of the Yellow Ribbon Reintegration Program (YRRP) current offerings, recommendations are described about how prevention and intervention programming could be strengthened to meet the emerging needs of families.

As recommended by the Department of Defense, the team drew upon recent reports from the Institute of Medicine (2010, 2013, and 2014), the RAND Corporation (Werber et al., 2013), and our own REACH lab (specifically the July 2014 report entitled "Anticipating the landscape in the years ahead: Military members' transition to a post-war mission"). These source documents were supplemented by more recent research findings.

We conducted a comprehensive literature search for materials related to the reintegration experiences of Service members, military spouses, and military children after deployment. The databases PsycINFO, Google Scholar, and Sociological Abstracts were used in the search. A variety of search terms were used, such as military, soldiers, reintegration, post deployment military spouse, military partner, post deployment, and military child. Overall, over 380 documents were critically reviewed for use within this report, including empirical articles, relevant literature reviews, reports, and policy briefs.

Most military personnel and their family members demonstrate resilience and adjust effectively to changes.

As summarized in detail below, most Service members, spouses, and children experience common reintegration challenges upon homecoming but do not develop long-term difficulties. Some period of adjustment is to be expected with the reintegration of the Service member back into family life.

Most military personnel and their family members demonstrate resilience and adjust effectively to the changes. However, research is documenting that some Service members and their families experience considerable challenges, some of which may include distress and functional impairment. Further, the challenges do not quickly abate for some military personnel, spouses, and children.

Overview of the Yellow Ribbon Reintegration Program (YRRP)

The Yellow Ribbon Reintegration Program (YRRP) is part of the Family and Employer Programs and Policy Office within the Office of the Assistant Secretary of Defense for Reserve Affairs. It is a Department of Defense-wide effort to support National Guard and Reserve Service members and their families across the deployment cycle via both in-person events and online resources. Programs are offered at four phases, including pre-deployment, during deployment (for family members only), demobilization, and after deployment (30, 60, and 90 days after homecoming). Service Members are required to attend the various programs throughout the deployment cycle, while spouses are encouraged to attend most meetings (except for the 90-day check-in event). Yellow Ribbon events provide participants with information and resources regarding health care, financial and legal benefits, and educational/training opportunities. According to the YRRP website, over 1.4 million National Guard and Reserve Service members and their families have used these resources since January 2008.

In addition to in-person meetings, YRRP has online curricula and resources to help Service members and their families through the deployment cycle. Online pamphlets cover a wide variety of topics such as *Legal Considerations of Deployment*, *Long-distance Co-Parenting*, *Reintegration*, *Addressing Your Stress*, and *Financial Planning for Deployment*. The pamphlets succinctly summarize the topic and describe both military and civilian resources. The curricula currently on the website include Community Services; Employment; Finances; Interpersonal Relationships; Legal; and Service and Family Member Well Being. The courses consist of PowerPoint presentations and accompanying facilitator notes.

YRRP has also partnered with the Department of Defense's National Center for Telehealth and Technology's Afterdeployment.org resource which houses a broad range of online modules for Service Members and families (Bush et al., 2011). The resource aims to help military families overcome challenges during the reintegration phase, and modules address mental health problems (e.g., suicide, anxiety, and stress), wellness issues, and resources.

The YRRP Program currently addresses many of the needs and challenges faced by Service members, spouses, and children.

As described in detail below, the YRRP Program currently addresses many of the needs and challenges faced by Service members, spouses, and children. The program offerings align quite closely with the research findings regarding potential problem areas. However, this report offers numerous research-based suggestions regarding program content, format, mode of delivery, and duration of services that may be useful as the Department of Defense refines and enhances its programming.

Organization of this Report

This report is organized in three sections corresponding to the target populations, namely: (1) Service members; (2) military spouses; and (3) military children. Each section begins with an overview of the research about functioning across several domains, including, but not limited to, mental health, social/role functioning, relationship functioning and family life, spiritual functioning, physical health, and

financial well-being. These categories were drawn from our previous report on reintegration among Service members (Sherman et al., 2014). Notably, some domains are not relevant for all family member groups. For instance, research does not exist regarding spiritual functioning among military children. In addition, the report adds unique functional domains to some sections; the section on children, for example, includes information about academic functioning.

Following the literature review, each section summarizes current YRRP programming for that group (Service member, spouse, and child), highlighting topics that are effectively addressed in available curricula. Finally, each section offers recommendations for content, approaches, and modes of service delivery that may be useful to consider. Specific evidence-informed programs that the Department of Defense might offer or adapt to meet these needs are described.

The Experience of Reintegration for Service Members

Over 2.6 million U.S. Service members have deployed in support of the Global War on Terrorism. For many, deployment represents a proud service to country, an opportunity for growth, and exposure to a range of cultures, experiences, and people. Deployment provides opportunities for financial gain, self-improvement, and strengthened personal relationships (Newby et al., 2005). Deployment is often associated with real-life application of military training, a sense of accomplishment, and strengthened bonds among military units (Hosek et al., 2006). Despite these opportunities for growth and self-improvement, some Service members face challenges and are exposed to trauma that can have lingering consequences, impacting their ability to reintegrate into civilian and family life after deployment.

This portion of the report reviews the research pertaining to Service members' experiences during reintegration. Six domains of functioning are examined, including mental health, relationship functioning, social functioning, spirituality, physical health, and financial well-being. This section concludes with information about current Yellow Ribbon Programming and recommendations for future programming based on the emerging research base.

Mental Health

Recent research has found a significant decrease in mental health and well-being between pre- and post-deployment assessments (McAndrew et al., 2013). As of 2011, 963,283 current and former Service members had been diagnosed with at least one psychological disorder, including general adjustment disorders, depression, anxiety, substance use disorders, and PTSD; this rate represents a 62% increase over 2001 (Institute of Medicine, 2014). Much research has been dedicated to understanding mental health functioning among Service members and Veterans.

As of 2011, 963,283 current and former Service members had been diagnosed with at least one psychological disorder, including general adjustment disorders, depression, anxiety, substance use disorders, and PTSD.

This section reviews research on distinct mental health challenges faced by Service members after deployment, including PTSD, depression, grief, insomnia, substance use disorders, suicide, physical and mental health challenges associated with traumatic brain injury, and high-risk behavior. This section also addresses resilience, issues faced by distinct populations (e.g., Reserve component members, women, and Service members who have deployed multiple times), and barriers to treatment.

Posttraumatic stress disorder. Posttraumatic stress disorder (PTSD) has been termed a signature injury of the wars in Iraq and Afghanistan (Tanielian et al., 2008) and can emerge from either direct or indirect exposure to trauma. Prevalence rates for PTSD have varied widely in research, ranging from 4-30% among Service members returning from Iraq and Afghanistan (Booth-Kewley et al., 2010; Hoge et al., 2004), and between 16–44% among Service members who sustained physical injuries during deployment (Hoge et al., 2008). Blakeley and Jansen (2013) report that the number of diagnosed cases of PTSD increased by 656% between 2001 and 2011. While some of the variance may be attributed to the psychological toll of combat exposure, the study suggests that the six-fold increase is likely also attributable to better screening and a reduction of the stigma associated with seeking help for mental health issues.

Recent research has investigated individual differences in PTSD symptomology, including consideration of co-morbid conditions (Elhai et al., 2015), disease progression (Steenkamp et al., 2015), and life conditions that may exacerbate PTSD symptoms (Smid et al., 2013). For example, some symptoms of PTSD (e.g., hyper-vigilance and exaggerated startle response) may be more likely to present early in the reintegration process, while other symptoms may emerge later (Steenkamp et al., 2015). Similarly, Smid and colleagues (2013) found that post-deployment PTSD progression was associated with more post-deployment life stress in high combat exposure groups.

Comorbid conditions may also affect the progression of PTSD. For example, in a study of 672 Ohio National Guard Soldiers who deployed between July 2008 and February 2009, Elhai and colleagues (2015) found that PTSD was likely to co-occur with major depressive disorder. Other research has linked PTSD to a range of conditions among OEF/OIF Veterans, including sleep disturbances (Koffel et al., 2013; Ustinov, 2013), suicidal ideation (DeBeer et al., 2014), substance use disorders (Kehle et al., 2012), aggressive behavior (Flannagan et al., 2014), obesity (Maguen et al., 2013), and binge eating (Hoerster et al., 2015).

Research has documented numerous predictors of PTSD including demographic variables such as young age, being single, and junior rank (Lapierre et al., 2007; Phillips et al., 2010; Seal et al., 2009, Smid et al., 2013). Other variables that are related to PTSD include combat exposure, difficult deployment conditions (e.g., troubles at home, lack of privacy, and problems with leadership), lifetime trauma, avoidant coping (Steenkamp et al., 2015), lack of social support following deployment (Pedersen et al., 2014; Shea et al., 2013), and post-deployment stressors (Smid et al., 2013).

Depression is the second most commonly diagnosed mental health disorder among OEF/OIF Service members.

Depression. While PTSD has been named one of the “signature injuries” of the wars in Iraq and Afghanistan, depression is the second most commonly diagnosed mental health disorder among OEF/OIF Service members (Seal et al., 2009). In a study of 678,382 Active Duty Service members between 2001 and 2006, Shen and colleagues (2012) found that those who deployed to Iraq and Afghanistan were significantly more likely to suffer depression after deployment than those who did not deploy. Estimates of depression prevalence among OEF/OIF Service members range from 5-37%. However, in a study of 114 Iraq and Afghanistan Veterans who had returned home at least three months prior, Phillips (2013) revealed that as many as 70% of Veterans were at an increased risk of depression.

Research suggests that depression often co-occurs with several other health risk factors in OEF/OIF Veterans following deployment. For example, Elhai and colleagues (2015) reported high rates of

comorbidity between major depression and PTSD. Other conditions commonly co-occurring with depression include physical health conditions such as obesity (Maguen et al., 2013), binge eating behaviors (Hoerster et al., 2015), and failure to meet daily physical activity recommendations (Hoerster et al., 2012). Other research has related depression to unemployment (Cohen et al., 2013), an increased risk of driving-related anxiety (Zinzow et al., 2013), an increased risk of aggression (Flanagan et al., 2014), increased alcohol misuse (Heltemes et al., 2014) and an increased risk of suicidal ideation (DeBeer, 2014).

Risk factors for depression among OEF/OIF Veterans fall into three categories: demographics, branch of service, and traumatic experience. Demographic groups with an increased risk of depression include women, younger Service members (between the ages of 17 and 25), unmarried Service members, and those with less than a college education (Gadermann et al., 2012). Rates of depression are higher among Army and Marine Corps personnel than among Navy and Air Force personnel. Army personnel who deployed for longer periods of time were also significantly more likely to be diagnosed with depression than those who deployed for a shorter period of time (Shen et al., 2012). Higher rates of depression exist for those who have experienced traumatic experiences such as military sexual trauma, and adverse childhood experiences (Cabrera et al., 2007; Fritch et al., 2010; Kimerling et al., 2010; Suris & Lind, 2008). Increased depression severity has also been documented among Service members who experienced changes in physical appearance due to an injury (Weaver et al., 2014).

Grief. Very little research has examined the experience of grief among military personnel after deployment. However, one study found that over 21% of returning Service members reported grief over the loss of someone close (Toblin et al., 2012). Further, after controlling for other variables, grief independently accounted for increased reports of physical health problems, poor general health, and missed work. Additional research on Service members' experiences of grief during the reintegration period may be useful.

Sleep disturbances may both intensify and become intensified by other mental health conditions, often resulting in reintegration challenges.

Sleep problems. Altered sleep habits may develop in response to deployment, or may present as a symptom of other mental health issues (e.g., PTSD, depression, or anxiety). Once present, sleep disturbances may both intensify and become intensified by other mental health conditions, often resulting in reintegration challenges.

Recent research has documented relatively high rates of sleep problems among OEF/OIF Service members. For example, Plumb and colleagues (2014) found that 89% of OIF/OEF Veterans experienced some type of sleep problem, such as problems falling asleep, getting less than 4.5 hours of sleep per night, or lying awake in bed for more than 15% of the night. Similarly, Luxton and colleagues (2011) found that 72% of a combat brigade team got less than six hours of sleep per night three-to-six months after returning from Iraq. Sleep disturbances are positively associated with less education, lower rank, and more combat exposure (Plumb et al., 2014), and are more severe among males and those with greater levels of stress (Seelig et al., 2010).

The relationships between sleep disturbance and physical health (Ferrie et al., 2007) and mental health (Benca et al., 1992) are well established. Sleep disturbances account for a 75-90% increase in comorbid conditions, including depression, anxiety, and physical and psychomotor functioning problems (King et al., 2013). Sleep problems can result in decreased combat readiness (Troxel, 2015). In light of these findings, some research has suggested concurrent treatment of sleep problems as part of comprehensive PTSD treatment (Ustinov et al., 2013).

Suicide. Suicide rates in the Department of Defense rose by 60% between 2005 and 2011 (Defense Center of Excellence, 2012), and military suicide rates have recently surpassed the rates in the general population (Department of the Army, 2012). Research has identified some risk factors associated with suicidal behavior and suicidal intention among Service members. Suicide behavior has been significantly correlated with demographic characteristics (White, young, and male), the loss of a significant other, and childhood abuse (Griffith, 2012). Suicidal ideation has been positively associated with PTSD and depression (DeBeer et al., 2014). In addition, social support can protect against suicidal behaviors and ideation, with studies demonstrating the protective effects of both unit cohesion (Mitchell et al., 2012) and social support (DeBeer et al., 2014).

While combat exposure has been linked to suicidal ideation (Mitchell et al., 2012), recent research has demonstrated that no clear link exists between deployment and suicide. In fact, a study by Kang and colleagues (2014) found that after controlling for demographic and service characteristics (including rank and branch of service), deployed Veterans had a lower risk of suicidal ideation than Veterans who never deployed. Similarly, research has shown a decreased risk of suicide among deployed Service members, and suggested that an increase in suicide risk was associated not with deployment, but with separation from military service (Reger et al., 2015). Nevertheless, a growing body of research has examined a host of characteristics that are associated with deployment, many of which have been shown to correlate with an increased risk of suicide. These characteristics include heightened pain tolerance, emotional reactivity, emotional numbing, distancing, and difficulties during reintegration (Lusk et al., 2015). Other research has shown that maladaptive coping responses to post-deployment difficulties (including denial and substance use) are also associated with an increased risk of suicidal ideation (Khazem et al., 2014).

Substance use disorders. Research has documented variable rates of alcohol use and abuse among Service members after deployment, ranging from 11-13% having symptoms of alcohol use disorder (Kehle et al., 2012; Seal et al., 2011) to 30% reporting disordered drinking (Blow et al., 2013; Scott et al., 2013). Kehle and colleagues (2012) found that 13% of Service members returned from Iraq and Afghanistan with symptoms of problematic drinking, and that 38% of those developed disordered drinking during their deployment. In the months after homecoming, Service members are at risk for increased alcohol consumption and problematic drinking. A study of 678,382 Active Duty Service members who served between 2001 and 2006 found that alcohol use disorder was positively associated with deployment to Iraq and Afghanistan (Shen et al., 2012). Similarly, in a study of a National Guard Infantry Brigade Combat Team surveyed three months before and after deployment, Russell and colleagues (2014) found that alcohol use increased and alcohol misuse more than doubled after deployment (increasing from 8% before deployment to 19% after deployment).

Alcohol use and misuse among OEF/OIF Service members is associated with PTSD symptom severity, higher levels of avoidance symptoms, lower positive emotionality, and combat exposure.

Researchers have shown that alcohol use and misuse among OEF/OIF Service members is associated with PTSD symptom severity, higher levels of avoidance symptoms, lower positive emotionality (Kehle et al., 2012), and combat exposure, especially killing others during combat (Russell et al., 2014). As with sleep disorders, alcohol use disorders may intensify or be intensified by co-morbid conditions. For example, Heltemes and colleagues (2014) reported that Service members exhibiting signs of mental health disorders and alcohol use disorders had more health complaints than those with mental health issues alone.

Beyond alcohol use and abuse, research has only recently begun to examine nicotine and marijuana use, and prescription drug misuse among Service members. Very little variance in nicotine and marijuana use, or prescription drug misuse has been associated with deployment (Golub & Bennett, 2013; Golub & Bennett, 2014; Trautmann et al., 2015).

Traumatic brain injury. One of the primary risks faced by deployed Service members is injury from explosive devices. Incidence rates for traumatic brain injury (TBI) range from 18-22% among deployed Service members (Hoge, 2008; IOM, 2014). Traumatic brain injuries are seldom penetrating (1%) or severe (1%), and mild traumatic brain injury accounts for 83% of all brain injuries (DCOE, 2014). Traumatic brain injury accounts for nearly 40% of all fatalities in OIF (IOM, 2014).

Given the high incidence of traumatic brain injury, researchers have been increasingly interested in determining cognitive and mental health implications of TBI for Service members. With respect to cognitive functioning, Haran and colleagues (2013) assessed 1,324 U.S. Marines one month and again eight months after returning home from deployment; self-reported concussion resulted in a decrease in cognitive performance at two-to-eight weeks post deployment and decreased performance on a reaction time test after eight months. Other research demonstrated a relationship between TBI and verbal learning and verbal memory performance (Sodza et al., 2014).

Findings also relate TBI to substance use and mental health challenges. For example, in a study of 6,824 Service members returning from Iraq and Afghanistan, TBI was associated with problematic drinking behaviors (Adams et al., 2013). Another study found that having multiple lifetime concussions was associated with increased emotional distress (Spria et al., 2014). In addition, Hoge and colleagues (2008) found that rates of PTSD were higher among Service members who reported injury with loss of consciousness. Further, those Service members who had experienced a head injury with a loss of consciousness were more likely to report poor overall mental and physical health, and more missed work than Service members with no reported head injuries. Given the association between physical injury, cognitive functioning, and emotional well-being, traumatic brain injury research has potential to provide important insights about reintegration challenges faced by Service members returning from deployment.

High risk behavior. Soldiers experiencing post-deployment challenges may also be more likely to engage in unsafe or impulsive behavior. As some OEF/OIF Service members experienced traumatic events while driving vehicles during deployment, Service members may experience high levels of driving-related anxiety during reintegration. For example, in a study of recently returned OEF/OIF Service members, Zinzow and colleagues (2013) found that many experienced high rates of anxiety and hyper-arousal in response to close proximity to other vehicles. Both combat exposure and PTSD have been linked to risky driving behaviors among Service members during reintegration, including unsafe and aggressive driving (Fear et al., 2006) and an increased risk of driving-related fatalities (Hooper et al., 2006; Kang et al., 2002; Lincoln et al., 2006). Furthermore, driving-related anxiety has been found to result in some adverse outcomes among returning Veterans, including limited community mobility, limited leisure activity, and diminished social participation (Hwang et al., 2014).

Other research has focused on the perception of invincibility among Service members and its relationship to high-risk behavior. In interviews with 319 Service members one month before and after deployment, Kelley and colleagues (2012) found that perceptions of invincibility, alcohol use, and

reckless driving all increased following deployment. Further, perceptions of invincibility, alcohol use, and reckless driving were higher among Service members with PTSD.

Finally, other types of high-risk behavior among returning OIF/OEF Service members include compulsive sexual behavior and criminal acts (resulting in incarceration). Compulsive sexual behavior is defined as abnormally frequent sexual thoughts and activities that are associated with significant distress and a perceived lack of control. One longitudinal study of OEF/OIF/OND Veterans found that 17% exhibited symptoms of compulsive sexual behavior, and that compulsive sexual behavior was positively associated with PTSD symptom severity, child sexual trauma, and negatively associated with Veterans' age (Smith et al., 2014). Regarding criminal behavior, a study of 1,388 formerly deployed OEF/OIF Service members showed that 9% had been incarcerated since returning home from deployment. Those with PTSD and TBI who showed signs of anger and irritability were more likely to have been incarcerated compared to other Veterans. Research on high-risk behavior among military personnel suggests that it is important to examine pathways to injury resulting from various forms of self-injurious behaviors.

Resilience. While much of this report focuses on negative aspects of deployment, it is important to acknowledge both the positive outcomes of deployment and protective factors that may insulate Service members against negative reintegration experiences. Research with OEF/OIF Veterans revealed benefits of deployment including financial gain, an ability to use training in the real world, a sense of accomplishment, and strengthened bonds with military units (Hosek et al., 2006). Similarly, a Pew Research Center Survey (2011) of post-9/11 Veterans revealed additional positive correlates of deployment, with over 90% of Service members reporting pride, increased maturity, and greater self-confidence associated with their service. Other research has demonstrated an association between deployment and post-traumatic growth, or positive psychological changes after facing adversity or challenges (Galloway et al., 2011; Tedeschi, 2011).

Alongside positive outcomes of deployment, researchers are also examining differences in mental and physical health outcomes after deployment. Specifically, research has studied the protective effects of resilience, coping, and social support in Service members, both before and after deployment. Resilience has been defined as a set of personal qualities that enable individuals to weather adversity and is often composed of feelings of control, feelings of commitment, and a willingness to accept a challenge (Gucciardi et al., 2011). In a study of 475 Active Duty Marines attending Transition Assistance Program workshops six months after military separation, higher scores on resilience scales were associated with lower levels of depression, anxiety, and PTSD symptoms (Hourani et al., 2012). Similarly, other research has shown an association between lower resilience scores and higher rates of depression (Phillips, 2013) and alcohol use one year following deployment (Green et al., 2014).

Social support can also buffer against the ill effects of stress. In a study of 132 Navy Service members who had deployed to locations throughout the world, 56% reported experiencing some adjustment difficulties. However, adjustment difficulties were inversely correlated with resilience, social support, and less stressful deployment environments (Cunningham et al., 2014). Further, in a study of 89 OEF/OIF Veterans, both perceived support and actual support received increased Service members' feelings of self-efficacy, which in turn, led to lower levels of stress and depression (Smith et al., 2013).

Distinct populations. While many research articles focus on reintegration issues as they pertain to all Service members, some research has evaluated the unique experiences of distinct Service member populations. Three populations that have received considerable attention are: (1) National Guard and Reserve members, (2) women, and (3) Service members who have experienced multiple deployments. In

this section, we review research on each population, and discuss the role of deployment in determining mental health outcomes and post deployment adjustment.

National Guard/Reservists. National Guard/Reservists make up 28% of all deployments (Belasco, 2007). Often pulled from civil employment, National Guard/Reservists may face a unique range of challenges associated with unexpected deployment, limited experience, and more limited support structures (Shea et al., 2013). The Millennium Cohort Study includes data on National Guard/Reservists, which has enabled researchers to study the experiences of both National Guard and career military Service members. Nevertheless, some studies have analyzed the unique challenges faced by Reservists with respect to deployment and subsequent reintegration. Specifically, studies have found that Reservists are more likely to struggle with PTSD than other Service members (Milliken et al., 2007). In fact, a study of UK OEF/OIF Reservists found that relative to regular forces, Reservists reported more exposure to trauma, lower unit cohesion, and more problems during reintegration (Browne et al., 2007).

National Guard/Reservists may face a unique range of challenges associated with unexpected deployment, limited experience, and more limited support structures.

Due to the incongruity between civilian life and deployment expectations, research has focused on Reservists' experiences reintegrating into civilian life. One qualitative study of nine National Guard and Reserve Veterans found that most transitioned successfully back into civilian work environments (Nagle, 2014). Other research has examined the issues faced by National Guard and Reserve Service members (Shea et al., 2013) or included National Guard and Reservists in more general studies (Sullivan & Elbogen, 2013). However, very few studies between 2012 and 2015 have compared the lived experiences of Reservists and career Service members.

Women. Women currently comprise 14-15% of Active Duty Service members and nearly 18% of Reserves (Department of Defense, 2012). The role of women in conflict has shifted dramatically in recent years. Since 2001, more than half of female Service members have deployed; more than half of those have deployed multiple times (Defense Advisory Committee on Women in the Services, 2011). Further, the Pentagon recently formalized the integration of women in direct

While men tend to have more, and more intense, combat exposure, women also face unique stressors associated with sexual harassment, military sexual assault, and issues related to negotiating gender and identity.

ground combat positions by 2016 (Pellerin, 2013). Given the increased representation of women in both military service and combat, recent research has focused on both the unique stressors faced by women in the military and on the differential impacts of both deployment and combat exposure on their adjustment during reintegration.

Women experience many deployment-related stressors that are faced by all deploying Service members, including separation from family and friends, coping with war and combat experiences, and reintegration difficulties (Demers, 2013; Mattocks et al., 2015). Women are also likely to experience similar reintegration-related stressors such as difficulties finding housing and employment (Mankowski, 2012). Further, as with men, women who deployed are at increased risk of experiencing mental health challenges upon reintegration (Seelig et al., 2013). Nevertheless, while men tend to have more, and more intense, combat exposure

(Macera et al., 2014), women also face unique stressors associated with sexual harassment, military sexual assault (Mattocks et al., 2012; Mattocks et al., 2015), and issues related to negotiating gender and identity (Demers, 2013).

Research has also examined gender differences in mental health symptoms of OEF/OIF Service members, and results have been mixed. Some research has found that women are at an increased risk for depression (Street et al., 2013) and PTSD (Macera et al., 2014), and that women experience more severe PTSD symptoms than men (Polusny et al., 2014). Other studies have shown no gender related differences regarding PTSD incidence or symptom severity (Maguen et al., 2012; Street et al., 2013).

Multiple deployments. According to the Institute of Medicine's 2014 report, 40% of Service members have deployed more than once in the wars in Iraq and Afghanistan. Multiple deployments appear to be associated with an increased risk of mental health problems after deployment. For example, the 2008 Mental Health Advisory Team (MHAT) report found that rates of mental health problems increased with additional deployments, from 12% among Service members after one deployment to 27% among Service members with three or four deployments (MHAT5, 2008). Multiple deployments have also been linked to decreased morale, increased PTSD symptomology, (MHAT 9, 2013), chronic pain (Kline et al., 2010), and an increased risk of motor vehicle collisions (Woodall et al., 2014). One variable that has not been found to relate to multiple deployments is the risk of suicide (Kang et al., 2014). While multiple deployments have been associated with negative mental and physical health outcomes, a study by MacGregor and colleagues (2014) suggests that increasing dwell times (amount of time between deployments) may diminish the deleterious effects of multiple deployments. Their study of 3,512 Marines showed that Service members with the greatest level of combat exposure were 49-92% less likely to receive a mental health referral when dwell time was longer.

Barriers to treatment. One obstacle that may exacerbate Service members' post-deployment difficulties is the inability or unwillingness to seek treatment. For example, Service members were often unwilling to seek help due to the stigma associated with seeking treatment, and negative affect and concerns about the therapy process (Cornish et al., 2014; Culbreth et al., 2014; Hoge et al., 2014). Some Service members also felt that they could handle mental health issues on their own (Hoge et al., 2014). These concerns lead to infrequent help-seeking among Service members. For example, one research study found that of 2,230 Soldiers who had received a PTSD diagnosis within 90 days of return from Afghanistan, only 41% were receiving minimally adequate health care, and 22% reported only one follow-up appointment (Hoge et al., 2014). Other concerns related to Service members' access to services include work interference or insufficient time with a mental health professional, and discomfort interacting with mental health professionals (Hoge et al., 2014).

Some Service members encounter difficulties as they reintegrate into established social and family relationships after deployment.

Relationship Functioning

Some Service members encounter difficulties as they reintegrate into established social and family relationships after deployment (Bowling & Sherman, 2008). Service members may experience challenges in readjusting to the roles of parent (Houston et al., 2013) and spouse/partner (e.g., Foran et al., 2013).

Reintegration issues related to parenting and intimate relationships are addressed in the Military Spouse and Military Children sections later in this report. In this section, we focus on other social relationships (e.g., with close friends, coworkers, and family of origin) that may be strained during reintegration. This research is of particular importance given the demonstrated buffering effect of social support highlighted in the previous Resilience section.

Some Service members experience difficulties relating to others, and they may experience an upsurge in interpersonal conflict during reintegration. In a large sample of married Army Service members following deployment, 18% reported interpersonal conflict with either spouses, family members, close friends, or coworkers (Gibbs et al., 2012). Further, using data from a VA reintegration survey, Sayer and colleagues (2010) reported that beyond marital conflict and dissolution, Veterans reported problems in other relationships, with 56% reporting difficulties confiding or sharing personal thoughts, 44% struggling to make new friends, and 45% having difficulty keeping up with nonmilitary friendships. A study of Service members who returned to their families of origin reported that while Service members appreciate the instrumental and emotional support provided by parents, they also may experience increased conflict and relationship strain during their adjustment (Worthen et al., 2012).

Increased risks of perpetration of violence to others is another area that has received specific attention. Although family violence is reviewed in the relevant sections below, violence is not limited to spouses and children. In a study of PTSD symptoms and violent behavior, Sullivan and Elbogen (2013) interviewed 1,090 Service members (including National Guard and Reservists) who deployed after 9/11. While Service members reported a 13% incidence rate of violence towards family members, there was also a 9% incidence of violence towards strangers. While violence against family was associated with being female and anger symptoms, the likelihood of stranger violence was associated with being male and increased PTSD symptoms.

Social Functioning

Whereas relationship functioning focuses primarily on interpersonal interactions, social functioning refers to integration into broad social structures such as work and school. Incongruities between military and civilian cultures can make such reintegration challenging for some Service members. According to Smith and True (2014), while the military demands submitting to the group and obedience, American civilian identity traditionally encourages individualism and social relationships. This cultural conflict can exacerbate Veterans' adjustment difficulties and create difficulties when reintegrating into social roles, including as an employee in the workforce and as student in higher education.

While some studies have shown a relationship between military/civilian cultural incongruity and workplace difficulties (McAllister et al., 2015; Redmond et al., 2015), other studies have found that Service members demonstrated resilience and personal growth during their reintegration into civilian professional environments. In a qualitative study of nine National Guard and Reservists returning to previously held civilian jobs, Nagle (2014) reported that while Reservists experienced reintegration challenges, most weathered reintegration challenges with limited difficulty. Other research has focused on the relationships between deployment, mental health, and unemployment. However, more recent research has not found any relationship between deployment and unemployment (Horton et al., 2013) or between mental health, traumatic brain injury, and unemployment (Cohen et al., 2013). Nevertheless, those studies have consistently demonstrated a link between unemployment and positive screenings for depression (Cohen et al., 2013) and anxiety/panic (Horton et al., 2013).

Another domain of social functioning that has received scant attention is student Veterans' academic performance in higher education and their mental health, and the available results in this area have been inconsistent. Barry and colleagues (2014) reviewed literature on student Service members and found that student Service members and Veterans exhibited higher propensity for health risk behaviors and psychological symptoms, as well as more personal and educational adjustment difficulties than their civilian peers. Further, the study reports that these behaviors were associated with combat-related trauma. Conversely, another research study surveyed 27,774 students at 44 colleges and universities and found that student Service members with a history of hazardous duty were less likely to report feeling low in the past 12 months (Cleveland et al., 2014). The results indicated no other associations between military service and poor mental health outcomes. Similarly, Livingston and colleagues (2015) studied the relationship between military service and suicidal action and intention among student Veterans. The study reported similar findings to those of Cleveland and colleagues, namely no association between past military service and suicidal ideation, plan, or attempt.

Minimal research has examined academic performance among student Veterans, with an exception of Bryan and colleagues (2014) who sampled 422 student Service members. While there was a negative correlation between depression and grade point average (GPA), there was no relationship between PTSD symptoms and GPA. Issues faced in the context of reintegrating into civilian institutions point to a disconnect between behavioral expectations in a military and a civilian context, and could indicate potential opportunities for Transition Assistance Program training.

Spiritual Functioning

More than 90% of Americans profess a belief in God (Newport, 2011), and over half say that religion is "very important" in their lives (Gallup, 2014). Religion can help people to make meaning of their lives and assist in coping with stress (Park, 2005); religiosity has also been linked to an increased sense of purpose, resilience, satisfaction, and happiness (Mahoney & Shafraanske, 2013). Nevertheless, stressful conditions encountered during deployment may evoke spiritual conflict within Service members and Veterans, as many military personnel struggle to reconcile scriptural teachings with the conditions and demands of combat deployment (Hale-Smith et al., 2012), evoking an internal distressing spiritual conflict (Harris et al., 2013). Some Service members utilize chaplains to help examine spiritual issues; the National Post-Deployment Adjustment Survey found that 18% of OEF/OIF Veterans had talked to a chaplain/pastor in the past year (Elbogen et al., 2013).

Research on spirituality following deployment has examined both the impact of deployment on spiritual functioning and the impact of spirituality on functioning during reintegration. For instance, the VA reintegration survey found that 42% of OEF/OIF Service members reported having lost touch with their spirituality or religion as part of deployment. This loss of spirituality may be particularly important given

A domain of social functioning that has received scant attention is student Veterans' academic performance in higher education.

the relationship between spirituality and post-deployment functioning (Sayer et al., 2010). For example, research has demonstrated a positive association between spiritual distress and suicidal ideation (Maguen et al., 2012). Nevertheless, while some research shows no association between religious affiliation and post deployment functioning (Webb et al., 2014), other studies have shown that coping skills were

positively correlated with Christian religious affiliation and more frequent religious service attendance among deployed Service members in all branches of service (Sterner & Jackson-Cherry, 2015).

Physical Health

Along with mental health and interpersonal issues, some Service members face physical health problems during reintegration. In a prospective study of OEF/OIF Service members, McAndrew and colleagues (2013) found that overall physical and mental health decreased between pre-deployment and post-deployment assessments. Further, health may continue to decline in the months after homecoming. A longitudinal study of 679 OEF/OIF Veterans across their first year after homecoming found general health decreased over time, even after adjusting for PTSD (Falvo et al., 2012).

A longitudinal study of 679 OEF/OIF Veterans across their first year after homecoming found general health decreased over time, even after adjusting for PTSD.

One issue that has received particular attention in the realm of physical health outcomes is obesity, as well as the relationship between obesity and mental health. A study of a large cohort of nearly 500,000 Iraq and Afghanistan Veterans found that nearly 75% were overweight or obese (Maguen et al., 2013). During the three-year period under study, persistent obesity among men was associated with PTSD, while women's obesity was associated with depression. Other studies have examined the relationship between obesity and unhealthy lifestyle choices. In a study of 332 Iraq and Afghanistan Veterans, Hoerster et al. (2015) found that binge eating behaviors (observed among just over 8% of Veterans) were significantly associated with both depression and PTSD. In a separate study, Hoerster and colleagues (2012) found that Veterans with higher levels of depression and somatic symptoms were significantly less likely to be getting appropriate daily physical activity.

In addition, separate studies have found negative associations between deployment and (1) respiratory, (2) cardiovascular, and (3) musculoskeletal and general health concerns. With respect to respiratory health, a 2009-2011 population based survey of Veterans demonstrated that Veterans who had deployed were 29% more likely to be diagnosed with sinusitis than Veterans who did not deploy (Barth et al., 2014). Further, longitudinal research has documented a relationship between an OEF/OIF deployment and both smoking initiation and smoking recidivism, especially among Service members with multiple or prolonged deployment and combat experiences (Hermes et al., 2012; Smith et al., 2008).

Other research using self-reported data has demonstrated a range of physical health concerns among OEF/OIF Service members during reintegration, including musculoskeletal pain (33%), fatigue (32%), and back pain (28%), as well as chronic, widespread pain.

Regarding cardiovascular health, Crum-Cianflone and colleagues (2014) used Millennium Cohort Study data and found a one percent increase in new coronary heart disease cases within 5.6 years of deployment. Combat exposure and PTSD were significantly related to coronary heart disease, although the effect of PTSD

disappeared after accounting for depression and anxiety. Similarly, Service members who had multiple combat exposures were 1.3 times more likely to report hypertension than Service members who had deployed but had not experienced combat (Granado et al., 2009).

Other research using self-reported data has demonstrated a range of physical health concerns among OEF/OIF Service members during reintegration, including musculoskeletal pain (33%), fatigue (32%), and back pain (28%) (Toblin et al., 2012), as well as chronic, widespread pain (Helmer et al., 2009). Furthermore, Service members who had combat experience reported significantly higher odds of a new onset headache diagnosis than Service members who did not deploy (Jankosky et al., 2011). The range

of physical symptoms following deployment points to the need for more research on comorbid conditions, and on the degree to which physical conditions are related to behavior and mental health.

Financial Well-being

Service members are generally paid more than employees in the civilian sector with comparable education and experience. Service members may also benefit from financial bonuses associated with deployment (Hosek et al., 2013). Despite the potential financial benefits of military service and deployment, many Service members face challenges associated with poor financial management and difficulty in securing employment following military service (Burnette-Zeigler et al., 2011). Using data from the Army's Reintegration Unit Risk Inventory, Griffith (2015) showed that 7% of Service members reported money problems during deployment, and nearly 12% reported money problems after returning home from deployment. According to the study, financial difficulties were associated with failure to resume pre-deployment occupations during reintegration, as well as combat exposure, anger, frustration, alcohol abuse, sleep disorders, and suicidal thoughts. These financial difficulties may create or exacerbate reintegration challenges for Service members and their families.

Other research has focused on the outcomes of money problems, including links between financial wellbeing and post-deployment functioning. A study of 1,388 OIF/OEF Veterans reported that major depressive disorder, PTSD, and TBI were each associated with financial difficulties, and Veterans who reported having money to cover basic needs were significantly less likely to have post-deployment adjustment problems including arrest, homelessness, substance abuse, suicidal behavior, or aggression (Elbogen et al., 2012). A later study showed that 30% of Veterans reported money mismanagement, including check bouncing/forging, going over credit limits, or falling victim to credit scams. Money mismanagement was associated with reintegration difficulties, homelessness, arrest, mental health diagnosis, and income (Elbogen et al., 2013).

Financial assistance is available to Service members suffering from medical problems connected to their service. According to Marchione (2012), 45% of OEF/OIF Veterans have applied and 28% have secured disability assistance. This stands in sharp contrast with the 21% disability application rate for Gulf War Veterans. While these services have the potential to help alleviate stress by allowing Veterans to meet financial obligations, there may be a downside to dependence on disability services, including inability to secure civilian sector employment experience and stigma. Financial challenges faced by Veterans who have deployed highlight the potential usefulness of education and financial wellness programs.

Yellow Ribbon Programming for Service Members

The YRRP deployment cycle events prepare Service members and their families for the coming deployment, support them during deployment, and assist with reintegration after deployment.

The YRRP deployment cycle events prepare Service members and their families for the coming deployment, support them during deployment, and assist with reintegration after deployment. YRRP facilitates workshops that address a wide range of topics, including parenting, employment, and financial counseling. In the interest of meeting Service members' needs, YRRP allows families to attend events offered by different branches of the Guard or Reserve. Many of the programs are also offered through distance learning options.

As described in the above literature review, some Service members face challenges with reintegration in the areas of PTSD, depression, sleep, substance abuse, TBI, and risky behaviors. The existing YRRP structure includes support services and programs for each of these topical areas as well as programs related to resiliency. For instance, the YRRP also connects military families with resources regarding PTSD and TBI, including the Defense and Veterans Brain Injury Center (<http://dvbic.dcoe.mil>) and Brainline.org. Connecting Service members and their families with these vetted resources enables them to access the research-based information to help in their reintegration process.

Recommendations for Service Member Programming

We offer recommendations regarding Service member programming in three sections, including ways to enhance the content of YRRP offerings, maximize the principles of adult learning, and expand the modes and duration of programming.

Program content. The YRRP appears to cover the vast majority of topics that emerged in our literature review regarding Service member functioning after deployment. The only identifiable gap in what is presented on the YRRP website regarding event offerings is the domain of spirituality. Although research on this topic is still in its infancy, preliminary findings indicate positive associations between spiritual distress and mental health problems (Maguen et al., 2012). Service members and their families are diverse regarding how they interact with spiritual and/or religious concepts in their lives, so a general program may not be useful. Rather, YRRP may wish to continue to encourage Service members and their families to utilize the military chaplaincy options or faith-based organizations as a resource to address any spiritually-relevant reintegration issues.

YRRP may also consider a new treatment for military personnel that have experienced moral injury, namely the Building Spiritual Strength program (BSS) (Harris et al., 2011). This 8-session group-based intervention addresses religious strain and helps military trauma survivors make meaning of their experience. Preliminary research using a randomized trial demonstrated significant reduction in PTSD symptoms in participants (Harris et al., 2011).

Given findings related to Service members' risk for mental and physical health problems during reintegration, the YRRP could partner with the Army's Comprehensive Soldier Fitness Program (<http://csf2.army.mil>; Cornum, Matthews, & Seligman, 2011). This prevention and resiliency-building program supports the mental and physical well-being of the entire Army community. It strengthens those who are already psychologically healthy to cope with life challenges, including those associated with combat deployments. The program also includes a specific family skills component (Gottman, Gottman & Atkins, 2011) and a spiritual fitness component (Pargament & Sweeney, 2011). An important element of participation in the Comprehensive Soldier Fitness Program is the explicit statement that it is not disciplinary. The Service member's results are confidential, and are not even accessible by the chain of command. This emphasis on the promotion of resilience is intended to promote the wellness of the entire force and prevent the development of serious mental health problems.

YRRP offerings may be strengthened by maximizing best practices of adult learning, such as ensuring programs use participants' real-world knowledge, offering opportunities for interaction, and assisting participants in understanding the personal relevance of the information.

Principles of adult learning. YRRP offerings may be strengthened by maximizing best practices of adult learning, such as ensuring programs use participants' real-world knowledge, offering opportunities for interaction, and assisting participants in understanding the personal relevance of the information (Imel, 1998; Kaufman, 2003). In addition to lecture-based PowerPoint-style briefs, YRRP events could offer interactive activities that clearly ground the information in the participants' experiences and needs. As our team did not have access to the actual content of YRRP programs, this is a general recommendation, not in response to any specific information from any particular program.

Mode and duration of programing. As the YRRP program appears to appropriately address the most common issues faced by Service members during reintegration, it may wish to consider enhancements in how the content is delivered, specifically regarding the accessibility and consolidation of programming and information. First, as Service members and their families are geographically dispersed across the country, continuing to offer flexible programming and various formats (i.e., in-person and online) will be important.

YRRP may consider developing a smartphone application (app) which could be helpful to busy young families who often use this form of technology.

Second, increasing the accessibility and interactivity of online formats may be useful. Currently, the YRRP hosts an interactive website, a Facebook account, and a Twitter feed, with emergency contacts visibly noted for people in distress. YRRP may consider allowing Service members to easily customize information they need. More specifically, YRRP

may want to develop a dashboard or portal interface that could allow Service members to consolidate relevant resources and information into one place. In addition, technologies are now available to track users' website hits and suggest related content that may interest him/her. For example, if a Service member is viewing a page about stressors related to parenting, the website could suggest a link to an online parenting program.

Third, YRRP may consider developing a smartphone application (app) which could be helpful to busy young families who often use this form of technology. An example of a current Smartphone app that allows for customization, consolidation, and easy access is My Fitness Pal (www.myfitnesspal.com). This app allows users to customize a profile, including a baseline measure of fitness levels and goals. It offers tracking systems for exercise, food, and water intake and makes recommendations for lifestyle changes. Essentially, all fitness and well-being information is integrated into one app that is individualized and easily accessible on one's smartphone.

Fourth, research findings show that many Service Members are impacted by their military service long after they return from deployment. To this end, YRRP may consider maintaining contact with Guard and Reserve Service members for a longer period of time after homecoming, beyond the 90-day check-in event. Given the geographic isolation of many Guard and Reserve families, maintaining this contact with their unit may be especially helpful. It would be hoped that extending the availability of events and programs may enhance social support and awareness of resources, and thereby decrease the risk of reintegration problems developing into serious, chronic problems.

The Experience of Reintegration for Military Spouses

Across the entire military, including Active Duty, National Guard, and Reserve Forces, 52% of Service members are married (Department of Defense, 2014). Forty-seven percent are married to a civilian, and 5% are dual-military. There are differences in marital patterns by branch, rank, gender, and component

(Active Duty vs. Reserve). Forty-two percent of Army Soldiers, 24% of Airmen, 21% of Navy Sailors, and 12% of Marines are married. Officers are more likely to be married than enlisted personnel, male Service members are more likely to be married than female Service members, and Active Duty members are more likely to be married than Reserve component members.

In total, there are over one million military spouses. According to this report the 2012 Survey of Active Duty spouses (Defense Manpower Data Center, 2014), 89% of Active Duty spouses are female and 69% have children. With respect to age, 46% of Active Duty spouses are under 30 years, 34% are between 31 and 40 years, and 20% are 41 years or older. Sixty-three percent of Active Duty spouses identify as non-Hispanic White and 36% identify as a non-White racial/ethnic minority. Eighty-seven percent have at least some college education with 26% possessing a four-year degree and 12% having a graduate or professional degree. Thirty-nine percent are employed.

Military spouses manage family life during deployments, deal with frequent geographic moves, and can experience disruptions in their employment and education trajectories. As summarized in detail in the following sections, many spouses do well during the reintegration period, especially during the early stages. One to two months after homecoming, spouses report relatively low

Military spouses manage family life during deployments, deal with frequent geographic moves, and can experience disruptions in their employment and education trajectories.

levels of problems. In an online survey of Guard and Reserve members and spouses conducted by the RAND Corporation, about 15% said they were experiencing relationship troubles, 15% reported financial problems, 10% described mental health and/or medical concerns, and 5% cited education problems (Werber et al., 2013). Reporting of problems increased considerably during follow-up interviews. By three to six months after homecoming, about 50% of interviewees (including both Service members and spouses) reported relationship problems, and greater than one-third were concerned about spouse mental or emotional health. Little is known about how these issues develop over time and what the trajectories looks like after 180 days.

In this section on spouses' experiences during reintegration, the most recent and significant research findings are summarized across six domains of functioning, including mental health, social/role functioning, relationship functioning, spiritual functioning, physical health and health care, and financial well-being. The sections on social/role and relationship functioning are further organized into subcategories. Social/role functioning addresses the spouses' experiences as household managers, employees, students, and caregivers for injured military personnel. Relationship functioning covers marital quality and satisfaction, divorce, intimate partner violence, and intimate relationships in the context of PTSD. The relationship functioning section also includes a short section on spouses as parents and describes recent findings regarding spouses' concerns about child well-being during the reintegration phase. Additional information about parenting is contained in the section of the report dedicated to children.

Mental Health

During reintegration, some military spouses experience mental health issues including changes in mood, depression, trouble sleeping, stress, and anxiety (Mansfield et al., 2010). While reintegration stress can affect spouse mental health status, preexisting mental health issues also influence the degree of reintegration stress experienced by spouses and the coping mechanisms available to them (Marek & D'Aniello, 2014).

Various studies have investigated the rates and types of mental health problems that military spouses experience during the first six months of reintegration. In a study conducted by the RAND Corporation, Guard and Reserve members and spouses were surveyed one to two months after homecoming; at that time, 10% reported that spouse mental health was a problem in their family (Werber et al., 2013). This percentage refers only to military spouses' mental health, as Service member mental health was measured as a separate variable. Three to six months after homecoming, one-third of study participants cited spouse mental health as a concern. Relatedly, other studies have found that 11% of spouses of National Guard Service members reported hazardous drinking during the first 45 to 90 days of reintegration (Blow et al., 2013), 34% of spouses met screening criteria for one or more mental health problems, such as depression, suicidal ideation, or hazardous alcohol use (Gorman, Blow, Ames, & Reed, 2011), and 61% of those spouses who met screening criteria sought help for their own mental health concern (Gorman et al., 2011).

Factors related to spouse mental health problems during reintegration include: the family not being ready for deployment, a deployment of 12 months or longer, the perception of inadequate communication with the Service or unit after homecoming, challenging family finances, and the Service member returning with a physical injury or psychological problem (Werber et al., 2013). When a Service member returns home with combat-related PTSD in particular, his or her spouse may exhibit elevated levels of psychological distress (Bjornestad, Schweinle, & Elhai, 2014; Renshaw et al., 2011).

Social/Role Functioning

Military spouses play a number of roles in society and in the family, including as household managers, employees, students, and caregivers of injured military personnel. Spouses' experiences in these roles are discussed below.

Household division of labor. When a Service member is deployed, his or her spouse takes on many new responsibilities within the household such as handling finances, managing home and yard care, and taking care of children. An important task during reintegration is the reallocation of these roles (Baptist et al., 2011; Bowling & Sherman, 2008; Marnocha, 2012). Some families experience a honeymoon period that lasts for four to six weeks during which time everything goes smoothly (Sahlstein, Maguire, & Timmerman, 2009). From three to six months after homecoming, the renegotiation of roles and routines is a dominant task (Pincus, House, & Christenson, 2001). By one year, families tend to re-stabilize as the ambiguity about household division of labor dissipates (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008) and couples relearn how to be interdependent (Karakurt, Christiansen, Wadsworth, & Weiss, 2013).

Although the additional responsibilities faced by spouses during deployment can be challenging, many spouses also experience an increased sense of independence during this time (Baptist et al., 2011; Faber et al., 2008; Pincus, House, & Christenson, 2001). As a result, they may feel a loss of independence during reintegration. Needs regarding personal space and alone time may also change. Research finds that staying in communication as a couple and working to reincorporate the Service member into household life are important for successful reintegration (Baptist et al., 2011; Faber et al., 2008; Sahlstein, Maguire, & Timmerman, 2009).

Employment and education. Due to the nature of military life (e.g., frequent geographic moves and the challenges of Service member deployment), some spouses face challenges with employment and their

pursuit of higher education. Minimal research exists pertaining to spousal employment and education during the reintegration period in particular.

With respect to overall employment rates, 39% of Active Duty military spouses are employed, 34% are not in the labor force, 13% are unemployed and looking for work, and 11% are also in the Armed Forces (Defense Manpower Data Center, 2014). For those spouses who are employed, frequent moves disrupt employment and military spouses earn, on average, less than their civilian counterparts (Hosek & Wadsworth, 2013). Moreover, military spouses have expressed concern that limited availability of child care (especially evening and overnight care) and employer bias can pose challenges to securing and maintaining appropriate employment (Castaneda & Harell, 2008).

Regarding education, 26% of Active Duty military spouses have a 4-year college degree, 49% have taken some college coursework, 12% have no college experience, and 12% have a graduate or professional degree (Defense Manpower Data Center, 2014). A 2013 study conducted by the RAND Corporation found that 10-18% of Guard and Reserve members and their spouses described challenges with education three to six months after homecoming (Werber et al., 2013). During interviews, spouses discussed difficulties in making time for school, paying for classes, and, in some cases, transferring GI bill benefits from the Service member to his/her spouse. Additional research is needed to better understand the educational and employment challenges faced by military spouses during the reintegration process.

Spouse as caregiver. Some spouses take on a new role as caregiver when their Service member returns from deployment with a physical or psychological injury such as traumatic brain injury or PTSD. Although many Service members demonstrate resilience and recover from injury, some experience short and potentially long-term changes in personality, behavior, and ability to complete the tasks of daily living. Throughout history, spouses have often taken the caregiving role for wounded or injured military personnel. Overall, 70% of caregivers of Veterans are spouses (National Alliance for Caregiving, 2010). Looking only at the youngest generation of Veterans, however, the caregiver profile is more diverse with spouses caring for one-third of injured OIF/OEF Veterans (Ramchand et al., 2014). Parents, siblings, and friends also provide care to this group.

Providing care to an injured Service member or Veteran can be challenging. Research has documented elevated rates of emotional stress, depression, anxiety, physical strain, and financial hardship among caregivers.

Providing care to an injured Service member or Veteran can be challenging. Research has documented elevated rates of emotional stress, depression, anxiety, physical strain, and financial hardship among caregivers (Blais & Boisvert, 2005; Calhoun, Beckham, & Bosworth, 2002; National Alliance for Caregiving, 2010; Ramchand et al., 2014). Caregivers also report making changes to their personal plans and sometimes feeling overwhelmed, inconvenienced, or confined (Ramchand et al., 2014). Caregiving can also lead to changes in employment such as reduced work hours or increased absenteeism. Together, these outcomes are referred to as caregiver burden. Longitudinal research is underway to examine the experiences of military spouses as caregivers over time (Crum-Cianflone, Fairbank, Marmar, & Schlenger, 2014). These types of studies will contribute significantly to the body of knowledge on caregiving for injured military personnel.

Relationship functioning

Relationship functioning during reintegration has received considerable attention in the research literature. Most of the literature describes intimate and marital relationships, including topics such as

marital quality and satisfaction, divorce, intimate partner violence, and intimate relationships in the presence of PTSD. The most recent research findings on these subjects are described below. A short section on spouses as parents is also included. More information about children’s experiences during reintegration can be found later in this report.

Marital quality and relationship problems. Over half of all military Service members are married (Department of Defense, 2014). The quality of these relationships is important for force readiness and has been the topic of considerable study. According to the 2013 Mental Health Advisory Team report, many Service members describe their marriages as strong. Nearly one-third of Army personnel agreed or strongly agreed with all three of the following statements: “I have a good marriage,” “My relationship with my spouse is very stable,” and “I really feel like a part of a team with my spouse.”

While many marriages are strong, relationship problems remain a concern. For example, an analysis of cross-sectional data collected three to six months after deployment as part of the Land Combat Study found that marital quality declined and reports of infidelity and intent to separate or divorce increased among enlisted Army Soldiers between 2003 and 2009 (Riviere, Merrill, Thomas, Wilk, & Bliese, 2012). The precise percentage of military personnel who report problems in their marriages after deployment varies depending on sample characteristics and the timing of the survey. In one survey conducted 90 to 180 days after homecoming, 18% of married Army Soldiers reported serious interpersonal conflict with their spouse, family members, close friends, or coworkers (Gibbs, Clinton-Sherrod, & Johnson, 2012). In another study, conducted four months after homecoming, 37% of Active Duty Soldiers reported problems in their marriages (Foran, Wright, & Wood, 2013). Interpersonal conflict appears to be more common among Service members who report health problems, depression, PTSD, or alcohol abuse (Gibbs, Clinton-Sherrod, & Johnson, 2012).

The concept of relationship turbulence (i.e., the turmoil people feel when their romantic relationships are in transition) has been used to examine the post-deployment transition among military couples (e.g., Knobloch, Ebata, McGlaughlin, & Ogolsky, 2013; Knobloch & Theiss, 2012).

The trajectories of relationship problems over the deployment cycle are not well understood.

Researchers who use this model of relationship development have found that some military couples experience upheaval and relational uncertainty during the first six months following homecoming. Relational uncertainty has three components: self-uncertainty (“How certain am I about my view of this relationship?”), partner uncertainty (“How certain am I about my partner’s view of this relationship?”), and relationship uncertainty (“How certain am I about the future of this relationship?”) (Knobloch, 2014). This uncertainty has been associated with difficulty with reintegration.

The trajectories of relationship problems over the deployment cycle are not well understood. Preliminary data suggest that there may be a decline or dip in marital satisfaction during the reintegration period (McLeland, Sutton, & Schumm, 2008; Parcell & Maguire, 2014). Additional research on this subject could be useful.

Divorce. Overall rates of divorce among military personnel increased between 2000 and 2011 (Department of Defense, 2014). Among Active Duty enlisted personnel, for instance, there was a 41% increase in the rate of divorce. During this time period, divorce rates hovered around 2% for Officers and ranged between 3 and 4% for enlisted personnel. Rates vary slightly by branch, are higher among female

than male Service members, and are higher among Active Duty members than among Reserve component members.

The cause of the increase is not well understood, but deployment is one factor that has received attention in the research literature. One study found that deployment reduces the risk of divorce (Karney & Crown, 2011). Other studies, however, conclude that deployment increases the risk (Negrusa & Negrusa, 2014; Negrusa, Negrusa, & Hosek, 2014). According to the most recent studies, deployment in and of itself seems to increase the risk of divorce. Moreover, longer deployments (Negrusa et al., 2014), deployments with high levels of combat exposure in conjunction with marital distress (Foran, Wright, & Wood, 2013), and deployments that result in PTSD (Negrusa & Negrusa, 2014) are especially damaging to marital stability.

After having risen for over a decade, rates of divorce in the military declined between 2011 and 2013 (Department of Defense, 2014). Still, during the 2013 Mental Health Advisory Team 9 (MHAT 9) survey conducted in-theater in Afghanistan, approximately 10% of Active Duty Army Soldiers reported an intent to divorce. In another sample of Active Duty Soldiers asked about their marriages nine months after returning home from deployment, again, 10% reported intent to divorce. Intent to divorce does not always lead to divorce, but it may be an important precursor. Researchers will undoubtedly continue to follow divorce trends, examine causes and consequences of divorce in the military, and investigate the relationship between intent to divorce and actual marital dissolution.

Intimate partner violence. Intimate partner violence (IPV) – also termed intimate partner aggression, spousal abuse, or domestic violence – is of concern among all families, including military families. Violence ranges in severity from mild to severe, and can be perpetrated in a variety of manners including, but not limited to, psychological, verbal, physical, financial, and/or sexual. Depending on characteristics of the sample, studies find that 13-58% of military Veterans and Active Duty Service members have perpetrated physical IPV (Foran, Slep, & Heyman, 2011; Marshall, Panuzio, & Taft, 2005). Two possible predictors of IPV among military couples have received considerable attention in the research literature, including deployment and PTSD. With respect to deployment, findings are mixed. Some studies have found increases in the probability of IPV perpetration after deployment, especially moderate to severe aggression and alcohol-related incidents (McCarroll et al., 2010; Rabenhorst et al., 2012). Others studies have found that it is not deployment per se that is associated with IPV perpetration, but rather deployment in conjunction with younger age and a history of pre-deployment abuse (McCarroll et al., 2003; Newby et al., 2005).

The relationship between PTSD and post-deployment IPV is clearer. Male military Service members and Veterans who experience PTSD are at increased risk for perpetrating IPV (Hoyt, Wray, & Rielage, 2013; Taft et al., 2012; Taft, Watkins, Stafford, Street, & Monson, 2011; Teten et al., 2010). They are also more likely to report being the victim of female-perpetrated aggression (Wolf et al., 2013). Symptoms of anger, hyperarousal, numbing, and re-experiencing seem to be particularly correlated with perpetration of aggression (Hellmuth, Stappenbeck, Hoerster, & Jakupcak, 2012; Sullivan & Elbogen, 2014). In addition to PTSD, other mental health issues may also be associated with IPV. In a study of National Guard members, for instance, experiential avoidance was related to perpetration of physical aggression after returning home from deployment (Reddy, Meis, Erbes, Polusny, & Compton, 2011)

Historically, attention has been focused on male Service members as the perpetrators of IPV. Recent studies, however, have begun to investigate mutually violent couples and one-sided violence in which the female partner is the aggressor. Of couples in abusive relationships, one-quarter seem to be

engaged in mutual physical aggression (Rabenhorst et al. 2012; Teten, Sherman, & Han, 2009; Tharp, Sherman, Bowling, & Townsend, 2014), and nearly all experience mutual verbal or psychological abuse (LaMotte, Taft, Reardon, & Miller, 2014; LaMotte, Taft, Weatherill, Scott, & Eckhardt, 2014; Tharp et al., 2014).

PTSD symptoms have been associated with psychological distress in both partners and relationship discord.

In cases of unidirectional violence, studies have found that female civilian partners perpetrate considerable physical aggression toward their male Veteran partners (LaMotte, Taft, Reardon, & Miller, 2014; LaMotte et al., 2014; Tharp et al., 2014). In addition, female Active Duty military members have been found to perpetrate substantial violence toward their male civilian partners (Forgey & Badger, 2006; 2010). In light of these rates of female-to-

male and mutual violence, it is important to assess both members of a couple for IPV perpetration and victimization.

Intimate relationships and PTSD. A large body of research has examined the impact of PTSD on intimate relationships. PTSD symptoms have been associated with psychological distress in both partners and relationship discord (Lambert, Engh, Hasbun, & Holzer, 2012; Taft, Watkins, Stafford, Street, & Monson, 2011). In a sample of male Active Duty Army personnel and their civilian spouses, for instance, PTSD symptoms were related to lower levels of marital satisfaction, confidence in the relationship, positive bonding between spouses, and dedication to the relationship (Allen, Rhoades, Stanley, & Markman, 2010). PTSD symptoms have also been associated with higher levels of negative communication (Allen et al., 2010; Gerlock, Grimesey, & Sayre, 2014), more difficulty resolving conflict (Gerlock et al., 2014), and poorer couple adjustment one year after deployment (Gerwitz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). At the same time, partner support seems to lessen the severity of PTSD symptoms, especially when the Service member feels he or she can talk about difficult deployment experiences (Balderrama-Durbin et al., 2013).

Research has begun to examine partners' attributions for Service member's PTSD symptoms. Emerging findings suggest that these attributions may be related to partners' distress. Partners who attribute their Service member's PTSD symptoms to external causes (e.g., combat-related trauma) tend to report lower levels of psychological distress than those who attribute the symptoms to internal causes (e.g., the Service member's personality or disposition) (Renshaw, Allen, Carter, Markman, & Stanley, 2014; Renshaw & Campbell, 2011; Renshaw & Caska, 2012). Symptoms of numbing and withdrawal may be especially damaging to relationships because partners tend to attribute these symptoms to internal factors. Re-experiencing symptoms, on the other hand, are usually seen as having an external basis and, therefore, are associated with less distress in partners.

Partners who attribute their Service member's PTSD symptoms to external causes tend to report lower levels of psychological distress than those who attribute the symptoms to internal causes.

Spouses as parents: Concern over child well-being. In addition to their role as partners, about 70% of military spouses are also parents (Department of Defense, 2014). One issue these spouses face during the reintegration period is concern over the well-being of their children. Spouses often worry about their children's emotional health, behavior, and academic performance (Werber et al., 2013). They worry that their children will be standoffish when their Service member parent returns or that they will be overly afraid that mom or dad will leave again. At one to two months after homecoming, 5% of

participants in a RAND study of Guard and Reserve families cited concerns about child well-being (Werber et al., 2013). One-quarter of these participants expressed such concerns three to six months after homecoming. Additional research is needed to better understand the parenting experiences of spouses in the months and years after their Service member returns home from deployment. For further information about children during reintegration, please see section on children, below.

Spiritual Functioning

Spirituality among military spouses has received very little attention in the scientific literature. A few studies address the role of religion in helping spouses cope with their partners' deployment (Brelsford & Friedberg, 2011; Wheeler & Stone, 2010), and one article applies the concept of moral injury to spouses' experiences (Nash & Litz, 2013). Moral injury is useful for understanding how the violation of deeply held moral beliefs can result in psychological trauma. The term "moral injury" has primarily been applied to the war-time experiences of Service members (Marine Corps Combat Development Command, 2010), but has recently been extended to spouses who can suffer a moral injury when exposed to stories about war or images of death and brutality that are inconsistent with their moral, spiritual, or ethical beliefs (Nash & Litz, 2013). Spouses can also inflict moral injury on themselves in the form of marital infidelity or by neglecting or abusing their children. This new area of research is ripe for additional inquiry and may prove fruitful for better understanding post-deployment spiritual functioning among military family members.

Physical Health and Health Care

The research team found no peer-reviewed journal articles about the physical health of spouses during the reintegration period. A report by the RAND Corporation, however, explored spouses' experiences with health care and health insurance during reintegration (Werber et al., 2013). One to two months after homecoming, 11% of Guard and Reserve members and spouses cited problems related to health care. Three to six months after homecoming, that number rose to 53-63%. Difficulties with health insurance was a prominent theme in this study.

Financial Well-being

Financial stress can contribute to the overall stress levels of some military spouses (Department of the Army, 2012). In a Department of Defense survey of spouses of Active Duty Service members, 64% of spouses described their financial condition as being "comfortable," 22% reported "some difficulty," and 13% reported feeling "not comfortable" (Defense Manpower Data Center, 2014). Spouses of junior enlisted Service members were the most likely to report being not comfortable with their financial condition (21%).

There are a number of financial issues that are particular to Guard and Reserve families during the reintegration period. In a study of this population conducted by the RAND Corporation, about 15% of spouses and Service members reported facing financial difficulties during the first one to two months after homecoming (Werber et al., 2013). Later in the reintegration period, between three and six months after homecoming, that number climbed to 25-30%. The problems Guard and Reserve members and their spouses described included difficulty paying bills, lower household income after returning home from deployment, and delays in military pay and travel reimbursement.

In sum, military spouses can experience challenges across all six domains of functioning during the reintegration period, including mental health, social/role functioning, relationship functioning, spiritual functioning, physical health and health care, and financial well-being. During the first one to two months after homecoming, most spouses report few problems. Challenges seem to increase between three and six months after homecoming. By one year, many families have established new patterns and routines and are functioning well. In special circumstances, however, such as when a Service member returns home with combat-related PTSD or when a spouse has an underlying mental health condition, challenges may persist for several years.

Yellow Ribbon Programming for Military Spouses

As summarized in the preceding literature review, military spouses can face an array of challenges across the deployment cycle, including during reintegration and beyond. Throughout the deployment cycle, families are a primary audience for YRRP workshops and programs, except for the 90-day postdeployment event which is reserved for the Service Member. YRRP programs and events inform both Service members and spouses about what they can expect before, during, and after deployment. Current YRRP programming educates family members about available benefits and services. The components of the YRRP website that are open to the public appear to offer relevant content for spouses. The PDF handouts offer checklists and general information about expectations and community resources. In addition, the website links directly to a YRRP Facebook page, a LinkedIn group, and YouTube. These networks can facilitate spouses connecting with others in similar circumstances.

Recommendations for Military Spouse Programming

As spousal wellness is both interrelated with and independent of Service member well-being, the YRRP may consider offering programs both at the dyadic and individual levels.

This report identified a range of potential challenges faced by partners, including difficulties with mental health, social/role functioning, physical health, and family/marital relationship functioning. In reviewing programming, the YRRP may wish to consider how to most effectively address these issues, both in the Service member/partner relationship and for the partner him/herself.

As spousal wellness is both interrelated with and independent of Service member well-being, the YRRP may consider offering programs both at the dyadic (for the couple together) and individual (separate programs for Service member and partner) levels. Programmatically, this may involve separate tracks in YRRP events, including curricula for Service members, couples, and partners. In this approach, Service members and partners could select the programs that most meet their needs and interests.

Spousal mental health. The above literature review revealed that some spouses experience depression, insomnia, stress, and anxiety during the reintegration period (Mansfield et al., 2010). These issues may be especially true when Service members return home with an injury or psychological problem such as PTSD.

YRRP programming regarding spousal mental health could be offered in a conjoint or individual format. Sessions could normalize some spousal mental health problems during reintegration, offer basic coping tools, and provide resources and referrals for assistance. Spouses may benefit from individual counseling, such as the services offered through Military Family Life Consultants or organizations like Give an Hour that provide free mental health counseling to military personnel and their families.

Telephone support groups for Active Duty, Guard, and Reserve spouses have been found to increase perceived social support and decrease both depression and anxiety in military spouses during the first year of reintegration following a deployment (Nichols, Martindale-Adams, Graney, Zuber, & Burns, 2013). The model includes twelve 60-minute conference calls over the course of a year. Sessions cover topics such as communication, mental health, independence, and family roles. The calls offer education and practice in problem solving, cognitive behavioral techniques, and stress management. The success of the pilot project led to the creation of a Spouse Telephone Support (STS) program in the VA healthcare system. The YRRP may consider this telephone-based mode of support as an extension of its spousal programming.

Two existing evidence-based curricula may be useful for the YRRP to consider in addressing spousal mental health issues, Pro-Change Stress Management Program and Mindfulness-Based Stress Reduction Program (MBSR).

Pro-Change Stress Management Program. Based on the Transtheoretical Model for Behavior Change (Prochaska, DiClemente, & Norcross, 1992), the Pro-change Stress Management Program (<http://www.prochange.com/stress-management-program>) is designed to teach long-term stress management techniques. It provides feedback to participants about their readiness to change and effective strategies to manage stress. The program is available in numerous formats, including online, telephone coaching version, and as a printed manual. This program has been implemented with Veteran populations, and research has found decreased self-reported stress and depression associated with program participation (Evers et al., 2006).

Mindfulness-Based Stress Reduction Program (MBSR). This group-based program strives to help participants effectively manage stress and cope with difficult life circumstances (<http://www.umassmed.edu/cfm/stress-reduction/>). The program includes three key components, namely an explanation of mindfulness and the mind-body connection, meditation/yoga instruction and regular practice, and problem-solving regarding barriers to regular practice. The program has been widely used with positive effects in a range of populations, including decreased symptoms and improved life satisfaction. A small pilot randomized trial with Veterans with PTSD found decreased PTSD symptoms and improved quality of life among participants (Kearney, McDermott, Malte, Martinez, & Simpson, 2013).

Spousal social and role functioning. As summarized in the preceding literature review, spouses may struggle with some roles in the reintegration process, including the changed role in the household, that of employee and student, and that of caregiver for an injured Service member.

To support spouses in renegotiating roles in the household, YRRP may offer some spouse-specific events, such as panels of spouses or couples who have successfully navigated the reintegration process. Panelists could provide concrete examples of how to manage issues related to household division of labor.

Regarding spousal employment, the Department of Defense has a comprehensive, holistic, and spouse-centered program called Spouse Education and Career Opportunities (SECO) (<http://www.militaryonesource.mil/seco>). Together, Spouse Education and Career Opportunities and the Department of Defense Employment Readiness program help military spouses reach their education and career goals as they balance work-life priorities and interests. SECO offers comprehensive information, tools, and resources to support career exploration; education, training and

licensing; employment readiness; and career connections. The YRRP could ensure that spouses of National Guard and Reserve personnel are aware of these resources, confirm that content and resources are relevant to Guard and Reserve families, and strive to overcome barriers to their utilization.

Finally, spouses acting as caregivers for their Service members with physical and emotional injuries may appreciate specialized and tailored Yellow Ribbon programming. Workshops and classes could provide information about caregiver burden, teach the importance of self-care strategies (e.g., regular exercise, good nutrition, and adequate sleep), and offer relevant resources. A free online family education curriculum developed in the VA healthcare system, the Support and Family Education (SAFE) Program (www.ouhsc.edu/SAFEProgram; Sherman, 2003), may contain useful content for such programming. The SAFE Program consists of a series of workshops for adults who care about someone living with mental illness and includes specific information about PTSD. Outcome data reveal decreased burden and increased understanding of mental illness among participants (Sherman, 2006). The SAFE Program has also been modified to meet the specific needs of OEF/OIF Service members and their families; this 5-session family education program, Operation Enduring Families, is also available free online (www.ouhsc.edu/OEF).

Spousal relationship functioning. Couples can face numerous challenges in their relationships across the deployment cycle, including during the reintegration phase. Currently, YRRP supports couples in their relationships through its Strong Bonds for Couples curriculum (Strong Bonds, n.d.); this program includes components from both faith-based and secular arenas, and addresses the stress that deployment can put on a relationship. Retreats are offered both before and after deployment and may include children in family-style retreats as well. The YRRP program may consider extending their programming in light of the research literature on relationship turbulence, intimate partner violence, and the impact of PTSD on relationships.

A growing literature is examining the construct of relationship turbulence (Knobloch, 2014) which suggests that “turbulence” (i.e., change accompanied by feelings of upheaval and turmoil) is a normal part of relationships. YRRP curricula could incorporate this concept in their relationship-focused programming to normalize couples’ challenges and help diminish couples’ shame and sense of isolation regarding conflicts that often arise after homecoming.

The literature review also highlighted issues regarding military couples and intimate partner violence (IPV), with documented increased risks for such violence in military couples managing PTSD. These findings underline the importance of educating Service members and partners about respectful, healthy ways of disengaging from conflict and empowering them with resources. A new 12-session cognitive behavioral intervention that may be useful to the YRRP is the Strength at Home Intervention which focuses on preventing conflict and violence in military couples (Taft et al., 2014); preliminary outcomes of this intervention are promising (Taft et al., 2013), and a randomized clinical trial is currently underway.

Research findings about female-perpetrated violence and mutual aggression are also noteworthy (Teten et al., 2014) and may merit consideration in program development. YRRP programs may wish to provide education on these types of IPV as a means of breaking down stereotypes of one-sided physical violence perpetrated by male Service members.

Finally, PTSD is a well-documented risk factor for psychological distress and relationship discord (Lambert et al., 2012). YRRP may wish to offer specialized programming to meet the unique needs of couples where one or both partners is experiencing PTSD symptoms. Programs could provide psychoeducation to couples regarding common symptoms, treatments, and resources for PTSD. In particular, programs may address spouses' attributions for PTSD symptoms, helping to clarify when some symptoms are part of the disorder rather than as part of the Service member's disposition. Several evidence-based programs exist to address relationship problems in couples managing PTSD, including Cognitive-Behavioral Conjoint Therapy for PTSD (Monson & Fredman, 2012), Structured Approach Therapy (Sautter, Armelie, Glynn & Wielt, 2011), and the multi-family group program entitled the Reaching out to Educate and Assist Caring, Healthy Families (REACH) Program (Fischer, Sherman, Owen, & Han, 2014). The YRRP could adapt components of some of these interventions and/or partner with community organizations that offer these services.

Spousal physical health and healthcare access. The YRRP's current curricula reviews medical benefits for Service members and families throughout the deployment cycle; however, research has found that some spouses have problems with health insurance surrounding deployment and would appreciate assistance in navigating the system (Werber et al., 2013). Thus, the YRRP may wish to add specific information in their events and on their websites regarding dealing with health insurance, especially during times of change.

The Department of Defense already offers some programs to assist military personnel and their families with physical wellness, such as the Crews into Shape Challenge (Navy and Marine Corps Public Health Center, n.d.) which promotes physical activity and healthy eating in the entire family. Ensuring that such programs are available for National Guard and Reserve spouses may assist in promoting their wellbeing.

The Experience of Reintegration for Military Children

Military children can also be significantly affected by reintegration-related stressors, including the Service member's potential mental health

According to the 2013 Department of Defense Demographics Report, 43% of all Department of Defense military personnel have children. Of the Active Duty and Selected Reserve population, 36% are married with children and 6.6% are single with children. Over one-third of military children are between birth and 5 years of age (37%), followed by 6 to 11 years of age (30%), and 12 to 18 years of age (25%). Of Active Duty and Selected Reserve members who have children, the average number of children is 2.0.

Almost half (49%) of deployed Service members in all service branches and components have dependent children (Institute of Medicine, 2013). Since 2001, nearly 2 million children in the United States have been affected by parental deployment (Flake, Davis, Johnson, & Middleton, 2009). Approximately 900,000 children have had a parent who deployed multiple times as a part of OIF or OEF (Lester et al., 2012).

Military children who have experienced parental deployment can benefit from numerous resources that can buffer them from risks, including access to high quality child care and health services, housing, sports and recreational facilities, and support services (Sheppard et al., 2010). However, military children can also be significantly affected by reintegration-related stressors, including the Service member's potential mental health challenges and renegotiation

YRRP may wish to offer specialized programming to meet the unique needs of couples where one or both partners is experiencing PTSD symptoms.

of boundaries and roles within the family (Mmari, Roche, Sudhinaraset, & Blum, 2009). Lengthy parental deployments can be disruptive and distressing for children and can be associated with difficulties in both emotional and behavioral functioning (Lester et al., 2010).

Limitations of Previous Research

Much of the existing research focuses on children's experiences and well-being during parental deployment. Very little research uses children's reports of their experience during reintegration; the majority of research on military children and reintegration focuses on parents' reports of their children's adjustment or adult children's retrospective reports of adjustment during reintegration. Research is needed on the mental and emotional well-being of children during reintegration. Study designs also lack clear distinction between whether the data are about children currently experiencing deployment or children with a recently returned Service member. Very few studies include information about how long data were collected post-homecoming. In this section, information specific to time since homecoming is included where available.

This section of the report is divided into seven sections: (1) Children's overall mental health during reintegration; (2) Behavior and externalizing problems during reintegration; (3) Child abuse and maltreatment during reintegration; (4) Physical health and safety during reintegration; (5) Academic functioning during reintegration; (6) Family relationships during reintegration; and (7) Parenting during reintegration.

Mental Health

Overall indices of mental health. Children's mental health can be affected in a variety of ways during reintegration. In an evaluation of a family-based program for reintegrating Navy families, female and male children in every age group had significantly higher levels of anxiety and depression compared to standardized norms for children (Lester et al., 2012). In another study, children of combat deployed personnel similarly showed higher levels of emotional and behavioral difficulties such as anxiety and depression compared to national mean scores for civilian children (Chandra et al., 2010, 2011).

Compared to military children whose parents did not deploy, children of deployed and combat-injured parents had more healthcare visits for mental health diagnoses during the reintegration period (after the 2006 deployment to the end of the 2007 fiscal year) (Hisle-Gorman et al., 2015). Furthermore, mental healthcare use during the reintegration time period was higher for boys and children who had older, unmarried, or junior-enlisted parents. Children whose parents deployed and returned uninjured had a 67% increase in visits for mental and behavioral healthcare during reintegration as compared to during deployment; children who had a parent deploy and return injured had a nearly 200% increase (specifically for mental health screening, adjustment disorder, attention-deficit/hyperactivity disorder, developmental conditions, and mood disorders) (Hisle-Gorman et al., 2015).

Anxiety. Elevated rates of anxiety have been documented among children whose parent had recently returned from deployment. In a phone survey of over 1,000 families, 30% of children ages 11-17 reported elevated levels of anxiety symptoms, compared to 15% of civilian children (Chandra et al., 2011). Children whose parent returned from deployment within the last 12 months showed higher levels of anxiety relative to community norms (Lester et al., 2010).

Depressive symptoms and suicidal thoughts. Some military children experience depressive symptoms and suicidal thoughts during reintegration. Adolescent males whose parent deployed to a combat zone were more likely to report low quality of life, depressed mood, and thoughts of suicide than both adolescent males whose military parent did not deploy and civilian adolescents (Reed, Bell, & Edwards, 2011). Adolescent females whose military parent deployed to a combat zone were more likely to report depressed mood and thoughts of suicide than civilian females (Reed et al., 2011). Psychological symptoms of the previously deployed parent and the cumulative length of deployment were both positively associated with depression in children ages 6-12 (Lester et al., 2010). After controlling for grade in school, gender, and race/ethnicity, research with the California Healthy Kids Survey found that deployment of a parent or sibling was associated with a 33% increase in the odds of children in grades 7, 9, and 11 feeling sad or hopeless, and a 34% increase in the odds of suicidal ideation compared to children with no connection to the military (Cederbaum et al., 2013). Another study found that children ages 9-17 who had experienced parental deployment in 2008 were more likely to experience a psychiatric hospitalization compared to children whose parent did not deploy (Millegan, Engel, Liu, & Dinneen, 2013).

Behavior and externalizing problems. Some military children display behavior problems during reintegration. Children who had experienced parental deployment had greater behavioral difficulties compared to civilian children (Wilson et al., 2011). One study found interaction effects between deployment and child gender. During parental deployment, girls showed higher levels of externalizing symptoms (acting out) than boys; shortly after parental homecoming, boys showed higher levels of externalizing symptoms than girls (Lester et al., 2010).

Child abuse and maltreatment. Rates of child maltreatment one to three years after parental return from deployment have been found to be higher than rates prior to deployment (Rentz et al., 2007). In a population-based retrospective study using health care data from the Military Health System, children of deployed and combat-injured parents had more healthcare visits for injuries and child maltreatment during the year after reunion than children who did not experience parental deployment (Hisle-Gorman et al., 2015). Compared to the parental deployment period, children of parents who deployed had more healthcare visits for injuries and child maltreatment one year after reunion than children whose parents did not deploy (Hisle-Gorman et al., 2015). Significant differences were also found for parents who were injured during deployment; children of combat-injured parents had twice as many healthcare visits one year after reunion due to maltreatment than children of parents who returned from deployment uninjured.

Physical health, safety, and alcohol use. Children may experience changes in physical health during the reintegration period. In one study, children reported recurrent headaches during reintegration (Swedean et al., 2013). Children ages 12-17 who had experienced the deployment of a parent or sibling were 33% more likely to report being the victim of physical aggression (been pushed or shoved, been in a fight, afraid of being attacked, been threatened with a weapon, or seen someone with a weapon) and 50% more likely to report carrying a weapon to school than children who did not experience the deployment of a parent or sibling (Gilreath, Astor, Cederbaum, Atuel, & Benbenishty, 2014).

Children in 8th grade who had experienced parental deployment in the past six years were more likely to report binge drinking than children whose parents did not deploy (Reed, Bell, & Edwards, 2014). Additional research on children's drug and alcohol use during reintegration may be useful.

Academic Functioning

Research on academic performance shows a decrease in both academic engagement (e.g., tardiness, readiness for class) and in standardized test scores. Specifically, scores on standardized math tests of children who experienced parental deployment during the last 4 years declined by an average of 0.63 points (one tenth of a standard deviation) (Lyle, 2006). Children who experienced a longer deployment (longer than 7 months) had a larger average decline in math test scores (1.5 points) compared to children who experienced a shorter deployment (1-6 months) during the last four years. Parental deployment in the past year was also associated with lower math scores (0.76% points) (Engel, Gallagher, & Lyle, 2010). Longer deployments (more than 8 months) were associated with significantly lower standardized test scores (3% points for math scores and 2% for total academic scores). Children ages 7-17 who experienced multiple parental deployments reported more academic engagement problems compared to children who did not experience parental deployment (Chandra et al., 2010).

Family Relationships

While military family reunions are expected to be joyful, having a parent return from deployment can create new stressors for children. These stressors include reintegrating the parent into a changed family system and supporting children who have advanced through developmental phases while the Service member was deployed (Chandra et al., 2010; Huebner & Mancini, 2005; Lester et al., 2010). Children's relationships with their parents are impacted when the deployed parent returns and reintegrates into family life.

Changes in family roles. Children report significant shifts in family roles and responsibilities during reintegration (Chandra et al, 2011; Mmari et al., 2009), and these shifts can cause anxiety in children (Huebner & Mancini, 2005). Specifically, adolescent children reported that they had taken on greater responsibilities in the family during deployment, but perceived a lack of recognition for their contribution to the family during deployment (Huebner & Mancini, 2005). Adolescents described their parents' return from deployment as being more stressful and creating greater challenges and changes in the family system than the parent's initial departure (Mmari et al., 2009). In a phone survey, the majority of children (54%) also reported that the hardest part of reintegration was "fitting the returning parent back into the home routine" (Chandra et al., 2011). Children in Reserve Component families cited difficulties returning to home routines as more of an issue compared to children in Active Component families.

One study focusing on National Guard families found that one-third to one-half of adolescents in the sample reported reintegration-related difficulties such as taking a while to get used to having the deployed parent back, feeling like the deployed parent could not see how they had changed, and increased arguing with the deployed parent about family rules (Wilson et al., 2011). However, over one-fourth (26%) of adolescents reported that their father treated them as more grown up after returning from deployment.

Multiple deployments can lead to children experiencing frequent shifts in their experience of parenting (Mmari et al., 2009). Almost half (47%) of children in one study reported that they worry about the next deployment (Chandra, 2011).

Parent-child relationships. Parent-child relationships can be strained during reintegration. Almost one-third of Veterans reported “getting along with children” as a problem during reintegration from an OEF/OIF deployment (Sayers et al., 2009). In addition, 25% of Veterans reported that their children acted afraid or were not warm toward them during reintegration. In a different study employing qualitative interviews, parents reported that some children were standoffish or withdrawn around the Service member during reintegration, while other children appeared overly attached to the parent and afraid that the parent would deploy again (Werber et al., 2013). Over one-third of children (39%) reported that dealing with the previously deployed parent’s mood changes was the hardest part of reintegration (Chandra, 2011).

Expectations about parent-child communication. Many military children report that getting to know their parent again after homecoming is difficult (Chandra, Burns, Tanielian, Jaycox, & Scott, 2008). Interviews with 10-13 year old military children revealed that expectations about reintegration were central to communication between the child and the reintegrating parent (Knobloch, Pusateri, Ebata, & McGlaughlin, 2014). Several children reported that they assumed their returning parent would be a specific “way” in terms of personality, warmth, and energy level. However, children also reported that they often found their expectations to be incorrect, which led to uncertain feelings with the reintegrating parent (Walsh, 2015). Overall, youth reported that their expectations about the reunion were too high, and that they did not expect their parent to be so tired or irritable. Children also reported feelings of confusion around new communication patterns and changed family identity. Children reported that the reintegrating parent’s hostility and anxiety led to a lack of positive parent-child communication.

Sibling relationships. Qualitative interviews with 10-13 year old military children who experienced parental deployment revealed that children reported more cordial communication and less conflict with siblings during reintegration as compared to the deployment period (Knobloch et al., 2014). Notably, the children in this sample had experienced parental homecoming quite recently; almost half (48%) had parents return in the previous year, and almost one-quarter (21%) had parents who returned in the previous 2 years.

Parenting

Parental coping and impact on children. Reintegration-related stressors can impact both parenting and children. For example, of 100 National Guard soldiers who had recently returned from Iraq or Afghanistan, 69% reported concerns about “child-rearing and getting along with children,” and 56% reported that parenting was “more stressful after deployment” (Khaylis et al., 2011).

Parents’ experiences of reintegration can impact their children as well (Amen et al., 1988; Mmari et al., 2009). Military children are keenly attuned to changes in the newly returned Service member and often express concern for the well-being of both parents recently after homecoming (Chandra et al., 2011). Depressive symptoms in the returning Service member are associated with higher rates of family reunion problems (Gewirtz et al., 2010; Sayer et al., 2009).

Almost one-third of Veterans reported “getting along with children” as a problem during reintegration from an OEF/OIF deployment.

Parental injury. Parents who were injured during deployment may have reduced capacity to respond sensitively to their children (Institute of Medicine, 2010). Physical injuries sustained during combat

deployment require families to adapt to potentially long and stressful rounds of treatment and rehabilitation (Holmes, Ranch, & Cozza, 2013). Children may receive reduced attention from their non-injured parent because of the needs of the returned injured family member (Perlesz et al., 1999).

PTSD and parenting. Service members living with PTSD symptoms can struggle with parenting and parent-child relationships. Parents with PTSD report more parenting and child behavior problems, lower parenting satisfaction, more family violence, and poorer parent-child relationships than parents without PTSD (Davidson & Mellor, 2001; Jordan et al., 1992; Lauterbach et al., 2007; Leen-Feldner et al., 2011; Ruscio, Weathers, King, & King, 2002; Samper, Taft, King, & King, 2004). Fathers who have PTSD from previous conflicts have been characterized as withdrawn, irritable, and controlling (Dekel & Goldblatt, 2008; Galovski & Lyons, 2004).

In other countries, similar findings have been reported regarding PTSD and parenting. For instance, among Israeli Veterans of the 1982 Lebanon War, PTSD symptoms have been associated with decreased paternal involvement in parenting, decreased co-parenting cooperation, decreased ability to meet the physical and emotional needs of children, and increased physical and verbal violence toward children (Solomon, Debby-Aharon, Zerach, & Horesh, 2011).

Although, much of the U.S. research has been conducted with Vietnam-era Veterans, the small literature on Iraq and Afghanistan Veteran parents with PTSD reveals comparable challenges, with PTSD symptoms being related to parenting stress (Blow et al., 2013), parenting difficulties (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010) and reports of children being “afraid or not being warm” toward Veteran parents (Sayers, Farrow, Ross, & Oslin, 2009). PTSD has also been associated with decreased parenting alliance, such as less parenting cooperation and poorer communication between the parents, in families where a parent had deployed in the last year (Allen, Rhoades, Stanley, & Markman, 2010).

In conclusion, military children can experience emotional, behavioral, and academic difficulties during reintegration. Children may also be at increased risk for child maltreatment and may feel less safe during this transition period. Changes in family roles and readjusting to new family routines may also be stressful for children. Parental injury and parental PTSD symptoms can influence parenting, which can also impact children’s experiences during reintegration. While some domains may be more affected sooner after reunion (within 6 months), such as changes in family roles, children may display difficulties beyond the initial transition period, up to several years after reunion.

Yellow Ribbon Programming for Military Children

As 43% of Service members are parents (Department of Defense, 2014), YRRP devotes considerable attention to parental reintegration into their children’s lives.

Reconnecting with children and strengthening disrupted family relationships are important tasks associated with successful reintegration back into the family (Bowling & Sherman, 2008). Currently, the YRRP website includes substantial resources and information regarding familial relationships and specific curriculum concerning parenting and children. Examples include the following: *Preparing Children to Cope with Separation during Deployment*, *Helping Young Children Cope with Deployment*, and *Dealing with Deployment as Teens*. Although the website clearly conveys the message that military children have special needs surrounding parental deployment, relatively little content specifically relates to children’s

Parents with PTSD report more parenting and child behavior problems, lower parenting satisfaction, more family violence, and poorer parent-child relationships than parents without PTSD.

experience of reintegration. The website does, however, include pamphlets that encourage Service members to make time to reconnect with children; pamphlets remind Service members that readjustment to a parenting role takes time and regular communication.

In addition to the online materials, some in-person YRRP events partner with the National Guard's Child and Youth Program and include activities for 6-18 year old children. Since events are designed on the state level, each facilitator decides whether or not to offer activities for children.

Recommendations for Military Child Programming

In program expansion, the YRRP may wish to consider several evidence-based programs, including curricula focused on broader family functioning, prevention programs targeting issues documented in the literature for which military children may be at greater risk, and intervention programs to address children's difficulties. As children whose parents were injured during deployment appear to be at elevated risk for mental health problems (Hisle-Gorman et al., 2015), specific programming to support these youth may be beneficial. Expansion of existing partnerships may also be useful.

Evidence-based programs: Families. In light of some shifts in family relationships, changes in family roles, and parenting challenges that families may experience after return from deployment (summarized above), some programs target the entire military family.

ADAPT. An innovative pilot program being conducted by University of Minnesota researchers through a partnership with the Minnesota YRRP is the ADAPT Program, which stands for After Deployment Adaptive Parenting Tools (Gewirtz, Pinna, Hanson & Brockberg, 2014). ADAPT assists military families with children ages 5-12 with building resilience during the reintegration process after deployment. ADAPT utilizes both in-person sessions and web-based tools to deliver its program content. Sessions target five positive parenting practices, including skill encouragement, positive involvement, family problem-solving, monitoring, and effective discipline. Feasibility and accessibility research has yielded promising findings, and randomized trials to determine effectiveness are currently underway (Gewirtz et al., 2014). Pending demonstration of effectiveness, YRRP may consider replicating the ADAPT program in other states. In its current format, some ADAPT components are integrated into the regular Minnesota post-deployment events; dissemination of the program on a larger scale would necessitate consideration of timelines, resources, and state-specific needs.

FOCUS. The Families OverComing Under Stress (FOCUS) Program (www.focusproject.org) is specifically designed for military families and is currently being implemented at 21 military installations in the United States (Lester et al., 2011). This program is designed to help families navigate the entire deployment process and includes information about reintegration. The program has sessions for the whole family, as well as separate sessions for the couple and children. FOCUS helps military families improve their skills in emotion regulation, goal setting, communication, problem solving, and management of deployment reminders. FOCUS has also been adapted for an online only format called FOCUS world (www.focusproject.org/focus-world-intro).

Although this program is relatively new and does not yet have documentation of its effectiveness over time, preliminary research has found increased family functioning as an outcome of participation (Lester et al., 2011). Given the preliminary positive outcomes of the

FOCUS program in the Active Duty sector; if subsequent research yields strong findings, the YRRP may wish to consider adapting this curriculum to meet the needs of National Guard and Reserve families.

Online family-based resources for families. The YRRP may also wish to inform Service members and their families of some free, online family-based resources that target family support during the reintegration phase.

Veteran Parenting Toolkits. The Veteran Parenting Toolkits are a series of five age-based parenting toolkits for OEF/OIF Service members/veterans and their families. All five booklets and a corresponding provider guide are available for free online (www.ouhsc.edu/VetParenting; Sherman, Bowling, Anderson & Wyche., 2010) and have been distributed nationally in the VA system. Each toolkit addresses common challenges in Service members' reconnecting after deployment, tips on strengthening your relationship with your child, suggestions on how to manage common behavioral challenges, and resource guides.

Parenting for Service Members and Veterans. This free online parenting course supports Service members and Veterans provides information and offers strategies to improve parenting skills (<http://militaryparenting.dcoe.mil/index.php>; Shore, Murphy, Lai, & Weingardt, 2013). Created via a partnership between the Department of Veterans Affairs (VA) Mental Health Services and the Department of Defense National Center for Telehealth and Technology, this 6-module interactive course includes videos of real families sharing their stories, reflection activities, and parenting tip sheets.

Military Kids Connect. This free online community provides resources for military children (ages 6-17), their parents, and educators (<http://militarykidsconnect.dcoe.mil/kids>; Blasko, in press). It includes age-based coping tips, games, and information about deployment and reintegration. It was developed by the Department of Defense's National Center for Telehealth & Technology, and is available to all military youth.

Evidence-based programs: Child mental health. As summarized in the preceding section, some military children experience mental health challenges during the reintegration period, including elevated rates of depression and anxiety. Numerous programs exist to prevent and treat childhood mood and anxiety disorders, two of which are described below. Both programs offer weekly sessions that use cognitive-behavior therapy to prevent or reduce anxiety and depressive symptoms in children. These programs may contain useful content for the YRRP in considering programming for at-risk military youth.

Penn Resiliency Program. The Penn Resiliency Project (<http://www.ppc.sas.upenn.edu/prpsum.htm>) includes an evidence-based curriculum to prevent childhood depression. The program teaches children to combat irrational/negative thoughts, relax, be appropriately assertive, solve problems, and manage strong emotions. Research findings suggest a positive association between participation in this program and the prevention of anxiety and depression among at-risk children, such as those with a family history of mood disorders (Gillham, Brunwasser, & Freres, 2007).

Cool Kids. Another promising evidence-based program is Cool Kids (Family Version) (www.centreforemotionalth.com.au/pages/cool-kids-program.aspx), which is designed to treat anxiety in 6-12 year old children through a family group model (Rapee et al., 2006). The

program involves ten weekly sessions for five to seven families, and both parents and children learn information about anxiety and coping. Research has documented numerous positive outcomes of program participation, including enhanced academic achievement, confidence, involvement in extra-curricular activities, and less worry, shyness, and fear (Center for Emotional Health, n.d.).

Numerous parenting curricula also address child behavioral issues, some of which may also be useful in meeting these families' needs. Examples include the Oregon Model of Parent Management Training (www.isii.net/; Forgatch, Bullock, & Patterson, 2004), Multi-systemic Therapy (www.mstservices.com; Henggeler et al., 2009), and the PATHS preschool curriculum (Promoting Alternative Thinking Strategies) (www.pathstraining.com; Arda & Ocak, 2012), all of which have been found to be effective in addressing externalizing symptoms and behavioral issues.

Across these preventive and intervention programs, YRRP might consider ways to partner with trained providers in the community to address behavioral issues of military children.

Additional Partnerships. YRRP has partnered with the website Afterdeployment.org, which includes a library of information about many topics regarding military families. Service members can take anonymous assessments, view videos, and gather information about a range of relevant topics; however, this website does not offer specific programs.

YRRP may wish to strengthen partnerships with organizations that could assist National Guard and Reserve families. For example, the Department of Defense has partnered with the YMCA on behalf of military families, including Guard and Reserve families, for fitness services and respite care (Armed Forces YMCA, n.d.). The YMCA offers camps for military children that may be helpful in the reintegration process. The Military Child Education Coalition (www.militarychild.org) sponsors a range of programs across the country for military children and adults who care about them, including some specific programs focused on National Guard/Reserve families and deployment issues. YRRP may also partner with organizations such as 4-H Youth Development programs or OurMilitaryKids.org, which is organized specifically for National Guard and Reserve children, and the National Military Family Association which offers free Operation Purple Camps for military youth (<http://www.militaryfamily.org/kids-operation-purple/camps>).

In response to some military children's mental health problems after parental homecoming from deployment, YRRP may partner with state and community-based organizations to both prevent and treat mental health issues in children. Identification of strong community partners and creating positive working relationships with civilian providers can decrease duplication of services and maximize military children's access to effective services.

Conclusion

A majority of Service members, military spouses, and military children are resilient and do not develop long-term difficulties related to deployment and subsequent reintegration. Research suggests, however, that a minority of military personnel and their family members have difficulty during the reintegration period. In general, Service members and their spouses tend to report few problems during the first 1-2 months after homecoming, but difficulties increase between 3 and 6 months. For some families, especially those dealing with PTSD or a combat-related injury, difficulties can persist long after the

Service member returns home. Longitudinal studies that follow participants over many years (such as the Millennium Cohort Study) will be helpful as researchers work to understand reintegration trajectories beyond 6 months.

YRRP appears to thoroughly cover many of the key challenges faced by Service members during the reintegration phase, including issues related to mental health, parenting, employment, finances, education, and health care.

The report summarizes challenges across a number of domains of functioning. For Service members and their spouses these domains include mental health, social functioning, relationship functioning, spiritual functioning, physical health, and financial well-being. For military children, areas of focus include mental health, academic functioning, family relationships, and parenting. When available in the

literature, the research team paid particular attention to measures of time, such as the onset, duration, and course of reintegration issues.

Following a review of the relevant reintegration literature for each group (Service members, spouses, and children), this report examines existing Yellow Ribbon Programming and offers recommendations regarding additional program content, formats, or modes of delivery. Overall, the YRRP appears to thoroughly cover many of the key challenges faced by Service members during the reintegration phase, including issues related to mental health, parenting, employment, finances, education, and health care. Programming and services available to military spouses and children appear to differ considerably across sites, and are often focused on understanding and supporting the returning Service member.

The literature review identified a number of content areas that could be addressed in YRRP programming. With respect to Service members, further attention to spiritual wellbeing may be useful, as well as continued collaboration with military chaplains. For spouses, programming related to spouse-specific mental health, caregiving, self-care, and coping with their Service members' PTSD symptomatology could be useful. Regarding children's needs during the reintegration period, research has found elevated rates of mental health concerns among children who have experienced parental combat deployment; children whose parent has PTSD or other mental health concern may be at greater risk. Prevention and early intervention programming may be useful to minimize the negative impact on children.

Beyond considerations of YRRP content, the report also offers considerations for other modifications in programming. As the YRRP program reviews and enhances their offerings, it may wish to consider the following four domains: (1) program format; (2) mode of delivery; (3) duration of services; and (4) partnerships with other programs and services.

Program Format

- YRRP professionals and event facilitators may assess how the inclusion of all family members may impact attendance and engagement in their programs. Child care and child-focused programming appear to differ by state, and increasing offerings for them may enhance the event for the entire family.
- The YRRP may consider offering programs at the dyadic (for the couple together), individual (separate programs for Service member and partner), and family levels. Programmatically, this may involve separate tracks in YRRP events, including curricula for Service members, families, couples, and partners. As has been requested by YRRP participants (Werber et al., 2013), greater

family-level interaction at these events might foster the reestablishment of family bonds following deployment.

- Although not a focus of this review, the YRRP may wish to expand programming to include other people that are important to the reintegrating Service member, including parents, unmarried partners, and siblings. Although comparably less research exists regarding the experiences of these groups during reintegration, these people often provide support for Service members throughout deployment cycle, and especially upon homecoming if the Service member has experienced combat-related injury.

Mode of Delivery

- Given the geographic dispersion of National Guard and Reserve families across the country, YRRP is encouraged to continue flexible programming and offerings in various formats, including both in-person and online formats.
- Continued grounding of all programs in the principles of adult education (e.g., encouraging interaction and emphasis on personal application) may strengthen program effectiveness and participant satisfaction.
- YRRP may consider increasing the accessibility and interactivity of online formats via a dashboard or portal interface where Service members could consolidate resources and information.
- YRRP may develop smartphone apps to increase Service members' easy access to information, resources, and support.
- Given the concerns about stigma associated with mental health problems and fears surrounding seeking help, the YRRP may continue to offer some services that participants can be used anonymously.
- YRRP may also want to further develop opportunities for peer support for Service members, spouses, and children. Such forums could include not only in-person events, but also support via phone-based groups, websites, and social media.

Duration of Services

- In light of the emerging research demonstrating persisting problems among some Service members and their families, YRRP may consider maintaining contact for a longer period of time after homecoming. Such continued availability of events may have the potential to enhance social support and awareness of resources.
- The content, format, and participants included in such extended programming may be tailored to meet the needs of the specific units and/or families.

Partnership with other Organizations and Programs

- In expanding its programming, YRRP may wish to consider the numerous evidence-based programs listed in this report, including those for Service member, spouses, children, and families. Although it is unlikely that the scope of YRRP would involve offering some of these resource-intensive services, partnerships with community providers may be useful.
- YRRP may also continue to partner with community- and faith-based organizations to expand its scope and reach of programming for Service members, spouses, children, and families.
- YRRP could also continue to inform families about the online resources described herein that support of families during the reintegration phase.

The YRRP program provides a broad array of preventive and supportive services to National Guard and Reserve Service members and their families. The YRRP offerings for Service members align well with the research literature, and the current re-evaluation of programming may be helpful in enhancing future efforts. New research on the experiences of military spouses and children during reintegration suggests an opportunity for the addition of content specific to these groups.

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