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Increasing Marital Satisfaction as a Resilience Factor Among Active Duty Members and Veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF)

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Supportive relationships are protective against a number of prevalent health risks among military populations, including post-traumatic stress disorder. Increasing marital satisfaction and strengthening that relationship is an important avenue for maintaining health among returning service members and their families. The current study builds upon two earlier studies that were limited to National Guard personnel from one state. An exploratory survey was employed to identify variables that influenced marital satisfaction among Operation Iraqi Freedom and Operation Enduring Freedom veterans. Using regression analysis, the statistically significant predictive model included five variables. In addition to the identification of this predictive model, other variables found to be non-predictive are reported.

KEYWORDS *Operation Enduring Freedom, marital satisfaction, post-traumatic stress disorder, Operation Iraqi Freedom*

The War on Terrorism has stretched the United States' fighting force thin, with soldiers currently on their third or even fourth combat deployment. A recent report, *Strengthening our Military Families: Meeting America's*

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Commitment, released in January 2011, noted the alarming number of US troops who have been deployed to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Since the War on Terrorism began, more than two million service members have been deployed to OIF or OEF (National Security Staff and Domestic Policy Council, 2011). The operational tempo at which units are being deployed appears to be slowing, but with the recent build-up of troops in OEF, more deployments are inevitable.

IMPACT OF DEPLOYMENT

Impact of Deployment on the Service Member

Many veterans returning from OIF and OEF exhibit psychological problems. The Office of the US Army Surgeon General (2008) reported mental health problems among 11.9% of soldiers who have completed one deployment, 18.5% who have completed two deployments, and 27.2% who have completed three or four deployments. Seal et al. (2009) noted that 21.8% of returning veterans met the criteria for a diagnosis of post-traumatic stress disorder (PTSD). Additionally, Seal et al. (2008) reported that returning veterans are at high risk for depression and alcohol abuse.

These mental health problems are of concern for a variety of reasons, including the increased risk of suicide. Ninety percent of general population suicides meet criteria for a psychiatric diagnosis (Arsenault-Lapierre, Kim, & Turecki, 2004; Cavanagh, Carson, Sharpe, & Lawrie, 2003; Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Kang and Bullman's (2008) study of suicide risk among OIF/OEF veterans concluded that risk in this group was not statistically significantly different from the overall U.S. population but noted that those with mental disorders and recently separated active duty veterans may be vulnerable subgroups. Also, substantial evidence supports a correlation between PTSD and suicide (e.g., Hudenko, 2007; Posey, 2009). Given that 21.8% of returning veterans have been found to meet criteria for a diagnosis of PTSD (Seal et al., 2009), suicide is considered a prevalent risk for veterans.

Impact of Deployment on Marriage

OIF/OEF veterans also appear to be experiencing increasing rates of marital dissolution; the military divorce rate steadily increased from 2001 to 2008 for all members except males in the Navy (Booth, Segal, & Place, 2009). Vietnam- and Desert Storm-era data suggested that, although a supportive marital relationship was associated with veterans' recovery from PTSD (Ford et al., 1993; Shehan, 1987), spouses of veterans with PTSD were more likely to exhibit PTSD symptoms themselves (Ford et al., 1993; Schlenger et al., 1992). Furthermore, length of deployment has been found to have a significant bearing on spouses' mental health (SteelFisher, Zaslavsky, &

Blendon, 2008). The researchers noted that spouses whose partners experienced an extension report higher levels of loneliness (85.3% vs. 72.3%), anxiety (64.2% vs. 40.6%), and depression (53% vs. 33.8%) than spouses of soldiers who were not extended. These data documenting the relatively high rate of mental health problems among returning veterans and their spouses are of utmost concern.

It is apparent that changing core risk factors among military personnel during wartime and conflict periods is unlikely. Consequently, a shift in focus to increasing protective factors appears to be a more feasible preventive approach. In a report on suicide risk among veterans, Posey (2009) highlighted protective factors against suicide compiled by the American Psychiatric Association (APA, 2004) including “social support, spirituality, responsibility to family and children, life satisfaction, positive problem solving skills, therapeutic relationship, and positive coping skills” (p. 369). Social support has been viewed as a protective factor for veterans combating suicide and PTSD for decades (Brenner, Homaifar, Adler, Wolfman, & Kemp, 2009; Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; King, King, Fairbank, Keane, & Adams, 1998). Social support can originate from friends, family, or the soldier’s unit members. Among social support options, the marital relationship appears to be one of the most powerful protective factors. For example, Goldsmith et al. (2002) reported that married individuals have lower suicide rates than those who are divorced or separated. Furthermore, in the Office of the US Army Surgeon General’s (2009) examination of probable contributing factors to suicide, in 2007, 68.4% of suicides in OIF were related to “failed relationships” and in 2008, 50% (p. 50).

Given the potential power of the marital relationship as a protective factor against mental health problems and suicide, it is important to assess the effects of deployment and combat exposure on a marriage. It is widely known that separation of family members is associated with elevated rates of depression and anxiety, adding to the stress a stateside spouse incurs (Eaton et al., 2008). In their sample of military spouses who returned from OIF/OEF, Eaton et al. (2008) found that 19.5% of spouses met *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) criteria for major depression or generalized anxiety disorder. The deleterious impact of separation on military families has increased during the current military operations as a consequence of longer deployments and an increase in the number of troops experiencing repeated deployments than in past military conflicts. The typical 12-month tour became extended to 15 months in 2007, adding to the stress and coping demands on military families (SteelFisher et al., 2008). Reporting data from the Department of Defense, SteelFisher and colleagues (2008) noted that, “nearly one-third of military personnel deployed in Operation Iraqi Freedom and Operation Enduring Freedom experienced extended tours and/or repeated deployments in 2004” (p. 221).

The added demands on families resulting from deployment take many forms, in addition to the threat of combat injury or death. Eaton et al. (2008) presented a laundry list of issues that military spouses and families experience: adjustment to a mobile lifestyle, isolation from previous family (nuclear and extended), new military regulations and rules, and family separations. Spouses and families must continue to meet the challenges of all families as well: jobs, child rearing, and household duties (Eaton et al., 2008).

The Office of the US Army Surgeon General's (2009) concluded that marital satisfaction scores have decreased for enlisted and noncommissioned officers (NCOs) since 2003. Of interest is that there was no significant decline in marital satisfaction among officers (Office of the US Army Surgeon General, 2009). Today's all-volunteer force includes more married women and men than earlier military cohorts; 55% of active duty personnel are married, enlisted troops account for 52%, and 70% are officers (Defense Manpower Data Center, 2008). This information raises concern that already stressed and vulnerable service members may be at greater risk of losing a vital source of protection against suicide and other health risks: a rewarding, supportive marital relationship.

Combat and Marital Satisfaction

Research on the association between combat and marital satisfaction has produced conflicting results. Several studies have postulated that combat exposure levels during deployments to Iraq for Desert Storm (Schumm, Bell, & Gade, 2000; Schumm, Bell, Knott, & Rice, 1996) and to Somalia for Operation Restore Hope (Bell, Tietelbaum, & Schumm, 1996; Schumm et al., 2000; Schumm et al., 1996) were not found to result in reduced marital satisfaction. More recent empirical evidence on soldiers deployed to OIF supports this finding (Karney & Crown, 2007; Renshaw, Rodrigues, & Jones, 2009). However, Renshaw et al. (2009) noted, "combat exposure was not directly related to marital satisfaction" (p. 110). Rather, combat exposure was directly related to PTSD and depression, which were both found to be directly related to marital satisfaction. Additionally, Renshaw, Rodrigues, and Jones (2008) found a positive relationship between combat exposure and marital satisfaction for spouses.

Renshaw et al. (2008) sampled 49 male veterans and their spouses utilizing several assessment instruments, three of which are used in this current investigation: Relationship Assessment Scale (RAS; Hendrick, 1988), Combat Exposure Scale (CES; Keane et al., 1989), and PTSD Checklist–Military (PCL-M; Weathers, Litz, Herman, Huska, & Keane, 1993). The aim of their study was to investigate the relationship with spouses' perception of veterans' experiences and symptoms. They showed the importance that spouses' cognitions can play when spouses perceived a high degree of problems in the service member and the soldiers did not endorse their perceived level of

distress, spouses reported greater distress. However, when the soldier's symptoms matched the perceived level of distress from the spouse, that soldier appeared to be more protected from distress. Renshaw and colleagues (2008) noted several limitations. The calculation of numerous analyses with the small sample size increased the chance of increased Type I error, and the sample was entirely National Guard, thus limiting generalizability.

In a follow-up investigation, Renshaw et al. (2009) examined 50 male Utah National Guard service members who recently returned from OIF. They noted, "The highest level of perceived social support came from spouses, with significantly less perceived support from family and particularly from friends" (p. 110). They concluded that combat exposure was correlated with a PTSD diagnosis that, in turn, was significantly associated with decreased marital satisfaction. Renshaw and colleagues (2009) noted some generalizability limitations; all participants completed high school, most had started college, and the majority of their sample was White.

The primary purpose of the current study was to build upon the work of Renshaw et al. (2008, 2009) by more clearly identifying variables that influence marital satisfaction among OIF and OEF soldiers and their spouses. The researchers secured a larger and more diverse sample and included many variables excluded from the earlier explorations by Renshaw and his colleagues. Karney and Crown's work (2007) with military marriage data led them to suggest that theoretical models for today's military family must take into account the military and nonmilitary context, spousal characteristics that change as a direct result of military experience, and institutional barriers and incentives to marital stability that may be independent of marital satisfaction as it is measured in civilian families. In support of future development of such models, this investigation added to those variables included in the National Guard studies. The selection of the additional variables, mental health service utilization, psychotropic medication, and length of time stateside, takes into account elements of the nonmilitary context, whereas selection of military occupational specialty, combat injuries, and deployment length takes into account additional elements of the military context. A further objective of our study was the generation of specific information for clinical use to promote increased marital satisfaction, thereby strengthening a significant suicide protective factor among service members.

METHOD

Procedure for Data Collection and Analysis

This exploratory study used an anonymous survey to investigate variables that influence marital satisfaction among OIF and OEF veterans. All procedures were approved by the University of Texas at Arlington Institutional Review Board. Veteran service organizations were asked if they would allow

data collection from their members. After permission was obtained from the organizations, the survey was posted to their private discussion boards and chat rooms and sent through e-mail. Only organizations that verified OIF or OEF service via DD214 were allowed to participate in this study. Data was collected for approximately 40 days. All data were analyzed using the Statistical Package for Social Sciences (SPSS) version 16.0. Because this study was exploratory, an alpha of .10 was set a priori; this liberal significance is deemed acceptable for exploratory studies (Black, 1999).

Participants

The sample consisted of 113 married participants. Ninety-six were males (85%) and 17 were females (15%). The majority were White (89.4%). Four other categories accounted for the remaining 11.6% (Hispanic, $n = 5$; Other, $n = 4$; Asian, $n = 2$; and African American, $n = 1$). For number of deployments, about one half of the participants had been deployed more than once (51.8%). For length of deployment, the data were collapsed into total amount of time deployed over multiple deployments with an average of a 16.75 months total time deployed ($SD = 8.64$). The shortest was 3 months and the longest 39 months. At the time of data collection, the majority (78.6%) of participants had been stateside longer than one calendar year. Length of marriage ranged from 1 to 37 years, with an average of almost 9 years ($M = 8.97$, $SD = 8.08$). This study's demographics are similar to those of Renshaw and colleagues (2009), with the exception of gender (see Table 1).

Instrumentation

COMBAT EXPOSURE SCALE (CES)

The CES is a seven-item self-report measure developed by Keane et al. (1989). The items are rated from one to five and measure extent and severity of active combat experiences using a score weighted for the severity of each

TABLE 1 Study Sample Demographics Compared to Renshaw et al. (2009) Demographics

	Study sample	Renshaw et al. (2009)
Sex ^a	Male = 85% Female = 15%	Male = 100%
Age	35.78 years old	33.72 years old
Race	White = 89% All others = 11%	White = 96% All others = 4%
Length of marriage ^b	8.97 years ($SD = 8.08$).	9 years and 1 month ($SD = 7.43$)
Married	100%	100%

^aFrom Renshaw, Rodrigues, & Jones (2009) sampled only the male soldiers from the Utah National Guard unit were provided; their spouses data were not applicable. ^bRenshaw et al. (2009) reported SD of length of marriage in months (89.21) that was then converted into years by these authors.

item. Scores can range from 0 to 41 with a higher score indicating heavier exposure. The test–retest reliability of the CES is .97 (Keane et al., 1989) showing excellent stability. For internal consistency, Cronbach’s alpha was calculated for the CES to be .85 (Keane et al., 1989). Additionally, Keane et al. (1989) concluded that the CES has good discriminant validity.

RELATIONSHIP ASSESSMENT SCALE (RAS)

The Relationship Assessment Scale (RAS) is a seven-item self-report measure that assesses satisfaction in close relationships (Hendrick, 1988). The cumulative scores range from one to five. Hendrick, Dicke, and Hendrick (1998) reported “Scores over 4.0 would likely indicate non-distressed partners, whereas scores closer to 3.5 for men and between 3.5 and 3.0 for women would indicate greater relationship distress and possibly substantial relationship dissatisfaction” (p. 141). The RAS has been found to have good discriminant validity (Hendrick et al., 1998). The RAS has good convergent validity with the Kansas Marital Satisfaction Scale (KMSS) (.64 for men and .74 for women) and the Dyadic Adjustment Scale (DAS) (.80 and .88) (Hendrick et al., 1998).

PTSD CHECKLIST–MILITARY (PCL-M)

The PTSD Checklist–Military (PCL-M) is a Likert-type scale standardized assessment instrument with 17 items assessing PTSD symptomology derived from the *DSM* (4th ed., APA, 1994). Each item relates to criteria for the PTSD diagnosis. Pratt, Brief, and Keane (2006) examined the PCL-M and concluded that it has good convergent and discriminant validity along with high internal consistency and test–retest reliability. A clinical cutoff score of 50 or greater is used within the military population to assess the intensity of PTSD symptomatology and, ultimately, to support the diagnosis (Weathers et al., 1993).

RESULTS

Combat Exposure

Means and standard deviations for the CES, RAS, and PCL-M in this study were compared to the data from Renshaw et al. (2009). Almost one half (48%) of the participants experienced moderate to heavy combat exposure (23% moderate, 19% moderate heavy, 5% heavy) (see Table 2). The minimum CES score was 0 and the maximum was 41, with a distribution approaching normality. The participants in this study are similar to those in Renshaw and colleagues (2009) in terms of combat exposure.

TABLE 2 Data Comparisons Between Present Study and Renshaw et al. (2009)

	This study			Renshaw et al. (2009)		
	CES	RAS	PCL-M	CES	RAS	PCL-M
<i>M</i>	16.53	3.47	43.25	15.70	4.25	31.86
<i>SD</i>	9.79	.60	17.53	8.53	.59	13.19
<i>N</i>	113	113	110	47	50	50

Note. CES = Combat Exposure Scale; RAS = Relationship Assessment Scale; PCL-M = PTSD Checklist–Military. Three veterans did not complete the PCL-M in this sample, and three veterans did not complete the CES in Renshaw et al. (2009).

Relationship Assessment Scale

The mean score of the RAS was 3.47 ($SD = .60$), indicating distress for the average participant in this study. The distribution of participants between distressed and nondistressed reveals that 68 participants (60.1%) scored in the nondistressed range (3.51 or higher) and 45 (39.9%) scored in the distressed range (3.5 or lower) on the RAS. This distribution approached normality. This is divergent from the findings of Renshaw et al. (2009), whose sample had only 14% of soldiers with a distressed score.

PTSD Checklist–Military

Three respondents did not complete the PCL-M, leaving 110 participants' responses. Within this sample, 40 participants (35%) met the criteria for a PTSD diagnosis. The minimum PCL-M score was 17 and the maximum was 85, with the distribution approaching normality. The percentage of veterans in this sample with a PTSD diagnosis (35%) is higher than the sample in the Renshaw et al. (2009) study, where 12% met criteria for a PTSD diagnosis. This study's findings show soldiers meeting criteria for PTSD diagnosis at a rate approximately 3 times higher than the findings of Renshaw et al. (2009).

Relationships Among Variables

Correlations were calculated for the impacts of deployment extension, severity of combat exposure, and PTSD on veterans' marital satisfaction. Of the 113 participants in this survey, only 56 indicated whether their deployment was extended; 16 were extended and 40 were not. Veterans whose deployments were extended had a lower mean RAS score ($M = 3.34$, $SD = .71$) than those not extended ($M = 3.46$, $SD = .58$). A t test was calculated to assess if there was a difference in the marital satisfaction of the group with extended deployments compared to those whose deployments were not extended, $t(23.5) = -.60$, $p = .55$, indicating the groups are not different on marital satisfaction. These findings are consistent with SteelFisher and colleagues'

TABLE 3 Intercorrelations of Combat Exposure Scale (CES), RAS (Relationship Assessment Scale), and PTSD Checklist–Military (PCL-M)

	Marital satisfaction	Combat exposure	PTSD	Deployment length	Number of deployments	Length of time stateside ^a
Combat exposure	-.07	1	.47*	.26*	.07	-.01
PTSD	-.12	.47*	1	-.02	-.05	-.01
Marital satisfaction	1	-.07	-.12	.02	.12	.22*

Note. PTSD = post-traumatic stress disorder.

^aLength of time stateside was a categorical variable so the correlations reported are Kendall's Tau.

* $p \leq 0.01$.

(2008) conclusion that extension was not a significant predictor of weakened marriages ($p = .105$).

To assess the impact of severity of combat exposure on marital satisfaction, Pearson's correlation coefficient between CES and RAS scores indicates a weak, negative correlation that was not statistically significant ($r = -.07$, $p = .44$). Though Renshaw et al. (2009) had a slightly higher negative correlation ($r = -.21$), it too was not statistically significant.

The impact of a PTSD diagnosis on marital satisfaction was calculated using Pearson's correlation coefficient between the PCL-M and RAS scores for the 40 participants who met criteria for the diagnosis (clinical cutoff of above 50 on the PCL-M). Pearson's correlation indicated a weak, negative correlation that was not statistically significant ($r = -.12$, $p = .48$). Renshaw et al. (2009) calculated Pearson's correlation for their sample and noted a moderate, negative correlation that was statistically significant ($r = -.48$, $p \leq 0.001$) (see Table 3).

Prediction of Marital Satisfaction

A major goal of this study was to explore if a model exists to predict marital satisfaction based on selected demographics (i.e., Military Occupational Specialties, age, whether taking medication for mental health issues, injuries, length of time stateside, and participation in mental health services) PCL-M scores, deployment length, and CES scores. All variables were selected based on gaps identified in previous research (e.g., McLeland & Sutton, 2005; Renshaw et al., 2008, 2009, SteelFisher et al., 2008). The entry method used for the multiple regression method in SPSS was "Enter" as this is the most conservative (Brace, Kemp, & Snelgar, 2006).

Six models based upon the gaps in previous research were tested before a statistically significant regression was found. If the Analysis of Variance (ANOVA) was not statistically significant, the predictor variable with the highest probability value was excluded; this process was repeated until a

statistically significant model was found. The variables were excluded in the following order: CES ($p = .99$), age ($p = .99$), injured during combat ($p = .94$), participation in mental health services ($p = .94$), and medication ($p = .56$). The final model was statistically significant, $F(4) = 3.29$, $p = .01$, and included Military Occupational Specialty (MOS), length of time stateside, PCL-M score, and deployment length. The significant predictors were PCL-M scores ($p = .07$) and length of time stateside ($p < 0.001$). Collinearity was not an issue, because no tolerances were close to zero. The model had an adjusted R^2 value of .08, which accounts for 8% of the variance in marital satisfaction.

DISCUSSION

This study investigated the impact of a variety of variables on the marital satisfaction of OIF and OEF veterans. OIF and OEF veterans might be at increased health risk, not only due to combat-related injury, but also because of mental health problems and family separation. Because about one half are married and marital satisfaction is a protective factor for many mental health problems, logically, marital satisfaction should be an area for intervention as a means of enhancing military member and family resilience. Knowledge of what influences marital satisfaction, especially within a unique population like OIF and OEF veterans, is key in developing strategies for strengthening the quality of marital relationships. Previous research has explored the impact of combat exposure, PTSD, and other variables on marital satisfaction. This study expands the body of knowledge through consideration of variables not included in previous research (e.g., McLeland & Sutton, 2005; Renshaw et al., 2008, 2009, SteelFisher et al., 2008) and through replication with a sample including a higher proportion with PTSD and experiencing marital distress. Of particular importance is the investigation of influence on marital satisfaction due to variables previously not studied including MOS, medication for mental health issues, combat injuries, length of time stateside, participation in mental health services, and deployment length. Additionally, the demographics of the sample used in this study is somewhat similar to that used in the study being replicated.

Prior research (Renshaw et al., 2009) provided evidence that combat exposure is related to PTSD symptoms, which is in turn related to lower marital satisfaction. Results of this study indicate a moderate positive correlation between combat exposure and PTSD symptoms. However, in this study, a weak negative correlation between PTSD symptoms and marital satisfaction was detected (but not statistically significant), lower than prior research findings ($r = -.48$, $p \leq 0.001$; Renshaw et al., 2009). One possible explanation for this discrepancy is that Renshaw et al. (2009) gathered their data at one military installation. The combat experiences of that unit may not be representative of other combat soldiers. This study was an online survey

providing a nationwide sample, reflecting greater diversity in experiences. The combat experiences of different personnel from different units may have produced a more representative depiction of the relationship between PTSD and marital satisfaction. In fact, a counterintuitive finding was that, despite the severity of combat exposure, only 40% of participants scored in the distressed range (3.5 or lower) on the RAS. However, an unexplored limitation of these studies including the present one is that data were only collected from the service members' point of view. For this reason, though the findings were that the relationship between the RAS and PCL-M is weak, future examination of this relationship is needed where the service member and spouse are included.

In assessing how these various variables influence marital satisfaction for the purposes of prediction, a model was identified that included only four of the variables either assessed or recommended in previous research and explained 8% of the variance in marital satisfaction. Although this study explored the influence of previously omitted variables (i.e., MOS, medication for mental health issues, combat injuries, length of time stateside, participation in mental health services, and deployment length), PCL-M and length of time stateside were the only significant predictors of this group (MOS and combined deployment length were also part of the statistically significant model). A third of the participants met the PCL-M cutoff for a PTSD diagnosis, and medication and mental health services were reported accessed by 36% of participants. These findings are consistent with the literature (e.g., Erbes, Westermeyer, Engdahl, & Johnsen, 2007; Hoge, Auchterlonie, & Milliken, 2006). This finding was of interest because the use of medication and mental health services was not useful in predicting marital satisfaction in this sample, whereas level of PTSD was. One interpretation is that mental health treatment engagement was not sufficient or effective to moderate the impact of symptoms on marital satisfaction. Alternatively, an unexamined variable may moderate the relationship among treatments, symptom level, and marital satisfaction. One such variable identified in prior literature is spousal attribution of symptom origin (Nelson Goff, Crow, Reisbig, & Hamilton, 2007; Renshaw, Chambless, & Steketee, 2006; Renshaw et al., 2008).

MOS, length of time stateside, PCL-M score, and combined deployment length accounted for 8% of variance in marital satisfaction, a finding that is important and puzzling. Specifically, it is puzzling that, though clinically many of these variables seem logical predictors of marital satisfaction, they accounted for a limited variance in marital satisfaction scores. Although this study aimed to fill in gaps in previous research and theoretical models, it raises questions about missing variables.

As part of the reassessment and revision of research initiatives in this area, it is recommended that researchers build on the work in this study to further explore the influence of PTSD and length of time stateside on marital satisfaction. Specifically, explorations should include multiple measures over

time to assess whether these and other variables tested for predictive influence in this study have changing rates of influence on marital satisfaction depending on time stateside. It is suspected that length of time stateside plays a mediating role in the influence of each of the variables explored in this study. Additionally, spouses should be included along with an assessment of the service members' other sources for support, including extended family and spirituality.

It is also recommended that researchers include mental health practitioners as partners in this process to ascertain which variables present clinically as problematic for service members and their spouses in terms of marital satisfaction. Additionally, it is especially important to gain insight from mental health practitioners who work with those considering suicide, as they are likely clinically different than nonsuicidal service members. However, this will provide insight into only a small part of the population. A majority of OIF and OEF veterans do not access mental health services, as evidenced in this study and others. Studies should be designed to gather information from a diverse sampling of veterans. The procedure for recruiting veterans in this study aimed at that goal but still resulted in a limited sample size.

Although there is still much to be done in researching this topic, mental health practitioners should use the results of this study to inform their practice with service members. A model has been identified that accounted for 8% of the variance in RAS scores. With the two significant variables that have been identified (length of time stateside and PCL-M scores), practitioners can assist veterans upon return home in a variety of ways. For example, Veterans Affairs (VA), military, and Department of Defense (DoD) contract social workers can collaborate to develop creative ideas to increase the likelihood that service members will have an easier time assimilating to life away from combat. Simple measures such as reassuring the veteran and spouse that it is normal to experience challenges in reuniting and the longer they are home, there is a greater likelihood that marital satisfaction will increase (establishing positive expectancy). Such efforts will set more realistic expectations with regard to the issues and problems commonly associated with reuniting and concomitantly provide hope and anticipation that the relationship will improve following a period of adjustment. It is paramount that mental health screening efforts be implemented with soldiers upon their return stateside, as has been initiated by the Army (Hoge et al., 2006), and continued up to one year after their return.

Dating back to World War I and World War II, social workers have a history of assisting those who return from battle (Council on Social Work Education, 2010). Presently, social workers are again answering the call. A recent publication by the Council on Social Work Education (CSWE; 2010), *Advanced Social Work Practice in Military Social Work* asserted, "Specialized education to prepare social work students and professional social workers to

aid this population is clearly indicated” (p. 1). The University of Southern California (USC) School of Social Work, for example, offers a military concentration to help social workers prepare for careers serving the military population. The findings from the current and other studies may provide useful information for application in academic and continuing education programs.

Limitations

Although the sample is somewhat similar to Renshaw et al. (2009), these findings should be interpreted with caution for several reasons. This survey was online and not in a venue where the respondent could ask clarifying questions if the respondent had any. The questions were formatted so that participants did not have to answer one question to move on to the next. This study only focused on married service members; there are probably numerous potential participants who were excluded because they were dating or cohabiting and not legally married. After completion of the analysis, several variables came to light that should have been included branch of service (Marines, Army, Navy, or Air Force), component (Reserve, Guard, Active duty), theatre (OIF or OEF), and spirituality (Ahmadi, Azad-Marzabadi, & Nabipoor Ashraf, 2008). Finally, gathering data on spouses of veterans may provide far greater insights into the issues addressed in this study.

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