Introduction to the Special Section on Communication and Wartime Deployment

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Introduction to the Special Section on Communication and Wartime Deployment

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Over the past decade, the wars in Iraq and Afghanistan have taken a heavy toll on the physical, psychological, and relational health of military service members and their families. The articles included in this special section of *Health Communication* add to the robust, interdisciplinary body of research on the health consequences of wartime deployment by examining how communication enables the recovery process of service members and their families. Because communication processes can signal health problems, construct and promote family resiliency, and shape the content and delivery of health interventions, our discipline’s theory and research can help inform ongoing efforts to support military families as the wars in Iraq and Afghanistan wind down.

Over the past decade, the wars in Iraq and Afghanistan have taken a heavy toll on service members and their families. As of December 31, 2012, more than 6,600 service members have died as a result of the Global War on Terror (GWOT), and another 50,000 have been wounded in action (Department of Defense, 2012a). The Department of Defense also tracks traumatic brain injury (TBI), reporting more than 260,000 cases worldwide that range in severity from mild to penetrating head wounds (Defense and Veterans Brain Injury Center, 2013). Additionally, experts estimate that between 11 and 20% of military personnel who served in the GWOT have symptoms of, or have been diagnosed with, posttraumatic stress disorder (PTSD) (Department of Veteran’s Affairs, 2012), which translates to between 220,000 and 400,000 service members. Behind each of these individuals is a family who also has experienced hardship during this period, often as a result of chronic worry for their service member’s safety and caring for the service member once he or she returns home.

As a result of wartime deployment, service members and their families report experiencing mental health concerns such as depression, anxiety, guilt, burnout, isolation, and loneliness, all of which could put them at risk of harm (National Institute of Medicine, 2010). Suicide is also a serious problem among service members, as are sexual assault and substance abuse; the incidence of domestic violence within military families is also high (National Institute of Medicine, 2010). At the same time, research shows that military service members and their families often display tremendous resilience in the face of wartime deployment, emerging from the situation as strong as, if not stronger than, before the deployment cycle began (Wiens & Boss, 2006). It is no surprise, then, that there is a robust body of research that documents the negative (and sometimes positive) health consequences of a wartime deployment on service members and their families, as well as the various resources, coping techniques, and interventions available to facilitate resiliency and aid them in their recovery.

Indeed, research published in the last decade suggests a number of roles that communication plays before, during, and after a military deployment (Clark-Hitt, Smith, & Broderick, 2012; Davis et al., 2007; Greene, Buckman, Dondeker, & Greenberg, 2010). For example, service
members may communicate signs to health professionals and family members that there are untreated, ongoing issues that need to be addressed (Cox et al., 2011). In addition, communication processes such as age-appropriate disclosure and collaborative conflict management have been theorized as family-level processes that promote resilience (Walsh, 2003). Likewise, communicative behaviors such as support provision, individual/communal coping, self-disclosure, topic avoidance, relationship maintenance, information seeking, uncertainty management, and storytelling could have either positive or negative effects on service members and their families as they cope with issues such as separation and combat-related trauma (Joseph & Afifi, 2010; Maguire, 2012; Maguire, Heinemann, & Sahlstein, 2013; Merolla, 2010). Furthermore, intervention programs designed to help families and military service members reconnect after deployment and cope with stress often include components dedicated to improving communication skills (Wilson, Wilkum, Chernichky, MacDermid Wadsworth, & Broniaczyk, 2011). The articles included in this special section of *Health Communication* add to this body of research by examining how communication enables the recovery process of service members and their families as a result of wartime deployment.

**THE WARTIME CONTEXT**

Wartime deployment is a unique context in which to study communication, as military culture places demands on service members and their families that constrain communication and potentially exacerbate problems associated with the negative health outcomes of war. In “an attempt to deal with (and, if possible to overcome) the uncertainty of war, to impose some pattern on war, to control war’s outcome, and to invest war with meaning and significance” (Burke, as cited in Snider, 1999, p. 15), the military creates a culture that values collectivism, hierarchy, structure, authority, and control, and requires service members to place mission readiness above all else. This culture may prevent or inhibit service members from seeking help, as they may be concerned about how they would be perceived by peers and leadership (e.g., as being “weak”) and may have fears of being stigmatized for having mental health problems (Hoge et al., 2004). Military culture also affects the activities and behaviors of military spouses and children who are expected to be as committed to the military mission as the service member (Knox & Price, 1999), which may mean changing the way they communicate as a family.

For example, because military culture encourages families to protect a deployed service member from undue family stress (McNulty, 2005), non-deployed spouses often refrain from talking to their deployed spouse about home stressors, which can result in worse mental health outcomes for those left behind (Joseph & Afifi, 2010). This closed communication environment can extend to when the couple is reunited (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008), which could have implications for the service member’s recovery. Research by Cox et al. (2011), for instance, found that service members often communicate messages to loved ones and health professionals that could serve as warning signs of suicide, but these messages sometimes are missed by the recipients, thereby preventing any intervention that could have saved the service member’s life. One of the biggest warning signs, thwarted belongingness (i.e., an inability to feel a sense of belonging, or rejection after attempts towards connection), is interpersonal in nature and likely intertwined with valued family relationships. It is therefore imperative that researchers begin to understand appropriate levels, modes, and topics of communication between and among family members as they face each phase of the deployment process to protect family relationships and increase resiliency for service members and the family alike (Greene et al., 2010).

With this backdrop in mind, we created a call for state-of-the-art research that examines communication and health in the context of a wartime deployment. When we developed the call, we had hoped to get submissions representing a wide range of topics (e.g., coping, social support, patient–provider interaction), health care contexts (e.g., PTSD, TBI, suicide prevention, depression, stress), and populations (e.g., service members, spouses, children, health care providers), as well as diverse theoretical and methodological approaches. The articles we chose for this special issue, however, are relatively narrow in scope, representing mainly mental health issues with a primary focus on the military spouse, which is reflective of most (but not all) communication scholarship conducted to date. It also underscores the difficulties with conducting research in military populations, as researchers without military connections can have a difficult time gaining access to deployed, full-time active duty service members and instead study the communication of more accessible populations such as spouses and families during deployment, and service members in the post-deployment period.

At the same time, focusing on military spouses is important, as the spouse serves as a “lifeline” to the deployed service member, while also experiencing significant stressors at home, ranging from chronic worry over their service member’s safety to acute distress in the face of significant life events in the family (e.g., births, deaths). Given that spousal communication during deployment has been linked with positive outcomes for service members, such as reduced PTSD symptoms (Carter et al., 2011), it is critical to understand the factors that can facilitate or inhibit spousal communication and relational health. In addition, although the deployment period is often stressful for military couples, the post-deployment or reintegration period can be as stressful as, if not more stressful than, the deployment. In addition to figuring out how to renegotiate relational roles, together time, and tasks (Flake, Davis, Johnson,
Middleton, 2009), there are other stressors that surround the reintegration period as well, including withdrawal from social support networks, children’s rejection of the returning parent, and changes in the physical and/or mental condition of the returning service member (Drummet, Coleman, & Cable, 2003; Maguire, 2012; Wadsworth, 2010). As such, research that examines the military spouse or the military marriage during the deployment and reintegration periods is a valuable addition to scholarship on communication and health during wartime deployment.

**AN OVERVIEW OF THE ARTICLES**

The three articles in this special section represent diverse and innovative approaches to understanding the interrelationship between relational communication and health during different phases of the deployment process. First, Knobloch, Ebata, McLaughlin, and Ogolsky (this issue) employed a longitudinal design using the relational turbulence model to understand the difficulties that military couples face during the reintegration period. They collected data from both members of military couples to ascertain how depressive symptoms, relational uncertainty, and partner interference predict cognitive, emotional, behavioral, or relational challenges upon reunion (i.e., difficulty with reintegration). Using multilevel modeling, Knobloch et al. found consistent actor effects, and inconsistent partner effects, in individuals’ reports of reintegration difficulty. Their study provides further evidence of the interrelationship between mental and relational health. For instance, although reintegration difficulty for military wives was positively associated with perceived partner interference in day-to-day goals (an actor effect), reintegration difficulty for service members was positively associated with their wives’ reports of depressive symptoms (a partner effect). The results of this study suggest that both members of military couples be involved in interventions aimed at improving mental health or relationship skills.

Nichols, Martindale-Adams, Graney, Zuber, and Burns (this issue) also employ a longitudinal design to assess a pilot program (funded by the Defense Health Program) of telephone support groups for spouses of returning Iraq and Afghanistan service members.

Support groups interacted monthly over a 1-year period to discuss reintegration tasks such as managing stress, identifying mental health issues, renegotiating roles and responsibilities, reestablishing relationships and intimacy, and accessing social support and resources. Based on a curriculum grounded in models of stress and coping, spouses whose partner had returned from deployment learned and practiced problem-solving techniques, communication skills (e.g., active listening), stress reduction skills, and cognitive/mood management techniques pertaining to each reintegration task, and brainstormed ways of overcoming obstacles to enacting new practices. Participants as a group reported significant reductions in anxiety, depression, and perceived social support, though relational outcomes such as marital satisfaction or quality of family communication were not impacted significantly over the course of the 12 months. About 60% of spouses were helping care for service members who had been injured during their deployment, and subgroup analysis revealed program benefits were especially strong for this group. Lessons learned from the pilot study are informing a randomized clinical trial as the program is rolled out at Veterans Administration (VA) medical centers across the country.

Finally, Villagran, Canzona, and Ledford (this issue) explore how military spouses communicatively construct resiliency. The authors draw on Buzzanell’s (2010) framework of resiliency as a sensemaking process triggered by life disruptions in which new normalcies are imagined, resisted, and talked into being. From this view, accounts, narratives, and other forms of discourse play a key role in (a) crafting normalcy, (b) affirming identity anchors, (c) maintaining and using social networks, (d) putting alternative logics to work, and (e) legitimizing negative feelings while foregrounding productive action. In-depth interviews with 24 military spouses whose service member had been deployed within the past year reveal ways in which military spouses enact all five processes as well as tensions or challenges associated with each process. For example, military spouses articulated their shared identity anchors of quiet strength and sacrifice in support of their partner’s service, but struggled to live up to this archetypal identity in that feelings of sadness, anger, or fear often were not legitimated. Thus, one health communication intervention might be to promote conversations within the military that acknowledge the existence of negative emotions during deployment. The picture of resilience that emerges is one of a continuing personal journey rather than an outcome or destination, where support from others functions to endorse newly crafted narratives of normalcy.

In closing, these studies suggest that communication between, and among, military spouses is a critical component of the recovery process and therefore linked to both psychological and relational health outcomes. The studies in this special issue employ communication theories (e.g., the relational turbulence model, discourse-oriented views of resilience) to deepen understanding of the interrelationship between deployment and health. While these are making important contributions to the literature, there are still issues that need to be addressed to further assist service members and their families in the future. For instance, one important issue that has received relatively limited attention in communication research involves the role that family members beyond spouses play in the recovery process. Using multiple goals theory, Wilson, Gettings, and Dorrance (2013) are now examining the dilemmas family members face when talking with returning service members about seeking help for mental health concerns. These conversations involve not just spouses but also parents, siblings, and adult children.
of service members. Information from studies like these can not only help extend communication theory but also inform interventions such as the Veterans Administration’s “Coaching into Care” program, a telephone support service that helps inform family members about mental health issues and provides tips for how to begin conversations with veterans about seeking help (U.S. Department of Veterans Affairs, 2013).

Another area in need of attention involves communication and long-term recovery from combat-related injury. Following the lead of professional associations such as the American Speech-Language-Hearing Association who have worked closely with the military to help service members recover from TBI (Polovoy, 2012), health communication scholars could also offer theoretically grounded, research-based recommendations that could aid the military community in their ongoing efforts to help families recover from wartime deployment. For example, health communication scholars could examine how best to coordinate civilian and military health care teams as they work with families to provide rehabilitation to service members. In addition, communication scholars could create and evaluate media campaigns to raise awareness of resources available to aid military members and their families as they recover from injury and reintegrate into civilian life. Similarly, scholars interested in telehealth and telemedicine could examine how best to utilize new media to connect military families who reside in rural locations with health care providers and reliable health information to support them after their initial treatment at a VA clinic. Because communication processes can signal health problems, construct and promote family resiliency, and shape the content and delivery of health interventions, our discipline’s theory and research can help inform ongoing efforts to support military families as the wars in Iraq and Afghanistan wind down. The three articles in this special issue offer models for the important work that remains to be done.

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REFERENCES


