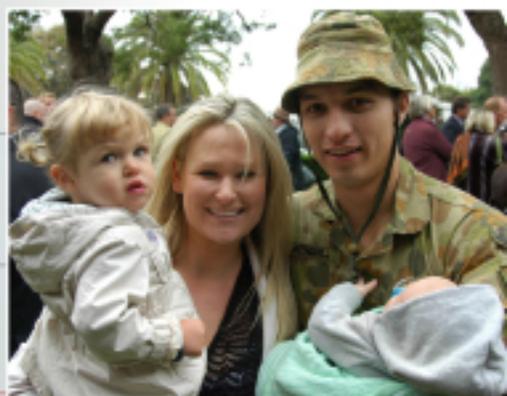




Australian Government  
Department of Veterans' Affairs

# Timor-Leste Family Study 2012



SUMMARY REPORT



THE UNIVERSITY  
OF QUEENSLAND  
AUSTRALIA



Front cover photographs,  
clockwise from top-left:

- Sapper Todd Snowden from 1 Combat Engineer Regiment, is greeted by his girlfriend Courtney at RAAF Base Darwin, on his arrival home from operations in East Timor.
- PTE Chris Wetherell, 2/17 Royal NSW Regiment Sydney, with wife Lee, daughter Madison and baby Harry following the Timor-Leste Task Group 3 farewell parade.
- CAPT Daniel Strack enjoys time with his five month old son, William at the Timor-Leste Task Group 4 family day during pre-deployment training at Puckapunyal.
- Commanding Officer of *HMAS Kanimbla* Commander Bannister with his family after Operation Astute duties in East Timor.

Images courtesy  
Department of Defence.

# TIMOR-LESTE FAMILY STUDY: SUMMARY REPORT

September 2012

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## **SUGGESTED CITATION**

McGuire, A, Runge, C, Cosgrove, L, Bredhauer, K, Anderson, R, Waller, M, Kanesarajah, J, Dobson, A & Nasveld, P 2012. *Timor-Leste Family Study: Summary Report*. The University of Queensland, Centre for Military and Veterans' Health, Brisbane, Australia.

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## The study

Military service, particularly deployment, has a profound effect not only on those who serve but also on their families. The Timor-Leste Family Study is the first Australian study designed to investigate the effects of recent deployments on the health and wellbeing of Australian Defence Force families.

The study was conducted by The University of Queensland, Centre for Military and Veterans' Health. It was funded by the Department of Veterans' Affairs as part of the Family Study Program and was designed to respond to two research aims expressed by the Department:

1. To determine what, if any, physical, mental, or social health impacts there are on a service member's family from the member's deployment to Timor-Leste.
2. To identify any risk and protective factors associated with any health impacts.

The objective was to identify the effects of deployment on Australian military families in order to facilitate the development of government policy relating to the provision of support for these families.

# Australian Defence Force deployments to Timor-Leste

Timor-Leste is a democratic republic lying north-west of Australia, on the eastern end of the island of Timor in the Indonesian archipelago. Australian Defence Force operations in the country began in 1999 and are continuing.

In June 1999 the United Nations established a mission in East Timor, UNAMET, to supervise the August independence referendum. The majority vote for Timor-Leste independence as opposed to Indonesian integration provoked a mass campaign of pro-integration militia violence. In response to the violence, the Australian Government, with a UN mandate and strong support from the Australian public, initiated the ADF-led International Force for East Timor, or INTERFET. (Note that the Democratic Republic of Timor-Leste was referred to as East Timor during Australia's initial deployments.)

Most deployments to Timor-Leste have been between three and seven months long (Australian War Memorial n.d.b) and have involved both warlike and non-warlike operations.<sup>1</sup> The present operations are non-warlike.

More than 20,000 current and ex-serving ADF members (the majority from the Australian Army) have deployed on one or more of the nine operations (Australian Peacekeeper & Peacemaker Veterans' Association 2010). To date, four soldiers have died in-country, all from non-combat related causes (Australian War Memorial n.d.a).

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<sup>1</sup> Warlike operations are military activities where the application of force is authorised in order to pursue specific military objectives and there is an expectation of casualties. Non-warlike operations are military activities where there is risk associated with the assigned tasks and where the application of force is limited to self-defence.

## The study design

The Timor-Leste Family Study compared the health of the families of personnel who had deployed to Timor-Leste with that of families of personnel who had not deployed to Timor-Leste. It also looked at risk and protective factors associated with the health of all such families.

There were three main components to the study:

- *Focus groups and interviews.* In mid-2010 four semi-structured focus groups and four individual interviews were held with partners of current and former ADF members. This resulted in identification of the primary concerns for partners and helped the study team develop a suitable questionnaire.
- *A trial questionnaire.* A pilot study that involved 100 ADF members began in December 2010 and finished in February 2011. It tested the systems and processes proposed for the main study.
- *The main study.* This began in mid-2011 and involved participants completing a questionnaire about their general health, coping style and family dynamics. More than 7,000 current and ex-serving ADF members were invited to participate in the study. ADF members were encouraged to provide their partner's contact details on the study consent form so that partners could be invited to participate.

In order to decide what questions to use in the quantitative study, the study team examined the academic literature and consulted representatives of the Department of Defence, the Defence Community Organisation, the Veterans and Veterans Families Counselling Service, Defence Families of Australia, and other family organisations. The findings of the qualitative study and pilot study were also used to help refine the questionnaire.

Questions that were shown to measure reliably and objectively the physical, mental, social and family health of respondents were chosen. The questionnaire and study design were also reviewed by the Family Study Program's Scientific Advisory Committee and the Timor-Leste Family Study Consultative Forum.

The study was approved by three Human Research Ethics Committees—the Australian Defence Human Research Ethics Committee, the Department of Veterans' Affairs Human Research Ethics Committee and The University of Queensland Behavioural and Social Science Ethical Review Committee. The study was personally supported by the Repatriation Commissioner, Major General MA Kelly AO DSC.

The finalised questionnaire was distributed to ADF members and partners, as follows:

- ADF members
  - full-time currently serving
  - Reservists
  - ex-serving
  - deployed to Timor-Leste
  - deployed to other locations
  - never deployed
- partners
  - current—wives, husbands, de facto partners, and so on
  - former
  - those who were with the ADF member when they deployed
  - those who began a relationship with the ADF member after deployment.

Another large study of military personnel—the Military Health Outcomes Program, or MilHOP (Centre for Military and Veterans' Health 2012)—was being conducted at the same time as the Timor-Leste Family Study. MilHOP measured some of the same health outcomes and shared some ADF member participants with the Timor-Leste Family Study. Rather than ask the same person the same questions within one year, the Timor-Leste Family Study team sought from participants permission to use questionnaire data collected by MilHOP. There were also different questionnaires for ADF members, partners and former partners. Altogether, the study involved six questionnaires that were automatically assigned to the relevant participant:

- ADF members (current, Reserves and ex-serving) who completed the MilHOP questionnaire
- ADF members who did not complete the MilHOP questionnaire
- current partners of ADF members who deployed to Timor-Leste
- current partners of ADF members who did not deploy to Timor-Leste and deployed elsewhere or not at all
- former partners of ADF members who deployed to Timor-Leste
- former partners of ADF members who did not deploy to Timor-Leste and deployed elsewhere or not at all.

## Collecting the data

There were three distinct phases of participant contact:

- ADF members were invited to participate in the study. Most invitations were sent by email or post between May and July 2011.
- If the person invited had not responded after two weeks, they were sent a reminder.
- If the person had not responded two weeks after being reminded, they were contacted by phone.

When the ADF member provided their partner's contact details, the partner was assigned to the relevant study group—current or former partner and Timor-Leste partner or comparison group partner—and invited by either email or post, the invitations being issued between May and December 2011. The invitation and follow-up was the same process as that used for ADF members.

Study participants completed the questionnaire between May 2011 and January 2012.

## Participation

The overall completion rate for the Timor-Leste Family Study was 36.6 per cent (4,186). Of ADF members who were invited, 36.8 per cent (2,854) completed their questionnaires. This latter participation rate is in keeping with the rates for other self-report questionnaire studies in military populations. The East Timor Health Study (2009) obtained a participation rate of 43 per cent (2,784).

Of current partners invited, 36.1 per cent (1,332) completed their questionnaire.

Only 24 former partners completed the questionnaire. To protect these participants from being identified, their responses were not included in the analysis or results. It is not clear whether the former partners' responses would have significantly changed any results. Had this been the case, additional caution would have been required when interpreting the results since it would mean the responses of 24 people overly influenced the responses of the 1,332 current partners.

## The results

Broadly, international research into the impacts of deployment on military families has found that deployment decreases the physical and emotional wellbeing of spouses and children. Positive outcomes have, however, been identified, among them increased independence for spouses and closer spousal relationships. The applicability of international findings to Australian military families is not clear, though, because of differences in each country's defence forces and social demographics.

In the Timor-Leste Family Study an ADF member's family was defined as 'the ADF member, their current partner, and any children living with their current partner'. ADF members who did not deploy to Timor-Leste between 1999 and 2010 (as recorded in the Defence Human Resources system) and their families were referred to as the comparison group.

No statistically significant differences were found between the physical, mental or family health of family members of people deployed to Timor-Leste when compared with comparison group family members. Similarly, the study found no statistically significant differences between Timor-Leste and comparison group partners' appraisal of their relationship or the reported incidence of intimate partner violence.<sup>2</sup> There was no evidence that deployment to Timor-Leste resulted in an increased incidence of birth complications; nor were any statistically significant differences between family health or perceived 'work-family conflict' reported by a Timor-Leste partner compared with a comparison group partner.

## Partners' health

Overall, the partners who participated in the Timor-Leste Study were found to be in good physical and mental health.

- Eighty-nine per cent of partners reported 'good', 'very good' or 'excellent' overall physical health. This is similar to the 91 per cent of females aged 25–44 years in the 2004–05 National Health Survey (Australian Bureau of Statistics 2006) who reported their physical health in the same positive categories.
- Partners were in the normal, or average, range for mental wellness.

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<sup>2</sup> The terms 'intimate partner violence' and 'domestic violence' are often used interchangeably. In the technical report 'intimate partner violence' is used. The term describes abuse between intimate partners, whether or not they live with the victim. In the Australian military, couples can live separately for service reasons. Domestic violence can include abuse from a household member such as a roommate or care giver.

- About 94 per cent of partners reported experiencing low or no psychological distress. In comparison, about 95 per cent of females aged between 25 and 44 years in the 2004–05 National Health Survey responded in the same categories.
- Less than 5 per cent of partners screened positive for Posttraumatic Stress Disorder.

## Children’s health

This is the first Australian study of its kind to assess pregnancy and birth outcomes for the partners of ADF members. Previous studies have typically focused on civilians only or on women who either were serving or had served in the military. The results of this study help to expand our knowledge of pregnancy and child outcomes for Australian military families. The study showed the following:

- The average number of children living with partners was 1.5 and their average age was about 10 years, there being approximately equal numbers of boys and girls.
- Eighteen per cent of partners had never had a pregnancy.
- The rate of pre-partum deaths (that is, miscarriages, ectopic pregnancies, terminations of pregnancy because of concern for the health of the mother or child, and stillbirths) was about 53 per 100 women. This does not mean that roughly half the women in the study reported the loss of a pregnancy. For example, women who had miscarriages sometimes had more than one: on average each person who reported such an event had about 1.6 miscarriages. This is similar to the findings from the Australian Longitudinal Study on Women’s Health, which found that more than half the women who reported a pregnancy outcome had lost a pregnancy (Loxton & Lucke 2009).
- In the case of post-partum deaths, there were two children per 100 families that were born alive but died after birth.

Partners were also asked to answer questions about any child living with them and aged between 4 and 17 years. For 80 per cent of these children their emotional and behavioural health was found to be within the normal range. About 10 per cent of children in a community will have scores on the behavioural difficulties measure (total difficulties—high scores) or on the behavioural strengths measure (prosocial, or positive, helping, behaviours—low scores) that categorise them as at risk of problems. A further 10 per cent will be considered to have elevated scores. On the basis of this information about 80 per cent of children in a community should be in the normal category, as was found in this study.

## The family's health

The partner questionnaires sought to gather information about family health and work–family conflict. Family health was measured in terms of 'cohesion and flexibility', 'communication' and 'satisfaction'. Most families displayed positive results for each quality:

- Ninety-one per cent of partners responded that their families were operating within the balanced (healthy) range of cohesion and flexibility, displaying moderate degrees of both.
- Sixty-four per cent of partners reported 'high' or 'very high' family communication levels.
- Sixty-three per cent of partners reported 'moderate' to 'very high levels' of family satisfaction.
- About 54 per cent of partners were either 'neutral' or 'agreed' that their partner's work caused some conflict in the family.

## The partner relationship

The questionnaire results suggested that, on average, most partners felt supported and positive about their relationship with their ADF member (a mean of approximately 3.4 out of a minimum of 1 and a maximum of 4) and reported low levels of conflict (a mean of approximately 1.8 out of a minimum of 1 and a maximum of 4).

About 90 per cent of partners screened negatively for domestic violence (intimate partner violence), suggesting that the great majority of relationships were free of violence.

# Risk and protective factors affecting ADF families

## Multiple deployments

### Partners

There was no evidence that the physical and mental health of partners varied with increasing numbers of ADF member deployments. Similarly, the overall health of the family and partners' satisfaction with their relationship did not appear to be associated with the number of deployments.

It is possible that this lack of difference in the findings reflects a 'healthy family' effect; that is, currently serving ADF members and their families who cope better with deployment are more likely to embark on further deployments. If an ADF member leaves the Defence Force or becomes medically unfit, they are no longer eligible to deploy. Additionally, there can be other reasons for an ADF member never deploying. Partners were, however, more likely to rate the military's impact on their relationship as negative as the number of deployments increased: after three deployments, more than half of them perceived the military's impact to be negative; this compares with about one-third of partners who had experienced either no deployments or just one deployment.

### Children

There was also an increase in the proportion of partners reporting the impact of the military on their children as negative as the number of deployments increased. After the third deployment, partners were more likely to respond that military commitments negatively affected their children.

Parents' ratings of their children's emotional and behavioural strengths and difficulties showed some effects of multiple deployments. Partners were twice as likely to report their children as having behavioural difficulties if they were from a family that had experienced two or more deployments. Similarly, parents reported lower levels of positive behaviours (or strengths) in children in a family that had experienced four or more deployments. These differences were statistically significant and affected a little less than 10 per cent of children.

### Changing partners' perceptions of deployment

Partners who rated Timor-Leste deployment negatively reported poorer physical and mental health and lower satisfaction with the quality of their relationship. They also reported that they received less social support from family and community sources. The more difficult the deployment was for the partner the poorer the reported outcomes.

The most frequently cited difficult aspects of Timor-Leste deployment were associated with the absence of the deployed member—for example, missing them, worrying about their safety, and not having them present on special occasions. There is little that could be done to prevent deployed personnel missing important family events. Neither is there anything that would prevent families worrying about and missing their deployed partner or parent. Nevertheless, how families feel about deployment does seem to directly affect their health.

Increasing the positive emotions relating to deployment might help mitigate negative outcomes. The broader Defence community has developed at least two strategies aimed at encouraging pride and acknowledging the sacrifices families make for the military. In 2011 the National Welfare Coordination Centre started issuing to Army families an Army Family Support Badge on receipt of a family registration form. Another initiative saw the creation of the 'kids' recognition medal', which is not officially sanctioned, has been embraced by families: about 1,000 medals 'for perseverance on the home front' were awarded to Australian military children in time for Anzac Day 2012 (Chudleigh 2012).

## Current deployment

The health of families can be affected in different ways depending on the stage of deployment—whether the ADF member is about to deploy, is on deployment, or has recently returned home. Eight per cent of the partner participants reported that their ADF member was currently deployed. The physical, mental and family health of these partners was, however, no different from that of partners whose ADF member was not deployed at the time of the study.

Again, it could be a 'healthy family' effect: in families that do not manage deployment well the serving member might be less likely to redeploy. Additionally, because current deployment was not the focus of this research, there were comparatively few partners in this situation, and there was insufficient statistical power to be confident about the findings.

## Facilitating balanced family functioning

Responses relating to family functioning suggest that healthy families maintain a balance between their emotional bonding (how dependent family members are on each other) and the flexibility they have in their roles in the family. For instance, if an ADF member took on all leadership roles in the family, it might be difficult for the non-deployed parent to take on these roles in the member's absence.

Partners reporting poorer family functioning also reported elevated symptoms of Posttraumatic Stress Disorder, higher psychological distress, worse mental health, and a high impact on child emotions and behaviours. In contrast, partners reporting higher levels of family functioning also reported lower levels of psychological distress, better mental health, and a low impact on child

emotions and behaviours. No association was found between family functioning and physical health.

Current programs that facilitate balanced family functioning might be making a positive contribution to the mental health of partners and children.

## Improving relationship quality

Relationship quality was significantly related to partners' mental health. Greater social support within the relationship and a higher degree of security and importance of the relationship were related to better scores on the mental health measure. In contrast, increased conflict in the relationship was associated with poorer mental health outcomes for partners. This pattern also held true for children, suggesting that the quality of the parents' relationship affects the children.

Programs and policies aimed at supporting improvements to the quality of relationships might be beneficial for all members of the family, including children.

## Social support

Social support was significantly associated with mental health: partners who reported higher family and non-family support had better mental health, reported lower psychological distress, less frequently screened positively for Posttraumatic Stress Disorder, and reported fewer problems for their children. Family support was more strongly associated with positive outcomes than non-family support (that is, the support of neighbours, co-workers, and so on). Partners turned most often to families for help—either their own extended family or other families also experiencing deployment.

Programs that facilitate connections to families—such as programs offering relocation during the ADF member's deployment (dependent on certain criteria)—might make a positive contribution to the health of partners and children. Similarly, Defence initiatives that connect families experiencing a deployment, such as mentoring programs or family readiness groups, might also be beneficial for partners.

## Perceived barriers to care

Partners of ADF members were asked to nominate how potential barriers—such as perceived expense, difficulty getting time off work, or not knowing where to get help—might affect their decision to seek help for mental health problems:

- About one-third of partners agreed that perceived barriers to care would prevent them from seeking help for mental health problems.

- The greatest perceived barrier for partners was that seeking help would be too expensive. Nearly one in three agreed or strongly agreed with this statement.
- Over half the partners who screened positive for symptoms of Posttraumatic Stress Disorder believed that if they sought help others would treat them differently, that they would be seen as weak or that seeking help was too expensive.

Research into veterans in the United States suggests that those who are more likely to need mental health care report barriers to care more frequently. This is supported by the findings of the Timor-Leste Family Study.

The ADF is already committed to redressing perceived barriers to care, and Defence senior leadership has acknowledged that a communications strategy aimed at reducing stigma and barriers to care is one of seven priority actions for immediate attention (see <http://www.defence.gov.au/health/DMH/i-dmhs.htm>).

## Preventing domestic violence

Domestic violence (or intimate partner violence) appeared to be a risk factor: it was significantly associated with poorer mental health scores and more symptoms of Posttraumatic Stress Disorder. In the case of children, domestic violence reported by their parent had a negative effect on the children's prosocial, or helping, behaviours.

Measurement of sensitive matters such as domestic violence is beset by difficulty and incidence is often under-reported. The measure used in this research did not explore the frequency, duration or severity of any abuse: the intention was to cause as little distress to partners as possible. This could have influenced the number of partners reporting domestic violence. The results represent, however, the first estimate of the possible level of partner abuse in ADF families. About 10 per cent of partners screened positively for domestic violence.

Although there will naturally be variation in physical and mental health, the acceptable level for domestic violence is zero. This research provides evidence that domestic violence constitutes a problem for Australian military families and affects not only partners but also children. Programs and policies aimed at preventing domestic violence would probably have beneficial effects for all members of a family. Both the Departments of Defence and Veterans' Affairs have produced fact sheets on domestic violence; they are available from [www.defence.gov.au/health/DMH/SelfHelp/Documents/FS\\_Family\\_Violence.pdf](http://www.defence.gov.au/health/DMH/SelfHelp/Documents/FS_Family_Violence.pdf) and [factsheets.dva.gov.au/factsheets/documents/Domestic\\_Violence.pdf](http://factsheets.dva.gov.au/factsheets/documents/Domestic_Violence.pdf).

## The association between an ADF member's health and their family's health

The relationship between family members is dynamic and their health can be interlinked. This study explored the relationship between an ADF member's health and their partner's health. Additionally, the intergenerational consequences of health were explored by looking at the ADF members' and their partners' health in relation to outcomes for children.

Ninety-two per cent of couples were satisfied or extremely satisfied with their relationship. On average, less than 4 per cent of couples reported being dissatisfied.

In general, there was a consistently strong relationship between the ADF member's mental health and their partner's mental health. High psychological distress in ADF members predicted high psychological distress and alcohol use in partners. High symptoms of Posttraumatic Stress Disorder in ADF members predicted high psychological distress, high symptoms of PTSD and high alcohol use in partners. Finally, higher alcohol use in ADF members predicted psychological distress and high alcohol use in partners.

In the analysis it appears that negative outcomes for children did not increase if both parents reported negative health compared with when only one parent reported negative health. In keeping with the literature, however, if either parent had mental health problems the outcomes for children were poorer.

The main finding for the three measures of child health—total behavioural difficulties, the impact of those difficulties, and reduced prosocial behaviours—was that there were statistically significant associations between both the partner's and the ADF member's PTSD symptoms and levels of psychological distress and poorer outcomes for children. Both parents contributed to negative outcomes, but it was the partner's mental health that was most strongly related to the child's outcomes—in particular, for difficult behaviour and the impact of that behaviour. The partner was, however, more likely to be the mother and potentially the at-home parent. It is possible that the stronger relationship was because of a 'negative reporting bias', whereby a partner's poor psychological state led them to report their child's outcomes more negatively than would partners with better mental health.

Overall, there was some suggestion that high alcohol use in ADF members had a stronger association with child impact scores than did high partner alcohol use. This finding should be treated with caution, though, since few partners reported high levels of drinking.

Throughout the study the impact of risk factors such as multiple deployments was apparent for children, even when the findings for partners were not statistically significant. The analysis of family systems suggested that children suffered if the ADF member had problems, but this effect was indirect; that is,

the ADF member's health is related to the partner's health, which in turn has consequences for children.

## Strengths and limitations of the study

This study examined the impact of deployment on the physical, mental and family health of military families, using Timor-Leste deployment as an example. Deployments to Timor-Leste began 13 years ago, in 1999. Selecting a random sample of those who experienced deployment to Timor-Leste means that comparatively fewer younger couples and newer members of the Defence Force were included in the study. This excluded population is likely to have newer, less-established relationships and younger children on average, and they might have different concerns in relation to established support networks and strategies for dealing with separation. The Timor-Leste Family Study population thus involved a biased sample of ADF members and their families.

More recently enlisted personnel might also have benefited from newer deployment-related policies and procedures that are applicable to both members and their families. It was evident throughout the research process that many organisations—for example, the Defence Community Organisation, the Veterans and Veterans Families Counselling Service and Defence Families of Australia—are committed to improving the family experience of service life. How effective these changes have been cannot be assessed by this research program.

This is the first Australian study to begin the process of measuring the impact of military service on family health. The findings provide an evidence base to guide the development of policy and interventions. For a study of this type the number of participants was very high: more couples (996) participated in this study than has been the case for similar international research. The study provides a firm foundation of baseline measures and a large and rich data set that will continue to be analysed.

One limitation of the study is that it was difficult to isolate completely the Timor-Leste deployment experience from all others. Many of the participating families had experienced deployments to a variety of other locations. Some ADF members might have deployed before they met their partner and might not have told their partner about that deployment. Alternatively, some partners might have included long trips, exercises or overseas activities that are not categorised by Defence as operational deployments but are experienced by partners as akin to a deployment.

Responses were gathered at only one point in the participants' lives, and the participants were required to provide answers about the past (retrospective cross-sectional research). As a result, although responses from people at different stages of life (for example, number of children and length of marriage) were collected, the study design did not have the capacity to measure changes in health outcomes on the basis of these life stages. The needs associated with different 'ages and stages' formed a theme strongly expressed by participants in the focus groups and interviews and also by Defence Families of Australia and

other stakeholders. Measuring changes in health outcomes on the basis of life stages can only be done through longitudinal research, which collects data from the same people over a number of years. Longitudinal research would also facilitate a deeper understanding of the complex effects arising from different and multiple deployments.

The literature on risk and protective factors is extensive, and it was not possible to include every plausible factor in the questionnaire. Concepts such as overall stress or loneliness were excluded. This study does, however, provide a foundation from which studies of more specific aspects of the impacts of military life on families could be built.

## Conclusion

In 1999, when the first Defence personnel deployed to Timor-Leste, it would have been difficult to foresee the number of operations Australian personnel would be part of in 2012. Operations continue in Timor-Leste, Solomon Islands, Afghanistan, Iraq, elsewhere in the Middle East, Egypt, and South Sudan. The ADF has responded to tsunamis, cyclones, fires and floods, and military families have supported their loved ones through these operations. There is a need for Australia to develop a broader research program that builds on the Timor-Leste Family Study and responds to the concerns of military families in the current environment and in the future.

There are many ways in which support for military families might be strengthened and improved. The positive outcomes and resilience shown by most families participating in this important research program are heartening. Many families expressed pride in the contribution they and their ADF member were making to Australia. But military service does have consequences for families, particularly for children. Acknowledging that many families are doing well in no way diminishes the responsibility and care that are owed to families who are not.

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