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## CHAPTER 1

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# Couple-Based Interventions for Military and Veteran Families

## *Evidence and Rationale*

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At the writing of this book, over 2 million U.S. service members have been deployed in service to the conflicts in Iraq and Afghanistan since 2001, and many other troops have been deployed from other countries as part of the Multinational Forces. Based on data indicating that each U.S. service member has an average of 1.5 eligible dependents (i.e., spouses, children, adult dependents) this means that approximately 3 million family members have been directly affected by military deployment (U.S. Department of Defense, 2007). These estimates do not take into account the many extended family members, such as grandparents, aunts/uncles, siblings, and adult children, who have also been affected by the reverberations of deployment and the mental health problems and physical disabilities that may result from experiences during deployment. The most recent conflicts have brought heightened awareness of the effects of deployment and mental health issues on couples and families that arise during the course of military service. As a result, the U.S. Departments of Defense (DoD) and Veterans Affairs (VA), as well as veteran service organizations, have come to recognize the pressing need for family support services and interventions. Yet many clinicians within and outside of these organization are not well-versed in family theory and interventions, the military subculture that influences individual and relational functioning, or the best ways to incorporate family members in assessment and treatment when problems develop. Our overarching goal

is to address this gap between the substantial family needs and clinician knowledge and skill to deliver high-quality couple and family interventions.

## BRIEF HISTORY OF FAMILY RESEARCH WITH PRIOR VETERAN COHORTS

The effects of combat and combat-related mental health conditions on family functioning and vice versa have been well-documented, dating back to at least World War II, when researchers and clinicians noted the changes in family roles and functions that accompanied long deployments, and the adaptations that needed to occur for veterans to reintegrate into their families. For example, labor shortages resulting from the number of men deployed and the casualties of World War II brought women into the workforce in record numbers, leading to transitions in family functioning regarding child care and roles for women within and outside of the home. Those veterans who returned home, as well as their families, were forced to adapt to a new set of roles and, for many, to confront mental health issues that were not well understood or treated at that time. As a result, most of the documentation on service members' and veterans' families was epidemiological (e.g., rates of increased divorce, as well as increases in the birthrate—a.k.a. the “baby boom”) or clinical descriptions of the types of struggles and transitions in family roles and functioning. Less was written about the associations between mental health conditions and their effects on the family or the role of the family in promoting individual veteran mental health, because much less was known about combat-related mental health sequelae at that time.

The Vietnam War brought a surge of empirical research and heightened public and professional recognition of individual combat-related mental health problems. In fact, Vietnam veterans and their posttraumatic reactions were a major impetus to the inclusion of the posttraumatic stress disorder (PTSD) diagnosis in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980. There was also more empirical attention paid to the association between PTSD and a range of psychosocial impairments, including its effects on couple and family functioning, as well as the individual mental health of spouses and children.

A landmark study of U.S. veterans' families came out of the congressionally mandated National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990). The larger NVVRS comprised 1,200 male and 432 female veterans who served during the Vietnam War at least 15 years prior to the study's completion. A subsample of the overall NVVRS sample was involved in a study focused on the intimate partners and children of these veterans and their family relationship functioning. This substudy has

yielded a number of substantial contributions to the understanding of the role of military service, combat exposure, and combat-related mental health problems in the context of family functioning. For example, the seminal paper from this study (Jordan et al., 1992) documented that the elevated rates of couple distress, divorce, parenting problems, and family violence found in these veterans was attributable to the psychopathology associated with combat trauma exposure (e.g., PTSD) versus combat trauma exposure per se. In fact, combat trauma exposure without a PTSD diagnosis was associated with *less* risk for perpetrating domestic violence. The rates of the various couple and family problems found in the NVVRS in those who were trauma exposed but without a PTSD diagnosis were comparable to the general population. Follow-up studies have found behavioral avoidance and emotional numbing symptoms to be more specifically implicated in the association between PTSD and intimate partner problems, as well as veterans' relationships with their children. The hyperarousal symptoms found in PTSD, which significantly overlap with symptoms of depression (e.g., irritability, sleep disturbance, attention/concentration problems), have been particularly associated with the perpetration of family violence in veterans. Studies with other samples of U.S. veterans and veterans serving other countries have found similar results (see Monson, Taft, & Fredman, 2009, for review).

A few studies regarding service members/veterans and their families have been conducted since the research focus on Vietnam veterans, to include studies with peacekeepers serving in various areas (e.g., Bosnia) and those serving in the first Iraq War. However, the current wars in Iraq and Afghanistan have led to the largest proliferation of studies on service members and veterans and their families during and after deployments. This focus on couple/family functioning is heartening given the well-documented effects of deployment, and especially combat deployments, on families (these effects are described by Beasley, MacDermid Wadsworth, & Watts, Chapter 4, and Snyder & Monson, Chapter 13). In addition, this recent research is more rigorous methodologically, because it is occurring during and more immediately following the deployments and, in some cases, is being conducted longitudinally to better understand the effects of deployment and deployment-related health problems on families over time.

In addition to these methodological improvements, there are characteristics about the current wars that may differentially affect families compared with prior conflicts. Specifically, in contrast to Vietnam, there is an all-volunteer military fighting force involved in these wars. Because the current cohort of service members is older, includes more women, and is more likely to be married and to have children compared with prior veterans, one could anticipate different individual and relational outcomes. In 2009, nearly 70% of enlisted troops were in their 20s, and most officers

were in their 30s. About 50% of service members were married, and more than 25% had dependent children. Women also represent the fastest growing demographic of service members and veterans, and women's roles in the military and combat have evolved significantly since prior conflicts. Also, compared with prior peacekeeping and combat missions, there is an unprecedented reliance on the Reserve and National Guard components of the DoD which, as described by Martin and Sherman (Chapter 2) and Slone, Friedman, and Thompson (Chapter 3), are without many of the institutional resources and supports to which active duty service members and their dependents are entitled. Service members and their families are typically facing not a single deployment, but rather multiple deployments, with some having weathered five or six deployments already. These deployments are sometimes extended beyond the expected time frame, and this time variance can be highly disruptive to service members and their families. Furthermore, the insurgency warfare and guerilla tactics (e.g., improvised explosive devices, suicide bombings) being used in Iraq and Afghanistan have brought different wide-reaching effects on the physical and mental health of this most recent cohort of veterans compared with cohorts in prior eras. Advances in medical technology have significantly decreased the number of service members who die as a result of these and other war-related tactics, but the number of long-term physical and mental disabilities resulting from these injuries has significantly increased. Partners and extended family members often are required to provide varying levels of assistance and care for those with these disabilities. Finally, technological advances have radically changed the landscape of contact between deployed service members and their families, which is in marked contrast to the experience of deployed service members and their families in years past. The ability to be in contact in real time, with audio and video capabilities in many cases, carries with it a number of potential advantages and disadvantages to the adjustment of service members and their families during deployment.

### **LANDMARK FAMILY FINDINGS RELATED TO THE WARS IN IRAQ AND AFGHANISTAN**

Alongside traumatic brain injury, we believe that the “signature wound” of the wars in Iraq and Afghanistan is the combat-related mental and physical health issues that adversely impact couple and family functioning. Epidemiological research indicates that approximately 20–35% of service members who served in combat deployments to Iraq or Afghanistan evidence clinical levels of PTSD, depression, general anxiety, or alcohol misuse, with rising rates of these problems over time (e.g., Hoge et al., 2004). In addition to documenting the high and increasing rates of veterans with mental health

problems, an important point to highlight from this research is the even greater rise in reported interpersonal problems. In a longitudinal study of over 88,000 soldiers who served in Iraq, Milliken, Auchterlonie, and Hoge (2007) found a fourfold increase in reported interpersonal problems from the first to second waves of assessment (a median of 6 months). Others have found that more than 75% of married/partnered veterans who screen positive for mental health problems in VA outpatient treatment clinics report difficulties with partners or children.

Studies of Iraq and Afghanistan veterans, like those of prior veterans, have documented positive correlations between symptoms of PTSD, depression, sleep disturbance, dissociation, and alcohol use disorder and intimate relationship discord and parenting problems (e.g., Gerwitz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). Extending this research to examine potential mechanisms accounting for the associations, partners' perceptions of service members' combat exposure have been found to influence the strength of the association between PTSD and relationship dissatisfaction. More specifically, when female partners perceive their husbands to have experienced relatively low levels of combat exposure and their husbands report high levels of PTSD symptoms, the association between PTSD symptoms and wives' discord is stronger (Renshaw, Rodebaugh, & Rodrigues, 2010). By contrast, when wives perceive their husbands to have experienced high levels of combat exposure, husbands' self-reported PTSD symptoms no longer predict their wives' relationship satisfaction; that is, wives appear to be less distressed if their husbands' PTSD symptoms can be understood as the result of combat exposure or other consequences of war. Wives' perceptions of caregiver burden for their veteran partners have also been found to be a mediator in the association between mental health problems and intimate relationship problems. Ultimately, over time the effects of PTSD on veterans' intimate relationships are likely to take a toll, but the meaning that caregivers give to their partners' symptoms can potentially serve either to soften or exacerbate that impact.

Rising rates of suicide by service members and veterans have been of great concern to the military and VA, and the role of interpersonal and family factors in precipitating suicidality and preventing attempts has become a focus of research and clinical attention. In the general suicide literature, relationship conflict emerges as a consistent and strong risk factor for suicidality. Other significant family risk factors include relationship separation or termination, as well as domestic violence in the relationship. Another important familial risk factor from the suicide literature is the veteran's or service member's own perception of being a burden to his or her family. Irrespective of type of mental or physical health condition, it is important for providers to remember the salient role of family relationship functioning in assessing and managing suicidality in veterans and service

members. This is more fully discussed by Whisman and Sayers in Chapter 9.

A study on the role of couples' communication during deployment provides some initial empirically informed guidance about the best means and frequency of communication with regard to service members' mental health functioning, and thereby their combat readiness (Carter et al., 2011). This study revealed that overall frequency of communication was not associated with the male soldiers' severity of PTSD symptoms. However, there was a significant inverse relation between frequency of communication and PTSD severity for those soldiers who had high levels of relationship satisfaction. In other words, more frequent communication among satisfied couples was protective against PTSD symptoms. The authors examined the speed of communication as well, including delayed (i.e., e-mail, letters, care packages) and interactive (i.e., instant messaging, phone calls, video messaging) methods. Relationship satisfaction was even more important in the association between delayed communication and PTSD symptoms. More frequent delayed communication was associated with less PTSD symptom severity in couples with high levels of relationship satisfaction and more PTSD symptom severity in couples with low levels of relationship satisfaction.

A disconcerting finding that has emerged in this newest cohort of service members is a sex difference in the rate of divorce. The Pentagon has reported that female service members, in general, are twice as likely as their male counterparts to divorce. Enlisted women are three times more likely than male enlistees to divorce (Karney & Crown, 2007). The various reasons offered for this sex difference include the fact that female service members are more likely to be married to male service members, which causes increased tension from balancing family and mission demands, and greater sacrifices for these dual-career couples. In addition, women's roles in the military and combat have evolved and expanded, which has resulted in increased expectations of women, and these service-related demands are not being offset with changes in the routines and responsibilities for women at home. Research with female service members documents that the expectations for household upkeep and child care have been maintained in spite of women's greater work demands and likelihood of deployment. Furthermore, it is a more common expectation for women to stay at home to single-parent and maintain family life than for men to manage these demands while their wives deploy. Future empirical research into the reasons for this disparity will help to inform support and intervention strategies for women service members and their at-risk marriages.

Several studies investigating the mental health and overall functioning of female partners and children of deployed service members have revealed the stressful effects of deployment on these individuals left at home. A medical record review of over 250,000 U.S. Army wives, with over 6.5 million

outpatient visits, revealed that those wives with a deployed husband were significantly more likely to be diagnosed with, and receive services for, a mental health condition compared with wives who did not have a deployed husband. The rates of the wives' mental health diagnoses increased even more as husbands' length of deployment increased (i.e., longer than 11 months; Mansfield et al., 2010). Similarly, as elaborated by DeVoe, Paris, and Ross in Chapter 5, rates of childhood behavioral and emotional problems can increase with the deployment of a parent. Although military families and dependents evidence a great deal of resilience under the pressures of military service, and deployments specifically, these studies point to the larger mental health effects of deployment on military dependents.

### **INTEGRATION OF FAMILY MEMBERS IN INTERVENTIONS**

All of the family-oriented studies discussed earlier have concluded that there is a pressing need to increase family support and intervention efforts for veterans and service members and their families. Several studies have also specifically addressed the desire of veterans and their families to be involved in these interventions. A large majority of veterans seeking mental health treatment have indicated that they recognize that their mental health problems affect their families and want their family members to be involved in treatment (e.g., Batten et al., 2009). Spouses have also indicated their desire to be involved in assessment and intervention efforts, with many of them expressing a sentiment that their struggles and sacrifices have been overlooked.

There also seems to be greater societal recognition of the need for family involvement in mental health prevention, assessment, and treatment services in order to improve treatment efficacy and expand the benefits of the treatment. For example, in 2003, there was a specific call by the President's New Freedom Commission for family-centered services and treatments. In 2008, the VA was provided authority by Public Law 110-387, the Veterans' Mental Health and Other Care Improvement Act, to include marriage and family counseling as a service for family members of *all* veterans eligible for care. As a result, clinicians with expertise in couple and family therapy were hired, and training and dissemination efforts were initiated to increase staff capacity to deliver evidence-based couple and family interventions. Similarly, the DoD has initiated several training programs for its mental health, family advocacy, and chaplaincy staff on evidence-based interventions to prevent couple discord and to address couple distress, when it develops, and specific couple-level problems, such as infidelity and domestic violence. Snyder, Baucom, Gordon, and Doss

(Chapter 6) and Hayman, Taft, Howard, Macdonald, and Collins (Chapter 7) address these important problems. There have also been efforts to train staff in couple therapies that address specific, individual mental health conditions that are commonly found in veterans and service members and have the added benefits of enhancing couple functioning and improving the health and well-being of partners. Couple therapies for these conditions are presented, featuring interventions for PTSD (Monson, Fredman, & Riggs, Chapter 8) depression (Whisman & Sayers, Chapter 9) alcohol and other substance abuse (Schumm & O'Farrell, Chapter 10), traumatic brain injury (Glynn, Chapter 11), and grief and loss (Scheider, Sneath, & Waynick, Chapter 12).

We consider this book to be an extension of these important efforts, as we aim to facilitate preparation of the myriad providers that serve veterans, service members, and their families. We hope to widen the scope of these training efforts to include the many clinicians who see these individuals and couples outside of military and veteran healthcare settings in the community, and providers in other countries who may not yet have access to training in these evidence-based practices. We have aimed to make this book as user-friendly and clinically relevant as possible. Toward this end, the reader will notice that the chapters include case examples to illustrate more fully the concepts presented. Each chapter concludes with a list of "Resources" also cited in the text of the chapter rather than a full bibliography of references. We asked each contributor to identify those key resources so that busy providers could easily discern and access those materials if more information is desired.

In order to promote a solid theoretical and practical foundation for providers, Part I of this book presents chapters focused on helping providers be culturally competent regarding the social context that surrounds military and veteran families (Martin & Sherman, Chapter 2), and thinking about matching available resources and family needs (Slone, Friedman, & Thompson, Chapter 3). There is also a focus on the normative transitions and adjustments to and from deployment as they affect military and veteran families (Beasley, Wadsworth, & Watts, Chapter 4). Part II of the book (Chapters 5 to 12) focuses on best practice and evidence-based couple interventions for specific couple-level problems and individual mental health conditions most common to military and veteran couples, as well as their children. Each of these chapters includes reproducible handouts to facilitate relevant interventions. (Larger versions of these handouts can also be downloaded from the book's page on The Guilford Press website.)

Part III examines implications of the previous chapters for institutional policies and clinical practice in both the military and civilian communities (Snyder & Monson, Chapter 13). The book concludes with appendices of resources specifically developed for veterans' and service members' families,



as well as an overview of military ranks, structural organization, and common terms that providers may encounter in the course of clinical work.

## SUMMARY

The wars in Iraq and Afghanistan have brought unprecedented professional and public attention to our need to support families as they face deployment and redeployment, and to address the collateral damage that deployment-related mental and physical health problems can have on the families of veterans. Likewise, we are beginning to appreciate the powerful role that couple and family relationships can play in sustaining health and preventing longer-term problems when the inevitable stress of combat deployment comes. Service members, veterans, and their spouses have expressed their desire to have greater family involvement in the planning and provision of interventions to enhance treatment efficacy and the breadth of improvements when mental health conditions arise. To help meet these crucial needs, this book provides a comprehensive “go-to” resource for facilitating the health and resilience of service members, veterans, and their families—a group richly deserving of the best possible care and support that can be provided.

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