Family and Couples Treatment for Newly Returning Veterans

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Civilian psychologists are being called on to assist the thousands of service members returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Newly returning veterans are at risk for depression, posttraumatic stress disorder, and alcohol use disorders. In addition, veteran partners and families are at increased risk for stress and conflict. The following article provides clinicians with information on the impact of military service on the veteran and the family, then reviews ongoing family services available to veterans through the Veterans Health Administration (VHA). Finally, we describe recovery-oriented implications for practicing psychologists when treating veterans and their families.

Keywords: family, couples, treatment, veteran, military

Veterans are returning to small towns and big cities all over the nation. Newly returned veterans and their families are seeking psychological help for various problems including posttraumatic stress disorder (PTSD), alcohol use disorders, and traumatic brain injury (TBI) sequelae. These mental health problems, along with other factors related to military service, have a significant impact on family functioning. Civilian psychologists can struggle with how to best help these families, especially when they do not have military experience themselves. This article aims to do three things: help practitioners understand characteristics of newly returning veterans and their families, inform practitioners of Veterans Health Administration (VHA) policies and initiatives promoting evidence-based practices for families, and provide recovery-oriented recommendations for practicing psychologists when treating veterans and their families.

Part 1: The Impact of Military Service on the Veteran and the Family

Since 2001, over 1.9 million people have been deployed as part of Operation Enduring Freedom (OEF) and Operation Iraqi Free-
were faced with many emotions. They may feel relief that their service member is home and alive. They may struggle with the positive and negative stress of incorporating the service member back into the family. They may also be surprised to find themselves mourning the loss of who the service member was before deployment and acclimating to who the service member is now. This acclimation can be difficult and can lead to significant relationship problems. In previous conflicts, service in combat has been associated with high rates of marriage dissolution (Ruger, Wilson, & Waddoups, 2002). Preliminary evidence suggests that divorce rates in the Army have increased since the start of OEF and OIF (Cotton, 2009). Further, TBI, PTSD, and depression, three common injuries of the present conflict, have all been uniquely and independently related to divorce (Tanielian & Jaycox, 2008), suggesting that future divorce rate increases are probable.

While many service members experience these psychological consequences, some will also experience physical consequences. OEF/OIF service members have a lower likelihood of fatality as compared to previous conflicts (DOD, 2009). This is the result of improved body armor, improved emergency medical care, and improved emergency evacuation services. Service members are now surviving physical trauma that previously would have been fatal, resulting in severe combat-related injuries, both physical and psychological (IOM, 2010). Any physical injury can have a serious impact on veterans and their families. Families may need to relocate to receive appropriate health care and physical injuries may lead to lasting changes in a consumer’s mood, behavior, and capacities.

Traumatic brain injury is the most common injury among OEF/OIF service members (IOM, 2010). Between 10 and 20% of OEF/OIF veterans return with TBI injuries (Elder & Cristian, 2009; Tanielian & Jaycox, 2008). Closed head injuries (head injuries that do not penetrate the skull) are the most common cause of TBI. Although mild TBI may go undiagnosed, this injury can result in a myriad of serious outcomes such as unprovoked seizures, depression, aggression, memory problems, pain, headaches, and dizziness (IOM, 2009). Other common physical consequences of the OEF/OIF conflicts include auditory and visual impairment, limb amputation, and chronic pain (IOM, 2010). In addition to these physical injuries, psychological injuries also take a heavy toll on veterans and their families.
Major depression, posttraumatic stress disorder, and alcohol misuse disorders are all common psychological problems experienced by OEF/OIF service members (IOM, 2010). Although estimates vary widely, 5% to 37% of active-duty service members meet criteria for major depression. Among Vietnam veterans, depression was associated with lower rates of employment and lower hourly wages (Savoca & Rosenheck, 2000). Depression among service members is also associated with relationship conflict, family conflict, and partner violence (Pan, Neidig, & O’Leary, 1994).

Between 5 and 15% of active service members meet criteria for PTSD (Tanielian & Jaycox, 2008). Service members with premilitary experiences such as a history of trauma or low mental or physical health status before combat exposure are at higher risk for developing PTSD (LeardMann, Smith, Smith, Wells, & Ryan, 2009; Tolin & Foa, 2006). PTSD is also associated with a host of both parenting and partner relationship difficulties (Monson, Taft, & Fredman, 2009). When assessing newly returned veterans who had been referred for a behavioral health evaluation, 78% of OEF/OIF veterans reported at least one family issue (Sayers, Farrow, Ross, & Oslin, 2009). One-fourth of veterans reported that their children were not warm to them or were afraid of them; 40% of veterans reported feeling like a guest in their own home. Further, those veterans with a provisional diagnosis of depression or PTSD were 5 times as likely to endorse family readjustment issues.

In addition to depression and PTSD, prevalence rates of substance use disorders in current service members and veterans range widely. In a Millennium Cohort study of 48,481 Reserve or National Guard personnel with combat exposures, postdeployment rates of heavy weekly drinking, binge drinking, and alcohol-related problems were 12.5%, 53%, and 11.9%, respectively (Jacobson et al., 2008). In another study of active service members, 43% reported current binge drinking (Stahre, Brewer, Fonseca, & Naimi, 2009). Unfortunately, treatment referral rates for active duty service members with alcohol use disorders are extremely low, e.g., 0.2% in one study, and barriers to care, such as stigma, are common (Milliken, Auchterlonie, & Hoge, 2007). Given evidence from previous conflicts, drug use problems are anticipated among returning service members but conclusive data on prevalence is not yet available. From 2003 to 2005, however, the number of veterans with opioid-dependence diagnoses increased more than 7% (Gordon et al., 2007). Alcohol problems are associated with marital distress (O’Farrell & Fals-Stewart, 2006) and with children’s behavioral problems. Conversely, fathers’ extended AA participation and sobriety post-alcohol abuse treatment can reduce their children’s externalizing symptoms (Andreas & O’Farrell, 2009).

In summary, although most service members and their families exhibit great strength and resilience in the face of enormous challenges, military service is associated with a myriad of physical and psychological consequences. When service members return, they have access to Veterans Health Administration (VHA) medical and mental health services. This rich system of services can be confusing to returning service members and their families, as well as private clinicians. In an effort to clarify VHA initiatives and services for community-based clinicians, veterans, and their families, we will next review the empirically-based family interventions currently available within the Veterans Health Administration.

Part 2: VHA Policies and Initiatives on Evidence-Based Practices for Veterans and Families

There are many reasons to involve family members in the treatment of veterans. First, as discussed above, family members are impacted by deployment and military life (Gibbs, Martin, Kupper, & Johnson, 2007; Steelfisher et al., 2008). Second, family engagement in treatment is associated with improved treatment outcomes in a variety of psychological disorders (Falloon, Roncone, Held, Coverdale, & Lairdall, 2002). Finally, veterans would like greater family involvement in services (Batten et al., 2009).

Family involvement in veteran mental health services is a national priority (VHA Directive 2006-041). In 2003, the President’s New Freedom Commission called for family-centered service and treatments. This spotlight on the importance of family involvement was championed in the VA Secretary’s New Mental Health Strategic Plan (2004). Specifically, this plan called for “veteran and family care that is recovery-oriented, high quality, and maximizes the delivery of evidence based practices.” In 2008, the Office of Mental Health Services developed the VHA Handbook 1160.01 Uniform Mental Health Services in VA Medical Centers and Clinics (OMHS, 2008), which defines the minimum clinical requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all veterans, wherever they obtain care in VHA, have access to needed mental health services. This VHA Handbook states that VA medical centers and very large community-based outpatient clinics must provide family consultation, family education, or family psychoeducation within existing statutory and regulatory counseling for veterans with serious mental illness who need these family services.

Mental health services that are recovery-oriented are characterized by 10 fundamental components: self-direction and nonlinear- ity; services that are individualized, person-centered, strength-based and holistic; and a focus on empowerment, respect, responsibility, peer-support and hope. A full discussion of recovery-oriented services is beyond the scope of this article— readers are referred to the National Consensus Statement on Mental Health Recovery (SAMHSA, 2010). The VHA has also emphasized that veterans’ recovery-oriented services must include culturally competent care, privacy, security, honor, and support for Veterans Administration patient rights. Culturally competent care includes both an understanding of the “unique experiences and contributions of those who have served their country” as well as ethnic, racial, and minority diversity training and expertise (VHA Handbook 1160.01; OMHS, 2008). In 2000, Hall and Purdy noted that:

“recovery begins with appropriate medical treatment, rehabilitation, and housing. But it encompasses much more: provider attitudes that are realistic but not therapeutically nihilistic; education and support for both consumers and families; service systems that are comprehensive and respectful of the needs and goals of individual consumers and families; and, ultimately, an end to the stigma and discrimination that so ruinously attaches itself to mental illness. The concept of recovery must be expanded—to include the family, the service system, the full range of disability, and the social context of mental illness . . . .” (p. 429)

Part 2: VHA Policies and Initiatives on Evidence-Based Practices for Veterans and Families
The Office of Mental Health Services within the Department of VA has taken a number of steps to ensure family involvement as part of a recovery-oriented approach to veteran care at VA medical centers and clinics. This involvement begins from the time veterans enter treatment, as providers invite consent from veterans to develop treatment plans that include family contact and involvement where appropriate. The Uniform Mental Health Services Handbook also specifies the provision of a continuum of family services to veterans struggling with mental illness. The continuum of family services includes family engagement, family education and access to the treatment team, family involvement in treatment planning, family consultation focused on problem-solving, and family psychoeducation. At minimum, VA providers discuss family involvement in care with all veterans with serious mental illness. Discussions of family involvement occur during both typical provider contact (at least yearly) and at each discharge from an inpatient mental health placement. There are also various family consultation, family education, and family psychoeducation services available to veterans with severe mental illness and to their families at all VA medical centers and large community-based outpatient clinics. In addition, for veterans who live far away from these services, family services are provided for all veterans with severe mental illness onsite, by telemental health, or through sharing arrangements with community providers. Implementation of these requirements is ongoing.

Two different models of family education have been nationally disseminated by the Office of Mental Health services: one provided by professionals, as in the SAFE program (Sherman, 2006), and one led by trained family members, as in the National Alliance on Mental Illness (NAMI) Family-to-Family Education Program. The Support and Family Education (SAFE) program manual; is an 18-session family education program developed at the Oklahoma City Veteran Affairs Medical Center (full manual available; see Table 1, which provides a list of resources for clinicians). SAFE has a special emphasis on PTSD, and is a critical component of the educational services being offered at many VA medical centers. SAFE sessions center on mental illness symptom and treatment education, skill development for family members, and linking family members with mental health services both in the VA and the community. Skills topics include communication, creating a low-stress environment, problem-solving, and anger management. The 90-minute family education sessions are provided once or twice a month, based on facility preference. Each session has three parts: group discussion and support, didactic presentation, and a question and answer period with a psychiatrist. A representative from NAMI, the nation’s largest grassroots organization for people with mental illness and their families, also frequently attends meetings, with the goal of providing information about NAMI activities and community events. Among SAFE participants, the number of SAFE sessions attended is significantly positively correlated with awareness of VA resources, level of caregiver distress, understanding of mental illness and ability to engage in self-care (Sherman, 2006).

The Veterans Health Administration has also partnered with NAMI in a memorandum of understanding to offer the NAMI Family-to-Family Education program (FFEP) in at least one VHA facility in each state. This is a collaborative effort between VHA and NAMI on the national, state, and local levels. FFEP is a manualized 12-week program comprised of 2–3 hour weekly sessions led by trained family-member volunteers. The program provides families with education about mental illness, medication, and treatment. It also addresses problem solving, communication techniques, caring for the caregiver, and information on community services and advocacy initiatives. FFEP is associated with decreased subjective caregiver burden, and increased caregiver empowerment, increased understanding of severe mental illness and mental health services, and increased caregiver self-care (Dixon et al., 2004). Similar positive outcomes have been found by independent researchers (Pickett-Schenk et al., 2006; Pickett-Schenk, Lippincott, Bennet, & Steigman, 2008).

The Office of Mental Health Services also spearheaded a national effort to train VHA clinicians in two evidence-based family psychoeducation interventions for veterans with serious mental illness: Behavioral Family Therapy and Multifamily Group Psychoeducation. In the past three years, approximately 300 VA mental health clinicians from 85 VA sites have attended multiple day trainings in either Behavioral Family Therapy or Multifamily Group Therapy. Consultation involves at least twice-monthly group telephone meetings, review of session audiotos with feedback, and fidelity ratings. Behavioral Family Therapy (Mueser & Glynn, 1999) is a behaviorally based family intervention with the treatment goals of informing consumers and family members about the mental illness and improving family communication and problem-solving skills. First, consumers and family members each meet individually with a clinician to complete an assessment of presenting problems and treatment goals. After the assessments are completed, the clinician meets weekly with the consumer and family members to review education about mental illness etiology, symptoms, and treatment (typically lasting between 4 to 6 sessions). Next, therapy sessions focus on communication and empathic listening skills training (typically lasting between 3 to 6 sessions). Families are encouraged to discuss problems and goals with each other regularly, both within and outside of the sessions. Finally, sessions focus on problem-solving skills training (typi-

Table 1

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<th>Resources for Clinicians</th>
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<td>National Center for PTSD Understanding Military Culture; <a href="http://www.ptsd.va.gov">www.ptsd.va.gov</a> The National Online Resource Center on Violence Against Women; Online resources on domestic and sexual violence. <a href="http://www.vawnet.org">www.vawnet.org</a></td>
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<td>Military One Source: Free 24-hour information and referral service; <a href="http://www.militaryonesource.com">www.militaryonesource.com</a>; 1–800–342–9647; En español llame al: 1–877–888–0727</td>
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<td>Center for Deployment Psychology: Training resources for civilian and military treatment providers; <a href="http://deploymentpsych.org/">http://deploymentpsych.org/</a> training/civilian-practice</td>
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<td>VHA Mental Health: Overview of mental health issues facing veterans; <a href="http://www.mentalhealth.va.gov/index.asp">http://www.mentalhealth.va.gov/index.asp</a></td>
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<td>Clinician Tools</td>
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<td>The Support and Family Education (SAFE) program manual; <a href="http://www.ouhsc.edu/safeprogram/">http://www.ouhsc.edu/safeprogram/</a></td>
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<td>The National Child Traumatic Stress Network: List of resources for both families and providers; <a href="http://www.ntsnet.org/nccs/nav.do/?pid=ctr_top_military#63">http://www.ntsnet.org/nccs/nav.do/?pid=ctr_top_military#63</a></td>
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cally lasting between 6 to 12 sessions). Extra sessions can address specific consumer and family problems as necessary. In randomized controlled trials, patients who received Behavioral Family Therapy experienced lower relapse rates and less symptom exacerbations at the one-year and two-year follow-ups, compared to patients in comparison groups (Randolph et al., 1994; Tarrier et al., 1989).

Multifamily Group Psychoeducation (MFG; McFarlane, 2002) is an intervention developed to address the increased social isolation and burden experienced by the family members of a severely mentally ill person. When untreated, this increased family stress can lead to family members acting both highly critical and overinvolved with the consumer, a predictor of consumer relapse (Hooley, Rosen, & Richters, 1995). MFG intervenes with consumers and families by helping group members develop rich social support networks, by providing the opportunity to meet families with similar struggles, and by providing hope through group members’ experiences and successes. MFG comprises three phases (Jewell, Downing, & McFarlane, 2009). First, the consumer and their family members meet with a therapist alone in a “joining” session. During this session, the therapist validates the consumer and family experience, develops rapport with the family, and helps family members develop their own goals for treatment. The consumer and family members subsequently attend a Family Education Workshop where they meet other families and are provided with information on the biology of severe mental illness, medication, stress reduction, and the MFG Family Guidelines. Next, the consumer and their family members begin attending multifamily groups, typically 90-minute meetings held every other week. In these groups, families and consumers use a structured problem-solving format, discussing relapse prevention and support for consumer social and vocational rehabilitation. Typically during the second year of MFG, groups transition to the second phase of treatment, in which the focus turns from stability in consumer functioning to gradual increases in community functioning. Finally, in the third phase of treatment, the group’s emphasis is centered on the family and the larger MFG growing into a social network that is satisfying, stable, and lasting. MFG has consistent empirical evidence (McFarlane, Dixon, Lukens, & Lucksted, 2003) and has shown to reduce consumer relapse, improve family member quality of life, and reduce family member burden (McFarlane, Link, Dushay, Marchal, & Crilly, 1995).

In addition to the family services listed above, OMHS is currently sponsoring national trainings of VHA clinicians in Integrative Behavioral Couples Therapy (IBCT; Christensen & Jacobson, 2000), IBCT evolved from Traditional Behavioral Couples Therapy (TBCT), which focused exclusively on change-focused strategies such as behavioral exchange and communication/problem-solving. IBCT expanded TBCT to focus on acceptance strategies such as learning to understand and accept one another’s experience of the relationship. Whereas TBCT was focused on following certain communication rules or methods, IBCT is focused on fostering constructive natural processes involved in intimate exchanges (i.e., natural versus arbitrary contingencies; Christensen, Atkins, Baucom, & Yi, 2010). The underlying assumption of IBCT is that genuine differences between couples may not be resolved through changing problem behavior. Instead, couples can increase closeness and improve relationship functioning through acceptance, which helps reduce emotional reactivity and allows couples to find common ground in spite of differences. Specifically, three clinical strategies are used to encourage acceptance: empathic joining surrounding the couple’s problems, unified detachment from the problem, and building a tolerance to individual emotional responses triggered by the problem. IBCT clinicians are also encouraged to use the change-focused strategies of Traditional Behavioral Couples Therapy as appropriate. In a study of 134 chronically stressed couples, 71% of couples who completed IBCT showed reliable improvement or recovery, compared to only 59% of couples who completed Traditional Behavioral Couples Therapy (Christensen et al., 2004). Within the Veterans Health Administration, IBCT training will include additional training on parenting and domestic violence. As reviewed above, family involvement in VHA services is a high priority that has been supported through various initiatives and policies in the past 10 years. Returning service members are entering a veteran health care system that values recovery-orientation and family involvement.

Part 3: Recommendations for Practicing Psychologists

The recovery-oriented perspective that is fundamental to veteran care in the Veterans Health Administration can also inform clinical care with returning veterans in the community. To review, recovery-oriented services in the VA include an emphasis on cultural competence, consumer-directed treatment planning, individualized and person-centered treatment, a strength-based approach to care, and access to high quality, evidence-based treatment. First, community care should be culturally informed. Military culture can seem mysterious to civilians. This is complicated by confusion or misunderstanding between military and civilian populations; for example, the belief that a civilian can never understand what a service member has experienced (Danish & Antonides, 2009). As with any clinician–consumer relationship, considerations of cultural difference and cultural competence are critical. Although service members and their families have unique experiences, civilian psychologists can offer help, support, and education to newly returning veterans and their families derived from the clinician’s own training and experiences. Clinicians can begin to bridge this military–civilian cultural gap by learning the terminology of military and VA and by undergoing training in military and veteran culture (Table 1). As is the case in learning about any culture, military and veteran culture is not monolithic. It is useful to be honest with consumers about your own lack of knowledge about their particular military experience and your interest in learning which aspects of the military and veteran experience are most salient to your customer.

Second, recovery-oriented care is individualized, person-centered, and strength-based. Care informed by these principles is centered on consumer perspectives about who they would like to have involved in treatment, what goals they want to address in treatment, and what protective factors and strengths they bring to their recovery. Openness to the service members’ definitions of family is encouraged. Family treatment may include work with the consumer, the consumer’s parent, child, siblings, extended family, or past and current romantic partners. For example, the source and focus of family relationships may change over the course of the lifespan from parents to siblings and others (Glynn, Cohen, Dixon, & Niv, 2006). Family treatment must be adapted to fit the indi-
vidual veteran’s particular family constellation, as well as the veteran’s and family’s culture. Veterans should be encouraged to explore their choices about the degree of family involvement; e.g., what they choose to share and not share. How to best integrate the family into complex medical settings and interdisciplinary treatment teams remains largely unknown, and requires sensitivity to individual, cultural, and contextual factors as well as openness to evaluating the relative success or failure of integrative efforts (Glynn et al., 2006).

The consumer and their family may also define risks and protective factors differently than the clinician. Discussing, understanding, and exploring these differences is critical to an individualized, person-centered approach. For example, a veteran who is homosexual may have complex and conflicted emotions about continuing to serve in the military or coming out after his or her military time has ended. In another example, consumers may view drag racing, downhill skiing, or bungee jumping as an adaptive way to cope with their high energy and need for thrills after returning from a war zone environment where they were always on high alert. In contrast, taking into account that behavior can be understood a number of different ways based on the context, the clinician may view this same behavior as risky and dangerous (Richers & Cicchetti, 2003). While both perspectives are valid, drawing from the lessons of developmental psychopathology, the clinician’s concerted effort to understand the veteran’s need for greater stimulation while avoiding other forms of stimulation (such as drug use) will benefit the alliance and extend the collaborative nature of the therapy. Finally, the clinician is encouraged to expand his or her conceptualization of adaptive coping techniques and social supports for the veteran and his or her family beyond the clinician’s own culturally derived ideas. Additional social supports could include veteran centers, Facebook military and partner groups, local churches, tennis groups, and pick-up basketball. At the Palo Alto Veterans Hospital, our veterans consistently report knitting groups and yoga as two of their favorite coping activities. As Glynn et al. (2006) state, “recovery-based professional care optimizes natural supports” (p. 452).

Third, recovery-orientation and best clinical practices require that consumers have access to high quality, evidence-based treatments. We have reviewed several of these in the context of OMHS initiatives, above. In addition, evidence-based alcohol disorders couple and family treatments such as Behavioral Couples Therapy (BCT; O’Farrell & Fals-Stewart, 2006) or Community Reinforcement and Family Training (RAFT; Smith, Meyers & Austin, 2008) should be considered for veterans presenting with problem drinking. For PTSD, a number of couple and family interventions have demonstrated promising pilot evidence—more rigorous evaluations are currently in progress. Briefly, Cognitive-Behavioral Conjoint Therapy for PTSD was developed to simultaneously improve PTSD symptoms and relationship functioning. In this 15-session intervention, couples are provided with psychoeducation, behavioral interventions, and cognitive interventions to address both PTSD symptoms and relationship distress. In a pilot study of seven couples, Cognitive-Behavioral Conjoint Therapy for PTSD has been shown to reduce consumer PTSD symptoms, improve both partners’ social functioning, and improve wife reports of relationship functioning (Monson, Schnurr, Stevens, & Guthrie, 2004). Further, pilot evidence suggests that couples-based Strategic Approach Therapy, a manualized behavioral partner therapy designed to target avoidance symptoms, reduces consumer avoidance, emotional numbing, and PTSD symptom severity (Sautter, Glynn, Thompson, Franklin, & Han, 2009).

As reviewed above, service members and their families may struggle with traumatic brain injury, PTSD, depression, anxiety, alcohol abuse, child abuse, suicide, and partner violence (Table 1). A thorough interview with service members and their families should examine each of these domains. In addition to an interview, assessment of these issues can be initiated through brief measures that are freely available for clinicians and consumers. The ‘My HealtheVet’ website offers free and anonymous screening tools for alcohol and substance use, depression, and PTSD (Table 2 provides a list of resources for service members and families). The Center for Disease Control also offers a full compendium of partner violence assessment measures, titled Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools, at no cost on their website (Table 1 & 2). It is also important to assess and discuss the risk of future deployments (Table 1).

When developing intervention plans, a number of psychoeducation and skill-building exercises may be especially well-suited for service members, veterans, and their families (see Tables 1 and 2 for resources with military terminology and pictures). First, clinicians can provide valuable information normalizing the consumer’s reintegration experience (Bowling & Sherman, 2008). Almost all service members need time to readjust; for most, the transition can be difficult for a few months. Common reactions can include disturbed sleeping and eating as well as feeling angry, sad, nervous, or numb. Newly returned service members may have trouble concentrating, feel jumpy and alert, and have trouble doing school, home, and work tasks.

Protective and risk factors can moderate a veteran and families’ resilience or vulnerability. Specifically, young families, families coping with many stressors, and families with low social support are at increased risk of conflict and mental health issues (Wiens &
Boss, 2006). Conversely, flexible gender roles, community and social supports, and active coping strategies can all help buffer a family as they deal with realignments (Wiens & Boss, 2006). Interventions that target increasing a family’s social supports and teach relationship building and active coping skills such as problem-solving may be useful for reducing risk for future problems (Bowling & Sherman, 2008).

Emotion regulation is a critical skill that can ameliorate the trauma and stress reactions common among newly returning veterans and their families (Blaustein & Kimnburgh, 2007; Frewen & Lanius, 2006). Up regulation or activation exercises such as physical activity, playing games with friends and family, and getting out of the house can help counteract common symptoms of avoidance and feeling numb. Down regulation or deactivation exercises such as yoga, mindfulness practice, deep breathing, and taking a time-out can help counteract common symptoms of hyperarousal, anger, or frustration. In addition to general emotion regulation skills, specific relationship-building exercises may be especially helpful for partner, parent-child, or friend relationships that have changed since the service member’s deployment (Blaustein & Kimnburgh, 2007). One important step toward a “new normal” (Bowling & Sherman, 2008) can include facilitating the creation of a shared story about the deployment, the existing relationships after the deployment, and their future. This shared story can be created by the veteran and his or her family members and can emphasize how all family members used the strengths they had to cope with the separation. Further, the shared story can include what things changed during the deployment, what things stayed the same during the deployment, and how all family members make meaning of this history as they move forward together.

Finally, when there are children in the family, a veteran is also transitioning back into the role of parent. During the deployment, children have grown and changed and parenting needs have changed as well. The reorganization of roles within the family can be ambiguous and anxiety-producing for children (McFarlane, 2009). To smooth this transition, parents should provide children with developmentally appropriate information about the deployment, as well as parent changes such as physical or psychological injuries (see Table 2). Further, parents should be supportive and understanding as children express a range of emotions about the deployment, the parent’s return, and the family changes. Parents may need help to understand a child’s typical responses to loss and reunification. Children may regress or act younger than their age, they may be clingy or distant from parents. Children may need extra attention, care, and physical closeness with parents. More details on these recommendations can be found at the Sesame Street Talk, Listen, Connect project (Table 2).

Given potential comorbid problems such as stress reactions, it may be helpful for veteran parents to begin realignment through supportive, positive parent-child interactions. These could include child-centered play or quality time with the children or adolescents in the family. As parents return to normal activities, continuing or re-establishing family routines and traditions can also help children and families establish a “new normal” (McFarlane, 2009). In contrast, developmentally appropriate discipline and behavior management may be difficult as the veteran struggles to manage their own emotion regulation. These parenting practices should be delayed until all adults in the family feel that the veteran can safely and calmly respond to misbehavior.

OE/F/OIF veterans are older, more diverse, and more likely to have partners and children than earlier generations of veterans. Longer and more frequent deployments, as well as the nature of the present conflicts, have put service members at risk for a host of physical and psychological injuries including TBI, PTSD, alcohol abuse, and family conflict. In response to the changing needs of veterans, family involvement in clinical services is now required throughout the Veterans Healthcare Administration system. Further, a number of evidence-based family and couples interventions are available to veterans in the VHA. In addition to the evidence-based interventions described above, clinicians can make a number of recovery-oriented adjustments to both assessment and intervention practices to best serve newly returning veterans and their families.

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