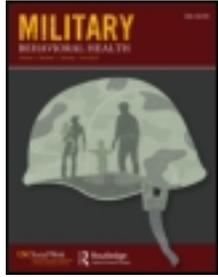


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Approaching Family-Focused Systems of Care for Military and Veteran Families

Shelley MacDermid Wadsworth^a, Patricia Lester^b, Christina Marini^a, Stephen Cozza^c, Jo Sornborger^b, Thomas Strouse^b & William Beardslee^d

^a Military Family Research Institute, Purdue University, West Lafayette, Indiana

^b UCLA Semel Institute for Neuroscience and Human Behavior, Los Angeles, California

^c Center for the Study of Traumatic Stress, Uniformed Services University of the Health Sciences, Bethesda, Maryland

^d Children's Hospital Boston, Harvard Medical School, Boston, Massachusetts

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Shelley MacDermid Wadsworth

Military Family Research Institute, Purdue University, West Lafayette, Indiana

Patricia Lester

UCLA Semel Institute for Neuroscience and Human Behavior, Los Angeles, California

Christina Marini

Military Family Research Institute, Purdue University, West Lafayette, Indiana

Stephen Cozza

Center for the Study of Traumatic Stress, Uniformed Services University of the Health Sciences, Bethesda, Maryland

Jo Sornborger and Thomas Strouse

UCLA Semel Institute for Neuroscience and Human Behavior, Los Angeles, California

William Beardslee

Children's Hospital Boston, Harvard Medical School, Boston, Massachusetts

Although current research recognizes robust interdependence among family members, it is not yet evident that such principles have fully integrated into existing systems of care for military and veteran families. Such gaps can create disadvantages in delivering effective support, prevention, and treatment, while including families may yield significant advantages. This article highlights theoretical frameworks and empirical evidence that illustrate the relevance of systemic approaches to supporting service members, veterans, and their families. We discuss examples of family-centered approaches already in place and identify gaps in existing systems of care.

Keywords: Family, military, veteran, ecological, attachment, resilience, wound, children

INTRODUCTION

Families play a prominent role in military culture, illustrated by such examples as the Army Family Covenant and the Air Force Year of the Family. In addition, the Department of Defense (DoD) (2002) has articulated a “social compact” that recognizes the reciprocal partnership between the DoD, service members, and their families. Despite these and other highly visible efforts, significant gaps remain in existing systems of care for families. In this article we review existing theory and empirical evidence from both civilian and military research regarding the importance of family-centered approaches to understanding military and veteran families.

We wish to express our appreciation to all the military and veteran families who are serving or have served their country, and all the paid and volunteer workers who work to help them. We also wish to acknowledge the leadership of the Office of the Military Community and Family Policy and its service counterparts in infusing a family focus throughout many military quality-of-life programs.

Correspondence should be addressed to Shelley MacDermid Wadsworth, Director, Military Family Research Institute, Purdue University, Hanley Hall, Room 210, 1202 West State Street, West Lafayette, IN 47907-2055. E-mail: shelley@purdue.edu

We propose a systemic model that provides guidance for enhancing care delivery across prevention and treatment settings, and provide examples of promising programs that have intentionally integrated a family-centered approach for military and veteran families.

RELEVANCE OF SYSTEMIC APPROACHES TO FAMILIES

There is considerable evidence that military service has implications for not only service members but also their spouses, children, and other family members (Andres & Moelker, 2011; Chandra et al., 2009; Lester et al., 2012). Service members' concerns about separation from family has emerged as a top noncombat determinant of service member mental health status in the Mental Health Advisory Team (MHAT) studies, which have been conducted annually with deployed service members for most of the past decade (e.g., MHAT V, 2008). Empirical research has suggested that healthy family relationships serve as a protective factor for veterans seeking out mental health services (Meis, Barry, et al., 2010). Evidence from quasiexperimental studies conducted by Jensen and colleagues (Jensen, Martin, & Watanabe, 1996) during the first Gulf War and from data gathered by Chandra and colleagues (Chandra et al., 2009; Chandra, Martin, Hawkins, & Richardson, 2010) during the current conflicts show that the well-being and functioning of military children depends heavily on that of their at-home parents.

It is also clear that family members are implicated in the quality of service members' experiences and recovery following the acquisition of wounds or injuries. More than 40,000 injured service members have returned from Iraq and Afghanistan since the start of combat operations in 2001. Early reports of family experiences suggested that injuries not only disrupted family processes in the immediate aftermath of the injury but also continued to impact the family's postinjury recovery over time, to include longer-term relationships between parents as well as between parents and children (Cozza & Guimond, 2011).

Military service also very likely affects parents, siblings, and other family members of service members, especially given that approximately half (41.7%) of service members in the U.S. military are not married (see the Millennium Cohort Study by Ryan et al., 2007). In most military programs, practices, and policies, however, the definition of *family* does not include these persons; thus, little is known about their experiences as a function of military demands. Definitions of *family* are beginning to expand, such as in the Yellow Ribbon Reintegration Program, where family may include spouses, children, parents, grandparents, or siblings recognized by the Defense Enrollment Eligibility Reporting System (DEERS; U.S. Department of Defense, 2011).

Despite their relevance, family-centered approaches have not yet fully penetrated into prevention/intervention ap-

proaches and treatment settings for military and veteran families. For example, in a recent commentary in the *Medical Surveillance Monthly Report* that defines issues of military importance, families are mentioned only in relation to political or public concern prompted by stories by or about family members (Armed Forces Health Surveillance Center, 2012).

INTERDEPENDENCIES WITHIN MILITARY FAMILIES

Decades of research on family functioning, child development, traumatic stress, and prevention science make it clear that the experiences of each family member have the potential to reverberate throughout the family system and that family-centered approaches offer meaningful opportunities to promote psychological health (National Research Council & Institute of Medicine, 2009). Interactions between the developing child and parents have been found to be bidirectional, mutually influencing, and mutually modifying (Sameroff & Chandler, 1975). This research coincides with both a cultural and operational priority for the DoD and the Department of Veterans Affairs (VA), which has been guided by the relevance of families to recruitment and retention, military readiness, national public health policy, and the increasingly strong political support for military and veteran families over a decade at war. This convergence provides an opportunity for examining the potential contributions of family-centered public health approaches to prevention and care for military and veteran families.

Current research emphasizes how "at-home" spouses of deployed service members are affected by service member experiences. For example, combat deployments are associated with increases in distress and mental health care utilization of at-home spouses (Chandra et al., 2010; Mansfield, 2010), with at-home parents being particularly vulnerable to increases in depressive symptoms and anxiety throughout their partners' combat deployment (Lester et al., 2010; Jensen, Martin, & Watanabe, 1996). During reintegration, service member posttraumatic stress symptoms have been found to explain a robust relation between the spouse's own emotionality and relationship satisfaction (Meis, Erbes, Polusny, & Compton, 2010).

Children's experiences of parental deployment have also received considerable attention in the last decade (see Card et al., 2011, for review); however, the precise impact of wartime deployment on child adjustment and development remains unclear. While parental deployment may be an opportunity for children to gain autonomy and maturity (Saltzman et al., 2011), it also is associated with emotional and behavioral stress, risky behaviors, and academic struggles (Chandra et al., 2010; Flake, Davis, Johnson, & Middleton, 2009; Lester et al., 2010; Reed, Bell, & Edwards., 2011). Consistent with civilian literature, current findings suggest that military children's response to

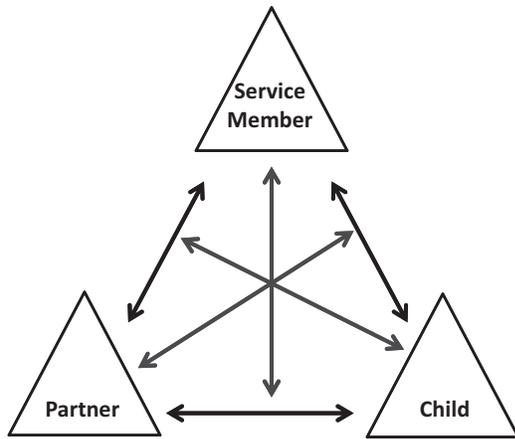


FIGURE 1 All Family Relationships are Interdependent.

parental deployment is largely dependent on family relational processes (e.g., communication, parenting) (Chandra et al., 2010; DeVoe, Paris, Ross, & Acker, 2010; Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010) in addition to the well-being of both the at-home caregiver (Chandra et al., 2010; Dekel, Enoch, & Solomon, 2008; Kelley, Finkel, & Ashby, 2003) and the service member during reintegration (Lester et al., 2010).

While these findings illustrate the direct influence of parental well-being on child outcomes in response to deployment, it is also relevant to consider how marital discord may influence child functioning. Research with civilian families has illustrated how the marital subsystem independently affects both the dyadic (marital) and triadic (parenting) subsystems within the family (Stroud, Durbin, Wilson, & Mendelsohn, 2011; Vandewater & Lansford, 1998). When marital conflict between parents is high, this can result in increased distress in children and disruption in parent-child relationships (Erel and Burman, 1995). Further, parents distracted by high levels of family conflict may be more withdrawn and less attuned to their children, as well as more likely to use negative parenting practices. Notably, family conflict may also threaten a child's emotional security and sense of safety within the family (Davies & Cummings, 1998) (see Figure 1).

Empirical research has yet to fully explore the interdependence between the marital and parent-child subsystems in military families, despite theoretical research that recognizes such reciprocity (e.g., Riggs & Riggs, 2011). However, studies of veterans with posttraumatic stress have demonstrated increased risk for marital distress, parenting disruptions, and domestic violence (see Galovski & Lyons, 2004, for review). Others have described the evidence for intergenerational transmission of trauma in children of veterans (e.g., Dekel & Goldblatt, 2008; Pearrow & Cosgrove, 2008). Families coping with a service member's posttraumatic stress have also been shown to be less supportive, cohesive, and adaptive (Davidson & Mellor, 2001; Riggs, Byrne, Weathers, & Litz,

1998; Westerink & Giarratano, 1999), suggesting the potential for reciprocal risk between the family context on child, spouse, and service member adjustment.

While this research primarily highlights how at-home family members' experiences (spouses and children alike) are influenced by those of returning service members, the application of a family systemic perspective to military families recognizes bidirectional reciprocity between family members. Although not as developed, there is also emerging evidence in the current literature that family member experiences influence the service member. For example, current research highlights how service members' concerns about family play an important role in their mental health both during deployment (e.g., McNulty, 2005) and reintegration (e.g., Erbes & Polusny, 2009).

Although family concerns are a potential source of stress for service members, it is important to acknowledge how the family context can also support service members (e.g., Meis, Barry, Kehle, Erbes, & Polusny, 2010). Some research has illustrated how support in intimate relationships actually facilitates service member use of mental health services in the context of PTSD (Meis, Barry, et al., 2010). Meis, Erbes, and colleagues (2010) frame their results as support for positive family involvement in service member treatment to promote treatment engagement and retention. Taken together, these findings suggest the potential role of a family-centered framework to enhancing the support and care of service members, spouses, and children.

SYSTEMIC APPROACHES TO UNDERSTANDING FAMILIES

Understanding families as systems rather than collections of individuals is relatively recent, propelled by the growing popularity of general systems theory following World War II. This perspective shifted dominant paradigms away from reductionist, mechanistic views toward models that acknowledged the possibility systems could possess properties not discoverable from the study of their "parts." Environmental conditions and dynamics, once dismissed as noise, came to be seen as important factors in the behavior of systems, particularly as they changed over time.

Systems perspectives offered ways to understand previously puzzling behavior within families, such as actions by family members that undermined efforts by another member to change behavior. When interpreted from a systemic perspective, these behaviors could be seen as efforts to maintain equilibrium or homeostasis in the family. Because all family members are by definition interdependent, changes made or experienced by one member have the potential to influence all other members and relationships. In addition, families have system-level properties not discernible from the perspective of only a single member (Cox & Paley, 1997). Finally, systems perspectives have offered tools with which

to understand the interdependencies between families and larger systems, such as systems of care, as well as interdependencies between families and biological systems.

Several important theoretical perspectives built on systemic thinking provide useful insights into family functioning particularly relevant for military families. Attachment theory, for example, enhances understanding about adults' and children's experiences of separation. Primary attachment figures are key role models for teaching children how to regulate emotions and relate effectively to others. For adults, attachment figures are primary sources of social support. Separations such as deployments challenge attachment systems, requiring individuals to reduce their reliance on primary attachment figures and then reestablish or renegotiate connections following reunion (Riggs & Riggs, 2011; Vormbrock, 1993). In a review of research about spousal reunions following war-related separation, Vormbrock (1993) observed, for example, that both partners tended to engage in anxious contact-seeking following reunion, but that at-home spouses also responded with emotional detachment and anger. At-home parents who cope constructively with the absence of primary attachment figures are thought more likely to reduce threats to children's socioemotional development posed by the absence (Riggs & Riggs, 2011).

Other useful perspectives focus on resilience in families. For example, Walsh's (2006) Family Resilience Theory proposes that shared beliefs, constructive communication practices, and healthy patterns of organization are precursors to family abilities to respond to adversity with resilience. In a recent review of mechanisms of risk and resilience in families, Saltzman and colleagues (2011) endorsed many of these elements, proposing, for example, that mechanisms of risk for military families include lack of guiding belief systems, impaired family communication, and impaired parenting practices. In contrast, evidence suggests that mechanisms of resilience include developing shared family awareness and understanding, improving family empathy and communication, and supporting effective and coordinated parent leadership. Military parents, for example, must be skilled at coparenting, or working together to provide consistent, constructive, coordinated guidance to their children—particularly as the family reconfigures due to military separations. When parents cannot work together effectively, a wealth of literature suggests that negative emotions or interactions between parents “spill over” (Erel & Burman, 1995) to the rest of the family, with the potential to disrupt parent-child relationships (Cox, Paley, Harter, & Karnos, 2001).

Systems perspectives also draw attention to contexts surrounding families. Bioecological theory, for example, provides a framework for understanding not only the proximal settings within which individuals live and work but also more distal settings in which individuals may not participate directly but by which they are nonetheless affected, such as exosystems (e.g., military jobs affecting children at home) and macrosystems (e.g., policies or cultural norms).

Although a family focus can be adopted at every level, mesosystems—or the links between settings—are of particular concern for those interested in addressing the needs of military and veteran families (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). Bronfenbrenner (1979) argued that mesosystems are more likely to support development when there are numerous supportive, mutually reinforcing links between settings, such as consistent information, compatible role demands, and persons who travel with, or are familiar to, families across settings.

FAMILY-CENTERED CARE AND PREVENTION: PRINCIPLES, RESEARCH, AND APPLICATIONS FOR MILITARY AND VETERAN SYSTEMS OF CARE

Systemic research across multiple fields has led to momentum for family-centered care practices, which are particularly needed in health care service settings. These practices have emerged out of an emphasis on the biopsychosocial model, as well as findings from family prevention science and developmental research highlighting the important role of parent-child relationships and family environment on developmental and health outcomes (Kilmer, Cook, & Munsell, 2010). Recognition of family environment and resilience factors in shaping health outcomes have provided key health promotion pathways for both health care and mental health providers, which has guided family-centered care (FCC) in health care settings (Heru, 2006).

FCC has been defined as a partnership between the family, the health care system, and the health care provider, and it has become regarded as a standard of care in pediatric treatment settings (Kuo et al., 2012). FCC has been conceptually embraced, with emerging evaluation across many pediatric illness types and treatment contexts demonstrating positive benefits (Kuo, Frick, & Minkovitz, 2011). Similarly, community and child mental health systems have integrated family-focused care into best practice models (Tolan & Dodge, 2005). Within adult health care and service settings, the acknowledgment and inclusion of the family system within adult health care settings remains less consistent than in child service settings. FCC has been studied in specific illness settings, particularly traumatic brain injury (TBI) and other physical injuries, although the literature has been focused primarily on spouse or parent caregiving roles, rather than broad family or child impact. Little is known about the long-term impact of serious parental injury on shaping child developmental trajectories, or on the impact of child psychological distress and behavioral problems on parental illness recovery, suggesting an important area for research to guide practices. Further, studies have identified many barriers to implementation of family-centered policies and practices within care systems, including limited resources, nonstandard

training, and challenges associated with organizational change (Coyne, O'Neill, Murphy, Costello, & O'Shea, 2011).

The integration of these approaches within military and veteran health care systems is less developed. Historically, veteran caregiving systems, with a primary orientation to providing treatment to individuals, have had limited provision of services for family members (primarily caregivers), including family members in support of the veteran's treatment plan. More recently, models have been introduced for expanding and standardizing family-centered care, education, and interventions for veterans in the Department of Veterans Affairs Polytrauma System of Care (Hall, Sigford, & Saver, 2010). Based on recognition of the impact of veteran injury and illness on caregiving family members, an initiative has been undertaken within the VA's Polytrauma Centers to better understand family experience and needs (Griffin, Friedemann-Sánchez, Hall, Phelan & van Ryn, 2009). Based on a review of family care approaches within civilian settings, this initiative has developed a systematic assessment of family informational and support needs, as well as integration of a family care plan. The initial assessment has documented the need for clear information for family members of injured veterans, as well as standardized guidelines for providers regarding family care. Evaluation of a learning collaborative dissemination model for integrating FCC within the polytrauma system describes a process for initiating organizational change (Hall et al., 2010).

In addition, family-centered educational and treatment interventions for veterans with PTSD and other mental health problems within the VA have shown promising outcomes (Monson, Taft, & Fredman, 2009; Sautter, Glynn, Thompson, Franklin, & Han, 2009; Sherman et al., 2009). However, challenges remain to integrating family-centered care and intervention practices broadly into military and veteran health care settings. When military support and health care services are targeted at the individual, the important role of the family—both regarding support and care of the service member as well as the opportunities to engage, support, and mitigate distress in family members—may be missed.

Limitations in patient and family-centered care are not unique to military and veteran care systems. Consensus models and research identifying best practices and establishing an empirical basis for the inclusion of family-centered approaches have been identified in several areas. A 2001 Institute of Medicine report articulated a framework of patient- and family-centered care as central to addressing gaps in quality and safety within our current health care system. Open sharing of information, collaboration, recognition of family values and beliefs, and regard for patient decision making are central to this framework. Two recent collaborative National Research Council and Institute of Medicine reports, one focused on prevention in children (1994) and the other on the effects of parental depression (2009), have also highlighted the importance of family systems perspectives and including families in care for individuals.

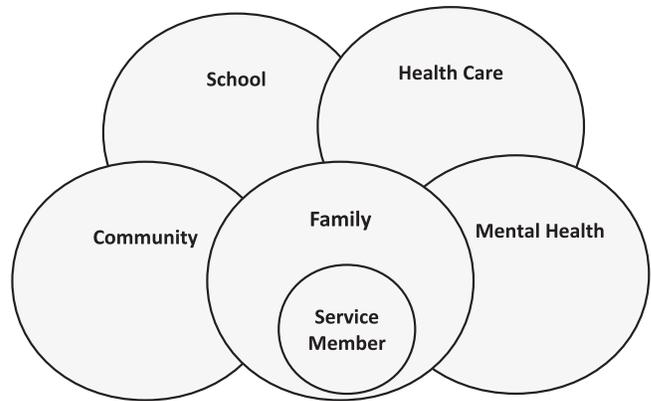


FIGURE 2 Service Members, Veterans and their Families are Embedded Within Interlocking Systems.

While there is an important role for family-centered practices to support service member and veteran recovery from the injuries of war, it is important to recognize the important public health opportunity for preventive and early interventions to address all family members at risk for psychological health problems due to wartime military service. These include the potential of embedding community-based, family-centered interventions that provide developmentally appropriate information; address family, marital, and parenting challenges; and enhance caregiving and communication, as well as promote psychological health across the family (see Figure 2).

POSITIVE EXAMPLES OF FAMILY-CENTERED APPROACHES

To illustrate the opportunity and benefits of family-centered approaches, we present examples of programs already serving military and veteran families that have embedded a systemic approach to military and veteran families across community and clinical systems. These are but a few of many worthy efforts currently under way.

Strong Bonds

Strong Bonds is a relationship distress prevention program based on the Prevention and Relationship Enhancement Program (PREP) administered by Army chaplains (Stanley, Blumberg, & Markman, 1996). The program typically takes the form of a one-day workshop and a weekend retreat. The program focuses on relationship enrichment and couple communication/intimacy through the use of cognitive-behavioral strategies covering topics ranging from affect management skills to principles of commitment, forgiveness, and stress management. Although the program takes the form of couple education, it is intended to strengthen military families in their entirety. Empirical findings suggest that PREP for

Strong Bonds effectively reduced (by one-third) the risk of divorce among Army couples who participated in the program a year later (Stanley et al., 1996). Further, Allen, Rhoades, Stanley, Loew, and Markman (2012) found that participating couples who indicated a history of infidelity showed greater gains in marital satisfaction and communication skills than did couples who did not report a history of infidelity.

After Deployment, Adaptive Parenting Tools (ADAPT)

After Deployment, Adaptive Parenting Tools (ADAPT) is a parent training program specifically designed for military families postdeployment. ADAPT is theoretically informed by the social interaction learning model Parent Management Training—Oregon (PMTO) (Patterson, 2005) but is further designed to address the unique challenges military families face during reintegration (e.g., hypervigilance, avoidance) by including an added emphasis on emotion regulation skills (e.g., emotion coping and mindfulness) (Gewirtz & Davis, under review). This emphasis stems from Gewirtz and colleagues' recognition that recalibration of "emotional responding from the battlefield to the home front" may be an integral strategy to successfully reintegrate service members back into their home environments and parenting roles. In fact, empirical results indicated that difficulties in emotion regulation actually mediated the association between deployment and parenting challenges. Gewirtz and colleagues also identify parenting practices as a central aspect of family life that has ties to both child and parental well-being, especially in light of family transitions. ADAPT therefore targets strengthening parental emotion regulation skills to improve both parenting practices and child adjustment (Gewirtz, Erbes, Polusny, Forgatch, & Degarmo, 2011).

Passport Toward Success

Passport Toward Success is an evidence-based program designed to build and strengthen resiliency skills in military children during reintegration. Although the program's intent is to promote resiliency skills in children (e.g., communication, stress reduction, and problem solving), it was built around a philosophy that recognizes the importance of family and community support in regard to child well-being. Coupled with a social cognitive learning modality, a systemic approach to resiliency is used to provide children and their parents with the opportunity to learn a similar set of skills to interact with each other, in addition to other military families, in hopes of building a strong sense of community among returning veterans and their families. The program focuses on promoting skills through the use of an island theme (e.g., Relaxation Island) to engage both children and their families. Findings illustrate that the program was most beneficial for children who reported the most distress at its start

(Wilson, Wilkum, Chernichky, MacDermid Wadsworth, & Broniarczyk, 2011).

FOCUS (Families OverComing Under Stress)

FOCUS (Families OverComing Under Stress) is an example of a family-centered preventive intervention specifically adapted to promote resilience in military and veteran families. As a trauma-informed preventive intervention, FOCUS adapted core components from existing evidenced-based family preventive interventions (Beardslee, Gladstone, Wright, & Cooper, 2003; Rotheram-Borus, Lee, Lin, & Lester, 2004) for at-risk families shown to have psychological health and family functioning benefits in a rigorous randomized control trial with longitudinal follow-up (Beardslee et al., 2003; Rotheram-Borus et al., 2004). The FOCUS intervention for military and veteran families is designed for culturally diverse, single-parent, and dual-parent families contending with challenges encountered during predeployment, deployment, reintegration, and long-term postdeployment.

Delivered as a targeted and indicated prevention protocol, FOCUS enhances family cohesion and strengthens parent-child, marital, and coparenting relationships by helping families develop a shared understanding of past experiences, and building skills consistent with positive family adaptation (emotional regulation, communication, problem solving, goal setting, and managing trauma and loss reminders). In 2008, it was initiated as a large-scale psychological health prevention program by the U.S. Navy Bureau of Medicine and Surgery that currently serves U.S. Navy, Marine Corps, Army, and Air Force families at 21 installations, with additional support from the Office of Military Community and Family Policy (Beardslee et al., 2011). Central to the dissemination of FOCUS has been a "suite of services" that integrates family-centered education and intervention skills across military leadership, school staff, health/mental health providers, and other community agencies. The eight-session family model has demonstrated positive psychological health benefits for parents and children and improved family functioning in a rigorous longitudinal service project evaluation (Lester et al., 2012).

Operation Mend

The FOCUS model has been adapted into a brief consultative care model for surgical patients and their families as part of the Operation Mend surgical reconstruction program for combat-injured service members at the University of California, Los Angeles (UCLA), Health Care System.

The Operation Mend family-centered care and resilience program model incorporates principles of patient- and family-centered care designed to enhance surgical preparation, coping, and recovery across the family. The Operation Mend program integrates a standardized, web-based family psychological health assessment, educational and resiliency skills training program, and family care recovery

plan into all aspects of patient care. Central intervention components include addressing marital and parenting impact of combat injury, surgical interventions and care recovery, and development of family-level understanding and communication regarding the veteran's injuries. The model includes a continuity family plan that maps out current and new strategies to optimize recovery and increase overall family functioning, and includes a telehealth delivery platform to provide distance delivery and continuity of services.

Preventive Medical Psychiatry at Walter Reed Army Medical Center

At the initiation of combat operations in Iraq and Afghanistan and the arrival of combat-injured at Walter Reed Army Medical Center (WRAMC), the Psychiatric Consultation Liaison Service at WRAMC initiated a program to engage all traumatically injured service members in a preventive intervention. Preventive Medical Psychiatry (PMP) was developed to reduce stigma related to mental health engagement, foster therapeutic alliance with mental health professionals, screen for traumatic responses, and provide supportive intervention to ensure healthy adaptation to injury through the recovery period (Wain et al., 2004).

Efforts to help families have resulted in programs that target the early, intermediate, and long-term needs of injured and ill military families. Early intervention strategies include ongoing consultation with families as well as health care providers who are treating injured service members. Typically, families with children have multiple challenges related to travel, housing, finances, education, and child care, among others. Care management support can be critical in coordinating services to meet these needs. Parents are often distracted by serious injuries and should be reminded of the needs of their children by providing developmental guidance about children's responses to parental injury. Parents should be given appropriate language to help their children understand what they might see and hear about the parent's injury and be reminded of the importance of protecting all children from unnecessary frightening exposures while in the hospital setting.

Parent Guidance Assessment–Combat Injury (PGA–CI)

The Parent Guidance Assessment–Combat Injury (PGA–CI) instrument was developed as a tool to assist in conducting discussions with injured service members and their spouses about the needs of their families (especially their children) in response to combat injury (Cozza et al., 2010). The PGA–CI interview was often the spouses' first opportunity to talk about their personal experiences, to describe the effects of this powerful event on the family, to think about their children's responses, and to ask questions about how best to meet their children's needs. Ultimately, the PGA–CI tool assisted health care professionals in the formulation of family assistance

strategies and plans, with specific interest and emphasis on the positive growth of children.

FOCUS–CI

A promising new intervention, Families OverComing Under Stress–Combat Injury (FOCUS–CI) integrates two existing evidence-based treatments—the Families OverComing Under Stress family resiliency training program and Early Combined Collaborative Care (ECCC)—and is currently undergoing a controlled research trial. As described previously, FOCUS (Saltzman et al., 2009) is an evidence-informed preventive intervention program. ECCC (Zatzick et al., 2004) is a shared patient–health care provider treatment approach that promotes long-term care management, active sustained follow-up, and continuity in care delivery sectors. A primary goal of FOCUS–CI is to encourage long-term, trusting, and helpful relationships with combat-injured families so that any family needs are identified and addressed as they develop throughout injury recovery. Families are encouraged to engage in innovative, mutually developed activities that allow them to practice new ways of relating to one another and being together. At times, this has included child participation in a parent's rehabilitation appointments. Open and honest discussions between parents can help injured service-member parents reinterpret and reframe their situations, develop new skills, and develop healthy coparenting strategies and competencies.

These examples illustrate the integration of an expanded family-centered care approach, adapting existing systems of care around families, attending the critical role of family as a primarily system of support, including interventions that address family-level stress and needs by promoting both individual and family resilience, and transforming caregiving systems through organizational and leadership changes.

IMPLICATIONS AND RECOMMENDATIONS

We have described a convergence of theory and empirical evidence regarding the merits of family-centered approaches to systems of care for military families. Regardless of whether the focus is individual development; family functioning; connections among biological, psychological, and social systems; or organizational responses to community challenges, current evidence suggests prevention and intervention will be more successful when individuals and families are understood in context—and when the systems surrounding families support their efforts to care for their members. Both military organizations and larger society rely on families to perform functions for which there are no good substitutes, including substantial amounts of medical care. In this concluding section, we suggest several recommendations for enhancing family-centered prevention and care within systems.

1. **Resist thinking about service members and veterans as separate from their families.** It is clear that service members' and veterans' experiences are inextricably tied to those of their families. Service members' parents, spouses, and children have made it equally clear that their loved ones' military careers have substantial implications for their own well-being and relationships. Thus, every effort to prepare, prevent, or intervene ought to consider the relevance of family dynamics in the development of military and civilian public health strategies across the continuum of care. To the extent that other family members will be called on to adjust to military demands, provide substantial support and care, or react in ways that are costly to the military, their well-being and functioning are relevant. As those who have served alongside their loved one, military and veteran family members' own prevention and care needs are also a relevant national public health priority.
2. **Identify and evaluate effective strategies for family engagement across service settings.** Recognizing that military and veteran families may be difficult to engage, it is important to not give up. While in the military it is possible to require service members to participate in training and intervention, this is not customary in civilian communities. Furthermore, this requirement extends only to service members and not their dependent family members. There is extensive literature on family-focused and community-based prevention and intervention efforts and what it takes to engage families across systems of care. Family-centered approaches, particularly those focused on enhancing family strengths, have been shown to be especially well received among culturally diverse and ethnic minority families (Kumpfer, Alvarado, Smith, & Bellamy, 2002; National Research Council & Institute of Medicine, 2009). Evidence suggests that approaches to psychological health prevention and treatment that engage families early, before pathology has emerged, are more likely to be appealing and culturally acceptable to military families, as is embedding evidence-based care in settings where veterans or families are already served.
3. **Consider barriers to care from the perspective of families' ecological niches.** From the perspective of many families, systems of care may not look very systematic at all, instead requiring extensive information gathering, interaction with multiple providers, and constant wariness about falling through the cracks. We should look for ways that systems can be made to work better *around* families, rather than putting the onus on families themselves to create the glue between system elements. At a more concrete level, physical treatment environments often have insufficient or inappropriate space for multiple family members or young children,

which makes it difficult for families to avail themselves of services. Physical treatment settings should include facilities that protect family members, especially children, from avoidable exposure to distressing or traumatic experiences, such as witnessing of painful procedures or patient distress, as well as providing a safe and comfortable place for families to rest and recover (Cozza & Guimond, 2011).

4. **Conduct research that both guides our understanding of family dynamics within military and veteran family trajectories and advances our ability to effectively implement family-centered practices and interventions across systems of care.** These two research agendas are interrelated. Important questions have emerged as families and children of all ages have navigated a lifetime of parents', spouses', or siblings' wartime service and, in many cases, dramatic changes in family relationships, roles, and responsibilities. The longer-term developmental and public health impact and needs for military and veteran families remain undetermined. This need is particularly salient for families affected by war-related injuries, for whom little is known about how best to support and sustain marital relationships and parent-child relationships, support child development, *and* maximize quality of life for the injured service member. But *all* military families can benefit from being fully prepared with the skills they need to respond constructively when faced with the challenges of military life—whether expected or unexpected. As community and medical systems are increasingly charged with addressing military and veteran family needs, research on the investigation of both program effectiveness and implementation processes is critical to advancing successful integration of family-centered practice and prevention into military- and veteran-serving systems of care.

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