

Bibliography of Key Sources on Veterans and Families Affected by Trauma and Substance Use Disorders (with abstracts where available)

Addressing the Substance Use Disorder Service Needs of Returning Veterans and Their Families: The Training Needs of State Alcohol and Other Drug Agencies and Providers (2009). Retrieved September 30, 2012 from http://partnersforrecovery.samhsa.gov/docs/Veterans_Report.pdf.

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) conducted an environmental scan of the training, outreach, and resources offered by the Single State Agencies (SSAs) in charge of drug and alcohol treatment and prevention services to respond to the needs of returning veterans and their families. This scan was conducted to learn how to more effectively serve returning veterans and family members impacted by substance use disorders (SUDs). To accomplish this, NASADAD conducted case studies of nine States that had been identified as having the largest number of initiatives for returning veterans. The data for these case studies were gleaned from 36 interviews with SSA staff and staff from publicly funded SUD treatment facilities. NASADAD staff gathered data on State policies, trainings, and outreach efforts, as well as recommendations for future development of technical assistance and training materials to address the gaps in services. Specific requests to the States for technical assistance and trainings included: Trainings for substance use services providers, as well as primary care providers, to identify and treat post traumatic stress disorder (PTSD) and traumatic brain injury (TBI); Trainings on models to treat veteran-specific trauma; Trainings on military culture; Trainings to help law enforcement officials, the courts, and hospital workers identify veterans' SUDs; and Technical assistance to increase telehealth and webinar capabilities to overcome distance/ transportation barriers.

Booth, B., Segal, M. W., Bell, D. B., Martin, J. A., Ender, M. G., Rohall, D. E., & Nelson, J. (2007). *What we know about Army families: 2007 update*. Family and Morale, Welfare and Recreation Command.

In 1993, the U.S. Army Research Institute for the Behavioral and Social Sciences (ARI) published a 61-page review of Army family research entitled *What We Know About Army Families*. This report, written by sociologist Mady W. Segal and social worker Jesse J. Harris, summarized research findings from approximately 70 studies on American military families and the implications of that research for Army policymakers, program managers, unit leaders, and supervisors. The goal of *What We Know About Army Families* was to disseminate research-based information and recommendations about Soldiers and their families throughout the Army community to help strengthen retention, readiness, and family adaptation to Army life. The report was written in a nontechnical fashion—free of scientific and Army jargon—to be of maximum value to readers with diverse backgrounds who shared a common interest in and commitment to the support of Soldiers and their families. This document represents an update of the original report. Like its predecessor, *What We Know About Army Families: 2007 Update* provides a summary of findings from recent social science research conducted on, with, and about Soldiers and their families. By design, the 2007 Update retains many of the original report's most valuable characteristics. For example, major findings are highlighted in bold, and the research reviewed is summarized in a style that minimizes the use of specialized

terminology. This approach results in a document that is accessible to a general audience. The key difference between the two reports is that the current volume draws on research produced, for the most part, after the 1993 report was published. The need for the 2007 Update is driven by the substantial changes that have occurred within the Army and its families, the U.S. military, and American society in general since the early 1990s. Some of these changes are highlighted in this introduction; others are addressed in more detail in subsequent chapters.

Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Han, B. (2010). Children on the homefront: The experience of children from military families. *Pediatrics*, *125*(1), 16-25.

OBJECTIVE: Although studies have begun to explore the impact of the current wars on child well-being, none have examined how children are doing across social, emotional, and academic domains. In this study, we describe the health and well-being of children from military families from the perspectives of the child and nondeployed parent. We also assessed the experience of deployment for children and how it varies according to deployment length and military service component. **PARTICIPANTS AND METHODS.** Data from a computer-assisted telephone interview with military children, aged 11 to 17 years, and nondeployed caregivers (n = 1507) were used to assess child well-being and difficulties with deployment. Multivariate regression analyses assessed the association between family characteristics, deployment histories, and child outcomes. **RESULTS:** After controlling for family and service-member characteristics, children in this study had more emotional difficulties compared with national samples. Older youth and girls of all ages reported significantly more school-, family-, and peer-related difficulties with parental deployment (P.01). Length of parental deployment and poorer nondeployed caregiver mental health were significantly associated with a greater number of challenges for children both during deployment and deployed-parent reintegration (P.01). Family characteristics (eg, living in rented housing) were also associated with difficulties with deployment. **CONCLUSIONS:** Families that experienced more total months of parental deployment may benefit from targeted support to deal with stressors that emerge over time. Also, families in which caregivers experience poorer mental health may benefit from programs that support the caregiver and child. *Pediatrics* 2010;125:16–25

Dekel, R., & Goldblatt, H. (2008). Is there intergenerational transmission of trauma? The case of combat veterans' children. *American Journal of Orthopsychiatry*, *78*(3), 281–289. doi:10.1037/a0013955

This article is a review of the literature on intergenerational transmission of posttraumatic stress disorder (PTSD) from fathers to sons in families of war veterans. The review addresses several questions: (1) Which fathers have a greater tendency to transmit their distress to their offspring? (2) What is transmitted from father to child? (3) How is the distress transmitted and through which mechanisms? And finally, (4) Which children are more vulnerable to the transmission of PTSD distress in the family? Whereas the existing literature deals mainly with fathers' PTSD as a risk for increased emotional and behavior problems among the children, this review also highlights the current paucity of knowledge regarding family members and extrafamilial systems that may contribute to intergenerational transmission of PTSD or to its moderation. Little is also

known about resilience and strengths that may mitigate or prevent the risk of intergenerational transmission of trauma.

Galovski, T., & Lyons, J. A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior, 9*(5), 477–501. doi:10.1016/S1359-1789(03)00045-4

This review of the literature reveals that veterans' posttraumatic stress disorder (PTSD) following exposure to combat violence affects veterans' familial relationships and the psychological adjustment of family members. Previous study within other trauma populations has conceptualized the negative impact of an individual's traumatic stress on his/her family members as "secondary traumatization." This review examines the processes by which secondary traumatization occurs within combat veterans' families. Research has identified PTSD as mediating the effect of veterans' combat experience on the family. Veterans' numbing/arousal symptoms are especially predictive of family distress; while, to a lesser extent, veterans' anger is also associated with troubled family relationships and secondary traumatization among family members. Empirical modeling of additional factors involved in secondary traumatization is needed. Marital/family interventions have largely focused on improving relationships and reducing veterans' symptoms, rather than targeting improvements in the psychological well-being of the spouse and children. Interventions directly addressing the needs of significant others, especially spouses, are advocated. The potential for increased effectiveness of PTSD interventions and possible cost-savings attained by improving relationships and reducing caregiver burden are also discussed.

Gibbs, D. A., Martin, S. L., Johnson, R. E., Rentz, E. D., Clinton-Sherrod, M., & Hardison, J. (2008). Child maltreatment and substance abuse among US Army soldiers. *Child maltreatment, 13*(3), 259-268.

Although substance abuse has consistently been linked to child maltreatment, no study to date has described the extent of substance abuse among child maltreatment offenders within the military. Analysis of U.S. Army data on all substantiated incidents of parental child maltreatment committed between 2000 and 2004 by active duty soldiers found that 13% of offenders were noted to have been abusing alcohol or illicit drugs at the time of their child maltreatment incident. The odds of substance abuse were increased for offenders who committed child neglect or emotional abuse, but were reduced for child physical abuse. The odds of offender substance abuse nearly tripled in child maltreatment incidents that also involved co-occurring spouse abuse. Findings include a lack of association between offender substance abuse and child maltreatment recurrence, possibly because of the increased likelihood of removal of offenders from the home when either substance abuse or spouse abuse were documented.

Gibbs, D. A., Martin, S. L., Kupper, L. L., & Johnson, R. E. (2007). Child maltreatment in enlisted soldiers' families during combat-related deployments. *JAMA: The Journal of the American Medical Association, 298*(5), 528-535.

Context: Parental stress is believed to play a critical role in child maltreatment, and deployment is often stressful for military families. Objective: To examine the association between combat-

related deployment and rates of child maltreatment in families of enlisted soldiers in the US Army who had 1 or more substantiated reports of child maltreatment. Design and Setting: Descriptive case series of substantiated incidents of parental child maltreatment in 1771 families of enlisted US Army soldiers who experienced at least 1 combat deployment between September 2001 and December 2004. Main Outcome Measures: Conditional Poisson regression models were used to estimate rate ratios (RRs) that compare rates of substantiated child maltreatment incidents during periods of deployment and nondeployment. Results: A total of 1858 parents in 1771 different families maltreated their children. In these families, the overall rate of child maltreatment was higher during the times when the soldier-parents were deployed compared with the times when they were not deployed (942 incidents and 713 626 days at risk during deployments vs 2392 incidents and 2.6 million days at risk during nondeployment; RR, 1.42 [95% confidence interval {CI}, 1.31-1.54]). During deployment, the rates of moderate or severe maltreatment also were elevated (638 incidents and 447 647 days at risk during deployments vs 1421 incidents and 1.6 million days at risk during nondeployment; RR, 1.61 [95% CI, 1.45-1.77]). The rates of child neglect were nearly twice as great during deployment (761 incidents and 470 657 days at risk during deployments vs 1407 incidents and 1.6 million days at risk during nondeployment; RR, 1.95 [95% CI, 1.77-2.14]); however, the rate of physical abuse was less during deployments (97 incidents and 80 033 days at risk during deployments vs 451 incidents and 318 326 days at risk during nondeployment; RR, 0.76 [95% CI, 0.58-0.93]). Among female civilian spouses, the rate of maltreatment during deployment was more than 3 times greater (783 incidents and 382 480 days at risk during deployments vs 832 incidents and 1.2 million days at risk during nondeployment; RR, 3.33 [95% CI, 2.98-3.67]), the rate of child neglect was almost 4 times greater (666 incidents and 303 555 days at risk during deployments vs 605 incidents and 967 362 days at risk during nondeployment; RR, 3.88 [95% CI, 3.43-4.34]), and the rate of physical abuse was nearly twice as great (73 incidents and 18 316 days at risk during deployments vs 141 incidents and 61 105 days at risk during nondeployment; RR, 1.91 [95% CI, 1.33-2.49]). Conclusions: Among families of enlisted soldiers in the US Army with substantiated reports of child maltreatment, rates of maltreatment are greater when the soldiers are on combat-related deployments. Enhanced support services may be needed for military families during periods of increased stress. Child maltreatment includes neglect, physical abuse, emotional abuse, and sexual abuse. Children who are maltreated are at increased risk for negative health behaviors, depression, and chronic health conditions, with negative sequelae extending into adulthood. Few studies have examined child maltreatment within military families, of which there were more than 1.1 million with children younger than 18 years in 2004. Limited knowledge regarding these families is of concern because of the possible impact of combat-related deployments on child maltreatment. Military families have been found to demonstrate high levels of resilience; nonetheless, deployments pose unique challenges. These deployments may affect the family's children, the soldier-parent preparing for (or returning from) deployment, and the parent remaining at home during deployment. Deployments have been associated with stress and behavioral problems among children in military families, situations that can exacerbate parental stress. Deployment also has been associated with increased stress among nondeployed parents, which may hamper their ability to appropriately care for their children. Parental stress (as mediated by their appraisals of the situation, available resources, and coping strategies) is believed to play a critical role in child maltreatment, particularly child neglect. Hillson and Kuiper's stress and coping model of child maltreatment suggests that parents respond to stress either with positive adaptive behaviors or with dysfunctional behaviors that may result

in child maltreatment. The findings of 2 studies suggest a relationship between large-scale military deployments and increases in child maltreatment; however, the study designs did not permit the investigators to compare rates of child maltreatment events within abusive families during periods of deployment and nondeployment.

Herzog, J. R., Everson, R. B., & Whitworth, J. D. (2011). Do Secondary Trauma Symptoms in Spouses of Combat-Exposed National Guard Soldiers Mediate Impacts of Soldiers' Trauma Exposure on Their Children? *Child and Adolescent Social Work Journal*, 28(6), 459–473. doi:10.1007/s10560-011-0243-z

This exploratory study examines the associated effects of combat exposure on Soldiers assigned to a Midwestern Army National Guard unit. It also explores the secondary and mediating effects of combat exposure on Soldier's spouses and children. The correlations of combat exposure with trauma symptoms, substance abuse, domestic violence and secondary trauma symptoms among family members are identified. Survey results suggest that immediate family members of combat-exposed Soldiers with high levels of post traumatic stress disorder (PTSD) are at risk for developing secondary traumatic stress. Secondary trauma symptoms in these spouses are a risk-increasing mediating variable between trauma symptoms in combat-exposed Soldiers and secondary trauma symptoms in their children. Results from this investigation emphasize the need for further inquiry into this topic. They further highlight the need for preventive and treatment efforts targeted toward all family members and relationships in order to lessen the effects of combat exposure.

Institute of Medicine (US). Committee on the Initial Assessment of Readjustment Needs of Military Personnel, Veterans, & Their Families. (2010). *Returning home from Iraq and Afghanistan: Preliminary assessment of readjustment needs of veterans, service members, and their families*. National Academy Press.

The statement of task for this study evolved out of discussions among the Department of Defense (DOD), the Department of Veterans Affairs (VA), and IOM. Specifically, it was determined that in phase 1, the IOM committee would identify preliminary findings regarding the physical and mental health and other readjustment needs for members and former members of the armed forces who were deployed to OEF or OIF and their families as a result of such deployment. The committee would also determine how it would approach phase 2 of the study, which is meant to be a comprehensive assessment of the physical, mental, social, and economic effects and to identify gaps in care for members and former members of the armed forces who were deployed to OIF or OEF, their families, and their communities.

Kizer, K. W., Demakis, J. G., & Feussner, J. R. (2000). Reinventing VA health care: systematizing quality improvement and quality innovation. *Medical care*, 38(6), I-7.

In this annual report for the Health Care Survey of Department of Defense (DoD) Beneficiaries (HCSDB), we describe results from a worldwide survey of beneficiaries eligible for health care coverage through the military health system (MHS). The survey contains questions about beneficiaries' ratings of their health care and health plan, access to care, choice of health plan, and other subjects relevant to the leaders and users of the MHS. We compare the results to

benchmarks from civilian health plans featured in the National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Benchmarking Database (NCBD).

Lester, P., Saltzman, W. R., Woodward, K., Glover, D., Leskin, G. A., Bursch, B., ... & Beardslee, W. (2012). Evaluation of a family-centered prevention intervention for military children and families facing wartime deployments. *Journal Information, 102*(S1).

Objectives. We evaluated the Families OverComing Under Stress program, which provides resiliency training designed to enhance family psychological health in US military families affected by combat- and deployment-related stress. *Methods.* We performed a secondary analysis of Families OverComing Under Stress program evaluation data that was collected between July 2008 and February 2010 at 11 military installations in the United States and Japan. We present data at baseline for 488 unique families (742 parents and 873 children) and pre–post outcomes for 331 families. *Results.* Family members reported high levels of satisfaction with the program and positive impact on parent–child indicators. Psychological distress levels were elevated for service members, civilian parents, and children at program entry compared with community norms. Change scores showed significant improvements across all measures for service member and civilian parents and their children ($P < .001$). *Conclusions.* Evaluation data provided preliminary support for a strength-based, trauma-informed military family prevention program to promote resiliency and mitigate the impact of wartime deployment stress.

Pond, M. H. (2010). Military Policy Academy Promotes, Plans for Behavioral Health. Retrieved September 30, 2012, from http://www.samhsa.gov/samhsnewsletter/Volume_18_Number_4/BehavioralHealthServiceMembers.aspx.

For many returning service members, veterans, and their families, a variety of services are needed to ease the adjustment to life away from the battlefield, including substance abuse and mental health services. To help, SAMHSA convened a Returning Service Members, Veterans, and their Families Policy Academy. For the 2-1/2-day event in early June, SAMHSA's planning partners included the Department of Veterans Affairs, Department of Defense, National Guard Bureau, National Association of State Mental Health Program Directors, and National Association of State Alcohol and Drug Abuse Directors. Related Stories: Paving the Road Home: Returning Vets and Their Families, Helping Children of Military Families, One Family's Story: Commitment to Suicide Prevention, Mental Health, Real Warriors: Reaching Out Makes a Real Difference. The goal of the Policy Academy—for the nine states and one territory participating—was to facilitate the creation of interagency strategic plans that ensure needed behavioral health services are accessible to the Nation's service men and women and their families. The Policy Academy was preceded by pre-planning site visits and followed by technical assistance site visits to help states activate their plans.

Mmari, K., Roche, K. M., Sudhinaraset, M., & Blum, R. (2009). When a Parent Goes Off to War Exploring the Issues Faced by Adolescents and Their Families. *Youth & Society, 40*(4), 455-475.

The objectives of this study were (1) to explore the consequences of parental deployment for adolescents and their families and (2) to identify potential strategies that may help adolescents cope with a parent's deployment. Eleven focus groups were conducted among adolescents in military families, military parents, and school personnel in military-impacted schools at five military bases. Findings reveal that one of the most prominent sources of stress for families is adjusting and readjusting to new roles and responsibilities. Notably, this stress was primarily felt after the deployed parent returned. School personnel also commented that many teachers and counselors are not prepared to deal with deployment issues among the military students. These findings suggest that parents need to be better prepared to handle the stresses after a deployed parent returns. School personnel also need special training, and military-impacted schools need to offer additional opportunities for students to discuss deployment issues.

Morris, A. S., & Age, T. R. (2009). Adjustment among youth in military families: The protective roles of effortful control and maternal social support. *Journal of Applied Developmental Psychology, 30*(6), 695-707.

This study examined coping, effortful control, and mental health among 65 youth (ages 9–15) residing in families where at least one parent was serving in the United States military. Parents provided basic demographic and deployment information. Youth reported on their coping, effortful control, and adjustment using standardized self-report measures. Results indicate that youth residing in military families report elevated levels of conduct problems according to established clinical norms. However, study findings also indicate that effortful control and maternal support act as important protective factors against the development of conduct problems and emotional symptoms, whereas avoidant coping is associated with greater emotional symptoms. No significant differences emerged among youth of recently deployed versus non-deployed parents. Findings are discussed in light of current stressors on military youth and families, and in terms of their implications for successful intervention and prevention programming.

National Council (n.d.). Providing Mental Health and Addiction Services for Service Members and Veterans. Retrieved September 30, 2012, from <http://www.thenationalcouncil.org/galleries/policy-file/MH%20and%20Addiction%20Services%20for%20Service%20Members%20and%20Veterans.pdf>.

As of December 2009, over 2,000,000 U.S. troops have been deployed to Iraq or Afghanistan since September 11, 2001. Among the U.S. troops returning from Iraq and Afghanistan, nearly 40 percent of soldiers, a third of Marines, and half of the National Guard members report symptoms of psychological problems. Thirty-one percent of all Army soldiers and other military personnel who have experienced heavy combat in Iraq and Afghanistan also have at least one mental or psychosocial disorder. Problems facing returning soldiers include anxiety, depression, and PTSD in addition to substance abuse, TBI, family violence, and grief or bereavement.

Post-Traumatic Stress Disorder in Military Veterans Effects on Family Relationships (2011). Retrieved September 30, 2012, from www.hfhc.ext.wvu.edu/r/download/90952

The focus of this intervention is on male military veterans who are experiencing post-traumatic stress disorder and their families. The prevalence rate of post-traumatic stress disorder is between 11-22% in Veterans returning from Operation Iraqi Freedom and Operation Enduring Freedom (Finley, Baker, Pugh, & Peterson, 2010). Post-traumatic stress disorder has three clusters of symptoms and is linked to increased marital and family conflict and stress (Ray & Vanstone, 2009; Allen, Rhoades, Stanley, & Markman, 2010). Those are re-experiencing, avoidance, and hyperarousal. There are many negative consequences associated with each of these symptom clusters, which is why this is such an important issue to address. Re-experiencing symptoms include things like nightmares and flashbacks (Dekel & Monson, 2010) and can possibly lead to couples sleeping separately, which could affect intimacy (Allen, Rhoades, Stanley, & Markman, 2010). Avoidance symptoms involve “diminished interest, emotional detachment, restricted affect, and a sense of foreshortened future” (Dekel & Monson, 2010) and unfortunately, often leads to isolation, emotional withdrawal, problems with intimacy, and sometimes spousal abuse (Allen, Rhoades, Stanley, & Markman, 2010; Ray & Vanstone, 2009; Monson, Taft, & Fredman, 2009). This emotional withdrawal appears to be a cyclical type of relationship, in that emotional withdrawal can push away family members, which takes away social support, a key component or successful recovery from post-traumatic stress disorder (Ray & Vanstone, 2009). In addition, this creates a type of block that negatively affects the attachment bond between parent and child. Also, avoidance symptoms are associated with less self-disclosure, which may be a form of protective buffering, but actually negatively affects the relationship of the couple dyad (Dekel & Monson, 2010). Hyperarousal symptoms include sleep disturbance, difficulty concentrating, and hypervigilance (Dekel & Monson, 2010) and “can contribute to tension, anger, and rapid escalation of conflict” (Allen, Rhoades, Stanley, & Markman, 2010). These symptoms do not only affect the afflicted individual, but rather, the actions of the afflicted individual affect their families, especially their wives and children. In fact, wives of veterans afflicted with post-traumatic stress disorder often experience tension, stress, loneliness, and somatic complaints in association to the severity of their husband’s post-traumatic stress disorder (Dekel & Monson, 2010). Veterans with post-traumatic stress disorder are at a higher risk of divorce than veterans without post-traumatic stress disorder (Monson, Taft, & Fredman, 2009). As mentioned previously, there is a risk of intimate partner violence (IPV) in relationships where one member has post-traumatic stress disorder and this risk is greater than in relationships without post-traumatic stress disorder. In fact, veterans suffering from post-traumatic stress disorder perpetuate IPV both more frequently and more severely, at rates two or three times the national average (Finley, Baker, Pugh, & Peterson, 2010). Finley et al (2010) also suggest that the violence committed accompanies certain PTSD symptoms. They classify the violence into three categories: violence committed in anger, dissociative violence (in which the perpetrator commits the act without conscious awareness), and parasomniac violence (which is an understudied form of violence in research).

Rentz, E. D., Marshall, S. W., Loomis, D., Casteel, C., Martin, S. L., & Gibbs, D. A. (2007). Effect of Deployment on the Occurrence of Child Maltreatment in Military and Nonmilitary Families. *American Journal of Epidemiology*, 165(10), 1199–1206. doi:10.1093/aje/kwm008

War has a profound emotional impact on military personnel and their families, but little is known about how deployment-related stress impacts the occurrence of child maltreatment in military families. This time-series analysis of Texas child maltreatment data from 2000 to 2003 examined

changes in the occurrence of child maltreatment in military and nonmilitary families over time and the impact of recent deployment increases. The rate of occurrence of substantiated maltreatment in military families was twice as high in the period after October 2002 (the 1-year anniversary of the September 11th attacks) compared with the period prior to that date (rate ratio $\frac{1}{4}$ 2.15, 95% confidence interval: 1.85, 2.50). Among military personnel with at least one dependent, the rate of child maltreatment in military families increased by approximately 30% for each 1% increase in the percentage of active duty personnel departing to (rate ratio $\frac{1}{4}$ 1.28, 95% confidence interval: 1.20, 1.37) or returning from (rate ratio $\frac{1}{4}$ 1.31, 95% confidence interval: 1.16, 1.48) operation-related deployment. These findings indicate that both departures to and returns from operational deployment impose stresses on military families and likely increase the rate of child maltreatment. Intervention programs should be implemented to mitigate family dysfunction in times of potential stress.

Rosen, L. N., & Martin, L. (1996). The measurement of childhood trauma among male and female soldiers in the US Army. *Military medicine*.

Assessed the validity and reliability of a 30-item version of the Childhood Trauma Questionnaire which was administered to 1,365 US Army soldiers, together with 4 questions on sexual abuse developed for a national survey of American adults. A 4-factor solution to the Childhood Trauma Questionnaire produced 4 subscales of emotional neglect, physical and emotional abuse, sexual abuse, and physical neglect. Results showed that half of female soldiers reported a childhood history of sexual abuse, compared with one-sixth of male soldiers. Half of both male and female soldiers reported a childhood history of physical abuse. Combined abuse histories were noted in 34% of female and 11% in male soldiers. Abused soldiers reported more psychological symptoms on the Brief Symptom Inventory than nonabused soldiers. Findings show psychometric properties similar to other studies that support the reliability of the measures.

SAMHSA. (2011). Military Families Fact Sheet - SAMHSA. Retrieved September 30, 2012 from <http://www.samhsa.gov/militaryFamilies/factSheet.aspx>

SAMHSA's support of behavioral health systems serving service members, veterans, and their families works with States, Territories, and Tribes to strengthen behavioral health care systems for Service Members, Veterans, and Their Families (SMVF). This initiative provides support through the provision of technical assistance (TA) and the promotion of ongoing interagency collaboration. This initiative builds upon SAMHSA's 2008 and 2010 SMVF Policy Academies, through which 18 States and Territories established interagency teams that: (1) developed strategic plans to accomplish the above goal; and (2) committed to sustaining and expanding the teams, and implementing and enhancing the plan. SAMHSA's support for behavioral health systems works with the teams in Policy Academy States and Territories and also reaches out to States, Territories, and Tribes that have not benefited from Policy Academies. The target audience for SAMHSA's support for behavioral health systems includes senior-level representatives from governors' offices; Tribal leaders; State, Territory, and Tribal agencies responsible for mental health and substance abuse, veterans affairs, National Guard, Medicaid and/or Social Security, housing, labor/employment, and criminal justice; and stakeholders, including but not limited to, veteran service organizations, military/veteran family support organizations, and providers, consumers, and families who are working with States, Territories,

and Tribes to improve behavioral health systems for SMVF. Key objectives for SAMHSA's support for behavioral health systems include the following: Providing a centralized mechanism for States, Territories, and Tribes to utilize when they have questions about strengthening their behavioral health systems for SMVF; Increasing awareness of and promoting integrated responses to the behavioral health needs of SMVF among agencies, providers, and stakeholders in the States, Territories, and Tribes receiving TA; Increasing awareness of and access to resources and programs that strengthen behavioral health care systems for SMVF; Increasing the number of States, Territories, and Tribes that implement promising, best, and evidence-based practices that strengthen behavioral health care systems for SMVF. Strengthening ongoing collaboration at the State, Territory, and Tribal level among key public and private agencies and stakeholders that are, or need to be, concerned with the behavioral health needs of SMVF. These include agencies responsible for and experts in mental health, substance use, emergency and crisis services, primary care, veterans affairs, labor/employment, housing/homelessness, children and families, and criminal justice; National Guard and Reserves; Medicaid and/or Social Security benefits; the U.S. Department of Veterans Affairs Veterans Integrated Service Network (VISN) serving that area; veterans service organizations; and Veterans (including Reserve components) and their families; and Providing a centralized mechanism for States, Territories, and Tribes to learn, connect, and share with experts and peers.

SAMHSA News Paving Road Home Helping Children of Military Families (2008). Retrieved September 30, 2012 from <http://store.samhsa.gov/product/SAMHSA-News-Paving-the-Road-Home-Returning-Veterans-and-Behavioral-Health/SAM08-165>

Covers a conference on returning veterans and their families that addressed suicide prevention, employment, homelessness, and traumatic brain injury. Also discusses bullying, mutual support groups, and mental health services in primary care settings.

Sayers, S. L., Farrow, V. A., Ross, J., & Oslin, D. W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry*, 70(2), 163.

Existing evidence suggests that military veterans with mental health disorders have poorer family functioning, although little research has focused on this topic. OBJECTIVE: To test whether psychiatric symptoms are associated with family reintegration problems in recently returned military veterans. DESIGN: Cross-sectional survey of a clinical population. Respondents who were referred to behavioral health evaluation from April 2006 through August 2007 were considered for the survey. SETTING: Philadelphia Veterans Affairs Medical Center, Pa. PARTICIPANTS: 199 military veterans who served in Iraq or Afghanistan after 2001 and were referred for behavioral health evaluation from primary care (mean age = 32.7 years, SD = 9.1). MAIN OUTCOME MEASURES: Measures included the Mini-International Neuropsychiatric Interview for psychiatric diagnoses, the 9-item Patient Health Questionnaire for depression diagnosis and severity, and screening measures of alcohol abuse and illicit substance use. A measure of military family readjustment problems and a screening measure of domestic abuse were developed for this study. RESULTS: Three fourths of the married/cohabiting veterans reported some type of family problem in the past week, such as feeling like a guest in their household (40.7%), reporting their children acting afraid or not being warm toward them

(25.0%), or being unsure about their family role (37.2%). Among veterans with current or recently separated partners, 53.7% reported conflicts involving "shouting, pushing, or shoving," and 27.6% reported that this partner was "afraid of them." Depression and posttraumatic stress disorder symptoms were both associated with higher rates of family reintegration problems. CONCLUSIONS: Mental health problems may complicate veterans' readjustment and reintegration into family life. The findings suggest an opportunity to improve the treatment of psychiatric disorders by addressing family problems.

Stagman, S. M., & Cooper, J. L. (2010). Children's mental health: What every policymaker should know. Retrieved from <http://academiccommons.columbia.edu/catalog/ac%3A126203>.

Active duty military personnel and National Guard and reservists experience multiple deployments as a result of the conflicts that comprise the War on Terror. A large body of research has accumulated on the behavioral health problems faced by military personnel as a result of these conflicts. After nearly a decade of war, a growing area of research shows the negative impact on children, youth and families of U.S. military personnel. Children of military families often experience multiple stressors before and during their parent's deployment and when they come home. Without appropriate mental health support systems, children of military personnel may be at a significant disadvantage compared with their peers in non-military families.

Strengthening Our Military Families: Meeting America's Commitment.

http://www.defense.gov/home/features/2011/0111_initiative/strengthening_our_military_january_2011.pdf

On January 24, 2011, President Barack Obama, First Lady Michelle Obama, and Dr. Jill Biden put forward nearly 50 commitments by Federal agencies responding to the President's directive to establish a coordinated and comprehensive Federal approach to supporting military families. These commitments, detailed in the *Strengthening Our Military Families: Meeting America's Commitment* report, represent the work of Cabinet Secretaries and other agency heads who have come together find better ways to provide our military families with the support they deserve. The Office of National Drug Control Policy stands with the President and our fellow agencies in furthering our commitment to the dedicated military families and veterans who serve our Nation. Far too many brave men and women who have risked their lives in service to our country are now suffering from physical, mental health, and substance abuse problems. We have an obligation to care for our military families and veterans and to improve their lives by increasing access to vital treatment services specifically geared toward our military heroes.

Tanielian, T., Haycox, L. H., Schell, T. L., Marshall, G. N., Burnam, M. A., Eibner, C., ... & Vaiana, M. E. (2008). *Invisible Wounds of War. Summary and Recommendations for Addressing Psychological and Cognitive Injuries*. RAND CORP SANTA MONICA CA.

The wars in Iraq and Afghanistan represent the largest stress on the all-volunteer force since its inception in the early 1970s. Since late 2001, the United States has deployed approximately 2 million service members to support these operations. The pace of these deployments has been frequent, with many service members deploying several times over the past nine years, often

with little quality time at home in between deployments. These deployments have also engaged the National Guard and Reserve forces extensively. In theater, the nature of combat exposure has placed additional stress on service members. Given the use of improvised explosive devices and the various insurgencies, there is no real front line. As such, even those in support roles are exposed to combat-related stressors. The stressors that service members face during deployment may also influence the experiences of family members, both during the deployment and after the return home. However, the impact of these unique deployments and the wartime environment on military families is still not well understood. A small but growing body of research has examined the impact of deployment on military families and has yielded valuable insights. However, there has been relatively little work in several areas: First, there is little information on how youth (and specifically pre-teens and teenagers) are faring across multiple domains or on understanding the experiences of youth as informed by both their own and adult perspectives. Second, there are few data on the challenges specifically related to deployment and reintegration that military youth face and how these challenges may differ by factors, such as youth age or gender, family military service or component, or the family's military deployment history, including number of deployments and total months of deployment. Finally, there has been relatively little analysis of how the wartime environment and deployments affect the emotional and psychological well-being of the spouse or other caregiver who stays at home to care for the family.

Veterans on the Road Home (2008). Retrieved September 30, 2012, from <http://www.thenationalcouncil.org/galleries/NCMagazine-gallery/NC%20Mag%20Veterans%20Final.pdf>.

As increasing numbers of soldiers return home from Iraq and Afghanistan bearing the scars of battle in the form of mental illnesses and addiction disorders, the need for treatment far exceeds the capacity of the Veterans Administration. Across our nation, more than 2,000 community-based mental health and addictions organizations are ideally equipped to treat our troops for disabling mental and substance use disorders and help them reintegrate into civilian life. With deep roots in their communities, these providers deliver critical mental health and addictions services to nearly six million Americans annually and now they're opening their doors and extending their services to veterans and veterans' families. This issue of *National Council Magazine* highlights the difficult road home and what treatment organizations around the country can do to make homecoming easier for our wounded heroes.

Wadsworth, S. M., & Riggs, D. (Eds.). (2010). *Risk and resilience in us military families* (2011th ed.). Springer.

War related separations challenge military families in many ways. The worry and uncertainty associated with absent family members exacerbates the challenges of personal, social, and economic resources on the home front. U.S. military operations in Iraq and Afghanistan have sent a million service personnel from the U.S. alone into conflict areas leaving millions of spouses, children and others in stressful circumstances. This is not a new situation for military families, but it has taken a toll of magnified proportions in recent times. In addition, medical advances have prolonged the life of those who might have died of injuries. As a result, more families are caring for those who have experienced amputation, traumatic brain injury, and profound psychological wounds. The Department of Defence has launched unprecedented efforts

to support service members and families before, during, and after deployment in all locations of the country as well as in remote locations. Stress in U.S. Military Families brings together an interdisciplinary group of experts from the military to the medical to examine the issues of this critical problem. Its goal is to review the factors that contribute to stress in military families and to point toward strategies and policies that can help. Covering the major topics of parenting, marital functioning, and the stress of medical care, and including a special chapter on single service members, it serves as a comprehensive guide for those who will intervene in these problems and for those undertaking their research.

Wounds of War: Drug Problems Among Iraq, Afghan Vets Could Dwarf Vietnam | The Partnership at Drugfree.org. (n.d.). Retrieved November 12, 2012, from <http://www.drugfree.org/join-together/alcohol/wounds-of-war-drug-problems>

The U.S. could face a wave of addiction and mental-health problems among returning veterans of the Iraq and Afghan wars greater than that resulting from the Vietnam War, according to experts at the recent Wounds of War conference sponsored by the National Center for Addiction and Substance Abuse (CASA*) at Columbia University (Join Together is a project of CASA).

Addendum to Bibliography (April 2013)

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