

Three-Generation Model: A Family Systems Framework for the Assessment and Treatment of Veterans With Posttraumatic Stress Disorder and Related Conditions

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This article describes the three-generation family systems health care model developed at the Veteran and Family Clinic of the Home Base Program, a partnership between the Red Sox Foundation and Massachusetts General Hospital designed to improve treatment engagement of veterans with posttraumatic stress disorder (PTSD) and related conditions, and to provide care to the entire military-connected family. This clinical model was designed to address 3 interdependent facets of the PTSD-affected family system: (a) the multiple attachment relationships that are often strained; (b) the veteran's family roles, which may be impaired; and (c) the multiple pathways for treatment engagement and amelioration of the veteran's PTSD-related distress and behaviors within the family system. In addition, we describe the assessment system, designed to probe the interrelationships of individual veteran, couple, parenting, child, and family levels of functioning. Three cases illustrative of the three-generation model's clinical application, how it can address unmet needs, and its ability to overcome barriers to health care for military families are also discussed.

Keywords: PTSD, veteran, family-centered health care, family systems, traumatic brain injury

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continued

Since September 11, 2001, more than 2.4 million U.S. service members have been deployed to Iraq and/or Afghanistan (National Council for Behavioral Health, 2012). Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) have been characterized by repeated and extended deployments, taxing not only service members but also their family members—partners, children, parents, and siblings (Tanielian & Jaycox, 2008). Immediate family members of these 2.4 million servicemen and women who have deployed include over 1.1 million spouses (Lyle, 2012) and 2 million children under the age of 18 (Department of Defense, 2010). The number of mothers and fathers with adult sons and daughters in the military is unknown. Furthermore, approximately 72% of enlisted service members and 35% of officers are under the age of 30 (Department of Defense, 2011), suggesting that an uncounted number of committed but nonspousal romantic partners and high-school-aged or younger brothers and sisters should be added to the total number of family members affected by the cycle of military deployment and post-combat reintegration. Even an extremely conservative estimate of one such uncounted relative per service member would bring the total number of family members potentially impacted above five million. Yet most remain largely unrecognized and underserved by both military and civilian health care systems.

Although many service members face reintegration challenges, many others will transition successfully back to civilian life when they return from deployment. However, although reported prevalence rates of posttraumatic stress disorder (PTSD), depression, and traumatic brain injury (TBI) range from 7% to 40% (Tanielian & Jaycox, 2008), one of the most cited sources from the (Tanielian & Jaycox, 2008) suggests approximately 33% of service members who return from combat suffer from at least one of these conditions, and 5% meet the criteria for all three diagnoses (Tanielian & Jaycox, 2008). The prevalence of substance use disorders in OIF/OEF veterans is estimated to be 11% to 20% (Fontana & Rosenheck, 2008; Seal et al., 2011), similar to the rates of 11% to 14% reported in epidemiologic studies of Vietnam veterans (Seal et al., 2011). Despite the significant distress and impairment caused by such conditions, fewer than half of these individuals seek mental health treatment (Hoge et al., 2004). Untreated PTSD and the associated changes in behavior, mood, and physiological and emo-

tional functioning impose enormous strains upon all family members and familial relationships.

A recent study of more than 250,000 wives of active-duty U.S. Army soldiers examined the familial stress associated with the challenge of military deployment and found that spousal deployment was associated with increased risk for depressive disorders, sleep disorders, anxiety, acute stress reaction, and adjustment disorders (Mansfield et al., 2010). Moreover, PTSD has been shown to be more strongly associated with both relationship discord and physical aggression in military samples compared with civilian samples (Taft, Watkins, Stafford, Street, & Monson, 2011). PTSD symptoms are associated with lower perceived relationship quality among intimate partners to a greater degree in military couples than in civilian couples (Lambert, Engh, Hasbun, & Holzer, 2012), and this inverse relationship has been demonstrated specifically in both National Guard (Erbes, Meis, Polusny, & Compton, 2011) and active-duty Army couples (Allen, Rhoades, Stanley, & Markman, 2010; Erbes et al., 2011). In another study, over three quarters of partnered veterans who screened positive for a mental health problem, including PTSD, reported difficulties with partners and/or children, including 41% “feel like a guest,” 57% “disagree about responsibilities,” and 25% experience their children as “not warm/afraid.” More than half of separated veterans reported conflicts with their partners that involved “shouting, pushing, or shoving,” and slightly more than one quarter of these veterans described their partner as “afraid of them” (Sayers, Farrow, Ross, & Oslin, 2009).

Although a study of more than 300,000 military children (ages 5 to 17) found that parental deployment was associated with acute stress reaction or adjustment, depressive, and pediatric behavioral disorders (Mansfield, Kaufman, Engel, & Gaynes, 2011), the effects of parental PTSD on a dependent child’s functioning or on parent–child attachment are not well understood. Limited self-report data suggest higher PTSD symptoms are associated with diminished parenting efficacy and emotional involvement with one’s children (Allen et al., 2010; Gewirtz, Erbes, Polusny, For-gatch, & DeGarmo, 2011); there are, however, no published data on the consequences of PTSD and related conditions on parent–child attachment, veteran’s parenting behaviors, or children’s emotional functioning and development. Scarce longitudinal data sug-

include forming national public private partnerships to address the invisible wounds of war.

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gest that family cohesion may be negatively affected by the veteran's PTSD, and reciprocally, reduced family cohesion may predict greater PTSD symptoms years later (Zerach, Greene, Ein-Dor, & Solomon, 2012).

Consistent with a wide range of adult psychiatric conditions such as depression (Miller et al., 2005), a growing body of evidence argues for the inclusion of close family members in the treatment of PTSD, as well as efforts to improve coping with deployment and reintegration stress. Dyadic interventions (i.e., psychotherapeutic interventions involving simultaneously two individuals such as a veteran and his or her spouse) for PTSD, such as cognitive-behavioral conjoint therapy (CBCT) for PTSD (Monson & Fredman, 2012) and strategic approach therapy (SAT; Sautter, Armelie, Glynn, & Wielt, 2011), are an exciting addition to evidence-based individual treatments such as prolonged exposure (PE) therapy (Foa, Hembree, & Rothbaum, 2007) and cognitive processing therapy (Resick, Monson, & Chard, 2008). Such dyadic interventions offer the possibility of simultaneously decreasing PTSD symptoms (and comorbid conditions) and improving the couple's relationship. CBCT for PTSD, compared with randomization to a waitlist (Monson et al., 2012), was associated with significantly greater improvements in PTSD symptoms, depression, anxiety, and anger in the partner with PTSD, as well as significant improvements in relationship satisfaction.

Preliminary data also suggest that triadic family interventions (i.e., psychotherapeutic interventions involving three individuals, such as a veteran, his or her spouse, and child) may enhance military family members' resilience and may reshape the interpersonal family milieu to facilitate the veteran's recovery from PTSD. For example, Families OverComing Under Stress (FOCUS) is an eight-session program delivered to individual families that relies on psychoeducation and skills building for emotional regulation, goal setting, problem solving, and family communication for military parents and their children. The goal of FOCUS is to improve coping with deployment-related experiences, and preliminary results have been promising (Lester et al., 2012). Similarly, early data from the 9-month Reaching out to Educate and Assist Caring, Healthy Families, a family psychoeducation program for veterans with serious mental illness or PTSD, also support its potential to improve interpersonal relationships, problem solving, communication, family coping, empowerment, and knowledge about PTSD for veterans and their family members (Sherman, Perlick, & Straits-Tröster, 2012). Finally, the efficacy of After Deployment: Adaptive Parenting Tools, a family adapted version of the Parent Management Training-Oregon model, which targets postdeployment adjustment reactions through a 14-week, web-enhanced parenting program, is being evaluated currently (Gewirtz et al., 2011).

Recent data suggest that the majority of veterans and service members may wish their family to be involved in their PTSD treatment (Batten et al., 2009; Friedemann-Sánchez, Sayer, & Pickett, 2008; Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011; Meis et al., 2013). In particular, 75% to 80% of surveyed veterans have reported a strong interest in having their intimate partner involved in their treatment (Batten et al., 2009; Khaylis et al., 2011; Meis et al., 2013). Similarly, 80% of veteran parents who participated in the study by Meis et al., 2013 stated a preference for family therapy involving their dependent-aged children over individual treatment. Finally, a healthy romantic partner relationship facilitates PTSD treatment engagement (Meis, Barry, Kehle,

Erbes, & Polusny, 2010). Taken together, these data suggest involving family members may be a helpful approach to improve both veterans' mental health outcomes and their associated relationship impairments. Such an approach may benefit service members or veterans with both clinical and subclinical levels of psychological difficulties, as well as the full range of family members affected by deployment-related stress (intimate partners and children but also parents and siblings); this inclusive family approach may prove synergistic in addressing both individual- and family-level distress beyond the traditional nuclear family.

The present article describes the potential benefits of a unique three-generational model of veteran and family-centered care developed at the Red Sox Foundation (RSF) and Massachusetts General Hospital (MGH) Home Base Program's Veteran and Family Clinic (hereafter referred to as "HBP Clinic"). Appropriate to the early state of the HBP Clinic's development, the goal of this article is descriptive: to introduce a clinical practice model designed to engage veterans and afford their family members access to care coordinated with that of their veteran loved one. To that end, first, an overview of the program's history and patient population is presented, and then the theoretical framework and implementation of our three-generation model is described, highlighting the clinical engagement and treatment opportunities associated with it. The article concludes with three typical case examples (rather than individual case reports, in order to protect confidentiality) developed to illustrate the model's potential usefulness, and recommendations for how the model may be applied in other settings.

Program History and Patient Characteristics

Established in 2009, the Home Base Program (HBP) is a public-private partnership providing outreach, clinical care, research, and education to veterans and their families affected by the signature wounds of the post-9/11 conflicts, PTSD, and TBI. Supported almost entirely by philanthropy, the care of military-connected family members is integral to the program's mission. The rare opportunity to provide clinical care to a veteran's extended family has allowed the clinical staff to observe and respond to the naturally occurring expression of needs within a family system challenged by deployment and postdeployment stressors, including combat and other service-related PTSD, and related conditions such as anxiety, depression, alcohol and drug abuse, and intimate partner violence.

The HBP Veteran and Family Clinic is one program of the HBP. It is designed as a multidisciplinary outpatient service of the MGH. Open Monday through Friday, 8:00 a.m. to 5:00 p.m., and staffed by adult and child psychiatrists, adult and child psychologists, physical medicine and rehabilitation medicine physicians, a clinical nurse specialist, a nurse, and social workers, the HBP Clinic provides combined expertise in the treatment of traumatic stress-related conditions such as PTSD, TBI, anxiety disorders, mood disorders, substance abuse, and child psychopathology. Treatment modalities include psychopharmacology, individual evidence-based trauma-focused therapy (PE and cognitive processing therapy), evidenced-based couple therapy (CBCT for PTSD and emotion focused therapy; Johnson, Hunsley, Greenberg, & Schindler, 1999; Monson & Fredman, 2012), child and family therapy, indi-

vidual and group support, stress management, and physical rehabilitation medicine services.

In addition, the HBP Clinic also employs four OIF/OEF combat veterans (Veteran Outreach Coordinators) who functionally serve as a veteran outreach team. In the model, these outreach coordinators play a critical role in the initial clinical engagement of veterans and serve as point person for each veteran throughout their care in the clinic to improve retention. They are also a valuable resource to the staff without a military background, providing guidance on military culture and terminology and methods to engage veterans. The outreach coordinators afford their fellow veterans access to mental health care initiated and supported by their peer support, and have been highly effective in engaging an at-risk population with a variety of factors contributing to a reluctance to seek and engage in treatment.

Since its inception, more than 550 veterans and family members have been evaluated in person at the HBP Clinic. In 2012, phone intakes were conducted with 226 veterans and family members. Clinicians at the HBP Clinic conducted 205 in-person clinical evaluations and initiated psychotherapy and/or pharmacotherapy for 121 patients. Based on the past year, the most common diagnoses seen at the HBP Clinic at the initial clinical evaluation of veterans are PTSD, TBI, anxiety disorders, and major depressive disorder. Seventy percent had two or more diagnoses at initial evaluation, and 39% had three or more diagnoses; 56% have a diagnosis of alcohol abuse/dependence and/or substance abuse/dependence. In many cases, the veteran's call for service is preceded by a family member's call requesting information about the program and/or guidance as to how to convince their veteran loved one to seek treatment (see Figure 1 for our intake and evaluation procedure). Family members who enter treatment most often have adjustment reactions or V-codes of the International Statistical Classification of Diseases and Related Health Problems (i.e., "factors influencing health status"), such as adjustment reaction related to reintegration stress or PTSD.

Three-Generation Family Model of Care

The work conducted at the HBP Clinic with veterans, their parents, grandparents, romantic partners, siblings, and children has led us to the formulation of a three-generation model of care. The model has been strongly influenced by family systems theory (Jackson, 1957), and, in particular, the concepts of "reciprocal influence" and "role relationships" (see Figure 2). "Reciprocal influence" defines the mu-

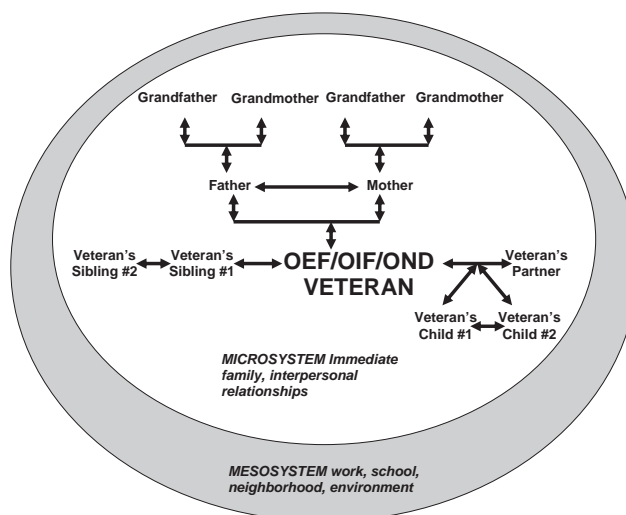


Figure 2. The Veteran's Multi-Generation Family System; for the purposes of this heuristic, we focus only on microsystem and mesosystem levels although we recognize the full social ecological model also includes the macrosystem and exosystem (Bronfenbrenner, 1977).

tual, multidirectional nature of family members' behavior upon one another, and the term "role relationships" conveys that the family is an organization defined by formal roles (e.g., parent, spouse), each associated with characteristic behaviors, tasks, and rules of interaction. More broadly, the model of care is situated within Bronfenbrenner's (1977) biopsychosocial model, underscoring that optimum health care for an individual veteran and his or her family requires a community educated about and committed to providing for the mental health needs of those 1% of citizens and their families who have served our country (see Figure 2).

In this framework, the veteran patient occupies the pivotal position in the family system with laterally connected members of the family, such as a romantic partner and/or siblings, and with vertically connected members, such as dependent children, parents, and grandparents. This conceptualization highlights three interdependent facets of the family system affected by deployment and related conditions: (a) the multiple attachment relationships that are potentially stressed by a veteran's invisible wounds; (b) the veteran's family *roles*—son or daughter, husband or wife, father or mother, sister or brother—that are at risk of being functionally impaired; and (c) the multidirectional

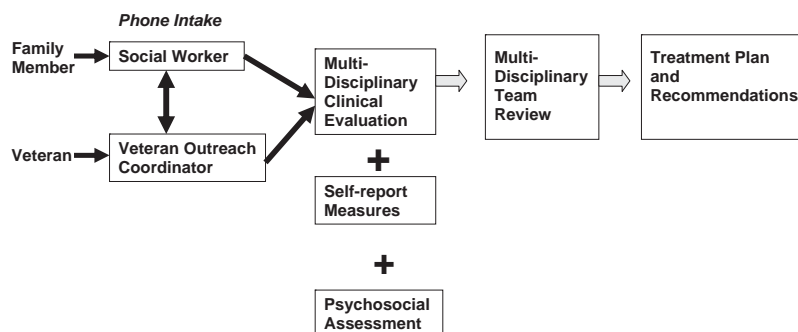


Figure 1. Veteran and Family Intake and Evaluation Procedure.

influences of individual family member's behavior on each other. Most importantly, this three-generation model suggests that improvement of *any* family member's distress may be a pathway for treatment engagement for the other family members, including the veteran, and, thus, that successfully addressing any individual or family subsystem's distress or dysfunction might improve functioning of other family members, family subsystems, and the entire family unit. The family member is therefore considered both a facilitator of the veteran's treatment engagement and a prospective patient in his or her own right.

From Multipathway Access to Family Subsystem Treatment

Calls requesting service may come from the service member or veteran, or from a member of his or her family (see Figure 1). The calls the HBP Clinic receives from family members are most frequently from a woman—a wife, fiancée, girlfriend, sister, or mother—requesting assistance getting the veteran into individual treatment for PTSD, couple therapy for relationship distress, psychiatric evaluation, and/or seeking services for a child. In the first instance, the caller is provided with information and guidance on how the veteran can contact one of our Veteran Outreach Coordinators to address questions, complete a phone intake, and schedule an in-person evaluation. Even if the veteran is not interested in treatment, the family member who called can request their own support (for the family member) in the form of groups, individual therapy, psychoeducation about PTSD and its comorbidities, and the challenges of living with their effects. Parents more often than other family members enter into treatment with the explicit goal of obtaining advice on how to get their adult veteran son or daughter into care. The Department of Veterans Affairs' (VA) "Coaching Into Care" program of phone support (www.mirecc.va.gov/coaching) is designed similarly to support and guide an extended family member's efforts to facilitate treatment engagement of their veteran loved one.

The veteran's psychiatric evaluation is conducted in conjunction with an extensive assessment of psychosocial needs, including insurance, housing, education, and employment. If the veteran has been evaluated and treated at the VA, with the veteran's permission, records are requested and reviewed to assist in diagnosis, treatment planning, and case management. For those who wish to continue VA treatment(s), collaboration between providers and coordination of care between the VA and the HBP Clinic occurs and helps to ensure well-coordinated case management activity. Results from all assessments are reviewed and integrated at a weekly interdisciplinary team meeting in which a personalized treatment plan is formulated for the veteran patient, and identification of needs for assessment and intervention with other members of the family (partner, dependent children, and parents) is also discussed.

The family system principle of "reciprocal influence" underlies the notion that PTSD likely disrupts relationships "laterally" (i.e., spouse and siblings) as well as "vertically" (i.e., parents and children) in the veteran's family system, and is the rationale for the formal assessments of both patients and family members through clinical interviews and self-report measures. The measures included in the initial assessment battery were selected to probe the interrelationships of the individual veteran, couple, parenting,

child, and family levels of functioning, and are administered to capture the interconnected functioning of individuals within the family system. At the initial in-person visit, all patients (veteran or family members aged 18 and older) meet with a clinician to conduct a comprehensive psychiatric evaluation and complete a battery of self-report measures designed to assess individual mental health symptoms and family functioning (see Table 1). Although the primary purpose of these assessments is clinical assessment of needs, treatment planning, and monitoring, a deidentified data repository was established with approval from the MGH Institutional Review Board for the purposes of assessing and improving quality of care delivered in the three-generation family care clinic.

Specifically, *veteran patients* complete a packet of self-report measures assessing a wide range of mental health symptoms, TBI symptoms, and family functioning: PTSD, TBI, depression, anxiety, grief, anger and aggression, pain, overall quality of life, interest in telemedicine, alcohol use, relationship satisfaction, and overall family functioning, and, if they have dependent children, measures on their parenting competence and perception of child psychological functioning. Further specific assessments, including that of comorbid substance use disorder, also occur during the clinician's diagnostic evaluation. Similarly, *family member patients* over the age of 18 complete self-report measures. With the exception of a measure used to assess their accommodation to a loved one's PTSD (Significant Others' Response to Trauma; Fredman et al., 2014), and a measure of their perceptions of the severity of the veteran's PTSD symptoms (PTSD Checklist–Collateral version [PCL-C]), the measures completed by adult family members are identical to those of the veteran patient, including a PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993).

For both veteran and family member patients, a smaller subset of these measures is readministered at 1-month intervals to supplement the treating clinician's clinical interview of the veteran's (or family member's) symptom severity and functioning, and to assist in monitoring therapeutic gains and improvement in functioning across the different family members and subsystems (see Table 1). This subset includes the PTSD Checklist–Identified Patient (PCL-I); the PCL-C; the Depression, Anxiety, and Stress Scales, 21-item version (DASS-21); the Couples Satisfaction Index (CSI-16); the Significant Others' Response to Trauma (SORTS); the Parenting Sense of Competence (PSOC); and the Family Assessment Device (FAD; see Table 1). The PCL-I and PCL-C are well-known measures of PTSD severity in the self and in a loved one, respectively. The DASS-21 is a brief 21-item inventory that categorizes the severity of depression, anxiety, and stress as "normal," "mild," "moderate," "severe," or "very severe." The SORTS assesses a family member's behavioral accommodation to a loved one's PTSD (i.e., the extent to which a family member changes their own behavior in response to PTSD symptoms and by so doing inadvertently reinforces the PTSD-affected individual's avoidance and other PTSD symptoms). The CSI-16 is a measure of relationship satisfaction, and the FAD General Functioning subscale is a 12-item assessment of overall family functioning based on problem solving, communication, family roles, affective responsiveness, affective involvement, and behavior control. The PSOC assesses a parent's confidence (low, moderate, high) in handling their child(ren)'s problems.

Table 1
Clinical Measures Used at the Home Base Program by Family Role

	Individual functioning	Intimate relationship functioning	Parenting and child functioning	Family functioning
Veteran	PCL-I, BTBIS, DASS-21, ICG, BAAQ, Pain, QLESQ, TAQ, AUDIT	CSI-16	PSC, PSOC	GF-FAD
Partner	PCL-I, PCL-C, DASS-21, ICG, Pain, QLESQ, TAQ, AUDIT	CSI-16, SORTS	PSC, PSOC	GF-FAD
Other adult family member	PCL-I, PCL-C, DASS-21, ICG, Pain, QLESQ, TAQ, AUDIT	CSI-16	N/A	GF-FAD
Child (<18 years old)	Child functioning assessed by parent report on PSC	N/A	N/A	N/A

Note. PCL-I = PTSD Checklist- Identified Patient (Weathers, Litz, Herman, Huska, & Keane, 1993); PCL-C = PTSD Checklist-Collateral (Weathers, et al., 1993); BTBIS = Brief Traumatic Brain Injury Screen (Schwab et al., 2006); DASS-21 = Depression, Anxiety, and Stress Scale, 21-item version (Lovibond & Lovibond, 1995); ICG = Inventory of Complicated Grief (Prigerson et al., 1995); BAAQ = Brief Anger and Aggression Questionnaire (Maiuro, Vitaliano, & Cahn, 1987); Pain = 3-item Pain questionnaire (created by Home Base clinicians); QLESQ = Quality of Life Enjoyment and Satisfaction Questionnaire (Endicott, Nee, Harrison, & Blumenthal, 1993); TAQ = Telehealth Attitudes Questionnaire (adapted from Grubaugh, Cain, Elhai, Patrick, & Frueh, 2008); AUDIT = Alcohol Use Disorders Identification Test, 5-item version (Bush, Kivlahan, McDonnell, Fihn, & Bradley, 1998); CSI-16 = Couple Satisfaction Index, 16-item version (Funk & Rogge, 2007); PSC = Pediatric Symptom Checklist (Jellinek et al., 1988); SORTS = Significant Others' Responses to Trauma Scale (Fredman, Vorstenbosch, Wagner, Macdonald, & Monson, 2014); PSOC = Parenting Sense of Competence (Gibaud-Wallston & Wandersman, 1978); GF-FAD = General Functioning Subscale of Family Assessment Device (Epstein, Baldwin, & Bishop, 1983).

Case Illustrations

The three case descriptions that follow illustrate the family system principle of interdependent, mutually influencing components of a system, and the manner upon which this can be capitalized to optimize treatment outcomes and improve quality of life for returning veterans with PTSD. The first example illustrates the involvement of a romantic partner to enhance treatment engagement and overall outcomes for a family system, the second describes the involvement of a parent, and the third illustrates the involvement of a sibling and the effects of the sibling's involvement with respect to the patient's individual mental health symptoms and the dyad's sibling relationship.

Romantic and coparenting partner. The wife of a Marine veteran in his 30s requested marital therapy because of her increasing distress regarding her husband's extreme withdrawal and emotional numbing following his fourth combat deployment to Afghanistan. The couple had three elementary-school-age children, all with academic difficulties that were made more difficult to remediate because of the veteran father's frequent anxious withdrawal, resulting in inconsistent implementation of behavioral and homework plans developed by the school. The veteran irregularly attended individual PTSD treatment, adding further to his wife's frustration and anger. The couple began conjoint therapy to address the relationship distress, but frequently failed to keep their appointments. In an effort to increase treatment engagement, the couple therapy was recast as parenting guidance, with the goal of strengthening the parenting bond to reduce the exclusive relationship between mother and children that developed during the husband's multiple deployments. As the couple worked together to reestablish the veteran's parenting role and authority, the wife's anger about being "a single parent" diminished, and she began expressing appreciation for having a parenting ally, creating an arena in their relationship with a positive rather than a chronic negative emotional tone. With this change, the couple was able to reengage productively in a conjoint intervention to work on other contributors to their relationship distress and the associated negative family milieu. Simultaneously, psychological and pharmacological support, and academic assessment and advocacy at the HBP Clinic, were provided to the children, thereby further reducing the stress upon the couple and the family system as a whole. As stress related to role conflict decreased, the veteran participated more fully and reliably in his own PTSD treatment. Thus, despite initial lack of engagement in care by the veteran, addressing multiple aspects of his family roles—as parent and spouse, alongside the needs of the affected children—was necessary to enable him to engage in care targeting his own PTSD. The veteran's commitment to his individual PTSD treatment improved significantly as the affective quality of the family milieu improved.

Parents. The parents of a divorced veteran of three combat tours to Iraq, living at home, sought assistance out of frustration with their son's increasing isolation from the family, excessive alcohol use, and lack of a relationship with his own children, to whom they provided regular childcare during their grandchildren's weekend visits with their son. Mother and father entered therapy to better cope with their anger about their son's inability to "get his life on track." Through psychoeducation about PTSD, particularly

the counterproductive role of accommodation to their son's avoidance behaviors, the parents were able to establish necessary boundaries and expectations regarding the use of alcohol in their home and their availability to provide childcare. Despite the parents' fears that these steps would further jeopardize their son's functioning, removing themselves as managers of the relationship he had with his own children ultimately led to the veteran contacting a HBP Veteran Outreach Coordinator. He began a course of trauma-focused therapy with adjunctive psychopharmacology. The therapist conducting the therapy for the veteran's PTSD incorporated management of his substance abuse into the treatment. Following successful completion of the PTSD treatment, the veteran requested parenting guidance to improve his interactions with his children. The parents continued in supportive therapy to reinforce the skills they learned and to address what they identified as grieving the loss of the son that went to war and learning to accept the son that returned. This case example illustrates the three-generation model of care, with an initial engagement of adult parents of a veteran impaired by PTSD and alcohol abuse, divorced, and struggling with maintaining a relationship with his children. Addressing the needs of the chronically distressed parents, and providing parenting guidance and individual treatment and parenting guidance for the veteran, were all needed to stabilize the family system and achieve a positive outcome for the veteran across his symptoms and family roles.

Sibling. A 25-year-old woman employed by a local human services organization contacted the HBP Clinic concerned about her 19-year-old sister, the ex-wife of a Marine veteran who had perpetrated physical and psychological aggression against her, as per her report, in the context of his untreated PTSD and comorbid substance use. The patient was assessed and diagnosed with PTSD secondary to intimate partner violence. The patient and her sister were living together and had a strained relationship characterized by frequent arguments and emotional distancing. Deficits in conflict management skills and problems with communication were conceptualized as impediments to the patient's recovery from PTSD by reinforcing her belief that she was chronically under interpersonal threat, and was physically and emotionally unsafe. The dyad was referred for family therapy with the simultaneous goals of treating the patient's PTSD symptoms and enhancing their relationship, and they subsequently began a course of CBCT for PTSD. Treatment began with psychoeducation about the bidirectional association between PTSD symptoms and couple and family functioning and the rationale for addressing the PTSD symptoms in a conjoint context. Over the course of the 15-session protocol, the patient and her sister learned conflict management strategies (e.g., taking a break when communication became unproductive and returning to the topic at hand after 30 min), communication skills (e.g., reflective listening, sharing emotions), and a dyadic process to challenge maladaptive thoughts that interfered with recovery from PTSD (e.g., "It's my fault that my ex-husband hit me"). By the end of treatment, the patient and her sister both reported reductions in the patient's PTSD symptom severity and increased relationship satisfaction. This case illustrates the importance of inclusion of key family supports, in this case, a sibling, beyond the usually considered romantic dyads or children in care to achieve positive outcomes for military families impacted by PTSD.

Discussion and Future Directions

This article describes the HBP Clinic, a mental health model developed to improve treatment engagement of veterans with PTSD and related conditions, and to provide often difficult to access care to three generations of military-involved family members. PTSD, depression, and TBI are estimated in total to affect one in three returning OIF/OEF combat veterans (Tanielian & Jaycox, 2008). A body of evidence is growing that partners, spouses, and dependent children of veterans who screen positive for, or present to mental health clinics for treatment of, PTSD and related conditions are at risk of emotional and behavioral distress related to the negative interpersonal impact of the veteran's untreated invisible wounds (Tanielian & Jaycox, 2008). These data, along with the large literature on the benefits of including close family members in engagement and treatment of both medical and other psychiatric conditions, were the impetus to establishing a three-generation family system model at the HBP Clinic. A veteran with untreated PTSD and/or TBI has suffered an invisible combat injury that undermines many spheres of identity and functioning, hence undermining the ability to reestablish a productive postmilitary civilian and family life. The members of the veteran's family, while also suffering greatly from the disruptions in their partner's, son's, daughter's, or parent's functioning, are not typically recognized in the military and civilian health care systems. Family members are seen at the HBP Clinic as patients in their own right, as well as for consultation with the goal of facilitating treatment engagement of their veteran loved one. Typical case examples were developed to illustrate facilitation of treatment engagement of veterans when the clinical practice model includes consultation and treatment pathways for members of the veteran's family as well as for the veteran.

Implementing the HBP Clinic model may not be feasible in every health care setting serving returning veterans. The model's multidisciplinary approach with multiple caregiver involvement and coordination means that the financial costs of delivering this care are high. Settings with fewer financial and staffing resources, or with payor-constricted permissions to serve specific populations (e.g., the current VA structure and funding as described below funding mandate), may be constrained to offer treatment to three generations of family members. This is especially true in areas of the country without a large pool of health care providers trained in evidence-based care across generations that results from a high concentration of academic and medical training centers. The shortage of clinicians with mental health expertise in child, couple, and family modalities, a national health manpower concern, is also a limitation to broad dissemination and implementation of the model described here.

Given the thousands of returning veterans who seek treatment at the VA, it is important to acknowledge the absence of a VA-funded mandate to treat family members. Although the provision of care to the veteran and family members within a single physical setting is optimal, the family system model does not require it. Veterans and their family members can be seen in different facilities, provided the therapies are coordinated through effective communication between treatment teams and skilled case management. For instance, a veteran patient might be receiving his or her trauma-focused therapy for PTSD at the VA facility, and working on being a more effective parent to his young children with his

girlfriend or coparent at a second agency if that intervention is not available at the VA facility. Cross-institution communication and coordination of care effectively allows for the two treatments to be conducted within a family system framework—one that addresses the veteran's role as combat survivor, and the other targeting the veteran's roles as coparenting partner and father or mother. Similarly, for a veteran under care at a VA facility, the veteran's children or adult parents, not eligible for VA care, might receive coordinated, informed care in the community.

Formal linking of established veteran-centered health care settings with hospitals and community mental health agencies specializing in child and family treatment affords the veteran and his or her family comprehensive support and treatment in a cost-effective manner that addresses the family system, and not the veteran in isolation, which we hypothesize would improve the likelihood of successful outcomes. Advances in telemedicine such as web conferencing will increasingly support such collaborations and sharing of scarce resources. The use of technology also represents an avenue for extending clinical expertise to community mental health providers across the country.

For facilities interested in building their capacity to serve veterans and their family members, hiring broadly trained mental health clinicians who work both with veterans and with family members is one strategy to implement a three-generation family program without incurring the greater cost associated with a service staffed by adult-oriented therapists for veterans and a separate service staffed by family oriented therapists for family members. This practice of hiring clinicians with multiple areas of expertise is an incremental method of expanding care to include all family members, affording flexible, cost-effective utilization of clinical time. In addition, examination and coordination of local resources already available for care in the community—including, for example, school-based mental health counselors and nurses working with military children—is another possible cost-effective approach.

Ultimately, the challenging logistics and the cost associated with integrating family care into veteran care must be weighed against the social and economic costs of *not* engaging veterans in treatment for PTSD and TBI. One study estimated 2-year costs associated with untreated PTSD and major depression range from \$119.8 million to \$204.7 million, the latter figure including the value of lives lost to suicide, but not the cost of longer term consequences such as substance abuse, domestic violence, unemployment, and homelessness (Tanielian & Jaycox, 2008). It is important to note that the likely sizable cost associated with lost productivity of adult family members because of caregiver burden, and the mental and non-mental-health consequences for each of the three generations impacted by or living with sustained duress, are overlooked in calculations of economic and social burden. Innovative approaches to improving treatment engagement, including reaching three generations of family members impacted by a veteran's service, are critically needed to reduce these societal burdens.

Although we are in the early stages of assessment and implementation of our model, our current priority is to empirically examine performance measures informing the implementation of the full three-generation model and its assumptions. We intend to examine preliminary associations of functioning across generations and across different familial roles, as well as program wide

treatment outcomes over time. This will enable future investigation of questions, such as what are the most effective points of intervention in a three-generation family system? For example, are help-seeking veterans more likely to remain engaged in treatment if a family member makes the first contact and remains involved in the veteran's treatment? Does the temporal sequencing of problem-focus or subsystem focus affect outcome? Would reduction of the veteran's PTSD symptoms occur more rapidly if the trauma-focused treatment follows a family intervention?

Research is needed on veterans' parents—in particular, those whose adult son or daughter returns to live with them, as they are a population at risk for impaired functioning. There are currently no data on the range of consequences of parents' support to a son or daughter with untreated PTSD and its comorbidities. The young, dependent children of veterans with PTSD are more universally recognized as vulnerable to the negative effects of parental PTSD, yet here, too, data are scarce. Empirical investigation that addresses the short-term and long-term psychosocial consequences of PTSD and its related conditions on the veteran's entire extended family system is urgently needed.

Conclusion

OIF, OEF and OND returning veterans with PTSD, TBI, and other deployment related conditions face substantial challenges in accessing medical treatment for their service-related conditions. These challenges to accessing informed systems of care are even more daunting for their family members who worry, struggle, and suffer alongside their service member or veteran loved one and who may themselves have developed psychological distress as the result of the veteran's untreated "invisible wounds" (Renshaw et al., 2011) yet may not qualify for health care or be officially recognized as part of the veteran's impacted family. The symptoms of PTSD also challenge the emotional and coping resources of the veteran's network of family and friends, those whose steady involvement and support are essential to recovery. There is much in the research literature on trauma to suggest treating the full range of relationship ruptures and mental health needs within an entire family network represents a compelling method of restoring individual functioning and family stability (Monson, Taft, & Fredman, 2009).

Treating patients and their family members over the past three years has solidified the HBP's commitment to a family centered model of care that extends beyond the triad of two parents and a dependent-aged child to other important horizontal and vertical relationships within a family as defined by the family members themselves. It is a model that views the experience of the veteran or service member and that of his or her family as inextricably connected to one another. Like the interdependent parts of a mobile, what happens to one person in the family reverberates in all the others. Successful engagement and retention in care to optimize treatment outcomes remains a challenge for this population of returning veterans. We encourage others treating veterans to consider how such a three-generation model of care might be applied in different settings. Considering the family system broadly affords multiple avenues of engagement and multiple points of access to support and successful treatment outcomes across the family system, thereby enlarging the hope of recovery for veterans and all those who love them.

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Correction to Mansfield et al. (2014)

In the article “One Day at a Time: The Experiences of Partners of Veterans With Posttraumatic Stress Disorder,” by Alyssa J. Mansfield, Kim M. Schaper, Alana M. Yanagida, and Craig S. Rosen (*Professional Psychology: Research and Practice*, 2014, Vol. 45, No. 6, pp. 488–495. <http://dx.doi.org/10.1037/a0038422>), the institutional affiliation of Alyssa J. Mansfield, Kim Schaper, and Alana M. Yanagida was incorrectly set as “Veterans Affairs Pacific Islands Health Care System, Honolulu, Hawaii”. It should have been “National Center for PTSD Pacific Islands Division, Veterans Affairs Pacific Islands Health Care System, Honolulu, Hawaii”. The institutional affiliation of Craig S. Rosen was incorrectly set as “Veterans Affairs Palo Alto Health Care System, Menlo Park, California and Stanford University School of Medicine”. It should have been “National Center for PTSD Dissemination and Training Division, Veterans Affairs Palo Alto Health Care System, Menlo Park, California and Stanford University School of Medicine”. The online version of this article has been corrected.

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