

Understanding the Experience of Military Families  
and Their Returning War Fighters:  
MILITARY LITERATURE AND RESOURCE REVIEW

underwritten by



THE NATIONAL CENTER ON  
Family Homelessness  
*for every child, a chance*



## EXECUTIVE SUMMARY

Military families face unique stressors associated with deployment and reintegration. During deployment, families are faced with worries about the safety of the service member, a need to adapt to changing situations and increased responsibilities. When war fighters return, often recovering from physical and psychological injuries, the challenge of reintegrating into family life, reconnecting to social supports, finding civilian employment and redefining their roles in the community can be overwhelming. Combat-related difficulties, such as Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD), the signature injuries of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF), have a significant impact on returning war veterans and their family relationships. The presence of TBI and PTSD increase the likelihood of other emotional problems (American Psychological Association [APA], 2007) and substance abuse, which increase family stress and the risk of intimate partner violence (IPV).

The “new normal” for the military combating insurgencies in OEF/OIF means increasing numbers and lengths of deployments, greater reliance on National Guard and Reserve, and new roles for women in the military. Successful in-theater medical treatment saves lives but increases the number of veterans with both visible and invisible wounds. Department of Defense and Department of Veterans Affairs primarily target resources and services to the military member/veteran, and in many instances to the spouse and children, but only in very limited circumstances to extended family members or friends which has adverse effects on the strength of the returning war fighters’ social safety net.

While there is heightened attention to the impact of PTSD and TBI on the returning war fighters, U.S. Department of Veterans Affairs (VA) health and mental health services are designed for the veteran themselves. Only recently have mental health services begun to include veterans’ spouses. Current services do not have sufficient resources to address the needs of all family members, including parents and siblings. In many cases parents, siblings, romantic partners or friends are the veteran’s only family. Community resources, particularly mental health services, are limited and have been negatively impacted by reduced tax revenues to state and local government. In addition, the service capacity of existing community programs and their ability to develop new programs to support the broadest definition of “family” have been further compromised by decreased philanthropic funding resulting from the effects of the economic recession.

In response to the gap in services for veterans’ families, The National Center on Family Homelessness (The National Center), with funding from the Walmart Foundation, created *Community Circles of Support for Veterans’ Families*, a comprehensive project designed to address the needs of veterans and their families by reducing relational difficulties and improving family support and functioning. Demonstration sites are funded by the Walmart Foundation in San Diego, California and Eugene, Oregon. Welcome Back Veterans, an initiative of Major League Baseball and the McCormick Foundation, funds the demonstration site in Mclean County, Illinois. Blue Shield of California Foundation recently committed funds to launch new California sites in 2010.

## EXECUTIVE SUMMARY

Using academic and general media sources, this review provides a snapshot of the key issues raised by this “New Kind of War,” highlighting the usage of the National Guard and Reserve, women in the military, and the culture of military families, and the impact of adverse military experiences which may lead to PTSD, TBI, substance abuse, unemployment and homelessness. An overview of health and mental health care, including the gaps in services for active duty, activated Reserve and National Guard and Veterans is accompanied by a chart of Department of Defense (DoD) and VA programs for veterans and military families. In addition, the Appendix offers a sample of community-based programs for military families and their war fighters.

By providing this comprehensive, although not exhaustive military literature review to community social service agencies and their coalition partners nationwide, The National Center hopes to build their knowledge base. This literature review is also aimed at helping community groups have information available to use in outreach campaigns aimed at educating the general population about the unique sacrifices made by recent veterans and their families. The National Center’s intent is to compliment existing DoD and VA resources/guides and assist community agencies in aiding veterans’ families and their war fighters.

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## ACRONYMS

**BASIC** – Battalion Alcohol Skills Intervention Curriculum  
**CCSVF** – Community Circles of Support for Veterans’ Families  
**CHAMPVA** – Civilian Health and Medical Program of the Department of Veterans Affairs  
**CONUS** – Continental United States  
**DADT** – “Don’t Ask, Don’t Tell”  
**DoD** – United States Department of Defense  
**DWELL Time** – assignment to CONUS non-combat duties in home communities  
**FAP** – Department of Defense Family Advocacy Program  
**HVOC** – Homeless Veteran Outreach Coordinator  
**HVRP** – Homeless Veterans Reintegration Program  
**IED** – Improvised Explosive Devices  
**IPV** – Intimate Partner Violence  
**MHS** – Military Health Service  
**MST** – Military Sexual Trauma  
**MTF** – Medical Treatment Facilities  
**OCONUS** – Other than Continental United States  
**OEF** – Operation Enduring Freedom  
**OIF** – Operation Iraqi Freedom  
**PDHA** – Post Deployment Health Assessment  
**PTSD** – Posttraumatic Stress Disorder  
**RESPECT-Mil** – Re-Engineering Systems of Primary Care Treatment in the Military  
**TBI** – Traumatic Brain Injury  
**TEMPO** – Pace of deployments  
**VA** – United States Department of Veterans Affairs  
**VBA** – Veterans Benefits Administration  
**VHA** – Veterans Health Administration  
**VISN** – Veterans Integrated Service Network  
**WHC** – Women’s Health Clinic

## A New Kind of War

The insurgent nature of the OIF /OEF wars combined with improvements in medical treatment both in the Iraq and Afghanistan military theater and at military installations has resulted in fewer deaths but more wounded warriors compared to Vietnam. Improvised Explosive Devices (IED), the emblems of insurgency warfare, are the number one cause of casualties, injuries, and emotional disorders particularly PTSD and TBI related symptoms, for American troops and their allies. Rates of PTSD and TBI are higher than other wars, with an estimated one-third of troops suffering from PTSD (Bender, 2009b). The warfare is different with more insurgent attacks and less defined battlegrounds (LaBash et al., 2009). As a result, every location including military bases has the potential to feel threatening (LaBash et al., 2009). Fighting frequently takes place in urban areas, around civilians (LaBash et al., 2009). Service members often experience feelings of helplessness and constant anxiety, along with feelings of hyper vigilance (Bender, 2009b; Friedman, 2006). The large number of wounded: 35,000 wounded service members to date (Still Serving Veterans, 2009) has strained existing resources (Bender, 2009a; Fairweather, 2006) as the wounded warriors are honorably discharged and transition to their veteran status. In addition to the high proportion of OEF/OIF wounded warriors, the frequency of deployments, usage of National Guard & Reserve and the role of women in the military are other hallmarks of this “new kind of war.”

### Frequency of Deployments

OEF/ OIF are unlike other military operations, deploying to date 1.64 million troops to Afghanistan and Iraq (Tanielian & Jaycox, 2008). Troops are deploying for longer periods of time, have shorter periods of time between deployments, and are redeploying at higher rates than in other wars (Tanielian & Jaycox, 2008). Repeated deployments and reduced troop morale have

contributed to an increase in the number of mental health diagnoses (Dao, 2009). Current policy is to provide all troops with one year “Dwell Time.” Research suggests that to facilitate recovery from PTSD/TBI and to enhance family connectivity optimal “Dwell Time” is two to three years (Tanielian & Jaycox, 2008).

### Role of National Guard & Reserve

These conflicts have included all branches of the military, including a significant participation from the Army and the Marine Corps, and an unprecedented reliance on National Guard and Reserve resources (LaBash et al., 2009; National Center for Post-Traumatic Stress Disorder & Walter Reed Army Medical Center, 2004). Approximately 40% of OIF/OEF troops and veterans are National Guard and Reserve (Fairweather, 2006). Not only are risk factors exacerbated for National Guard and Reserve, but their families are located in more geographically diverse areas compared to active duty service members and have less access to support networks. National Guard organizations’ efforts to inform members of available services can vary greatly. Most of these programs largely depend on volunteer efforts of family members. Guard and Reserve are almost half as likely to file VA claims as their regular forces counterparts and half as likely to have their claims approved. This may be due to a lack of knowledge about earned benefits, difficulty navigating the claims process, barriers to legal guidance and service records split between state and federal entities.

The unprecedented reliance on National Guard and Reservists, Individual Ready Reservists, and the extension of military service contracts through stop loss orders are all practices necessitated by operational pace of deployments (TEMPO) demands that are contrary to attracting the best recruits to the All Volunteer Services and retaining National Guard and Reserve members (Fairweather, 2006). As National Guard/ Reserve are deactivated and fulfill their service commitments, they face greater challenges in

reconnecting to the work force and maintaining their housing security. The profile of today's National Guard/Reservist is both older than active duty and older than in recent National Guard/Reserve history because of the change of age limits post 9/11. Older National Guard/Reservists means they are more likely to have children and to suffer more in difficult economic times. There is concern that efforts like Yellow Ribbon Reintegration and other existing programs, such as dedicated VA OEF/OIF staffing, can not address the volume of anticipated needs of deactivating Guard/Reserve as OIF winds down.

### **Women in the Military**

The percentage of women enlisted in the military have increased since previous wars. In 2008, women made up 14.2% of the active duty force (Murdoch et al., 2006; Women in Military Service for America Memorial Foundation, Inc., 2009) and 11% of our forces in Iraq and Afghanistan. According to the VA estimates, the number of female veterans will grow from 1.75 million in 2006 (7% of all veterans) to 1.9 million (10%) in 2020. At the same time, the number of male veterans is expected to decline (Perl, 2009). Female veterans are generally younger than male veterans with a median age of 46 years old compared to 60 years old for males (United States Department of Veterans Affairs, 2006). Women have had a greater role in recent conflicts (LaBash et al., 2009). Women serve in all branches of the military, but are most likely to serve in the Air Force and least likely to serve in the Marine Corps (Women in Military Service for America Memorial Foundation, Inc., 2009). Throughout U.S. military history various rules and regulations have limited official involvement, rank attainment and role within the services (Murdoch et al., 2006). However, this has changed and in OEF/OIF more women have been in combat-related roles (Alvarez, 2009a; LaBash et al., 2009). In addition, assignment to supply operations (historically considered back line non-combat duty) in OEF/OIF mean female service members frequently fight alongside their male counterparts (Alvarez, 2009a).

Women in the military face challenges that may differ from their male colleagues. More than 40% have children according to a report by Iraq and Afghanistan Veterans of America and approximately 30,000 single mothers have been deployed. Women report higher levels of stress over the impact of their deployment on family and relationships (Vogt, Pless, King & King, 2005). Due to these factors, women are less likely to feel prepared for deployment than men (Carney et al., 2003) and are often highly stressed (Vogt et al., 2005). Women are in the minority when serving in the military and have fewer opportunities for peer support, leading to feelings of isolation (Myers, 2009; Vogt et al., 2005). Female soldiers are often subject to sexual harassment or assault, creating an increased risk of PTSD.

## The Culture of the Military

Serving in the military is more than an individual occupation; it also has a culture of shared beliefs, practices and experiences. The impact of deployments and reintegration on military marriages and children are a part of the shared sacrifice that comes with military service. Military families have a unique culture. Frequent moves, non-traditional work hours and long absences of the deployed parent are common among military families. Families must live with constant worries about the safety of their war fighter (Houston et al., 2009).

Prior to entering military service, many service members have already experienced trauma since the All Volunteer Service draws heavily from those who enter military service as a means of improving their lives. Unfortunately, Military Sexual Trauma, (MST) which includes sexual harassment, particularly for female service members, compounds previous traumatic experiences and has many adverse impacts including increasing the risk for PTSD and homelessness. The strength of military training includes unit cohesiveness but there is also a shared stigma that prevails around seeking individual help for emotional and mental health issues.

### The Impact of Deployments and Reintegration on Military Marriages & Children

As of 2007, 55.2% of Active Duty military members were married and 43.2% had children (United States Department of Defense, 2007). Similarly, 49% of the Selected Reserve were married and 41.9% had children (United States Department of Defense, 2007). Almost two million children live in Active Duty and Reserve military households (Chartrand & Siegel, 2007).

Military marriages frequently face challenges (Sayers et al., 2009). Members of the military may marry more quickly when facing deployment which often results in marrying and having children at a younger age, leading to greater

marital tensions (Karney & Crown, 2007). The stress of these life changes, combined with the possibility of deployment or re-deployments often contributes to divorce (Karney & Crown, 2007). Spouses of service members frequently report difficulty finding employment because of frequent moves, lack of child care if living off of a military installation and stigma against employing military spouses (Castaneda & Harrell, 2008). The lower income and stress of unemployment may also contribute to marital dissatisfaction. Since 9/11, military divorce rates, as measured by the Defense Manpower Data Center, have increased to 3.6% for fiscal year 2009, a full percentage point higher than around 9/11. The methodology used for measuring the percent change is criticized because it does not track individual marriages but rather compares the aggregate number of married service members year after year. These numbers also do not capture troubled but intact marriages and may under represent the military divorce rate. "In an Army battlefield survey taken in Iraq in the spring (2009), nearly 22% of young combat soldiers questioned say they planned to get a divorce or separation, compared to 12.4% in 2003" (Jelinek, 2009).

Heavy burdens are placed on all members of a military family when they are in service and after separation from military service. Spouses of veterans frequently find themselves in a caregiver role, often living with someone who is physically disabled and/or emotionally withdrawn or aggressive. Caregiver burden is a significant problem, especially for those who have partners with PTSD (Calhoun, Beckham & Bosworth, 2002). Veterans often feel their partners cannot understand their feelings of grief, anxiety and anger, while partners feel their efforts to help are often rebuffed. When a marriage is strained, the veteran lacks the social supports needed to overcome some of the problems e.g., depression, anxiety, etc. that are exacerbating the marital discord (Sayers et al., 2009).

Veteran status has been associated with three times the rates of intimate partner violence (IPV) than

among civilians (Marshall, Panuzio & Taft, 2005; Sayers et al., 2009). The hero status of military service members and veterans as warriors/war fighters makes reporting IPV and seeking help for the victims of violence even more difficult. When veterans commit IPV they are more likely than civilians to cause significant injury to their spouses (Marshall et al., 2005). The increased risk for domestic violence is not surprising given the high co-morbidities between PTSD and other variables e.g., depression, substance abuse, relationship distress, impaired problem-solving skills (Riggs, 1997). Research suggests that risk factors for IPV include individual issues such as depression, anger and isolation from others, relationship factors such as marital conflict and instability, and community factors such as a lack of broader social connections to people and institutions (World Health Organization, 2002). Veterans and their families experience multiple stressors that include combat-related experiences, family disruption and separation, and the strain of deployment and reintegration. IPV within military families can largely be attributed to combat-related PTSD or to a prior history of trauma (Marshall et al., 2005; Orcutt, King & King, 2003; Taft et al., 2005).

The culture of the military enforces violence as a means of resolving conflicts (Taft et al., 2005). Upon leaving service, veterans may apply this culture to domestic life (Taft et al., 2005). The DoD Family Advocacy Program (FAP) was created in 1984 in order to assist with issues related to military family violence (Family Advocacy Program, n.d.). The program seeks to identify family violence as early as possible, prevent family violence, and provide treatment for victims of family violence (Family Advocacy Program, n.d.).

Given the large number of armed services members currently returning from Iraq and Afghanistan who experience PTSD (Hoge et al., 2004) and the fact that approximately one-third of PTSD patients fail to recover even after many years (Kessler, Bromet, Hughes, & Nelson, 1995), attention to how the experience of PTSD reverberates through an individual's relationships is important. High rates

of marital instability (Kessler, 2000) and significant relationship problems (Riggs, Byrne, Weathers, & Litz, 1998) have been documented among veterans with PTSD.

The impact of deployment and reintegration are significant for children of active duty and National Guard/Reserve members. Increased responsibilities are often given to children when a parent is deployed creating disruptions in routines (Houston et al., 2009). They are frequently sensitive to the remaining parent's moods and concerns and are worried about adding to that parent's stress (Houston et al., 2009). As a result, children frequently experience behavioral issues, anxiety, nightmares and difficulties in school (Alvarez, 2009b; Zoroya, 2009). If children are living in a single-parent family or in a family where both parents are deployed, separations may be particularly difficult (Alvarez, 2009b). Military families move frequently and the children need to adjust to new schools, new rules and new routines (Alvarez, 2009b).

Stress typically continues when the deployed service member returns home. While nearly always a joyous occasion, homecoming generally brings further change to a household. When service members are deployed for long periods, role confusion may occur upon their return (Sayers, Farrow, Ross & Oslin, 2009). Service members may be away during key developmental stages in a child's life and often return home to children who have grown in significant ways (Sayers et al., 2009). They may find spouses that have adjusted to the needs of running a household with one parent and feel unneeded (Friedman, 2006; Sayers et al., 2009). The family's role in the service member's life has also often changed. After living and working with one's military unit, a service member may view his or her colleagues as a family, which causes further readjustment issues (Friedman, 2006). The returning service member may also be suffering from a host of issues, including physical injury or PTSD. PTSD symptoms such as numbness, dissociation and aggression make readjustment to family life even

more difficult for veterans and their families (Taft et al., 2008; Watkins et al., 2008). This is particularly true for female service members who are more likely to be in a primary caretaker role than their male counterparts (Taft et al., 2008).

### **Military Sexual Trauma (MST)**

To understand MST, it is necessary to discuss sexual harassment which sometimes leads to an escalation of inappropriate behaviors. In recent years, the high rate of sexual harassment occurring in the military has been brought to the public's attention because of its high costs in terms of health and mental health, as well as its negative impact on unit cohesion, retention and recruitment of service members. Sexual harassment takes on different forms and affects men as well as women. Sexual harassment also contributes to the vulnerability of gay and lesbian service members to job loss because of the provisions of Don't Ask, Don't Tell (DADT). This common term refers to the federal law Pub.L. 103-160 (10 U.S.C. § 654) which prohibits anyone who "demonstrate(s) a propensity or intent to engage in homosexual acts" from serving in the armed forces of the United States. Sexual harassment may take the form of allegations of intent to "engage in homosexual acts." In 2009 alone, 400 male and female service members left the military under Don't Ask Don't Tell.

For female service members, sexual harassment may occur in the form of inappropriate comments, unwanted advances, or in the spread of stories of a woman's sexual life, particularly if she has recently been promoted (Miller, 1997). Sexual harassment is generally initiated by men and both men and women rarely report being sexually harassed by other women (Magley, Waldo, Drasgow & Fitzgerald, 1999).

Sexual harassment lowers morale and decreases productivity (Magley et al., 1999). Programs seeking to decrease sexual harassment by creating policies and procedures, providing resources such as counseling for victims and training service

members in what constitutes sexual harassment, have had some success (Williams, Fitzgerald & Drasgow, 1999). Reducing sexual harassment increases satisfaction with one's job and can increase one's commitment to military service (Williams et al., 1999). Studies have shown that when harassment is tolerated within a unit, it continues and can escalate into situations that are more conducive to sexual assault (Murdoch et al., 2006; Fitzgerald, Drasgow & Magley, 1999).

It is estimated that 16% to 23% of military personnel have experienced MST. Women and men are both at risk for MST (Kimerling et al., 2007). Experiencing MST increases the risk of further abuse after separating from military service. Female veterans experience sexual assault at up to 12 times the rate of the general female population and male veterans experience sexual assault at up to 24 times the rate of the general male population (Murdoch, Polusny, Hodges & O'Brien, 2004). Service members typically have higher rates of trauma earlier in their lives, sometimes joining the military to escape trauma and this places them at greater risk of MST (Bostock & Daley, 2007; Kimerling et al., 2007; Sadler et al., 2001; Sadler et al., 2004; Zinzow, Gruhaugh, Frueh & Magruder, 2008)

MST is strongly associated with PTSD (Davis & Wood, 1999; Kang, Dalager, Mahan & Ishii, 2004). Regardless of their experience of other traumas, victims often regard military sexual trauma as the most upsetting experience they have had (Yaeger, Himmelfarb, Cammack & Mintz, 2006). Fontana and Rosenheck (1998) found that female veterans are four times more likely to be affected by sexual stress than duty-related stress. Women who are assaulted in the military are nine times more likely to exhibit symptoms of PTSD than those who have not been sexually assaulted (Suris et al., 2004).

The effects of MST are long-lasting (Sadler, Booth, Nielson & Doebbeling, 2000). MST places victims at risk for increased physical and mental health problems, including substance use, depression, and dissociative disorders including PTSD, respiratory

problems, heart problems, hypertension, arthritis, diabetes, endometriosis and eating disorders (Chang, Skinner & Boehmer, 2001; Davis & Wood, 1999; Frayne et al., 1999; Kimerling et al., 2007; Sadler et al., 2004; Suris et al., 2004). Military sexual trauma can also lead to poor self-image, feelings of loneliness and isolation, and ultimately suicide (Kimerling et al., 2007; Skinner et al., 2000).

MST frequently includes physical violence or the threat of physical violence, but victims often first experience sexual harassment which may include being intimidated, isolated, coerced, or receiving threats to their children (Valente & Wight, 2007). MST frequently goes unreported (Valente & Wight, 2007). Victims often fear their attacker will seek retaliation, their careers will be affected or that they will not be taken seriously (Suris, Lind, Kashner, Borman & Petty, 2004; Valente & Wight, 2007). Even when assaults are reported, victims are often told the issue was not serious, which frequently dissuades the victim from taking additional action (Sadler et al., 2004). Other reasons for not reporting assault include lack of knowledge of how to report such an incident, belief that rape is “normal” in the military, and fear of negative consequences (Sadler, Booth, Cook & Doebbeling, 2003). Since MST often goes unreported, the trauma is frequently prolonged (Kimerling et al., 2007).

While both men and women experience MST, women service members represent the majority of victims. According to a study released in 2004, the percentage of all female veterans seeking medical care through the VA (not just those returning from Iraq or Afghanistan) who reported they have experienced sexual assault ranged from 23% to 29% (Perl, 2009).

The military is an occupation; members live together, creating greater chances for sexual assault and greater trauma if a victim needs to live with her assailant (Frayne et al., 1999). In fact, most assaults take place between the hours of 6:00 p.m. and midnight in the victim’s sleeping area (Sadler et al., 2001). Due to the constant fear of

such threats, women in the military report the need to arm themselves against attacks on the base, particularly at night (Myers, 2009).

Women who have been victimized at any point in their lives tend to experience higher rates of violence upon leaving service (Sadler et al., 2004). In addition, women who experience MST frequently lack social support upon returning home, leading to further isolation (Fontana & Rosenheck, 1998). The prevalence of long-term health problems increase if a victim is repeatedly assaulted (Sadler et al., 2001). Victims of MST are more likely to have problems with alcohol or drugs than those who have not (Hankin et al., 1999). In addition to health consequences, women who have experienced MST have lower economic and educational outcomes than those who did not, as well as difficulties in maintaining relationships (Sadler et al., 2000; Skinner et al., 2000) and housing stability.

Due to the widespread nature of the problem, the Veterans Health Administration (VHA) mandates universal screening for MST (Kimerling et al., 2007; Kimerling, Street, Gima, & Smith, 2008). Screening is recorded in electronic records and is coordinated by a representative in each site (Kimerling et al., 2008). Treatment for any medical condition related to MST is provided free of charge (Kimerling et al., 2007). This is also true for reservists, regardless of eligibility for other military-related health services (Street, Stefford, Maham, & Hendricks, 2008). Universal screening has had positive results on the number of victims referred for mental health treatment (Kimerling et al., 2008). However, female survivors of MST often do not trust the care received in these settings (Kelly et al., 2008). Victims are more likely to seek care at VHA facilities than those who have not experienced MST, but are less likely to be satisfied with the care received (Kelly et al., 2008). Women need to be in therapeutic milieus conducive to sharing feelings and beliefs that they often find shameful, guilt inducing and self-recriminating, without

the additional concerns of rejection, labeling and ridicule by men (Benda, 2006; Bride, 2001; Nelson-Zlupko, Kauffman, & Dore, 1995).

### **Stigma about Seeking Help**

Many service members, especially those most in need of mental health treatment, do not access needed health care because of stigma (Hoge et al., 2004; Kelly et al., 2008). Service members are often ingrained in a military culture that promotes strength, self-reliance, and independence. Seeking mental health services may lead to a questioning of strength (Tanielian & Jaycox, 2008). There is a large concern about how one will be perceived by his peers if he or she receives treatment for mental health issues (Hoge et al., 2004). Seeking mental health treatment may also hinder a military career, as service members often have to adhere to strict physical and mental health standards in order to qualify for a promotion (Tanielian & Jaycox, 2008).

The military, with assistance from non-profit organizations, have attempted to eliminate the stigma associated with seeking mental health care by normalizing reactions to traumatic events. An example is the “*Real Warriors, Real Battles, Real Strength*” campaign, which stresses the impact of war on service personnel and emphasizes that seeking help for psychological concerns is a sign of strength. The Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, The Military Child Education Coalition and Sesame Street have partnered to produce DVDs for the children of military families coping with the stress of deployed loved ones. However, stigma against seeking mental health services is deeply engrained and requires enhanced efforts including partnerships among military, VA and community based organizations in order to make an impact.

## Impacts of Military Service

In order for private and non-profit organizations to partner with DoD and VA to improve and expand existing services and address current unmet needs, it is important to describe the impact of adverse military experiences. The following discussion of adverse military experiences highlights the issues and provides references to the literature detailing the issues faced by veterans.

### Post Traumatic Stress Disorder (PTSD)

PTSD is an “injury to the mind” in which a traumatic event causes lasting anxiety (National Center for PTSD, 2009). PTSD may be difficult to treat, since stigma may prevent service members from seeking help (Bender, 2009b). According to studies by Colonel Charles W. Hoge, published in the *Journal of the American Medical Association*, over one third of troops returning from Iraq have screened at risk for PTSD and other mental health needs on their Post Deployment Health Assessment (PDHA). The Military Health Service (MHS) recorded 39,365 patients who have been diagnosed with PTSD (United States Department of Defense, 2008). The scope of the problem is considered to be greater given the likelihood of undiagnosed, unreported PTSD. Stigma and the fact that negative behaviors associated with PTSD can lead military service members to be dishonorably discharged are some of the reasons why PTSD may be undiagnosed and unreported. Dishonorably discharged service members are not eligible for VA benefits increasing the likelihood that if they have PTSD it will remain undiagnosed.

The conditions of the Iraq and Afghanistan wars place war fighters at an increased risk for PTSD. They are exposed to extremely hostile conditions, in constant 360-degree danger of drawing fire, coming under mortar attack and falling prey to IEDs. The repeated exposure to trauma and the fact that just being in Iraq/Afghanistan is itself a traumatic stressor is resulting in unprecedented numbers of veterans experiencing mental health issues, from difficult transition to full blown PTSD requiring crisis intervention.

In addition to the traumatic experience of combat exposure, other traumatic events that may trigger PTSD include sexual trauma/MST, unexpected death of a friend or family member, natural disasters, or serious accidents (National Center for PTSD, 2009). Those at higher risk for PTSD include individuals who have experienced traumatic events as a child, those with existing mental health issues, and/or substance abuse issues and females (National Center for PTSD, 2009). The duration and severity of PTSD can vary, depending on factors such as the intensity of the trauma, perceived control of the traumatic event and the amount of social support received (National Center for PTSD, 2009). PTSD can have lasting effects on one’s life. PTSD is associated with impaired physical, social and mental health (Barrett, et al., 2002; Engel, Liu, McCarthy, Miller & Ursano, 2000). Thus, those with PTSD use health services more often (Calhoun, Bosworth, Grambow, Dudley & Beckham, 2002; Dobie et al., 2006).

#### The hallmark symptoms of PTSD include:

- Avoidance – Avoiding situations or experiences that remind the person of a past traumatic event.
- Hyper arousal – A persistent feeling of heightened anxiety that includes being constantly on alert for danger and focused on survival.
- Re-experiencing – Re-experiencing the traumatic event in the form of flashbacks, nightmares, intrusive thoughts, images, etc.
- Emotional Numbing – Disconnecting or “dissociating” from overwhelming feelings associated with the traumatic experience. This disconnection can lead to difficulties feeling and expressing a range of positive and negative emotions. (National Center for PTSD, 2009). These symptoms are related to problems with substances, trouble with interpersonal relationships, difficulties with employment, and physical symptoms (National Center for PTSD, 2009). There may be overlapping symptoms with Traumatic Brain Injury (TBI). (see discussion on TBI page 16)

### PTSD/TBI: Overlapping Symptoms

- Sleep disturbances/insomnia/fatigue
- Irritability/anger/aggression
- Problems thinking & remembering
- Changes in personality
- Withdrawal from social, work, family activities
- Hypersensitivity to noise

(Drake, Defense and Veteran Brain Injury Center, 2009)

PTSD may be treated in a variety of ways including medication and a variety of cognitive, exposure, group and family therapies. Cognitive therapy uses techniques to help participants identify thoughts and feelings that are causing the symptoms of PTSD and then through a series of exercises learn how to change the individual responses. Exposure therapy is when one speaks with a therapist about his or her thoughts and feelings related to the event with the ultimate goal of gaining control over his or her thoughts and feelings about the traumatic event. Group, couples and family therapies are most often based in Cognitive therapy techniques. (National Center for PTSD, 2009).

### Traumatic Brain Injury (TBI)

*“Traumatic brain injury is the signature injury of the war in Iraq and Afghanistan. In fact, 22% of all returning service personnel have some form of TBI, the majority of whom (69%) were injured by roadside bombs, rocket propelled grenades and other blasts. TBI screening that began in August at National Naval Medical Center showed 83% of wounded Marines and sailors with brain injury.”*

Rep. Bill Pascrell (D-NJ) and Rep. Todd Platts (R-PA), Co-Chairs of the Congressional Brain Injury Task Force, A March 2007 letter to the House Appropriations Committee

TBI is caused when a blast creates a sudden change of pressure, producing concussions, contusions, or air emboli that travel to the brain (Center for Disease Control, 2009; Okie, 2005). TBI may also occur when the brain collides with the skull or when an object pierces the brain through the skull, resulting in bruising and damaging (Mount Sinai Medical Center, 2008a; Tanielian & Jaycox, 2008). When a blast occurs, flying objects can also hit one’s head, causing further injury (Okie, 2005). Cases of TBI vary in severity (Okie, 2005). Members of the military have always had higher rates of TBI than the civilian population, but this is particularly true of recent conflicts (Okie, 2005; Warden, 2006). Medical technology and body armor have resulted in less mortality and recent conflicts have seen greater use of explosives (Warden, 2006). The Military Health Systems (MHS) has recorded 43,779 patients who have been diagnosed with a TBI injury in calendar years 2003-2007 (Department of Defense, 2008).

TBI may result in headaches, dizziness, insomnia, and impaired memory, poor sleeping patterns and chronic pain (Mount Sinai Medical Center, 2008b; Summerall, n.d.). People with TBI may have trouble with their executive functioning and impaired senses of vision, hearing, taste, touch and smell (Mount Sinai Medical Center, 2008b). Other symptoms include change in behavior, confusion, lightheadedness, fatigue, lethargy, restlessness and agitation (National Institute of Neurological Disorders and Stroke, n.d.). Mild cases of TBI are often managed in theater and the war fighter is returned to duty. Moderate to severe causes of TBI result in difficulties concentrating and reduced memory (Mount Sinai Medical Center, 2008b). More severe cases of TBI can result in depression, anxiety, increased levels of aggression, and impulsiveness (Okie, 2005). In most cases, these symptoms will decrease in approximately six months (Summerall, n.d.). However, some cases of TBI will result in severe brain damage (Summerall, n.d.).

According to the report, *Range of Statistics Cited on the Number of Returning Service Members*

with TBI, DoD does not have a comprehensive screening program to detect TBI in returning service members (Brain Injury Association of America, 2007). Thus, it is likely that large numbers of mild or moderate cases of TBI are going undetected. Unfortunately, mild TBIs are not necessarily “mild” in effect and can still lead to substantial disability. Earlier this year, the Brain Injury Association of America published a position paper, entitled “Traumatic Brain Injury in the United States: A Call for Public/Private Cooperation.” In this paper, Bob Woodruff’s report for ABC News was cited in his documentary, *To Iraq and Back*, which posited that the number of men and women serving in OIF/OEF who have incurred TBIs could be upwards of 150,000. “Severe and penetrating head injuries are readily identified, but cases of mild-to-moderate TBI can be more difficult to identify and their incidence harder to determine. Overlapping symptoms with PTSD may also contribute to difficulties making identification of TBI. A recent report indicated that when some 35,000 returnees believed to be healthy received a screening test, 10 to 20 percent had apparently experienced a mild TBI during deployment.”

### Substance Abuse

Substance abuse, in particular alcohol abuse, is among the most critical adverse impacts of military service. It is related to many negative behaviors and impedes the veteran’s ability to resolve issues such as trauma and successfully reintegrate into their families, retain employment, and maintain stable housing. Military personnel have a drinking rate of 16.1%, which is higher than the civilian rate of 12.9% (RTI International, 2006). Research shows homeless male vets from the All Volunteer Force have advantages (i.e., education, training, access to physical/mental health benefits) not shared by the general male homeless population with one exception, substance abuse, because male veterans have more severe substance abuse problems both during and after military service. Alcohol abuse, in particular, may be reinforced

through conformity to peer group influences in the military (Tessler, Rosenheck & Gamache, 2002).

Experiencing a traumatic event is associated with increased rates of substance use (Hourani, Yuan & Bray, 2003). Substance use is often a means of self-medication. The most common reasons to self-medicate are to avoid confronting feelings about experiencing traumatic events, both related to the veterans’ non-combat and combat experiences and difficulty adjusting to ordinary life after deployment in a war zone. The majority of these victims do not receive treatment for their substance abuse (Hankin et al., 1999). While numerous military and VA substance abuse programs exist, there is a need to both reinforce and expand these efforts to provide alcohol/substance abuse treatment services not only to the returning war fighter but support to their family members as well and to expand the definition of family beyond spouse and children to include parents, siblings, romantic partners and care givers.

Reckless driving is highly related to substance abuse, particularly alcohol abuse. Veterans of OEF/OIF within the first years of separating from military service are 75% more likely to die in motor vehicle accidents than civilians of comparable age, race and sex, and the rate for motorcycle deaths is 148% higher (MacQuarrie, 2009). The VA has launched a safe-driving initiative which counsels home-bound veterans about the risks of careless driving and encourages them to be screened for risky behaviors. However, recent veterans avoid screening and treatment. Coleman Nee, Massachusetts Undersecretary of Veterans Department, attributes reckless driving “to ...the bullet proof theory. If I didn’t get killed over there, nothing’s going to happen to me here.”

### Suicide

Recent wars have seen an increase in suicides among service members and veterans. (Goode, 2009). Factors influencing this trend, include frequent deployments, hostile living arrangements, extreme stress, death of a close friend or family

member, financial troubles, previous suicide attempts and combat exposure and injuries (National Suicide Prevention Lifeline, n.d.; Navy Personnel Command, 2008; Tanielian & Jaycox, 2008). Military sexual assault is also associated with an increased risk of suicide (Zinzow et al., 2008).

The rising rates of suicides are higher in the Army and the Marine Corps, which are the two ground forces involved in most of the fighting in OEF/OIF. In 2009, the Army widened its suicide prevention efforts including the October 2009 introduction of its comprehensive Soldier Fitness Program in Basic Training. This program places the same emphasis on mental and emotional strength as the traditional military emphasis on physical strength. While some success can be claimed in reducing suicides that occurred in the beginning of 2009, this year's rate is on pace to exceed 2008's numbers.

Army Vice Chief of Staff, General Peter Chiarelli notes that the number of active-duty soldiers believed to have died of self-inflicted wounds to date is 140, which is the same number of confirmed suicides for all of 2008. Chiarelli is quoted as saying "we are almost certainly going to end the year higher than last year..." In response to a question asking if the rate of suicides reflect high stress from repeated deployments required by OEF/OIF, General Chiarelli said he didn't know because "the reality is there is no simple answer... each suicide is as unique as the individuals themselves" (Jelinek, 2009).

For warriors numerous DoD, VA, and community hotlines offering suicide prevention crisis assistance exist including but not limited to:

- Air Force Suicide Prevention Program, Army Suicide Prevention Program, Marines Suicide Prevention
- Military One Source
- VA National Suicide Prevention Lifeline

These lines are most often staffed 24 hours a day, seven days a week, by trained personnel. Please see the listing of resources on pages 25-26 for the links to military and VA suicide prevention services.

## Unemployment

While veterans overall earn higher than average wages, some have difficulty translating military training and experience into civilian jobs. The jobless rate for post 9/11 veterans is 11.3% which is higher than the national civilian rate of 10% (Patterson, 2009). In their civilian lives National Guard/Reserve members are often small business owners, which increases the likelihood that reductions in consumer spending and difficulty securing loans will negatively impact the financial viability of their businesses. Repeat deployments with longer durations make it more difficult to arrange for interim management for their small businesses. Many other National Guard/Reserve members are employed in safety jobs (fire/police). Returning National Guard/Reserve veterans may face some fitness for duty issues from visible and invisible wounds of war that may jeopardize their fire/safety jobs.

Through The Homeless Veterans Reintegration Program (HVRP) the VA funds employment training programs for all veterans. These include the Veterans Workforce Investment Program and the Transition Assistance Program and Homeless Veterans Reintegration Program. Established in 1987 as part of the McKinney-Vento Homeless Assistance Act (P.L. 100-77), the HVRP is authorized through FY2009 as part of the Veterans' Housing Opportunity and Benefits

Improvement Act of 2006 (P.L. 109-233). The program has two goals. The first is to assist veterans in achieving meaningful employment and the second is to assist in the development of a service delivery system to address the problems facing homeless veterans. Eligible grantee organizations are state and local Workforce Investment Boards, local public agencies, and both for- and non-profit organizations and receive funding for one year, with the possibility for two additional years of funding contingent on performance and fund availability. HVRP grantee organizations provide services that include outreach, assistance in drafting a resume and preparing for interviews, job search assistance,

subsidized trial employment, job training, and follow-up assistance after placement. HVRP grantees also provide supportive services not directly related to employment such as transportation, provision of assistance in finding housing, and referral for mental health treatment or substance abuse counseling. HVRP grantees often employ formerly homeless veterans to provide outreach to homeless veterans and to counsel them as they search for employment and stability. In fact, from the inception of the HVRP, it has been required that at least one employee of grantee organizations be a veteran who has experienced homelessness.

### Homelessness

Active Duty military separating from service are also leaving a world in which their housing was either supplied or subsidized. National Guard/ Reserve are returning to their home communities and may be impacted by the wave of foreclosures triggered by adjustable rate loans that are no longer affordable or facing a new reality of being “underwater” with their property worth less than what they owe. A minimum wage worker cannot earn enough to pay for a two-bedroom dwelling anywhere in the United States (Wardrip, Pelletiere & Crowley, 2009). It is even a struggle for two minimum wage workers living together. Given the diminished stock of affordable housing, people working at the bottom of the wage scale are at the greatest risk for homelessness. Despite greater opportunities for education and training that arise from military service, many veterans struggle to make ends meet.

Veterans comprise one-third of the adult individual homeless population with 131,000 homeless veterans each night and of that population approximately 10% or 13,100, are female homeless veterans (United States Department of Veterans Affairs, 2009). After Vietnam, it generally took 9 to 12 years for veterans’ circumstances to deteriorate to the point of homelessness. OEF/OIF veterans, though, are already seeking housing services, some just months after returning from

Iraq (Fairweather, 2006). It is estimated that 7,400 of the 131,000 homeless veterans are OEF/OIF veterans and 12% of the homeless veterans younger than 34 are women (Patterson, 2009).

The trend in the last decade had been a decrease in veteran homelessness, but the financial crisis of the Fall of 2008, higher unemployment rates for veterans and the continued significant representation of both male and female veterans in the overall homeless population, led Eric Shinseki, Secretary of the U.S. Department of Veterans Affairs, to announce ambitious \$3.2 billion Department of Housing and Urban Development (HUD), Department of Labor (DOL) and VA funding to end veteran homelessness within five years (Shinseki, 2009).

The commonly held notion that the military experience provides young people with job training, educational and other benefits, as well as the maturity needed for a productive life conflict with the presence of veterans among the homeless population (Robertson, 1987). Many of the new homeless veterans who were in the regular forces are very young. These individuals entered the service as teenagers leaving their homes for the first time, never having been responsible for their own housing. The All Volunteer Service also attracts recruits from lower social economic circumstances with fewer alternatives to improve their lives. In addition, young veterans who were exposed to childhood risks, such as unstable housing, marginal family status and trauma including sexual abuse, are returning to the same unstable environments, with the added stress of combat experience (Gamache, Rosenheck & Tessler, 2001). The 1998 Rosenheck/Fontana study found three variables present in the lives of veterans before they joined the military had a significant direct relationship to homelessness. These included exposure to physical or sexual abuse prior to age 18; exposure to other traumatic experiences, such as experiencing a serious accident or natural disaster, or seeing someone killed; and placement in foster care prior to age 16. The researchers also found that a history of conduct disorder had a substantial indirect effect on homelessness.

Conduct disorders include behaviors such as being suspended or expelled from school, involvement with law enforcement, or having poor academic performance. Another pre-military variable that might contribute to homelessness among veterans is a lack of family support prior to enlistment.

Soldiers returning from the wars in Iraq and Afghanistan suffer from high rates of PTSD and TBI which may put them at an increased risk of homelessness. In response, the military has provided extensive resources to address these issues. Preliminary research findings suggest that highly developed networks of ongoing supports are available for veterans with PTSD and TBI, and that these veterans are at substantially lower risk for becoming homeless. This clearly illustrates how support networks can mitigate the risk for homelessness. Typical homelessness programs focus on housing, benefits, assessment, and referral for mental health problems, and they generally do not involve the provision of therapy. It is important to note that female active duty soldiers have been found to suffer from PTSD at higher rates than male soldiers. Experience with sexual assault has been linked to PTSD, depression, alcohol and drug abuse, disrupted social networks, and employment. These factors can increase the difficulty with which women veterans readjust to civilian life, and could be risk factors for homelessness (Perl, 2009).

Female veterans, have three to four times greater risk of homelessness compared with their civilian counterparts. Women nevertheless still make up a relatively small proportion of the homeless veteran population. In the VA's national Health Care for Homeless Veterans Program, for example, women make up about 3% of the veteran population served, although they generally make up about 5% of most VA patient populations. Current programs serving homeless veterans do not have adequate facilities for female veterans at risk of homelessness, particularly transitional housing for women and women with children.

Homeless female veterans need therapy to address MST, supportive services that create community

among veterans, including linkages to participating in faith based communities, transitional employment and safe living environments in addition to options for substance abuse treatment. Since mixed-gender living arrangements and therapy groups can present risks of sexual harassment and assault for women and invite interactions that are reminiscent of perpetrator-victim relationships, separate female veteran homelessness transitional housing programs that are not co-located with programs/housing for male veterans are recommended. Male veterans' needs are more focused on substance abuse and peer-to-peer support networks but less community connectivity (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008).

Many services for homeless veterans are provided in VA Hospitals, outpatient clinics and Vet Center facilities. In addition, the Veterans Benefit Administration has made efforts to coordinate with the Veteran Health Administration regarding homeless veterans by placing Homeless Veteran Outreach Coordinators (HVOCs) in its offices in order to assist homeless veterans in their applications for benefits (Perl, 2009). VA Homelessness Veteran resources traditionally have not been designed to address the needs of family homelessness and the specific needs of female homeless veterans but there is now a shift to begin to respond to these emergent needs. The VA is also developing a new Supportive Services for Veterans' Families program.

The VA, HUD and DOL along with their community partners are focusing on four primary areas to combat veteran homelessness: healthcare and rehabilitation services for homeless veterans (the Health Care for Homeless Veterans and Domiciliary Care for Homeless Veterans programs), employment assistance (Homeless Veterans Reintegration Program and Compensated Work Therapy program), transitional housing (Grant and Per Diem and Loan Guarantee programs) as well as preventative services (rapid re-housing) (Perl,2009).

## Supportive Services for Active Duty & Veterans

### Health Care

#### *Active Duty & Veterans*

The military health system provides health care to service members and their dependents through civilian providers and TRICARE, a regionally managed health program that is monitored by the DoD (Tanielian & Jaycox, 2008). TRICARE is a worldwide health care program for active duty members, retirees, their families, and survivors (TRICARE, 2008b).

TRICARE has a number of different health care plans. TRICARE Prime offers the most comprehensive coverage. It is more cost-effective and offers more services to those who live in designated TRICARE Prime areas, which are typically located in areas with a high concentration of military personnel (TRICARE, 2008d). TRICARE Prime is offered to all active duty service members, as well as Reserve and Guard members who have served in active duty for at least 30 days (Tanielian & Jaycox, 2008). TRICARE Standard is a fee-for-service option for active duty service members, active duty retirees not eligible for Medicare, and their families (Tanielian & Jaycox, 2008; TRICARE, 2008e). TRICARE offers a range of services, including most “medically necessary” inpatient and outpatient procedures (TRICARE, no date). Dental care is also offered to family members of active duty service members (TRICARE Dental Program, 2006). TRICARE for Life supplements Medicare Parts A and B by contributing to out-of-pocket costs (TRICARE, 2008c).

The Veterans Health Administration (VHA) operates hospitals and outpatient clinics across the country through 21 Veterans Integrated Service Networks (VISNs). Each VISN oversees between five and eleven VA hospitals as well as outpatient clinics, nursing homes and domiciliary care facilities. In all, there are 157 VA hospitals,

750 outpatient clinics, 134 nursing homes and 42 domiciliary care facilities across the country. In 2007 there were approximately 22.9 million veterans living in the United States (American Community Survey, 2007). The VHA administers all health benefits and services requested by veterans. The only eligibility requirement, with a few exceptions, is that the veteran had at least two years of continuous military service, and that his or her discharge was not dishonorable (Tanielian & Jaycox, 2008). Veterans are prioritized for enrollment depending on their disability level and level of income (Tanielian & Jaycox, 2008).

Veterans and their dependents receive benefits under the larger health care insuring entity known as Civilian Health and Medical Program of the VA (CHAMPVA). CHAMPVA provides coverage for a majority of health expenses, including mental health. Services are offered through local VA hospitals and/or Vet Centers (United States Department of Veterans Affairs, 2008).

Vet Centers offer outpatient counseling and outreach services to veterans who have served in a war zone and their family members for all military related issues (Kudler, 2006; Tanielian & Jaycox, 2008). They were initially created by Congress in 1979 as a way to help Vietnam veterans integrate back into mainstream society. Vet Centers provide an alternative to veterans who are not labeled high-priority at VISNs (Tanielian & Jaycox, 2008). These centers are staffed largely by veterans with training in mental health issues (Tanielian & Jaycox, 2008). Vet Centers offer such services as bereavement counseling to family members who lost a loved one during their term of duty, individual counseling, family counseling, and assistance in accessing benefits, outreach, and community education (United States Department of Veterans Affairs, 2007b). Unfortunately, increasing caseloads and small staffs may make it difficult for some veterans to access Vet Center services.

Many veterans do not exclusively use VA care (Borowsky & Cooper, 1999). Veterans may feel conflicted about seeking medical care from the VA (Damon-Rodriguez et al., 2004). Veterans may be unclear as to what kind of services they are able to receive (Damon-Rodriguez et al., 2004). Depending on prior experiences, veterans may associate VA care with welfare or disabilities (Damon-Rodriguez et al., 2004). When veterans feel that respect is accorded by healthcare providers, they are very likely to regard the VA in a positive light (Damon-Rodriguez et al., 2004). Patients most likely to use VA care exclusively tend to be older and have a service-connected disability (Hoff & Rosenheck, 2000). Access to VA health services could be a critical component of reintegration into the community for some veterans and there is concern that returning veterans might not be aware of available VA health programs and services.

The VA has multiple means of reaching out to injured veterans and veterans currently receiving treatment through the DOD to ensure that they know about VA health services and to help them make the transition from DOD to VA services. (For more information about these efforts see CRS Report RL33993, *Veterans' Health Care Issues*, by Sidath Viranga Panangala.)

### *Health Care for Female Veterans*

As of 2007, there were approximately 1.8 million female veterans living in America (United States Census, 2009). Not only have recent years seen more women serving in the military, but overall, women have a higher survival rate compared to men (United States Department of Veterans Affairs Office of Policy and Planning, 2007). Research indicates that female veterans that experience MST are at a higher risk for a variety of problems, from traumatic stress to homelessness (Gamache, Rosenheck, & Tessler, 2003). Compared to non-veterans, female veterans are more likely to have health problems (Frayne et al., 2006; Skinner et al., 1999). Since good health is a requirement of joining the military, it is likely that poor health is caused by experiences and behaviors occurring while serving (Frayne et al., 2006). Women

presently compose only five percent of the veterans with access to health care services in the VA system (Salgado, Vogt, King, & King, 2002). However, the proportion of active-duty military personnel who are women rose from 2% to 15% between 1970 and 2000 (Quester & Gilroy, 2002). Experts forecast that the percentage of female veterans seeking services at the VA will double in the next ten years because of women's increased presence in the military and in combat and the high costs of alternative medical care (Gamache et al., 2003). The lack of specialized services for women seems to be a primary reason that most female veterans currently seek services outside the VA, often at their own expense (Hoff & Rosenheck, 2000).

The increase in female veterans has caused demand for women's health care in the VA to steadily increase (Kelly et al., 2008). Women's health care in the VA has significantly expanded in response and now provides health services such as prenatal care, maternity services, and fertility treatments (Washington, Caffrey, Goldzweig, Simon & Yano, 2003). Female veterans may also receive care in separate Women's Health Clinics (WHCs), which have increased in number in the past several years (Yano, Goldzweig, Canelo & Washington, 2006). In these clinics, there is a focus on women's health with more female providers than can generally be found at a VA Center (Yano, Washington, Goldzweig, Caffrey & Turner, 2003).

Despite these efforts to improve women's health services, women do not always feel comfortable using VHA care (Kelly et al., 2008). There is some evidence that female veterans may choose the VA as a care provider for some services at lower rates than male veterans, particularly for substance abuse services (Perl, 2009). A recent survey shows that only one in five women feel comfortable seeking VA health care services (Kressin et al., 1999). Women who have experienced combat were more likely to feel that services provided at the VHA were too male-centered (Kelly et al., 2008). A study found that while providers at VHA centers were knowledgeable and supportive of female patients, many providers lacked complete

understanding of an increased likelihood of a female patient being in a caregiver role and its implications for her health (Vogt et al., 2001). Women who use VA services at higher rates have certain characteristics, including being older, unmarried, not having children and having lower socioeconomic status than less frequent users (Ouimette, Wolfe, Daley & Gima, 2003). They are more likely to experience poor health, be unemployed and lack health insurance than those who do not regularly utilize VA services (Ouimette et al., 2003).

### **Mental Health Care**

It is often difficult for service members to obtain mental health treatment. The number of facilities varies widely across the country and there is a shortage of military mental health providers (Tanielian & Jaycox, 2008). Mental health care is provided to service members in a number of different ways. Mental health professionals are embedded into operational line units (Tanielian & Jaycox, 2008). These programs enable service members to receive continued support throughout deployment from mental health professionals who are aware of individual situations (Hoyt, 2006). In addition, individual and group counseling is available at a branch level. Service members reporting with more serious mental health issues are then referred to Medical Treatment Facilities (MTF) (Tanielian & Jaycox, 2008). The availability of these services varies. There are often long waits, which may delay treatment or discourage a service member from seeking treatment (Tanielian & Jaycox, 2008).

The military is in the process of integrating primary care and mental health care. Re-Engineering Systems of Primary Care Treatment in the Military (RESPECT-Mil), a program in which primary care providers work alongside mental health professionals in order to provide complete care, has been implemented in several locations (Tanielian & Jaycox, 2008). Since these programs are located in medical facilities, they may be less imposing to those who

may not otherwise seek mental health services (Tanielian & Jaycox, 2008). Mental health care is also provided through Military OneSource, which provides confidential counseling services to service members and their families (Tanielian & Jaycox, 2008). Service members and their families may call Military OneSource, which is staffed by trained counseling consultants (Tanielian & Jaycox, 2008). The consultant provides referrals to counseling services, MTFs, or TRICARE provider, and follows up with the service member to ensure that he or she is receiving adequate assistance (Tanielian & Jaycox, 2008).

The National Guard Bureau has established a Psychological Health Program which supplies in-person Directors of Psychological Health to screen for PTSD, TBI and to provide counseling services at Armories and other locations with concentrations of National Guard/Reserve for drill, deployment and reintegration activities.

Military chaplains have a long standing and vital role in providing mental health support. Chaplains provide marital counseling, anger management and other support to service members (Short, 2009). Care is not always provided in a clinical setting, but rather through a series of confidential conversations (Tanielian & Jaycox, 2008). Since chaplains are deployed with service members they are readily accessible (Short, 2009). In addition, many chaplains use electronic means to communicate with families of soldiers, regardless of where the soldier or chaplain is located. This form of communication allows couples to receive therapy together, even from long distances.

### **Other Programs to Support Veterans and their Families**

The DoD literally has a Social Compact with its Active Duty and activated National Guard and Reserve that specifies the benefits to be provided to the service member and their dependents that is valid throughout their enlistment. These benefits are reviewed regularly through the Quadrennial Review of Military Compensation, which is

comprised of seven components including Health Care and Quality of Life. These two components include services that are focused on supporting active duty service members and their families from child care to mental health services. In addition, the VA, whose mission statement includes fulfilling President Lincoln's promise – "To care for him who shall have borne the battle, and for his widow, and his orphan," is increasing service offerings for recent veterans and their families.

A plethora of websites, hotlines and referral services connect service members and their families with resources on such topics as health care, education, housing, financial issues, new parent support, child care, deployment, combat stress, casualty assistance, child abuse, domestic violence and suicide prevention. The following table highlights primary programs to support warriors and their families, but it is not an exhaustive listing (data compiled from Real Warriors: <http://www.realwarriors.net>).

## RESOURCES FOR MILITARY & VETERANS

National Guard Bureau's Psychological Health Program  
<http://www.joinservicessupport.org/PHP>

Yellow Ribbon Reintegration Program  
<http://www.yellowribbon.mil>

Defense Centers of Excellence for Psychological Health & TBI  
<http://www.dcoe.health.mil/default.aspx>

Veterans Affairs' Mental Health Home  
<http://www.realwarriors.net/go/153>

Veterans Affairs' Vet Center Home  
<http://www.realwarriors.net/go/154>

Military OneSource  
<http://www.militaryonesource.com>

Veterans Affairs' Veterans & Their Families  
<http://www.realwarriors.net/go/155>

Veterans Affairs' Women Veterans Health Care  
<http://www.realwarriors.net/go/149>

Veterans Affairs' Returning Service Members (OEF/OIF)  
<http://www.realwarriors.net/go/145>

AfterDeployment  
<http://www.realwarriors.net/go/86>

National Resource Directory  
<http://www.realwarriors.net/healthprofessionals/Militaryculture/resourcedirectory.php>

Center for the Study of Traumatic Stress  
<http://www.realwarriors.net/go/117>

Defense and Veterans Brain Injury Center  
<http://www.realwarriors.net/go/115>

Deployment Health Clinical Center  
<http://www.pdhealth.mil>

TRICARE  
<http://pdhealth.mil>

Veterans Affairs' Nat'l Ctr for Posttraumatic Stress Disorder  
<http://www.realwarriors.net/go/96>

Veterans Suicide Prevention Hotline  
<http://www.realwarriors.net/go/30>

Military Health System  
<http://www.health.mil>

Force Health Protection & Readiness  
<http://deploymentlink.osd.mil/audience.jsp?option=1>

## RESOURCES FOR MILITARY FAMILIES

National Guard Bureau's Psychological Health Program  
<http://www.join servicessupport.org/PHP>

Yellow Ribbon Reintegration Program  
<http://www.yellowribbon.mil>

Defense Centers of Excellence for Psychological Health  
& TBI  
<http://www.dcoe.health.mil/default.aspx>

U.S. Department of Veterans Affairs, General VA  
Health Content  
<http://www.realwarriors.net/go/88>

Military & Family Life Consultants  
<http://www.realwarriors.net/go/126>

Military OneSource  
<http://www.militaryonesource.com>

Veterans Affairs' Veterans & Their Families  
<http://www.realwarriors.net/go/155>

National Military Family Association  
<http://www.realwarriors.net/go/78>

Sesame Workshop & Sesame St. Family Connections  
<http://www.realwarriors.net/go/124>  
<http://www.realwarriors.net/go/526>

AfterDeployment  
<http://www.realwarriors.net/go/86>

National Resource Directory  
[http://www.realwarriors.net/healthprofessionals/  
Militaryculture/resourcedirectory.php](http://www.realwarriors.net/healthprofessionals/Militaryculture/resourcedirectory.php)

Deployment Health & Family Readiness Library  
<http://deploymenthealthlibrary.fhp.osd.mil/frf.jsp>

Please see the appendix for a selection of Featured Resources highlighting innovative programming.

## Addressing Unmet Needs: Community Circles of Support for Veterans Families

The gaps in service documented in this military literature review, combined with the anticipated increase in need for reintegration services that will occur as the 2011 withdrawal deadlines trigger troops returning from both Iraq and Afghanistan, create a call to action.

The military, VA and community based service delivery infrastructures currently do not have either enough resources or capacity to meet the needs of recent veterans. In addition, services are available primarily for the veteran and only in limited cases the veterans' dependents defined as spouse and children. But parents, siblings, caregivers, spouses, romantic partners and children play a significant role in the successful reintegration of recent veterans back into their community as demonstrated by their attachment to the labor force, housing stability, physical and mental health.

There is a need for replicable, scalable and self-sustaining initiatives that address some of the gaps in services highlighted in this literature review including those that:

- Reduce stigma around seeking mental health services through public education and “no wrong point of entry” services.
- Expand eligibility or services by broadly defining military/veterans' families to include parents, siblings, girlfriends or boyfriends, friends/caregivers.
- Address the need to provide services for geographically dispersed activated Reserve & Guard members, veterans and their families.
- Provide supports that help maintain and sustain family and community supports that can facilitate veterans effective transition, especially for those with PTSD and TBI.

The National Center on Family Homelessness (The National Center) created *Community Circles of Support for Veterans Families* (CCSVF) in an effort to address some of these unmet needs.

CCSVF is a comprehensive, community-based mental health and education initiative that incorporates knowledge of the impact of PTSD/TBI on both the veteran and family. Its approach represents a change in practice because it is prophylactic, fills a gap in services available to veterans' families and is innovative with its “no wrong door of entry” philosophy. This national multi-site demonstration builds capacity among community social service providers. Funding comes from the **Wal-Mart Foundation** to implement this initiative in *Eugene, Oregon* and *San Diego, California* and from the **McCormick Foundation's Welcome Back Veterans Fund** for a third site in *Bloomington, Illinois*. **Blue Shield of California Foundation** has made a grant award to fund additional sites in California in 2010. A focus of these demonstration projects is the emerging needs of veterans' families who are reuniting with their war fighters as they separate from the military after tours of duty in Iraq and Afghanistan.

The goals of this multi-site program are to enhance relationships between returning veterans and their family members, strengthen connections among veterans' families, train service providers in specialized programming and educate the broader community about the experiences of veterans and their families. The ultimate goal of this initiative is to support veteran reintegration into civilian life and prevent future difficulties such as family separation and homelessness.

The key components of this project include:

- **A specialized group therapy for veterans' families.**

This multi-dyad group therapy is an abbreviated form of cognitive-behavioral conjoint therapy for PTSD (Monson, Fredman, & Stevens, 2008) and TBI. The therapy builds skills relevant to dyads (romantic and non-romantic significant others) in which one member is a veteran with a traumatic stress-related disorder. The therapy is designed to improve both traumatic stress-related symptoms and relationship functioning. Therapy sessions are two hours long and include psycho-education about the connections between stress disorders and relationship difficulties, conflict management strategies, communication skills training, and instruction in how to simultaneously decrease traumatic stress-related avoidance and promote increased relationship positivity.

- **A community awareness campaign designed to increase public and individual awareness of the experiences of veterans and their family members.**

This psycho-educational component of the program consists of a monthly series of brief workshops, lectures and/or discussion groups for veterans, veterans' families, providers, community agencies, and the public. They include topics of general interest, such as traumatic stress and its impact on veterans and their families; TBI and its effects; the impact of TBI on family members; the effects of trauma and familial disruptions on children; and general education on the military culture and needs of returning veterans. At the broadest level, all veterans, their spouses or romantic partners and their children will benefit from the entire community understanding the challenges, including both visible and invisible wounds, facing returning war fighters as they reintegrate into civilian life. In addition, community awareness campaigns may reinforce creating and sustaining local efforts to support both troops and veterans.

- **Specialized trainings for providers.**

Specialized trainings involve educating community social services providers on the specific service needs of veterans and their families and training providers in specialized interventions. For example, The National Center provides each local CCSVF and up to twenty community-based masters' level clinicians' a two day (15 hour) manualized training with a workbook of the Con-joint Cognitive Behavioral short-term (8 session model) Group Therapy for war fighters with PTSD/TBI paired with a family member (parent/sibling/romantic partner). Trainees have been drawn from Veterans Medical Centers, Vet Centers, law enforcement agencies, local university and community college mental health clinics, clinicians' from social service agencies including those providing substance abuse and interpersonal violence prevention and private clinicians' whose practices include military families.

- **A peer networking strategy for fostering community among veterans' families.**

Peer networking activities at the local sites include activities such as peer-to-peer counseling, participation in drop-in center activities and recreational events. These activities provide the opportunity for veterans' families to have fun, express their frustrations, share their experiences, and relate to peers who best understand their challenges.

In developing this program, The National Center worked in partnership with military experts who understood both community capacity and the needs of veterans' families. Our consultants included:

- *Richard Talbot*, Regional Manager of Veterans Affairs for Pacific Western Region (the liaison to all Vet Centers in California and Oregon).
- *Candice Monson*, PhD, Deputy Directory of the Women's Health Sciences Division, National Center for PTSD in the Boston, VA Healthcare System.

The evaluation data from the multiple site *CCSVF* will contribute to gauge how to strengthen relationships between recent veterans' and their family members and meeting unfilled needs to offer support to the most expansively defined veterans' family.

Family, friends, service providers, and community supports can buoy people up in times of crisis, allowing them to survive until circumstances improve. Without such a network, a person has nowhere to turn for financial or emotional support that will help prevent a downward spiral. Most returning war fighters and recent veterans are able to re-engage in their lives and become self-sustaining, often with help from family, friends, and caretakers. Veterans without social networks can find themselves isolated and at high risk for homelessness. Strong social networks often make the difference between a productive life in the community or being out on the streets. Initiatives such as *CCSVF*, that include evidence based clinical interventions, are necessary to strengthen relationships between our men and women who have served our country in challenging circumstances and their families.

## References

- Alvarez, L. (2009a, August 16). G.I. Jane breaks the combat barrier. *New York Times*, pp. A1. Retrieved August 26, 2009, from <http://www.nytimes.com/2009/08/16/us/16women.html>.
- Alvarez, L. (2009b, September 27). Wartime soldier, conflicted mom. *New York Times*, pp. A1. Retrieved September 28, 2009, from [http://www.nytimes.com/2009/09/27/us/27mothers.html?\\_r=1&emc=eta1](http://www.nytimes.com/2009/09/27/us/27mothers.html?_r=1&emc=eta1).
- American Community Survey. (2007). Table S2101: Veteran Status. Retrieved August 25, 2009, from [http://factfinder.census.gov/servlet/STTable?\\_bm=y&-geo\\_id=01000US&-qr\\_name=ACS\\_2007\\_1YR\\_G00\\_S2101&-ds\\_name=ACS\\_2007\\_1YR\\_G00\\_&-lang=en&-caller=geoselect&-state=st&-format=](http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2007_1YR_G00_S2101&-ds_name=ACS_2007_1YR_G00_&-lang=en&-caller=geoselect&-state=st&-format=).
- American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. (2007). The psychological needs of U.S. military service members and their families: A preliminary report. Retrieved January 23, 2008, from <http://www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf>.
- Barrett, D.H., Doebbeling, C.C., Schwartz, D.A., Voelker, M.D., Falter, K.H., Woolson, R.F., & Doebbeling, B.N. (2002). Posttraumatic stress disorder and self-reported physical health status among U.S. military personnel serving during the Gulf War period: A population-based study. *Psychosomatics*, 43(3), 195-205.
- Benda, B.B. (2006). Survival analyses of social support and trauma among homeless male and female veterans who abuse substances. *American Journal of Orthopsychiatry*, 76(1), 70-79.
- Bender, B. (2009a, July 6). More female veterans are winding up homeless: VA resources strained; many are single parents. *Boston Globe*. Retrieved July 22, 2009, from [http://www.boston.com/news/nation/washington/articles/2009/07/06/more\\_female\\_veterans\\_are\\_winding\\_up\\_homeless/](http://www.boston.com/news/nation/washington/articles/2009/07/06/more_female_veterans_are_winding_up_homeless/)
- Bender, B. (2009b, August 24). Veterans forsake studies of stress: Stigma impedes search for remedies. *Boston Globe*. Retrieved August 26, 2009, from [http://www.boston.com/news/nation/washington/articles/2009/08/24/few\\_iraq\\_afghanistan\\_veterans\\_willing\\_to\\_take\\_part\\_in\\_boston\\_vas\\_studies\\_on\\_post\\_traumatic\\_stress/](http://www.boston.com/news/nation/washington/articles/2009/08/24/few_iraq_afghanistan_veterans_willing_to_take_part_in_boston_vas_studies_on_post_traumatic_stress/).
- Borowsky, S.J. & Cooper, D.C. (1999). Dual use of VA and non-VA primary care. *Journal of General Internal Medicine*, 14, 274-280.
- Bostock, D.J. & Daley, J.G. (2007). Lifetime and current sexual assault and harassment victimization rates of active-duty United States Air Force women. *Violence Against Women*, 13, 927-944.
- Brain Injury Association of America. (2007). Range of Statistics Cited on the Number of Returning Service Members with TBI. Retrieved December 3, 2009, from [http://www.biausa.org/Indiana/docs/tbi\\_dv\\_stats.doc](http://www.biausa.org/Indiana/docs/tbi_dv_stats.doc).
- Brain Injury Association of America. (2007). Traumatic Brain Injury in the United States: A Call for Public/Private Cooperation. McLean, VA: Brain Injury Association of America.
- Bride, B.E. (2001). Single-gender treatment of substance abuse: Effect on treatment retention and completion. *Social Work Research*, 25(4), 223-232.

- Calhoun, P.S., Beckham, J.C., & Bosworth, H.B. (2002). Caregiver burden and psychological distress in partners of veterans with chronic posttraumatic stress disorder. *Journal of Traumatic Stress, 15*(3), 205-212.
- Calhoun, P.S., Bosworth, H.B., Grambow, S.C., Dudley, T.K., & Beckham, J.C. (2002). Medical service utilization by veterans seeking help for posttraumatic stress disorder. *American Journal of Psychiatry, 159*(12), 2081-2086.
- Carney, C.P., Sampson, T.R., Voelker, M., Woolson, R., Thorne, P., & Doebbeling, B.N. (2003). Women in the Gulf War: Combat experience, exposures, and subsequent health care use. *Military Medicine, 168*(8), 654-661.
- Castaneda, L.W. & Harrell, M.C. (2008). Military spouse employment: A grounded theory approach to experiences and perceptions. *Armed Forces & Society, 34*(3), 389-412.
- Center for Disease Control. (2009). What is Traumatic Brain Injury? Retrieved September 16, 2009, from <http://www.cdc.gov/ncipc/tbi/TBI.htm>.
- Chang, B., Skinner, K.M. & Boehmer, U. (2001). Religion and mental health among women veterans with sexual assault experience. *International Journal of Psychiatry and Medicine, 31*(1), 77-95.
- Chartrand, M.M. & Siegel, B. (2007). War in Iraq and Afghanistan: Children in US military families. *Ambulatory Pediatrics, 7*, 1-2.
- Damon-Rodriguez, J., White-Kazemipour, W., Washington, D., Villa, W.M., Dhanani, S., & Harada, N.D. (2004). Accessibility and acceptability of the Department of Veterans Affairs health care: Diverse veterans' perspectives. *Military Medicine, 169*(3), 243-250.
- Dao, J. (2009, July 17). Vets' mental health diagnoses rising. *New York Times*, pp. A10.
- Davis, T.M. & Wood, P.S. (1999). Substance abuse and sexual trauma in a female veteran population. *Journal of Substance Abuse Treatment, 16*(2), 123-127.
- Department of Defense Task Force on Mental Health. (2007). *An achievable vision: Report of the Department of Defense Task Force on Mental Health*. Falls Church, VA: Defense Health Board.
- Desai, R.A., Harpaz-Rotem, I., Najavits, L.M., & Rosenheck, R.A. (2008). Impact of the Seeking Safety program on clinical outcomes among homeless female veterans with psychiatric disorders. *Psychiatric Services, 59*, 996-1003.
- Dobie, D.J., Maynard, C., Kivlahan, D.R., Johnson, K.M., Simpson, T., David, A.C., & Bradley, K. (2006). Posttraumatic stress disorder screening status is associated with increased VA medical and surgical utilization in women. *Journal of General Internal Medicine, 21*, S58-64.
- Engel, C.C., Liu, X., McCarthy, B.D., Miller, R.F., & Ursano, T. (2000). Relationship of physical symptoms to posttraumatic stress disorder among veterans seeking care for Gulf War-related health concerns. *Psychosomatic Medicine, 62*, 739-745.

- Fairweather, A. (2006). *Risk and Protective Factors for Homelessness among OIF/OEF Veterans*. San Francisco, CA: Swords to Ploughshares.
- Family Advocacy Program. (No date). Department of Defense Family Advocacy Program. Retrieved September 17, 2009, from <http://www.defenselink.mil/fapmip/>.
- Fitzgerald, L.F., Drasgow, F., & Magley, V.J. (1999). Sexual harassment in the Armed Forces: A test of an integrated model. *Military Psychology*, 11(3), 329-343.
- Fontana, A. & Rosenheck, R. (1998). Focus on women: Duty-related and sexual stress in the etiology of PTSD among women veterans who seek treatment. *Psychiatric Services*, 49, 658-662.
- Frayne, S.M., Parker, V.A., Christiansen, C.L., Loveland, S., Seaver, M.R., Kazis, L.E. & Skinner, K.M. (2006). Health status among 28,000 women veterans: The VA Women's Health Program Evaluation Project. *Journal of General Internal Medicine*, 21, S40-46.
- Frayne, S.M., Skinner, K.M., Sullivan, L.M., Tripp, T.J., Hankin, C.S., Kressin, N.R. & Miller, D.R. (1999). Medical profile of women Veterans Administration outpatients who report a history of sexual assault occurring while in the military. *Journal of Women's Health & Gender-Based Medicine*, 8(6), 835-845.
- Friedman, M.J. (2006). Posttraumatic stress disorder among military returnees from Afghanistan and Iraq. *American Journal of Psychiatry*, 163(4), 586-593.
- Gamache, G., Rosenheck, R. & Tessler, R. (2001). The proportion of veterans among homeless men: A decade later. *Social Psychiatry and Psychiatric Epidemiology*, 36(10), 481-485.
- Gamache, G., Rosenheck, R., & Tessler, R. (2003). Overrepresentation of women veterans among homeless women. *American Journal of Public Health*, 93(7), 1132-1136.
- Goode, E. (2009, August 2). After combat, victims of an inner war. *New York Times*, pp. A1.
- Hankin, C.S., Skinner, K.M., Sullivan, L.M., Miller, D.R., Frayne, S., & Tripp, T.J. (1999). Prevalence of depressive and alcohol abuse symptoms among women VA outpatients who report experiencing sexual assault while in the military. *Journal of Traumatic Stress*, 12(4), 601-612.
- Hoff, R.A. & Rosenheck, R.A. (2000). Cross-system service use among psychiatric patients: Data from the Department of Veterans Affairs. *The Journal of Behavioral Health Services & Research*, 27(1), 98-106.
- Hoge, C.W., Auchterlonie, J.J., & Milliken, C.S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295(9), 10223-1032.
- Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351(1), 13-22.
- Hourani, L.L., Yuan, H., & Bray, R.M. (2003). Psychosocial and health correlates of types of traumatic event exposures among U.S. military personnel. *Military Medicine*, 168(9), 736-743.

- Houston, J.B., Pfefferbaum, B., Sherman, M.D., Melson, A.G., Jeon-Slaughter, H., Brand, M.W., & Jarman, Y. (2009). Children of deployed National Guard troops: Perceptions of parental deployment to Operation Iraqi Freedom. *Psychiatric Annals*, 39(8), 805-811.
- Hoyt, G.B. (2006). Integrated mental health within operational units: Opportunities and challenges. *Military Psychology*, 18(4), 309-320.
- Jelinek, P. (2009, November 28). Military divorces increasing from war stress. USA Today. Retrieved December 1, 2009, from <http://content.usatoday.net/dist/custom/gci/InsidePage.aspx?cId=thenewsstar&sParam=32157893.story>.
- Kang, H., Dalager, N., Mahan, C., & Ishii, E. (2004). The role of sexual assault on the risk of PTSD among Gulf War veterans. *Annals of Epidemiology*, 15, 191-195.
- Karney, B.R. & Crown, J. (2007). *Families Under Stress: An Assessment of Data, Theory, and Research on Marriage and Divorce in the Military*. Santa Monica, California: RAND Corporation.
- Kelly, M.M., Vogt, D.S., Scheiderer, E.M., Ouimette, P., Daley, J., & Wolfe, J. (2008). Effects of military trauma exposure on women veterans' use and perceptions of Veterans Health Administration care. *Journal of General Internal Medicine*, 23(6), 741-747.
- Kessler, R.C. (2000). Posttraumatic Stress Disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry*, 61(Supp1.5), 4-12.
- Kessler, R.B., Bromet, E., Hughes, M. & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Study. *Archives of General Psychiatry*, 5, 1048-1060.
- Kimerling, R., Gima, K., Smith, M.W., Street, A., & Frayne, S. (2007). The Veterans Health Administration and military sexual trauma. *American Journal of Public Health*, 97(12), 2160-2166.
- Kimerling, R., Street, A.E., Gima, K. & Smith, M.W. (2008). Evaluation of universal screening for military-related sexual trauma. *Psychiatric Services*, 59(6), 635-640.
- Kressin, N., Skinner, K., Sullivan, L., Miler, D., Frayne, S., Kazis, L. & Tripp, T. (1999). Patients' satisfaction with VA health care: Do women differ from men? *Military Medicine*, 164, 283-288.
- Kudler, H. (2006, May). *The Public Health Approach in DoD/VA Outreach to Service Members/Veterans and their Families*. Presentation for the Annual Meeting of the American Psychiatric Association, Toronto Canada.
- LaBash, H.A.J., Vogt, D.S., King, L.A. & King, D.W. (2009). Deployment stressors of the Iraq War: Insights from the mainstream media. *Journal of Interpersonal Violence*, 24(2), 231-258.
- MacQuarrie, B. (2009, July 26). For returning vets, a tragic toll on the roads: Devastating death rate from crashes sounds the alarm at Veterans Affairs. *Boston Globe*. Retrieved August 6, 2009, from [http://www.boston.com/news/local/massachusetts/articles/2009/07/26/for\\_returning\\_vets\\_a\\_tragic\\_toll\\_on\\_the\\_roads/](http://www.boston.com/news/local/massachusetts/articles/2009/07/26/for_returning_vets_a_tragic_toll_on_the_roads/).

- Magley, V.J., Waldo, C.R., Drasgow, F., & Fitzgerald, L.F. (1999). The impact of sexual harassment on military personnel: Is it the same for men and women? *Military Psychology*, 11(3), 283-302.
- Marshall, A.D., Panuzio, J., & Taft, C.T. (2005). Intimate partner violence among military veterans and active duty servicemen. *Clinical Psychology Review*, 25, 862-876.
- Military Homefront. (No date). Military Homefront: Supporting our Troops and Families. Retrieved September 21, 2009, from [http://www.militaryhomefront.dod.mil/portal/page/mhf/MHF/MHF\\_SITE\\_MAP](http://www.militaryhomefront.dod.mil/portal/page/mhf/MHF/MHF_SITE_MAP).
- Miller, L.L. (1997). Not just weapons of the weak: Gender harassment as a form of protest for Army men. *Social Psychology Quarterly*, 60(1), 32-51.
- Monson, C.M., Fredman, S.J., & Macdonald, A. (2009). *Group cognitive-behavioral conjoint therapy for traumatic stress-related problems: Therapist's manual*. Unpublished manual.
- Mount Sinai Medical Center. (2008a). What happens immediately after the injury? Retrieved September 16, 2009, from <http://www.brainline.org/content/2008/07/what-happens-immediately-after-injury.html>.
- Mount Sinai Medical Center. (2008b). What impact will moderate or severe TBI have on a person's life? Retrieved September 16, 2009, from <http://brainline.org/content/2008/07/what-impact-will-moderate-or-severe-tbi-have-persons-life.html>.
- Murdoch, M., Bradley, A., Mather, S.H., Klein, R.E., Turner, C.L., & Yano, E.M. (2006). Women and war: What physicians should know. *Journal of General Internal Medicine*, 21, S5-S10.
- Murdoch, M., Polusny, M.A., Hodges, J., & Cowper, D. (2006). The association between in-service sexual harassment and post-traumatic stress disorder among the Department of Veterans Affairs disability applicants. *Military Medicine*, 171(2), 166-173.
- Murdoch, M., Polusny, M.A., Hodges, J., & O'Brien, N. (2004). Prevalence of in-service and post-service sexual assault among combat and noncombat veterans applying for Department of Veterans Affairs posttraumatic stress disorder disability benefits. *Military Medicine*, 169(5), 392-395.
- Myers, S.L. (2009, August 17). Living and fighting alongside men, and fitting in. *New York Times*, pp. A1. Retrieved August 26, 2009, from <http://www.nytimes.com/2009/08/17/us/17women.html>.
- National Center for Post-Traumatic Stress Disorder & Walter Reed Army Medical Center. (2004). *Iraq War Clinician Guide, 2nd Edition*. Retrieved August 26, 2009, from <http://www.ptsd.va.gov/professional/manuals/iraq-war-clinician-guide.asp>.
- National Center for PTSD. (2009). What is PTSD? Retrieved September 16, 2009, from <http://www.ptsd.va.gov/public/pages/what-is-ptsd.asp>.

- National Institute on Neurological Disorders and Stroke. (No Date). NINDS Traumatic Brain Injury Home Page. Retrieved September 16, 2009, from <http://www.ninds.nih.gov/disorders/tbi/tbi.htm>.
- National Suicide Prevention Lifeline. (No Date). Veterans Mental Health. Retrieved September 17, 2009, from <http://www.suicidepreventionlifeline.org/Veterans/MentalHealth.aspx#VeteransAndSuicide>.
- Navy Personnel Command. (2008). Suicide Prevention. Retrieved September 17, 2009, from <http://www.npc.navy.mil/CommandSupport/SuicidePrevention/>.
- Nelson-Zlupko, L., Kauffman, E., & Dore, M.M. (1995). Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women. *Social Work*, 40(1), 45-54.
- Okie, S. (2005). Traumatic Brain Injury in the war zone. *New England Journal of Medicine*, 352(20), 2043-2047.
- Orcutt, H.K., King, L.A., & King, D.W. (2003). Male-perpetrated violence among Vietnam veteran couples: Relationships with veteran's early life characteristics, trauma history, and PTSD symptomatology. *Journal of Traumatic Stress*, 16(4), 381-390.
- Ouimette, P., Wolfe, J., Daley, J., & Gima, K. (2003). Use of VA health care services by women veterans: Findings from a national sample. *Women & Health*, 38(2), 77-91.
- Patterson, T. (2009, September 25). U.S. seeing more female homeless veterans. CNN. Retrieved December 1, 2009, from <http://www.cnn.com/2009/LIVING/09/25/homeless.veterans/>.
- Perl, L. (2009, June 26). Veterans and homelessness. Washington, DC: Congressional Research Service.
- Quester, A.O. & Gilroy, C.L. (2002). Women and minorities in America's volunteer military. *Contemporary Economic Policy*, 20(2), 111-121.
- Real Warriors. (No date). Real Warriors, Real Battles, Real Strength. Retrieved October 1, 2009, from <http://www.realwarriors.net/>.
- Riggs, D.S. (1997). Posttraumatic stress disorder and the perpetration of domestic violence. *National Center for PTSD Clinical Quarterly*, 7(2), 22-25.
- Riggs, D.S., Byrne, C.A., Weathers, F.W. & Litz, B.T. (1998). The quality of intimate relationships with male Vietnam veterans: Problems associated with posttraumatic stress disorder. *Journal of Traumatic Stress*, 11, 87-102.
- Robertson, M.J. (1987). Homeless veterans, an emerging problem?" In R.J. Bingham, R.E. Green & S.B. White (eds.) *The Homeless in Contemporary Society*. Newbury Park, CA: Sage Publications.
- RTI International. (2006). 2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Personnel. Research Triangle Park, North Carolina: RTI International. Retrieved September 30, 2009, from [http://www.ha.osd.mil/special\\_reports/2005\\_Health\\_Behaviors\\_Survey\\_1-07.pdf](http://www.ha.osd.mil/special_reports/2005_Health_Behaviors_Survey_1-07.pdf).

- Sadler, A.G., Booth, B.M., Cook, B.L., & Doebbeling, B.N. (2003). Factors associated with women's risk of rape in the military environment. *American Journal of Industrial Medicine*, 43, 262-273.
- Sadler, A.G., Booth, B.M., Cook, B.L., Torner, J.C., & Doebbeling, B.N. (2001). The military environment: Risk factors for women's non-fatal assaults. *Journal of Occupational and Environmental Medicine*, 43(4), 325-334.
- Sadler, A.G., Booth, B.M., Mengeling, M.A., & Doebbeling, B.N. (2004). Life span and repeated violence against women during military service: Effects on health status and outpatient utilization. *Journal of Women's Health*, 13, 799-811.
- Sadler, A.G., Booth, B.M., Nielson, D., & Doebbeling, B.N. (2000). Health-related consequences of physical and sexual violence: Women in the military. *Obstetrics & Gynecology*, 96(3), 473-480.
- Salgado, D.M., Vogt, D.S., King, L.A., & King, D.W. (2002). Gender awareness inventory-VA: A measure of ideology, sensitivity, and knowledge related to women veterans' health care. *Sex Roles*, 46(7-8), 247-262.
- 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), 163-170.
- Sesame Workshop. (2008). Talk, Listen, Connect: Helping Military Families through Difficult Transitions. Retrieved September 21, 2009, from <http://www.sesameworkshop.org/initiatives/emotion/tlc/deployments>
- Sherman, M.D. (2003). The S.A.F.E. Program: A family psychoeducational curriculum developed in a VA Medical Center. *Professional Psychology: Research and Practice*, 34(1), 42-48.
- Sherman, M.D. (2008). SAFE Program: Mental Health Facts for Families. Retrieved September 8, 2009, from <http://www.wouhsc.edu/Safeprogram/>.
- Shinseki, E.K. (2009). Remarks by Eric K. Shinseki, National Summit on Homeless Veterans. Retrieved December 3, 2009, from [http://www1.va.gov/opa/speeches/2009/09\\_1103.asp](http://www1.va.gov/opa/speeches/2009/09_1103.asp).
- Short, S.C. (2009, May 19). Face of defense: Chaplains reinforce more than faith. *American Forces Press Service*. Retrieved September 16, 2009, from <http://www.defenselink.mil/news/newsarticle.aspx?id=54400>.
- Skinner, K.M., Kressin, N., Frayne, S., Tripp, T.J., Hankin, C.S., Miller, D.R., et al. (2000). The prevalence of military sexual assault among female veterans' administration outpatients. *Journal of Interpersonal Violence*, 15(3), 291-310.
- Skinner, K., Sullivan, L.M., Tripp, T.J., Kressin, N.R., Miller, D.R., Kazis, L. & Casey, V. (1999). Comparing the health status of male and female veterans who use VA health care: Results from the VA Women's Health Project. *Women & Health*, 29(4), 17-33.
- Still Serving Veterans. (2009). Still Serving Veterans. Retrieved September 24, 2009, from <http://www.stillservingveterans.org/Home.asp>.

- Street, A.E., Stafford, J., Mahan, C.M. & Hendricks, A. (2008). Sexual harassment and assault experienced by reservists during military service: Prevalence and health correlates. *Journal of Rehabilitation Research & Development*, 45(3), 409-419.
- Summerall, E.L. (No date). Traumatic Brain Injury and PTSD. Retrieved July 22, 2009, from [http://www.ncptsd.va.gov/ncmain/ncdocs/factsheets/traumatic\\_brain\\_injury\\_and\\_pts.html?opm=1&rr=rr1906&srt=d&echorr=true](http://www.ncptsd.va.gov/ncmain/ncdocs/factsheets/traumatic_brain_injury_and_pts.html?opm=1&rr=rr1906&srt=d&echorr=true).
- Suris, A., Lind, L., Kashner, T.M., Borman, P.D., & Petty, F. (2004). Sexual assault in women veterans: An examination of PTSD risk, health care utilization, and cost of care. *Psychosomatic Medicine*, 66, 749-756.
- Taft, C.T., Pless, A.P., Stalans, L.J., Koenen, K.C., King, L.A., & King, D.W. (2005). Risk factors for partner violence among a national sample of combat veterans. *Journal of Consulting and Clinical Psychology*, 73(1), 151-159.
- Taft, C.T., Schumm, J.A., Panuzio, J., & Proctor, S.P. (2008). An examination of family adjustment among Operation Desert Storm Veterans. *Journal of Consulting and Clinical Psychology*, 76(4), 648-656.
- Tanielian, T. & Jaycox, L.H. (eds.) (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: The RAND Corporation.
- Tessler, R., Rosenheck, R., & Gamache, G. (2002). Comparison of homeless veterans with other homeless men in a large clinical outreach program. *Psychiatric Quarterly*, 73(2), 109-119.
- Tragedy Assistance Program for Survivors. (2009). TAPS. Retrieved September 25, 2009, from <http://www.taps.org/>.
- TRICARE. (2008a). What is TRICARE? Retrieved June 30, 2008, from <http://tricare.mil/mybenefit/home/overview/WhatIsTRICARE>.
- TRICARE. (2008b). Eligibility. Retrieved June 30, 2008, from <http://tricare.mil/mybenefit/home/overview/Eligibility>.
- TRICARE. (2008c). TRICARE for Life. Retrieved June 30, 2008 from <http://tricare.mil/mybenefit/home/overview/Plans/ForLife>.
- TRICARE. (2008d). TRICARE Prime. Retrieved June 30, 2008, from <http://tricare.mil/mybenefit/home/overview/Plans/Prime>.
- TRICARE. (2008e). TRICARE Standard and Extra. Retrieved June 30, 2008, from <http://tricare.mil/mybenefit/home/overview/Plans/StandardExtra>.
- TRICARE. (No date). Covered Services. Retrieved July 2, 2008, from <http://tricare.mil/mybenefit/home/Medical/IsItCovered.jsp?>
- TRICARE Dental Program. (2006). TRICARE Dental Program Benefit Booklet. Retrieved June 9, 2008 from [http://tricare.mil/mybenefit/Download/Forms/TDP\\_Handbook.pdf](http://tricare.mil/mybenefit/Download/Forms/TDP_Handbook.pdf)
- United States Census Bureau. (2009). Statistical Abstract of the United States: 2009, Table 503. Retrieved July 21, 2009, from <http://www.census.gov/compendia/statab/>.

- United States Department of Defense. (2005). *2005 Department of Defense Demographics Report*. Retrieved May 2, 2008, from: <http://www.cfs.purdue.edu/mfri/pages/military/2005DemographicsReport.pdf>
- United States Department of Defense. (2007). *2007 Demographics: Profile of the Military Community*. Retrieved August 26, 2009, from <http://www.militaryonesource.com/MOS/ServiceProviders/2007DemographicsProfileoftheMilitaryCommunity.aspx>.
- United States Department of Defense. (2008). Report to Congress in Accordance with Section 1634 (b) of the National Defense Authorization Act for Fiscal Year 2008. Retrieved December 3, 2009, from <http://www.tricare.mil/planning/congress/downloads/ExpendituresforActivitiesonTBIandPost-TraumaticStressDisorderNDAAforFY2008.pdf>
- United States Department of Veterans Affairs. (2006). Strategic Plan FY 2006-2011. Washington, DC: Office of the Secretary.
- United States Department of Veterans Affairs. (2007). Vet Center Services. Retrieved June 30, 2008, from <http://www.vetcenter.va.gov/VetCenterServices.asp>.
- United States Department of Veterans Affairs. (2008). Mental health home. Retrieved May 20, 2008, from <http://www.mentalhealth.va.gov>.
- United States Department of Veterans Affairs. (2009). Overview of Homelessness. Retrieved December 3, 2009, from <http://www1.va.gov/homeless/page.cfm?pg=1>.
- United States Department of Veterans Affairs Office of Policy and Planning. (2007). Women Veterans: Past, Present and Future Revised and Updated. Retrieved May 30, 2008 from, <http://www1.va.gov/vetdata/docs/Womenveteranspastpresentfuture9-30-07a.pdf>
- Valente, S. & Wight, C. (2007). Military sexual trauma: Violence and sexual abuse. *Military Medicine*, 172(3), 259-265.
- Vogt, D.S., Pless, A.P., King, L.A., & King, D.W. (2005). Deployment stressors, gender, and mental health outcomes among Gulf War I veterans. *Journal of Traumatic Stress*, 18(2), 272-284.
- Vogt, D.S., Stone, E.R., Salgado, D.M., King, L.A., King, D.W., & Savarese, V.W. (2001). Gender awareness among Veterans Administration health-care workers: Existing strengths and areas for improvement. *Women & Health*, 34(4), 65-83.
- Warden, D. (2006). Military TBI during the Iraq and Afghanistan wars. *Journal of Head Trauma Rehabilitation*, 21(5), 398-402.
- Wardrip, K.E., Pelletiere, D., & Crowley, S. (2009). *Out of Reach 2009*. Washington, DC: National Low Income Housing Coalition.
- Washington, D.L., Caffrey, C. Goldzweig, C., Simon, B., & Yano, E.M. (2003). Availability of comprehensive women's health care through Department of Veterans Affairs medical center. *Women's Health Issues*, 13, 50-54.
- Watkins, L.E., Taft, C.T., Hebenstreit, C.L., King, L.A., & King, D.W. (2008). Predictors of child behavior problems among children of female Vietnam veterans. *Journal of Family Violence*, 23, 135-140.

- Williams, J.H., Fitzgerald, L.F., & Drasgow, F. (1999). The effects of organizational practices on sexual harassment and individual outcomes in the military. *Military Psychology*, 11(3), 303-328.
- Zoroya, G. (2009, June 25). Troops' kids feel war toll. USA Today. Retrieved September 17, 2009, from [http://www.usatoday.com/news/military/2009-06-24-military-kids\\_N.htm](http://www.usatoday.com/news/military/2009-06-24-military-kids_N.htm).
- Women in Military Service for America Memorial Foundation, Inc. (2009). Statistics on Women in the Military. Retrieved July 21, 2009, from <http://www.womensmemorial.org/PDFs/StatsonWIM.pdf>.
- World Health Organization. (2002). *The World Health Report 2002: Reducing Risks. Promoting Healthy Life*. Geneva, Switzerland: World Health Organization.
- Yaeger, D., Himmelfarb, N., Cammack, A., & Mintz, J. (2006). DSM-IV posttraumatic stress disorder in women veterans with and without military sexual trauma. *Journal of General Internal Medicine*, 21, S65-69.
- Yano, E.M., Goldzweig, C., Canelo, I., & Washington, D.L. (2006). Diffusion of innovation in women's health care delivery: The Department of Veterans Affairs' adoption of women's health clinics. *Women's Health Issues*, 16, 226-235.
- Yano, E.M., Washington, D.L., Goldzweig, C., Caffrey, C., & Turner, C. (2003). The organization and delivery of women's health care in Department of Veterans Affairs medical center. *Women's Health Issues*, 13, 55-61.
- Zinzow, H.M., Gruhaugh, A.L., Frueh, B.C., & Magruder, K.M. (2008). Sexual assault, mental health, and service use among male and female veterans seen in Veterans Affairs primary care clinics: A multi-site study. *Psychiatric Research*, 159, 226-236.

## Appendix: Selected Community Based Programs for Military Families & their Warriors

NOTE: The following Featured Resources are not program endorsements but rather a more in-depth sampling of resources identified in the body of the literature review.

### Military Child Education Coalition

The Military Child Education Coalition  
909 Mountain Lion Circle  
P. O. Box 2519  
Harker Heights, TX 76548-2519  
(254) 953-1923  
[www.militarychild.org](http://www.militarychild.org)

The Military Child Education Coalition (MCEC) is a non-profit organization that seeks to ensure that military children receive educational opportunities and that education is not disrupted by the transitions that occur in military life. It researches ways to support military children, develops resources for military parents, children, and teachers, holds an annual conference and maintains a website that enables parents and teachers to connect with appropriate resources.

MCEC provides a variety of programs to military families. *Student 2 Student*, which is currently being implemented in 27 states, seeks to ensure that military children feel welcomed by their peers when starting a new high school. *Parent to Parent* provides a series of workshops to military parents. These workshops assist parents with advocating on behalf of the educational needs of their children. The *Transition Counselor Institute* is a two-day professional development opportunity for professionals who work with military children. These workshops provide information on topics such as the military lifestyle and culture, as well as social and emotional challenges that children face during times of transition. MCEC also offers similar trainings for professionals who work with

military children enrolled in special education or gifted programs. In addition to providing these services, the MCEC website provides resources to military parents, relating to school transfer, deployment, and education.

### Stand Downs

Stand Downs for Homeless Veterans – CCSVF partner  
VVSD  
Stand Down  
(202) 546-1969  
[www.nchv.org/standdown.cfm](http://www.nchv.org/standdown.cfm)

A battlefield stand down is the process in which troops are removed from danger and taken to a safe area to rest, eat, clean up, receive medical care, and generally recover from the stress and chaos of battle. Stand Downs for Homeless Veterans are modeled on the battlefield stand down and are local events, staged annually in many cities across the country, in which local veterans service organizations, businesses, government entities, and other social service organizations come together for up to three days to provide similar services for homeless veterans. Items and services provided at stand downs include food, clothing, showers, haircuts, medical exams, dental care, immunizations, and, in some locations where stand downs take place for more than one day, shelter. Another important facet of stand downs, according to the National Coalition for Homeless Veterans, is the camaraderie that occurs when veterans spend time among other veterans.

### Military Homefront

Military Homefront  
[www.militaryhomefront.dod.mil/](http://www.militaryhomefront.dod.mil/)

This comprehensive website offers information on all stages of life and deployment (Military Homefront, n.d.). Topics include health care, education, housing, financial issues, new parent support, child care, deployment, combat stress, casualty assistance, child abuse, domestic violence and suicide prevention (Military Homefront, n.d.). Each topic contains extensive information,

frequently asked questions, a glossary, as well as a list of outside resources. Some topics, such as moving, offer customizable tools (Military Homefront, n.d.). Extensive information is also available for service providers.

### **Talk, Listen, Connect**

Sesame Workshop  
 One Lincoln Plaza  
 New York, NY 10023  
 (212) 595-3456  
[www.sesameworkshop.org/initiatives/emotion/tlc/deployments](http://www.sesameworkshop.org/initiatives/emotion/tlc/deployments)

Talk, Listen, Connect, a program developed by Sesame Workshop, provides support to military families through a series of publications, videos, and online resources (Sesame Workshop, 2008). The initiative seeks to use Sesame Street characters to open a dialogue between children and parents about the stresses of deployment (Sesame Workshop, 2008). Publications offer advice to caregivers on assisting children through a difficult time (Sesame Workshop, 2008). In addition to web-based resources, the initiative offers a facilitator guide so that sessions may be conducted in programs providing support to military families (Sesame Workshop, 2008). The sessions include activities that detail different kinds of emotions felt throughout the cycle of deployment, strategies for staying connected and tips for reducing stress (Sesame Workshop, 2008).

### **The SAFE Program**

Support and Family Education Program  
 Michelle D. Sherman, Ph.D.  
 Director, Family Mental Health Program  
 Oklahoma City VA Medical Center  
 921 NE 13th Street (116A)  
 Oklahoma City, OK 73104  
 (405) 270-5183  
[www.ouhsc.edu/safeprogram/](http://www.ouhsc.edu/safeprogram/)

The SAFE Program is a curriculum made up of 18 sessions that last for approximately 90 minutes (Sherman, 2008). Administered via the Vet Centers by trained mental health professionals,

this program is designed for caretakers of veterans living with PTSD and other mental illnesses (Sherman, 2008). Caretakers are taught about mental illness and the stigma that is frequently associated with such illnesses (Sherman, 2008). In addition, attendees are given a space to ask questions, air concerns, and be genuinely thanked for the work that they are doing. Participants are given access to resources, both through peers and through information about the VA (Sherman, 2008). Participants frequently reach out to one another independently of the monthly program (Sherman, 2003). The program is designed to be flexible to meet the needs of the participants (Sherman, 2008).

Other programs seek to assist veterans and their families as they transition away from military life. Programs offer such services as mental health services, therapeutic retreats and workshops, and connections with appropriate referrals. Services are provided by mental health professionals and spiritual leaders in a confidential and flexible manner, allowing veterans to seek therapy without feeling stigmatized. In most programs, the word “family” is broadly defined, allowing spouses, children, parents, siblings and partners to receive needed services.

### **Featured Resource: Tragedy Assistance Program for Survivors (TAPS)**

Tragedy Assistance Program for Survivors  
 National Headquarters  
 1777 F Street NW, Suite 600  
 Washington, DC 20006  
 (202)588-8277  
[www.taps.org](http://www.taps.org)

Tragedy Assistance Program for Survivors (TAPS) offers services to families and friends of fallen service members. This program is unique in that it reaches out to adult siblings of service members. The program offers seminars on grief, as well as camps for children and teens (Tragedy Assistance Program for Survivors, 2009). These camps allow grieving children to spend time with other children in similar situations (Tragedy Assistance

Program for Survivors, 2009). TAPS also offers a peer support network, in which survivors are matched with a peer mentor (Tragedy Assistance Program for Survivors, 2009). The peer support network offers assistance through phone calls, emails, and visits (Tragedy Assistance Program for Survivors, 2009). The program offers assistance in connecting to resources, bereavement counseling, and a 24-hour hotline for grief support (Tragedy Assistance Program for Survivors, 2009). TAPS has a magazine for survivors, which contains personal accounts, and advice on issues such as finances.

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For more information on this Initiative, please contact The National Center on Family Homelessness, 181 Wells Avenue, Newton Centre, MA; (617) 964-3834, [www.familyhomelessness.org](http://www.familyhomelessness.org)

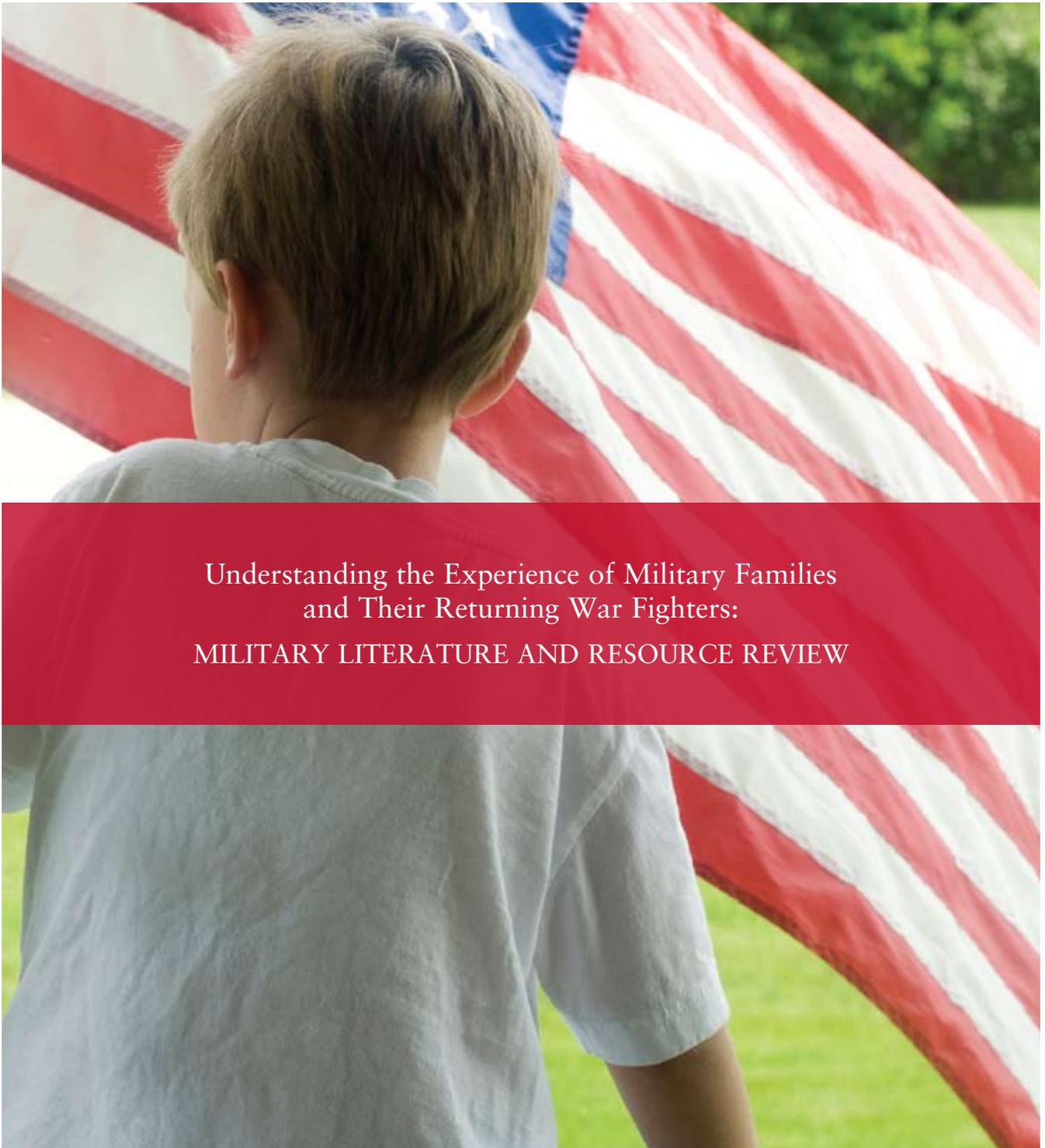


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Community Circles of Support  
for Veterans' Families

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MILITARY LITERATURE AND RESOURCE REVIEW

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