REVIEW

Posttraumatic Stress Disorder and Military-Connected Families: The Relevance of a Family-Centered Approach

Patricia Lester, M.D., Paula Rauch, M.D., Laura Loucks, Ph.D., Jo Sornborger, Psy.D., Bonnie Ohye, Ph.D., Niranjin S. Karnik, M.D., Ph.D.

Since the September 11, 2001, terrorist attacks, military service in the United States has been linked to a range of behavioral health and physical injuries in a significant number of the almost three million service members who have returned from wartime deployment. These injuries have occurred in the larger context of wartime military service, which is characterized by an array of stressors that have been associated with increased risk for behavioral health problems not only for service members but also for their family members. For the past 15 years, military-connected (defined as active-duty, reserve component, and veteran) family members have shared their own experiences of military service, including multiple deployments in the context of danger, high operational stress within their communities, and living with the physical and behavioral health injuries and ongoing care needs of a loved one. This article provides an overview of the evolving research on the specific impact of posttraumatic stress disorder (PTSD) and other war zone–related behavioral health problems among families in the context of contemporary warfare, as well as research on the impact of family adjustment on veteran recovery and care. We propose an empirically supported, family-centered framework to inform a continuum of prevention and care for veterans with PTSD and their families. Gaps in the current continuum of behavioral health services for veterans with PTSD are identified, as well as efforts underway to develop trauma-informed, family-centered screening, prevention, and treatment approaches. Future research recommendations are provided.

Focus 2017; 15:420–428; doi: 10.1176/appi.focus.20170027.

Since the September 11, 2001 (9/11), terrorist attacks, military service in the United States has been linked to a range of behavioral health and physical injuries in a significant number of the almost three million service members who have returned from wartime deployments (1–3). Unlike previous eras in U.S. military history, about half of post-9/11 service members have been married and about 41% have been parents during their active-duty service, with more becoming parents after service. Even before the possibility of service members' returning with behavioral health problems, they and their families have often weathered a range of challenges specific to wartime military service. The longest war in U.S. history has presented many unique challenges: multiple and sometimes prolonged deployments by an all-volunteer military; a higher proportion of deploying female service members as well as dual-career military couples; increased use of Reserve component personnel; higher survival rates among severely injured service members; and increased, cumulative wartime service exposures for military-connected family members (4, 5). Technological advances have facilitated more immediate and ongoing communication between family members and service members, resulting in greater opportunities for both positive and problematic connections at a distance. Current warfare techniques have also included increased use of Special Forces and new combat modalities such as drone warfare with poorly understood implications for both service members and their families (6). Both the context and the characteristics of contemporary military service provide a foundation for understanding the cumulative impact of wartime service not only on service members but on their families as a whole. Specifically, increasing evidence has shown that wartime military service has implications not only for the mental health of service members but also for the well-being of their spouses, children, and other family members, particularly those in dependent relationships or caregiving roles (7–12).

In the context of these wartime service experiences, returning service members are at increased risk for a range of behavioral health problems, including posttraumatic stress disorder (PTSD), depression, and substance use disorders, as well as traumatic brain injury (TBI). About one third of service members returning from combat deployment in Iraq and Afghanistan will have PTSD, TBI, or depression, which are often referred to as the signature injuries of the recent wars, and 5% will meet the criteria for all three conditions (1, 13, 14). More than 50,000 service members have had physical injuries severe enough to require medical evacuation, and a much greater number have sustained lesser injuries that nonetheless affect their postservice physical health. These injuries are often termed *visible wounds* because observers can directly see their impact. Both visible and invisible wounds may affect multiple generations of family members—parents of

those who serve, their intimate partners, siblings, and dependent children—through a number of pathways, including ongoing demands of treatment and rehabilitation care, possible exposures to invasive procedures, and sustained need for caregiving support. Describing research to guide effective approaches to supporting veterans with PTSD and their families, this article focuses on the impact of behavioral health injuries, specifically PTSD, on families, as well as the influence of family adjustment on veteran well-being and care. We provide recommendations for the inclusion of a family-centered framework for prevention and clinical approaches for veterans with PTSD.

PTSD AND COUPLES

Research from multiple eras of military conflict has indicated an association between a service member's exposure to traumatic events, the development of PTSD, the presence of comorbid behavioral health problems, and their partner's well-being (15). Veterans diagnosed with PTSD are also at increased risk for experiencing an array of relationship difficulties, including divorce and separation (16, 17). These findings are consistent with studies of veterans from previous wars that indicated that the negative effects of military-related PTSD on family adjustment extend to marital relationships, including increased risk for infidelity, intimacy problems, and impaired communication (18–20). Furthermore, a systematic review of domestic violence demonstrated a consistent finding that PTSD symptom severity is associated with increased risk for intimate partner violence among veteran populations (21). Studies have also shown that veterans with PTSD are especially likely to experience long-term difficulties in establishing and maintaining intimate relationships (19).

A recent meta-analysis has indicated that not only are veterans with PTSD at greater risk for marital dissatisfaction, but their partners are at risk for increased psychological distress (22). Notably, partner perceptions of veterans' PTSD symptoms and combat experiences have been associated with partner relationship and psychological distress (23). For example, in a study of 206 National Guard service members, when partners perceived that the veteran experienced a low level of combat exposure, higher veteran-reported re-experiencing symptoms were related to higher partner psychological distress and hyperarousal, and numbing and withdrawal symptoms were associated with lower partner-reported relationship satisfaction (24). In addition, discrepancies between spousal and veteran reports of PTSD symptoms have been related to increased spousal distress (25).

The link between PTSD and couple functioning is complex and dependent on many interactive processes (26). Studies examining reciprocal relations between PTSD symptomatology and couple distress have been inconsistent, with some finding that couple distress can exacerbate PTSD symptomatology (16, 27) and others identifying PTSD symptoms as a predictor of subsequent couple distress (28). Other studies have indicated that couples living with PTSD demonstrate greater hostility in the context of disagreements (29) and increased anger, anxiety, and physiological reactivity (30) than couples not living with PTSD. In this context, a focus of recent research has moved from examining the associations between PTSD and couple outcomes to elucidating the underlying processes that increase risk for couple distress, particularly those that might be linked to opportunities for intervention.

When examining processes that explain the complex associations between PTSD symptoms and couple distress, several findings are notable for guiding treatment. Established associations between emotional numbing and couple distress in both partners (17, 31) have been explained by less disclosure of deployment-related experiences (32, 33). In addition, veteran self-disclosure explained the association between having a supportive intimate partner and a lower level of PTSD symptoms (34). Recent studies examining the impact of PTSD symptoms on communication have indicated specific pathways leading to reduced satisfaction and support within the couple's relationship (35, 36). Military couples living with a service member's PTSD are more likely than military couples not living with PTSD to experience greater hostility and less bonding during conflicts, and both partners have been found to engage in these problematic communication behaviors (29, 37). To shield one another from distress, veterans and their partners often avoid talking about stressful situations, a pattern identified as *protective buffering*. Although intended to spare the partner from distress, this type of buffering has been linked to negative mental health outcomes, whereas greater disclosure within the couple has been associated with increased sense of support and satisfaction (38, 39).

PTSD AND CAREGIVING

An estimated one million individuals, many of them family members, have been unexpectedly placed into the role of caregiver for veterans returning from war (40). Family caregivers are typically regarded as extensions of a veteran's health care and often manage adherence to complex medical and therapeutic tasks. Although there are many similarities to caregiver roles in other medical contexts, post-9/11 veteran caregivers are significantly younger (40% are between the ages of 18 and 30), and many have dependent children (40, 41). These caregivers are usually spouses, parents, adult children, or other extended family members who have unexpectedly been drawn into long-term caregiving roles, with implications for their own well-being over time.

In the context of larger demands on caregivers, the particular impact of PTSD has been identified in research with veteran populations. Compared with partners of veterans seeking help for non-PTSD behavioral health problems, partners of veterans with PTSD reported higher caregiver burden (42). PTSD symptom severity has also been strongly associated with higher caregiver burden in veterans' partners (42–45). Emerging research has identified important factors affecting veterans' caregivers that may guide care. A recent study by Waddell and colleagues (46) found that in

a sample of female partners of male veterans, there was a strong sense of social disconnection and invisibility, particularly derived from actions of the government and health care providers. The authors noted that there is a need to educate government officials and health care providers about the needs of caregivers and the important role that they play in supporting their partners. An added conclusion to this study might also involve educating caregivers to seek more advanced treatments for their partner's PTSD if they are witnessing ongoing, unaddressed symptoms.

PTSD AND PARENTS

Given that almost half of service members are unmarried, parents frequently serve as a primary emotional and instrumental support for many service members, and many return to live with their parents after deployment (47). As noted earlier, parents frequently serve as caregivers for their injured veteran children and may be responsible for navigating complex treatment and rehabilitation needs, leading to growing concern about caregiver burden (40). Despite this, research on the experiences of parents of service members is limited, and all of the studies have had relatively small samples. The few studies conducted with these parents have not examined their psychological adjustment but have focused on issues of service member postdeployment stress symptoms and communication within the family system. Many parents report being hesitant to talk with their adult children about their military experiences, citing worries about triggering stress reactions (48). Other research has suggested that supportive and direct communication about military experiences is associated with greater emotional connectedness between military children and their parents (47). Furthermore, information about PTSD, such as diagnostic and psychoeducation, was identified as helpful for both service members and parents in generating communication opportunities about challenges (47).

PTSD AND CHILDREN

Just as for couples, military-connected families with children function as interdependent relational units, with the impact of visible or invisible injuries affecting multiple attachments within the family system (49, 50). The behavioral health of the injured service member and his or her coparent may influence both of them, each parent's adjustment influences their dependent children, and children's emotional and behavioral adjustment may affect parental and family adjustment. Notably, disruptions in important family relationships have been found to contribute to increased PTSD symptomatology among returning service members. Leen-Feldner et al.'s (51) comprehensive review of the psychological and biological correlates of parental PTSD, although not specific to military parents, suggested increased risk for psychological problems among the children of parents with PTSD, including internalizing and externalizing problems as well as alteration in the functioning of the hypothalamic-pituitary-adrenal axis. They posited that parenting behaviors, genetics, and epigenetics may each play a role in the impact on child functioning.

Compared with the number of studies examining the relationship of military PTSD to spousal outcomes and family interactions, less is known about associations of parental PTSD with child outcomes. PTSD symptoms in veterans of prior military conflicts, however, have accounted for the impact of combat exposure on family violence and aggression, lower parenting satisfaction, and more child behavior problems (19, 52–55). Specifically, an association between parental war-related PTSD avoidance symptoms and disrupted parenting and family dysfunction has been identified (27, 56).

A growing literature on parenting in recent-era military-connected families has helped to illuminate the impact of wartime service, and specifically PTSD, on parenting, parent-child relationships, and child adjustment. Creech et al. (57) found that the impact of military deployment and reintegration on children and parenting highlighted that parental wartime deployment is associated with higher rates of child health care visits for psychological problems and that parental PTSD and depression symptoms may be associated with increased child symptoms and parenting challenges that extend long after reintegration. Both self-report and observational studies have indicated that increased PTSD symptoms in parents are associated with child emotional and behavioral symptoms (8, 58), as well as with reduced adaptive parenting behaviors such as positive engagement, parent-child connectedness, and effective monitoring and discipline (59, 60).

Gewirtz and Davis (50) provided a research-based model for military family stress that indicated that both mothers' and fathers' PTSD symptoms are associated with a child adjustment variable derived from parent, child, and teacher reports. This study indicated that mothers' but not fathers' PTSD symptoms were associated with parent-child attachment and parenting behaviors and that these parenting behaviors were then also associated with child adjustment. Snyder et al. (60) investigated school-aged child internalizing and externalizing symptoms in association with paternal service member PTSD symptoms. They noted reciprocal cascades among fathers' and mothers' PTSD symptoms and both types of child symptoms, with child internalizing symptoms associated with parental PTSD and positive parenting engagement and externalizing behaviors linked with coercive parenting.

In an observational study that provided insights into the relationship of PTSD and family processes that may influence child outcomes, Brockman et al. (61) explored the relationships among military service members' deployment trauma, PTSD symptoms, and experiential avoidance on family engagement during reintegration. Avoidance in the postdeployment parent was associated with less positive engagement, more withdrawal, and more distress avoidance, suggesting that addressing both traumatic stress symptoms and avoidant parenting behaviors could enhance

parent-child interactions. Sherman and colleagues (62) also found that parenting challenges clustered around the PTSD symptoms, for example, not feeling able to attend a child's activities because of avoidance, reactivity, and hyperarousal, leading to angry outbursts at home or hypervigilance, and negative cognition and mood, including feeling shame about their level of functioning. In addition, veterans identified painful negative emotional reactions in their children such as fear, confusion, hurt, and behavioral withdrawal. They also identified the ways in which their child tried to protect or care for them and provided emotional or practical support.

Assessing the impact of a parent's invisible injuries on parenting and child emotional health is complicated by the low percentage of veterans with PTSD who seek care; only 23%−40% of those who screened positive for a mental health disorder sought treatment (63). Underscoring the public health relevance of parental PTSD for veterans' children, Janke-Stedronsky et al. (64) examined more than 36,000 post-9/11 veterans in a Veterans Health Administration (VHA) database review and found that veterans with dependent children were 40% more likely to have a diagnosis of PTSD than a demographically matched peer group without children. This association was even stronger for men than for women (64). Although parenting concerns are identified as a stressor in the context of PTSD (65, 66), it is important to note that the parenting role may also serve as a powerful motivator for seeking care (67).

FAMILY WELL-BEING ALSO INFLUENCES VETERAN BEHAVIORAL HEALTH AND RECOVERY TRAJECTORIES

Just as studies of veterans with PTSD have indicated increased risk for family members' adjustment, the well-being of any individual family member (spouse, sibling, parent, child) and the relational functioning within the family (marital, parent-child, etc.) may all have an influence on veterans with PTSD and their recovery. For example, research has indicated that disruptions in family adjustment may negatively influence veteran well-being, and positive family adjustment may buffer the impact of PTSD and enhance treatment engagement (27, 68, 69). Given the research indicating a bidirectional reciprocity between family member and veteran well-being, we propose a framework for the routine inclusion of family members in the prevention, engagement, and treatment of PTSD in veteran populations.

FAMILY-CENTERED INTERVENTION RESEARCH IN MILITARY AND VETERAN SYSTEMS OF CARE

Considerations of cumulative longitudinal and contextual exposures to adversity in family members of veterans with PTSD are relevant to clinical practice and suggest an opportunity to enhance traditional individual treatment modalities and improve early identification and reduction of risk in family members. Both public health prevention approaches and novel behavioral health treatment programs for military and veteran populations with PTSD have increasingly begun to incorporate family-centered practices, including the development of intervention and treatment approaches that address the family as a whole, target parenting or couples functioning, or include family members as supports in PTSD couples-based treatments.

Foundational to treatment efforts to target couple and psychological distress, assessment of PTSD symptoms and trauma experiences via both veteran and spousal report can help to clarify families who are at risk for greater distress and form the foundation for personalized psychoeducation to partners and other family members. The inclusion of families in evaluation and intervention pathways provides a foundation for greater understanding and effective communication during the course of PTSD treatment. Although individual treatments for PTSD have the potential to reduce individual distress related to traumatic events, interventions designed to also promote adaptive communication processes and enhance supportive interactions, which are often exacerbated by PTSD, are warranted. Clinical decision making regarding the treatment or sequence of treatments requires careful assessment of both individual and family-level functioning (70), veteran preferences, and readiness to engage.

Early engagement of the family system in veterans' PTSD care leverages research indicating that improvements in one individual or family unit have potential to improve functioning for other units or open the door for additional care, as has been demonstrated by several emerging comprehensive PTSD treatment programs providing care that engages and evaluates not only the veteran but also individual family members, the entire family unit, and the couple (71). When a comprehensive program is unavailable, there would ideally be close coordination between treatment providers and acknowledgment of the interaction between PTSD symptoms and family-level distress in all treatments.

The review of literature examining associations between PTSD and family functioning highlights the importance of treating the veteran's PTSD in the context of the family relationships. A range of empirically supported family-centered interventions has been developed to reduce the risk for posttraumatic stress symptoms among the family, to treat PTSD in the veteran, and to augment individual treatment for PTSD by enhancing family well-being and support. Many of those developed for couples focus on intervention skills that improve effective communication, increase self-disclosure, promote understanding, and enhance intimacy and support. Depending on the individuals' and couples' needs as well as their readiness to engage, treatment options may include a combination of psychoeducation, individual trauma-focused treatment (e.g., prolonged exposure, cognitive processing therapy), couple skill building for military families (e.g., Families OverComing Under Stress; 72), and couples therapies (e.g., integrative behavioral couples therapy [73]; emotionally focused therapy [74]) that have been adapted to military couples (75, 76). Sherman and colleagues (77) reviewed PTSD symptom clusters and their impact on couple functioning and provided a useful

and comprehensive overview of treatment elements designed to address relationship challenges with each cluster.

For couples interested in targeting the veteran's PTSD symptoms as well as the impact of PTSD on the couple, cognitive-behavioral conjoint therapy (CBCT) for PTSD (78) and structured approach therapy (SAT) for PTSD (79) are evidence-based treatments that demonstrate promise in reducing PTSD symptoms and couple distress concurrently (80, 81). Both CBCT and SAT incorporate evidence-based treatment elements designed to target PTSD and couple distress consistent with those identified in this review. Although CBCT incorporates additional components designed to address maladaptive couple and trauma cognitions, SAT incorporates stress inoculation strategies designed to target hyperarousal and mood dysregulation (e.g., mindfulness, distress tolerance).

Family-centered interventions that address parenting and family adjustment as a whole have emerged to address the needs of veterans with PTSD who have children. Increased awareness of the needs of military and veteran families has led to the development of a number of family-centered interventions across a continuum of behavioral health prevention and care (e.g., MacDermid Wadsworth et al. [49], Cigrang et al. [82], DeVoe and Paris [83], Gewirtz et al. [84]). The most widely implemented preventive intervention for military and veteran populations is Families OverComing Under Stress (FOCUS; 58). This intervention includes a Web-based family assessment and personalized feedback, family psychoeducation and developmentally informed parent guidance, creation of narrative timelines to enhance understanding and communication, and development of individual and family-level cognitive-behavioral skills (emotional regulation, communication, goal setting, problem solving, and managing trauma and loss reminders). FOCUS has shown effectiveness with active-duty families with children, including increased positive coping, prosocial behaviors, and improved family functioning, as well as improved parent and child behavioral health outcomes that are sustained over longitudinal follow-up (85, 86).

After Deployment, Adaptive Parenting Tools (ADAPT) is a multisession parenting intervention adapted from the evidence-based parent management training model for postdeployment service members and their spouses that assists with reintegration parenting challenges and has been shown to improve parenting self-efficacy and psychological health outcomes (87). Parent-child interaction therapy is a manualized evidence-based intervention designed to enhance parenting skills and parent-child relationships for parents of children aged two to eight years that focuses on teaching warm positive parenting engagement and consistent limit-setting skills. Pemberton et al. (88) asserted that the adoption of this intervention in the VHA would be feasible and beneficial.

RESEARCH RECOMMENDATIONS

The recent surge in the military family literature demonstrates a commitment by researchers, clinicians, national and philanthropic funding agencies, and the Department of Defense to improve military and veteran family outcomes, particularly in the context of PTSD. However, longitudinal data on the impact of wartime military service and related injuries on military and veteran families remain limited. For families affected by war-related injuries such as PTSD, little is known about how best to develop and sustain marital relationships and parent-child relationships, support child development, and maximize quality of life for the injured service member over time. Longitudinal research examining how specific family-level risk and protective processes may mediate PTSD outcomes over time is needed. For example, research clarifying the influence of coparenting interactions on the management of posttraumatic reactivity and traumatic reminders on parent-child relationships and child well-being could help to illuminate the process of potential spillover within military-connected family systems (89). Ultimately, a better understanding of individual and family differences will enable clinicians and other professionals who work with military and veteran families to provide timely, high-quality evidence-based assessment, intervention, and recommendations that are tailored to each family's unique needs. Other key areas of future research include an examination of what mediates relationships among cumulative traumatic exposures, PTSD, and other behavioral health problems and family disruptions, including caregiver burden.

An increasing number of promising preventive and treatment intervention programs for military-connected families already exist, including a growing body of research on the lessons learned from advances in family-centered public health approaches to program implementation (5, 90). Future research would benefit from the identification of specific targets for intervention based on individual strengths and weaknesses to provide a more tailored approach to care for all military families. Although many promising family-centered interventions have been adapted from civilian evidence-based interventions, most published reports are either descriptive or present feasibility or nonexperimental outcome data for military and veteran populations. Both randomized controlled trials and rigorous attention to implementation research design will help to advance the field toward specific interventions that are effective in promoting family well-being as well as guide rigorous dissemination processes. Research needs to include a focus on systems-level innovations, such as community-level and VHA settings, that are required to ensure appropriate identification of, engagement with, access to, and support of military and veteran families with high-quality family-centered care.

The care of veterans and their families would benefit from research that identifies and evaluates effective strategies for family engagement across service settings. There is extensive literature on family-centered and community-based prevention and intervention efforts and what it takes to engage families across systems of care that has identified family-centered approaches as more likely to be positively received (compared with individual treatments) among culturally diverse families (91, 92).

CONCLUSIONS

Challenges remain with transforming military and veteran care systems to reflect this growing body of research supporting the relevance of family-centered approaches to veterans with PTSD, including administrative, policy, and financial barriers. Furthermore, the development of family-centered systems requires both logistic and cultural changes in adult mental health treatment settings, such as creating environments that are welcoming to families, including children of all ages, and training adult mental health providers to work effectively with families. Treatment settings need to include attention to protecting family members, particularly children, from avoidable exposure to distressing experiences, such as witnessing patient distress, as well as providing a safe and comfortable place for families to rest and recover (93).

High-quality clinical care of veterans and their family members cannot be achieved by the military or veteran health systems alone. Civilian health care systems must step up to serve those who have served the nation. Multiple academic medical center–affiliated programs and additional freestanding and linked clinics have recently been established to address the mental health needs of veterans and their family members. The provision of empirically supported treatments to parents and children in specialized clinics and expansion of community providers' skill sets is also needed. Integrated models for veteran behavioral health outpatient and intensive treatment programming that include attention to individual family treatment as well as family-centered interventions have also emerged through philanthropic support. Other hybrid models have been undertaken to address these challenges, incorporating families into veteran treatment through colocated community mental health with VHA clinic settings.

Despite these innovations, broad system-level reforms will likely be required if military and veteran families are to have adequate access to and coverage for family-centered services (49). Many challenges remain to engaging veterans and their families that have resulted from the fragmentation of veteran-serving and civilian health care systems, as well as from administrative and regulatory barriers to serving families. Current systems of care often require veterans and their families to navigate a series of complex steps to gather information and engage multiple service systems and providers. These potential barriers can be particularly challenging to navigate in the context of behavioral, emotional, and cognitive symptoms associated with PTSD, TBI, and associated mental health problems. Stigma and low care-seeking also continue to be significant barriers to the effective provision of services to military and veteran families (94). Limited access to providing family-centered care in VHA settings suggests the need for high-quality training programs designed to prepare civilian clinicians for military and veteran culture, behavioral health problems affecting veterans and their families, and empirically supported practices known to address these problems.

The nature of modern warfare places additional and new burdens on military-connected families. The prolonged nature of recent conflicts requiring multiple deployments and facing new forms of injury all add to the burdens faced by families. Society has been slow to recognize the impact of military service on parents, partners, spouses, and children of veterans, and this has come at a significant cost. Only by acknowledging these needs and expanding access to evidence-based modalities of care can this nation fulfill its promise to veterans and their families.

AUTHOR AND ARTICLE INFORMATION

Dr. Lester is with the Nathanson Family Resilience Center, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles (UCLA). Dr. Rauch is with the Department of Psychiatry, Massachusetts General Hospital, Boston. Dr. Loucks is with the Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta. Dr. Sornborger is with Operation Mend, UCLA Health. Dr. Ohye is with the Massachusetts General Hospital Program, Harvard Medical School, Boston. Dr. Karnik is with the Department of Psychiatry, Rush University Medical Center, Chicago. Send correspondence to Dr. Lester (e-mail: plester@mednet.ucla.edu).

The authors acknowledge, with gratitude, critical support from Wounded Warrior Project, which has supported the four partner institutions and served as a partner in the Warrior Care Network, which is dedicated to filling gaps in mental health care for the invisible wounds of war in service members, veterans, and military families. Dr. Lester acknowledges general support for the UCLA Nathanson Family Resilience Center's military and veteran family programs from Welcome Back Veterans, an initiative of the Robert R. McCormick Foundation and Major League Baseball, the Frederick R. Weisman Philanthropic Trust, and the Georges and Germaine Fusenot Charity Foundation. Dr. Karnik acknowledges general program support for the Road Home Program: Center for Veterans & Their Families from core grants from the Wounded Warrior Project and Welcome Back Veterans, an initiative of the Robert R. McCormick Foundation and Major League Baseball. The Children & Families Program at Road Home Program is supported by a grant from the Michael Reese Health Trust and support from the Crown Family.

Drs. Lester, Loucks, Sornborger, Ohye, and Karnik report no financial relationships with commercial interests. Dr. Rauch reports receiving book royalties.

REFERENCES

1. Fulton JJ, Calhoun PS, Wagner HR, et al: The prevalence of posttraumatic stress disorder in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans: a meta-analysis. J Anxiety Disord 2015; 31:98–107
2. Milliken CS, Auchterlonie JL, Hoge CW: Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. JAMA 2007; 298: 2141–2148
3. Thomas JL, Wilk JE, Riviere LA, et al: Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. Arch Gen Psychiatry 2010; 67:614–623
4. Committee on the Initial Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families: Returning Home From Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington, DC, National Academies Press, 2010
5. Institute of Medicine: Preventing Psychological Disorders in Service Members and Their Families: An Assessment of Programs. Washington, DC, National Academies Press, 2014
6. Lester P, Flake E: How wartime military service affects children and families. Future Child 2013; 23:121–141

7. Andres M, Moelker R: There and back again: how parental experiences affect children's adjustments in the course of military deployments. Armed Forces Soc 2011; 37:418–447
8. Lester P, Peterson K, Reeves J, et al: The long war and parental combat deployment: effects on military children and at-home spouses. J Am Acad Child Adolesc Psychiatry 2010; 49:310–320
9. Mansfield AJ, Kaufman JS, Marshall SW, et al: Deployment and the use of mental health services among U.S. Army wives. N Engl J Med 2010; 362:101–109
10. Chandra A, Lara-Cinisomo S, Jaycox LH, et al: Children on the homefront: the experience of children from military families. Pediatrics 2010; 125:16–25
11. Paley B, Lester P, Mogil C: Family systems and ecological perspectives on the impact of deployment on military families. Clin Child Fam Psychol Rev 2013; 16:245–265
12. Reed SC, Bell JF, Edwards TC: Adolescent well-being in Washington state military families. Am J Public Health 2011; 101:1676–1682
13. Tanielian TL, Jaycox L: Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery. Santa Monica, CA, RAND Center for Military Health Policy Research, 2008.
14. Ramchand R, Schell TL, Karney BR, et al: Disparate prevalence estimates of PTSD among service members who served in Iraq and Afghanistan: possible explanations. J Trauma Stress 2010; 23:59–68
15. Institute of Medicine: Returning Home From Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington, DC, National Academies Press, 2013
16. Monson CM, Taft CT, Fredman SJ: Military-related PTSD and intimate relationships: from description to theory-driven research and intervention development. Clin Psychol Rev 2009; 29:707–714
17. Riggs DS, Byrne CA, Weathers FW, et al: The quality of the intimate relationships of male Vietnam veterans: problems associated with posttraumatic stress disorder. J Trauma Stress 1998; 11:87–101
18. Cook JM, Riggs DS, Thompson R, et al: Posttraumatic stress disorder and current relationship functioning among World War II ex-prisoners of war. J Fam Psychol 2004; 18:36–45
19. Jordan BK, Marmar CR, Fairbank JA, et al: Problems in families of male Vietnam veterans with posttraumatic stress disorder. J Consult Clin Psychol 1992; 60:916–926
20. Ruscio AM, Weathers FW, King LA, et al: Male war-zone veterans' perceived relationships with their children: the importance of emotional numbing. J Trauma Stress 2002; 15:351–357
21. Marshall AD, Panuzio J, Taft CT: Intimate partner violence among military veterans and active duty servicemen. Clin Psychol Rev 2005; 25:862–876
22. Lambert JE, Engh R, Hasbun A, et al: Impact of posttraumatic stress disorder on the relationship quality and psychological distress of intimate partners: a meta-analytic review. J Fam Psychol 2012; 26:729–737
23. Campbell SB, Renshaw KD: Military couples and posttraumatic stress: Interpersonally based behaviors and cognitions as mechanisms of individual and couple distress; in War and Family Life. Edited by MacDermid Wadsworth S, Riggs DS. New York, Springer International Publishing, 2016
24. Renshaw KD, Campbell SB: Combat veterans' symptoms of PTSD and partners' distress: the role of partners' perceptions of veterans' deployment experiences. J Fam Psychol 2011; 25:953–962
25. Renshaw KD, Rodrigues CS, Jones DH: Psychological symptoms and marital satisfaction in spouses of Operation Iraqi Freedom veterans: relationships with spouses' perceptions of veterans' experiences and symptoms. J Fam Psychol 2008; 22:586–594
26. Karney BR, Crown JS: Families Under Stress: An Assessment of Data, Theory, and Research on Marriage and Divorce in the Military. Santa Monica, CA, RAND, 2007
27. Evans L, Cowlishaw S, Hopwood M: Family functioning predicts outcomes for veterans in treatment for chronic posttraumatic stress disorder. J Fam Psychol 2009; 23:531–539
28. Meis LA, Erbes CR, Kramer MD, et al: Using reinforcement sensitivity to understand longitudinal links between PTSD and relationship adjustment. J Fam Psychol 2017; 31:71–81
29. Knobloch-Fedders LM, Caska-Wallace C, Smith TW, et al: Battling on the home front: posttraumatic stress disorder and conflict behavior among military couples. Behav Ther 2017; 48: 247–261
30. Caska CM, Smith TW, Renshaw KD, et al: Posttraumatic stress disorder and responses to couple conflict: implications for cardiovascular risk. Health Psychol 2014; 33:1273–1280
31. Taft CT, Schumm JA, Panuzio J, et al: An examination of family adjustment among Operation Desert Storm veterans. J Consult Clin Psychol 2008; 76:648–656
32. Campbell SB, Renshaw KD: Distress in spouses of Vietnam veterans: associations with communication about deployment experiences. J Fam Psychol 2012; 26:18–25
33. Solomon Z, Dekel R, Zerach G: The relationships between posttraumatic stress symptom clusters and marital intimacy among war veterans. J Fam Psychol 2008; 22:659–666
34. Balderrama-Durbin C, Snyder DK, Cigrang J, et al: Combat disclosure in intimate relationships: mediating the impact of partner support on posttraumatic stress. J Fam Psychol 2013; 27:560–568
35. Knobloch LK, Theiss JA: Experiences of US military couples during the post-deployment transition: Applying the relational turbulence model. J Soc Pers Relat 2012; 29:423–450
36. Allen ES, Rhoades GK, Stanley SM, et al: Hitting home: relationships between recent deployment, posttraumatic stress symptoms, and marital functioning for Army couples. J Fam Psychol 2010; 24: 280–288
37. Miller MW, Wolf EJ, Reardon AF, et al: PTSD and conflict behavior between veterans and their intimate partners. J Anxiety Disord 2013; 27:240–251
38. Baptist JA, Amanor-Boadu Y, Garrett K, et al: Military marriages: the aftermath of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) deployments. Contemp Fam Ther 2011; 33:199–214
39. Joseph AL, Afifi TD: Military wives' stressful disclosures to their deployed husbands: the role of protective buffering. J Appl Commun Res 2010; 38:412–434
40. Ramchand R, Tanielian T, Fisher MP, et al: Hidden Heroes: America's Military Caregivers. Santa Monica, CA, RAND, 2014
41. Tanielian T, Ramchand R, Fisher MP, et al: Military Caregivers: Cornerstones of Support for Our Nation's Wounded, Ill, and Injured Veterans. Santa Monica, CA, RAND, 2013
42. Calhoun PS, Beckham JC, Bosworth HB: Caregiver burden and psychological distress in partners of veterans with chronic posttraumatic stress disorder. J Trauma Stress 2002; 15:205–212
43. Beckham JC, Lytle BL, Feldman ME: Caregiver burden in partners of Vietnam War veterans with posttraumatic stress disorder. J Consult Clin Psychol 1996; 64:1068–1072
44. Klarić M, Francisković T, Pernar M, et al: Caregiver burden and burnout in partners of war veterans with post-traumatic stress disorder. Coll Antropol 2010; 34(suppl 1):15–21
45. Manguno-Mire G, Sautter F, Lyons J, et al: Psychological distress and burden among female partners of combat veterans with PTSD. J Nerv Ment Dis 2007; 195:144–151
46. Waddell E, Pulvirenti M, Lawn S: The lived experience of caring for an Australian military veteran with posttraumatic stress disorder. Qual Health Res 2016; 26:1603–1613
47. Worthen M, Moos R, Ahern J: Iraq and Afghanistan veterans' experiences living with their parents after separation from the military. Contemp Fam Ther 2012; 34:362–375
48. Crow JR, Myers DR, Ellor JW, et al: Military deployment of an adult child: ambiguous loss and boundary ambiguity reflected in the experiences of parents of service members. Marriage Fam Rev 2016; 52:481–509

49. MacDermid-Wadsworth SM, Lester P, Marini C, et al: Approaching family-focused systems of care for military and veteran families. Military Behavioral Health. 2013; 1:31-40
50. Gewirtz A, Davis KL: Parenting practices and emotion regulation in National Guard and Reserve families: Early findings from the After Deployment Adaptive Parenting Tools/ADAPT study; in Military Deployment and Its Consequences for Families. Edited by MacDermid Wadsworth S, Riggs DS. New York, Springer, 2014
51. Leen-Feldner EW, Feldner MT, Knapp A, et al: Offspring psychological and biological correlates of parental posttraumatic stress: review of the literature and research agenda. Clin Psychol Rev 2013; 33:1106–1133
52. Byrne CA, Riggs DS: The cycle of trauma: relationship aggression in male Vietnam veterans with symptoms of posttraumatic stress disorder. Violence Vict1996; 11:213-25
53. Caselli LT, Motta RW: The effect of PTSD and combat level on Vietnam veterans' perceptions of child behavior and marital adjustment. J Clin Psychol 1995; 51:4–12
54. Harkness L, Giller EL, Groton CT: Families of Vietnam veterans with post-traumatic stress disorder: Child social competence and behavior; in The Legacy of Vietnam Veterans and Their Families: Survivors of War: Catalysts for Change. Edited by Rhoades DK, Leaveck MK, Hudson JC. Washington, DC, U.S. Government Printing Office, 1995
55. Samper RE, Taft CT, King DW, et al: Posttraumatic stress disorder symptoms and parenting satisfaction among a national sample of male Vietnam veterans. J Trauma Stress 2004; 17:311–315
56. Ray SL, Vanstone M: The impact of PTSD on veterans' family relationships: an interpretative phenomenological inquiry. Int J Nurs Stud 2009; 46:838–847
57. Creech SK, Hadley W, Borsari B: The impact of military deployment and reintegration on children and parenting: a systematic review. Prof Psychol Res Pr 2014; 45:452–464
58. Lester P, Klosinski L, Saltzman W, et al: Families Overcoming Under Stress (FOCUS): a family-centered preventive intervention for families facing trauma, stress and adversity: implementation with military families; in Family-Based Prevention Programs for Children and Adolescents. Edited by Van Ryzin MJ, Kumper KL, Fosco GM, et al. New York, Psychology Press, 2015
59. Gewirtz AH, Polusny MA, DeGarmo DS, et al: Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq: associations with parenting behaviors and couple adjustment. J Consult Clin Psychol 2010; 78:599–610
60. Snyder J, Gewirtz A, Schrepferman L, et al: Parent-child relationship quality and family transmission of parent posttraumatic stress disorder symptoms and child externalizing and internalizing symptoms following fathers' exposure to combat trauma. Dev Psychopathol 2016; 28(4, Pt. 1):947–969
61. Brockman C, Snyder J, Gewirtz A, et al: Relationship of service members' deployment trauma, PTSD symptoms, and experiential avoidance to postdeployment family reengagement. J Fam Psychol 2016; 30:52–62
62. Sherman MD, Gress Smith JL, Straits-Troster K, et al: Veterans' perceptions of the impact of PTSD on their parenting and children. Psychol Serv 2016; 13:401–410
63. Sheppard SC, Malatras JW, Israel AC: The impact of deployment on U.S. military families. Am Psychol 2010; 65:599–609
64. Janke-Stedronsky SR, Greenawalt DS, Stock EM, et al: Association of parental status and diagnosis of posttraumatic stress disorder among veterans of Operations Iraqi and Enduring Freedom. Psychol Trauma 2016; 8:72–79
65. Sayers SL, Farrow VA, Ross J, et al: Family problems among recently returned military veterans referred for a mental health evaluation. J Clin Psychiatry 2009; 70:163–170
66. Kimerling R, Iverson KM, Dichter ME, et al: Prevalence of intimate partner violence among women veterans who utilize Veterans Health Administration primary care. J Gen Intern Med 2016; 31:888–894
67. Khaylis A, Polusny MA, Erbes CR, et al: Posttraumatic stress, family adjustment, and treatment preferences among National Guard soldiers deployed to OEF/OIF. Mil Med 2011; 176:126–131
68. Evans L, Cowlishaw S, Forbes D, et al: Longitudinal analyses of family functioning in veterans and their partners across treatment. J Consult Clin Psychol 2010; 78:611–622
69. Meis LA, Barry RA, Kehle SM, et al: Relationship adjustment, PTSD symptoms, and treatment utilization among coupled National Guard soldiers deployed to Iraq. J Fam Psychol 2010; 24: 560–567
70. Sayers SL: Family reintegration difficulties and couples therapy for military veterans and their spouses. Cognit Behav Pract 2011; 18: 108–119
71. Ohye BY, Brendel RW, Fredman SJ, et al: Three-generation model: a family systems framework for the assessment and treatment of veterans with posttraumatic stress disorder and related conditions. Prof Psychol Res Pr 2015; 46:97–106
72. Lester P, Mogil C, Saltzman W, et al: Families overcoming under stress: implementing family-centered prevention for military families facing wartime deployments and combat operational stress. Mil Med 2011; 176:19–25
73. Christensen JA: Integrative Couple Therapy: Promoting Acceptance and Change. New York, NY, Norton, 1996
74. Johnson S: The Practice of Emotionally Focused Couple Therapy, 2nd ed. New York, NY, Brunner-Routledge, 2004
75. Blow AJ, Curtis AF, Wittenborn AK, et al: Relationship problems and military related PTSD: the case for using emotionally focused therapy for couples. Contemp Fam Ther 2015; 37: 261–270
76. Erbes CR, Polusny MA, Macdermid S, et al: Couple therapy with combat veterans and their partners. J Clin Psychol 2008; 64: 972–983
77. Sherman MD, Zanotti DK, Jones DE: Key elements in couples therapy with veterans with combat-related posttraumatic stress disorder. Prof Psychol Res Pr 2005; 36:626–633
78. Monson CM, Fredman SJ: Cognitive-Behavioral Conjoint Therapy for Posttraumatic Stress Disorder: Therapist's Manual. New York, NY, Guilford Press, 2012
79. Sautter FJ, Armelie AP, Glynn SM, et al: The development of a couple-based treatment for PTSD in returning veterans. Prof Psychol Res Pr 2011; 42:63–69
80. Sautter FJ, Glynn SM, Arseneau JR, et al: Structured approach therapy for PTSD in returning veterans and their partners: pilot findings. Psychol Trauma 2014; 6(suppl. 1):S66–S72
81. Schumm JA, Fredman SJ, Monson CM, et al: Cognitive-behavioral conjoint therapy for PTSD: initial findings for Operations Enduring and Iraqi Freedom male combat veterans and their partners. Am J Fam Ther 2013; 41:277–287
82. Cigrang JA, Cordova JV, Gray TD, et al: The marriage checkup: adapting and implementing a brief relationship intervention for military couples. Cognit Behav Pract 2016; 23:561–570
83. DeVoe ER, Paris R: Engaging military fathers in a reflective parenting program: Lessons from Strong Families Strong Forces. Zero to Three 2015; 35:43–47
84. Gewirtz AH, Pinna KL, Hanson SK, et al: Promoting parenting to support reintegrating military families: after deployment, adaptive parenting tools. Psychol Serv 2014; 11:31–40
85. Lester P, Saltzman WR, Woodward K, et al: Evaluation of a family-centered prevention intervention for military children and families facing wartime deployments. Am J Public Health 2012; 102(suppl 1):S48–S54
86. Lester P, Liang LJ, Milburn N, et al: Evaluation of a family-centered preventive intervention for military families: parent and child longitudinal outcomes. J Am Acad Child Adolesc Psychiatry. 2016; 55(1):14-24

87. Pinna KL, Hanson S, Zhang N, et al: Fostering resilience in National Guard and Reserve families: a contextual adaptation of an evidence-based parenting program. Am J Orthopsychiatry 2017; 87:185–193
88. Pemberton JR, Borrego J, Sherman S: Differential attention as a mechanism of change in parent–child interaction therapy: support from time-series analysis. J Psychopathol Behav Assess 2013; 35:35–44
89. Erel O, Burman B: Interrelatedness of marital relations and parent-child relations: a meta-analytic review. Psychol Bull 1995; 118:108–132
90. Beardslee WR, Klosinski LE, Saltzman W, et al: Dissemination of family-centered prevention for military and veteran families: adaptations and adoption within community and military systems of care. Clin Child Fam Psychol Rev 2013; 16:394–409
91. Kumpfer KL, Alvarado R, Smith P, et al: Cultural sensitivity and adaptation in family-based prevention interventions. Prev Sci 2002; 3:241–246
92. National Research Council, Institute of Medicine: Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Washington, DC, National Academies Press, 2009
93. Cozza SJ, Guimond JM: Working with combat-injured families through the recovery trajectory, in Risk and Resilience in U.S. Military Families. Edited by MacDermid Wadsworth S, Riggs D. New York, NY, Springer, 2011
94. Burnam MA, Meredith LS, Tanielian T, et al: Mental health care for Iraq and Afghanistan war veterans. Health Aff 2009; 28: 771–782

Appreciation to Reviewers

As *Focus* concludes another successful year, we thank and acknowledge with appreciation the following individuals who reviewed papers submitted for publication consideration. The four themes covered in the 2017 volume were "Neurocognitive Disorders in Geriatric Psychiatry," "Anxiety Across the Lifespan," "Advances in Collaborative Care," and "Treating the Invisible Wounds of War: Focus on PTSD and TBI."

Robert Boland M.D.
Peter F. Buckley, M.D.
Robert O. Cotes, M.D.
Arden Dingle M.D.
Benjamin G. Druss, M.D., M.P.H.
Boadie W. Dunlop, M.D.
Edna B. Foa, Ph.D.
Ebrahim Haroon, M.D.
Donald Hilty, M.D.
Seth Himelhoch, M.D.
David J. Katzelnick, M.D.
Susan Kornstein M.D.
Barry Lebowitz Ph.D.
Ira M. Lesser, M.D.
Annette M. Matthews, M.D.
William M. McDonald, M.D.
David Mischoulon, M.D., Ph.D.
Philip R. Muskin, M.D.
Meera Narasimhan, M.D.
Patrick T. O'Neill, M.D.
Henry J. Orff, Ph.D.
Jeffrey Jay Rakofsky, M.D.
Lori Raney, M.D.
Thomas Allen Roesler, M.D.
Barry D. Sarvet, M.D.
Andrew J. Saxon, M.D.
Steven S. Sharfstein, M.D.
Jerome Henry Taylor, M.D.
Ole J. Thienhaus, M.D.
Robert J. Ursano, M.D.
Marcia L. Verduin, M.D.
Mark D. Williams, M.D.
Gary H. Wynn, M.D.