Chapter 18
Medical Family Therapy in Military and Veteran Health Systems

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The military is the largest employer in the United States, with more than 3.5 million personnel currently serving in the Department of Defense (DoD) active duty, coast guard, and reserve (DoD, 2014a, b). As of 2017, there were 1,298,017 DoD active duty Service members, of which 1,055,972 were enlisted, 229,869 were officers, and 12,176 were cadets-midshipmen (DoD, 2017). In the reserve component, there are a total of 813,037 reservists: 131,928 officers and 681,109 enlisted (DoD, 2017). Alongside the active duty population, it is estimated that there are currently over 22 million veterans in the United States (U.S. Census Bureau, 2012). Couple these figures with the number of partners and dependents/children of current or former Service members, and the opportunity for practitioners in medical family therapy (MedFT) to extend relational care to military and veteran populations grows exponentially. To give some perspective, approximately 54% of all military personnel are married, with higher rates for men (58%) than women (45%), and just over 11% of all active duty marriages as "dual marriages" (DoD, 2015). About 45% of those in a reserve component are married, with higher percentages in the Air National Guard (56%) and Air Force Reserve (55%) than as compared to the Marine Corps Reserve (27%) (U.S. Census Bureau, 2015). Of all current veterans, about 65% of men and 49% of women identify as married (United States Department of Veterans Affairs, 2017a). Further, 2.2% of active duty men and 10.7% of active duty women identify as lesbian, gay, or bisexual (LGB) (Gates & Newport, 2012). While the true number of LGB

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T. Mendenhall et al. (eds.), *Clinical Methods in Medical Family Therapy*, Focused Issues in Family Therapy, https://doi.org/10.1007/978-3-319-68834-3_18

veterans is unknown, it is estimated that 3% of all LGB Americans are U.S. veterans. Approximately 15,500 of active duty Service members identify as transgender, with at least 134,000 veterans who identify as transgender (Gates & Herman, 2014). Whether partnered or not, there are approximately 1.2 million dependent children in active duty families and almost 744,000 dependent children in guard and reserve families (DoD, 2012). Behind each of these statistics is a face that is situated within multiple relationships, and whose biopsychosocial-spiritual (BPSS) health is determined—at least in part—by their likelihood to sustain a career with the military.

The BPSS health (Engel, 1977, 1980; Wright, Watson & Bell, 1996) of military and veteran individuals, couples, and families is vast because it stretches across the life-span, encompasses cultural differences (e.g., diversity by ethnicity) within marked subcultures (e.g., military, reserve, veteran status, branch, hierarchy, and corresponding rules) and can be treated across a range of health-related and family-centered contexts. Attention to detail in type of military and veteran healthcare needed is necessary given that these populations may be served on military installations, in war zones, Veterans Affairs (VA) clinics, vet centers, or across civilian communities. In each of these systems, MedFTs must consider social location (e.g., unique health needs of active duty women in comparison to active duty men) because this workforce strives for sameness among its members rather than deviance (i.e., to be seen as outside of the norm) and, as such, subtle differences in health needs can be easily overlooked.

Another reason that MedFTs must attend to social location is that some social locations (such as ability) could mean the difference between maintaining and ending a military career. A similar situation with civilian careers may not result in such limited outcomes. Still another example is that life as an LGB Service member or veteran can be even more oppressive than as compared to civilian populations (see https://www.diversity.va.gov/programs/files/lgbt/fact-sheet.pdf). After all, it was not until 2011 that LGB Service members were no longer discharged from the military because of their sexual orientation. In relation to gender, more women are now serving in complex job roles within the military. As of 2017, approximately 15.8% of all enlisted Service members and 17.5% of all officers are women (DMDC, 2017), and yet many are hesitant to seek out health services to meet their BPSS needs. MedFTs' systemic training, alongside their training in cultural awareness and humility, allows them to toggle between the Service member's or veteran's BPSS and familial dynamics—while at the same time, honoring religious and ethnic diversity and duty-related experiences as U.S. -born or foreign-born active duty member or veteran.

Beyond the ability to attend to BPSS and relational needs among diverse military and veteran populations, MedFTs are able to extend prevention and intervention programs through a variety of military, reserve, and veteran health-related and family-centered systems described throughout this chapter. Below is an example of how one MedFT provided treatment for military and veteran patients through (a) an integrated behavioral healthcare (IBHC) intervention for a couple on a military installation, wherein the wife was the identified patient; (b) a family-centered agency, wherein a veteran couple was seeking treatment for complex mental health concerns and marital distress; and (c) a mobile unit that travels to military- and veteran-dense communities to extend care for homeless veterans.

Clinical Vignette

[Note: This vignette is a compilation of cases that represent treatment in military and veteran health systems. All patients' names and identifying information have been changed to protect confidentiality.]

The week began for Amy (a MedFT) in a family medicine clinic on-base. An active duty woman in her early 30s—Sally—had been telling her husband—Joe—about how much she resented coming in to see her primary care provider (PCP) (note: In military health, PCPs are often identified as primary care managers (PCMs)). On the day of Sally's first integrated behavioral healthcare visit (and the first time that Joe came with her to a visit), she was told by her PCP that she may not be able to have children because of challenges associated with body weight. After hearing this, Amy stayed with the couple to process what they had learned and to explore what they wanted to do. Sally shared that she felt overwhelmed and that she had heard this news before. Joe began to empathize with his wife and shared that he now understood better why Sally was so upset about coming in for care. He also understood better why Sally had been isolating from him prior to each healthcare visit. Together, the couple began to work with Amy and the PCP to establish realistic health goals, while also improving communication in their marriage. These goals, grounded in solution-focused brief therapy, were conjointly focused on ways that Sally could work toward improving her health. The couple discussed, too, how to collaborate with each other on meal preparation and workouts.

Amy also provided services at an off-base/post family therapy clinic. It is not uncommon to treat military or veteran couples there, particularly given that most mental health and family therapy services for these populations occurs in civilian communities. Amy engaged in a follow-up session with a young couple. The wife, Jodi, had been receiving individual therapy services for approximately 3 months prior to her husband, Mark, joining the sessions. Jodi was a non-Hispanic white female in her mid-20s who presented with depressive and post-traumatic stress (PTS) symptoms secondary to repeated sexual assaults from her stepfather that had lasted for more than 15 years. Mark was Jodi's high school sweetheart, and they had a young child together. Individual therapy for Jodi had evolved into couple's therapy because their relational health (i.e., increasing dyadic conflict) was influencing her individual progress. Mark was a non-Hispanic white male in his mid-20s. He was a disabled veteran diagnosed with a traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). He also struggled with chronic back pain. He had recently undergone surgery, but it went terribly wrong—leaving him with serious mobility issues and worsening pain. Mark's PTSD was severe; his PCP had told him that he had [potentially] experienced more TBIs than anyone she had seen before. Due to Mark's PTSD, he and Jodi did not sleep in the same bed (i.e., for safety reasons). Jodi was designated as Mark's primary

caregiver through the VA. As Mark had recently begun to show improvement, however, Jodi's PTS symptoms worsened. She had become accustomed to helping her husband; by focusing on Mark's problems (e.g., disability claims, healthcare needs), Jodi had been suppressing some of her own needs. Neither partner lived near family, and Jodi had a difficult time letting their child stay with others secondary to her fear that the child would be sexually assaulted (as she had been). Also, both Mark and Jodi lived in fear that terrorists may single them out for attack and thereby worked hard to remove and/or hide evidence of their military connections (e.g., bumper stickers, clothing).

*Throughout the course of therapy, Amy worked with Jodi and Mark on mindfulness, I-statements, and a variety of cognitive behavioral therapy techniques. The couple made significant progress over time. They became more involved in individual hobbies without feeling guilty for engaging in self-care. They started to communicate needs to each other more clearly (*e.g.*, asking for personal space on a "bad" day, requesting help with a household task), and Jodi made a goal of working through what she described as shame, embarrassment, and betrayal felt from her early abuse. She learned to set boundaries and adjust expectations with family members. She also grew in her parenting skills, which eased her anxieties about their child's safety. After a series of sessions with Amy, the couple began attending a mindfulness group, during which Jodi described further improvement in managing anxiety and Mark described noticeable differences in physical pain. Before terminating with the couple, Amy also made them aware of VA respite and other services they were eligible for to include other pain management services and rehabilitation programs.*

Amy also provided care through a HIPAA-approved mobile unit that drove around the state to meet with homeless veterans who needed physical, dental, and/or psychosocial health support. The unit was equipped with an interdisciplinary team that could work to assess for and respond to diverse BPSS needs. One day, Amy met John at a local homeless shelter. John was initially uncertain about whether to trust Amy, or anyone else on the mobile unit, as he expressed frustration with government systems (especially the VA). As a Vietnam-era veteran in his mid-60s, John primarily relied on the VA for his care targeting hypertension. Over the course of several weeks, John opened up to Amy and revealed that he had recently walked out of an appointment with his PCP because he had felt disrespected by his provider's use of a computer during the visit. John maintained that he had no plans to return. As a result, however, he had not taken his hypertension medication for several weeks. Amy (as the MedFT), a substance abuse counselor, and vocational rehabilitation counselor worked together to validate John's frustration and employed motivational interviewing (MI) to explore his readiness for change in managing hypertension. Their approach honored and respected John's experience, while at the same time avoided criticizing the VA or John's

PCP. The team discussed with John current trends toward using computers and technology during healthcare visits and then role-played how he could advocate for his needs. During the session, John made an appointment with his provider at the VA and agreed to resume taking medication as prescribed. Over the next several months, the team worked with John on how to manage anger and frustration, using brief mindfulness-based interventions, with goals targeting both hypertension and interactions with the PCP. John later shared that he felt that he was better equipped to achieve these goals.

What Are Military and Veteran Health Systems?

The U.S. Military Health System (MHS) is an intricate web of healthcare led by the Office of the Assistant Secretary of Defense for Health Affairs within the Department of Defense; it includes healthcare delivery, medical education, public health, innovative military research, and collaborative efforts with private sector providers (MHS, 2017). The MHS is made up of healthcare professionals from the Army, Navy, and Air Force who extend care into both the battlefield and local healthcare systems (e.g., hospitals, clinics, dental clinics) around the world. The MHS extends care to approximately 10 million beneficiaries who are active duty and retired Service members, as well as their dependents (MHS Genesis, 2017). A primary focus of MHS is to increase military readiness and ensure that the military force is ready for deployment and prepared for a full range of military missions.

For active duty Service members, military readiness is key. In the field, care begins with a first responder (e.g., self, combat lifesaver) and then advances to higher echelons of care, including advanced trauma management and critical care transport, as needed. In 2016, injuries/poisoning, musculoskeletal diseases (e.g., back problems), and mental disorders (e.g., anxiety disorder, adjustment disorder) comprised more than half of the medical encounters for active duty Service members (Armed Forces Health Surveillance Branch, 2017a). MedFTs are called upon in these instances to assist with pain management and to assess for and treat behavioral health conditions, psychological disorders, and relational distress across both brief and traditional sessions.

As is the case with civilians, Service members and their families are more likely to seek out behavioral and relational health services (whether related to a physical concern or not) when stigma is minimized. One way that stigma may be reduced is by extending integrated behavioral healthcare services (Maguen, Cohen, et al., 2010) (i.e., services offered through a team of behavioral and primary care providers (simultaneously)). Based on recent findings, it is clear that relational health is relevant to many Service members and thus must be extended treatment and support in a stigma-free environment. In fiscal year 2013, Military OneSource provided

more than 200,000 counseling sessions, with the most common concerns being partner relational problems (59%) and phase of life/religious or spiritual problems (24%), relational problem not otherwise specified (7%), parent-child relational problem (6%), and acculturation (4%). In the same year, Military Family Life Consultants provided almost 2.6 million in-person services to military Service members (not available to retirees), with the most common concerns including communication (26%), marital/relationship distress (21%), job stress (19%), general stress (13%), and problematic family dynamics (11%; Department of Defense, 2014a). Through a relational and BPSS lens, MedFTs are uniquely suited to provide care to address these issues while simultaneously assisting with the aim of military readiness on installation, in combat, or in the community.

Envisioning care delivery on an installation may seem challenging to some MedFTs, given that military installations are most commonly described as property that serves only as a command center, training grounds, and/or military housing for Service members. However, the reality is that MedFTs may find themselves delivering care in a variety of contexts on-base/on-post, including at child care centers, military treatment centers (military treatment facilities (MTFs): clinics and hospitals), family support centers (e.g., Fleet and Family Support; Army Community Service), schools, spiritual life centers, and much more. These essential services are specifically tailored to meet the needs of military personnel and their families. As evidenced by the high numbers of Service members utilizing therapy to address relational concerns (DoD, 2014a, b), it is clear that the BPSS health of military families also impacts readiness. As such, MedFTs must be in tune with both the variety of contexts for care and the unique treatment needs of military families in order to maximize Service members' and their families' well-being.

As an example, more than 200,000 children between 0 and 12 years old receive care on a daily basis from child development centers, school-age care, and family child care programs (Department of Defense, 2014a, b), and over 70,000 children are enrolled in Department of Defense schools (Department of Defense Education Activity, 2017). Among these pediatric beneficiaries, mental health issues (e.g., autism, developmental speech/language disorders, attention deficit disorder, adjustment disorders, depressive disorders, anxiety disorders) account for a significant challenge in the school system. Furthermore, these diagnoses account for the largest percentage of healthcare visits among military dependents, insofar as they reflect the reason for the highest number of pediatric medical encounters and hospital bed days (Armed Forces Health Surveillance Branch, 2017b). Through the training that MedFTs receive in BPSS care, alongside their ability to collaborate with diverse disciplines and systems (e.g., schools, healthcare), these clinicians should be on the front lines of supporting military children and families who live on military installations.

Beyond the families who live on an installation are those who have decided to move to homes in communities off-base/off-post. Approximately 80% of the 1.2 million school-aged military children attend a public school (Department of Defense, 2014a, b). Military families who live off-base/off-post are also more likely to receive their healthcare off-base/off-post. In 2016, 89.1% of non-Service

beneficiaries received care in a nonmilitary medical facility (Armed Forces Health Surveillance Branch, 2017b). This figure also reflects families of active duty Service members and National Guard and Research Service members/retirees (Armed Forces Health Surveillance Branch, 2017b). It is important to clarify that many military family members (and retirees) may be receiving care through civilian providers approved by the MHS. In fact, due to the needs of the active duty population who must be seen in an MTF, in some locations, retirees and family members can only be seen in the community through the TRICARE system. In these contexts, particularly in areas with large military populations, MedFTs should be aware of the MHS structure, military culture, and ancillary services for military families as described above.

While clinics and medical centers within the MHS meet the needs of millions of beneficiaries, more than half of all veterans are likely to receive care from a civilian/community health system. Once retired or separated, veterans may opt to receive care from a civilian/community healthcare context, including community-based outpatient clinics, vet centers, specialized treatment programs for substance use disorders (SUD) or PTSD, or as described in our vignette through mobile health units (U.S. Department of Veterans Affairs, 2017b).

To clarify, veterans' healthcare is administrated through a completely separate system from those extending care to active duty, known as the Veterans Health Administration (VHA), which is part of the Department of Veterans Affairs (Military Health System, 2014)—not the DoD. Retired military members have the ability to seek services from MTF (i.e., MHS) or through the VHA, whereas veterans (i.e., members who served in the military and were released from service under conditions other than dishonorable) who are not retired are not eligible for healthcare at a MTF (Military Health System, 2014).

In 2014, there were 9.1 million veterans enrolled in the Veterans Health Administration for services. That year, veterans had 92.4 million outpatient visits and 707,400 inpatient admissions, and these numbers have all continued to increase over the past decade (U.S. Department of Veterans Affairs, 2016a). Additionally, the VA operates the Vet Center Program, which provides readjustment counseling, outreach, and referral services to veterans and their families, as well as bereavement services to parents, spouses, children, and siblings of Service members who die while on active duty (U.S. Department of Veterans Affairs, 2015). Veterans who enroll for health benefits through the U.S. Department of Veterans Affairs do so through an enrollment system that is based on priority groups (i.e., priority group 1–8; priorities are defined based on different types of needs, not on a continuum for severity of need). The priority groups are designed to assist veterans in getting services that better align to their specific needs (e.g., disability, low income, unemployable; U.S. Department of Veterans Affairs, 2016b). The average enrollee in the VA is male, 61 years old, white/non-Hispanic, and married with dependents. Approximately one-fifth of veterans receiving care from the VA stated that they were coping with memory loss, 25% reported coping with a stressful situation, and an additional one-fifth endorsed being a current smoker (Huang et al., 2017). These findings indicate that memory care support, stress management, smoking cessation, VA benefits, and

an understanding of community-based services to meet their other needs (e.g., housing, financial, specialty care services, placements, etc.) are important areas for MedFTs to be trained insofar as to better support veterans and their families.

Treatment (and Support) Teams in Military and Veteran Health Systems

Due to the diversity in and between military and veteran healthcare systems, there are several potential collaborators who are important for MedFTs to be able to identify when working with military and veteran individuals, couples, families, and units. To provide clarity for MedFTs, this section is divided between (a) treatment teams that typically exist within on-base/on-post military healthcare systems and (b) treatment teams that typically exist within veteran-based healthcare systems.

Treatment Teams in Military Health Systems

The main goal for this military healthcare system section is to provide descriptions for direct patient care, readiness training, wellness education, and preventive care for members and their beneficiaries. There are several points to consider while reading this section due to the vast information that is available. First, the titles of roles may vary between Service branches; thus, if the treatment team member listed below represents a certain branch, rather than being a common role across all branches, it will be denoted accordingly: Air Force = *, Army = **, and Navy/Marines = ***. For example, all military branches use the patient-centered medical home (PCMH) model for primary care, but each branch implements their own version (Marshall et al., 2011). For example, the Navy PCMH model is called Medical Home Port (MHP), the Army model is called Army Soldier Centered Medical Home (SCMH), and the Air Force calls it the Family Health Operations. Thus, there may be roles within each of these models that are distinct to that particular branch. Second, it is important to keep in mind that across all Service branches, there are roles for officers (e.g., healthcare providers, physicians, nurses, behavioral health providers) and enlisted Service members (e.g., healthcare specialists, medical technicians). These distinctions are important to recognize because their titles may look different than as compared to civilian contexts. For example, a certified "medical assistant" in a civilian context may be referred to as "hospital corpsman" in a military setting.

Lastly, the treatment team members discussed in this chapter refer to those found in aerospace (i.e., flight) medicine, family medicine, integrated care, or pediatric primary care contexts. There is limited information below regarding military personnel injured during combat because those treatment teams vary for each branch, and that conversation goes beyond the scope of this chapter. However, it is essential for a MedFT to be knowledgeable about the process of how injured military men and

women are treated on the battlefield, then transferred to a stateside hospital, because a MedFT may see these patients when said patients are receiving treatment in the United States. For example, the protocol for treating Service members who have been injured on the battlefield is guided by four levels of care, referred to as "roles" (U.S. Army Medical Department, 2013). Keep in mind, too, that these roles vary based on Service branch. The first role refers to point of injury care to triage, treat, and evacuate the patient with the goal to return the Service member to duty or get him or her stabilized and transported to the second role. The second role refers to providing basic primary care but could also include limited optometry, combat and operational stress control, dental, laboratory, radiographic, and/or surgical services. The third role expands the support provided in the second role and refers to patients transported to medical treatment facilities (typically located in the theater of operations) who are not stable enough to be transported over long distances. The care in this role includes resuscitation, initial wound surgery, damage control surgery, and postoperative treatment. The final role is when Service members have been transported to medical care provided in continental U.S.-based hospitals or other safe havens, including hospitals in the Department of Veterans Affairs and those in the National Disaster Medical System (U.S. Army Medical Department, 2013). For a more detailed description of these roles, refer to the U.S. Army Medical Department (2013).

Treatment and Support Teams for Military Populations and Their Dependents

Teams that serve military populations and their dependents via treatment or support services include the following:

Aerospace medical service specialists*. Specialists enlisted as personnel who assist medical providers in a variety of ways, such as administrating immunizations, assembling/operating/maintaining medical equipment, and assisting in aeromedical evacuations.

Aerospace medicine specialists/flight surgeons*. Providers who are primary care physicians with either a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degree; they treat pilots and crew members traveling in air or space**.**

Behavioral healthcare facilitators (BHCF). These professionals are registered nurses who act as liaisons between the external behavioral health consultant (EBHC) and the primary care team. The BHCF reinforces, encourages, checks, and supports the treatment plan created by the primary care manager (PCM) and the internal behavioral health consultant.

Behavioral health technicians***. These technicians aid medical officers in the care and treatment of mental health patients, administrative procedures, and maintaining clinic equipment. They also observe and report patient symptoms to the medical officer.

Beneficiary counseling and assistance coordinators (BCAC). Professionals who are located at military treatment facilities (MTFs) and TRICARE regional offices; they assist beneficiaries in accessing medical and dental care.

Case managers. Professionals who assist patients in developing plans to control their illness or injury, especially those with complex medical, social, financial, and/or mental health issues. Case managers in the military may help with linking patients to helpful community or federal support systems, coordinate services among providers, and/or schedule said services.

Certified alcohol and drug abuse counselors (CADAC)*. Mental health technicians who serve as alcohol and drug counselors. Officers can also be CADACs; they are responsible for screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, education, referral, report/record keeping, and consultation with patients.

Exceptional family member program (EFMP) staff. Staff who facilitate initial enrollment into the EFMP (a mandatory program for someone identified as having a special need) and guide families to additional services. They also assist in referrals, individualized service plans, and case management from one duty station to the next. "Special needs" refer to any special medical, dental, mental health, developmental or educational requirement, wheelchair accessibility, adaptive equipment, or assistive technology devices and services.

External behavioral health consultants (EBHC). Consultants who assist the primary care manager and behavioral healthcare facilitator regarding psychotropic medications for patients by providing verbal and/or written consultation on medication decisions, changing medications, and managing side effects.

Hospital corpsmen***. Professionals who assist healthcare providers in delivering medical care to Service members and their families. They may act as a clinical or specialty technician at a MTF or as a battlefield corpsman with the Marine Corps, providing emergency medical services in combat. Hospital corpsmen also help maintain treatment records, administer injections, and perform clinical tests.

Internal behavioral health consultants. Consultants who function as mental health providers embedded in primary care settings to assist primary care managers in helping patients with a wide range of behavioral health conditions, chronic medical problems, and adverse health behaviors. These consultants assist patients with issues related to anxiety, depression, grief, increasing exercise, managing home or work stress, quitting smoking, cholesterol and blood pressure management, weight management, improving sleep, chronic pain management, and managing diabetes.

Medical corps officers**. Graduates of an American Medical Association or American Osteopathic Association accredited medical school; these officers are responsible for the overall health of Service members and those eligible to receive care in the military community.

Medical evaluation board case managers. Professionals who do initial counseling with Service members before being entered into the Disability Evaluation

System, signed up for an Integrated Disability Evaluation System Consultation Course (ICC), or given contact information for a Physical Evaluation Board Liaison Officer (PEBLO).

Mental health service specialists*. Specialists who work with psychiatrists, psychologists, and/or other providers to help formally assess and provide behavioral healthcare to Service members in order to get them back to their jobs.

Mental health specialists.** Specialists who are enlisted personnel; they assist with inpatient and outpatient treatment of psychiatric, drug, and alcohol patients. They are also responsible for collecting and recording patients' psychosocial and physical data.

Military family life consultants (MFLC). Consultants who have at least a master's degree in mental health (e.g., marriage and family therapy, counseling, social work, psychology); they provide confidential nonmedical therapy or counseling services related to deployment stress, reintegration, relocation adjustment, separation, anger management, conflict resolution, parenting, and relationship issues. Meetings are face-to-face and can be held on- or off-military installation

Military service coordinators (MSC). Coordinators who function as essential representatives throughout the Integrated Disability Evaluation System process; they act as a liaison between the Service member and the Department of Veterans Affairs. The MSC helps patients with their VA claims and keep them and the Physical Evaluation Board Liaison Officer informed of all VA processes.

Patient advocates. Professionals who respond to patient grievances and complaints. They also assist obtaining information or services for Service members and their families and help increase communication among clinic staff and patients and their families regarding wait issues, scheduling problems, billing matters, and physician concerns.

Patient relations representatives (PRR)*. Representatives who act as liaisons between clinic staff and patients and their families; they also aid in resolving conflicts or areas of concerns from patients and families.

Physical evaluation board liaison officers (PEBLO). Professionals who assist Service members in their fitness for duty, rights, and entitlement to benefits and ensure that they are aware of options and required decisions through the Integrated Disability Evaluation System (IDES) process.

Primary care managers (PCM). Professionals who provide all routine, nonemergency, and urgent healthcare to patients. If PCMs are unable to provide the level of care needed, the patient will be referred to a specialist.

Privileged mental health providers*. Active duty military, reservists, and civilian personnel who have privileges to diagnose, initiate, alter, or terminate healthcare treatment plans within the scope of their license, certification, or registration.

Resiliency staff. Specifically focus on resiliency related to vicarious traumatization and stress management.

Sexual assault response coordinators (SARC). Professionals who serve as a single point of contact to coordinate sexual assault response when a sexual assault is reported. They are available 24 hours per day/7 days per week to assist victims of sexual assault and report the information to the installation commander.

Victim advocates. Professionals who provide nonclinical advocacy services and support to Service members and their families who are experiencing domestic abuse. They are on-call 24 hours per day/7 days per week to provide immediate assistance, safety planning, nonjudgmental support, and information about available resources. They can also help victims and families find shelter and support, secure a military protective order (MPO), and assist with locating clinical counseling services.

Treatment and support teams in veteran facilities. Teams that function within veteran facilities are extensive (including a variety of providers who treat military sexual trauma, polytrauma, and TBI via rehabilitation services) as well as the following staff and provider types.

Mental health intensive case management (MHICM) staff. A multidisciplinary team that provides a variety of services (e.g., crisis intervention, medication management, socialization skills, transportation, family/caregiver support) to veterans with mental illness to maintain their independence through intensive case management services.

Mental health treatment coordinators (MHTC). Professionals who ensure that all veterans who receive specialty mental health services have continuity through their mental healthcare/transitions. MHTCs are assigned to veterans in order for the veteran to have a continuous point of contact while the veteran is receiving mental health services.

Military service coordinators. Coordinators who assist Service members in the IDES process by guiding and counseling them and by helping them file their VA benefits in a timely manner in order to receive benefits as soon as possible after separating from the service.

Patient advocates. Professionals who collect and manage feedback from veterans and their families regarding their experiences at the clinic. Patient advocates assist with complaints or concerns regarding patients' quality of medical care.

Patient aligned care teams (PACTs). Primary care medical teams that include behavioral health professionals. Primary care providers utilize these team members to coordinate appropriate services for patients. For example, the PCP can manage a veteran's mental health problems with the collaboration of a behavioral health provider, but if more intensive treatment is necessary, he or she will refer the veteran to a specialized mental health program. The VA also has Geriatric Patient Aligned Care Teams (GeriPACT).

Peer support specialists. Individuals with a mental health struggle and/or co-occurring condition who have been trained to work with others with similar conditions. Peer support specialists aid others by sharing their personal experiences and by helping veterans navigate the VA system.

Primary care-mental health integration (PC-MHI) staff. Staff who work in the primary care-mental health integration program who are fully licensed behavioral health professionals; they are embedded in a primary care setting as part of an interdisciplinary team delivering brief consultation services to veterans. Veterans meet with the behavioral health provider as part of their routine primary care service to identify, treat, and manage behavioral conditions.

Readjustment counselors. Licensed mental health providers who work in community-based counseling vet venters. They provide free services to all veterans who have served in any combat zone.

Fundamentals of Care in Military and Veteran Health Systems

MedFTs may typically focus their sessions on ways in which physical health conditions influence psychosocial functioning or vice versa, but it is essential in military and veteran healthcare systems that they have a fundamental understanding of military culture. Understanding this culture helps MedFTs to build credibility and advance joining efforts as they address BPSS concerns of military/veteran patients, couples, and/or families. While there are many cultural dynamics that are unique to military service (e.g., geographic mobility, periodic or enduring separations, unpredictable duty hours), this section focuses primarily on requisite knowledge regarding the roles of deployment, combat, and reintegration in the lives of active duty and veteran populations. We also highlight several BPSS health factors experienced by these groups. MedFTs working in a military and veteran contexts should also be aware of common health concerns experienced by Service members, including alcohol and tobacco use, intimate partner violence, military sexual trauma, moral injuries, post-traumatic stress, traumatic brain injuries, sexual health, and suicide.

Deployment

Deployments have received considerable attention in military and veteran research because they have immediate- and long-term effects on relationships, which are at least partly due to the gaps in communication and increases in anxiety between couples and families that they bring (Lowe, Adams, Browne, & Hinkle, 2012). Investigators have reported that families are not the only ones stressed by deployments, either: Service members who deploy also show an increase in work- and family-related stress (Deployment Information and Resources, 2010) than as compared to non-deployed personnel.

For every branch of the military, family stress is significantly higher for members who had deployed than members who had not deployed (Bray et al., 2010). However, it is possible that after a certain length of time deployed, military spouses adapt to the stressors brought on from deploying. For example, Karney and Crown (2007) found that for every branch except the Air Force, the longer the military spouse was deployed, the more stable his or her relationship. On the other hand, researchers have suggested that military spouses often experience loneliness, anxiety, and depression (MacGregor, Han, Dougherty, & Galarneau, 2012; Makin-Byrd, Gifford, McCutcheon, & Glynn, 2011; Mansfield et al., 2010) throughout the deployment cycle. Researchers have also found that spouses tend to experience more emotional stress during deployments if the Service member is of lower rank, the Service member has less military experience and social support, and the non-deployed spouse is unemployed (Allen, Rhoades, Stanley, & Markman, 2010).

Although military Service members and their families commonly experience stress during times of deployment, the literature is inconsistent about the impact of multiple deployments (MacGregor et al., 2012). For example, the "healthy warrior effect" is a term used for Service members who are deemed healthier prior to a deployment and who go on to deploy or who may be more likely to experience multiple deployments in comparison to those who do not deploy (Larson, Highfill-Mcroy, & Booth-Kewley, 2008). The use of this term implies that the more psychologically resilient Service members are, the more likely they are to deploy (and then asked to redeploy). This sequence is less likely for Service members who experience more serious illnesses, such as depression or bipolar disorder (MacGregor et al., 2012).

Combat

Since the introduction of PTSD to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in the 1980s, researchers have continued to find positive relationships between combat exposure and high levels of psychological distress (McCuaig-Edge & Ivey, 2012). Service members, especially those who have recently returned from combat, often experience difficulties coping with daily life, significant emotional distress, increases in risk-taking behaviors, relationship distress with spouses and families, and significantly more health concerns than as compared to their civilian counterparts (Allen, Rhoades, Stanley, & Markman, 2010; Brooks, 2005; Fischer, 2007; Jordan, 2011).

Although PTSD continues to plague veterans (and is discussed in more detail later in this chapter), it is important for MedFTs to understand that the stress of combat does not always lead to PTSD. In fact, research continues to show that the unpredictable and persistent potential for imminent danger which accompanies deployment to a combat zone is often the prominent source of distress upon returning home (Junger, 2010; Van Der Kolk, 2015). This is mainly caused by the hardening of neuro-pathways in the brain, which strengthen the fight-or-flight response

and cause a significant increase in baseline levels of stress hormones (Van Der Kolk, 2015). More specifically, the chronic anxiety and fear that comes from being deployed to a combat area cause the body to maintain a heightened state of arousal, regardless of whether the Service member ever experiences contact or a life-threatening (or otherwise "traumatic") situation.

Thus, much of the emotional, behavioral, and relational distress that researchers have found to correlate with combat exposure has an inherently biological component. Because of this, MedFTs should garner skills in behavioral medicine (e.g., treatment for insomnia, pain) and in providing psychoeducation about the biological implications related to combat stress to both veterans and their families as a way to normalize and depersonalize any sudden and significant changes in personality, mood, or behaviors. Similarly, as PTSD and combat-related stress continue to carry stigma in the military, reframing the biological alterations associated with combat stress as the body's natural survival response has the potential to relieve Service members of feelings of personal weakness or shame (Fox & Pease, 2012; Lorber & Garcia, 2010).

Reintegration

In the military community, reintegration applies to two important life phases: (a) reintegration back into the family following deployment and (b) reintegration back into the civilian world following military service. Although the levels of distress that result from each type of reintegration are subject to the uniqueness of each Service member's personality, military career, and family dynamics, it is clear from the literature that stress paired with reintegration is predominantly caused by role change (Marek, Stetzer, Adams, Popejoy, & Rantz, 2012).

For example, when a Service member deploys, his or her spouse is left to run the household (e.g., functioning as a single parent, being responsible for all bill payments and household chores, and adjusting to a new duty station with little to no community or family support). Spouses of deployed Service members, as a consequence, often feel high levels of stress, anxiety, depression, sleep disturbance, and grief (Makin-Byrd, Gifford, McCutcheon, & Glynn, 2011; Mansfield et al., 2010; Steelfisher, Zaslavsky, & Blendon, 2008). Also significant is that these symptoms are often exacerbated when the Service member returns home. Through this reintegration process, both partners typically struggle to restructure the altered family dynamics that occurred during deployment. Each partner must also adapt to and cope with any personality or mood changes (e.g., irritability, unable to concentrate, violent episodes) that the Service member or spouse may exhibit secondary to combat or deployment stress (Makin-Byrd et al., 2011; Marek et al., 2012). Similarly, veterans reintegrating into the civilian world may experience an increase in stress across both their family and personal life as they struggle to "fit" in a civilian society that is less structured and stable than the military culture from whence they came.

Due to multiple levels of stress and distress, ambiguity of roles, and constantly changing family dynamics, MedFTs working with veterans and their families

through any period of reintegration should rely on skills gained through their systemic family therapy training. Assessing for rigid and permeable boundaries; highlighting problematic communication patterns, comradery, and alliance with other veterans to the exclusion of family members; and altering triangulated relationships are all effective skills for reducing ambiguity and role uncertainty in family units and larger societal systems (Greenman & Johnson, 2012; Guay, et al., 2011; Johnson, 2005; Shapiro, 2007; Weissman et al. 2011). Interventions pertaining to these presenting problems are further discussed in the research-informed practices described later in this chapter. Additionally, because reintegration impacts more people than the Service member, couples therapy and family therapy should be considered when treating BPSS concerns (Greenman & Johnson, 2012; Johnson, 2005; Sayers, 2011; Shapiro, 2007; Weissman et al., 2011). Below are just some of the complex BPSS concerns that tend to become more evident in times of deployment, combat, and/or reintegration.

Tobacco and Alcohol Use

Despite the fact that physical fitness is required in the military, many Service members still take part in activities that are detrimental to their physical health. For example, Smith and Malone (2014) found that military members risk the negative health consequences of tobacco use because it helps relieve stress and allows individuals to take "breaks" from work. MedFTs should be knowledgeable about the effects of tobacco use and nicotine, alongside evidence-based options for reducing and/or stopping it. In addition, since Smith and Malone (2014) found that most Service members did not report alternative ways to manage stress, MedFTs should be equipped with skills and knowledge about how stress impacts one's body. They should be able to teach healthier techniques (e.g., deep breathing, muscle relaxation, guided imagery) to manage stress, rather than resorting to the use of substances.

Men who serve in the military drink alcohol at higher rates compared to civilian men, whereas military women drink less alcohol compared to civilian women (Teachman, Anderson, & Tedrow, 2015). Similar to tobacco use, researchers have found that the culture of the military promotes alcohol use because it has traditionally been used to promote bonding and unit cohesion (Teachman et al., 2015). Sadly, the trend does not change once becoming a veteran; McCauley, Blosnich, and Dichter (2015) found that veterans were significantly more likely (24.9%) than non-veterans (17.4%) to use substances. MedFTs must be knowledgeable about the connections, too, between tobacco and alcohol use and other biopsychosocial concerns. For example, both tobacco and alcohol use increase when PTSD symptoms are present (Hermes et al., 2012; Marshall et al., 2012). Also, MedFTs should use their systemic training to recognize how the military organization as a larger system impacts substance use; alternative techniques to reduce stress have yet to be endorsed by the military, and the myth of tobacco as effective at reducing stress is still pervasive (Smith & Malone, 2014).

Intimate Partner Violence

Although intimate partner violence (IPV) affects both civilian and military families, military stressors such as multiple deployments, family separation and reintegration, work demands, previous head traumas, mental illness, and substance abuse can increase the risk for IPV (Gierisch et al., 2013). In fact, researchers have found that IPV in military families is more severe than in civilian families (Rentz et al., 2006). This is a significant health concern because of its impact on victims (Anderson, 2002), children in the home (Kitzmann, Gaylord, Holt, & Kenny, 2003), and the economic burden that IPV has on society as a whole (National Center for Injury Prevention and Control, 2003). It is essential to remember that there are several factors that correlate with IPV (e.g., childhood trauma, relationship adjustment, psychopathology, substance abuse, military factors, etc.), but discussing these confounding factors in depth goes beyond the scope of this chapter. With that said, MedFTs must be knowledgeable about these risk factors in order to understand how they interact with one another and could lead to violent behaviors in military families.

It is essential that MedFTs have a thorough understanding of the military structure and the options available to military families in order to know how to best assess and intervene in IPV cases. For example, every branch of the military has a Family Advocacy Program (FAP) that offers a variety of services to IPV victims (Military OneSource, 2016). However, it is important to recognize that IPV in a military context presents unique challenges; if the perpetrator is a Service member, there could be negative career consequences like reassignment or discharge (Klostermann, Mignone, Kelley, Musson, & Bohall, 2012). Since researchers report rates of IPV up to three times higher in military families compared to civilian counterparts and there is no standardized way to measure IPV in military settings (Klostermann et al., 2012), MedFTs can play an important role in identifying, preventing, and helping treat both perpetrators and victims of IPV. MedFTs are experts in collaborating with a variety of providers on the interconnectedness between biopsychosocial issues; they are thereby able to identify the BPSS repercussions of IPV and communicate those health issues to the treatment team as indicated.

Military Sexual Trauma

Although sexual assault in general is not unique to the military community, it is more common for those in the military than as compared to civilians (Bostock and Daley, 2007). More specifically, military sexual trauma (MST) refers to sexual assault that occurs while the individual is in the military; it includes any and all incidents ranging from harassment to violent rape. It is important to know, too, that sexual harassment is not only more common for Service members, but it is complicated by the fact that it is often perpetrated by another Service member within the context of work (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007). This is an important distinction compared to sexual assault in the civilian world,

because the military is often seen as a family—especially when preparing for or during deployments. The military member often seeks support and stability from the military family instead of his or her family at home (Goodcase, Love, & Ladson, 2015). There are several benefits to being a part of the "military family" (e.g., successful missions), but when MST occurs the detrimental effects that ensue can look similar to a child experiencing incest (Goodcase et al., 2015). It is not surprising, then, that the negative effects of MST are best understood and treated through a systemic and BPSS lens. MedFTs working in military settings must be equipped to assess for prior trauma, especially MST, and be able to provide sensitive, inclusive, and comprehensive support to victims (Holland, Rabelo, & Cortina, 2016). For more specific guidance on how to assess MST from both individual and systemic perspectives, see Goodcase et al. (2015).

Moral Injuries

According to the National Center for Posttraumatic Stress, moral injury is defined as any act, or the witnessing of any act, which fundamentally transforms moral and ethical expectations that are rooted in religious, spiritual, cultural, organizational, and/or group-based rules (Maguen & Litz, 2016). To put concisely, moral injury typically occurs when a veteran perpetrates, fails to prevent, bears witness to, or learns about instances which violate and permanently alter previously held beliefs and expectations of humanity and/or society as a whole (Litz et al., 2009; Maguen & Litz, 2012). Examples of experiences which typically lead to moral injury include witnessing or perpetrating disproportionate acts of violence, being betrayed by peers or leadership, witnessing or perpetrating any act of violence toward civilians, and witnessing or perpetrating violence within peer groups (e.g., sexual assault) (Maguen & Litz, 2012).

Moral injury results in a negative altering of a one's world view, and as such many veterans often present to primary care, behavioral health providers, or spiritual leaders with feelings of anhedonia, difficulty relating to others, relationship distress, emotional avoidance, feelings of numbness, and/or intrusive thoughts (Maguen & Litz, 2016; Maguen & Litz, 2012). Veterans may also report self-harming behaviors and/or experiencing overwhelming suicidal thoughts in context of a moral injury. In particular, veterans who have experienced a moral injury after taking another person's life are more likely to screen positive for PTSD; they are also more likely to abuse substances (Maguen & Litz, 2012; Maguen, Lucenko, et al., 2010).

It is important to note, however, that while a veteran struggling with moral injury may be diagnosed with PTSD, not all veterans with PTSD have sustained moral injury (just as veterans with moral injury may not have PTSD or may have never experienced combat). In fact, the distinguishing factor between PTSD and moral injury is that a diagnosis of PTSD requires that veterans experience or witness a life-threatening incident linked to feelings of helplessness and loss of safety (American Psychiatric Association, 2013), whereas moral injury requires that veterans witness

or perpetrate an act that alters their worldview and, thus, beliefs about the goodness and purpose(s) of life. More specifically, veterans suffering from PTSD may exhibit thoughts such as "bad things happened to me and I cannot control them," while veterans suffering from moral injury may exhibit thoughts such as "bad things have happened because I did not control them." Beliefs such as these often cause deep shame and guilt or survivor guilt, alongside losses of hope (Maguen & Litz, 2012).

Due to the overwhelming similarities in symptom presentation and comorbidity of PTSD and moral injury, MedFTs must be diligent in the assessment of negative beliefs, grief, and loss vis-à-vis biological and behavioral impacts and impairments expressed by the patient. Although little research has been done on best practices for treating moral injury, existing studies suggest that multimodal interventions that include experiential techniques, cognitive behavioral therapies, bilateral simulation, and co-occurring couples therapy have proven to be most effective in ameliorating shame, anhedonia, and relational sabotage common to moral injuries (e.g., Johnson, 2005; MacIntosh & Johnson, 2008; Forrest & Shapiro, 1998; Maguen & Litz, 2012; Van Der Kolk, 2015; Wiebe & Johnson, 2016).

Post-Traumatic Stress and Traumatic Brain Injuries

Soldier's heart, shell shock, combat fatigue, and post-traumatic stress are common terms that have been used over decades of research related to traumatic exposure and experiences that influence the mental health of service men and women. Recently, researchers have become more attuned to the ways in which physical trauma to the brain—called traumatic brain injury (TBI)—interfaces with post-traumatic stress symptoms (PTS) or post-traumatic stress disorder (PTSD). Untangling TBI and PTS/PTSD symptoms experienced by Service members or veterans— alongside those perceived or observed by others—has not been an easy task for clinicians or researchers. We are continuing to learn about how these fit together and about what ways to best advance care.

Post-Traumatic Stress

Post-traumatic stress has become one of the most common conditions associated with military Service members. Approximately 8% of those who were deployed to the Iraq and Afghanistan conflicts were diagnosed with PTSD (Institute of Medicine [IOM], 2014). And even though PTSD has received a lot of attention among military and veteran healthcare providers and populations for decades, a chasm still exists in continuity of care (i.e., gaps in treatment stability between cares as an active Service member versus retired military or veteran). These gaps make it difficult to track the quality of care for those with PTSD (IOM, 2014). This also makes it difficult to track health outcomes for active duty Service members versus veterans who are experiencing PTS or PTSD. Since PTSD impairs an individual's physical,

psychological, social, and occupational functioning, MedFTs must be sure to assess how each of these areas is impacting one another in order to provide quality BPSS treatment. In fact, the Institute of Medicine recommended an integrated and comprehensive approach to preventing and treating PTSD in active duty members and veterans (IOM, 2014). Relatedly, Bohnert, Sripada, Mach, and McCarthy (2016) also found that same-day integrated mental health services in primary care settings increased the odds of accurately diagnosing PTSD and initiating treatment for it. MedFTs are uniquely trained to such models of integrated behavioral healthcare secondary to their systemic and BPSS training, ability to diagnose, and philosophical beliefs regarding the importance of interdisciplinary collaboration.

MedFTs working in military contexts should not only be skilled at assessing for PTSD and providing comprehensive, evidence-based treatment options; they should also be knowledgeable about the BPSS impacts of PTSD on military members' partners and children throughout the treatment process. MedFTs can use a relational lens to find predictor variables (as well as mediators and moderators) that can minimize the likelihood for PTSD for active duty Service members, veterans, and their families (Campbell & Renshaw, 2013). It is not uncommon for family members (who share a home with a veteran or Service member who is experiencing PTS/PTSD) to experience post-traumatic symptoms at levels equal to or beyond those of their loved one. For this reason, MedFT's BPSS and systemic clinical skills are essential to the future of PTSD research and treatment. For a comprehensive summary about current evidence-based practice, the VA and DoD have released a pocket guide to aid primary care and behavioral health providers in the treatment of PTS and PTSD (see Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury, 2013).

Traumatic Brain Injuries

Traumatic brain injuries are primarily caused direct or indirect blast impacts to the head from improvised explosive devices (IEDs), motor vehicle accidents (MVAs), and/or gunshot wounds (Summerall, 2017). Though the cause of most TBIs suggests severe bodily harm, the majority of Service members who qualify for a TBI diagnosis appear healthy to the outsider's eye—i.e., with no physical wounds or obvious cognitive deficits (Jordan, 2011). Additionally, many symptoms of TBI—including irritability, anger/outbursts, trouble concentrating, fatigue, hyperarousal, insomnia, difficulty with balance or mobility, general feelings of anxiety, and depression (Morissette et al., 2011; Stein & McAllister, 2009)—overlap with other frequently occurring diagnoses such as PTSD, major depressive disorder, and generalized anxiety disorder (American Psychiatric Association, 2013). These similarities can easily lead to misdiagnoses that leave the TBI untreated. Providers must thereby be diligent in utilizing all axioms of care in order to ensure accurate identification and quality treatment. Examples of such should include involving the patient's family members during assessment phases of care; after all, many patients who have a TBI are not aware of recent changes in personality and neurological impairments that those close to said patients can more readily see (Jordan, 2011).

Collaboration with healthcare personnel (e.g., neurologists, primary care physicians, and polytrauma care teams) is an especially important skill set for MedFTs in the case of TBI, particularly because the timeline for assessment, diagnosis, and indicated care for TBIs is an essential ingredient toward the healthiest outcomes for Service members or veterans (Summerall, 2017). According to research, untreated TBI can lead to seizures, infections, pneumonia, olfactory impairment, perilous falls, and significant neurodegeneration. These sequelae can result in impairment to executive functioning, memory loss, and continued behavioral changes (CDC, 2017; McKee & Robinson, 2014; Ruff, Riechers, Wang, Piero, & Smith-Ruff, 2012). Providing systemic therapy and BPSS treatment to patients and their families is paramount. In particular, reframing symptoms as a neurological condition, rather than a temporary shift in mood or an adverse reaction to current relationship dynamics, provides an opportunity for spouses and families to view TBI as a diagnosis which they can face together—rather than a demon of sorts that pulls them apart (Greenman & Johnson, 2012; Johnson, 2005; Jordan, 2011).

Sexual Health

Sexual health refers to both positive and negative experiences around sexuality, including foci related to overall reproductive health. Sexual health is important to understand in the military community, because military-specific factors are readily able to impact it. For example, researchers have found that Service members who had experienced military sexual trauma (MST) reported higher rates of sexually transmitted diseases and sexually transmitted infections compared to those who had not experienced MST (Turchik et al. 2012). Also, although there is a lack of research on the sexual health of lesbian, gay, and bisexual military members, some evidence exists that demonstrates how military members who were unable to share their sexual identity at work experienced greater symptoms of depression and PTSD (Cochran. Balsam, Flentje, Malte, & Simpson, 2013) and increased suicidal ideation compared to heterosexual counterparts (Blosnich, Bossarte, & Silenzio, 2012). Good sexual health is associated with good mental health and good well-being in general. Thus, in order to promote good sexual health, MedFTs working in military contexts should use assessments that include questions about sexual orientation; gender identity; role of physical, emotional, and sexual safety in intimate relationships (including an understanding of the presence/use of pornography); and healthy sexual practices (Kauth, Meier, & Latini, 2014). MedFTs can play a role in assessing for sexual health practices and address health disparities; this is important because only 57.6% of primary care providers feel confident in addressing and treating patients' concerns about sexual health (Wittenberg & Gerber, 2009). MedFTs should acquire training in relation to sexual health, sexual pathology, and intimacy across casual and committed relationships in order to adequately and accurately address these issues with military members, veterans, dependents, and healthcare collaborators. This knowledge will also assist in reducing common disparities that exist as Service members become veteran patients in VA clinics and community health systems.

Suicide

Suicide remains a major concern for our military community (Lineberry & O'Connor, 2012). According to the Armed Forces Medical Examiner System, there were 438 suicide deaths from active, reserves, and guard components in 2014 (Pruitt et al., 2014). When taking a closer look at those who took their own lives, most were non-Hispanic white males under 30 years of age and of enlisted rank (E1–E9; Pruitt et al., 2014). MedFTs working in military and veteran healthcare contexts must be aware of the risk factors associated with suicide and use their systemic skills and training when assessing for it. This is especially important for relationally trained providers, insofar as 42% of suicide deaths and 42.9% of suicide attempts involved "failed relationships" within 3 months of the attempt or death (Pruitt et al., 2014). MedFTs are in a unique position to intervene with Service members and veterans at risk for suicide, especially in light of the influence(s) that relationships have on individuals contemplating or completing a suicide.

MedFTs should also expand their knowledge and training beyond what they know about suicide among civilian populations because military-specific factors, such as deployments and combat exposure, may also contribute to risk. For example, over half of Service members who had completed suicide in 2014 had experienced at least one deployment (Pruitt et al., 2014). LeardMann et al. (2013) found that untreated mental illness (mood disorders) and substance abuse disorders were considerable risk factors for current and former military members who had completed suicide. This finding, coupled with results from a review conducted by Harmon, Cooper, Nugent, and Butcher (2016), suggested that 33% of military members who had completed a suicide had not come in contact with a behavioral health provider after being deployed. This outcome signals that MedFTs must be proficient in assessing for suicidal ideations even in sessions wherein the presenting concern is more benign or biological/physical in nature. Furthermore, MedFTs must be prepared to extend research-informed interventions (such as those described later in this chapter) and collaborate with larger systems to reach beyond the therapy room. They must recognize when commanders, unit leaders, chaplains, family members, healthcare providers, and community members can be helpful in the care of patients who are struggling.

Military and Veteran Health Across the MedFT Healthcare Continuum

Whatever their level of involvement in the military and veteran community, all MedFTs who encounter Service members or veterans and their families must have a basic understanding of military culture. Further, MedFTs must familiarize themselves with an entire subculture of American society that is steeped in hierarchy, social class division, heroic morals and values, unique bonds of brotherhood and

sisterhood, and constantly changing family roles and dynamics. Because of this, MedFTs working in the military community should approach learning military culture as they would approach learning about any other foreign culture—i.e., by seeking to understand social norms, cultural quirks, and, to some extent, a new language.

Additionally, MedFTs working in the military community must understand trauma and the effects that it has on all BPSS domains. While different levels of MedFTs will have varying experience and knowledge about trauma treatment, all MedFTs working with the military should able to identify symptoms of PTSD and be familiar enough with PTSD and trauma-based care modalities so that they can provide informed referrals. This same level of understanding should also apply to TBI and substance use disorders. With that said, the levels described in Hodgson, Lamson, Mendenhall, and Tyndall's (2014) MedFT Healthcare Continuum serve to illustrate a range of knowledge and skills for providers; see Tables 18.1 and 18.2.

MedFTs working at *Level 1* are typically clinicians positioned in a private practice or agency unaffiliated with military organizations and installations. MedFTs working at this level should have a basic understanding of military culture, the effects of deployment on family relationships, and stressors associated with combat and military service. *Level 1* MedFTs should also be able to diagnose PTSD and identify possible signs of TBI. Although MedFTs working at *Level 1* may not have the expertise to treat PTSD (and certainly not TBI), they should be familiar with local resources that offer research-informed or evidence-based care in order to make appropriate referrals and treatment recommendations. *Level 1* MedFTs should also be able to use the BPSS model in order to provide education about, and normalize the effects of, deployment, combat, and reintegration back into civilian life and the impact(s) that each has on family and couple dynamics.

MedFTs functioning at *Level 2* should be further able to advance, collaborate, and/or coordinate treatment with other clinicians, healthcare professionals, and military family support and relief organizations (like those described in the second and third cases of our vignette above) in order to ensure that both the patient and/or partner are receiving quality care.

MedFTs functioning at *Levels 3* and *4* of the healthcare continuum will likely be working on a military installation or for a military/veteran organization. They are more apt to interact with active duty Service members and/or veterans and their families on a regular basis. Performance at these levels will require MedFTs to have full knowledge of military rank and command structures, as well as special populations such as SEALS, Green Berets, and rangers. MedFTs will need to be prepared to collaborate with a Service member's chaplain, chain of command, and possibly the mental health unit at the military hospital (as was the case described in the first couple in our vignette). As chaplains, chain of commands, and military hospital mental health are all held to different levels of confidentiality (chaplains are the only providers with absolute confidentiality), MedFTs need to be knowledgeable of their clinic's, hospital's, or organization's policies surrounding release of information sequences. They must be prepared to advocate and coordinate services for their patients when their commanders are hesitant to allow participation in care.

Table 18.1 MedFTs in Military and Veteran Health Systems: Basic Knowledge and Skills

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Knowledge	Basic understanding of military culture to include the effects of deployment on family relationships and stressors associated with combat and military service. Familiar with interventions used to provide relief to individuals, families, and couples struggling with varying levels of multisystemic stress. Familiar with resources that offer TBI and PTSD treatment.	Familiar with the benefits of ongoing couple and family therapy in conjunction with individual trauma treatment. Ability to differentiate between depression and anxiety symptoms from those of PTSD and TBI.	In-depth understanding of military culture and military installation policies and procedures. Understanding of limits of confidentiality and policies surrounding release of information when collaborating with other providers. Basic understanding of treatment options for PTSD, TBI, and substance use for active duty military. Basic understanding of different medication and physical therapy options available for patients who have experienced trauma.
Skills	Ability to diagnose PTSD and refer patients to appropriate resources. Ability to identify possible signs of TBI and refer patients to treatment resources. Can use BPSS model to provide education on, and normalize the effects of, deployment, combat, and reintegration back into civilian life. Minimal collaboration with other providers and resources located on military installations.	Ability to collaborate with resources within both the civilian and military community in order to ensure both veterans and their families are taken care of in the event of veteran admission to an inpatient facility or the family's relocation to another duty station. Knowledgeable about how to apply systemic interventions in practice but does it occasionally; capable of assessing patients BPSS and invite support system members to be present for background health issues such as family history and risk-related factors, as well as treatment planning.	Can discuss treatment options with patients and their families as well as patient's chain of command. Frequently collaborates with healthcare professionals for purposes of medication management. Skilled with standardized measures to track patients' individual and relational strengths and challenges (e.g., depression, PTSD, anxiety, pain, social support).

Table 18.2 MedFTs in Military and Veteran Health Systems: Advanced Knowledge and Skills

MedFT Healthcare Continuum Level	Level 4	Level 5
Knowledge	Understands the different levels of trauma and types of trauma as well as different trauma diagnoses. Is aware of different mental health clinics, treatment groups, and education programs that are available on the military installation for Service members and their families or in the community for veterans. Knowledgeable about benefits and risks of associated treatments for multiple complex conditions (e.g., pain, PTSD, TBI, musculoskeletal injuries, depression, anxiety). Understands how to collaborate with other disciplines to implement evidence-based BPSS and family therapy protocols in traditional and integrated behavioral healthcare military and veteran health contexts.	Understands and educates others about treatment and care sequences for unique and/or challenging topics in military and veteran healthcare practice (e.g., pain management, comorbidities); can consult proficiently with professionals about BPSS topics from other fields. Proficient understanding in policies, procedures, and available treatment options for veteran, retired, and active duty Service members. Has an understanding of the physical and neurobiological changes that can occur after experiencing combat, sexual assault, and other traumatic events. Knowledgeable about BPSS research designs and execution, policies, and advocacy needs as relevant to military and veteran care. Proficient in developing a curriculum on integrated behavioral healthcare, BPSS applications, MedFT, etc. to behavioral health and other health professionals employed in a military or veteran healthcare setting. Understands leadership and supervision strategies for building integrated behavioral healthcare teams in a military or veteran healthcare setting.

(continued)

Table 18.2 (continued)

MedFT Healthcare Continuum Level	Level 4	Level 5
Skills	Able to deliver seminars and workshops about the BPSS complexities of a variety of commonly reported diagnoses injuries to a variety of professional types (e.g., behavioral health, biomedical). Can apply several BPSS interventions in care (including most types of brief interventions); can administer mood- and disease-specific assessment tools as the military and veteran health context requires. Can independently and collaboratively construct research and program evaluation studies that study the impact of BPSS interventions with a variety of diagnoses and patient/family units of care. Ability to advocate for treatment for active duty Service members in seeking research-informed treatment. Ability to provide continuity of care for Service members and their families who have experienced trauma until specialized trauma treatment becomes available.	Certified in at least one trauma-focused intervention (e.g., EMDR, CPT, PE). Ability to advocate for BPSS treatment plans in context of the level of collaboration existing among mental and physical health specialists. Ability to provide research-informed relational practices in integrated mental healthcare in both primary care and traditional therapy settings for military and veteran couple and family systems. Leads, supervises, and/or studies success of the implementation and dissemination of BPSS curriculum on integrated behavioral healthcare, BPSS applications, MedFT, etc. for military and/or veteran healthcare contexts. Routinely engages as an administrator/leader and supervisor in a team-based approach to inpatient and/or outpatient care, with consistent communication through electronic health records, patient introductions, curbside consultations, and team meetings and visits. Works proficiently as a MedFT and collaborates with other providers from a variety of disciples.

Additionally, clinicians operating at *Levels 3* and *4* should be familiar with the symptoms of PTSD, TBI, and substance use, as well as an understanding of the needs of amputees and burn survivors—alongside organizations and specialty clinics and services within the military installation and VA system that exist to treat these conditions. It is also at these levels that MedFTs may need to be well versed in research-informed or evidence-based methods of trauma treatment so that they are able to provide interim care to Service members (most active duty trauma treatment programs lack immediate availability for Service members' entry).

MedFTs functioning at the highest level of the healthcare continuum, *Level 5*, will typically be working in a military hospital, VA facility, or MHS/VA clinic.

They will usually function, too, in the capacity of an integrated behavioral healthcare clinician, care coordinator/case manager, supervisor, and/or director. MedFTs at *Level 5* should have an in-depth understanding about military culture and should be able to confidently collaborate and coordinate care with veteran organizations, healthcare staff and trauma treatment teams, spiritual leaders, military commands, and veteran and active duty case managers. These MedFTs should understand the changes in biology, neurobiology, psychology, and behavior that occur after a TBI, combat deployment, sexual assault, or traumatic combat experience—and should thereby be prepared to educate Service members and their families about these effects. MedFTs should also be trained and certified in at least one research-informed trauma intervention—e.g., eye movement desensitization and reprocessing (EMDR; Shapiro, 1989), cognitive processing therapy (CPT; Resick et al., 2008), and prolonged exposure therapy (Foa, Rothbaum, & Hembree, 2007)—and be able to coordinate care with psychiatrists, neurologists, physical therapists, and other marriage and family therapists in order to ensure the best possible care is advanced. Further, *Level 5* MedFTs should be able to advocate for BPSS-based treatment plans for veterans and their families, even if integrated behavioral healthcare policies and treatment teams do not yet exist in the facility in which the MedFT functions. MedFTs working at this level of care must also be prepared to face challenges related to the bureaucracy and policy restrictions that come with military and veteran healthcare and health systems and be willing to use innovation and creativity vis-à-vis these restrictions so as to ensure that patients receive high-quality care.

Research-Informed Practices

For military and veteran populations, MedFT services that are brief and integrated into healthcare contexts may be critical in reducing barriers to treatment and receiving mental healthcare in tandem with acute and complex physical health concerns (Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). MedFTs' systemic and BPSS perspectives make them ideal collaborators for addressing common concerns experienced by military Service members and veterans (e.g., depression, anxiety, trauma, substance abuse). While there is extensive research on evidence-based practices for working with the military and veteran populations in traditional care settings, some of these treatments have only begun to be adapted for integrated behavioral healthcare models. The DoD (2014b) recently released guidelines for behavioral health interventions in primary care; these include recommendations for four or fewer sessions with appointment durations of 15 to 30 minutes. Fortunately, MedFTs are trained to offer both traditional and IBHC sessions that span from 15 to 30 minutes for brief encounters and up to 50 minutes for traditional encounters. While MedFTs are commonly trained first as family therapists, all are well trained in extending BPSS and relational care to individuals, couples, families, and other communities of interest.

Individual Approaches

When serving any context, MedFTs should be cognizant of their patients' culture(s). As stigma regarding mental health issues is often cited as a barrier in treatment engagement (e.g., Zinzow et al., 2012), some researchers recommend avoiding terms such as "patient," "PTSD," "therapy," and "treatment" (Steenkamp et al., 2017). Due to the prevalence of such stigma among military and veteran populations, some programs have implemented universal screenings for depression and PTSD in primary care as part of standard of care (Engel et al., 2008) and resiliency staff. The prevailing evidence-based treatments for PTSD include prolonged exposure therapy (PE; Foa et al., 2007), CPT (Resick et al., 2008), and EMDR (Van der Kolk, et al., 2007). Core elements of these treatments (and others) have been adapted for brief, integrated delivery formats. Cigrang et al. (2011) utilized PE, combined with aspects of CPT, to treat PTSD in a brief, four-session format. Their intervention included homework via a workbook format, in which patients wrote their trauma narratives and self-monitored their emotional responses. Throughout treatment, the clinician served as a collaborator and assisted patients with implementation. Glover et al. (2016) applied focused acceptance and commitment therapy (FACT; Strosahl, Robinson, & Gustavsson, 2012), an abbreviated version of acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999, 2011), to create a four-session group at the VA. This intervention, which included mindfulness and cognitive exercises, was effective in the reduction of depression, anxiety, and stress. Further, cognitive behavioral therapy (CBT) techniques have demonstrated effectiveness for the treatment of insomnia in primary care (Edinger & Sampson, 2003; Edinger et al., 2009).

While some brief interventions may have the primary goal of symptom reduction, others—such as Steenkamp et al. (2017)—aim to "plant seeds" for new, more adaptive ways of coping with trauma. Their exposure-based treatment for active duty Service members with PTSD combined elements of PE, CPT, CBT, EMDR, as well as Gestalt therapy (Perls, Hefferline, & Goodman, 1957), through imaginal exposure, interpersonal sharing, increasing Service members' awareness of personal meaning-making regarding traumatic events, and a modified empty chair technique. In particular, the modified empty chair technique was used to address concerns related to moral injury. Other brief interventions with demonstrated efficacy in treating PTSD and common comorbid concerns include behavioral activation, relaxation techniques, written exercises, and creating impact statements (e.g., Corso et al., 2009).

Brief interventions may have long-term effects for Service members and veterans. In an outcome study in a primary care setting that served military Service members, veterans, and their families, Ray-Sannerud et al. (2012) found that patients improved over the course of treatment and that these improvements were maintained 2 years posttreatment. Common presenting concerns included insomnia, depression, stress/anxiety, and panic, with interventions including psychoeducation, mindfulness training, diaphragmatic breathing, and behavioral activation. While

MedFTs should be adept at implementing individual BPSS psychotherapy approaches, they are also uniquely positioned to promote relational change.

Couple and Family Approaches

In recent years, numerous programs have been implemented to support the relational health of Service members and veterans. However, many of these programs are in the form of traditional therapy or weekend retreats. Recently, Cigrang et al. (2016) adapted the Marriage Checkup (MC; Cordova, 2009) for primary care, which MedFTs may find helpful in their service delivery. The adapted MC takes place over the course of three 30-minute sessions, with the goals of prevention, detection, and early intervention of relational health concerns to promote long-term marital health. This brief intervention encompasses a relationship history interview, the assessment of relational strengths and concerns, and motivational feedback with specific therapeutic techniques consisting of uncovering "soft" emotions (e.g., sadness, loneliness), discovering understandable reasons, and identifying patterns and themes. While brief couples interventions are relatively new in this context, military and veteran couples have additional resources available to them (Lewis, Lamson, & Lesueur, 2012).

The Strength at Home Couples program is a CBT-informed, 10-week couples group for the prevention of IPV among veteran and Service member couples (Taft et al., 2016). This intervention includes psychoeducation, strategies to improve emotional expression, and skill building in conflict management, assertiveness, listening, and communication. While this program does not punctuate BPSS health per se, MedFTs who deliver such programs must be proficient at knowing signs of PTSD and TBI, among other diagnoses, that could influence the physical or psychosocial dynamics of couples. Having a MedFT skill set can allow the MedFT to access knowledge beyond what may be provided in the intervention manual; it can assist in knowing when an intervention should be concluded in order to turn to more serious physical or psychosocial concerns.

Army couples have the opportunity to participate in weekend retreat-style programs such as PREP (Prevention and Relationship Education Program) for Strong Bonds (Allen, Rhoades, Markman, & Stanley, 2015). These programs are typically facilitated by Army chaplains. Aspects of this 14+ hour intervention include communication skills, emotion regulation, relaxation, core beliefs, and forgiveness. The Navy also offers a couple's retreat, CREDO (Chaplain Religious Enrichment Development Operation (Department of the Navy, 2017)). These retreats have demonstrated effectiveness in reducing divorce and breakup rates for minority couples, couples experiencing financial strain, and precommitment cohabiting couples. MedFTs are commonly great leaders or coleaders for programs such as these, because of their training with and awareness for diverse social locations (i.e., factors that are influential in significant findings from this program).

For many couples, outcomes from relational (Baptist & Nelson Goff, 2012) and BPSS assessments may become influential in the interventions they receive and may open the door for more targeted treatments if indicated. Relational-focused assessment and treatment, particularly in primary care contexts, have important implications for Service members' readiness. Trump, Lamson, Lewis, and Muse (2015) highlighted the interplay between partners' physical health (e.g., pain), mental health (e.g., depression), and marital satisfaction, underscoring the importance of BPSS assessments as a part of IBHC couples' treatment in primary care and other health-related contexts (e.g., the Army Child and Family Services). Some of the most common challenges cited by other authors and tied to education or intervention with military and veteran populations include amputations, TBI, insomnia, chronic pain, IPV, MST, substance use, and relational distress (Blaisure, Saathoff-Wells, Pereira, MacDermid-Wadsworth, & Dombro, 2016; Goff, Crow, Reisbig, & Hamilton, 2007; Mansfield, Kaufman, Marshall, Gaynes, Morrissey, & Engel, 2010; Trump, Lamson, Lewis & Muse, 2015).

Only minimal research exists about the BPSS needs of dual military couples (Lacks, Lamson, Lewis, White, & Russoniello, 2015) and LGB military and veteran couples (Johnston, Webb-Murphy, & Bhakta, 2016). More interventions must thereby be developed, implemented, and evaluated for these couples. For more information about interventions that have been tested with military or veteran dyads, see Lewis, Lamson, and White (2016).

For military and veteran families with children, interventions that attend to BPSS and relational needs of both the caregiver/parent/guardian and child are important (Chandra et al., 2010). Many family therapy interventions have emerged over the past decade for military and veteran families. These interventions commonly consist of psychoeducation, self-monitoring, relaxation training, and altering maladaptive beliefs (Friedberg & Brelsford, 2011; Kortla & Dyer, 2008; Murphy & Fairbank, 2013). Given the volume of family-based programs that may be available in military and veteran communities, MedFTs should take time to review systematic reviews and meta-analyses that offer a consolidated perspective on promising and research-informed interventions (Creech, Hadley, & Borsari, 2014). Below are examples of some of the promising interventions delivered to military and veteran families with children and adolescents.

FOCUS (Families OverComing Under Stress; Beardslee et al., 2011) is a program that is theoretically grounded in individual and family resilience and has received national recognition for its success. It is an eight-session resiliency training program for military children and families that aims to improve emotion regulation, honor family members' multiple perspectives on deployment, enhance family strengths and coping skills, engage community supports and services, create a family narrative about the deployment experience, strengthen parental leadership, and advance collaborative problem solving and goal setting. MedFTs would serve as an asset to a FOCUS team, given their training in parent psychological health, child behavioral health, and family functioning.

For reserve component and National Guard families, the After Deployment Adaptive Parenting Tools Program (Gewirtz, Erbes, Polusny, Forgatch, & DeGarmo, 2011; ADAPT), an extension of Parent Management Training-Oregon (Forgatch & Martinez, 1999; PMTO), may be useful. In this 14-week multifamily sessions program, parents learn emotion regulation and parenting skills with a focus on deployment-related issues through role-plays and group discussions. Again, MedFTs' prevention and intervention skills in relational health would offer a strong contribution to any ADAPT team.

Passport to Success (Wilson, Wilkum, Chernichky, MacDermid-Wadsworth, & Broniarczyk, 2011) is a research-informed program that was constructed for adolescent dependents of reservists. The program was developed as part of the Department of Defense's Yellow Ribbon Program. MedFTs who collaborate with program leaders would assist in focusing on challenges associated with PTS that exist with parents or are intergenerationally transmitted. While many other family-based programs have been developed over the years for these populations, MedFTs must become good consumers of research in order to recognize what is best indicated for the social locations of the potential participants.

Community Approaches

Limited outcome research exists regarding interventions for community-dwelling members of the military and veteran populations (Murphy & Fairbank, 2013). Vet centers are located throughout the country and may assist veterans and their families with mental health needs. Standard group psychotherapy for PTSD at vet centers is emotion focused and centered on the impact of symptoms on current functioning; group member input, feedback, and disclosures are also encouraged (Daniels, Boehnlein, & McCallion, 2015). While this approach produces some benefits, the inclusion of a "life-review" component was found to significantly improve PTSD symptoms in a small sample of older veterans (Daniels et al., 2015). For the structured life-review component, MedFTs should collaborate with group members on best ways to share content associated with premilitary history, military/war zone history, and post-military history.

More recently, researchers have initiated interventions for the partners of Service members. HomeFront Strong (Kees & Rosenblum, 2015) is an 8-week community-based group intervention for military spouses that emphasizes self-care, building community, stress management, re-authoring narratives, allowing emotions, and building positive coping skills. Though the sample size in this initial pilot study was small, spouses reported reductions in stress and anxiety, but not depression, as well as increases in life satisfaction and engagement. Research on interventions for community-dwelling children is very limited, but it is notable that nonmilitary providers deliver physical and mental healthcare to more than 50% of military

children (particularly those of activated Service members in the National Guard and Reserve; Gorman, Eide, & Hisle-Gorman, 2010). For this reason, even if a MedFT is not working in a context that primarily serves Service members, veterans, or their families, MedFTs should strive to be military informed. Military-informed MedFTs should consistently ask patients: "Have you or a member of your family ever served in the military?" (Brown, 2012; Murphy & Fairbanks, 2013; Siegel, Davis, & the Committee on Psychosocial Aspects of Child and Family Health and Section on Uniformed Services, 2013).

Veterans may also benefit in peer-to-peer models of care. Matthias et al. (2015) found that veterans with chronic pain reported reduced pain severity and interference after receiving phone and/or in-person meetings at least twice per month with a trained "peer coach." Coaches are trained in areas such as communication, cultural competence, crisis management, and motivational strategies, alongside basics of chronic pain, relaxation, self-care, cognitive behavioral skills, and interpersonal functioning. In a study of peer-led pain self-management groups, Baur et al. (2016) recommended that peers focus on goal setting, and how to make goals measurable, when working with veterans. It is important that MedFTs be aware of such programs in the community given that "experience with mental health" and "barriers to treatment" were two concerns that National Guard soldiers mentioned would be harder to discuss with a peer (Pfeiffer et al., 2012).

Research has also shown that peer-to-peer models in military and veteran healthcare increase utilization of psychotherapy services and reduce dropout. Goetter et al. (2017) found that after trained non-clinician veterans performed a telephone check-in with prospective veteran patients (1 week after a clinical evaluation and 1 month after the initial session), patients were likely to attend more psychotherapy sessions and had lower dropout rates than those who had received only one or zero check-ins.

Another peer-to-peer network that should include MedFTs is one that targets healthcare provider burnout and vicarious traumatization, which is a common concern for those who provide care to military and veteran populations. Among behavioral health providers serving Operation Enduring Freedom (OEF) and/or Operation Iraqi Freedom (OIF) veterans, researchers found that the more confidants a provider had at work, the lower the burnout rates (Ballenger-Browning et al., 2011). MedFTs are commonly trained in how to maintain awareness of their own self-of-the-therapist needs and can raise that awareness further through initiatives that focus on provider to provider well-being. MedFTs must recognize their own risks for burnout, as well as the risks for providers on the care team. Given MedFTs' training in larger systems, an (additional) important role awaits them in improving provider/staff quality of life. Initiatives that address prevention of or solutions to burnout can increase the wellness of the integrated behavioral healthcare team, both personally and professionally (Ballenger-Browning, Schmitz, Rothacker, Hammer, Webb-Murphy, & Johnson, 2011).

Conclusion

The Department of Defense is the largest employer in the United States, and it is clear that this workforce and its retirees be a prime focus for MedFT practice, research, training, and advocacy. BPSS conditions experienced by civilians may be more acute and/or complicated in the military by nature of the variety of job duties, risks, and social locations associated with active duty or veteran patients. MedFTs must be on the front lines of creating and implementing research-informed interventions that can maximize relational and BPSS health for diverse military personnel and veterans, alongside their dependents and communities. Furthermore, MedFTs can strengthen the well-being of the provider workforce and sustainability of the integrated behavioral healthcare team by using their systemic lenses to identify risks to productivity (e.g., burnout) and then offering strength-based solutions that promote workforce success.

Reflection Questions

1. What are some of the BPSS factors that must be taken into consideration when assessing, diagnosing, or treating a military or veteran individual, couple, or family that may be different from civilian counterparts?
2. What are some of the research-informed practices that MedFTs may use to improve mental health symptoms when working with military or veteran couples and families facing challenges after a combat injury?
3. What programs could be implemented by a MedFT in a military or veteran healthcare context, or in the community, that could help to reduce military or veteran health disparities?

Glossary of Important Terms in Military and Veteran Health Systems

AD Active duty; refers to Service members who serve full time in the armed forces.

ADAPT Air Force Alcohol and Drug Abuse Prevention and Treatment Program.

AMEDD Army Medical Department of the United States of America; refers to the Army's healthcare organization.

ASAP Army Substance Abuse Program; the anti-substance abuse program in the U.S. Army.

BHIP Behavioral Health Integration Program; the U.S. Navy's model for embedding behavioral health providers into primary care settings.

BHOP Behavioral Health Optimization Program; the U.S. Air Force's model for embedding behavioral health providers into primary care settings.

BUMED Bureau of Medicine and Surgery; the organization that manages healthcare services for the U.S. Navy and U.S. Marine Corps.

CAC Common Access Card; the standard identification for active duty personnel, selected reserve, DoD civilian employees, and eligible contractor personnel. It also allows the card holder to have access to buildings, controlled areas, and DoD computer systems.

CAF Comprehensive Airman Fitness; refers to the well-being of Airmen from a four-pillar approach (mental, physical, social, and spiritual).

CBOC Community-based outpatient clinics; created by the VA to expand healthcare services to veterans in rural areas and/or those without access to the larger VA medical centers.

CHAMPVA Civilian Health and Medical Program of the Department of Veterans Affairs; refers to a health benefits program.

CSF2 Army's Comprehensive Soldier and Family Fitness; uses five areas (physical, social, family, spiritual, and emotional) to promote resiliency and performance enhancement in soldiers, their families, and civilians.

DEERS Defense Enrollment Eligibility Reporting System; the database of military members and their beneficiaries to receive TRICARE benefits.

Deployment A long-term assignment, often situated in a combat zone.

DoD Department of Defense; a branch of the federal government that oversees national security and the U.S. Armed Forces.

EBHP Embedded behavioral healthcare providers; professionals who work in units to help in preventing behavioral health issues from becoming a serious issue for the Service member or unit. They tend to teach classes on behavioral health and coordinate referrals to those who have a need for specialty services.

Fleet and Family Support Services The Navy's Family Readiness programs that include services for work and family life, counseling, advocacy, and prevention, as well as sexual assault prevention programs.

IDES Integrated Disability Evaluation System; a joint process between the Department of Defense (DoD) and Department of Veterans Affairs (VA) to determine if a Service members have sustained wounds that may prevent them from performing their duties and their ability to continuing serving in the armed forces.

Installation Generic term used for a military facility (e.g., base, camp, post, fort, or station).

MEB Medical Evaluation Board; recommends whether a Service member's medical condition prevents him/her from performing assigned work duties.

MHS Military Health System; the organization within the DoD that provides healthcare to active duty and retired military personnel and their dependents.

MOS Military occupational specialty; code used to identify a specific job in the military.

MST Military sexual trauma; refers to sexual assault or repeated harassment that occurs during military service.

MTF Military treatment facilities; military hospitals and clinics at military installations around the world.

OEF Operation Enduring Freedom; began in 2001 when the U.S. military deployed to Afghanistan to combat terrorism. The conflict ended in 2014.

OIF Operation Iraqi Freedom; began in 2003 when the U.S. military deployed to Iraq. The initiative ended in 2011.

PCS Permanent change of station; the mandatory relocation of an active duty service member to a different duty location.

PDHRA Post-Deployment Health Reassessment; a comprehensive health screening that examines physical and behavioral health concerns associated with deployment, 3 to 6 months after return from deployment.

PEB Physical Evaluation Board; reviews the findings from the MEB to determine the Service member's ability to perform his/her work duties.

PHA Periodic Health Assessment; an annual health screen to evaluate medical readiness.

Profile An official document that prohibits a Service member from certain types of military duty due to injury or disability; can be temporary or permanent.

SARP Substance Abuse Rehabilitation Program; the anti-substance abuse program for all active duty members.

SCMH Army Soldier Centered Medical Home; the U.S. Army's version of the patient-centered medical home (PCMH).

TDY Temporary duty assignment; refers to a travel assignment to a location other than the permanent duty station.

Transitioning The readjustment period of transitioning from military back into civilian life; also known as "reintegration."

Veteran Someone who has served in the military.

VA Veterans Administration.

VHA Veterans Health Administration.

Additional Resources

Literature

Anderson, W. (2015). *Battlefield doc: Memoirs of a Korean war combat medic*. St. Louis, MO: Moonbridge Publications.

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Junger, S. (2016). *Tribe.* New York, NY: Grand Central Publishing.

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Van Der Kolk, B. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma.* New York, NY: Penguin Books.

Measurements/Questionnaires

Alcohol Use Disorders Identification Test (AUDIT). http://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf
CAGE Alcohol Questionnaire. http://www.integration.samhsa.gov/images/res/CAGEAID.pdf
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). http://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp
Generalized Anxiety Disorder. http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf
Patient Health Questionnaire (PHQ-9). http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf
Sexual Harassment Scale. http://www.ptsd.va.gov/professional/assessment/deployment/sexual-harassment.asp
Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS). http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/, http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Organizations/Associations

After Deployment. http://afterdeployment.dcoe.mil/
Center for Deployment Psychology. http://deploymentpsych.org/
Department of Defense. https://www.defense.gov/
Family Advocacy Program. http://www.militaryonesource.mil/phases-military-leadership?content_id=266712
Military Family Research Institute. https://www.mfri.purdue.edu/
Military OneSource. http://www.militaryonesource.mil/
National Center for PTSD. http://www.ptsd.va.gov/
National Child Traumatic Stress Network. http://www.nctsn.org/
National Military Family Association. http://www.militaryfamily.org/
SAMHSA Military Families. http://www.samhsa.gov/MilitaryFamilies/
Veterans Affairs. https://va.gov/

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