

Perspectives of Family and Veterans on Family Programs to Support Reintegration of Returning Veterans With Posttraumatic Stress Disorder

Ellen P. Fischer

Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas; University of Arkansas for Medical Sciences

Michelle D. Sherman

South Central Mental Illness Research, Education and Clinical Center, Oklahoma City, Oklahoma; University of Oklahoma Health Sciences Center

Jean C. McSweeney

University of Arkansas for Medical Sciences

Jeffrey M. Pyne and Richard R. Owen

Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas; University of Arkansas for Medical Sciences

Lisa B. Dixon

VA Capitol Health Care Network Mental Illness Research, Education and Clinical Center, Baltimore, Maryland; University of Maryland

Combat deployment and reintegration are challenging for service members and their families. Although family involvement in mental health care is increasing in the U.S. Department of Veterans Affairs (VA) system, little is known about family members' preferences for services. This study elicited the perspectives of returning Afghanistan and Iraq war veterans with posttraumatic stress disorder and their families regarding family involvement in veterans' mental health care. Semistructured qualitative interviews were conducted with 47 veterans receiving care for posttraumatic stress disorder at the Central Arkansas Veterans Healthcare System or Oklahoma City VA Medical Center and 36 veteran-designated family members. Interviews addressed perceived needs related to veterans' readjustment to civilian life, interest in family involvement in joint veteran/family programs, and desired family program content. Interview data were analyzed using content analysis and constant comparison. Both groups strongly supported inclusion of family members in programs to facilitate veterans' postdeployment readjustment and reintegration into civilian life. Both desired program content focused on information, practical skills, support, and gaining perspective on the other's experience. Although family and veteran perspectives were similar, family members placed greater emphasis on parenting-related issues and the kinds of support they and their children needed during and after deployment. To our knowledge, this is the first published report on preferences regarding VA postdeployment reintegration support that incorporates the perspectives of returning male and female veterans and those of their families. Findings will help VA and community providers working with returning veterans tailor services to the needs and preferences of this important-to-engage population.

Keywords: veterans, family, PTSD, service preferences

Editor's Note. This is one article of eight in a special section on Veterans and their families during reintegration after deployment.

Ellen P. Fischer, Center for Mental Healthcare and Outcomes Research, Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas; Department of Psychiatry, University of Arkansas for Medical Sciences; Michelle D. Sherman, South Central Mental Illness Research, Education and Clinical Center, Oklahoma City, Oklahoma; Department of Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center; Jean C. McSweeney, College of Nursing, University of Arkansas for Medical Sciences; Jeffrey M. Pyne and Richard R. Owen, Center for Mental Healthcare and Outcomes Research, Central Arkansas Veterans Healthcare System, North Little Rock, Arkansas; Department of Psychiatry, University of Arkansas for Medical Sciences; Lisa B. Dixon, VA Capitol Health Care Network Mental Illness Research, Education and Clinical Center, Baltimore, Maryland; Department of Psychiatry, University of Maryland.

Michelle D. Sherman is now at the Department of Family Social Sciences, University of Minnesota, and the Minnesota Veterans Research Foundation, Minneapolis, Minnesota. Lisa B. Dixon is now at the Department of Psychiatry, Columbia University Medical Center, and the Center for Practice Innovations, New York State Psychiatric Institute, New York, New York.

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Correspondence concerning this article should be addressed to Ellen P. Fischer, Center for Mental Healthcare and Outcomes Research, Central Arkansas Veterans Healthcare System, 2200 Fort Roots Drive, Building 58 (152/NLR), North Little Rock, AR 72114-1706. E-mail: fischerellenp@uams.edu

Posttraumatic stress disorder (PTSD) is prevalent among veterans using U.S. Department of Veterans Affairs (VA) health care services, including veterans returning from Afghanistan and Iraq. Approximately 30% of the veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn who use VA health care services have been diagnosed with PTSD (Epidemiology Program, Post-Deployment Health Group, Office of Public Health, Veterans Health Administration, & Department of Veterans Affairs, 2014).

PTSD can negatively impact functioning and quality of life for both affected individuals and their family members (Monson, Taft, & Fredman, 2009). The emotional numbing, hypervigilance, and hyperarousal symptoms of PTSD increase the risk of interpersonal problems with partners and children, including divorce, intimate partner aggression, and difficulties in child rearing (Keane, Marshall, & Taft, 2006). Persistent PTSD symptoms can also erode supportive relationships in other social and work settings. Research has shown that social and emotional support protect against development of chronic PTSD (Keane et al., 2006; Schnurr, Lunney, & Sengupta, 2004). Conversely, interactions with unsupportive partners are associated with lower likelihood of seeking treatment (Institute of Medicine, 2013; Meis, Barry, Kehle, Erbes, & Polusny, 2010) and poorer treatment outcomes (Makin-Byrd, Gifford, McCutcheon, & Glynn, 2011), and a stressful environment can adversely affect an individual's ability to benefit from PTSD treatment (Tarrier, Sommerfield, & Pilgrim, 1999). Because poor family functioning and lack of social support are associated with poorer outcomes of PTSD treatment (Byrne & Riggs, 2002; Evans, Cowlshaw, Forbes, Parslow, & Lewis, 2010; Kaniasty & Norris, 2008; Keane et al., 2006; Sayer et al., 2010; Taft, Watkins, Stafford, Street, & Monson, 2011; Tarrier et al., 1999), practice guidelines increasingly emphasize family involvement in mental health care for PTSD (Foa, Keane, & Friedman, 2009; Ursano et al., 2004; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2010).

Over the past decade, the VA has systematically expanded efforts to involve family members in the care of veterans (Glynn, 2013). Since 2008, the VA has required all VA medical centers to offer family consultation, couples and family therapy, and family education or family psychoeducation services for veterans with PTSD (U.S. Department of Veterans Affairs, Veterans Health Administration, 2008). This initiative is consistent with findings in the small, but growing, literature on Iraq and Afghanistan veterans' interest in greater family involvement in care. Several studies have shown that a majority of veterans with PTSD report interest in and endorse greater family involvement in treatment and believe that their family member(s) would be interested in family-centered educational and support services as well (Batten et al., 2009; Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011; Meis et al., 2012; Sayer et al., 2010). Veterans reported interest in receiving and having their family members receive information on a variety of topics including PTSD and its impact on the family, improving communication, problem solving, and other relationship-related issues (Batten et al., 2009), and Khaylis et al. (2011) found a strong preference among returning National Guard soldiers for family-based rather than individual-oriented treatment. In a study by Sayer et al. (2010), veterans expressed greater interest in receiving services and information face-to-face rather than by tele- or videoconferencing. Despite the interest expressed by veterans in

family-involved services and the focus of VA programs on topics and formats of interest, one of the challenges faced in the VA's ongoing transition to more family-centered care has been underutilization of family-involved programs for veterans with PTSD (Institute of Medicine, 2014; Meis et al., 2012). The gap in knowledge about how best to engage family members in care for PTSD, especially with respect to the newest generation of returning veterans (Institute of Medicine, 2012; Monson et al., 2009), may arise in part from the relative dearth of published information on family members' own perspectives and preferences.

This study was designed to elicit the priorities and preferences of returning veterans with PTSD and their families relevant to family involvement in care, specifically, their interest in a program focused on postdeployment readjustment and reintegration that would involve both veterans and family members, on preferred content for such a program and preferred program format(s).

Method

Participants

We recruited veterans from the Central Arkansas Veterans Healthcare System (CAVHS) and the Oklahoma City VA Medical Center (OKC). Veterans were eligible if they were aged 18–65 years, had served in Iraq or Afghanistan after October 2001, and had received treatment for PTSD at either CAVHS or OKC in the previous 12 months. We used several methods to inform potential participants about the study. Outpatient clinicians at CAVHS and OKC were asked to inform potentially eligible veterans about the study in person or by mail or telephone and to encourage them to contact project personnel. All OKC veteran participants were recruited through clinician referral to the study. At CAVHS, potential participants could also learn about the study from other participating veterans, from fliers posted at CAVHS and veterans' service organizations, or from advertisements in the local newspaper. Family participants were recruited solely from among the individuals designated by participating veterans. *Family* was defined broadly as "anyone you would select to take part in a program with you," including relatives, significant others, and adult friends who are "as close to you as family."

We spoke with a total of 81 veterans and 65 family members regarding participation in the study. A total of 47 veterans and 36 family members consented and were interviewed; 34 veterans and 29 family members declined to participate. Veteran participants were predominantly male, married or cohabiting, and had minor children at home (see Table 1). Non-Hispanic Blacks composed the largest ethnic group, followed by non-Hispanic Whites. Most were in their 20s or 30s (28/47; 59.6%). More than 60% of family participants were the spouses or significant others of participating veterans. Family participants were predominantly female, married or cohabiting, and had minor children at home. Approximately 25% were aged 50 or older; the remaining 75% were equally divided among those in their 20s, 30s, and 40s. Several family participants had served in the military, including five who had deployed to Iraq or Afghanistan.

After complete description of the study to participants, written informed consent was obtained. All aspects of this research were approved by the Institutional Review Boards of CAVHS and the

Table 1
Characteristics of Participants

Characteristic	Veterans (<i>n</i> = 47)		Family (<i>n</i> = 36)	
	<i>n</i>	%	<i>n</i>	%
Male	31	70.0	9	25.0
Race/ethnicity				
Native American ^a	6	12.8	2	5.6
Non-Hispanic Black	19	40.4	12	33.3
Non-Hispanic White	18	38.3	19	52.8
Other and missing	4	8.5	3	8.3
Marital status				
Married or cohabiting	27	57.4	30	83.3
Separated	5	10.6	1	2.8
Divorced	6	12.8	2	5.6
Never married	8	17.0	3	8.3
Missing	1	2.1	0	0.0
Children <18 years old in the home				
Yes	30	63.8	25	69.4
No	16	34.0	11	30.6
Missing	1	2.1	0	0.0
Veteran: Rank				
Junior enlisted	27	57.4		
Noncommissioned officer	15	31.9		
Officer	1	2.1		
Missing	4	8.5		
Family: Relation to veteran				
Spouse or significant other			22	61.1
Parent			5	13.9
Child			1	2.8
Other family member			5	13.9
Friend			3	8.3
Family: Ever served in military			9	25.0
Family: Ever deployed to Iraq or Afghanistan			5	13.9

Note. Veterans' mean age = 37.3 years (*SD* = 10.9); family participants' mean age = 39.1 years (*SD* = 13.1). Veterans' mean number of deployments to Iraq/Afghanistan = 2.0 (*SD* = 1.0).

^a Includes three veterans who self-identified as multiracial including American Indian.

University of Oklahoma Health Sciences Center and the Research and Development Committees at CAVHS and OKC.

Data Collection

We initially intended to conduct focus group interviews only. However, the competing demands (e.g., work, school, child care) facing potential participants made an individual interview option essential. We interviewed 25 veterans in six focus groups. Two focus groups included three veterans each; the other four included two, four, five, or eight veterans. We interviewed 27 family members in six focus groups. Two of these included two participants each; the remainder included four, five, six, or eight family members. We interviewed 22 veterans and nine family members individually.

The same experienced qualitative interviewers facilitated focus groups and conducted individual interviews. Interviews took place in private rooms at CAVHS or OKC between January 2010 and October 2011. Separate focus groups were conducted for male veterans, female veterans, and family members.

All interviews followed the same interview guide and covered the same topics. Each interview began with a general question to elicit discussion of what had helped and what had hindered participants' readjustment following the veteran's most recent deployment. The remainder of the interview focused on how participants felt VA programs for veterans and families had or could have helped them deal with readjustment and with the veteran's PTSD, the content that would be most useful in such a program, and perceived obstacles to participation (see Table 6).

Following each interview, we asked participants to complete an anonymous paper-and-pencil questionnaire addressing demographics, deployment history, and preferences regarding program structure and format. The questionnaire also asked veterans to complete a checklist indicating the goals that were important to them at that time. (Copies of questionnaires are available on request from the first author.)

Analyses

Audio recordings of each focus group or individual interview were transcribed verbatim, reviewed for completeness and accuracy, and entered into ATLAS.ti V5.6, a software program that facilitates management, coding, and analysis of narrative data (Muhre & Friese, 2004).

Qualitative data were analyzed using the techniques of content analysis and constant comparison (Harding, 2013). Transcripts from the first focus groups with male veterans were examined by three team members (EPF, JCM, and an interviewer) who had been present at them. Using the technique of content analysis, we read each transcript line-by-line to identify relevant words and key phrases. The team discussed the meaning of these key words and phrases. We then selected the most descriptive term for them and assigned a code name to reflect each key issue raised by participants. After reaching consensus on code names, we jointly developed an initial codebook incorporating definitions for each code (Miles, Huberman, & Saldana, 2014; Rubin & Rubin, 2012). To establish intercoder reliability, we used the codebook to independently code transcripts and discussed differences in coding until consensus was reached (Bernard & Ryan, 2010). We repeated this process separately with transcripts of interviews with female veterans and transcripts of interviews with family members. Codes capturing new issues raised by female veterans or family members were added to the codebook. This final codebook was used to analyze transcripts from both focus group and individual interviews with male veterans, female veterans, and family members.

After we had analyzed each transcript separately, we analyzed the combined transcripts for each group (male veterans, female veterans, family members). Combining focus group and individual data aided in reaching saturation (Rubin & Rubin, 2012). We then used the technique of constant comparison, an iterative process in which researchers thoroughly explore the commonalities and differences in reported experiences to promote conceptual understanding of the phenomenon of interest (Harding, 2013). We used this technique to explore commonalities and differences in the perspectives of male and female veterans and of veterans and family. We then combined related codes into subthemes and related subthemes into broader, more abstract themes to better understand differences and similarities in perspective across groups.

We also compared the perspectives of veterans and family members, as reflected in the frequency of themes and subthemes emerging from the interviews and responses to the questionnaire, quantitatively using chi-squared analysis with Yates's correction for continuity as appropriate. Quantitative analyses were performed using the Opus 12 Foundation Chi-Square Calculator (http://www.opus12.org/Chi-Square_Calculator).

Results

Context and Goals

Although they were not the focus of the study, participants' remarks during the interviews about veterans' reintegration experience and the goals veterans endorsed on the questionnaire merit comment because they provide context for participants' program content preferences. Both veterans and family members remarked on veterans' relationship problems with partners, children, friends, and employers; issues with trust, motivation, and isolation; problems with anger management, substance use, and other risky behaviors; physical health problems; and the challenges of dealing with systems like the Department of Defense (DoD) and the VA. On the self-administered questionnaire, veterans checked goals that were "important to [them] right now." Checklist responses paralleled comments made during the qualitative interviews and are presented in Table 2.

Program Content

Veterans and family members expressed a desire for the same four types of program content: information, practical skills, support, and gaining perspective on each other's experience (see

Tables 3 and 4 for themes, subthemes, and illustrative quotations). However, details varied by group as discussed below.

Information. The majority of participants said that a family program should provide information, especially with respect to PTSD and to VA services and systems. Veterans, all of whom were or had been in treatment for PTSD, focused most heavily on getting information about PTSD to their family members. Comments like this one from a male veteran were common: "Pretty much everybody needs to understand what PTSD is . . . You got to understand it in order to help."

Family members echoed veterans' desire that family members, including children, receive more information about PTSD. The fiancé of one veteran said, "I wish I would have known what PTSD was . . . For a long period of time I thought that was an excuse he was using, you know, not to do things." The cousin of another veteran remarked that ". . . the kids. . . need some education on it. . . someone else to tell the symptoms and tell, you know, what could happen and how to deal with it."

About a third of veterans also expressed a desire for information about current VA services and benefits, as well as how VA health care programs operate and communicate internally: "It's like you need a PhD in just Veterans Affairs [to figure out what services are available]. . . every time you look around, it's like we used to do, oh, no, it's not like that now." Female veterans, in particular, expressed the need for better information on programs available for women: "They need to tell you about the women's programs. . . The only reason I found out about the women's recreational therapy is one of the women that's in there saw me [and approached me about it]."

Practical skills. Closely aligned with the desire for information was a desire for skills to handle challenges related to PTSD and reintegration. As shown in Table 3, veterans and family members perceived a need for skills training in seven areas: living with a person with PTSD, interpersonal relationships and communication, structuring and managing daily life, parenting, trust and friendship, family members' coping with their own emotions, and anger management. The need for skills training to help families living with a person with PTSD was mentioned most frequently by both veterans and family members. As one male veteran noted,

[They need] not just awareness, but tools as well. . . . Our families have already noticed that we've come home. . . and we have issues. . . [They need] tools to understand what to do, tools on how to deal with the stress that is on me, and how to deal with it in a [respectful] way. . . .

Although a desire for a program that includes interpersonal and communication skills, strategies for structuring and managing one's life, and skills related to parenting were raised by both groups, veterans and family differed in the frequency with which they expressed a need for these three skill sets. Among veterans, interpersonal and communication skills were the most frequently mentioned of these three. Comments in this area included the following from a male veteran:

. . . it was probably last year I started hugging my kids . . . I was so used to like seeing Iraqi children. . . I could not get close, so if there were a class where you're showed communication skills. Like, this is how you deal with stuff and this is how you come back and are able to make some sort of emotional attachment.

Table 2

Goals Endorsed by Veterans on Anonymous Questionnaire, in Descending Order of Frequency

I would like to . . . (Check all that apply)	<i>n</i>	%
Be able to trust people more	41	87.2
Communicate better with my family and friends	41	87.2
Have less tension and fewer arguments with people	39	83.0
Learn how to relax	39	83.0
Have my family/friends understand better what I'm going through	38	80.9
Learn how to better manage my temper	38	80.9
Do more fun things/have fun hobbies	37	78.7
Get back to how I was before deployment	37	78.7
Have less stress at home	34	72.3
Learn how to solve problems more effectively	34	72.3
Feel closer to important people in my life	33	70.2
Have my family more involved in my mental health care without sacrificing my privacy	32	68.1
Help my family/friends learn to back off and stop pressuring me	30	63.8
Improve my relationship with my children	30	63.8
Manage money more effectively	26	55.3
Find a job that I can enjoy	23	48.9
Learn how to manage my medications and their side effects better	21	44.7
Figure out what to do with my free time	18	38.3
Learn ways to reduce my alcohol or drug use	16	34.0

Table 3

What a Program Should Provide: Frequency of Themes and Subthemes Raised in Qualitative Interviews by Veteran and Family Participants

Theme and subtheme	Frequency					
	Veterans (<i>n</i> = 47)		Family (<i>n</i> = 36)		Total (<i>N</i> = 83)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Information	33	70.2	20	55.6	53	63.9
PTSD	27	57.4	20	55.6	47	56.9
Services and system*	15	31.9	1	2.8	16	19.3
Skills training	27	57.4	16	44.4	43	51.8
Living and coping with a person with PTSD	15	31.9	7	19.4	22	26.5
Interpersonal and communication skills	11	23.4	4	11.1	15	18.1
Structuring and managing daily life	8	17.0	6	16.7	14	16.9
Parenting-related skills ^a	4	13.3 ^a	4	16.0 ^a	8	14.5 ^a
Trust and friendship	3	6.4	3	8.3	6	7.2
Family members' coping with their own emotions	2	4.3	4	11.1	6	7.2
Anger management	2	4.3	2	5.6	4	4.8
Support*	12	25.5	17	47.2	29	34.9
For family*	5	10.6	12	33.3	17	20.5
For veterans	8	17.0	8	22.2	16	19.3
Perspective*	19	40.4	5	13.9	24	28.9
Family perspective on veterans' experience*	19	40.4	3	8.3	22	26.5
Veterans perspective on family experience	2	4.3	2	5.6	4	4.8

Note. PTSD = posttraumatic stress disorder.

^a The denominators for this item include only the 30 veterans and 25 family members with minor children in the home.

* $p < .05$.

Family members mentioned both the need for veterans to develop skills in structuring and managing their own lives and the need for both parties to enhance their parenting skills more frequently than they mentioned a need for interpersonal and communication skills. Comments like the following were common among family members:

... they should have classes where you deal with paying bills and doing just everyday things. ... a lot of veterans say that they just have a hard time going back to doing things on their own because they've been so used to being told what to do.

... if he was hearing it from somebody else, maybe it would be a little bit more clear, so I do agree on the parenting classes. I think that would ... help both of us deal with it a little better.

Support. Both groups emphasized that preparation and support for postdeployment readjustment were needed by family members as well as service members, and should begin before deployment, continue through deployment, and be maintained for a substantial period postdeployment. Participants recognized that that would necessarily involve the DoD as well as the VA and, ideally, other sectors of the community such as schools, civilian primary-care providers, and employers.

With respect to postdeployment support for family members, participants emphasized the importance of opportunities for groups of spouses/partners and groups of children to get together to offer mutual support and recognition that they were not alone in their experience. With respect to veterans, participants focused on the veterans' having a "safe" place to share their experience with other veterans, to build self-esteem, and to find spiritual and motivational support. Participants suggested a "buddy system" for veter-

ans to provide peer support, as well as a place for veterans to "hang out," exercise, and "blow off steam," whether alone or with family members.

Gaining perspective on each other's experience (perspective-taking). Veterans and family members felt that the other group did not understand what they had gone through and what they were going through. They wanted the program to help the other better understand their perspective on the deployment period as well as on the return. Veterans wanted family and friends to better understand what they had gone through ("You know, I went to war; I didn't go to summer camp") as well as what they were going through:

They needed to know what I was battling, where I was, how I felt about myself. My negative self-image which led to a lot of defensiveness. Led to a lot of guilt, angry at myself. I used to be a leader and I was able to do all these things, and then when I came back I felt like I had failed because some of my guys had died.

Veterans also wanted their family and friends to understand why they behaved in the ways they did. One male veteran put it so poignantly: "And how in the hell are we going to talk to our families if we've lost ourselves?"

Family, especially intimate partners, wanted the veteran to understand what they had gone through while the veteran was deployed. The wife of one veteran said, for example,

... I know they're over there. I know they go through a lot, but we're over here. We're paying the bills, trying to keep things going, trying not to tell them all the things going on and maybe they need to know—some of them may not understand what we're going through while they're gone.

Table 4

Desired Program Content: Illustrative Quotes From Qualitative Interviews, by Theme and Subtheme

Theme and subtheme	Illustrative quote
Information giving	
PTSD	<p>“. . . knowledge of what PTSD is . . . helps [family] deal with our shit.”</p> <p>“My wife keeps thinking that . . . there’s an actual cure . . . I have a hard time telling her I’m not the same person.”</p> <p>“If you just knew what to expect, that would go a long way . . . we felt like we were on the outside looking in.” (family)</p>
Services and system	<p>“They need to tell you about the women’s programs.” (OKC)</p> <p>“I didn’t know we had a women’s health clinic at the VA in Little Rock.”</p>
Skills training	
Living and coping with a person with PTSD	<p>“. . . teaching you how to cope.” (family)</p> <p>“. . . how to recognize your [family member’s] triggers.” (family)</p>
Interpersonal and communication skills	<p>“. . . there should be some sort of program that allows them to resocialize. Those skills that we learn in college or high school, you know, how to interact, how to make a joke . . .” (family)</p> <p>“I think to teach dating skills again . . . You got in an argument. But you’re really just scared, but you’re not going to tell you wife that you’re afraid [in public places]. You know, so, you have communication teaching, I mean I can’t even express or explain it. I just know that PTSD will eventually destroy a relationship.”</p>
Structuring and managing daily life	<p>“The hardest part is you’re in such a structured environment, then you come out in the civilian world, and . . . There’s no one telling you ‘be here at this time, do this, do that . . . you need to pay your bill . . .’ money management was really difficult for me when I first came out. And dealing with civilian authority was a little difficult too because you’re kind of like ‘what have you ever done?’</p> <p>“I don’t actually get anything done . . . Just show me how to complete a task . . .”</p>
Parenting-related skills	<p>“Teach the parent how to talk to the children about what’s going on with momma or daddy or whoever.” (family)</p> <p>“. . . when you come back home, you hear so much about ‘don’t go home and try to take over’ and ‘your wife has been doing this on her own,’ and it’s like you’re just kind of left up. Well, when do I, you know, start doing my bag? There’s really not a lot of guidance there. . . sometimes it’s hard for me to adapt.”</p>
Trust and friendship	<p>“. . . a friendship class to teach you proper friendship techniques, to teach you not to over-give yourself and hurt yourself, and you come right back into treatment.”</p> <p>“. . . when I trust you that means I trust you with my life. And that’s how I know I trust a soldier on the battlefield, but when we bring it back here. . . we have to adjust and actually know that there are different levels [of trust].”</p>
Family members’ coping with their own emotions	<p>“. . . everybody that’s associated with a service member that’s been to Iraq and come back, there’s anger. I bet you somewhere there is anger, hostility . . . let somebody explain that this is a natural process.”</p> <p>“So I’m still holding all the anger and resentment and everything because I haven’t been able to work through it. So he’s coming back [from treatment programs] trying to be a different person, but I’m still stuck where I am, so where was my help?” (family)</p>
Anger management	<p>“I think the VA should focus way more on anger management.”</p> <p>“I mean, there’s a lot of animosity, a lot of anger. We barely speak.” (family)</p>
Providing support	
For family	<p>“I wish they had a support group for wives or spouses or parents just to come in . . . and go, ‘This is what I’m dealing with, how do you fix that problem . . .’ I wish they had a support group for us.” (family)</p> <p>“He was having nightmares. . . it would have been great if [there] could have been a support group for him, for someone to talk to him. . . beside the parent, to let him understand what other children were going through . . .” (family)</p> <p>“. . . allow the family members to talk about things that they wouldn’t say in front of their service member.”</p>
For veterans	<p>“. . . self-esteem classes. It’s almost like they lose that.” (family)</p> <p>“A place for them to blow off steam . . . where it’s not going to matter.” (family)</p> <p>“I think they should always just have somebody there that they can contact and talk to no matter what because, I think, if it wasn’t for my battle buddy . . .”</p>
Understanding the other’s experience	
Understanding the veteran’s experience	<p>“How did she feel when that mortar came in . . .?”</p> <p>“We want [family] to be in on the meeting so you can understand . . . see, a lot of veterans aren’t going to sit here and tell you the truth that they miss their wives/ they miss their husbands and that’s why they come back with tempers because they felt like they weren’t missed.”</p>

Table 4 (continued)

Theme and subtheme	Illustrative quote
Understanding the family's experience	<p>"... trying to deal with a completely different person with frequent mood swings. It is an absolute roller coaster and extremely taxing for me and my three children trying to deal with 'who is this person living in our house, and how do we respond and how do we deal with it?'" (family)</p> <p>"... we basically went on with our life. ... we've got work to do and things are still going on at home ... I think we all change because it's, it's an ordeal. ... they've got a part but, by golly, we've got a part too in this coming-home deal." (family)</p>

Note. All quotations are from veterans unless otherwise indicated. PTSD = posttraumatic stress disorder; OKC = Oklahoma City VA medical center; VA = U.S. Department of Veterans Affairs.

Some veterans as well as some family members commented that it might be easier for their respective family member or veteran to hear and understand their perspective if it came from someone outside their own family.

Program Format and Logistics

Interviews also explored participants' views on optimal program delivery and logistics. Suggestions about how VA should deliver program content fell into two main categories: "classes/programs" for provision of information and skills training and "outings/group activities." Outings and group activities were seen as a way for couples and families to reestablish relationships, in part by having fun together. Family members especially emphasized the importance of including fun activities for children that would allow them to express their feelings and share their experiences. Several participants remarked on the value of couples' weekends for reestablishing their relationship, working on joint problem-solving skills, and helping family members better understand the deployment experience. Veterans, who generally had more experience with PTSD-focused therapies than family members, talked about the utility of role-playing, joint problem-solving exercises, team-building exercises, and vet-to-vet support for conveying program content and achieving program goals. One male veteran suggested activities like the following for couples:

I would probably administer like some type of scenario where they have to work together to do something, not just, you know, talking and how you feel. But they actually have to hands-on figure something out. So that means you have to work with each other to reconnect.

Responses to paper-and-pencil questions about preferences for program logistics are summarized in Table 5. Participants' marked preference for face-to-face rather than Web-, video- or telephone-based sessions is notable in both interview comments and questionnaire responses.

Discussion

To our knowledge, this is the first published report on preferences for VA postdeployment reintegration support that incorporates both the perspectives of returning Iraq and Afghanistan veterans and those of the veterans' own family members and close friends. Participants uniformly and enthusiastically supported inclusion of family and friends in VA programs to facilitate postdeployment readjustment and reintegration into civilian life. When

asked about optimal program content, participants described the information and skills training they considered essential to successful readjustment and reintegration. They also emphasized the critical importance of a supportive environment for veterans and family, including children, that would begin prior to deployment and continue for a substantial period following the veteran's return. Family members generally echoed veterans' perspectives on the kinds of information, skills, and support needed by veterans. However, they placed greater emphasis on parenting-related issues and the kinds of support they and their children needed during and after deployment to help them understand and support the veteran in his or her readjustment. Several family focus groups turned into spontaneous support groups after the formal interviews were completed; that rapid bonding may be due in part to the isolation many families experience when the veteran has PTSD.

Implications of study findings for clinical practice within and outside the VA include the following:

1. Reintegration programs should include a family component and should specifically target the following domains: information about the origin, symptoms, and impact of PTSD; skills for veterans and families in fostering healthy relationships and effectively coping with PTSD; and perspective-taking for veterans and families to improve understanding of and empathy for each other's situation. Many family education programs address these issues and offer guidance for providers wishing to offer such services (e.g., Operation Enduring Families: <http://www.ouhsc.edu/OEF>; LifeGuard: <http://www.mirecc.va.gov/apps/activities/lifeguard>).

2. When working with returning veterans who have children, providers will want to consider supplementing individual and/or couples therapy with programs that involve the children. The preference for such involvement is clear from the great majority of veterans (83%) and families (86%) who indicated on the questionnaire that it would be "very important" to include teenagers and younger children in some family program activities (see Table 5). Participants also expressed a desire for skills in learning how to talk with their children about the veteran's PTSD. These outcomes can be achieved in a variety of ways, including family therapy, psychoeducation for children, bibliotherapy, and skills training for both veteran and nonveteran parents around how to manage the issue with their children. Programs and clinics that primarily treat adults rather than families (e.g., the VA health care system) may form partnerships with community providers and/or be prepared with referrals for their families.

Table 5
Responses to Format and Structure Items on Anonymous Questionnaire

Question	Veterans (n = 47)			Family members (n = 36)		
	n	%		n	%	
		Total	Replies		Total	Replies
Would you prefer to gain information and skills in . . .?						
Veteran and family groups	8	17.0	17.0	7	19.4	19.4
Veteran-only groups	1	2.1	2.1	4	11.1	11.1
Individual sessions with a provider	6	12.8	12.8	7	19.4	19.4
A combination of all above	28	59.6	59.6	15	41.7	41.7
Another combination	4	8.5	8.5	3	8.3	8.3
In what ways would you like to gain information and skills . . .? ^a						
Interactive activities in groups/classes	28	59.6		26	72.2	
Veteran-led discussion and support	34	72.3		22	61.1	
Talks/oral presentations	21	44.7		10	27.8	
Written and/or Internet materials	16	34.0		14	38.9	
Other	4	8.5		1	2.8	
Acceptable meeting formats ^a						
In-person meetings	40	85.1		32	88.9	
Videoconferencing	14	29.8		7	19.4	
Teleconferencing	17	36.2		10	27.8	
Internet	11	23.4		17	47.2	
In-person + phone, e-mail, or Internet	23	48.9		18	50.0	
Other	1	2.1		4	11.1	
The one format you would like best . . .						
In-person meetings	32	68.1	76.2	22	61.1	71.0
Videoconferencing	1	2.1	2.4	0	0.0	0.0
Teleconferencing	3	6.4	7.1	2	5.6	6.5
Internet [*]	0	0.0	0.0	3	8.3	9.7
In-person + phone, e-mail, or Internet	5	10.6	11.9	4	11.1	12.9
Other	1	2.1	2.4	0	0.0	0.0
Missing	5	10.6		5	13.9	
Who should lead group meetings? [*]						
A mental healthcare professional	12	25.5	26.1	10	27.8	27.8
A veteran	8	17.0	17.4	1	2.8	2.8
A family member	2	4.3	4.3	0	0.0	0.0
Professional with veteran or family	22	46.8	47.8	23	63.9	63.9
Other	2	4.3	4.3	2	5.6	5.6
Missing	1	2.1		0	0.0	
How important is it for at least one leader to be an Operation Enduring Freedom/ Operation Iraqi Freedom veteran . . .?						
Very important	42	89.4	91.3	29	80.6	80.6
Somewhat important	4	8.5	8.7	7	19.4	19.4
Not very important	0	0.0	0.0	0	0.0	0.0
Missing	1	2.1		0	0.0	
How often would you like a program to meet?						
More than weekly	7	14.9	14.9	2	5.6	5.6
Weekly	20	42.6	42.6	11	30.6	30.6
Biweekly	9	19.1	19.1	12	33.3	33.3
Monthly	6	12.8	12.8	8	22.2	22.2
Other	5	10.6	10.6	3	8.3	8.3
How long should the program last?						
One meeting/workshop	1	2.1	2.1	3	8.3	8.3
2–7 weeks	5	10.6	10.6	5	13.9	13.9
8–12 weeks	20	42.6	42.6	6	16.7	16.7
3–11 months	5	10.6	10.6	7	19.4	19.4
12 months or longer	15	31.9	31.9	14	38.9	38.9
Other (“as long as needed”)	1	2.1	2.1	1	2.8	2.8
Acceptable locales for in-person meetings ^a						
VAMC	36	76.6		25	69.4	
CBOC	16	34.0		18	50.0	
Vet Center	18	38.3		14	38.9	
Military facility	11	23.4		7	19.4	
Community facility	16	34.0		18	50.0	
Other	7	14.9		4	11.1	

Table 5 (continued)

Question	Veterans (<i>n</i> = 47)			Family members (<i>n</i> = 36)		
	<i>n</i>	%		<i>n</i>	%	
		Total	Replies		Total	Replies
Importance of including teenagers and younger children in some activities?						
Very important	39	83.0	83.0	31	86.1	86.1
Somewhat important	7	14.9	14.9	5	13.9	13.9
Not very important	1	2.1	2.1	0	0.0	0.0
Desired format of activities with youth ^a						
Groups for teens only	24	51.1		20	55.6	
Groups for younger children only	19	40.4		17	47.2	
Single-family meetings	33	70.2		20	55.6	
Other	6	12.8		5	13.9	

Note. In the Total columns, percentages were calculated based on the total number of veterans/family members in the study. In the Replies columns, percentages were calculated based on the total number of veterans/family members who answered the specific question. VAMC = U.S. Department of Veterans Affairs medical center; CBOC = community-based outpatient clinic.

^a Respondents could check more than one response.

* $p < .05$.

3. The frequency with which both veterans and family expressed a desire for social activities facilitated by the VA, especially multifamily outings involving children, was striking. Providers may wish to facilitate family involvement in such activities (e.g., fishing derbies, basketball, and outdoor sports) as a vehicle for practicing interpersonal skills and decreasing social isolation. Because interests vary regionally and providers may be constrained by the resources available in their programs and communities, providers would want to help their clients identify the types of activities that would be most appealing and most likely to strengthen bonds within the family system and with the broader community.

4. There was more consistency than difference in veteran and family perspectives. Observed differences were logical and intuitive, reflecting each group's emphasis on its own reality during and after deployment (i.e., greater emphasis among veterans on the need to increase family understanding of the veteran's experience, greater emphasis among family members on parenting issues and the need for increased family support). Historically, VA's family services have focused on veterans' desires for information and skills training. As family-involved care within and outside the VA continues to grow, programs will want to consider tailoring their curricula to meet both veterans' and family members' desires.

5. Providers will want to consider the strong preference for a program with in-person meetings rather than one that is technology-based. More than 70% of family members and veterans preferred in-person meetings (see Table 5). This finding was unexpected; with an average age in the late 30s, participants belong to a cohort that is generally comfortable with and adept in using technology. However, participants may believe that some of their major goals (e.g., the desire for social interaction and social support) are less likely to be met through telephone-, video-, and/or Web-based sessions than through in-person sessions.

As is the case for all research, findings from this study need to be considered in context. VA uses telehealth care widely and effectively in therapy and medication management for PTSD. In this study, veterans were asked specifically about their preferred format for a group program involving veterans and family; their responses to that question should not be generalized to other types

of care. It is also important to note that we asked study participants about services and activities they found useful or thought would have been useful during the readjustment process. Thus, their suggestions do not mean that they had no access to any of the services they considered important. Although this was sometimes the case, many participants commented on services that had been especially helpful. For example, participating veterans who had previously taken part in OKC's multifamily group psychoeducation program (Reaching Out to Educate and Assist Caring, Healthy Families; Sherman, Fischer, Sorocco, & McFarlane, 2009) commented on the elements of that experience of greatest value to them in readjustment, and participating veterans who had participated in VA recreational therapy programs commented on helpful aspects of that experience. In addition, participants were often aware that VA and DoD were working in many of these areas, and that conditions and programs were evolving rapidly.

Indeed, although interviews focused on how VA programs could help veterans and families with readjustment and reintegration, much of what participants described is outside the sole purview of the VA. Family-oriented programs that start before deployment, continue through deployment, and are maintained following the veteran's return require coordination across federal departments (DoD, VA) and with community agencies (e.g., schools, employers). DoD and VA are working to create a "seamless transition" with respect to health care and to reduce the stigma of help-seeking, and many communities have created programs for returning veterans (Institute of Medicine, 2013). Participants' experiences make it clear that, although programs exist and are helpful when connections are made, continued efforts are needed as high-quality programs are not consistently available and accessible (Institute of Medicine, 2013; Tanielian, Martin, & Epley, 2014).

Although deployment of U.S. military personnel to Iraq and Afghanistan is declining, the perspectives and recommendations of these returning veterans and family members remain salient. Reintegration into civilian life is an ongoing process that often continues to affect veterans and their families over a considerable period of time postdeployment. Participants' emphasis on the importance of seamless support for veterans and family from predeployment through postdeployment will remain critical into

Table 6

Interview Guides for Veteran and Family Member Focus Group and Individual Interviews

Veterans	Family members/friends
Global opening question	
What has it been like trying to readjust to your life and family life since returning home?	What has it been like trying to readjust to life and family life since your family member returned home?
Probe questions	
1. What have been the biggest problems you have faced since returning from active duty?	1. What have been the biggest problems you have faced since your family member returned from active duty?
2. What has helped you to adjust?	2. What do you think has helped your <i>veteran</i> adjust to life after deployment?
	3. What do you think has helped <i>you and your family</i> adjust to his/her return?
3. What has made it harder for you to adjust?	4. What has made it harder for your <i>veteran</i> to adjust to family life after deployment?
	5. What has made it harder for <i>you and your family</i> to help your veteran adjust to family life after deployment?
4. Where do you still need the most help in making adjustments?	6. Where do you still need the most help in making adjustments?
We are interested in developing a program involving veterans and family members to help both veterans and their families deal with problems such as those we have been discussing, which are common when veterans return from active duty and have PTSD. We want to get your ideas about what would be most useful to you and how to offer it. As you think about these next topics, think about when you/your veteran first returned and any readjustment problems you are still experiencing.	
5. What can the VA do to help with active-duty-to-civilian readjustment problems?	7. What can the VA do to help with active-duty-to-civilian readjustment problems?
• How would you feel about taking part in a program that would involve both you and your family members?	• How do you feel about taking part in a program that would involve both you and the veteran?
• What kind of information would be most helpful to you and other veterans dealing with your day-to-day problems?	• What kind of information would be most helpful to you and other veterans' families dealing with day-to-day problems?
• What kind of information do you think would help your family members understand the readjustment process?	• What kind of information do you think would help the veteran in returning to his/her previous family life?
• What type of skills do you think would be helpful to you and your family members in dealing with day-to-day problems arising from PTSD?	• What type of skills do you think would help you, your family and the veteran in dealing with day-to-day problems arising from PTSD?
• What other types of services do you think would be helpful to you and to your family members?	• What other types of family services do you think would be helpful to you and other family members?
• How could we best involve your family or others who provide support to you in such a program?	• How could we best involve you and others who provide support to the veteran in such a program?
6. What obstacles do you think there might be that would make it hard for you or your family members to take part in such a program?	8. What obstacles do you think there might be that would make it hard for you or your family members to take part in such a program?
7. How could we best advertise the program to veterans and their families?	9. How could we best advertise the program to veterans and their families?

Note. PTSD = posttraumatic stress disorder; VA = U.S. Department of Veterans Affairs.

the future as U.S. military personnel are deployed to new combat zones. By intervening early on both individual and systems levels, we may be able to minimize long-term effects of recent, current, and future deployment on veterans and their communities.

This study has limitations. First, qualitative data were collected both via focus groups and individual interviews. Some focus group participants may not have commented explicitly on subthemes raised by others, leading to an underestimate of subtheme importance. Second, all participants were recruited from two facilities in two South-Central states. Participants' preferences and priorities may differ from those of veterans and families in other parts of the country. Third, because we designed this as a primarily qualitative study, we based sample size on the ability to achieve saturation, the point at which no new information is emerging. Our samples of 47 veterans and 36 family members were relatively large and more than sufficient to achieve saturation; however, this study was neither designed nor powered for testing hypotheses. Although we

have indicated where differences achieved statistical significance in Tables 3 and 5, a lack of statistical significance must be interpreted with caution. We feel that this limitation is far outweighed by the nuanced, in-depth data we were able to obtain through qualitative interviews. Lastly, our study participants uniformly and enthusiastically supported family involvement in a joint veteran/family program. Interest in family involvement may be lower in the broader population of veterans and family because it is likely that individuals willing to take part in a study on this topic would be positively inclined toward family involvement. We feel that this limitation is offset by our having elicited preferences about content and format from precisely those individuals who would be most likely to use such a program. Comparison of the perspectives of male and female veterans is beyond the scope of this article and will be addressed in a separate report.

Participants strongly endorsed the utility of a VA family program involving veterans with PTSD and those they consider fam-

ily to support the veteran's reintegration into civilian life and the veteran/family readjustment process following the veteran's return from Iraq or Afghanistan. Successfully supporting family members and reinforcing positive intrafamily relationships should also improve outcomes of care for the veteran's PTSD (Byrne & Riggs, 2002; Evans et al., 2010; Kaniasty & Norris, 2008; Keane et al., 2006; Sayer et al., 2010; Taft et al., 2011; Tarrier et al., 1999). The importance of strengthening social support to improve outcomes of PTSD is highlighted by recent evidence that suicide among veterans is more strongly associated with veterans' mental health than with their deployment history (LeardMann et al., 2013). The growing literature on successful family and couples programs for returning veterans, especially veterans with PTSD, provides a resource for providers interested in supplementing existing services with family programming (Davis et al., 2012; Fischer, Sherman, Han, & Owen, 2013).

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