# Preventing Violence in Veteran and Military Families

## *A Guide to Understanding a Promising Community-Based Intervention*

THE NATIONAL CENTER ON
Family Homelessness

# Acknowledgements

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# Preventing Violence in Veteran and Military Families

## *A Guide to Understanding a Promising Community-Based Intervention*

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# Introduction

As tens of thousands of military members are deployed home from Iraq and Afghanistan, many are leaving the military. As these Veterans reintegrate into family and community life, the experiences they faced in combat may present challenges for them at home and in the workplace. By understanding and addressing these challenges, we can help Veterans reestablish themselves on the home front.

Modern warfare is characterized by a battlefield without clear boundaries in which a military member must be ever vigilant. The unremitting stress of constant danger leaves it marks, experienced by some Veterans as Post Traumatic Stress Disorder (PTSD). Concussion from improved explosive devices (IED), so prevalent in Iraq and Afghanistan, can result in Traumatic Brain Injury (TBI). These wounds of war may be seemingly invisible, but the aftermath can interfere with every aspect of a Veteran's life, including personal and family relationships.

This guide offers an overview of a promising program developed to help returning Veterans learn skills to foster healthy relationships. The program, *Strength at Home: Family and Friends*, imparts communication and relational skills to a Veteran in tandem with a romantic partner, family member, or friend. The guide is not intended as a manual. *Strength at Home: Family and Friends* must be conducted by a trained clinician and requires proper funding. To learn more about how to bring this program to your community, please contact Dr. Casey Taft at Casey.Taft@va.gov.

# I. Understanding Intimate Partner Violence Among Veterans

IPV stands for:

**I**ntimate
**P**artner
**V**iolence

Military families face unique stressors associated with deployment and reintegration. During deployment, families are faced with worries about the safety of the service member, increased responsibilities when one parent is deployed, and a constant need to adapt to changing surroundings and situations.

When Veterans return, the challenge of reintegrating into family life, reconnecting to social supports, finding employment, recovering from physical and psychological injuries, and redefining their roles in the community can be overwhelming.

Combat-related difficulties such as Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD) have a significant impact on family relationships. The presence of TBI and PTSD increases the likelihood of emotional problems[1] and substance abuse, which increase the risk of intimate partner violence (IPV).

Research points to several factors that promote increased rates of IPV among military personnel, including PTSD, TBI, substance use, mental health issues, and military cultural norms.

Veteran status is associated with increased rates of IPV, with Veterans perpetrating violence up to three times as much as civilians.[2] When Veterans commit IPV, they are more likely than civilians to cause significant injury.[3]

Research points to several interrelated factors that promote increased rates of IPV among military personnel:

- PTSD
- TBI
- Substance use
- Mental health issues
- Military cultural norms

## 1. Post Traumatic Stress Disorder

Research indicates that IPV within military families can largely be attributed to combat-related PTSD, or to a prior history of trauma.[4] Veterans with PTSD are more likely to engage in IPV than Veterans without PTSD.[5]

Hallmark symptoms of PTSD [6] include:

*Reexperiencing*

Reexperiencing a traumatic event in the form of flashbacks, nightmares, intrusive thoughts or images.

*Avoidance*

Avoiding situations or experiences that are reminders of a past traumatic event.

*Emotional Numbing*

Disconnecting or dissociating from overwhelming feelings tied to a traumatic experience; difficulties with feeling a range of both positive and negative emotions.

*Hyperarousal*

Persistent feelings of heightened anxiety, constantly being on alert for danger and focused on survival.

Symptoms of PTSD can be related to problems with substance use and may overlap with symptoms of TBI.[7]

### *Did you know?*

An estimated one-third of troops returning from Iraq have been screened at-risk for PTSD and other mental health needs on their Post Deployment Health Assessment.

# *Impact of Intimate Partner Violence*

The effects of IPV have far-reaching consequences for individuals, families, and the broader community. A meta-analysis of studies on the mental health impact of IPV show that almost half of all women victimized by domestic violence suffer from depression, almost one-fifth struggle with suicidal thoughts and feelings, and over 60% meet criteria for PTSD.[8] While some women manage to maintain consistent and effective parenting despite their victimization,[9] their own struggles with the impact of IPV often affect their capacity to stay attuned to their children's needs or to foster a sense of safety and security.[10] Research has shown a positive association between abused women's levels of parental stress and their children's functioning.[11] In addition to the emotional effects of intimate partner violence on adults and children, IPV interferes with housing and employment stability and a family's access to community supports. Domestic violence is the direct cause of homelessness for all the mothers in domestic violence shelters and 22-55% of women in general family shelters.[12]

## *Modern Warfare and IPV*

The nature of modern war may also help to explain IPV among Veterans. Dr. Casey Taft reports that in current wartime situations, a combatant does not always know who the enemy is and must be constantly ready to respond to potentially threatening situations with aggression. Furthermore, war-related trauma may make it difficult for returning Veterans to trust others. These processes may be particularly likely in those deployed to Iraq and Afghanistan, conflicts that are characterized by less defined battlegrounds[13] and where every location may feel threatening.[14]

### 2. Traumatic Brain Injury

TBI is caused when a blast creates a sudden change of pressure, producing concussions, contusions, or air emboli that travel to the brain.[15] TBI can also occur when the brain collides with the skull or when an object pierces the brain.[16]

Military members have always had higher rates of TBI than the civilian population, but this is particularly true of recent conflicts in Iraq and Afghanistan.[17] Between 2003-2007, Military Health Systems recorded 43,779 patients diagnosed with a TBI injury.[18] Approximately 19 percent of all Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) soldiers have reported a possible TBI during their deployment.[19]

TBI can cause personality changes, loss of temper, communication difficulties, and relationship problems.[20] More severe cases of TBI can result in depression, anxiety, and increased levels of aggression and impulsiveness[21] that put families at risk for violence.

### 3. Substance Use

The percentage of Veterans who drink alcohol (16 percent) is higher than that of the civilian population (13 percent).[22] Alcohol use can interfere with Veterans' abilities to resolve issues perpetuated by traumatic events and can impact the family and community reintegration process. The influence of alcohol can impact executive function and lead to aggressive behavior.[23]

### 4. Mental Health

Mental health issues also contribute to the risk of IPV among Veterans. The prevalence of mental health issues among deployed Veterans is captured by an initial mental health screening (Post Deployment Health Assessment) and a 3 to 6 month follow-up screening (Post Deployment Health

Reassessment). These assessments have shown an increase in the rate of mental health concerns for service members on active duty (3.5 to 14 percent) and for service members in the reserves (4.2 to 21.1 percent).[24] IPV rates increased four-fold in this screening.[25]

### 5. Military Cultural Norms

Military service members and their families have unique characteristics that can place them at higher risk for marital conflict and potential violence when compared to the civilian population. Military families face the stress of deployment and fears about a service member's safety. Service members may return home with lasting emotional or physical health challenges that impact the quality of relationships and the risk for conflict or violence.[26]

Evidence suggests that military service can promote or hasten marriages, and male service members tend to marry younger and have children at a younger age than their civilian counterparts. These experiences may exacerbate existing challenges during and post-deployment and may contribute to increasing divorce rates among the military population.[27] In an Army battlefield survey conducted in Iraq in the spring of 2009, nearly 23 percent of young combat soldiers questioned said they planned to get a divorce or separation compared to 12 percent in 2003.[28]

Active duty servicemen are often exposed to combat and called on to use violent means to achieve expected outcomes and survive. After leaving the service, this way of operating in the world may carry over into family life, resulting in increased risk of escalated conflict and in some cases, intimate partner violence.[29]

The stigma against seeking help can influence service members long after they separate from the military. Reporting incidents of IPV or seeking help for those involved is not always seen as an acceptable response.[30] This stigma, compounded by avoidance behavior - a symptom of PTSD - can make it difficult to identify Veterans and families in need of assistance.

# II. Strength at Home: Family and Friends Intervention



*Strength at Home: Family and Friends (Strength at Home)* is a relationship-strengthening intervention for Veterans/service members and their families and friends designed to address conflict, anger, and readjustment to civilian life after deployment.

The intervention is designed to prevent intimate partner and interpersonal violence by helping participants develop effective communication skills to improve relationships with others. *Strength at Home* pairs Veterans with relatives or close friends within a group setting to help reduce the sense of isolation and enhance social support.[31]

By using cognitive behavioral therapy-based treatment, *Strength at Home* offers Veterans suffering from Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBI) a non-medical and evidence-based intervention.

This intervention is intended for Veterans that are experiencing relationship difficulties and may be at risk for intimate partner or interpersonal violence. It is not designed for those actively committing violence.[32]

The mission of *Strength at Home* is to advance the clinical care of America's Veterans and service members through research, development, and dissemination of evidence based treatments for stress-related disorders.

# *Cognitive Behavioral Therapy (CBT)*

Cognitive behavioral therapy is an evidence-based treatment for traumatic stress that aims to reduce symptoms by changing a participant's cognitive thought process. CBT challenges the way participants interpret events by helping them modify their past assumptions about the event.

For example, a Veteran who observes an event has immediate thoughts about that event which effects his or her emotions and behaviors. Thoughts after an event are formed subconsciously, automatically, and derived from past experiences or past perceptions. The goal of CBT is to help Veterans understand how thoughts after an event are formed from past experiences, and change these thoughts if they are negatively affecting behavior.[33]

CBT is based on guided self-questioning. By challenging a Veteran's automatic thoughts, CBT compels the Veteran to question his/her perceptions and cope with "triggers" that make the Veteran experience unwanted symptoms. CBT teaches participants to:

- Monitor their automatic thoughts;
- Recognize connections between thoughts and behaviors;
- Reconsider automatic thoughts against reality;
- Substitute more realistic automatic thoughts; and
- Alter past dysfunctional perceptions which predispose the participant to wrongly interpret experiences.[34]

*Strength at Home: Family and Friends* incorporates components of CBT for intimate partner violence[35] and anger management for Veterans.[36] The intervention has been tailored for military couples and others who are part of Veterans' support systems.

## Ten Session Model

*Strength At Home: Family and Friends* follows a ten, two-hour session model (See box, page 9). Each session or "class" includes brief instructional materials; group activities to discuss, learn, and practice new behaviors; and flexible time to solve ongoing problems, explore change efforts, and build group cohesion.

The program is designed for a "dyad" (two people) who participate in a group setting to demonstrate to participants that they are not alone. The group setting also creates a bonding experience that can lead to socialization after the intervention is completed.

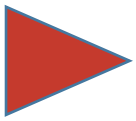
In each session, group members complete in-session practice exercises and are provided "practice assignments" to review information learned during the group session. Assignments also involve intimacy enhancing exercises such as self-monitoring of positive relationship behaviors.

Practice assignments reinforce the intervention's tools and techniques to help the dyads strengthen communication and conflict resolution skills.

This process can sometimes bring up strong emotions and experiences. When this happens, the dyad can request to work in a separate setting from the group for a portion of the intervention.

It is common for Veterans with PTSD to be emotionally passive until their emotions build up and are expressed in an aggressive manner. Through this intervention, Veterans learn to express anger and emotions in an assertive and positive way.

After successfully completing the intervention, Veterans and their partners have new skills to correct dysfunctional behavior and prevent the risk of violence.



*Strength at Home: Family and Friends* **is designed for Veterans who are at risk of perpetrating violence. It is not designed for those actively committing violence.**

# *Strength at Home: Family and Friends*

Session 1- Introduction and Welcoming
- Clinician establishes a working alliance with each dyad, validates and addresses participants' concerns and reservations about counseling, and models and encourages healthy group interactions.

Session 2 - PTSD and Relationships I
- Explore beliefs about healthy and unhealthy relationships;
- Understand forms of partner abuse, PTSD symptoms, and the impact of trauma and PTSD on relationship functioning.

Session 3 - PTSD and Relationships II
- Discuss themes related to trauma that can affect relationships, including trust, power and control, self- and other-esteem, and intimacy.

Session 4 - Conflict Management I: Assertiveness
- Understand the impact of trauma and PTSD on relationships and conflict management styles;
- Identify positive, rather than harmful, communication styles during conflict.

Session 5 - Conflict Management II: Time Outs
- Develop strategies to de-escalate conflict situations;
- Design a detailed "Time Out Plan" for potential conflict situations.

Session 6 - Communication Skills I: Active Listening
- Practice active listening skills, the foundation of good communication and critical to de-escalating conflict and enhancing intimacy.

Session 7 - Communications Skills II: Assertive Messages
- Develop communication skills to reduce the negative impact that PTSD has on communication, and to further expand intimacy, improve relationship problem solving, and facilitate the sharing of trauma-related material.

Session 8 - Communication Skills III: Expressing Feelings
- Understand how PTSD-related avoidance can lead to difficulties expressing emotions in relationships and strategies for expressing feelings.

Session 9 - Communication Skills IV: Common Communication Tips
- Strategize how to avoid traps that undermine assertive communication.

Session 10 - Reviewing Treatment Gains and Planning for Future
- Identify goals and strategies for future change and barriers to change and ways to overcome these barriers;
- Develop a realistic appraisal of changes made, identify areas needing continued attention, and design strategies for continuing this work after the group ends.

# III. Implementation Strategies

When preparing to offer the *Strength At Home: Family and Friends* intervention at a community-based site, five key points need to be addressed to ensure program success:

1. Program Staffing
2. Enrolling Participants
3. Military Cultural Competence
4. Trauma-Informed Care
5. Self-Care for Staff

## Program Staffing

### *Clinicians*

The *Strength At Home* intervention is conducted by clinicians who serve as co-leaders who have either a formal (paid staff or consultants) or informal (volunteers or affiliates) connection to the sponsoring agency. Volunteer clinicians may be available through local colleges and universities, or community-based agencies that provide mental health services.

Co-leaders must be willing to complete the entire training regime and maintain fidelity to the intervention model. They will also have to participate in reaching out to potential participants and engaging with them during the enrollment process prior to the first group session.

Group sessions are conducted in a way to support group cohesion and positive clinician-client relationships. Clinicians receive training and supervision in

facilitating a positive group dynamic. Those with less experience and training in group interventions are paired with those with more experience.

### *Clinician Credentialing*

Clinicians must have a master's degree in a relevant field and have appropriate credentials to implement *Strength At Home*. Examples of relevant fields are marriage, family therapy, and forensic or clinical psychology. It is imperative that *Strength At Home* administrators maintain copies of the participating clinicians' credentials. Clinicians do not have to be licensed and do not have to have a PhD, but they must complete two days of in-person training prior to conducting the program, or undergo shadow training with a clinician who is trained and experienced with the intervention.

When reviewing clinicians' experience, the agency offering *Strength At Home* should look for individuals who have worked with military populations. If a clinician has not had experience with military populations, it is important they have experience with populations who have been exposed to trauma.

### *Required Program Training*

*Strength At Home* must be conducted by trained clinicians. Implementing the intervention requires a two day, in-person training on the intervention along with instruction on how to use the intervention manual. While conducting the intervention, clinicians should receive ongoing clinical support from the trainer.

The main goal of the two-day training is to teach clinicians how to work with Veterans paired with another person with whom they have a valued relationship (friend, spouse/romantic partner, or relative).

Shadow training is an effective alternative to the formal two day, in-person training sessions. Clinicians untrained in the intervention meet with an experienced clinician and receive an overview of the *Strength at Home* intervention. The new clinician is given a copy of the *Strength at Home* manual and shadows the experienced clinician for an entire 10-week intervention. The new clinician can then become qualified to co-facilitate or lead a *Strength At Home* group. See Page 12 for more information about training.

## Two Day In-Person Training

The two-day training includes the theoretical foundation and program overview of *Strength At Home: Family and Friends*, evaluation components, and clinical considerations. Once the foundation of the intervention has been reviewed, the trainer uses interactive techniques, including role playing, to establish the critical components of each stage of the intervention and proper use of the *Strength At Home* manual.

Training Overview: Topics Covered

*Stage One*

Psycho-education, healthy group interaction, impact of trauma, and healthy relationships.

*Stage Two*

Conflict management, de-escalation.

*Stage Three*

Communication skills, active listening.

*Conclusion*

Change appraisal, continued positive change.

Since less than one percent of the country's population serve in the military, the number of clinicians in any community is not likely to be militarily culturally competent. The two-day training program and the intervention manual can be adapted to incorporate an understanding of military culture.

Learn More

If you have identified a potential funding source and are interested in learning more about *Strength at Home: Family and Friends* implementation and training, please email Dr. Casey Taft at the National Center for PTSD at Casey.Taft@va.gov.

### *Hiring Veterans*

Hiring qualified Veterans as staff members can contribute positively to the success of the intervention. Veterans are better able to understand the experiences and behaviors of other Veterans. Hiring a Veteran can also provide tax benefits through the Work Opportunity Tax Credit (see the U.S. Department of Labor website for more details).

When advertising a job opening, messaging should stress how the program values the service of Veterans and their families and supports the hiring of returning service members and their spouses. Supporting the hiring of military spouses is seen as valuable by the military community.

## Enrolling Participants

### *Institutional Referrals*

Group therapy can be difficult for Veterans. Military stigma against addressing mental health issues and avoidance behavior, a signature symptom of PTSD, prevent many Veterans from acknowledging that they may be at risk for IPV. Given these barriers, it is useful to develop a broad array of institutional sources that can refer Veterans to the intervention.

When launching a *Strength At Home* site, strategically target government and non-governmental organizations as potential referral sources. Include Veteran service organizations such as the VFW, American Legion as well as newer groups (e.g., Vets4Vets), and faith- and community-based organizations. Colleges, universities,

## *Testimonials are Effective for Outreach*

Prior to starting *Strength At Home: Family and Friends*, one community partner obtained testimonials about the need for the program. After the program was launched, the agency was able to secure endorsements from participants and professionals engaged with the program. Below are examples of testimonials the agency used in presentations, brochures, and fliers to engage support for the program:

"We have been waiting a long time for a program like yours. *Strength At Home* truly is a God send."- VA PTSD Staff Psychologist

"One of my Vets was recently in a *Strength At Home* program. I saw him smile for the first time in almost two years. I didn't need to ask him if the program had helped. It was written all over his face."- Physician, VA Hospital

and technical/vocational schools are also good sources for referrals.

### *Traditional Outreach to Veterans*

Successful marketing efforts will inform Veterans about the program and create interest. Outreach must engage two hard-to-find audiences:

- Veterans recently separated from service; and
- Veterans' families and friends.

Family members and friends are often the first to identify the need for help. They may be able to encourage the Veteran to seek early support to help mitigate the impact of physical and psychological wounds of war.

Traditional outreach encompasses the "tried and true" techniques to reach and engage Veterans and their families:

- Public service announcements
- Newsletters
- Brochures
- Flyers
- Newspapers/magazines
- Television/radio
- Press releases
- Mailings[37]

Flyers have proven to be the most effective printed materials. Perforated "tear-off" sections at the bottom of the flyer should display full program contact information, including e-mail address and telephone numbers. Posted in public places, these types of flyers allow for anonymity because it is easy for Veterans and family members to take the contact information quickly.

Public service announcements (PSAs) can reach a wide audience. PSAs are delivered largely through traditional media channels: radio, television, billboards, or bus shelter signs. These messages are intended to educate, influence public opinion, and motivate viewers and listeners to take action. Many media outlets still regularly provide free air time or print space for PSAs to enhance perception of their community engagement and as part of their corporate philanthropy.

### *Using Social Media*

Veterans returning from Operation Enduring Freedom/Operation Iraqi Freedom are generally in their mid-twenties. They are technologically oriented and savvy users of online and social media.

Social media allows for portable communication anytime, anywhere. Readers can access information and connect with one another from their phone, computer, tablet, or other mobile device. Geographic boundaries do not prevent participants from joining online communities.

With recent technologies and invention of the smart phone, a

cell phone texting campaign is an effective technique for engaging technologically fluent Veterans. A texting campaign involves sending a short text message to participants' cell phones. The decreasing cost of cell phones and cell phone services make this a cost-effective means of communication.

Sending information directly to a Veteran's cell phone may be more effective than using e-mail. If a Veteran is unemployed, lacks stable housing, or does not have a strong support system, he/she may be less likely to have access to a computer with internet connection. Email may be checked infrequently or messages could accidently end up in spam boxes.

One challenge of conducting a texting campaign is gathering Veterans' cell phone numbers and contact permissions. To resolve this challenge, intake forms (online and print) can be developed to collect mobile phone numbers and provide formal permission to send text messages. Intake forms should explain the types of texts a Veteran may receive and include an "opt out" feature. See Page 16 for more tips on using social media.

### *Outreach Materials*

Because of the strong stigma against seeking mental health services and admitting that IPV may occur, promotional materials for *Strength At Home* should not use any clinical or medical language. The sessions should be described as "classes" designed to build stronger relationships that support a stable transition to civilian life.

The language used should be simple and direct. Veterans in need of services may suffer from mental disorders such as PTSD or TBI. Some may function at a seventh to eighth grade reading level or lower.

Materials should highlight *Strength At Home's* approach to enhancing communication, closeness, and happiness in relationships after deployment or separation from

**Tip: When reaching out to Veterans, refrain from using the words "therapy" and "treatment" when referring to the intervention, which can have negative connotations for Veterans.**

## Online Outreach

Online outreach is primarily conducted in three ways:

1. Traditional online outreach includes email newsletters, online flyers, and other one-way communications that convey information but do not allow the recipient to interact with the content.

2. Two-way interaction features publishing information on a blog, wiki, or other social network sites, and the republishing of that information with additional comments or content by readers.

3. Sharing content via mobile devices (i.e. cell phones, tablets). This includes using mobile websites, texting, and tweeting.

Popular Social Network Sites: Facebook, Twitter, YouTube, LinkedIn, and Google+.

It is easy to create social media accounts and the majority of social media features are free. Create social media accounts by visiting the following sites:

Facebook www.facebook.com

Twitter www.twitter.com

YouTube www.youtube.com

LinkedIn www.linkedin.com

Google+ www.plus.google.com

service, and easing the return to family and community life.

## Military Cultural Competence

Community-based agencies play an increasingly important role in supporting Veterans and their families as they transition to civilian life. To ensure that Veterans feel safe, comfortable, and understood, it is important for organizations implementing interventions like *Strength At Home* to demonstrate a level of knowledge and awareness of the unique aspects of the military culture and how this culture impacts a service member's world view.

"Military cultural competence" refers to understanding the values, attitudes, goals, structure, and terminology associated with the military system.[38]

Understanding military culture offers *Strength at Home* staff valuable information about how to provide support and tailor services. For example, talking about trauma that occurred while serving in the military may be viewed as shameful or taboo. The military's culture of independence and self-sufficiency may impact a Veteran's desire to ask for and accept help from others, particularly service providers with a limited understanding of the military.

## *Military Cultural Competence Training*

There are many resources for service providers who are interested in receiving additional training in military cultural competence. Concepts covered in most trainings include: branches and services, military terms and rank, demographics, combat stress, PTSD, TBI, Military Sexual Trauma (MST), and an overview and glossary of terms and acronyms.

*Department of Veterans Affairs*
National Center for PTSD
PTSD 101: Military Culture Online Course
www.ptsd.va.gov

*Swords to Plowshares*
Combat to Community Training
www.swords-to-plowshares.org/combat-to-community/

*Center for Deployment Psychology and Essential Learning*
Military Cultural Competence Online Training
www.deploymentpsych.org
www.essentiallearning.com

Allowing Veterans to share their unique experiences is important; however, it is equally important that staff not look to Veterans to bear sole responsibility for translating military language or explaining military structure. There are many resources for staff who are interested in receiving additional training in military cultural competence (See Page 17).

## Trauma-Informed Care

A traumatic experience involves an overwhelming threat to one's physical or emotional well-being and survival, and elicits intense feelings of helplessness, terror, and lack of control.[39] Returning Veterans have often been exposed to a range of potentially traumatic experiences during their military service such as threat of death or injury, witnessing death, injury or disfigurement, chronic strain of long deployments, separation from family, harsh living conditions, and Military Sexual Trauma (MST).[40]

Exposure to trauma can have a significant impact on how a returning Veteran thinks, feels, and relates to others. Prolonged exposure to traumatic stress can impact all areas of a Veteran's life, including biological, cognitive, and emotional functioning; social interactions/relationships; and identity formation.[41] Trauma survivors have unique service needs that require *Strength at Home* staff to tailor their approach.

Given the high rates of exposure to traumatic stress among Veterans, understanding trauma and its impact is essential to providing quality care. Meeting the needs of Veterans requires a trauma-informed approach (See box, Page 19).

Trauma-informed care involves using what we know about trauma and its impact to respond empathically to Veterans, ensure their physical and emotional safety, develop realistic treatment goals, make effective referrals, provide supportive services, and avoid engaging in behaviors that may cause additional harm.

When implementing *Strength At Home* using a trauma-informed approach, staff will be more aware of the ways that a Veteran's experiences of trauma may impact responses to providers and family members, handle group activities, and express thoughts and feelings. Understanding the ways that previous trauma impacts current functioning will encourage staff to be more patient and supportive in their response and find ways to be flexible in tailoring the intervention to meet a Veteran's specific needs.[42]

## *Trauma-Informed Care Training*

Trauma-informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."[43] The following organizations provide training in trauma, trauma-informed care, and other related topics:

*The National Center on Family Homelessness*
Extensive experience providing training and technical assistance at the local and national levels, with particular expertise in trauma and trauma-informed care. The National Center offers resources, training, and consultation to support organizations to integrate a trauma-informed approach into daily practice.
www.familyhomelessness.org
info@familyhomelessness.org

*t3 (think. teach. transform.)*
Innovative training institute founded by The National Center on Family Homelessness and the Center for Social Innovation. Through self-paced online units, advanced skills courses, and onsite trainings, t3 offers evidence-based, skills-focused training on trauma, trauma-informed care, motivational interviewing, and other relevant topics.
www.thinkt3.com
info@thinkt3.com

## Self Care for Staff

Service providers who work in the helping professions frequently find themselves doing emotionally intense work. Staff working with Veterans who are trauma survivors are exposed to the additional stress associated with bearing witness to these experiences. This can have a significant effect on how staff view themselves, their work, and the world around them, and can lead to staff burn-out.

Burn-out is described as "physical or emotional exhaustion, especially as a result of long-term stress." Signs of burnout may include exhaustion, disconnection from work, diminished sense of accomplishment, increased conflict with others, or feelings of anger, sadness, anxiety, or irritability.

Staff working with trauma survivors are at risk for additional impact that includes experiencing post-traumatic stress responses similar to those of the people being served. This phenomenon, known as secondary trauma, vicarious trauma, or compassion fatigue, is defined as "a state of tension and preoccupation with the individual or cumulative trauma of clients,"[44] which can result in "the transformation or change in the

helper's inner experience as a result of responsibility for an empathic engagement with traumatized clients."[45]

Staff who are traumatized by the work may experience changes in their ability to trust, have difficulties with intimacy, be concerned about their own safety, and experience intrusive thoughts and images related to the traumatic stories of others. These experiences can significantly impact a provider's responses to and relationships with family members, colleagues, and those they serve.

Individual and organizational self-care is essential to providing successful services to all consumers, including Veterans. *Strength at Home* sites can play a key role in supporting employees in their efforts to balance their lives and keep stress levels manageable (See box, Page 20).

## Other Implementation Tips

*Strength At Home* is designed for groups because group cohesion is linked to violence reduction.[47] The group dynamic enables a sense of shared experience. This setting enables couples to recognize similarities/differences among one another, help each other, and discover a sense of togetherness and common purpose. Group interventions may also reduce isolation and enhance social support, and they require less time and resources than individual-based interventions.[48]

## *Self-Care: What About You?*

Individual and organizational self-care is essential to providing successful services to Veterans.

For individuals: Practice the "ABC's" of self-care:

1. Awareness – Of how you are feeling, your level of fatigue or burn-out, where you feel stress, what you need to be healthy and successful.

2. Balance – Between work, types of work, enjoyable activities, and rest.

3. Connection – To others in your life who provide support you, to the meaning behind your work, and to the bigger picture.

For organizations: Strategies for creating healthy work environments and a culture of self-care include: offering necessary training and education; providing adequate supervision and support; encouraging employee control and input; fostering effective communication; and creating a safe working environment.[46]

Resource: *What About You? A Workbook for Those Who Work With Others*
www.familyhomelessness.org/resources.php?p=sm

### *Program Location*

A *Strength At Home* program location should have a well-lit meeting room, parking access, a controlled entrance/exit, numerous people onsite, and unobstructed stairways. All *Strength At Home* co-facilitators should have access to telephones in case issues related to personal safety or health arise during the intervention.

A first aid kit with sufficient supplies to meet basic first-aid requirements should be available, and direct care staff should be trained in basic first aid and CPR. Situations beyond the scope of basic first aid should be handled accordingly. Incidents involving alleged cases of abuse or neglect that arise in a *Strength At Home* group should be reported to the appropriate agencies as soon as possible.

### *Program Scheduling*

Interested clinicians and participants should provide their availability upon joining the program. Using this information, program administers can designate a few times each week when everyone can meet as a full group.

Some couples may prefer to meet separately from the group, which will require special scheduling. Clinicians should develop a way to schedule 45-minute "make-up" sessions for couples who miss a group session.

**Tip:** Program supports such as onsite child care, refreshments, transportation, and incentives for program compliance are helpful in achieving successful enrollment and completion of the intervention. These supports can help make participation possible for a Veteran and their partner who would otherwise not be able to sustain attendance for ten consecutive classes.

### *Group Size*

The optimal size for a group is five dyads. Because many Veterans are in the National Guard or Reserve and might be activated for duty during the intervention, special arrangements should be available for couples to work individually with the trained clinician. Clinicians should work together to cover group and dyad sessions for one another as needed.

### *Program Attrition*

The most common reason that participants drop out of the *Strength At Home* program is couple separation. Couples entering the intervention often have acute, existing issues in their relationships. Program attrition can also occur when a Veteran needs to relocate for employment reasons.

### *Program Criteria*

To be admitted to the intervention, one member of the couple must be a Veteran and both members must be 18 or older. Before each participant can enroll in this intervention, he/she must complete a one-hour intake assessment (which is provided as part of *Strength At Home* training and manual).

Clinicians must exclude participants whose assessment interview demonstrates evidence of: substance dependence, severe brain damage, active psychosis, or prominent suicidal or homicidal ideation.

Clinicians must also exclude any participant whose assessment interview demonstrates some form of "severe" aggression (i.e., used a knife or a gun; punched or hit with something that could hurt; choked; slammed someone against a wall; burned or scalded on purpose; etc.). Individuals are also excluded if they demonstrate reading difficulties that inhibit their ability to understand the program materials or assignments.

These criteria are in place to help ensure the safety of the participants and clinicians. Participants who are screened out are encouraged to re-apply when they have experienced three months without incidents of IPV.

# IV. Evaluation and Sustainability

## Program Evaluation

### *Evaluation Process*

The program evaluation process should start during the clinician training. Program evaluators should examine the clinician's understanding of the core program components of trauma, trauma-informed care, and military cultural competency. Clinicians should have the opportunity to provide feedback on the training content and experience.

*Evaluation measures* are made available as part of the *Strength at Home* two-day training discussed in Section III of this Guide.

Program implementation can be monitored by asking the following questions:

- Are clinicians covering the proper material each week?
- Is there too much or not enough material to cover?
- Are the two-hour group sessions finishing early or taking too long?

Periodic focus groups with program participants should also be implemented to understand their experiences with the intervention. Helpful focus group questions include:

- What was the best part of the intervention?
- What was the worst part?
- What would you change?
- What did you learn?
- How are you different?

Program evaluation and sustainability require preparation and planning from the beginning project stages.

After most intervention sessions, participants are assigned therapeutic practice assignments, asked questions concerning in-session measures (e.g., Is there a feeling of belongingness in this group?) and are asked to fill out the *Couples Therapy Alliance Scale* which measures how well participants feel the clinician is leading the group.

These measures are useful tools for understanding how well the group is coming together and determining how well group facilitators are meeting the needs of participants. They can also form the basis of a program evaluation. These measure are made available as part of the *Strength At Home* in-person training.

## Program Sustainability

Community-based organizations can help meet the costs of *Strength At Home* by acquiring TRICARE accreditation, billing private pay insurance plans, and applying for government grants, including those targeted for Veterans.

### *TRICARE Insurance Accreditation*

TRICARE is the insurer for approximately 9.6 million active and retired members and families of the Army, Navy, Marine Corps, Air Force, Coast Guard, National Guard, and Reserve forces. This healthcare entitlement program, supported by the Assistant Secretary of Defense for Health Affairs, reimburses Veterans for medical and behavioral health services that are delivered outside of military treatment facilities.

To become an authorized participating TRICARE provider, an organization must agree to treat TRICARE members at the reimbursement level allowed by law. TRICARE is administered regionally by managed care contractors that include HealthNet in the North, Humana in the South, and TriWest in the West.

One of the primary goals of the Substance Abuse and Mental Health Services Administration (SAMHSA) Military Families Initiative is to improve military families' access to community-based behavioral health care through coordination among SAMHSA, TRICARE, Department of Defense, and Veteran Health Administration services.

The *SAMHSA Technical Assistance Packet for Becoming A TRICARE Provider* contains information on the TRICARE healthcare entitlement, authorized provider categories, services that may be reimbursed, and the role and expectations of an authorized participating provider for behavioral health. This packet also contains required forms that are part of the certification application and links to the

regional websites and contact information for the TRICARE/ SAMHSA liaison.

### *Health Benefit Parity*

The Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343: MHPAEA) may prevent large group health plans from imposing financial requirements and treatment limitations on mental health and substance use disorder benefits that are more restrictive than financial requirements and treatment limitations on medical/ surgical benefits. MHPAEA also may prevent large group health plans from placing annual or lifetime dollar limits on mental health and substance use disorders benefits, and medical/surgical benefits offered under the plan. MHPAEA does not apply to small group health plans or health insurance coverage in the individual, non-employment based market.

### *Private Insurance*

*Strength At Home* is a cognitive behavioral therapy-based program which may be covered by private health insurance. This will be determined by the coverage terms of each healthcare plan.

### *Supportive Services for Veteran Families (SSVF)*

Department of Veterans Affairs program that awards grants to private non-profit organizations and consumer cooperatives that provide supportive services to very low-income Veterans and their families residing in or transitioning to permanent housing. Grantees provide a range of supportive services designed to promote housing stability.

### *State Grants*

State grants may be available to non-profits organizations that serve Veterans. For example, in California, the Employment Development

Department has Workforce Investment Act funds to provide services to Veterans.

### *DoD Family Advocacy Program*

The DoD Family Advocacy Program assists with issues related to military family violence. The goals of this program are to identify family violence as early as possible, prevent family violence, and provide treatment for victims of family violence.

### *Onsite Programs at Colleges/ Universities*

A *Strength At Home* intervention can be conducted onsite at a local college or university to provide services for students who are enrolled via the GI Bill and who seek mental health services through campus health centers. If the university has a psychology graduate program, graduate students can serve as interns or clinicians for the program.

# References

## *References*


[1] American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members. (2007). *The psychological needs of U.S. military service members and their families: A preliminary report*. Washington, DC: Author.

[2] Marshall, A.D., Panuzio, J. & Taft, C.T. (2005). Intimate partner violence among military veterans and active duty servicemen. *Clinical Psychology Review*, *25*, 862-876.

[3] Marshall, A.D. et. al, 2005.

[4] Taft, C.E., Pless, A.P., Stalans, L.J., Koenen, K.C., King, L.A. & King, D.W. (2005). Risk factors for partner violence among a national sample of combat veterans. *Journal of Consulting and Clinical Psychology, 73*(1), 151-159.

[5] Monson, C.M. & Taft, C.E. (2005). *PTSD and Intimate Relationships*. White River Junction, VT: The National Center for PTSD VA Medical and Regional Office Center.

[6] National Center for PTSD. (2009). *What is PTSD?* Retrieved from http://www.ptsd.va.gov/public/pages/what-is-ptsd.asp

[7] National Center for PTSD, 2009.

[8] Golding, J.M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*, 99-132.

[9] Levendosky, A. A., Lynch, S., & Graham-Bermann, S. A. (2000). Maternal perceptions of the impact of violence on their parenting strategies. *Violence Against Women, 6*, 247-271.

[10] Levendosky, A. A., & Graham-Bermann, S. A. (1998). The moderating effects of parenting stress on children's adjustment in woman-abusing families. *Journal of Family Violence, 13*(3), 383–397.

[11] Levendosky, A.A. & Graham-Bermann, S.A., 1998.

[12] Levin, R., McKean, L. & Raphael, J. (2004, January). *Pathways to and from Homelessness: Women and Children in Chicago Shelters*. Chicago, IL: Center for Impact Research.

[13] Taft, C. *BU Prof Study Partner Abuse by Vets*. Retrieved from Bostonia Web Exclusives at: http://www.bu.edu/bostonia/web/abuse/

[14] LaBash, H.A.J., Vogt, D.S., King, L.A. & King, D.W. (2009). Deployment stressors of the Iraq War: Insights from the mainstream media. *Journal of Interpersonal Violence, 24*(2), 231-258.

[15] Center for Disease Control (2009). *What is Traumatic Brain Injury*? Retrieved from http://www.cdc.gov/ncipc/tbi/TBI.htm

[16] Tanielian, T. & Jaycox, L.H. (Eds) (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: The RAND Corporation.

[17] Warden, D. (2006). Military TBI during the Iraq and Afghanistan wars. *Journal of Head Trauma Rehabilitation, 21*(5), 398-402.

[18] Department of Defense Family Advocacy Program. (2008). Retrieved from http://www.defenselink.mil/fapmip/.

[19] Tanielian, T. & Jaycox, L.H., 2008.

[20] Warnken,W., Rosenbaum, A., Fletcher, K., Hoge, S., Adelman, S. (1994). Head-injured males: A population at risk for relationship aggression? *Violence and Victims, 9*, 153-166.

[21] Okie, S. (2005). Traumatic brain injury in the war zone. *New England Journal of Medicine, 352*(20), 2043 2047.

[22] RTI International (2006). *2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Personnel*. Research Triangle Park, North Carolina: RTI International.

[23] Giancola, P. (2000). Executive functioning: A conceptual framework for alcohol-related aggression. *Experimental and Clinical Psychopharmacology,8*(4), 576-597.

[24] Milliken, C.S., Auchterlonie, J.L., & Hoge, C.W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War. *Journal of the American Medical Association, 298* (18), 2141–48.

[25] Miliken, C.S. et. al, 2007.

[26] Karney, B.R. & Crown, J. (2007). *Families Under Stress: An Assessment of Data, Theory, and Research on Marriage and Divorce in the Military*. Santa Monica, California: RAND Corporation.

[27] Karney, B.R. & Crown, J., 2007.

[28] Jelinek, P. (2009). *Military divorces increasing from war stress*. Retrieved December 1, 2009, from http://content.usatoday.net/dist/custom/gci/InsidePage.aspx?cId=thenewsstar&sParam=3215

[29] Marshall, A.D. et. al, 2005.

[30] Marshall, A.D. et. al, 2005.

[31] Taft, C.T., Howard, J., Monson, C.M., Walling, S.M., Resick, P.A., & Murphy, C.M. (in press). "Strength at Home" intervention to prevent conflict and violence in military couples: Pilot findings. *Partner Abuse: New Directions in Research, Intervention, and Policy*.

[32] Taft, C.T. et. al, in press.

[33] Monson C. M., Fredman, S. J., & Macdonald, A. (2009). *Group Cognitive-Behavioral Conjoint Therapy for Traumatic Stress-related Problems: Out of Session Workbook*. Unpublished workbook.

[34] Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

[35] N Murphy, C. M., & Scott, E. (1996). *Cognitive-behavioral therapy for domestically assaultive individuals: A treatment manual*. Unpublished manuscript, University of Maryland, Baltimore County.

[36] Grace, M., Niles, B., Quinn, S., & Taft, C. T. (unpublished manual). *Anger Management Manual: National Center for PTSD, VA Boston Healthcare System*.

[37] Nonprofits.org. (2010). *Web 1.0, Web 2.0, Web 3.0 Simplified for Nonprofits.* Retrieved from http://nonprofitorgs.wordpress.com

[38] The National Center on Family Homelessness (2010). *Engaging Veterans and Families to Enhance Service Delivery*. Newton, MA: Author.

[39] American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition).

[40] Department of Veterans Affairs. (2004). *Iraq War Clinician Guide 2nd edition*. National Center for Post-Traumatic Stress Disorder and Walter Reed Army Medical Center.

[41] American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition).

[42] Guarino, K. (2011). *Trauma-Informed Care for Women Veterans Experiencing Homelessness: A Guide for Community-Based Organizations.* The National Center on Family Homelessness and the U.S. Department of Labor Women's Bureau.

[43] Hopper, E., Bassuk, E. & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness service settings. *The Open Health Services and Policy Journal*, 3, 80-100.

[44] Figley, C. R. (2002). *Treating Compassion Fatigue*. New York: Rutledge.

[45] Saakvitne, K.W., Gamble, S., Pearlman, L.A., and Lev, B.T. (2001). *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse.* Baltimore: Sidran Institute.

[46] The National Center on Family Homelessness. (2008). *What About You? A Workbook for Those Who Work with Others*. Newton, MA: Author.

[47] Taft, C.T., Murphy, C.M., King, D.W., Musser, P.H., & DeDeyn, J.M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology, 71*, 812-820.

[48] Taft, C.T. et. al, 2003.

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