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Contextualizing Military Health and Trauma: Recommendations for Integrated Care and Couple-Centered Interventions

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Contextualizing Military Health and Trauma: Recommendations for Integrated Care and Couple-Centered Interventions

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Military personnel and their family members are currently facing risks to their health and well-being, yet interventions such as prevention and treatment remain unsuccessful for many families. For instance, almost one-quarter of a million returning troops have been diagnosed with post-traumatic stress disorder (PTSD); however, the estimated prevalence of PTSD is grossly underestimated due to ineffective assessment. Further, only half of military PTSD sufferers are finding relief in their treatment. Through this literature review, assessment, prevention, and treatment recommendations to improve health outcomes for military personnel are provided by expanding previous medical models and incorporating biopsychorelational principles and data.

*Keywords:* Military couples, biopsychosocial, integrated care, PTSD

### THE IMPLICATIONS OF POST-TRAUMATIC STRESS DISORDER

The increased rates of post-traumatic stress disorder (PTSD) for military members have staggering effects on service personnel, families, and the health care system (Burnam, Meredith, Tanielian, & Jaycox, 2009). Around 1.5 million troops have been deployed to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), and around 15% return home and screen positive for PTSD (Tanielian & Jaycox, 2008). Of those 230,000 PTSD sufferers, only around half of them will seek treatment. Further, the U.S. health care system spends up to $1.5 billion treating just combat-related PTSD (Tanielian & Jaycox, 2008), not to mention noncombat-related PTSD. The U.S. Department of Veterans Affairs estimates that it will be treating approximately 200,000 active and reserve military members in the next 10 years, and researchers have estimated that the cost to treat PTSD each year is around $5,000 per person (Tanielian & Jaycox, 2008). Unfortunately, less than half of the PTSD patients find relief with the normative treatment of medication and psychotherapy. Military researchers have also noted this failure rate and have spent almost $300 million in the past five years to find new ways to treat or even prevent the diagnosis of PTSD (Tanielian & Jaycox, 2008).

### WHAT ARE WE MISSING? THE IMPLICATIONS OF INDIVIDUALLY FOCUSED HEALTH CARE

Several components are missing in the treatment of military personnel and veterans, including (1) treatment in which physical and mental health symptoms are treated simultaneously, (2) the inclusion of biopsychorelational assessments, and (3) partners/family members present during medical visits. Although the effects for individuals suffering from PTSD are profound and include persistent stressful thoughts and nightmares (American Psychiatric Association, 2000), little attention is paid to the relationships in which PTSD exists. Much of the literature suggests that supportive relationships reduce the risk and severity of the disease process (Taft, Walling, Howard, & Monson, 2011; Figley, 1988; Mansfield et al., 2010), but rarely is the marital relationship...
thought of as a reciprocal conduit of positive or negative health.

In fact, interpersonal relationships may suffer the most following a PTSD diagnosis and also may hold the key to recovery. Military-related experiences are linked to decreased relational satisfaction, such as occupational challenges (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008; Hourani, Williams, & Kress, 2006), preparing for or returning from deployment (McLeland, Sutton, & Schumm, 2008), and work-related separations (Orthner & Rose, 2009). Traumatic military experiences seem to relate the strongest to poor marital outcomes (Goff, Crow, Reisbig, & Hamilton, 2007): increased marital problems (Wood, Scarville, & Gravino, 1995), intimate partner violence (Taft et al., 2011), marital instability, and divorce (Hogan & Seifert, 2010).

When a member of a military marriage is diagnosed with PTSD, he or she is less likely to have a satisfying relationship and more likely to experience poor marital functioning (Dirkwzager, Bramsen, Ad`er, & Van der ploeg, 2005). Compared to couples in which the military member has not experienced combat stress, those who did experience combat stress reported increased marital conflict and less intimacy, commitment, support toward one another, and safe feelings about their relationship (Rosen & Moghadam, 1991; Solomon et al., 1992). Over time, the magnitude of the combat experience seems to erode marital functioning (Goff et al., 2007). Specifically, at the time of marriage, the year before war, the year after war, and six years after war, marital cohesion and satisfaction declined while marital conflict increased for combat stress couples yet remained the same for noncombat couples. PTSD is a risk to marital satisfaction over time and is also more strongly related to relational problems for military couples than for civilian marriages (Taft et al., 2011).

While some think of PTSD as a psychological disease, the strength of its effects on interpersonal relationships suggests that it may be a disease of relationships.

THE RELATIONSHIP BETWEEN MARITAL AND PHYSICAL HEALTH

PTSD in military and veteran populations not only is linked to psychological problems such as depression (Hoge et al., 2008) and alcohol abuse (Jakupcak et al., 2010; McFarlane et al., 2009; Spera, Thomas, Barlas, Szoc, & Cambridge, 2011) but also poses a risk to physical functioning, such as dermatologic, gastrointestinal, cardiovascular, and musculoskeletal conditions even when other health risk behaviors such as smoking and body mass index (BMI) are controlled (Schnurr, Spiro, & Paris, 2000). While a PTSD diagnosis has been found to be related to a worsening in physical functioning, the exact mechanisms are unclear. An unexplored yet probable route for some may exist via the marital relationship.

The quality of a couple’s marriage appears to have significant implications for the physical health of the two individuals. It is hypothesized that conflictual marriages elicit responses in the sympathetic nervous system resulting in a stress response that may be related to negative implications in other health systems (Smith et al., 2011). For instance, members of happy marriages are more likely to have good health, avoid illness and disease, and recover from illness more quickly (Kiecolt-Glaser & Newton, 2001), while patients in conflictual or stressful marital relationships are more likely to suffer from health risks in immune, autonomic nervous system, endocrine, and cardiovascular functioning (Graham, Christian, & Kiecolt-Glaser, 2006; Miller, Dopp, Myers, Stevens, & Fahey, 1999; Smith, Gallo, Goble, Ngu, & Stark, 1998). In addition, military experiences such as high-stress job environments, long workdays, unpredictable absences from home and family members, combat training and combat exposure, and separation from social networks are risk factors to the well-being of military personnel and their spouses and are events that military personnel have noted as being sources of stress (Cooney, Segal, & De Angelis, 2009; Hourani et al., 2006; Karney & Crown, 2007).

Military marriages tend to experience health risks coming from both within and outside of the relationship. For instance, in a large study investigating the source of stress and distress for military members, those who met the minimum criteria for anxiety or depression reported that both their work and their home lives were highly stressful (Hourani et al., 2006). Reporting stress in both domains was three times higher than in those personnel who did not meet criteria for anxiety or depression. The perpetual, severe, and unrelenting stresses of military life combined with conflicted marriages are a serious risk to health, and such situations need to be addressed immediately for those experiencing them.

Marital relationships play a crucial role in the diagnosis and treatment of PTSD for both military members and spouses (Taft et al., 2011; Figley, 1988; Mansfield et al., 2010). As the effects of PTSD work their way into a marriage, many risks to individual and marital health increase, including (1) lack of support for the military member to cope with the disease (Tanielian & Jaycox, 2008), (2) development of PTSD symptoms in the partner (Mansfield et al., 2010), and (3) increased marital conflict, which is related to worsening physical functioning for both individuals (Graham et al., 2006; Miller et al., 1999; Smith et al., 2011). Thus, treatment must change in two very specific ways: (1) treatment can no longer be conducted in silos; distinct health systems must collaborate; and (2) treatment for PTSD in the military should be done through couple-centered care using a biopsychorelational lens.

TREATMENT IN SILOS

To increase the number of patients assessed and then treated for mental health symptoms, medical health professionals need to perform regular mental health assessments with their patients. For instance, patients who speak to a health
professional about their mental health symptoms are more likely to speak to a medical professional (6.4%) in comparison to a mental health specialist (5.9%) (Regier et al., 1993). Therefore, if the medical arena is the location in which patients feel most comfortable discussing their mental health symptomatology, medical health professionals need to be ready to assess, refer, and/or treat this population. Referral to mental health counseling is also a problem for providers who service military and veteran patients. However, when medical providers do refer patients for behavioral health services, only 44% of patients attend their first appointment, compared to 76% when the provider introduces the patient to the behavioral health specialist (e.g., colocates or with a warm handoff) (Smeeding, Bradshaw, Kumpfer, Trevithick, & Stoddard, 2011). Unfortunately, medical providers servicing military patients rarely collaborate with mental health specialists when there is mental health symptomatology (Apostoleris, 2000). Overall, about one-third of all soldiers are in need of mental health assessments, but only 12.5% receive that care (Burnam et al., 2009).

If a military member does decide to seek help for behavioral health symptoms, he or she will likely encounter another obstacle. In a study of reservists in Indiana, many returning soldiers found problems with access to behavioral health care (Avery, 2011). The inability to find appropriate behavioral health care providers was due to outdated lists of providers (e.g., turnover with insurance panels), geography, high-utilization areas, long wait times, few providers accepting new patients, and the sporadic needs of patient due to deployment. Further, doctoral-level psychologists and licensed mental health counselors are less likely to participate in TRICARE insurance than any other provider (Avery, 2011).

Once the military member gets inside the health clinic, unfortunately, risk factors for inadequate treatment still persist. For example, PTSD has on-again-off-again symptoms that are exacerbated by a number of triggers and, therefore, should be assessed early after deployment (one month or sooner) and at regular increments afterward to detect PTSD symptoms (Avery & Wadsworth, 2011), which is generally not the standard of care.

Further, many medical professionals are not trained, nor do they typically assess for psychosocial difficulties, which is strongly related to worsening PTSD symptoms. For instance, lack of social support has consistent, negative effects for military members (Milliken, Auchterlonie, & Hoge, 2007). Interpersonal problems increased by four times from postdeployment return (3.5%) to six months postdeployment return (14.0%). Marital relationships in which a military member has PTSD are at risk for lowered marital satisfaction (Defense Health Board Task Force on Mental Health, 2007). Further, partners of military members with PTSD are more likely to experience relational distress (Orthner & Rose, 2009), poorer marital satisfaction, somatic and sleeping problems, and less social supports (Riggs, Byrne, Weathers, & Litz, 1998), while wives whose partners were deployed suffered from increased prevalence of anxiety, depression, adjustment disorder, stress reactions, and sleep problems (Gottman & Levenson, 1999).

INTEGRATED CARE AS AN ALTERNATIVE TO THE MEDICAL MODEL

To more successfully address risks to physical health and frequent users of the military medical system, a systemic approach to medical assessment and treatment is necessary. The integrated care model employs additional psychosocial assessments, medical team collaboration, and mental health treatment, if needed, all under one treatment plan (Blount, 2003). Inclusion of spouses/significant others and family members as a part of treatment is endorsed in the primary care setting for the following scenarios: (1) a new diagnosis, (2) a new developmental stage, (3) individual, marital, or family crisis, (4) mild depression and anxiety, (5) grief and stress reactions, and (6) behavioral problems (Granado et al., 2009). Integrated care interventions are already validated and utilized at the national level. For example, the Center for Integrated Health Solutions (CIHS) aims to

The success that integrated care has received in the civilian population is clear (Cummings, O’Donohue, & Ferguson, 2002; Katon, 1995; Phelps et al., 2009; Pratt, Lazorick, Lamson, Ivanescu, & Collier, 2013), especially in hard-to-reach and comorbid populations, which makes the case for implementation in military medical settings. Specifically, in civilian populations, 90% of integrated care patients will complete their treatments, compared to less than half of patients only referred to a behavioral health specialist by a medical provider (Cummings et al., 2002; Katon, 1995). Given the biopsychosocial implications of PTSD, integrated care may have the added benefit of allowing PTSD sufferers to receive physical and behavioral health care to address all their symptoms.

COUPLE-CENTERED CARE

Further, couple/family therapy (grounded in systems theory) may be related to a significant decrease in health care utilization for patients and family members. While it is difficult
to accurately assess cost offset for partners (Crane, 2011), in a study investigating the difference between health care utilization for patients seeking either individual or family therapy, researchers discovered that high health care utilizers who received family therapy reduced health care utilization in urgent care by 78%, health screening by 68%, and illness visits by 38% (Crane & Christenson, 2008). It appears a systemic, couple-centered care perspective results in improved behavioral and physical health outcomes by reverberating positive change within patient, couple, and medical systems (Gallagher, 2009; Jorgensen, 2009; Manne, Alfieri, Taylor, & Dougherty, 1999). This further punctuates the need for both an integrated care and couple-centered care approach to treating military personnel and veterans, especially those at risk or suffering from PTSD.

**POLICY RECOMMENDATIONS**

If medical facilities that service military members (active, reserve, veteran) implemented the inclusion of couple and family members as a part of treatment as the standard of care, many opportunities to address the health needs of military families would be possible, as well as to reduce health care costs. In the White House’s strategic plan to address the needs of service personnel, the well-being and psychological health of military families was identified as the number-one priority (Whisman, Uebelacker, & Settles, 1999). This further punctuates the need for both an integrated care and couple-centered care approach to treating military personnel and veterans, especially those at risk or suffering from PTSD.

1. Mental health assessments, especially those centered on trauma, loss, and family functioning, should be completed early and often after deployment to avoid undiagnosed psychosocial conditions (Milliken et al., 2007) and subsequent medical health risks.

2. Military medical centers should encourage patients to bring their spouses to medical visits given the positive effects for both the individual and the family member (see Lewis, Lamson, & Lesueur, 2012; Defense Health Board Task Force on Mental Health, 2007).

3. Mental health assessments of spouses of PTSD victims should be mandated, given the reciprocal and shared relationship between PTSD and marital health (Figley, 1988; Lewis et al., 2012; Riggs et al., 1998).

4. Medical care for service personnel should always include interviews/assessments in the biological, psychological, and social (BPS) domains (Engel, 1977).

5. Research testing both the effectiveness and efficacy of implementing care with the inclusion of spouses or family members in military medical settings is imperative. Successful interventions include those that reduce/prevent patient and spouse BPS symptoms, offset health care costs, and reduce provider burnout (see Cummings et al., 2002; Katon, 1995; Lewis et al., 2012).

See appendix for additional resources for integrated care and family-focused health care for military members and veterans.

**IMPLICATIONS FOR A NEW MODEL**

Generally, primary care contexts assess and treat using a physical-biological viewpoint with an individualized treatment plan, as opposed to couple-centered care using a biopsychorelational treatment plan whereby medical and mental health is treated simultaneously.

Medical care requires both tracking patient symptomatology and using a series of tests and logic models to assess and treat symptoms. Rarely do providers interview patients about psychosocial health. However, with the policy recommendations as a guide, fewer mental health issues would go unassessed, underdiagnosed, and undertreated, which has significant implications for military members and their families. For instance, the medical patient’s support system could have considerable effects on disease prevention, recovery, and treatment implications (Barth, Schneider, & Von Känel, 2010; Wang, Wu, & Liu, 2003). Further, most people prefer to have their family members involved with their health care visits and treatment decisions; around half of patients actively involve a family member in their health care decisions. The majority of military behavioral health patients would rather their family be involved in their care compared to going through treatment alone (McDaniel, Campbell, Hepworth, & Lorenz, 2005). Therefore, treating a patient in isolation (i.e., without consideration of integrated care) or without involving their partner is not patient centered or considerate of the obvious influences of biopsychorelational well-being.

A further reason to implement couple-centered care models is that marital and family support is related to increased treatment plan adherence (Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011), which is also related to improved cost management (DiMatteo, 2004). With the systemic perspective in mind (i.e., that change in one area of a family system resounds throughout), when a patient and his or her partner attend a medical visit together, the accompanying spouse is less likely (21%) to present health symptomatology just by attending the medical visit with their partner (DeSimone, 2000). Overall, medical visits by couples are related to reduced physical and mental health care symptoms for both members of the couple along with reduced medical visits overall (Law & Crane, 2000), punctuating the assets of using integrated care and couple-centered care.

Military medical contexts that engage in couple-centered care are an answer to providing patient-centered (Khaylis et al., 2011), cost-effective (Law & Crane, 2000), and evidence-based care (DiMatteo, 2004). The support of family members is related to (1) a reduction in pathological
symptom development, (2) an increased rate of recovery (DeSimone, 2000), and (3) an increased adherence to the treatment plan (i.e., taking medications when prescribed, completing treatment recommendations), all three of which are ultimately related to better health and cost management outcomes (DeSimone, 2000). Couple-centered care has the potential to have significant outcomes on the way health care is delivered to service personnel, costs associated with care, and health outcomes for military members, their spouses, and families receiving services that are financed by the TRICARE and Veterans Affairs systems.

REFERENCES


APPENDIX: RECOMMENDED RESOURCES

The Alliance of Military and Veteran Family Behavioral Health Providers, http://www.ecu.edu/che/alliance/

Collaborative Family Healthcare Association, http://www.cfha.net/
