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PRACTICE REVIEW

Help-Seeking Among Airmen in Distressed Relationships: Promoting Relationship Well-Being

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Although a substantial proportion of service members returning from a combat deployment report individual emotional and behavioral disorders as well as intimate relationship difficulties, previous studies indicate that only a minority actually seek mental health services. Little is known about factors that predict help-seeking in this population. We first review key findings from the literature on help-seeking in military and veteran populations, including mixed findings regarding the role of perceived stigma and attitudes toward mental health treatment. We then present data from a longitudinal study of United States Air Force Security Forces following a year-long high-risk deployment to Iraq—including findings regarding who seeks help, for what problems, and from which providers. We also examine whether these findings differ for Airmen in a married or committed relationship versus nonpartnered Airmen and, for the former group, whether findings differ for those in a distressed versus nondistressed relationship. Finally, we discuss implications of these findings for extending couple-based interventions to service members and veterans, and describe a multitiered "stepped" approach for promoting relationship resiliency.

Keywords: help-seeking, stigma, military, veterans, couples, resiliency

Various surveys of service members returning from combat operations in Iraq and Afghanistan have found alarming rates of postdeployment mental health symptoms but low levels of formal help-seeking (Cigrang et al., 2014; Hoge et al., 2004; Kim, Britt, Klocko, Riviere, & Adler, 2011; Osório, Jones, Fertout, & Greenberg, 2013). Paradoxically, service members' anticipation that mental health help-seeking would lead to stigmatization by peers and supervisors has been shown to be greatest among those most in need of help. Such findings have galvanized researchers and government leaders to focus on stigma as a dominant problem associated with the provision of mental health care to our newest veterans.

However, studies directly examining the association between perceived stigma and seeking of mental health services have yielded little evidence to support this hypothesized linkage (Sharp et al., 2015). For example, a handful of cross-sectional studies involving active duty service members (Kehle et al., 2010; Kim et al., 2011; Valenstein et al., 2014) as well as prospective studies of veterans seeking care (Harpaz-Rotem, Rosenheck, Pietrzak, & Southwick, 2014; Hoerster et al., 2012; Rosen et al., 2011) have found stigma to be unrelated to receiving subsequent mental health care. One possible explanation is that veterans anticipating greater stigma choose helping resources that offer greater anonymity or less visibility. Studies to date have not examined the possible association between anticipated stigma and where veterans choose to seek help, and most have provided only minimal distinction among different sources of help. Two studies comparing rates of use of mental health professionals to rates of alternative providers such as chaplains found them to be similar in a national sample of United States (Elbogen et al., 2013) and United Kingdom (Iversen et al., 2010) military personnel. In both of those

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studies, however, rates of mental health professional use increased over alternative providers when subgroups of veterans who screened positive for a mental health disorder were examined. In contrast, Kim et al. (2011) found that active duty Soldiers' postdeployment use of mental health services at the on-base military facility was notably higher than use of chaplains or civilian resources. Further studies are clearly needed to improve our understanding of veterans' help-seeking choices, particularly involving active duty members.

Previous studies suggest that severity of psychological distress may predict help-seeking behavior. For example, both cross-sectional studies (Di Leone, Vogt, Gradus, Street, Giasson, & Resick, 2013; Kehle et al., 2010) and longitudinal studies (Harpaz-Rotem et al., 2014; Hoerster et al., 2012; Rosen et al., 2011) of veterans receiving medical care in the U.S. Department of Veterans Affairs (VA) found that greater severity of depression and posttraumatic stress significantly predicted subsequent mental health visits. Severity of distress may also predict mental health help-seeking while service members are on active duty, but to our knowledge, this has not been examined. Not surprisingly, negative attitudes toward mental health treatment (e.g., mistrust of mental health professionals or beliefs that mental health care doesn't work) also predict lower interest in seeking help (Brown, Creel, Engel, Herrell, & Hoge, 2011) and reduced service use (Kim et al., 2011; Valenstein et al., 2014).

Given the potentially destabilizing effect of deployment and mental health conditions on service members' close relationships (Cigrang et al., 2014; Milliken, Auchterlonie, & Hoge, 2007; Riviere, Merrill, Thomas, Wilk, & Bliese, 2012), it may also be that relationship distress contributes to increased help-seeking behaviors. Although marital distress has been associated with increased overall mental health care utilization in studies of civilian couples (Schonbrun & Whisman, 2010), one study that examined this question in the military (Meis, Barry, Kehle, Erbes, & Polusny, 2010) found that level of intimate relationship distress two months postdeployment did not uniquely predict receiving either individual or couple/family treatment within the first year.

In sum, a large proportion of service members and veterans reporting emotional or behavioral disorders do not seek mental health services for these difficulties. Levels of anticipated stigma for mental health help-seeking do not reliably influence whether active-duty service members or veterans choose to obtain help. Although the association between perceived stigma and help-seeking may be more nuanced—for example, influencing where service members with greater concerns for social stigma may seek help—no studies have addressed this specifically. Level of psychological distress and one's own attitude toward mental health treatment appear to be better potential predictors of help-seeking. And finally, given the comorbidity of individual disorders and intimate partner distress in civilian samples and the association of marital distress with mental health care utilization and response to treatment (Snyder & Whisman, 2004), the influence of relationship distress on patterns of help-seeking in military and veteran populations seems particularly important to examine.

Evaluating the Need Versus Demand for Mental Health Care Among Returning Service Members

Against this general theoretical and empirical backdrop, our own work on help-seeking emerged from a very specific context and the need to care for a particular group of service members demonstrating high-risk for both individual and relationship deterioration following deployment. The year was 2008, and the U.S. Air Force (USAF) had committed personnel from its Security Forces to 1-year deployments to train Iraqi police, a high-risk mission that required patrolling in communities with a high insurgent presence. Anecdotal reports to USAF command following the first detachment of these Security Forces indicated high rates of mental health difficulties during and immediately following deployment. In response to those reports, the USAF command enlisted the assistance of our research group—comprising both military and civilian researchers—to address the following questions: What individual and relationship dysfunctions were Security Forces at greatest risk for incurring during deployment? What trajectory did these difficulties exhibit following deployment during the reintegration phase? What mental health services were available to Airmen following deployment, to what extent were these being used, and what factors could be influencing their utilization? What new services might be needed—particularly those supporting the intimate partner relationships of returning Airmen—and how could these services be most effectively disseminated?

The Impact of Combat Deployment on Psychological and Relationship Health

Our team followed two consecutive detachments of USAF Security Forces incurring 1-year deployments to Iraq, assessing them across a broad spectrum of individual and relationship health prior to, during (in theater), and 6–9 months following deployment (Cigrang et al., 2014). Our findings revealed substantial deterioration in Airmen's individual and relationship functioning from pre- to postdeployment. Rates of posttraumatic stress disorder (PTSD) at moderate or severe levels increased by more than sixfold from 7% to 47%. Similarly, rates of depression at moderate or severe levels increased across deployment from 3% to 29%. Problematic alcohol use—already substantial at predeployment (at 25%)—nearly doubled to 45%. And of the 92 Airmen in a committed relationship prior to deployment, at the 6–9-month follow-up, over half (54%) reported their relationship as significantly distressed, dissolving, or already dissolved, whereas only 25% had reported significant relationship distress at predeployment.

Patterns of Help-Seeking

At each of the three assessments, Airmen were asked whether they had sought any mental health or related counseling services and, if so, for what reasons and from which providers. Overall, at follow-up, 37% of Airmen indicated that they had sought counseling services of some kind since returning from deployment. More importantly, rates of help-seeking increased among Airmen screening positive for mental health problems—reaching 59% for individuals with clinical levels of PTSD, 50% for those with depression, and 42% for those meeting criteria for alcohol misuse (Figure 1). Nevertheless, many service members needing mental health services were not receiving them—in part because they were not seeking them out. Of those Airmen who sought mental health care, the most common reasons were for deployment-related experiences (22%), depression or anxiety (19%), and anger (19%) (Figure 2). Only a small percentage of partnered participants (4%) sought couple counseling with their partner, although a larger group (11%) sought individual counseling for relationship problems.

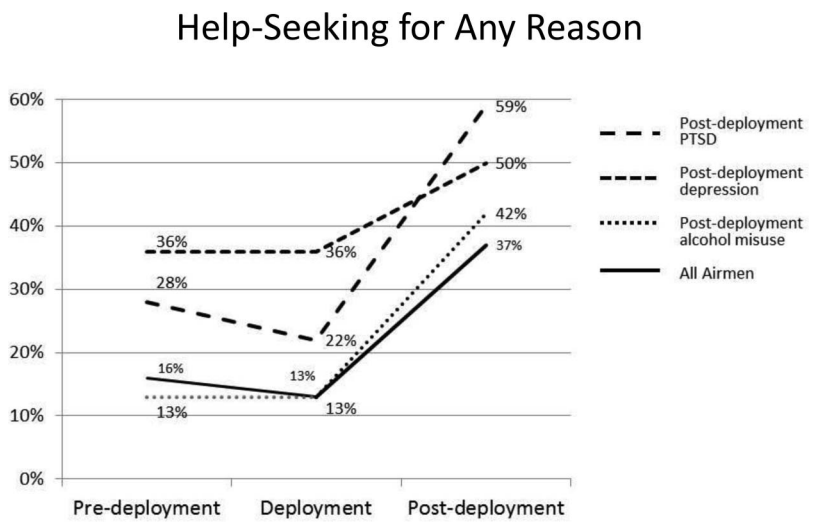


Figure 1. Rates of help-seeking across the deployment cycle for any reason among Airmen reporting clinical levels of posttraumatic stress disorder (PTSD), depression, or alcohol misuse at 6–9 months postdeployment. ADAPT = alcohol/drug abuse prevention and treatment program.

We had anticipated that perceived stigma associated with receiving mental health services and negative attitudes toward mental health treatment might both be related to subjective distress of specific mental disorders and, hence, adversely impact help-seeking from any source or possibly influence the specific source of services sought. Indeed, both perceived stigma and negative attitudes toward mental health services were positively associated with levels of PTSD symptoms, depression, and alcohol misuse. However, neither perceived stigma nor attitudes toward mental health treatment discriminated between those Airmen who sought mental health services versus those who did not. Moreover, over half of Airmen reporting clinical levels of PTSD, depression, or alcohol misuse sought services from a mental health provider, whereas fewer than 10% sought counseling from a chaplain or military family life consultant, or from Military OneSource or an alcohol/drug abuse prevention and treatment program (ADAPT) (Figure 3). That is, contrary to our hypothesis that higher anticipated stigma might lead to help-seeking from more anonymous providers, there was no significant difference in perceived stigma ratings for Airmen who used specialty mental health services versus those who used other counseling services.

Do Patterns of Help-Seeking Differ for Airmen in Distressed Relationships?

We were especially interested in whether help-seeking patterns would differ for Airmen in committed intimate relationships versus

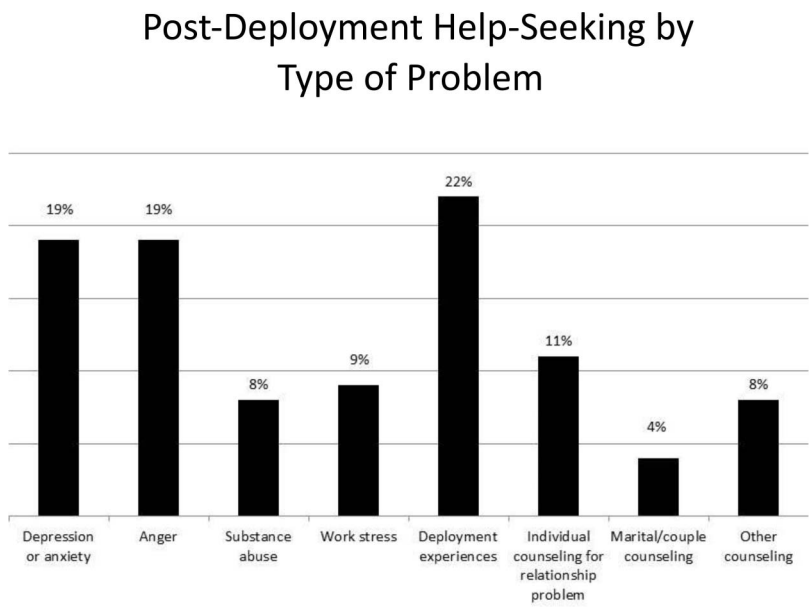


Figure 2. Rates of reported help-seeking at 6–9 months postdeployment by type of problem.

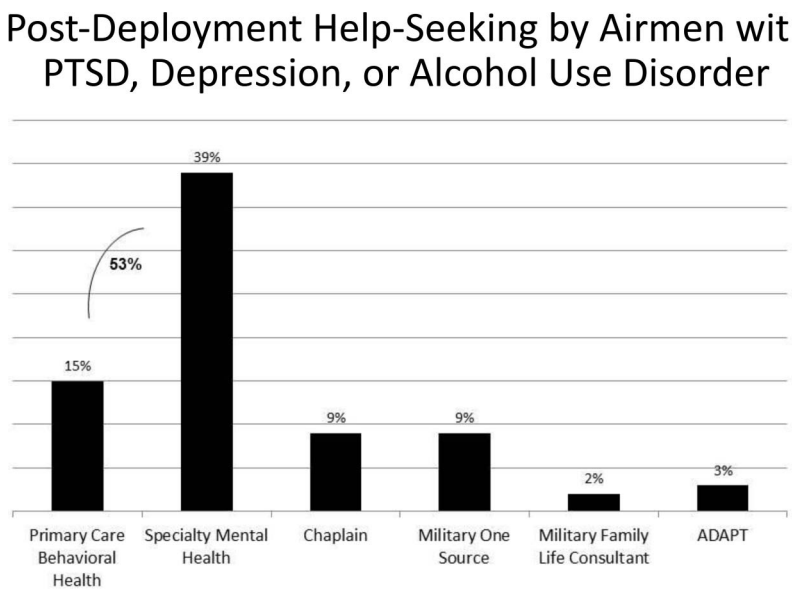


Figure 3. Rates of help-seeking at 6–9 months postdeployment from specific providers by Airmen with posttraumatic stress disorder (PTSD), depression, or alcohol-use disorder. ADAPT = alcohol/drug abuse prevention and treatment program.

nonpartnered Airmen and, if so, whether those patterns might also vary as a function of relationship quality or couple distress. Several factors contributed to our interests in this regard. First, the majority of service members (70% of officers, and 50% of enlisted personnel) are married, and there is considerable evidence indicating the adverse impact of mental health problems of returning service members on their intimate partners and relationships (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). Second, multiple studies affirm the association between high levels of intimate partner support and lower levels of PTSD symptoms, and one study (Balderrama-Durbin et al., 2013) suggests that this association is mediated by the partner providing a safe context for the service member's disclosure of painful combat-related experiences. And finally, couple-based interventions have been developed for a broad array of emotional and behavioral disorders confronting service members and veterans—with additional evidence that these couple approaches are more effective than individual treatments when such disorders and relationship distress are comorbid (Snyder & Monson, 2012).

However, in our longitudinal study of USAF Security Forces, both relationship status (partnered vs. nonpartnered) and, for partnered Airmen, relationship quality (distressed vs. nondistressed) were largely unrelated to help-seeking patterns. Moreover, only about 1 in 6 Airmen in a distressed intimate relationship actually sought help for relationship problems and, of those, the majority sought help through individual counseling rather than couple counseling.

The Challenge of Promoting Relationship Well-Being

Although various counseling resources exist for service members and veterans with individual emotional and behavioral disorders, resources in both the Department of Defense (DoD) and Veterans Health Administration specifically targeting distressed intimate relationships have historically been scarce. There are numerous reasons for this, but one in particular has been a generalized slowness in the mental health field to recognize the comorbidity of individual and relationship disorders and their recursive effects. The majority of mental health providers in the DoD and VA systems have been trained in individual treatments, and efforts to disseminate evidence-based couple treatments for specific disorders and general relationship distress in those environments comprise a relatively recent phenomenon. Moreover, when active-duty service members or veterans seek services for intimate relationship problems from well-trained couple therapists in the civilian sector, too often those clinicians have little familiarity with unique challenges of military life and reintegration into the family or community following military deployments—and hence their credibility and effectiveness can be compromised.

If We Build It, Will They Come?

Beginning with Security Forces, but then extending to Headquarters for Airman and Family Readiness, the USAF discerned the need to develop and deploy a couple-based resiliency and intervention program aimed at identifying Airmen at risk for significant intimate partner relationship problems that could contribute to, exacerbate, or maintain individual emotional or behavioral dysfunction and thereby compromise Airmen's duty-performance. Our team responded with a proposal for designing, implementing, and evaluating USAF-ARMOR, a convenient acronym for "Unified Strategy of Action for Airman Resilience and Maintenance of Operational Readiness." The acronym was also consistent with our intent to promote relationship resilience by "up-armoring" couples with critical relationship skills before initial difficulties became more entrenched or severe.

Developing a relationship-focused program is one thing, but getting service members and their partners to avail themselves of it is another. An initial question we asked ourselves was, "If we build it, will they come?" (to paraphrase Ray Kinsella in *Field of Dreams*). Our ap-

proach was to develop a multitiered, stepped program that would provide Airmen with relationship resources they wanted, in the amount they needed, at a time they were able and willing to receive them, and from persons they preferred to get them.

Toward this end, we first approached over 100 partnered Airmen in our longitudinal study in small focus groups of 10–15 participants each, and invited them to discuss what relationship problems they had experienced during or following deployment, information or counseling services they had received and Airmen's perception of their helpfulness, and resources they wished they had received but did not. Our Airmen also rated approximately 30 common relationship challenges across the deployment cycle regarding how useful it would have been to receive information on that specific issue, whether they had received such information and, if so, from whom. On average, group members reported having received little or no information on most topics rated as "considerably" or "extremely" useful, such as managing relationship conflict, staying connected, maintaining a strong relationship, and dealing with fears of infidelity. For almost all topics, roughly 70–95% of Airmen who desired assistance with that topic reported being underserved.

Based on results of these focus groups and ratings of topics' importance and resources received (or mostly not received), we developed 18 trifold "Action Sheets" or psychoeducational fliers addressing specific relationship concerns or challenges across the deployment cycle. Some Action Sheets address general relationship issues (e.g., coping with stress, handling relationship problems, managing finances), others focus on issues related to preparing for or coping with deployment as a couple (e.g., discussing the upcoming deployment or maintaining strong connections during deployment), whereas others address specific couple challenges following deployment (e.g., rebuilding intimacy, dealing with changes in family roles, or talking about deployment experiences). Table 1 provides a complete listing of specific topics addressed by the 18 Action Sheets.

Each Action Sheet addresses a specific relationship issue by summarizing common features or concerns, providing evidence-based tips and strategies for dealing with that issue, and then directing the consumer to develop a specific action plan. An example of such an Action Sheet—Couples Coping With Stress—is shown in Figure 4. A strength of USAF-ARMOR is that materials are integrated across specific topics and levels of intervention. For example, a common core of relationship communication skills—for both speaker and listener—is replicated across several Action Sheets addressing diverse specific relationship concerns. This repetition serves to promote consistency as well as to strengthen core communication skills having strong empirical support for their impact on relationship functioning.

Table 1
Topics of USAF-ARMOR Action Sheets

Couples coping with stress
Sharing responsibilities to manage work/home strain
Handling problems with your partner
Showing you care
Couples tackling money
Is our relationship in trouble?
Operational stress and your relationship
Talking to family about upcoming deployment
Maintaining a strong relationship during deployment
Fears of infidelity
Easing back into family life
Your changing family role
Involving your partner in reintegration
Feeling disconnected from others
Talking with your partner about deployment experiences
Rebuilding your relationship
Rebuilding intimacy with your partner
Recovering from infidelity

Note. USAF-ARMOR = Unified Strategy of Action for Airman Resilience and Maintenance of Operational Readiness.

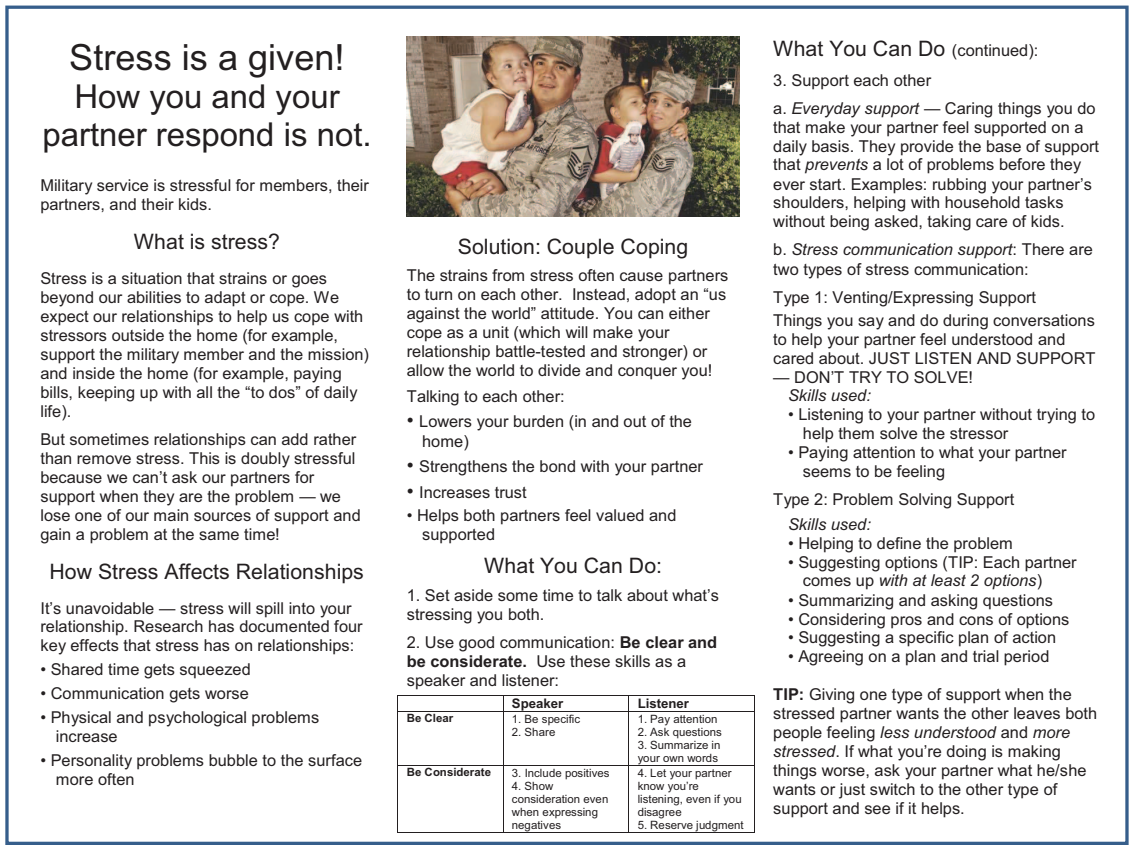
Each Action Sheet then directs the consumer to (1) choose a specific target behavior of their own to change; (2) assess pros and cons of their current behavior; (3) create a specific plan of when, where, or how to enact the new or changed behavior; (4) enact the plan; and then (5) a few days or week later, review the outcome and consider potential revisions to their initial strategy (see Figure 5 for a sample Action Strategy Plan Sheet). The language of the Action Sheet (e.g., "targeting" the problematic behavior, "shifting fire" to identify specific changes needed to address the problem, and engaging in "after action review" to evaluate progress or identify further steps) adopts constructs familiar to service members and promotes active engagement and accountability in the change process.

Following their initial development, these Action Sheets were then reviewed by a new sample of approximately 235 USAF Security Forces at two different Air Force bases, and rated for organization, interest level, clarity, completeness, length, and readability. Replicating findings from the first stage of development, topics addressed by the Action Sheets were consistently rated as moderately to very useful, and ratings on additional criteria of organization, clarity, and so on were uniformly high (averaging above 4.0 on a 5-point scale) (Heyman et al., 2015).

A Multitiered Approach to Promoting Relationship Well-Being

Building on these materials, we then developed a multitiered, stepped approach to dissemination based on prevention science previously found to be successful in distributing effective parenting strategies at the community level (Sanders, 2012). This multitiered approach, depicted in Figure 6, underscores a continuum of assistance; integration of universal, selective, and indicated prevention/intervention; self-regulation; and an emphasis on evidence-informed interventions. At the lowest level of intervention, awareness of intimate relationship challenges for active military is promoted by informing personnel at multiple existing base service and support units (e.g., Airman and Family Readiness Centers, primary and mental health care facilities, offices of chaplains and family life consultants) of their prevalence and providing Action Sheets for prominent display and dissemination to potential consumers. Providers and service members or their partners can then select among the 18 Action Sheets focusing on specific relationship challenges and guiding partners through the development of a self-directed, targeted action strategy emphasizing positive, adaptive change.

At intermediate levels of intervention, the program encourages brief "conversations" with front-line supervisors or other individuals within the military unit who had already been identified as "natural helpers" and trained specifically to disseminate basic relationship skills at a low intensity. Those conversations may occur in various



Stress is a given! How you and your partner respond is not.

Military service is stressful for members, their partners, and their kids.

What is stress?

Stress is a situation that strains or goes beyond our abilities to adapt or cope. We expect our relationships to help us cope with stressors outside the home (for example, support the military member and the mission) and inside the home (for example, paying bills, keeping up with all the "to dos" of daily life).

But sometimes relationships can add rather than remove stress. This is doubly stressful because we can't ask our partners for support when they are the problem — we lose one of our main sources of support and gain a problem at the same time!

How Stress Affects Relationships

It's unavoidable — stress will spill into your relationship. Research has documented four key effects that stress has on relationships:

- Shared time gets squeezed
- Communication gets worse
- Physical and psychological problems increase
- Personality problems bubble to the surface more often

Figure 4. Sample Action Sheet. See the online article for the color version of this figure.

lengths, and may or may not include follow-up discussions, depending on the interest and receptiveness of the service member or partner.

Finally, at higher levels of prevention, family life consultants or clinical staff can offer brief (e.g., 60-min) seminars or workshops for couples on selected topics (e.g., coping with deployment) that encourage partner interactions and explicit action strategies. Commanders of military units about to deploy can also be approached to support a brief (e.g., half-day) training for service members and their partners that promotes specific preparations for the relationship challenges of deployment and encourages explicit plans for staying connected. The foci of such workshops are informed by topics already identified by service members as important to their relationship well-being, and expand upon information and evidence-based strategies reflected in the Action Sheets supporting lower levels of intervention. In this manner, service members receive consistent, integrated care promoting relationship well-being across all levels of assistance—from self-help to "light-touch" discussions with identified peers or supervisors to more intensive couple-based or group interventions.

Implications for Mental Health and Other Service Providers

It is neither reasonable nor feasible to require that the majority of mental health providers in the DoD or VA systems become competent in the delivery of intensive couple-based interventions; nor is likely that a majority of couple and family therapists in the civilian sector will develop in-depth familiarity with the language, culture, and unique challenges of military service across the entire deployment and reintegration cycle. But it is important that a critical mass of providers in both environments become equipped to strengthen and protect the intimate partner relationships of men and women who have served their country. Doing so requires that they become well-versed in basic relationship skills, knowledgeable about military contexts that impact and challenge service members' and veterans' intimate relationships, and competent in disseminating evidence-informed resources for promoting relationship well-being.

Promoting Relationship Well-Being in the Military and Veteran Communities

The data affirming the need to preserve and protect the intimate relationships of service members and veterans are compelling. In a recent study, over half (51%) of suicides among active-duty service members were associated with the failure of a marriage or similar intimate relationship, with the majority of those (59%) having failed within the past 30 days (Bush et al., 2013). Among veterans, 42% report struggles in getting along with their spouse or intimate partner, and roughly a third (35%) report experiencing a divorce or separation since their deployment (Sayer et al., 2010).

Mental health counselors, providers across the allied health professions, family life consultants, personnel affiliated with the broad spectrum of family support services, and designated super-

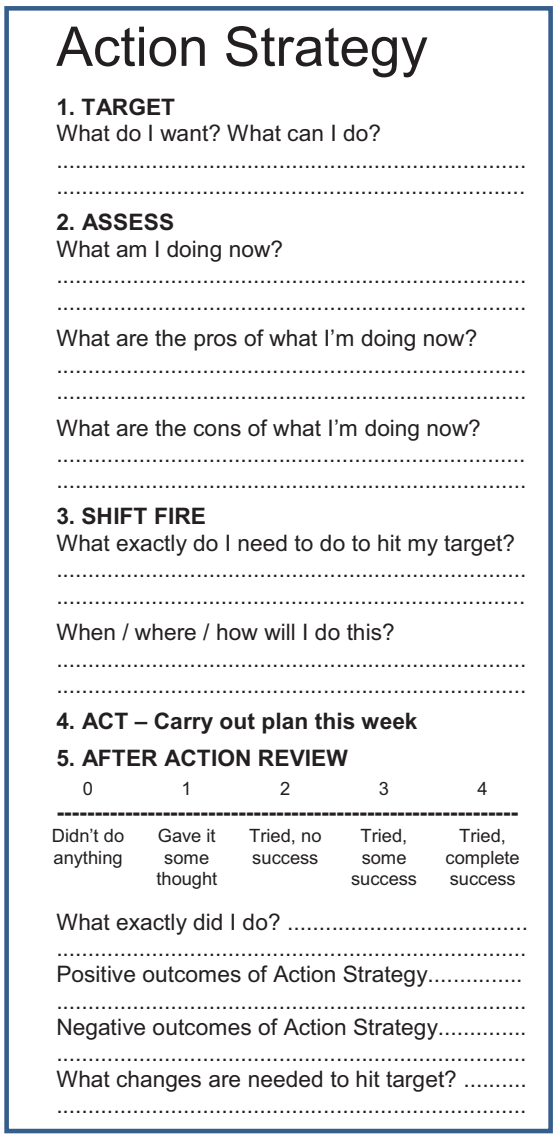


Figure 5. Sample Action Strategy Plan Sheet. See the online article for the color version of this figure.

visors and other "natural helpers" identified at any point of potential interaction can all be trained to offer "brief conversations" that direct the service member or veteran to evidence-based, self-directed resources or low-intensity consultations. An example of such a brief conversation follows:

Consultant or "natural helper" (CNH):	Last week we were talking about problems you were having sleeping, and you said you thought it might be related in part to stress at home.
Service member or veteran (SMV):	Yeah, that's not the only reason, but it could be a part.
CNH:	Stress with your partner?
SMV:	Sometimes.
CNH:	Have you and she ever tried to get any help with that—talking with someone or reading anything for advice?
SMV:	I don't think we're up for marriage counseling or anything like that.
CNH:	Well, that's okay. You may not need it. But would it be all right with you if I shared some information that other couples have found useful in similar situations?
SMV:	Sure, that would be fine.
CNV:	I've got a couple of short, easy-to-read pamphlets that folks sometimes find helpful. They're based on some specific strategies that often work for couples dealing with various issues—and they offer some step-by-step advice for making some small changes that sometimes can make a big difference.
SMV:	What kinds of pamphlets?
CNH:	Well, actually, I have a whole set of them—almost 20. But, let's see, I've got one here on "Couples Coping With Stress"—let's take a look. Inside here, it just talks a bit about what stress is, and how it affects relationships. And then over here it lists some simple strategies for supporting each other and doing some problem-solving together.
SMV:	Seems pretty basic. Then what?
CNH:	Well, sometimes "basic" is good—or good enough. On the back side here, it helps you make an "action plan"—deciding what you'd most like to change, what you could do differently, why that might be worth the effort, and then creating a plan for trying it out and seeing how it works.

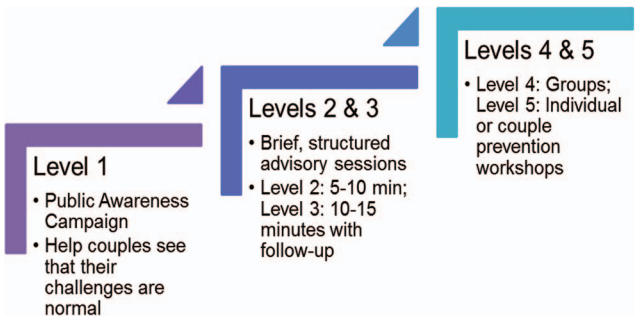


Figure 6. Levels of USAF-ARMOR (Unified Strategy of Action for Airman Resilience and Maintenance of Operational Readiness). See the online article for the color version of this figure.

SMV: I'd do this on my own?

CNH: Well, probably best if you shared it with your partner, and maybe you could each decide on something you could do on your own that would help reduce the stress for both of you, and see if that makes a difference.

SMV: What if doesn't make any difference at all?

CNH: Well, that's certainly a possibility. But if you want to try it out and then check back in with me in a couple of weeks, we could chat some about how it went—and see then if you want to revise your strategy and give it another shot.

SMV: I guess it couldn't hurt.

When service members are helped to understand that relationship challenges involving everyday stress, maintaining emotional and physical intimacy, or dealing with conflicts around such issues as money or children are common and often can be improved upon with a few straightforward interventions, they are more likely to seek additional help. A sample follow-up discussion with the service member portrayed earlier follows:

CNH: Hey there. How's it going?

SMV: Okay. Better, I guess.

CNH: Want to chat about it?

SMV: Well, the main thing, I guess, is that we both recognize we've been struggling and want to do something about it.

CNH: You and she talked?

SMV: Yeah—I showed her that pamphlet you gave me, and we actually went through it together.

CNH: What was that like?

SMV: Helpful, I guess. Like—it was good to see how stress can affect relationships—because we could see that happening with us, how it sometimes brings out the worst in us instead of the best.

CNH: Were you able to figure out things to try different?

SMV: Some, I guess. I agreed that if I feel stressed out when I get home, I'll take 20 minutes by myself to decompress and then come out to see what she needs. She agreed not to hassle me for those 20 minutes, and also to let me know when she's feeling stressed out and what she needs me to do for her.

CNH: So how has that worked?

SMV: It helps about half the time.

CNH: That's pretty good! Getting it to work better half the time is no small deal.

SMV: Yeah, I guess so.

CNH: Any thoughts about the other half?

SMV: Well, when she tells me she's stressed out, I can usually see ways she could handle it better and I try to offer suggestions.

CNH: And how does that go?

SMV: Not very well.

CNH: Yeah—well, how about if we look at this Action Sheet together again, just for minute—because I remember something about that. See over here—where it says sometimes your partner just wants you to listen, and not try to solve anything?

SMV: Yeah.

CNH: Well, you could try that and see if it works any better.

SMV: Like how?

CNH: Well, you know, just giving her space to talk—without trying to fix anything. Or letting her know you've listened by repeating back some of what she's said. Or asking her to describe more of what it's like for her.

SMV: I guess I could give that a try.

CNH: Well, if it helped with another 25% of the time, that wouldn't be bad, would it?

SMV: Nope—that would be pretty good—probably good enough!

Beyond such "conversations" as these (at the middle level of our multitiered approach), both the military and veteran communities can offer preventive couple-based resources to targeted groups known to be at risk for specific relationship challenges accompanying various phases of the deployment cycle. For example, at higher levels of this stepped approach, service members anticipating deployment and their partners can be offered a brief workshop that helps them develop a specific plan for how to stay connected with each other and with their children, how to manage black-out periods when they cannot communicate, what they want to be able to discuss—or not discuss—during their separation, and how to manage needs for physical intimacy and protect against threats to fidelity. Similarly, following deployment and the initial reunion, workshops can be offered to couples to address challenges of reintegration including rebuilding emotional and physical intimacy, coping with changes in their children's development, and restoring or redefining roles for the service member in the couple's and family's lives.

A unique feature of our multitiered approach is that resources across levels of prevention/intervention are integrated—that is, cross-referencing evidence-informed strategies for guiding couple communication around common challenges such as home- or work-related stress, family roles, emotional and physical intimacy, finances, children, or individual difficulties (e.g., PTSD, depression, or alcohol misuse) impacting the couple's relationship. In implementing this approach in our preliminary dissemination through the USAF Airman and Family Readiness Centers, we

developed specific workshop modules on each of these topics that were consistent in evidence-informed content with our lower-level interventions reflected in Action Sheets disseminated across various units on the base and "informal conversations" provided by trained supervisors and "natural helpers." That is, military members receive a unified message across all levels of the intervention.

Promoting Relationship Well-Being for Service Members and Veterans in the Civilian Community

Couple and family therapists in the civilian sector are uniquely positioned to provide active-duty military and veteran couples the relationship skills they need—having expertise in evidence-based interventions to promote effective communication (e.g., emotional expressiveness and responsiveness, and joint decision-making skills), coparenting skills (based in part on well-defined progressions in child and adolescent development), and related skills for common couple problems around extended families, management of time and money, physical intimacy, and so on. But to be optimally effective with military and veteran couples, therapists in the civilian sector also need to develop two additional skills sets.

As the DoD's (2007) Task Force on Mental Health concluded, "The military is a unique cultural context, and the psychological health problems experienced by service members and their families are inextricable from the unique experiences of military service." Hence, to become "culturally competent," civilian mental health providers should avail themselves of summaries describing resources for military and veteran couples and families (including Internet-based resources linked to each of the basic military branches), ranks of enlisted service members and officers across the respective branches, military structure (recognizing, e.g., the differences between "platoon" and "brigade"), and common terms and abbreviations (e.g., "FOB" or "IED") (see, e.g., appendixes in Snyder & Monson, 2012). An annotated listing of Internet-based resources for active military and veterans—and their family members—is provided in Table 2. As when working with any cultural subgroup with whom a provider may have limited familiarity or expertise, civilian providers working with military or veteran clients should be transparent about their limits of understanding and invite the consumer into a collaborative informational exchange.

Second, separate from "cultural competence," there now exist a number of well-developed couple-based interventions targeting indi-

Table 2
Annotated List of Internet-Based Resources for Service Members, Veterans, and Their Families

Deployment Health Clinical Center (DHCC)
The DHCC is the psychological health component of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. This comprehensive Web site includes sections for clinicians (with resources for implementing the DoD/VA postdeployment health clinical practice guidelines), service members and veterans (with links to programs to assist with deployment-related health concerns), and families and friends (with information for partners and children on coping with deployment).
Web site: http://www.pdhealth.mil/

United States Department of Veterans Affairs: Mental Health
This Web site provides mental health information for veterans, their families, and providers. Topics include depression, military sexual abuse, posttraumatic stress disorder, substance abuse, and suicide prevention.
Web site: http://www.mentalhealth.va.gov/

Military OneSource
Military OneSource provides support and educational materials for military personnel and their families. Services provided include a telephone referral service, free short-term counseling, telephone consultation, webinars, podcasts, and discussion boards.
Web site: http://www.militaryonesource.com

National Resource Directory
This Web site aims to provide a variety of support and informational material to service members and their loved ones. Information regarding benefits, compensation, health, family support, and additional resources can be found on this Web site.
Web site: https://www.ebenefits.va.gov/ebenefits/nrd

Afterdeployment.org
This Web site provides numerous resources for service members, veterans, families, and providers. Topics include depression, posttraumatic stress disorder, anger, substance use, family relationships, physical injury, traumatic brain injury, and sexual abuse. Clinical practice guidelines are also provided for professionals.
Web site: http://www.afterdeployment.org/

Survivingdeployment.com
This Web site provides families of deployed military personnel with resources to help understand and overcome family challenges that arise due to deployment.
Web site: http://www.survivingdeployment.com/

Veterans Support Organization (VSO)
The VSO is a nonprofit organization that provides social support to needy veterans. Issues they deal with include veteran homelessness, financial need, as well as funding programs for veterans.
Web site: http://www.theveteranssupport.org/

The National Guard Bureau Joint Services Support
This Web site offers a variety of support programs and resources to assist military personnel and their families with the challenges of reintegration, financial strain, mental health issues, and transitioning to and from deployment.
Web site: http://www.jointservicessupport.org

An annotated listing of additional Internet-based resources for active military and veterans and their family members—including information on specific mental health conditions, substance abuse, suicide, domestic violence, grief and loss, social support, and challenges of the deployment cycle—is listed in Appendix A of Snyder and Monson (2012), *Couple-Based Interventions for Military and Veteran Families: A Practitioner's Guide*. New York: The Guilford Press.

vidual emotional and behavioral disorders common among military and veteran populations. Among these are conjoint therapies for posttraumatic stress (Monson & Fredman, 2012), depression (Whisman & Sayers, 2012), substance use disorders (Schumm & O'Farrell, 2012), combat-related traumatic brain injury (Glynn, 2012), and grief and loss (Scheider, Sneath, & Waynick, 2012). Hence, therapists working with military and veteran couples should be certain also to develop "technical competence" in these evidence-based treatments. An example of a civilian therapist pursuing conjoint couple therapy for PTSD with a military couple follows:

Mental Health Provider (MHP): Last week we were discussing what it's like for you when you have those flashbacks to when that IED went off and hit your tank.

SMV: It wasn't an IED—it was an RPG, and it hit our LAV, not a tank—and totally took us out.

MHP: I'm sorry—sometimes I get those terms confused. Help me again?

SMV: Rocket-propelled grenade, and we were in a light armored vehicle.

MHP: Thank you. It's hard for me to even imagine what that must have been like.

Partner (P): Hard for me too—and sometimes I want to know, but other times it's too much and I have my own nightmares dreaming about what it was like for him there.

MHP: What happens then, for the two of you?

SMV: Mostly we don't talk about it—because it's too much for her, or too much for me. But somehow that just seems to keep it festering beneath the surface for both of us.

MHP: That's the kind of vicious cycle we talked about last week—the kind of "re-experiencing" that leads to avoidance—not allowing yourself to think about or feel the trauma—but then prevents you from processing or working through the experience so you can move beyond it.

P: That's why we're here—to try to find a way to work through this together.

MHP: Tony, last week we began talking about that time when your LAV was hit by an RPG. You were seriously wounded, and I know that many of your team members didn't survive. I understand that this isn't a memory you find comfortable talking about. In fact, sometimes it may seem best to avoid it entirely. I'm wondering, though—what are some ways you avoid reminders of that experience now? Maria, perhaps you'd be willing to join in and share some of your own observations about this. How do you see this avoidance occurring in Tony's life now? I'm wondering whether sometimes you may also avoid this topic. Can you both help me understand how such avoidance has affected the relationship between the two of you?

The couple then engaged in a discussion of their respective efforts to protect each other from these difficult discussions, as well as their sadness over the distance this sometimes created between them. Maria could sometimes sense Tony's preoccupation and was reluctant to inquire whether this was related to deployment experiences for fear of triggering more intense flashbacks. Tony described sometimes feeling painfully alone in his re-experiencing, but didn't want to cause distress to Maria in describing traumatizing events. Maria had also struggled during Tony's deployment with her own challenges in dealing with their young children and maintaining the home front, but believed these experiences paled in comparison to Tony's struggles and hence felt reluctant to share these with him. This sometimes deepened her own feelings of aloneness.

Their therapist was able to recognize this common mutual avoidance pattern among couples following deployment. She labeled and normalized this pattern during the couple's session, and offered some specific strategies for addressing the avoidance—adopting information from one of the Action Sheets on this topic.

MHP: I have a pamphlet here that I sometimes share with couples describing challenges similar to yours—struggling to figure out when and how much to share about things that happened during deployment, and when to recognize their own or their partner's limits in sharing.

SMV: It would be helpful to have some kind of plan we could agree on.

MHP: Well, if we look together at this first section, it talks about how this is pretty common among couples following a deployment. But over here in this next section, it offers some strategies for dealing with this perhaps a bit better.

P: Like what?

MHP: Well, let's read it together. Here are some basic guidelines. First, it suggests being clear and direct with each other about what you feel able to discuss, and what you don't. It says, "If you don't know how to explain, or it's too overwhelming to talk, just say so. Discuss with your partner how best to address difficult subjects."

SMV: So—she could ask whether something's wrong—and I could just let her know whether I'm able and willing to discuss it or not, right?

P: That would work for me—because it would help me just to know that when you're upset, it's not about me or us.

MHP: Exactly. And it goes on here to say, "Don't avoid. If you don't know how or can't answer, say so, but show your family and friends they shouldn't be afraid to ask or feel ashamed."

SMV: So I have to figure out what I can discuss or not.

MHP: Yes—but you don't have to get it perfect. If you start out on a topic but then discover it's too much for you,

just let Maria know. You can drop it, or come back to it another time.

P: What if I ask him what's going on, but then discover it's too much for me to hear?

MHP: You can do the same. Let Tony know it's a little overwhelming at the moment—and ask to take a short break or come back to it again later or the next day.

SMV: Any other tips?

MHP: Just one for now, I guess. The last thing it says here is, "Just listen. It's about mutual support. Talking about your feelings and asking questions will let you each know what the other is dealing with and that you care."

P: Do you think we should have specific ways of asking the other what they're feeling, or letting the other one know if we're not yet ready to talk?

MHP: Well, how about if we turn this over to look at the "Action Strategy" on the back and talk about some specific ways of approaching and responding to each other differently that you think might work better? Then you could try that out for a week or two and see how it goes, and decide if you want to revise your strategy.

SMV: Sounds good to me.

Conclusions

Over 2.6 million members of the U.S. military have deployed in support of Operations Enduring Freedom, Iraqi Freedom, and New Dawn since the Global War on Terrorism began in 2001. As they return home and reintegrate into their families and communities, many of these service members and veterans will struggle with individual mental health problems as well as serious relationship difficulties. Significant numbers of these men and women, however, will not seek appropriate counseling services, even when effective treatments exist alongside adequate resources in the DoD, VA, and civilian communities.

Individual mental health concerns and relationship problems influence each other in a recursive manner. Intimate partner relationships often struggle with spillover effects of increased rates of PTSD, major depression, alcohol misuse, and traumatic brain injury or other physical trauma secondary to combat deployment. Concurrently, intimate relationships may either provide a safe and salutary context in which healing from deployment-related experiences may be facilitated or, alternatively, may contribute to, exacerbate, or maintain individual dysfunctions.

In our own longitudinal work with Airmen experiencing yearlong high-risk deployments and high rates of traumatic experiences, we observed significantly increased rates of PTSD, depression, alcohol misuse, and intimate relationship problems up to 6–9 months after returning home. Those experiencing the highest levels of individual distress were more likely to seek counseling services and, in our study, most of those seeking assistance did so from mental health specialists rather than alternative resources potentially lower in anticipated stigmatization. However, many Airmen experiencing significant problems sought no formal assistance of any sort. Help-seeking for relationship difficulties was particularly infrequent, despite well-documented comorbidity of such difficulties with individual mental health disorders.

To meet the diverse needs of these men and women, both prevention and intervention efforts will need to span a range of modalities (e.g., self-guided resources, online-programs, phone-based coaching, and face-to-face services) across varying degrees of intensity and a broad spectrum of both formal and informal providers (Sherman, Larsen, & Borden, 2015). Given the adverse impact of mental health problems of returning service members on their intimate partners and relationships, the potential for intimate relationships to constitute either ameliorating or exacerbating contexts, and the association of relationship distress with mental health care utilization in civilian samples, we believe it will be particularly important for providers in both military/veteran and civilian contexts to become proficient in delivering a broad spectrum of prevention and intervention resources for promoting relationship well-being. In our own preliminary work, we now have some evidence that "if we build it, they will come." There is far more abundant evidence that, if we do not build it, they will not seek it and we will underserve those who have already served and given much. A variety of resources for military couples have already been developed for prevention of relationship difficulties (Stanley, Allen, Markman, Rhoades, & Prentice, 2010) as well as more intensive treatment protocols for a variety of specific disorders (Snyder & Monson, 2012). Our own program has emphasized an integrated multitiered approach based on evidence-informed relationship interventions that progresses in intensity across the continuum of care from self-directed resources, to brief consultations with informal or "natural" helpers, to more systematic brief relationship education modules that can be implemented by paraprofessionals specifically trained to disseminate these resources.

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