**Military families across the lifespan**

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Paper #2: **Combat-related traumatic experiences and the health of aging veterans**

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Paper #3: **A comparison of U.S. military veterans’ and civilians’ leisure participation and its association with psychological adversity and health care visits among older adults**

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Paper #4: **Adapting the Together We Can program for use with military families**

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**Abstract**

 This symposium is focused on the well-being and experiences of military families across the lifespan and is guided by the stress process framework and social integration

The first two studies explore how chronic or eventful military-related life conditions influence varied health outcomes. Study three explores how leisure participation as a resource relates to mental and physical health outcomes. Study four presents a family program that can provide military families with additional resources to cope with chronic military conditions and associated stressors in hopes of decreasing negative health outcomes.

In combination, the intent of each paper is to provide relevant findings regarding military populations in multiple contexts that can promote better health and functioning for the individual service member/veteran and the military family as a whole. This is accomplished by presenting research specific to active servicemembers and research on veterans who have finished their military service. Furthermore, these studies focus on multiple domains of health and well-being, addressing psychological and physical well-being of service members and their families. The first three studies are purposeful to identify mechanisms that can be targeted for intervention/prevention and study four provides an illustration of the process by which empirical work can inform adaptation in programming to address the needs of specific populations (in this case service members and their families).

 First, Reed-Fitzke and colleagues utilize a person-centered approach to understand profiles of adverse childhood traumatic experiences among soldiers-in-training and link these profiles to mental health and a resilient mindset. Ferraro et al. then explore the impact of combat-related traumatic experiences among an aging veteran population and considers the long-term impact on mental health, physical health, and health care expenditures. Duncan et al. then explores the interrelationship of serious leisure engagement and psychological adversity, and how these processes may impact health care visits amongst civilian and veteran older adult populations. Finally, Dalton and colleagues present the development of the Together We Can program (military adapted), a family education program designed specifically for use with military families across the lifespan, which targets skill-building in concentrated areas of mindfulness, strengthening family relationships, problem solving, readiness, and stress management. Linkages with prior literature and discussion of the findings of basic research studies (i.e., studies 1-3) may inform the development of family education programming.

 Taken together, by having a symposium that ties together multiple research projects on military populations from different stages of life, with both basic and applied research techniques represented, it will be possible for the audience to take away a more holistic understanding of the intersection of research and practice associated with military populations. Findings presented will have the potential to stimulate new knowledge and new family programming for military families across the lifespan.

**Three Measurable Objectives**

* To demonstrate linkages between the empirical findings of research on military families with the development of family education programming.
* To provide recommendations for helping professionals who work with military family and veteran family populations.
* To analyze well-being outcomes of military individuals from large nationally representative datasets to aid in better generalizing findings that can be applicable to military families in a variety of settings.

**Identifying at-risk U.S. Army soldiers-in-training based on adverse childhood experiences**

 There are over 3.5 million individuals serving in the U.S. Armed Forces (U.S. DoD, 2014), who are placed in military environments, characterized by transition and stress (Blaisure et al., 2012). As junior service members (SMs) train and progress through their military career, they will likely be confronted with numerous military stressors, including deployments overseas. Given the military’s desire to maintain mission readiness and respond to rising global threats quickly (U.S. DoD, 2016), it is imperative to identify areas of prevention or intervention early in the SMs’ training to help promote optimal functioning and health. Widely recognized as a risk factor for health (e.g., physical, psychological, and social) well into adulthood are *adverse childhood experiences* (ACEs; Reuben et al., 2016). The primary goal of this study was to use the stress process framework (Pearlin et al., 1981) to identify typologies of new SMs based on ACE domains (socioeconomic, neglect, sexual trauma, exposure to physical violence, emotional trauma, parental absence, impaired parenting, and removal from home) and to examine differences in mental health (anxiety, depression, PTSD) and a resilient mindset by typology to identify those who may benefit from additional resources during basic combat training (BCT).

Data from the Army Study to Assess Risk and Resilience in SMs New Soldier Study (Ursano et al., 2015) were used, specifically 30,836 soldiers who were surveyed within the first two weeks of BCT. Data were weighted in order to represent the national composition of SMs in BCT over a two-year period. Latent class analyses were conducted, followed by MANOVA to assess for mean differences on outcome variables based on class membership.

Five profiles emerging from the sample (Table 1). The largest proportion of SMs were in the *low cumulative stressed* group, which was characterized by the lowest rates of ACEs. *Elevated structural stressed* and *moderate emotional stressed* groups had moderate rates of structural and emotional ACEs, respectively. *High cumulative stressed* and *elevated emotional stressed* groups had the highest rates of ACES, with the *elevated emotional stressed* group having the highest rates of neglect and the *high cumulative stressed* group having the highest cumulative experience of ACEs. MANOVA results indicated significant group mean differences in outcomes (Table 2). Post hoc analyses revealed *high cumulative stressed* and *elevated emotional stressed* groups had the highest rates of anxiety, depression, and PTSD. However, the *elevated emotional* group was found to have the lowest level of a resilient mindset, whereas the *high cumulative stressed, elevated structural stressed,* and *moderate emotional stressed* groups had the highest.

Results from this study supplement existing research that explores the association between ACEs and functioning among service members (e.g., LeardMann et al., 2010) by demonstrating how utilizing a holistic conceptualization of ACEs can be used to understand discrepancies in well-being among service members at the start of military careers. By identifying new soldiers’ history of ACEs, leaders can refer service members to resources at the start of training in an effort to promote resilience and healthy coping before service members are exposed to military stressors.

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**Combat-related traumatic experiences and the health of aging veterans**

 As individual’s age they face health challenges that require health care services at higher rates than younger populations (Lubitz et al., 2001). Research has indicated veterans tend to have higher health care expenditures than civilians because they are more likely to report their health is poor, to have clinically diagnosed disabilities, and to have prior exposure to combat-related traumatic experiences (CRTE; e.g., witnessing dead bodies; West & Weeks, 2009). Previous research has indicated a history of both interpersonal (e.g., parental divorce) and impersonal (e.g., natural disasters) traumas were associated with the prevalence of post-traumatic stress disorder (Carbrera et al., 2007), and both physical and mental disability (Casey et al., 2008). According to the stress process framework (Pearlin et al., 1981), exposures to CRTE may thus exasperate veterans’ already elevated risk for health challenges.

When considering the complexity of factors that may play a role in aging veterans’ health, researchers should consider the type of health issues occurring and where they are being treated, as recent studies have found that approximately 46% of veterans use a combination of health services (i.e.,, obtaining Medicare services in conjunction with Veterans Affairs Health Care [VAHC]; Hynes et al., 2007; Petersen et al., 2010). As multiple health care programs are used with increased frequency, health care expenditures have steadily risen (Trivedi et al., 2012), underscoring the complexity of veteran’s interactions with the health care system and their ability to receive adequate treatment.

To this end, this study considers two primary research questions: What type of health care facilities and services are veterans using and are they adequately meeting veteran’s needs (RQ1)? What is the role of CRTE in veteran’s health and health care utilization (RQ2)? This study used secondary data from the Health and Retirement Study (HRS, 2016) to explore these research questions. The HRS is a repeated measures panel study of older adults with questionnaires administered biennially. The current analyses utilized a subsample of veterans who completed core questionnaires and participated in a 2013 veteran mail survey (*n*=1,463).

Preliminary findings indicated that among the veterans surveyed, 40.8% had experienced at least some form of CRTE and 22.3% had experienced multiple CRTEs. Among those with CRTE, 27.4% had a VAHC disability rating, with 8.9% having a disability rating of 70% or more. In contrast, only 8.7% of those without CTRE had a disability rating, with 1.2% having a disability rating of 70% or more. Findings also indicated that 73.3% of HRS veterans were eligible for VAHC services, yet less than 50% of those eligible veterans actually used a VAHC provider. Many eligible veterans relied exclusively on non-VAHC providers (42.5%) or a combination of VAHC and non-VAHC providers (26.6%). Table 1 provides preliminary findings linking CRTE to likelihood of being diagnosed with depression, emotional/psychiatric problems, and sleep disorders.

This study has the potential to expand upon base-level understanding of traumatic experiences and health care expenditures years after military service that can have direct implications for the services provided to veterans through the VAHC and other providers.

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Table 1. *Summary of Binary Logistic Regression Analyses Predicting Health Outcomes*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Clinical Depression | Clinical Emotional/ Psychiatric Problems | SleepDisorder |
|  | *B* | *SE B* | *eB* | *B* | *SE B* | *eB* | *B* | *SE B* | *eB* |
| *Block 1: Covariates* |  |  |  |  |  |  |  |  |  |
|  Education | -0.28 | 0.16 | 0.76 |  0.70 | 0.17 | 1.07 |  0.14 | 0.14 | 1.15 |
|  Race/Ethnicity | -0.10 | 0.17 | 0.91 | -0.15 | 0.18 | 0.86 | -0.12 | 0.17 | 0.89 |
|  Age | -0.05 | 0.01 | 0.95 | -0.06 | 0.01 | 0.95 | -0.03 | 0.01 | 0.97 |
|  Gender | -0.82 | 0.29 | 0.44\*\* | -0.53 | 0.31 | 0.59 |  0.50 | 0.13 | 1.38 |
| *Block 2: Predictor* |  |  |  |  |  |  |  |  |  |
|  Combat-Related Trauma |  0.45 | 0.14 | 1.57\*\*\* |  0.60 | 0.15 | 1.82\*\*\* |  0.32 | 0.13 | 1.38\* |
|  *χ2* | 84.74\*\*\* | 75.71\*\*\* | 26.65\*\*\* |
|  *df* | 5 | 5 | 5 |

*Note*: Education, 1 = Some College or More, 0 = H.S. Diploma or Less; Race/Ethnicity, 1 = White, 0 = Other;

Sex, 1 = Male, 0 = Female. \**p* < .05. \*\**p* < .001. \*\*\**p* < .001.

**A comparison of U.S. military veterans and civilians leisure participation and its association with psychological adversity and health care visits among older adults**

Transitioning into older adulthood represents a unique time that includes health changes. According to the stress process framework (Pearlin et al., 1981), aging U.S. military veterans are particularly vulnerable to poor health outcomes (Hoerster et al., 2012) and as the DoD continually meets recruitment goals (DoD, 2015) the veteran population who will likely experience universal stressors and military specific stressors will continue to grow. Because of aging challenges for both civilians and veterans, it is important to explore mechanisms that may influence *health care visits (HCV)* to better understand older adults’ engagement in health services to promote optimal functioning through the aging process.

 According to Self-Determination Theory perceptions of *relatedness* to others through social participation and community integration is an important component to promoting optimal human functioning (Ryan & Deci, 2017). This is particularly true for older adults as research has shown social isolation to be linked to higher psychological adversity (PA; Coyle & Dugan, 2012) and social engagement has been linked to lower PA (Cheery et al., 2013).

Research has demonstrated that *serious leisure participation* (SLP) creates environments that facilitate relatedness for older adults, however, less is known about how SLP plays a role among veterans and if associations between SLP and HCVs are significantly different for veterans compared to civilians.

We hypothesized that SLP and HCV would be related indirectly through PA (anxiety, depression, and stress; H1). Next, we hypothesized veteran status would be a moderator of this relationship (H2). Our supposition is that SLP acts as an environment that break down perceptions of mental health stigma and provides individuals with meaningful connections encouraging them to go to the doctor when necessary.

 Data originated from NSHAP (Waite et al., 2010-2011), a longitudinal nationally representative study of individuals over age 57. 2435 answered a military history question (22.5% had prior military service). Most were male (48%) and White (79.5%).

Measures are displayed in Table 1.SLP was examined via 2-items that asked about frequency of participation in volunteering and organized groups. PA was examined latently with an abbreviated version of the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) and Perceived Stress Scale (Cohen et al., 1994). A 1-item indicator was used to measure HCV: “*How many times have you seen a doctor or other health care professional about your health.”*

Latent variable structural equations models were fitted into AMOS.Results indicated good fit for H1 (CFI=.995, RMSEA=.015). Increased perceptions of SLP were significantly related to decreased PA (*β* =-.099, *p*<.010), and, in turn higher PA was significantly related to higher reports of HCV at time two (*β*=.166, *p*<.001). The Sobel test confirmed the statistical significance of the indirect effect PA (*z*=-2.98, *p*<.01). Results for H2 indicated there was not a significant difference between veteran and civilians and its influence on SLP, PA, and HCV (Table 2).

 Limitations and future directions will be discussed. Results imply that SLP influences HCV regardless of veteran status, thus providing another tool for professionals to recommend when promoting successful aging.

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Table 1

Descriptive statistics of all study variables

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Range | *α* | Mean | *SD* | Skew | Kurtosis |
| Serious Leisure Participation (T1) | 0-6 | .75 | 2.38 | 1.90 | .165 | -1.266 |
| Serious Leisure Participation (T2) | 0-6 | .73 | 2.37 | 1.89 | .053 | -1.242 |
| Anxiety & Depression (T1) | 1-4 | .74 | 1.49 | .45 | 1.227 | -1.995 |
| Anxiety & Depression (T2) | 1-4 | .72 | 1.75 | .52 | .615 | .143 |
| Stress (T1) | 1-4 | .61 | 1.44 | .56 | 1.361 | 1.583 |
| Stress (T2) | 1-4 | .59 | 1.83 | .68 | .401 | -.663 |
| Health Care Visits (T1) | 0-7 | n/a | 2.61 | 1.39 | .604 | 1.093 |
| Health Care Visits (T2) | 0-7 | n/a | 3.01 | 1.50 | .721 | .801 |
| Veteran Status | 0-1 | n/a | .28 | .44 | .994 | -1.013 |

Note. α = Cronbach’s Alpha Coefficient, *SD* = standard deviation, T1 = time 1, T2 = time 2.

Table 2

Model Fit and comparison of multi-group comparison with Veteran Status as a moderator

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | CFI | TLI | RMSEA | *χ*2 test of model fit |
| Unconstrained Model | .998 | .996 | .017 | *χ*2 = 32.256, *df* = 30, *p* = .356 |
|  |  |  |  |  |
| Constrained Model | .999 | .999 | .014 | *χ*2 = 42.900, *df* = 42, *p* = .432 |
| *χ*2 Difference Test |  |  |  | *χ*2 = 10.645, *df* = 12, *p* = .560 |

Note. *χ*2 = chi-square, *df* = degrees of freedom, *p* = significance level, CFI = comparative fit index, TLI = Tucker-Lewis index, and RMSEA = root mean square error approximation. Difference test is non-significant indicating no moderation based on veteran status.

**Adapting the Together We Can Program for Military Families**

As of 2015, there were 1,000,000+ active duty service members in the United States (Parker et al., 2017). To be effective Soldiers, military members must manage the typical daily stressors that civilians encounter and the stressors from a military lifestyle including lengthy daily and weekend work hours, combat activities, frequent relocation, and multiple transitions and separations (Blaisure et al., 2012). Their job does not end after leaving the workplace and often impacts family members. Servicemembers are frequently concerned about the effect their job has on their families (Blaisure et al., 2012).

Together We Can (TWC) is a seven-week program designed by cooperative extension for single or struggling parents to enhance goal-setting, dual parent involvement, and healthy communication (Michigan State University Board of Trustees, 2009). TWC was designed for and has been widely implemented in civilian community settings nationwide. Despite the programs’ strengths, two primary issues exist for implementation with military families: (a) the curriculum does not address military-specific experiences, and (b) the format of a regular multi-week meeting schedule is not convenient or practical for military families (where servicemembers are on-call 24/7), especially for those with financial constraints. Many military families do not feel included in the larger community and frequently relocate (Blaisure et al., 2012), and consequently may be hesitant to attend civilian TWC programs. Additionally, TWC does not include financial management content nor does it teach children how to communicate about their perceptions of stressful military-related experiences or how to problem solve their way through family trials often encountered in the military.

 To address these curriculum limitations, this paper describes the development of the TWC-Military adaptation, utilizing the existing TWC curriculum embedded with supplemental modules and activities designed specifically to address the issues facing military families, and restructured to fit their lifestyles and schedules. The program will (a) be implemented in a one-time, two-day retreat-style format to increase accessibility for military families, (b) provide opportunities for families to learn together and separately in developmentally-appropriate ways, and (c) provide space for families to bond through fun, engaging recreational activities. The new TWC-Military curriculum focuses on helping military family members increase their mindfulness, strengthening family relationships, problem solving, readiness, and stress management skills, which are empirically tied to military family functioning. The TWC-military modules are described in Table 1, which highlights the purposeful goals that directly tie to the aforementioned skill-building targeted. For example, module two is specifically oriented toward helping military families know what to expect about transitioning into civilian life and the possible challenges including choosing health-care, finding a job, and finding a home. This program strives to teach military families skills (e.g., self-care, problem solving, stress management, etc.) they will need to work through traumatic and stressful experiences. Implementing TWC-Military has the potential to enhance servicemembers' and their families’ quality of life by providing resources and knowledge to manage chronic military conditions and stressors across the military and thus will improve health outcomes and the readiness of the nation’s all volunteer military force (Pearlin et al., 1981).

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Table 1. Together We Can-Military Program Curriculum Overview

|  |  |  |  |
| --- | --- | --- | --- |
| **Module Number** | **Subject** | **Who** | **Goal** |
| Module 1 | Goal Setting | Whole family | Individuals/ Families use goal-setting principles to implement a plan for their future military experiences |
| Module 2 | Differences Between Military & Civilian Life | Parents | Help parents prepare for the transition into civilian life (forced or chosen) |
| Module 3 | Healthy Relationships | Parents | Parents live and demonstrate healthy relationships with each other to actively teach children how to develop healthy relationships |
| Children | Children build healthy relationships with those around them (family members and friends) |
| Module 4 | Parenting skills | Parents | Parents increase knowledge and practice of positive parenting skills |
| Module 5 | Family Roles/Strong & Intentional Families Activity | Whole family | Help families feel they can be strong through intentionality despite what happens with military life |
| Module 6 | Communication Skills | Parents | Parents will practice healthy communication patterns with each other and with their children to increase their family strength |
| Children | Children will practice healthy communication patterns with family members, contributing to family strength |
| Module 7 | Finances | Parents | Help military families practice healthy spending and saving behaviors |
| Module 8 | Problem Solving Family Activity | Whole family | Help military families understand how to best solve any problems that may arise |
| Module 9 | Stress & Conflict Managing | Whole family | Family members feel able to manage conflict and stress in their homes in healthy ways |
| Module 10 | Self-Care | Whole family | Help family members experience the benefits of self-care and commit to self-care practices post-retreat |