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Family Functioning During Deployment and Reintegration of Military Members

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
2020

Abstract

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MS, Walden University, 2019

BS, University of Alaska Anchorage, 2010

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Military members and their families face unique stressors related to separation and reintegration. These life-changing events can lead to domestic violence, divorce, depression, suicide, and behavioral problems within the family. It was unknown whether the implementation of a nursing clinical practice guideline (CPG) would help nurses to identify family functioning concerns or psychosocial issues enabling earlier interventions. The purpose of this doctoral project was to create a CPG that can be used at military treatment facilities (MTFs) to screen military members and their families to identify family functioning concerns so that the provider can make referrals as needed. The circumplex model of marital and family systems was used to address the problem. The Family Satisfaction Scale was identified as a tool in accord with the circumplex model that nurses can use for screening patients. Finally, the Appraisal of Guidelines for Research and Evaluation (AGREE II) was used to develop and grade the CPG. A systematic review of the literature yielded 16 evidence-based studies applicable to the project. Using the Hierarchy of Evidence for Intervention Studies, the articles were rated based on the types of evidence; 13 articles were Level VI, 1 was a Level II, and 2 were Level I. Four doctoral nurses appraised the CPG using the AGREE II. Overall scores were greater than 85% in all domains of the AGREE II. Recommendations include disseminating the CPG to all MTFs and civilian facilities that treat military families. Nursing staff should screen all patients who meet the criteria provided. Early identification and treatment may result in improvements in military families' lives.

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Dedication

I want to thank my husband, Michael “Teddy” Graham, for being supportive and driving me to further my education. I also want to thank my parents, Susan and Bruce Cunningham, who have always been there to help me during my education from the beginning. Without you, I would not be where I am today. To all the military families around the world, whether you are a service member, spouse, or dependent, this is for you in the hope that it will help in improving and maintaining a positive and safe family life. Finally, to my kids, Aiden and Aurora, always pursue your dreams and push yourself to accomplish your goals, and never give up. I’ll love you forever.

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Table of Contents

List of Tables

Section 1: Nature of the Project

Introduction

The military population in the United States (U.S.) can face life-changing events such as deployments and combat that result in separation from family for long periods of time followed by reintegration to the family. Positive family functioning is important for service members during these times of separation and reintegration. Separation and reintegration of military service members can have negative impacts on families and can result in unique stressors, such as depression, relationship failure, suicide, domestic violence, or behavioral problems (Rodriguez & Margolin, 2015). In this section, I present the problem statement and the project purpose. I also describe the nature of the doctoral project and discuss its significance.

Problem Statement

Nurses working in outpatient military treatment facilities (MTFs) provide care to a variety of patients, including service members, their spouses, and children. Nursing care is tailored to routine annual visits as well as complaint-oriented care. There currently is no consistent and specific requirement to identify the stressors associated with separations and reintegration at the local MTF. Implementation of a nursing clinical practice guideline (CPG) may result in earlier identification and treatment of potential problems associated with separation and reintegration. I developed a CPG based on current evidence and clinical practice to identify and treat the negative consequences of separation and support reintegration of military service members and their families. Initiating a screening to identify and detect potential problems early on can be beneficial

for military families. The CPG ultimately should be utilized in all departments within the MTF to screen military members, their spouses, and dependents.

Purpose

I developed a CPG for this Doctor of Nursing Practice (DNP) project to screen military families who are experiencing separation or reintegration of a service member for family dysfunction and psychosocial concerns. The gap in practice is that there was no formal process for nurses to screen military members and their families for family functioning needs. A CPG is used in health care to aid in translating evidence into practice for an improvement in patient outcomes (Walden University, 2017). Implementing a CPG to screen for family functioning can help nurses to identify those family members experiencing issues such as depression, suicidal ideation, and other stressors that can occur within a military family to assist in ensuring better outcomes. The practice-focused question for this project was, Will the development of a CPG for nurses improve their assessment of family functioning during times of separation and reintegration of the military member?

Nature of the Doctoral Project

In speaking with various departments and the chief nursing officer (CNO) of the hospital, I confirmed that there is not a CPG available for nurses treating families during routine or acute visits to clinics. A CPG is needed to screen for psychosocial issues such as depression, suicidal ideation, poor or affected family functioning, or any other family needs so that interventions can begin early on, before any potential or serious event occurs.

Evidence of the Nature of the Problem

A number of researchers have studied the effects of deployments and reintegration on families. In a study conducted with 76 U.S. service member participants to assess families dealing with reintegration following deployments to war-time locations, one in five participants stated that they had moderate to severe issues in multiple aspects of reintegration with their families (Balderrama-Durbin et al., 2015). Separately, Rodriguez and Margolin (2015) found that, during deployments, spouses and children exhibited a higher risk of depression and anxiety. In another study, researchers assessed the effects of deployments on family functioning and found that there was a decrease in family functioning and an increase in marital issues the more times a family experienced a deployment (Lester et al., 2016). Younger children were found to have more impairments with social emotional adjustments (Lester et al., 2016). The authors of this study, Lester et al. (2016), stated that there was increased anxiety in children and adjustment issues among those who were school-aged.

In 2020, a female military spouse took her life and the life of her child (Lomsdale, 2020). She tried to reach out to other military spouses for help on Facebook and was met with statements such as “deal with it” because “this life [military life] is hard” (Lomsdale, 2020). In 2017, the Department of Defense started to collect data on suicides among military spouses and dependents; there were 123 spouse suicides reported (Lomsdale, 2020). Its findings also showed that in 2017, 63 dependents took their lives (Lomsdale, 2020). Situations such as these potentially could have been identified with screening during clinic visits and interventions.

Potential to Address the Gap

This DNP project has the potential to decrease the gap that currently exists in practice. MTFs may be able to provide this CPG to nursing staff to help identify psychosocial issues and improve family functioning. Early intervention may help decrease potentially serious social and psychological complications and physical health issues, thereby helping society. Heyman et al. (2015) stated that the divorce rate increased during times of deployment; this incidence may be decreased with a purposeful evaluation of family dynamics during routine exams. By identifying and addressing family functioning and mental health problems in a timely manner, nursing staff who use the CPG may be able to promote positive outcomes for military families. When families experience positive functioning, that positivity can be reflected in their social and work lives. Conversely, if a person is suffering from psychosocial concerns or having issues with their family functioning, that person may have poorer work performance. Improvements in their lives can thus have a positive social impact on society.

It is also important to identify children who may be showing signs of disrupted education. Interventions can help prevent issues and promote success in school. Lester et al. (2016) noted research that shows an impact of deployments on academics, substance abuse, and risky behaviors among children of military members. With deployments, there is increased risk of neglect towards children, and as a result, children can develop emotional and behavioral issues (Saltzman et al., 2011). Children may develop social or mental health or behavioral problems when dealing with a dysfunctional family. With early identification of potential problems, nurses can implement interventions to help

lower these rates and give military children a chance to grow up in a healthy environment.

Significance

The significance of this project is to provide an assessment tool to ensure that military families are appropriately screened and treated. An assessment tool can lead to a more standardized method of screening and treatment resulting in delivery of safe and effective care based on evidence and knowledge (see Walden University, 2017). There are eight principles to a CPG: (a) providing appropriate care based on scientific evidence, (b) reducing preventable variations, (c) providing a rational basis for referrals, (d) providing focus for continuing education, (e) promoting efficient use of resources, (f) providing focus for quality control, (g) identifying gaps in the literature, and (h) suggesting appropriate areas for continued research (Walden University, 2017). The Institute of Medicine defined CPGs as "statements that include recommendations intended to optimize patient care that is informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (as cited in Walden University, 2017, p. 3). I expect that this guideline will be used by nurses at the project MTF to assess military members, their spouses, and dependents for potential family dysfunction.

Medical professionals develop guidelines specifically for targeted patient and family populations. According to the Institute of Medicine, "clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (as cited in National Center

for Complementary and Integrative Health, 2017, para. 1). Health care professionals can use CPGs to identify and recommend courses of intervention such as screening for family dysfunction.

Key stakeholders include the commander of the facility; the CNO; and the squadron commanders from the mental health, active duty, women's health, pediatrics, and family health units. This guideline may help nurses at the project site identify potential family dysfunctions early on for interventions and treatment to prevent potential future complications. Doing so can decrease the number of provider visits or even hospitalizations a patient may require. With early identification, the military population could see a decrease in depression rates, relationship failures, suicide, and domestic violence and an improvement in child behaviors related to separation and reintegration of service members. These outcomes could improve the lives of service members and their civilian families who often bear the responsibility for supporting them during these stressful times.

Summary

The problem was the lack of a CPG at the project MTF to aid in screening military members and their families for family functioning during stressful times such as deployments and reintegration. The purpose of this project was to develop a CPG that nursing staff could use to more quickly identify potential problems such as depression, suicidal ideation, or domestic violence and create interventions to help improve family functioning. Earlier diagnoses and implementation of interventions could improve mental health and decrease future behavioral problems in the military population. In Section 2, I

will provide background information and context for the project to include key concepts, models, and theories. I will also discuss the project's relevance to nursing practice and my role as a DNP student.

Section 2: Background and Context

Introduction

Military families face unique stressors during times of deployment and reintegration. These stressors can exact a toll on the military member, their spouse, and dependents and can lead to problems such as depression, relationship failure, suicide, domestic violence, or behavioral problems (Rodriguez & Margolin, 2015). War-time events lead to these unique stressors for military families, long deployments separate families, and it can be difficult to reintegrate into the family upon return. Not only does the spousal relationship suffer, but child development and behaviors are affected as well (Lester et al., 2016).

To address this issue, I created a CPG to screen for family dysfunction. Nurses at the project MTF will use the Family Satisfaction Scale during appointments with the military member, spouse, and dependents when appropriate. Early identification of potential issues may enable the issues to be treated before worse outcomes occur. In this section, I will discuss the circumplex model of marital and family systems and the Family Satisfaction Scale (see Appendix A) that I used, the relevance of the project to nursing practice, the local background and context, and my role as a DNP student.

Concepts, Models, and Theories

For this project, I used the circumplex model of marital and family systems, the Family Satisfaction Scale, and the Appraisal of Guidelines for Research and Evaluation (AGREE II, Walden University, 2017). The circumplex model consists of three dimensions: cohesion, flexibility, and communication (Olson, 2000). The circumplex

model demonstrates that a family is more functional when there is balance (Olson, 2000). The Family Satisfaction Scale is a questionnaire to be utilized in assessing families. I used the AGREE II tool to organize the information gleaned and to create the CPG (see Walden University, 2017). Specifically, the AGREE II was used for the evaluation of the information presented from this project. I used Fineout-Overholt and Melnyk's rating system (Fineout-Overholt et al., 2010; see Appendix D) to appraise the level of evidence for each article in the literature review.

This CPG can help to improve the care process for military families. The CPG can be used at any medical appointment and will be prompted if the patient states that they or their family member is or has deployed or returned within the past 12 months, and the assessment can be repeated annually. This CPG is intended for use with spouses, the military member if available, and children if applicable. The preferred outcome is early intervention for potential mental health issues and family dysfunction. According to the *Manual for Clinical Practice Guideline Development (CPGD): Doctor of Nursing Practice (DNP) Scholarly Project* (Walden University, 2017), the steps for the process include the following:

1. Identification of a problem and creation of a PICO question.
2. Evidence criteria (discuss systems used, outline procedures, and analyze procedures used).
3. Literature review with an appraisal of the evidence using Fineout-Overholt and Melnyk's guide and a synthesis of the evidence.
4. Creation and revision of the guideline based on feedback.

5. Identification of stakeholders/panel of experts.
6. Use of AGREE II to validate content and score,
7. Presentation of guideline to stakeholders.
8. Dissemination of guideline.

Circumplex Model

The circumplex model of marital and family systems encompasses different aspects of a family for cohesive functioning. Olson et al. created this model in the late 1980s to help bridge a gap between theory, practice, and research (as cited by Olson, 2000). As mentioned in the introduction to this subsection, there are three dimensions of the model: cohesion, flexibility, and communication. Cohesion concerns the emotional bond that families have with each other and how the family balances life together and separated (Olson, 2000). Separation from spouses, parents, and children can leave a patient feeling lost or missing connection with their loved ones in their lives. Patients can also experience poor communication with others, a loss of faith, poor sleep and diet, a loss of enjoyment with everyday activities, and decreased emotional support from their families (Olson, 2000). The next dimension is flexibility, where the focus is on change in roles, relationship rules, and even leadership (Olson, 2000). With separation, families may experience role changes when dealing with discipline and responsibilities within the household (Olson, 2000). These changes can cause a disruption within the family system. The third dimension is communication; this dimension facilitates the first two dimensions (Olson, 2000). Poor communication can lead to problems within a family system;

therefore, it is important to have adequate communication among all members of the family.

Family Satisfaction Scale

Olson (2010) created the Family Satisfaction Scale to provide a reliable tool to measure family satisfaction. It includes the three dimensions of the circumplex model within its assessment framework (Olson, 2010). The Family Satisfaction Scale is intended to be used with the CPG in clinical practice for screening family functioning. The scale consists of 10 questions that are rated on a 5-point likert scale from *Very Dissatisfied* to *Extremely Satisfied* (Olson, 2010). The questions focus on how the patient views different aspects of their family and how they function as a unit (Olson, 2010). The patient completes the questionnaire and then the nurse will score it and use the interpretation chart to determine if their scores show a high or low satisfaction within their family.

Approach to Organize and Analyze the Evidence

I critically appraised all relevant data collected to determine the level of evidence and whether the information provided was strong or weak. The Hierarchy of Evidence for Intervention Studies was used to guide and appraise the evidence (Fineout-Overholt, Melnyk, Sitwell, & Wiliamson, 2010).

Critical Appraisal of the Evidence

I obtained evidence by reviewing a variety of articles from different databases that pertained to the specified topic. As Melnyk, Fineout-Overholt, Stillwell, and Williamson (2010) noted, after selecting articles, researchers need to evaluate them “to determine

which are most relevant, valid, reliable, and applicable to the clinical question" (p. 52). Fineout-Overholt and Melnyk formulated a guide to appraise evidence (Fineout-Overholt et al., 2010). The guide includes the different types of evidence, the levels, and a description to help determine a study's level (Fineout-Overholt et al., 2010). The types and levels of evidence in Fineout-Overholt et al.'s (2010) typology are as follows:

- systematic review of meta-analysis (Level I),
- randomized controlled trial (Level II),
- controlled trial without randomization (Level III),
- case-control or cohort study (Level IV),
- systematic review of qualitative or descriptive studies (Level V),
- qualitative or descriptive study (Level VI), and
- expert opinion or consensus (Level VII).

Connection of the Gap

The purpose of the CPG is to improve family functioning with early identification of family or personal dysfunction. Currently, there is no formal guideline that nurses at the project MTF can use when assessing their patients. Once this guideline is implemented, I anticipate that there will be a decrease in family dysfunction in relation to separation and reintegration of service members receiving treatment at the facility.

Definition of Terms

Following is a list of terms that appear throughout this document and may need clarification:

Active duty: A full-time occupation in the military services.

Chief nursing officer (CNO): A senior nurse in a management position within an organization who leads the nursing staff of the facility.

Dependent: Spouses, children, or other familial members that the service member sponsors for pay, benefits, privileges, and rights to the military installation.

Deployment: The movement of military members around the world; deployment also includes the infrastructures involvement in these movements (U.S. Department of Veterans Affairs, n.d.b).

Military: An armed force intended for warfare; it is also known as *armed forces*.

Military treatment facility: Facilities on U.S. military bases that are used to treat the military population, veterans, and their dependents.

Reintegration: The process of integrating into society from deployments. This can include adding new roles such as parenting if the member had been gone for a long period of time.

Tricare: The health insurance program for military members, retirees, and dependents.

Relevance to Nursing Practice

Nursing practice changes with new technology and research to ensure the best practice is utilized for optimum patient quality care. CPGs are created to help nurses consider different approaches for patient care (National Center for Complementary and Integrative Health, 2017). The implementation of this guideline is intended to impact nurses during routine patient visits. Nurses would use the Family Satisfaction Scale to help identify potential issues so they can be addressed and treated. By identifying

underlying concerns a patient may have due to separation or reintegration, the provider may have to make referrals or recommend other treatments. However, by treating early on, the provider can prevent the patient from dealing with potentially worse outcomes.

Our country still faces war and continues to deploy service members to numerous locations around the world. It is estimated that over three million family members are affected by deployment of United States (US) military members (Gewirtz, Pinna, Hanson, & Brockberg, 2014). In 2010, about 50% of suicides in the military were related to a failed relationship; 30% due to dissolution of the relationship because of reintegration (Knobloch, Ebata, McGlaughlin, & Ogolsky, n.d.). Spouses have reported feelings of loneliness, role shift and overload, loss of emotional support, and concerns for safety of their loved one who is deployed (Gewirtz et al., 2014). Reintegration can be just as difficult as the time of deployment. Families have to confront new challenges and adjust to life together after their time apart (Knobloch et al., n.d.). Some of these families do not get emotional or physical help they require during the spouse's deployment. Spouses often suffer in silence awaiting their loved ones return, only to struggle dealing with reintegration into the family life.

Not only do spouses face issues with deployments and reintegration, but children do as well. Families have reported difficulty with managing their children's behaviors, letting go of control, deciding parenting roles, and co-parenting (Strong & Lee, 2017). Parents identified barriers to seeking help including a lack of awareness of resources or resources offered (Strong & Lee, 2017). Children may develop social or mental health issues when dealing with a dysfunctional family.

Heyman et al. (2015) conducted a study and found that before deployment 17% of the members reported a distressed relationship, during deployment that number was increased to 27%, and after the return of deployment, about 25% of those relationships ended. Research has also shown that there is an increased risk for behavioral, emotional, and academic problems with children of military families dealing with deployments (Lester et al., 2016). Other studies have shown links to depression, suicide, and domestic violence in the home as well due to deployments and reintegration. A number of serious consequences occur during these times of separation and reintegration.

The local MTF does not have a current practice guideline in place to screen for family functioning. The facility offers resources and a briefing to discuss expectations, but this is not widely known to military families. According to Gil-Rivas, Kilmer, Larson, and Armstrong (2017), there is a lack of literature supporting strategies for successful reintegration of service members. Gil-Rivas et al. (2017) discusses different ways the service member can reintegrate into family life by utilizing local resources, viewing the family as a whole unit, ways to develop family support, and addressing the needs of the family.

This CPG will help fill the gap in practice with early identification and treatment of patients needs for adequate family functioning when dealing with separation and reintegration. Nurses will be able to utilize the Family Satisfaction Survey to screen their patients to determine their level of functioning based on the use of the circumplex model of marital and family systems (Olson, 2000, 2010). If areas are evaluated as poor

functioning, the provider can then address the issue and offer interventions, local resources, or a referral to seek more in-depth screening with a family counselor.

Local Background and Context

Some military members and their families may be suffering from family dysfunction and mental health concerns and need interventions to preserve their families. Relationship failure, depression, domestic violence, and suicide are elevated among the military population; children have also been found to have adjustment issues and behavioral problems. A CPG can be implemented to screen spouses, active duty members, and dependents if applicable for family dysfunction. When identified, treatment and interventions can occur early on. With early identification and implementation, there may be a decrease in depression, relationship failures, suicide, domestic violence, and an improvement in child behaviors. Satisfaction among military members and their families during separation and reintegration may improve with this CPG.

Family dysfunction is an issue that military families face due to the separation and reintegration of the service member and lead to stressors within the family. These stressors lead to different issues among the family that can lead to further problems or worsening outcomes if not addressed and treated. The facility is a military clinic, and it provides a variety of services within five specialty clinics. The MTF provides oversight for the care of the service member and their dependents (spouse and children). However, this is one of many military clinics around the world that provide care to military members and their families.

During my rotations for clinical practice in the graduate program, I have interacted with military members and their families. I observed a lack of screening for issues that arise from unique stressors such as deployment and reintegration of the service member. When questioned about it, nurses said there was no such screening process. As a spouse, I reached out to other spouses and asked their thoughts and feelings about the lack of screening. Some spouses stated that it would be helpful to have a tool to screen them, their children, and their service member spouse to help identify issues such as depression, behavioral problems, and poor functioning of the family and intervene early on.

Role of the DNP Student

My role was to identify a rich base of evidence to help form the development of the CPG; to assess the status of military members and families for functioning concerns. This role was consistent with the DNP Essential VI. Essential VI is Interprofessional Collaboration for Improving Patient and Population Health Outcomes (American Association of Colleges of Nursing [AACN], 2006). Based upon essential VI, this CPG will utilize different departments to collaborate with one another to provide the essential care needed for the military families in dealing with their functioning.

Summary

In this section I discussed the relevance of this DNP project to nursing by assessing, identifying, and treating patients to meet their needs for improved quality of life. Based on evidence and research there is documented medical issues that relate to separation and reintegration of service members and their families. These issues need to

be identified and addressed to improve family functioning. Section 3 will include information such as the practice-focused question, sources of evidence, and the analysis and synthesis of evidence.

Section 3: Collection and Analysis of Evidence

Introduction

The local problem was the lack of a CPG to ensure early identification of family dysfunction during deployments and reintegration of military members. Often military families negotiate hardships and stressors that can cause relationship problems, mental health problems, and even behavioral problems. The Family Satisfaction Scale, which is in the CPG, can be used by nurses at the project site to screen military members, their spouses, and children for early signs of medical needs to potentially prevent divorces, suicides, or problems in school. In this section, I will present the practice-focused question, discuss sources of evidence, and provide an analysis and synthesis of the literature.

Practice-Focused Question

The practice-focused question for this project was, Will the development of a CPG for nurses improve their assessment of family functioning during times of separation and reintegration of the military member? Family functioning is important for patients' well-being. Often military families have to endure hardships that civilian families may not face. Because family functioning problems can lead to other medical issue, as discussed in section 1, I wanted to know if implementing a CPG with the Family Satisfaction Scale (see Appendix A) as a screening tool would improve nurses' assessment of family functioning during times of separation and reintegration of the military member. This approach aligned with my question and allows for a determination of whether screening families on a routine basis will lead to less long-term family

dysfunction. Rates of divorce, depression, suicide, or behavioral issues can be monitored to determine if the screening is helping military families.

Sources of Evidence

Consistent with the guidance from the Walden University *Manual for Clinical Practice Guideline Development*, I derived the evidence for this project from peer-reviewed literature that I obtained from the following Walden library databases: Cochrane, CINAHL Plus with Full Text, MEDLINE with Full Text, Google Scholar, and EBSCOhost. Searches included combinations of specific key terms selected. Search terms included the following: *active duty*, *behavior*, *deployment*, *depression*, *divorce*, *family adjustment*, *family functioning*, *mental health*, *military family*, *military*, and *reintegration*. Results yielded 257 articles total from all databases. After narrowing the topics, I limited the results to 20 that met the inclusion criteria for this project. Of the 20 articles, 16 articles were selected and reviewed. Of the 16 articles that were directly related, 13 were Level VI, one was Level II, and two were Level I based on Fineout-Overholt et al.'s (2010) typology. There was a limited number of articles related to this project, and only a small number were directly related to the topic.

Due to the limited availability of supporting evidence on this topic, I sought additional information on the gap in practice. On the U.S. Department of Veterans Affairs' website, I found CPGs and tools developed in collaboration with Department of Defense (U.S. Department of Veterans Affairs, n.d.a). However, these CPGs are focused on the needs of service members rather than their dependents (spouses and children). I limited searches to scholarly evidence from the past 5 years. However, there are some

seminal resources that are more than 5 years old. All sources of evidence were reviewed to ensure that they contained quality information (see Appendix D).

AGREE II

There are six domains that make up the AGREE II. Within the domains, there are a total of 23 items to help organize information (Walden University, 2017). Table 1 shows the AGREE II domains and key items.

Table 1

AGREE II

Domain	Key items
Domain 1: Scope and Purpose	1. Overall objective is described 2. Health questions covered are described 3. Population is specifically described
Domain 2: Stakeholder Involvement	4. Inclusion of individuals from all relevant parties 5. Views and preferences have been sought from target population 6. Clear identification of target users
Domain 3: Rigor of Development	7. Use of systematic methods when searching for evidence 8. Criteria is clearly described for selecting evidence 9. Strengths and limitations are clear with the evidence 10. Methods are clear for forming recommendations 11. Considerations for health benefits, side effects, and risks were made when forming recommendations 12. There is an explicit link with recommendations and supporting evidence 13. Experts have reviewed prior to publication 14. Procedure for updating is provided
Domain 4: Clarity of Presentation	15. Recommendations are specific and unambiguous 16. Different options for managing the condition or health issue are presented 17. Recommendations are identifiable
Domain 5: Applicability	18. Facilitators and barriers to the application have been described 19. Advice and/or tools have been recommended on how to implement into practice 20. Potential resource implications have been considered 21. Monitoring and/or auditing criteria has been presented
Domain 6: Editorial Independence	22. Funding body has not influenced the content 23. Competing interest of development have been recorded and addressed

Note. The information is from *Manual for Clinical Practice Guideline Development (CPGD): Doctor of Nursing Practice (DNP) Scholarly Project* by Walden University, 2017 (https://academicguides.waldenu.edu/ld.php?content_id=32773066).

Collection and Analysis of Evidence

Upon collecting and analyzing the evidence gathered, I used Fineout-Overholt and Melnyk's (2010) rating system (see Section 2) to sort the evidence into levels of hierarchy. Rating the data helped to provide support for the gap in practice for this project. I then gave the expert panel a questionnaire based on the AGREE II model that was used for the development of this CPG (see Appendix B). According to the copyright and reproduction statement from Brouwers et al. (2017), the AGREE II instrument "may be reproduced and used for educational purposes, quality assurance programmes and critical appraisal of guidelines" (p. ii). I obtained approval from Walden University's Institutional Review Board (approval no. 02-26-20-0635926) and the MTF to conduct the project.

The AGREE II is an assessment instrument that consists of six domains; within the domains are 23 key items to rate (Brouwers et al., 2017). Each item is rated on a scale from *strongly disagree* to *strongly agree* using a 7-point likert scale (Brouwers et al., 2017). Recommendations for assessment include at minimum of two appraisers (preferably four) to help increase the reliability of the results (Brouwers et al., 2017). Based upon results, scores were given for each appraiser's rating and were used in a formula for percentage results (see Brouwers et al., 2017). Finally, I asked the appraisers if they would recommend the use of the proposed guideline (see Brouwers et al., 2017). Findings will be discussed in Section 4.

Validity and Reliability of the EBP Guideline

Validity and reliability are important to ensure a test is accurate and can be utilized properly. Face validity is determining if claims stated in the test are measured accurately (McLeod, 2013). The Family Satisfaction Scale was tested and it was determined to have "an alpha reliability of .92 and test re-test of .85" (Olson, 2010, p. 4). According to Olson (2010), validity of the Family Satisfaction Scale had been tested during different studies to include a study of over 1,000 families to prove the test is accurate with results.

Analysis and Synthesis

The CPG was presented to an expert panel. They used the AGREE II to rate the CPG and determined readiness for implementation. Appendix B is the questionnaire that was presented to the expert panel for review. The CPG was revised and sent to be graded a second time by the expert panel.

Description of Systems

The AGREE II utilizes six domains with 23 key items to rate the CPG (see Appendix B). The expert panel rated on a scale of one to seven, with one being strongly disagree and seven being strongly agree.

Outline of Procedures

I provided the CPG, a disclosure agreement, the Family Satisfaction Scale, and the AGREE II questionnaire. The CPG provided reasons for wanting to implement the new process and data collected. The CPG also included a list of references for the resources utilized to support the evidence of the problem. The importance of early

identification of family dysfunction was also noted in the CPG. Because at least four people were in my expert panel, I was able to have more focused feedback from the panel.

Description of Analysis Procedures

The information gathered was provided to the expert panel to determine if the CPG is something they would like to see implemented into practice. The panel utilized the AGREE II tool to determine if the information provided was adequate and reliable for use and to determine whether or not the CPG has the potential to benefit military families. I was also able to revise the CPG based on the feedback and return for a second evaluation. A second review was completed in lieu of the lack of ability to test the CPG during the rules set in place by the Department of Defense during the Coronavirus-19 pandemic.

Potential Biases

There will be no issues of bias since the Family Satisfaction Scale that will be used has been tested and purchased. Permission has been given for its use for this project. Some bias may be with my affiliation as a spouse of a military member due to the sensitivity of the subject. However, I have protected the identities of those who assisted in this project. Also, all questionnaires provided for the CPG using the AGREE II tool were given to one panelist who then returned them for my review to help prevent bias.

Summary

This section provided information on how the evidence was collected and analyzed. The practice-focused question was, Will the development of a CPG for nurses

improve their assessment of family functioning during times of separation and reintegration of the military member? This will help to determine if the circumplex model and Family Satisfaction Scale will be sufficient in identifying family dysfunction for early intervention. There were a variety of search engines utilized to gather information and articles were narrowed down and rated using the different levels of evidence seen in Section 2. The information gathered provided the evidence necessary to validate the need for the CPG to be implemented. Finally, the steps were outlined and described to analyze and synthesize the information provided. In Section 4, findings, implications, and recommendations will be discussed. The strengths and weaknesses will be mentioned as well.

Section 4: Findings and Recommendations

Introduction

There is a gap in practice concerning the identification of family dysfunction issues in military families that have to manage unique stressors and hardships. To address this issue, I developed a CPG that includes a screening tool for families. A CPG provides a way to translate evidence into practice to improve patient outcomes (Walden University, 2017). This tool can help with early identification of family functioning issues so that an intervention can take place early on. The Institute of Medicine has defined a CPG as "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (as cited by Walden University, 2017, p. 3). The practice-focused question for this project was, Will the development of a CPG for nurses improve their assessment of family functioning during times of separation and reintegration of the military member? In this section, I will discuss the project findings and implications, offer recommendations, and consider the strengths and limitations of the project.

Findings and Implications

The expert panel used the AGREE II (see Appendix B) to grade the CPG. The expert panel consisted of four nursing experts, two with PhD degrees and two with DNP degrees. One panel member is a Psychiatric-mental health nurse practitioner who is also a military veteran, one member served on a military IRB, one member is a spouse of a retired military member and one a women's health nurse practitioner who is also the chief

nurse of the military instillation. I gave each panelist a copy of the CPG, the Family Satisfaction tool, the AGREE II, and a disclosure form. They were asked to review the material and grade the CPG with the AGREE II questionnaire and have them returned within 1 week. Surveys were returned to my mentor to help keep information unbiased. After reviewing the questionnaires, I modified the CPG based on the panelists' feedback and recommendations. The panel was asked again if they could complete the questionnaire for the CPG for a final rating (see Table 2).

Domain 1 is an overview of scope and purpose. The key items focus on the overall aim for the CPG, specific health questions, and identification of the target population (Walden University, 2017). The expert panel's overall score was 83% for this domain. In their comments, the panelists recommended bulleting the objectives, providing more specifics about the health questions, and more clearly identifying the target population. I made changes based on the recommendations. The second rating score came to 92%.

Domain 2 is stakeholder involvement and includes how the guideline was developed, whether appropriate stakeholders were involved, and whether the guideline represents views of the intended users (Walden University, 2017). The overall rating was 67%. The panelists recommended further specifying the target population and clearly stating that the guideline is for nursing. I made changes based on the comments. The second rating increased to 89%.

Domain 3 is rigor and development. This domain focuses on the process for gathering and synthesizing the evidence and the methods for formulating and

recommending updates (Walden University, 2017). The expert panel's overall score was 63%. Comments included the lack of a reference list or literature review matrix and discussion of the evidence. There was a lack of discussion about the strengths and weaknesses within the CPG as well as benefits and risks. One panelist suggested adding references to the CPG to locate the grading tool and other resources used to develop the CPG. Specific procedures were not identified or stated as far as updating the guideline in the future, changes were made based on these recommendations. The second rating showed improvement with a score of 94%.

Domain 4 is the clarity of presentation. The focus of this section is the language, structure, and format of the CPG (Walden University, 2017). Results from raters were 86%. One rater commented that she loved the algorithm and found it easy and clear to use. Another rater stated that the algorithm showed appropriate interventions for score ranges. The second rating score was 94%.

Domain 5 is applicability. This domain encompasses the barriers and facilitators to the implementation of the guideline and ways to improve uptake (Walden University, 2017). Overall ratings were 61%. One rater commented that provider buy-in should be considered as a possible barrier and should be addressed. Another comment suggested adding more options on the flow chart for those patients who score low. The final feedback was to provide more clarity regarding monitoring or auditing criteria for the guideline. The second rating score was 89%.

Finally, Domain 6 is editorial independence. The focus of this domain is to ensure the formation of recommendations that are unbiased with no competing interests (Walden

University, 2017). Scores for this section totaled 79%. Raters felt disclosure was appropriate and clearly documented. After changes, the second score was 89%.

The expert panels rated the overall quality of the guideline at 75%. The feedback from the expert panel was used to guide the changes made to enhance the strength of the nursing guideline. Raters were then asked to grade the CPG again to verify improvements. All scores were calculated based on the AGREE II guidelines. The second rating score was 90%. Each domain saw an increase in the percentages after recommended changes were made. There were still a few suggestions for changes within the CPG. Also, there were edits that were suggested after the second grading of the CPG. I made those corrections.

Table 2

AGREE II Results From Second Questionnaire

Key items	Appraiser				Total	Percentage total
	1	2	3	4		
Domain 1						
Key Item 1	7	7	7	6	27	
Key Item 2	6	7	7	3	23	
Key Item 3	7	7	7	7	28	92%
Total	20	21	21	16	78	
Domain 2						
Key Item 4	6	7	7	6	26	
Key Item 5	2	7	7	3	22	
Key Item 6	7	7	7	7	28	89%
Total	15	21	21	16	76	
Domain 3						
Key Item 7	7	7	7	7	28	
Key Item 8	7	7	7	7	28	
Key Item 9	7	7	7	6	27	
Key Item 10	5	7	7	6	25	
Key Item 11	7	7	7	6	27	94%
Key Item 12	5	7	7	6	25	
Key Item 13	6	7	7	7	27	
Key Item 14	6	7	7	5	25	
Total	50	56	56	50	212	
Domain 4						
Key Item 15	7	7	7	6	27	
Key Item 16	7	7	7	5	26	
Key Item 17	7	7	7	6	27	94%
Total	21	21	21	17	80	
Domain 5						
Key Item 18	6	7	6.5	4	23.5	
Key Item 19	6	7	6.5	7	26.5	
Key Item 20	6	7	6.5	6	25.5	89%
Key Item 21	7	7	6.5	5	25.5	
Total	25	28	26	22	101	
Domain 6						
Key Item 22	7	7	7	7	28	
Key Item 23	7	7	6.5	4	24.5	93%
Total	14	14	13.5	11	52.5	
Overall rating	6	7	6.5	6	25.5	90%

Recommendations

A strong recommendation should include a clear description of the focus population, a baseline of risks, quality of evidence, and the strength of the recommendation (Hassan Murad, 2017). Recommendations are for the nursing staff to utilize this guideline (see Appendix C) to screen military members, their spouses, and dependents at any appointment who state an active duty family member is separated due to work, or an active duty member (can be self) has returned within the last 12 months from separation. They will ask the patient to fill out the Family Satisfaction Scale (see Appendix A), a 10-question survey. If the screening identifies potential issues, the nurse will inform the provider, and the patient and their family will be referred to a family counselor or therapist to complete further screening and obtain treatment. They will also offer other services provided by the facility or local resources if applicable.

Strengths and Limitations of the Project

Barriers for this guideline include being able to successfully screen all the applicable target population members due to dependents being able to be seen at civilian facilities and not just MTFs. For successful implementation, roles and responsibilities need to be clearly identified and information must be clearly defined. User buy-in may pose to be a limitation in utilization of the CPG. However, the screening tool was selected due to it being a short survey of a 10-question format. Other limitation is the lack of evidence found when researching information for a CPG to screen military families for family functioning. However, this has also strengthened the need for a CPG to be implemented. Peer-reviewed literature was gathered from Walden Library Database,

Cochrane, CINAHL Plus with Full Text, MEDLINE with full text, Google Scholar, and EBSCOhost.

A review of the literature shows evidence of mental health and family functioning concerns in relation to separation and reintegration of the service member. The articles were rated and placed into the levels of hierarchy using Fineout-Overhold and Melnyk's system (see Section 2). From the 16 articles chosen, 13 of the articles were Level VI, one was Level II, and two were Level I based on the levels of hierarchy (see Appendix D). There was a lack of Level II studies due to them being randomized control trials; there may be ethical concerns with providing care to one group and not another.

Identifying and addressing family functioning and mental health problems in a timely manner can lead to positive outcomes for military families. Early identification can lead to early treatment and potentially prevent serious events. Over time these interventions may lead to a decrease in divorce rates, depression, suicidal ideation, suicide, behavioral problems, domestic violence concerns, and other psychosocial concerns. Future studies can be conducted to determine the evidence of impact. When families experience positive functioning, that positivity can be reflected in their social and work lives. Often if a person has struggles in their personal life, it can be reflected in their work environment. By making improvements in their lives, it can lead to a positive social impact on society, an improvement in lives and better outcomes for military families and civilian population.

A CPG requires a search of the literature and the use of a systematic method with inclusion and exclusion criteria and a way to grade the evidence for strength (Walden

University. 2017). The AGREE II is a framework that can be utilized to guide the development of a CPG and a way to assess the quality (Walden University, 2017). The AGREE II is a validated tool that is extensively used to judge the quality of a guideline (Hassan Murad, 2017). As mentioned in Section 3, the AGREE II consists of six domains and within the domains there are 23 key items (Walden University, 2017). The AGREE II was distributed to the expert panel to appraise the CPG. This also provides strength for the CPG as a guideline to implement into a medical facility. Brouwers et al. (2017) recommended that guidelines be assessed by two to four appraisers to help increase the reliability of the assessment. This CPG was rated by four appraisers.

Section 5: Dissemination Plan

The plans to disseminate project findings include implementing a new CPG (see Appendix C) for the MTF to follow. The AGREE II overall score was 71% before changes were made. The second grading revealed an overall score of 90%. The overall score and each of the six domains had significant increases in the grading from the appraisers. Training would have to occur for staff to be educated on the new plan for screening patients; the nurses will be given a quick reference flow chart (see Appendix C) and the Family Satisfaction Scale (see Appendix A). The CPG may be beneficial within the family health, pediatric, women's health, mental health, and active duty clinics. The CPG could then be disseminated and implemented across all MTFs worldwide. Further dissemination could include facilities off of military installations that accept patients who are dependents of a service member. Nursing staff at these facilities could incorporate the screening for further identification and early intervention and treatment of psychosocial issues.

Analysis of Self

During my time as a military spouse, I have met with other spouses and families. I noticed trends in failed relationships, elevated stress, and a number of divorces due to hardships the families have faced. When I was pregnant, I was screened for depression, and this screening continued after I gave birth. I was screened not only at my obstetrical appointments, but at my child's wellness exams and at any other visits I had with my primary care provider. For these reasons, I questioned why this type of system was not in place for military families negotiating deployments and reintegration of service members.

I enjoyed completing a project that has the potential to help families with their hardships and provide better outcomes to those in need. As a nurse practitioner I want to help those in need and provide the best care possible. This journey from beginning to end has been trying at times, but the outcome has brought great satisfaction and is a reminder that I have chosen the right career path. However, my journey will not end with this project or with the completion of my degree. I plan to continue to advocate for the use of this CPG and would like to present it to the surgeon general of the Air Force and seek publishing in the journal *Military Medicine*.

Summary

Military families have unique hardships that can be challenging to manage and overcome. These hardships have led to psychosocial problems that, left unidentified or untreated, have led to worsening outcomes. The implementation of this nursing CPG has the potential to help military families worldwide in obtaining interventions for family dysfunction or psychosocial concerns. With proper education and training of intended users, early identification and treatment can occur for those experiencing psychosocial hardships.

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Appendix A: Permission to Use the Family Satisfaction Scale

PREPARE ENRICH, LLC

Leyla Paola Calle Grillo
August 19th, 2019

Permission to use
Family Satisfaction Scale

We are pleased to give you permission to use the Family Satisfaction Scale in your research project, teaching or clinical work with couples or families. You may either duplicate the materials directly or have them retyped for use in a new format. If they are retyped, acknowledgement should be given regarding the name of the instrument, the developers' names, and PREPARE/ENRICH, LLC.

In exchange for providing this permission, we would appreciate a copy of any papers, theses or reports that you complete using Family Satisfaction Scale. This will help us to stay abreast of the most recent developments and research regarding this scale. We thank you for your cooperation in this effort.

In closing, I hope you find Family Satisfaction Scale of value in your work with couples and families. Good luck with your project!

Appendix B: AGREE II

Domain 1: Scope and Purpose

1. The overall objective(s) of the guideline is (are) specifically described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

2. The health question(s) covered by the guideline is (are) specifically described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

Domain 2: Stakeholder Involvement

4. The guideline development group includes individuals from all the relevant professional groups.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

5. The views and preferences of the target population (patients, public, etc.) have been sought.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

6. The target users of the guideline are clearly defined.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

Domain 3: Rigor of Development

7. Systematic methods were used to search for evidence.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

8. The criteria for selecting the evidence are clearly described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

9. The strengths and limitations of the body of evidence are clearly described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

10. The methods for formulating the recommendations are clearly described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

11. The health benefits, side effects and risks have been considered in formulating the recommendations.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

12. There is an explicit link between the recommendations and the supporting evidence.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

13. The guideline has been externally reviewed by experts prior to its publication.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

14. A procedure for updating the guideline is provided.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

Domain 4: Clarity of Presentation

15. The recommendations are specific and unambiguous.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

16. The different options for management of the condition or health issue are clearly presented.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

17. Key recommendations are easily identifiable.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

Domain 5: Applicability

18. The guideline describes facilitators and barriers to its application.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

19. The guideline provides advice and/or tools on how the recommendations can be put into practice.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

20. The potential resource implications of applying the recommendations have been considered.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

21. The guideline presents monitoring and/or auditing criteria.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

Domain 6: Editorial Independence

22. The views of the funding body have not influenced the content of the guideline.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

23. Competing interests of guideline development group members have been recorded and addressed.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments:

Rate the overall quality of this guideline

1 Lowest possible quality	2	3	4	5	6	7 Highest possible quality

Comments:

I would recommend this guideline for use:

Yes	
Yes, with modifications	
No	

Note: From "Appraisal of Guidelines for Research and Evaluation II: Instrument," by Brouwers et al., 2017. Reformulated with permission.

Appendix C: Nursing Clinical Practice Guideline

Clinical Practice Guideline: Screening for Family Functioning

Background

The military population can face life-changing events such as deployments and combat which result in separation from family for long periods of time followed by reintegration to the family. Positive family functioning is important for the service member during these times of separation and reintegration. Separation and reintegration of military service members can have negative impacts on the family. Separation and reintegration can result in unique stressors, such as depression, relationship failure, suicide, domestic violence, or behavioral problems (Rodriguez, & Margolin, 2015). Since becoming a military spouse I have noticed the impact separation and reintegration can have on families. This section discusses the problem statement, the purpose, the nature of the doctoral project, and the significance of this project.

Scope and Purpose

Objectives

- Provide evidence-based recommendations to clinicians to screen for family functioning among military members and their dependents.
- To have a nursing clinical practice guideline (CPG) based on current evidence and clinical practice to identify and treat the negative consequences of separation and reintegration of the service member.
- Early identification and treatment can begin and may help to reduce divorce rates, mental health illnesses, and behavioral problems among dependents and the service member.

Questions

- Will the nursing CPG improve the assessment of family functioning during times of separation and reintegration of the military member?
- Will screening military members and their families for family functioning decrease rates, of mental health illnesses, and behavioral problems?
- Will the use of the CPG help improve the lives of military families and their functioning needs?

Target population

This guideline is intended to be utilized for military members, if available, their spouses, and their dependents, who are dealing with separation or reintegration of the service member. Speaking with military spouses, some feel this would be a beneficial tool to help their families.

Stakeholder Involvement

Intended users

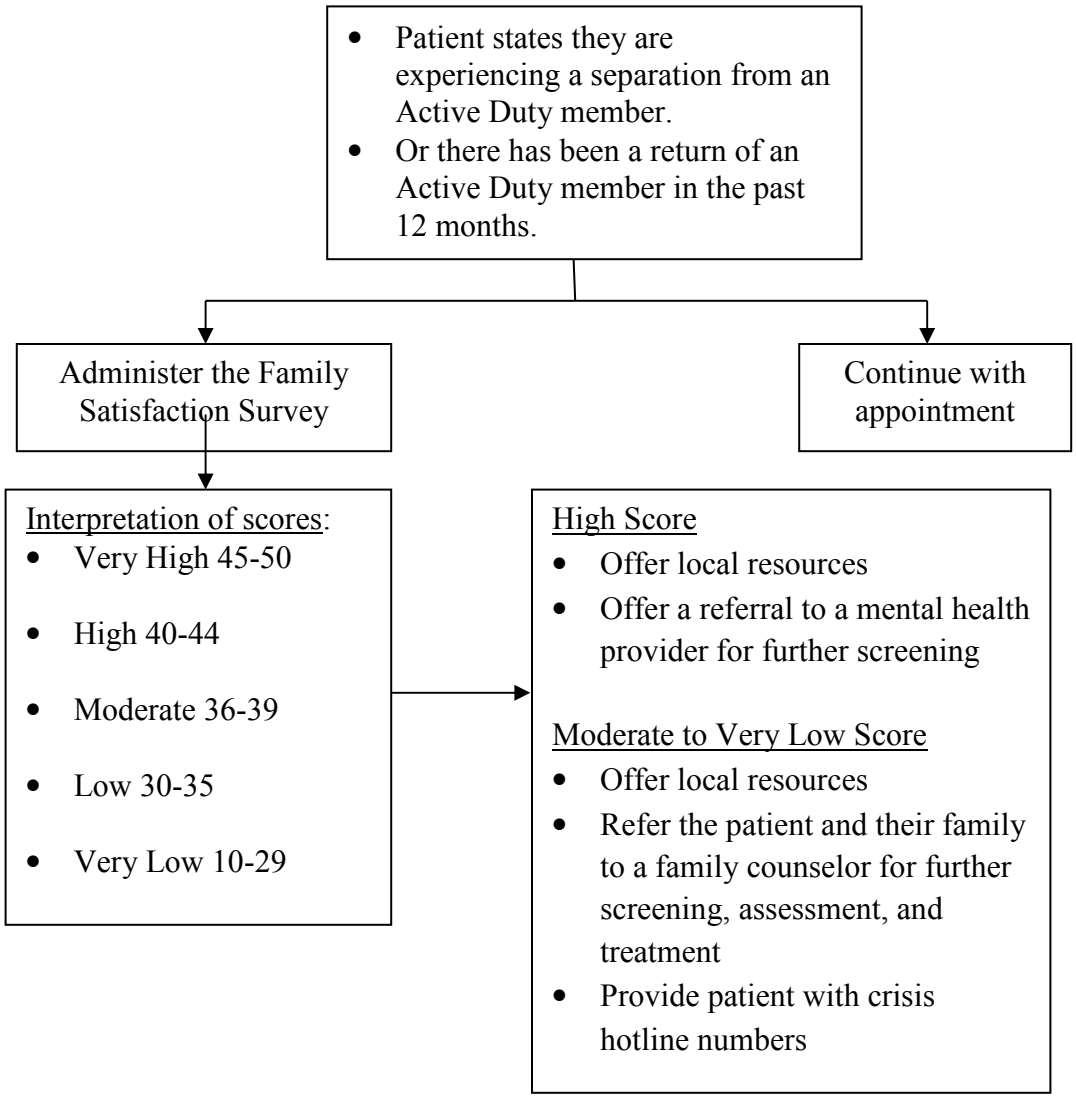
Users of this guideline are to include nursing members within the family health, active duty, pediatrics, women's health, and mental health clinics to screen their patients for psychosocial issues such as depression, suicidal ideation, poor or affected family

functioning, or other needs. Results will be shared with the provider to make referrals if needed. Crisis hotline information should be shared as well.

Accessing the tool

To obtain access to the Family Satisfaction Scale, users can either go to prepare-enrich.com or call 1-800-331-1661 to purchase.

Flow chart for intended users:



Rigor of Development

Supporting Evidence

Peer reviewed literature was gathered from Walden Library Database, Cochrane, CINAHL Plus with Full Text, MEDLINE with full text, Google Scholar, and EBSCO Host. A review of the literature shows evidence of mental health and family functioning concerns in relation to separation and reintegration of the service member. All articles utilized are in the reference page.

Hierarchy of Evidence for Intervention Studies

Type of evidence	Level of evidence
Systematic review or meta-analysis	I
Randomized controlled trial	II
Controlled trial without randomization	III
Case-control or cohort study	IV
Systematic review of qualitative or descriptive studies	V
Qualitative or descriptive study	VI
Expert opinion or consensus	VII

Note: From "Critical Appraisal of the Evidence: Part 1 An Introduction to Gathering, Evaluating, and Recording the Evidence," by Fineout-Overholt, Melnyk, Sitwell, & Wiliamson (2010), *American Journal of Nursing*, *110.*

Strengths and Limitations

Limitation include the lack of evidence found when researching information on this topic. However, this has also strengthened the need for a clinical practice guideline to be implemented. The articles chosen were rated and placed into different levels of hierarchy using Fineout-Overhold and Melnyk's system. All sources of evidence were reviewed to ensure quality information was available. However, there are some seminal resources that are more than 5 years old. From the 16 articles chosen, 13 of the articles were level VI, one was a level II, and two were a level I based on the levels of hierarchy.
This guideline has been reviewed by an expert panel and graded using the AGREE II.

Benefits

Identifying and addressing family functioning and mental health problems in a timely manner can lead to positive outcomes for military families. When families experience positive functioning, that positivity can be reflected in their social and work lives. Often if a person is not mentally stable, it can be reflected in their work environment. By making improvements in their lives, it can lead to a positive social impact and lead to an improvement in lives and better outcomes for military families and civilian population.

Management and Key Recommendations

Nurses will utilize this guideline during appointments, to screen patients who state an active duty family member is separated due to work, or an active duty member (can be self) has returned within the last 12 months. The reason for screening at any appointment is due to the fact that a family member can be separated or reintegrated at any time. Extending it to the past 12 months can allow for a more accurate screening since issues may not occur right away upon return. They will ask the patient to fill out the Family Satisfaction Scale, a 10 question survey. If the screening identifies potential issues, the patient and their family will be referred to a family counselor or therapist to complete further screening and obtain treatment. In addition, other services provided by the facility will be offered along with local resources.

Applicability

Barriers and Facilitators

Barriers for this guideline is to successfully screen all the applicable target population due to dependents being able to be seen at civilian facilities and not military treatment facilities. Additional screening requires more work on the part of the clinic staff, this may be a barrier to use. However, the tool to be used is short and can be done quickly. For successful implementation, roles and responsibilities need to be clearly identified and information must be clearly defined.

Implementation

Plans for dissemination are to have the CPG available at all military treatment facilities worldwide, also to try and have it incorporated at facilities that accept military insurance and who may treat military spouses and dependents. Nurses will utilize the CPG to screen their patients, administer the scale, and inform the provider of the results.

Editorial Independence

Funding/Conflict of Interest

This guideline was developed as part of a Doctor of Nursing project. There has been no funding for this project and it is free from competing interests. Identities of those who helped critique the guideline have been left anonymous to prevent bias.

Monitoring/Updates and Data Collection

This guideline should be reviewed annually. It should be updated as needed to be current with the latest evidence based practice. Once in place, it is recommended that the military treatment facility audit staff and patients to receive their feedback about the tool and this guideline.

Disclaimer

Recommendations have been formulated based on evidence in the literature. This guideline is not intended to overrule clinical judgement of qualified health care providers. Providers must continue to use their clinical judgement while utilizing this guideline to assist in recognizing at risk service members or their dependents.

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Appendix D: Literature Review Matrix

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Balderrama-Durbin, C., Cigrang, J. A., Osborne, L. J., Snyder, D. K., Talcott, G. W., Smith Slep, A. M., … Tatum, J. (2015). Coming home: A prospective study of family reintegration following deployment to a war zone. *Psychological Services, 12*(3), 213-221. http://dx.doi.org/10.1037/ser0000020	Assess military members before deployment, during deployment, and after a year-long deployment to a high-risk mission location for reintegration concerns.	Prospective study	76 service members who were deployed were assessed for a year during and post deployment. The relationship of the service member and their family was assessed before, during, and after deployment.	One in five members had significant difficulties with reintegration to their families. Concerns included uncertainty about roles, feelings of not being needed, adjusting to routines, and reestablishing join decision making.	VI
Brenner, L. A., Betthauser, L. M., Bahraini, N., Lusk, J. L., Terrio, H., Scher, A. I., & Schwab, K. A. (2015). Soldiers returning from deployment: A qualitative study regarding exposure, coping, and reintegration. *Rehabilitation Psychology, 60*(3), 277-285. http://dx.doi.org/10.1037/rep0000048	Exploring physical and/or emotional trauma related to exposure to deployments with military members. Also, viewing reintegration experience. The study wanted to view the impact of these events on the soldier when returning home from deployment.	Qualitative study	103 participants were selected to be interviewed. There was a semi-structured interview completed. Questions were focused on exposure with physically or emotionally traumatic events as well as reintegration post-deployment.	Themes were identified and helped to support the idea of deployment-related mild traumatic brain injury and posttraumatic stress disorder as discrete conditions. Findings also helped to highlight the need for constructs and clinical efforts for improving the lives of military members.	VI

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Chesmore, A. A., He, Y., Zhang, N., & Gewirtz, A. H. (2018). Parent Discrepancies in Ratings of Child Behaviors Following Wartime Deployment. *Journal of Traumatic Stress, 31*(1), 79–88. http://dx.doi.org/10.1002/jts.22257	To see if family factors and contextual risk factors were related to deployments during wartime. To examine interparental discrepancies in ratings of children's adjustment problems related to post-deployment.	Randomized control trial	147 families were utilized in a randomized control trial of parenting intervention designed for military families. A family had to have at least one child aged four to 12 and one parent deployed in a military conflict zone.	Of the children, the females showed more internalizing symptoms whereas males had externalizing symptoms. Clinicians may find this study helpful to discuss with parents how their mental health concerns can influence their children.	II
Conforte, A. M., Bakalar, J. L., Sbrocco, T., Tanofsky-Kraff, M., Shank, L. M., Quinlan, J., & Stephens, M. B. (2017). Assessing military community support: Relations among perceived military community support, child psychosocial adjustment, and parent psychosocial adjustment. *Military Medicine, 182*(9), e1871–e1878. http://dx.doi.org/10.7205/MILMED-D-17-00016	The development of a Community Assessment of Military Perceived Support (CAMPS).	Cross-sectional study	157 military parents completed the CAMPS. The CAMPS was used to examine the relationships among the community support and psychosocial symptoms.	Community support was measured by the CAMPS and associated with fewer child and parent psychosocial symptoms. Results helped to support the need for military community support, the CAMPS can be a tool for program evaluation.	VI

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Freytes, I. M., LeLaurin, J. H., Zickmund, S. L., Resende, R. D., & Uphold, C. R. (2017). Exploring the post-deployment reintegration experiences of veterans with PTSD and their significant others. *American Journal of Orthopsychiatry, 87*(2), 149-156. http://dx.doi.org/10.1037/ort0000211	A family's ability to support military members dealing with PTSD's rehabilitation and reintegration.	Qualitative Study	12 veterans significant others were interviewed about perceptions of family functioning.	Deployment impacts result in changes in the individual's family dynamics and this lasted years after the veteran returned home. The significant others perceptions of family functioning was altered.	VI
Gewirtz, A. H., Pinna, K. M., Hanson, S. K., & Brockberg, D. (2014). Promoting parenting to support reintegrating military families: After deployment, adaptive parenting tools. *Psychological Services*, *11*(1), 31-40. http://dx.doi.org/10.1037/a0034134	To identify a need for services to aid in reintegration for military members when transitioning into the family roles. Determination if After Deployment, Adaptive Parenting Tools (ADAPT) can help in the process of reintegration.	Randomized Control Effectiveness Trial	42 families that had at least one child between the ages of four and 12 were utilized for a 14-week web based group for a parenting training program. Participation rates were high as well as satisfaction with the 14 sessions.	The ADAPT intervention has shown that it is feasible and an acceptable tool to utilize. It was speculated that motivation may be based on an individual's readiness to practice strategies provided.	I

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Heyman, R. E., Smith Selp, A. M., Sabathne, C., Eckardt Erlanger, A. C., Hsu, T. T., Snyder, D. K., ... Sonnek, S. M. (2015). Development of a multilevel prevention program for improved relationship functioning in active duty military members. *Military Medicine*, *180*(6), 690-696. http://dx.doi.org/10.7205/MILMED-D-14-00491	To develop a multilevel approach to the prevention of problems within a relationship.	Qualitative Study	There were two studies. The first utilized the target population's high interest topics to help guide the development of prevention information/action planning with 18 identified relationship issues. Study two all active duty members gave feedback on the content from the first study.	Feedback from study two showed that the content was moderately to very useful. Results implied that this multilevel approach may be beneficial for formal services to meet military members' needs.	VI
Knobloch, L. K., Ebata, A. T., McGlaughlin, P. C., & Ogolsky, B. (n.d.). Depressive symptoms, relational turbulence, and the reintegration difficulty of military couples following wartime deployment. *Health Communication*, *28*(8), 754-766. http://dx.doi.org/10.1080/10410236.2013.800440	To have an understanding of the difficulties that military families may experience with reintegration with use of the relational turbulence model.	Qualitative Study	118 military couples participated by completing an online questionnaire each month for the first three months after the return of the military member from a wartime deployment.	Results indicated that depressive symptoms, relational uncertainty, and interference from partners had an influence on the military member's reintegration.	VI

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Leroux, T. C., Hye-Chung Kum, Dabney, A., Wells, R., & Kum, H.-C. (2016). Military deployments and mental health utilization among spouses of active duty service members. *Military Medicine, 181*(10), 1269–1274. http://dx.doi.org/10.7205/MILMED-D-15-00583	View the ties with mental health concerns and military spouses. Analysis of the utilization of mental health services among military spouses of active duty members.	Retrospective longitudinal approach	2,530 military spouses over a 36-month timeframe and 491 spouses were present for both deployments. Military spouse of an active duty member that is assigned to an aircraft carrier from 2001 to 2014. A negative binomial generalized estimated equation was used to determine the rate mental health change in relation to various deployment phases.	Identified mental health utilization ranging from 12 to 20% for spouses. The study also identified that between deployment phases there were similar rates for use of mental health care. Due to these results it is determined that military leaders should monitor the health and well-being of military families throughout all phases of deployment.	VI
Lester, P., Aralis, H., Sinclair, M., Kiff, C., Lee, K., Mustillo, S., & Wadsworth, S. M. (2016). The impact of deployment on parental, family and child adjustment in military families. *Child Psychiatry Human Development*, 938-949. http://dx.doi.org/10.1007/s10578-016-0624-9	How do deployments affect adjustment in young children and their families. Examine the influence of deployment on adjustment in military families with children 0 to 10 years of age.	Single-stage stratified sampling	Data was collected from phone interviews and web-based surveys. Families had to be located within the United States and have one parent serving in the military. The sample size was 301 primary caregiver parents and 150 primary military parents.	Increased deployment exposure was related to impaired family functioning and instability among marriages. Parent's mental health was associated with impairments in social emotional adjustments in young children, an increase in anxiety, and adjustment problems with school-age children.	VI

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Marek, L., & D'Aniello, C. (2014). Reintegration stress and family mental health: Implications for therapists working with reintegrating military families. *Contemporary Family Therapy: An International Journal, 36*(4), 443. http:dx.doi.org/10.1007/s10591-014-9316-4	Identify factors that contribute to reintegration stress and how it can affect the families emotional health and well-being.	Qualitative study	675 participants, 380 are service members and 295 are partners of the service members. Data was collected from a variety of events that are designed to support military families during reintegration. Electronic links were send to complete a survey from home.	Results indicate that the model can help predict variance in reintegration stress levels. Mental health providers need to understand the variation in levels of stress and coping skills when dealing with families and reintegration.	VI
McGuire, A. C. L., Kanesarajah, J., Runge, C. E., Ireland, R., Waller, M., & Dobson, A. J. (2016). Effect of multiple deployments on military families: A cross-sectional study of health and well-being of partners and children. *Military Medicine, 181*(4), 319–327. http://dx.doi.org/10.7205/MILMED-D-14-00310	Association between physical, mental, and family health of military families dealing with deployments.	Cross sectional study	1,332 Australian Defense Force partners with 1,095 children aged four to 17 years. Each member had experienced more than one deployment. Surveys were given by hardcopy or available online based of participant preference.	There was little evidence associated with physical and mental health of the partners and the number of deployments. More behavioral problems were reported with children who had experienced more than one deployment. Significant trends with increased behavioral difficulties with the number of deployments.	VI

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Renshaw, K. D., & Campbell, S. B. (2017). Deployment-related benefit finding and postdeployment marital satisfaction in military Couples. *Family Process, 56*(4), 915–925. http://dx.doi.org/10.1111/famp.12249	Does benefit finding lead to better functioning on both individual and interpersonal levels?	Quantitative study	67 male service members who have deployed at least once since 9/11/2001 and their wives. Each couple completed a marital satisfaction at baseline and had a follow-up four to six months later. The service member also provided posttraumatic stress (PTSD) symptoms.	The severity of PTSD symptoms showed that wives benefit finding was positively associated with increases in the service member's relationship satisfaction. Results indicate the need for support for spouses during deployments.	VI
Rodriguez, A. J., & Margolin, G. (2015). Military service absences and family members' mental health: A timeline followback assessment. *Journal of Family Psychology, 29*(40), 642-648. http://dx.doi.org/10.1037/fam0000102	There are links to depression and anxiety among spouses and children of an active duty member. Use of the Timeline Followback Military Family Interview (TFMFI) to collect information about the service member's absence. Does the length of time or number of important events missed lead to depressive or anxious feelings.	Qualitative study	70 mother-adolescent pairs participated in a 2.5 hour meeting. The TFMFI was used in a 45 minute session. The TFMFI is an interview-based tool to understand lived experiences during separation from the active duty member.	The number of important family events missed by the active duty member was liked to increased symptoms of depression with youth. The mothers' showed symptoms of depression based on duration of separation and not events missed.	VI

Reference	Purpose	Study design	Data collection/Outcomes measures	Findings/Conclusion	Level
Strong, J., & Lee, J. J. (2017). Exploring the deployment and reintegration experiences of active duty military families with young children. *Journal of Human Behavior in the Social Environment*, *27*(8), 817-834. https://doi.org/10.1080/10911359.2017.1339653	What is the impact of deployments on behavioral health and well-being for the family. The purpose is to identify challenges faced among families with young children, understand resources utilized, and explore strengths and strategies used during the separation.	Qualitative study	19 active duty families completed a structured interview, the families had to have young children under the age of five-years old. Each family needed to have experienced a deployment within the last year, or currently were experiencing one.	Data showed significant social isolation and the need for formal and informal social support and including self-care for parents at home, challenges with co-parenting and using known resources, and a range of strategies to manage separation and reintegration.	VI
Trautmann, J., Alhusen, J., & Gross, D. (2015). Impact of deployment on military families with young children: A systematic review. *Nursing Outlook, 63*(6), 656-679. https://doi.org/10.1016/j.outlook.2015.06.002	Describe the impact of deployment since 9/11 with military families and their mental health and identify support needs for these families.	Systematic review	Databases from 2001-2014 were reviewed, 26 studies met the criteria. Each study was appraised for the purpose, design, methods, sample size, demographics, and results. The studies were set into three categories: descriptive, intervention, and program evaluation.	Separation was associated with increased stress in parents, behavioral problems in children, health care utilization, and maltreatment of children. Methodological limitations were noted.	I