

# **Military Children and Families**

## ***Challenges of Complicated Deployments***

Heroes at Home: Understanding the Impacts of Wartime  
Deployments in Military and Veteran Families

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## RESOURCES FOR RECOVERY

FOR FAMILIES

*Advancing the Health and Care of our Nation's Combat Injured Service Members, their Families and Children*

2010 BRAIN INJURY AWARENESS DAY ON CAPITOL HILL

### *Understanding the Impact of TBI on Military Families and Children*

An important and often overlooked aspect of traumatic brain injury (TBI) is its impact on the families and children of the injured. TBI is unique because it often leads to dramatic changes in personality and behavior without altering physical appearance. Invisible injuries such as TBI can be especially troubling, confusing and embarrassing for one's children and family.

Military families are extremely vulnerable to the effects of TBI due to its prevalence and range of severity in combat veterans. TBI, often referred to as the "signature wound" of our war on terrorism, results from



exposure to blast, gunshot wounds, shrapnel, falls and motor vehicle accidents. In combat, many TBI injuries occur during training exercises. TBI can be mild (referred to as mTBI or concussion) or severe. Even in milder cases, veterans say that they are experiencing changes in their personality. More serious TBI, often from war injuries, profound anger, and outbursts, or possibly with depression) can be present.

Despite limited research on the impact of TBI on children, clinical case studies, focus groups, and small samples have

short and long-term consequences on child development. Family support pro





# Military Family Challenges



## Deployment

- \*transient stress
- \*modify family roles/function
- \*temporary accommodation
- \*reunion adjustment
- \*military commun maintained
- \*probable sense of growth and accomplishmt

**Multiple Deployments ?**

## Injury

- \*trans or perm stress
- \*modify family roles/function
- \*temp or perm accommodation
- \*injury adjustment
- \*military commun jeopardized
- \*change must be integrated before growth

## Psych Illness

- \*trans or perm stress
- \*modify family roles/function
- \*temp or perm accommodation
- \*illness adjustment
- \*military commun jeopardized
- \*change must be integrated before growth

## Death

- \*perm stress
- \*modify family roles/function
- \*permanent accommodation
- \*grief adjustment
- \*military commun jeop or lost
- \*death must be grieved before growth

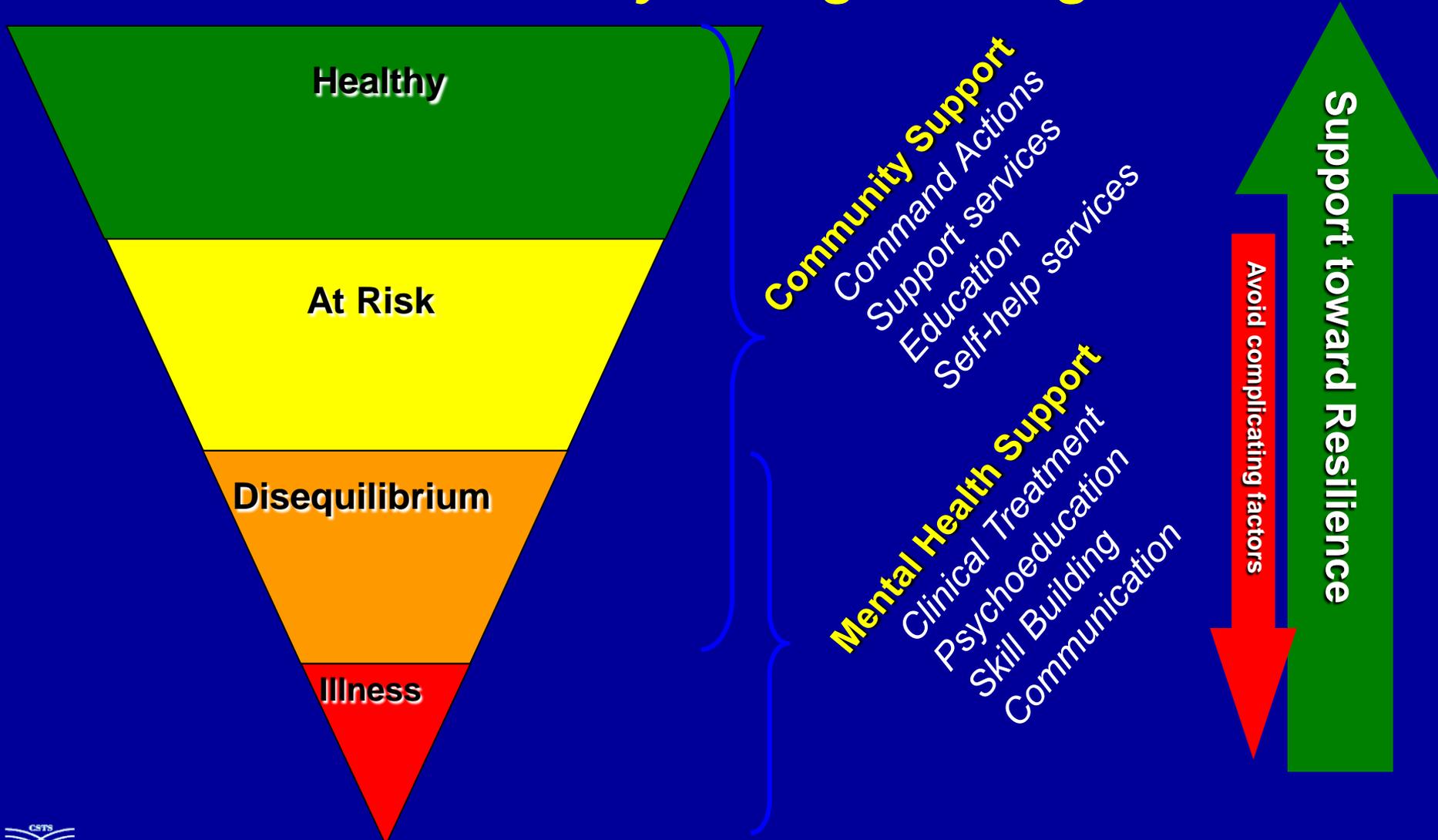
**Complicated Deployment**

**STRESS LEVEL**

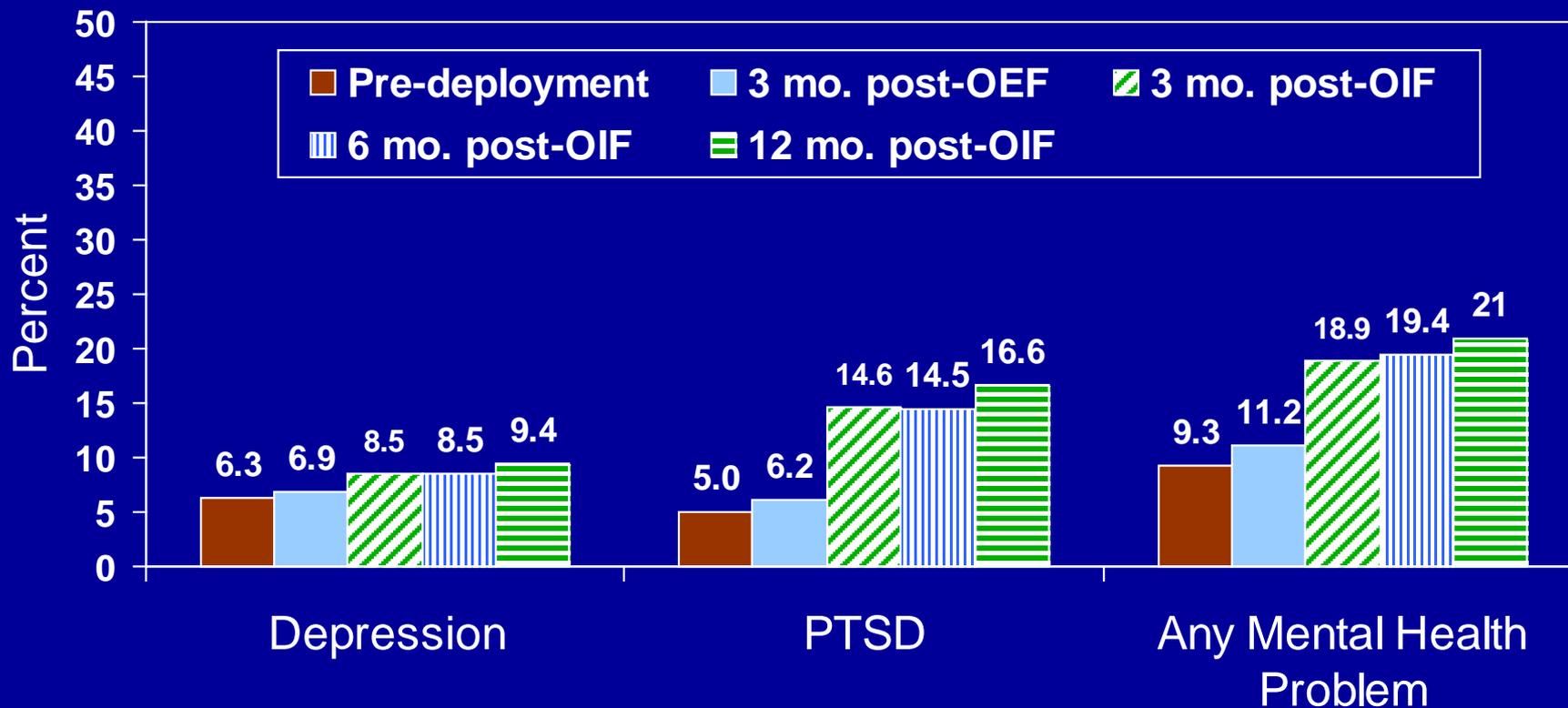


# Range of Functional Responses

*All Adversity is Stigmatizing*

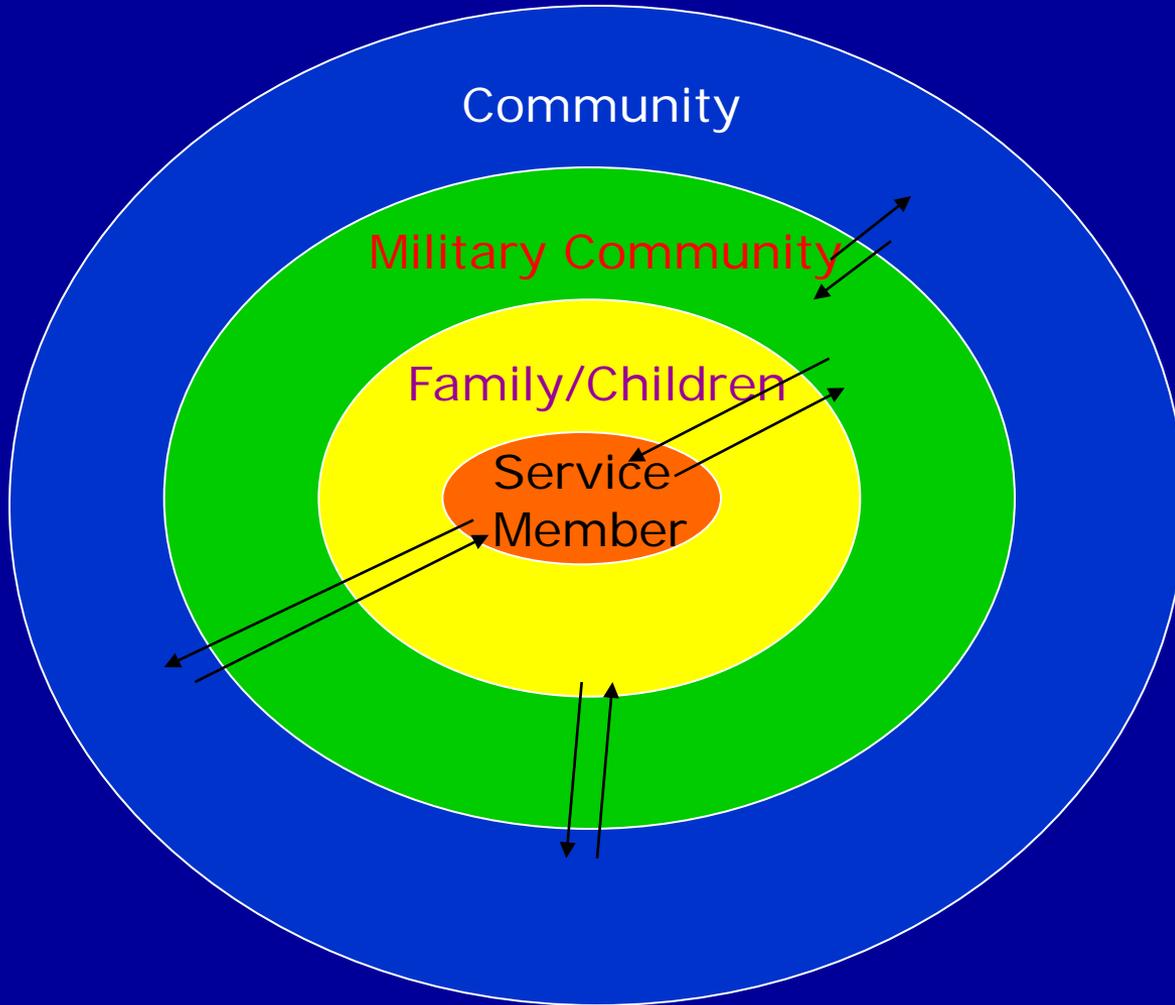


# Percent of Soldiers Screening Positive



• From WRAIR Land Combat Study and NEJM July 2004  
 Hoge, et.al.

# The Recovery Environment



Transactional interplay between layers

Interaction may be mutually helpful or disruptive

Family is the closest social support

***Health of family and service member is interrelated***

# Post-Deployment Health Re-Assessment (PDHRA) Results

ORIGINAL CONTRIBUTION

## Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War

Charles S. Milliken, MD  
Jennifer L. Auchterlone, MS  
Charles W. Hoge, MD

OUR PREVIOUS ARTICLE<sup>1</sup> DESCRIBED the Department of Defense's (DoD's) screening efforts to identify mental health concerns among soldiers and Marines as they return from Iraq and Afghanistan using the Post-Deployment Health Assessment (PDHA). However, the article also raised concerns that mental health problems might be missed because of the early timing of this screening. It cited preliminary data showing that soldiers were more likely to indicate mental health distress several months after return than upon their immediate return.<sup>2,3</sup> Based on these preliminary data, the DoD initiated a second screening similar to the first, to occur 3 to 6 months after return from deployment.<sup>4</sup>

This report reviews the mental health responses of the first cohort of soldiers to complete both the PDHA and the new Post-Deployment Health Re-Assessment (PDHRA) after return from the Iraq war. Because of the longitudinal focus of the study, we included soldiers only from the Iraq war (not from Afghanistan), the larger cohort with the most consistently high rates of combat exposure. We addressed several questions regarding the 2 screening programs: (1) Overall, what percentage of veteran soldiers of the Iraq war were

**Context** To promote early identification of mental health problems among combat veterans, the Department of Defense initiated population-wide screening at 2 time points, immediately on return from deployment and 3 to 6 months later. A previous article focusing only on the initial screening is likely to have underestimated the mental health burden.

**Objective** To measure the mental health needs among soldiers returning from Iraq and the association of screening with mental health care utilization.

**Design, Setting, and Participants** Population-based, longitudinal descriptive study of the initial large cohort of 88235 US soldiers returning from Iraq who completed both a Post-Deployment Health Assessment (PDHA) and a Post-Deployment Health Re-Assessment (PDHRA) with a median of 6 months between the 2 assessments.

**Main Outcome Measures** Screening positive for posttraumatic stress disorder (PTSD), major depression, alcohol misuse, or other mental health problems; referral and use of mental health services.

**Results** Soldiers reported more mental health concerns and were referred at significantly higher rates from the PDHRA than from the PDHA. Based on the combined screening, clinicians identified 20.3% of active and 42.4% of reserve component soldiers as requiring mental health treatment. Concerns about interpersonal conflict increased 4-fold. Soldiers frequently reported alcohol concerns, yet very few were referred to alcohol treatment. Most soldiers who used mental health services had not been referred, even though the majority accessed care within 30 days following the screening. Although soldiers were much more likely to report PTSD symptoms on the PDHRA than on the PDHA, 48% to 59% of those who had PTSD symptoms identified on the PDHA improved by the time they took the PDHRA. There was no direct relationship of referral or treatment with symptom improvement.

**Conclusions** Rescreening soldiers several months after their return from Iraq identified a large cohort missed on initial screening. The large clinical burden recently reported among veterans presenting to Veterans Affairs facilities seems to exist within months of returning home, highlighting the need to enhance military mental health care during this period. Increased relationship problems underscore shortcomings in services for family members. Reserve component soldiers who had returned to civilian status were referred at higher rates on the PDHRA, which could reflect their concerns about their ongoing health coverage. Lack of confidentiality may deter soldiers with alcohol problems from accessing treatment. In the context of an overburdened system of care, the effectiveness of population mental health screening was difficult to ascertain.

JAMA. 2007;298(18):2141-2148

www.jama.com

identified as having clinically significant mental health problems and are rates higher on the PDHRA than on the PDHA? (2) As the UK experience sug-

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Sampled over 88,000 SMs  
Elevated rates of positive screening of PDHRA compared to PDHA  
Over 40% of combat veteran reserve and NG component referred to mental health  
Variability in persistence of PTSD symptoms between PDHA and PDHRA  
**Four fold increase in veteran concerns related to interpersonal conflict**  
Problems with mental health service access for non-active and family members

Milliken, et al JAMA 2007



# Effects of PTSD on Families

- Vietnam veteran families with PTSD
  - problems in marital and family adjustment, parenting and violent behavior (Jordan et al .1992)
  - difficulty with intimacy correlated with severity of PTSD symptoms (Riggs et al. 1998, MacDonald et al. 1999)
- Sayers et al. (2009)
  - impact of mental illness in recent veterans
  - Three fourths of married/cohabitating veterans reported family problem in past week
  - Veterans with depression or PTSD had increased problems
- Solomon et al. (2011)
  - 1982 Lebanon War veterans
  - “Emotional sharing” moderator of PTSD effects on marital relationship and parental functioning

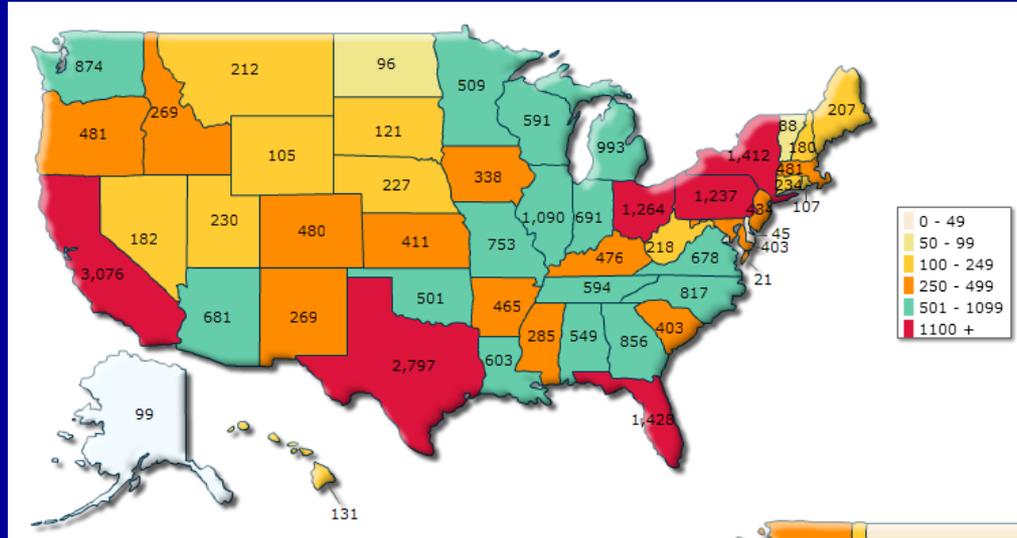
# PTSD Mediating Factors

- *Emotional numbing/avoidance*
  - most closely linked to interpersonal impairment in relationship with partners and children (Ruscio et al. 2002, Galovski & Lyons 2004)
- Co-morbid *veteran anger and depression* as well as *partner anger*
  - also mediate problems in Vietnam Vet families with PTSD (Evans et al. 2003)

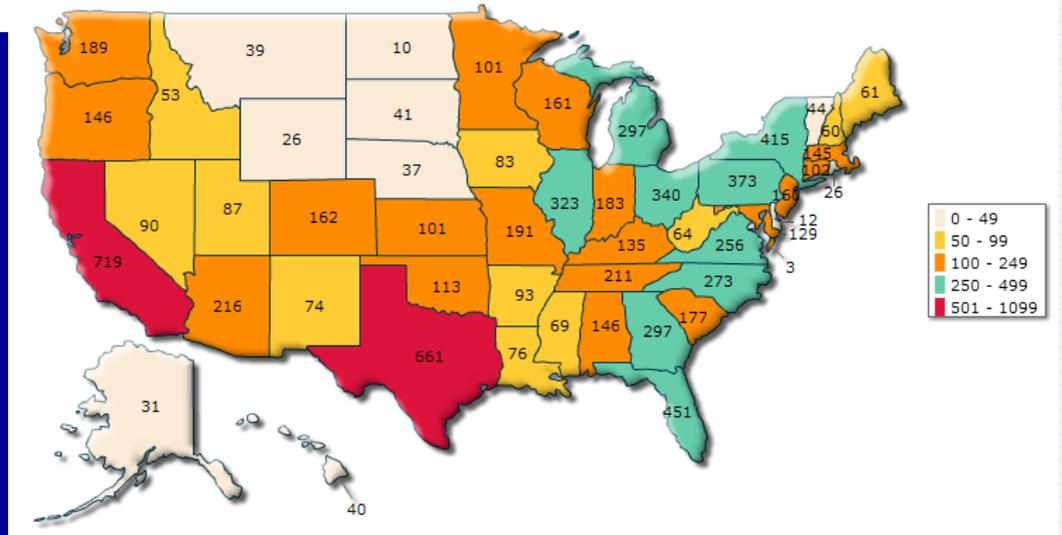
# Combat Injury



Wounded in Afghanistan



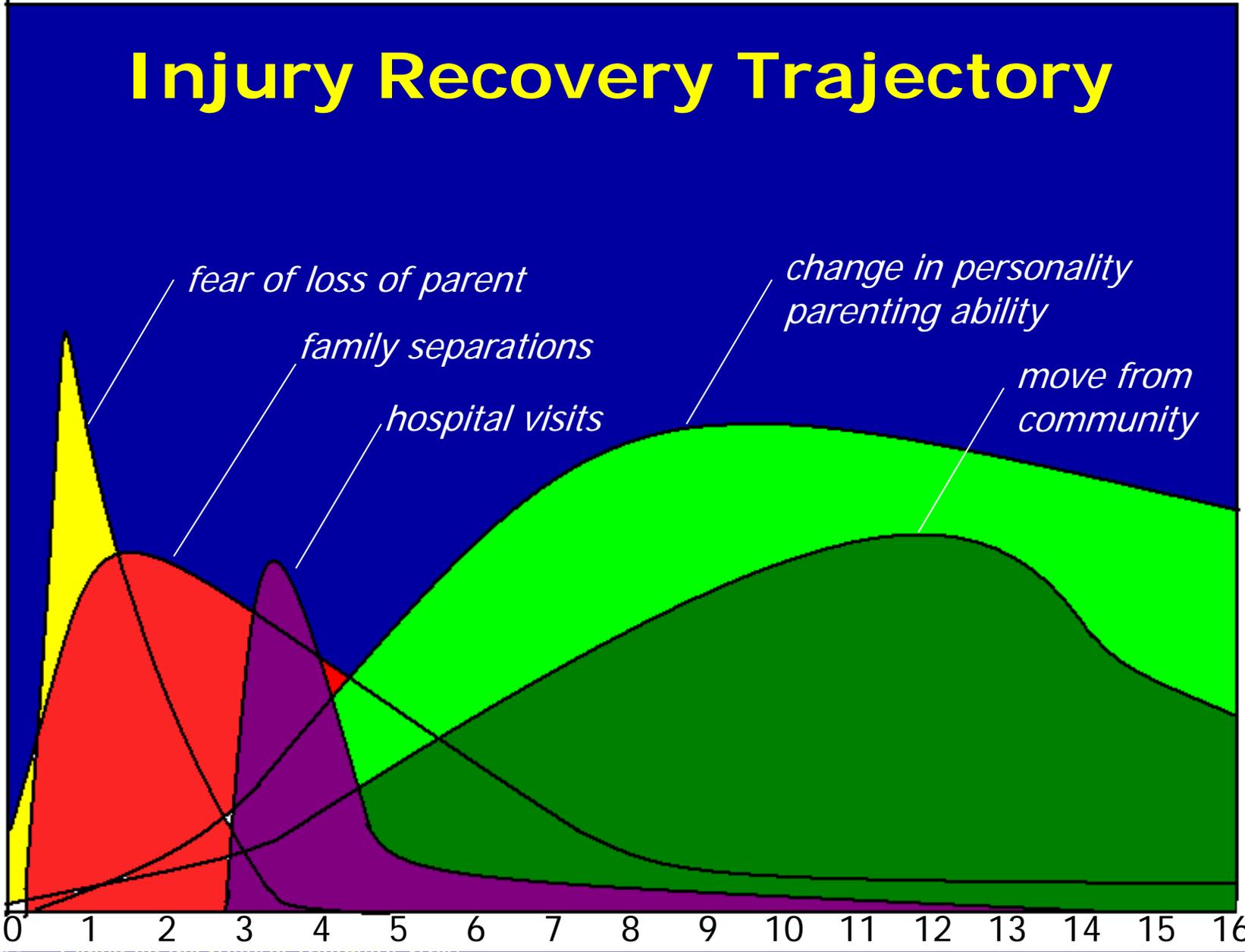
Wounded in Iraq



Reported 27 FEB 2011  
source: <http://www.icasualties.org>

# Injury Recovery Trajectory

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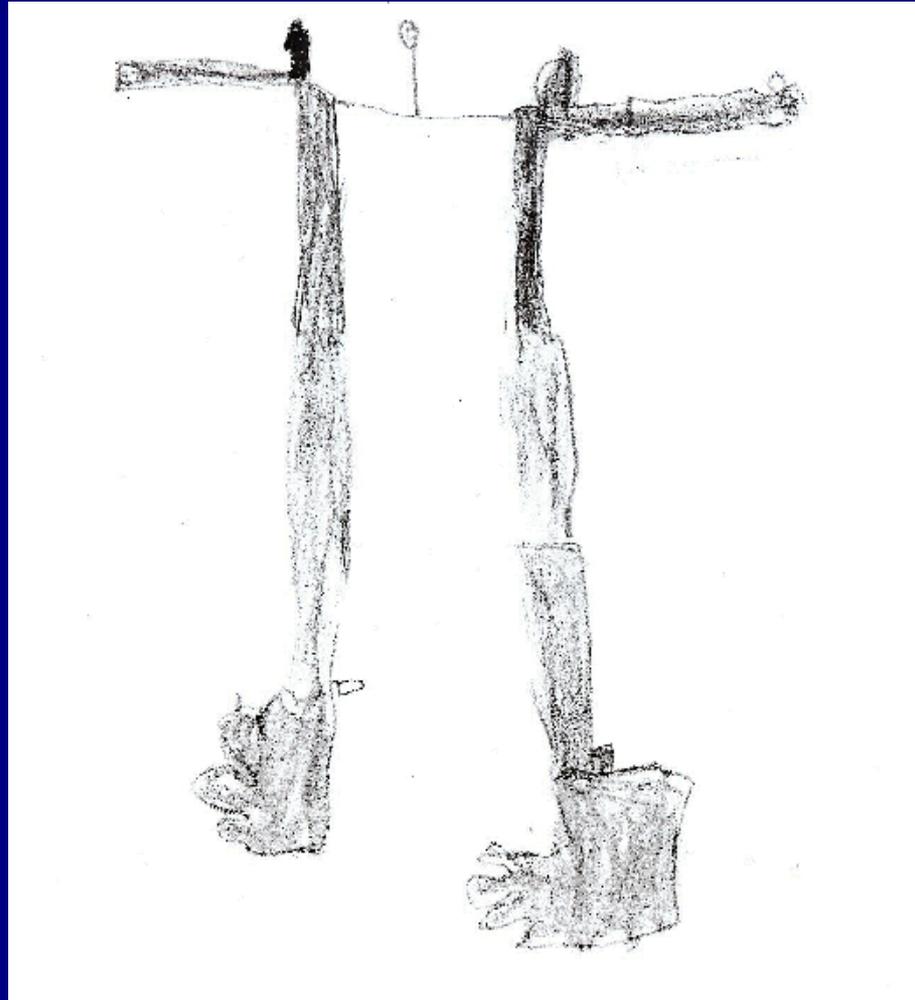


# Impact of the Injury on the Parenting Process

- Self concept of “idealized parent image” is challenged
- Must develop an integrated sense of “new self”
- Requires parent to “try on” new ways of relating
- Unique impact of TBI or co-morbid PTSD on parenting process

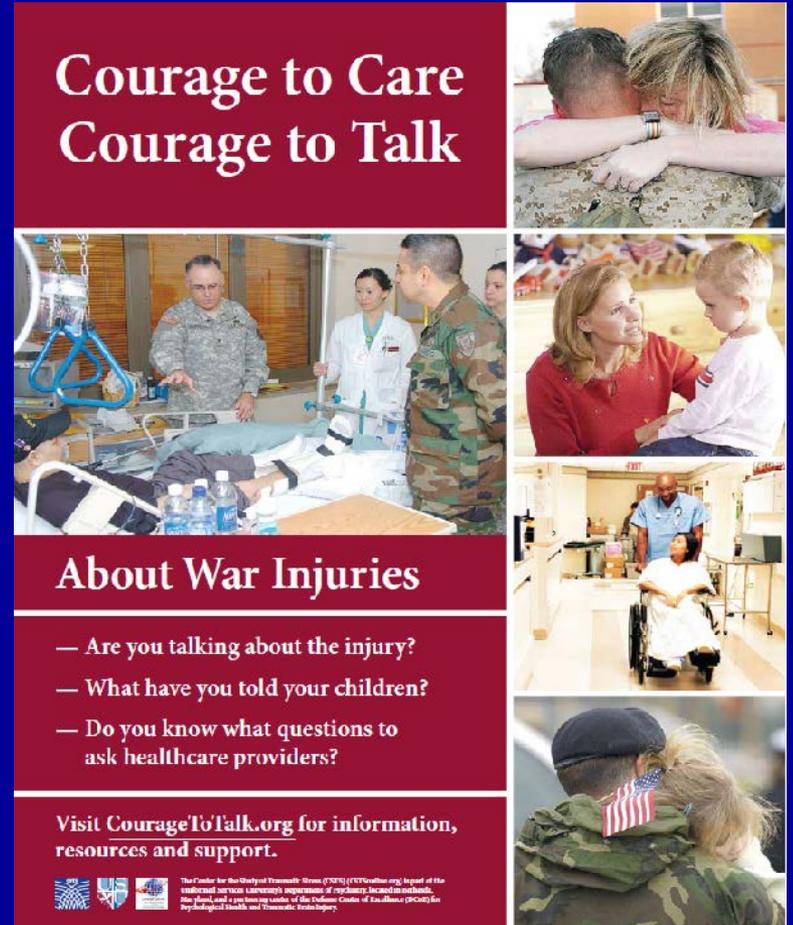


# Impact of Parental Injury on Children



# Injury Communication

- Risk communication
- Integrate the experience through a process of *shared understanding*.
- Dialogue about the injury within and outside the family
- Involves multiple parties



**Courage to Care  
Courage to Talk**

**About War Injuries**

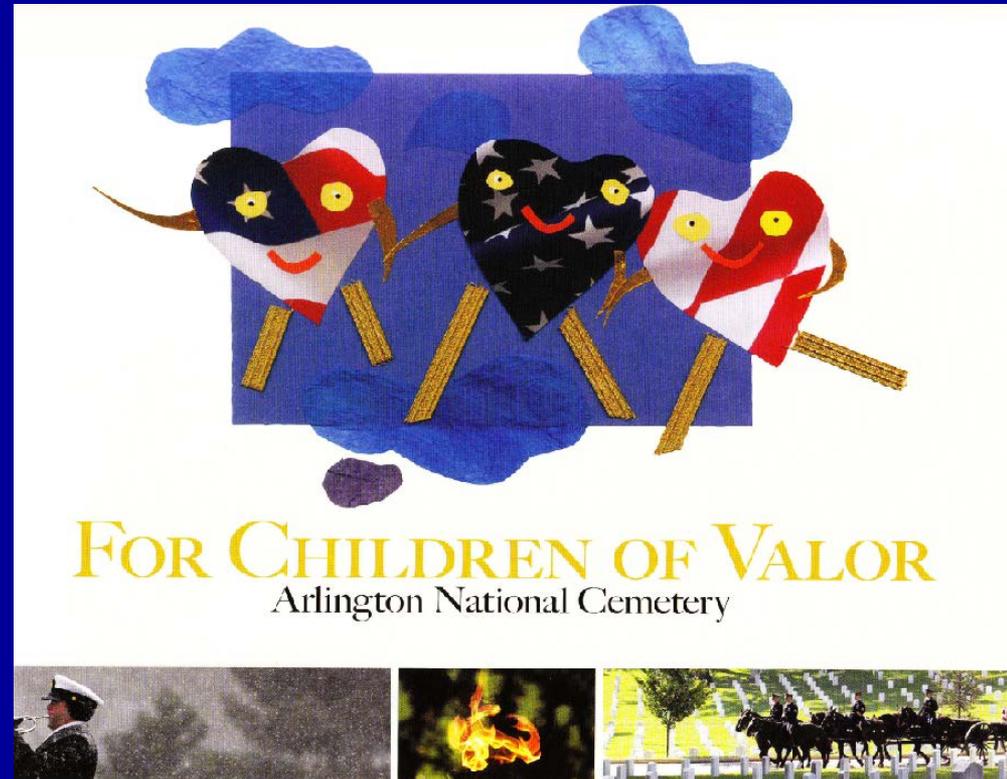
- Are you talking about the injury?
- What have you told your children?
- Do you know what questions to ask healthcare providers?

Visit [CourageToTalk.org](http://CourageToTalk.org) for information, resources and support.

The Center for the Study of Traumatic Stress (CSTS) ([CSTS.usmva.edu](http://CSTS.usmva.edu)), part of the Uniformed Services University of the Health Sciences (USUHS), is a leading center of excellence in research, education, and clinical care for military and civilian trauma survivors. The Center is a part of the Department of Psychiatry and Behavioral Science, and is a part of the Department of Psychological Health and Traumatic Stress Injury.

# Parental Death in Military Families

- Family and child grieving
- Potential loss of military community support
- Probable family relocation
- Change of schools
- Services typically shift to the civilian community



# Children and combat death

- No reported studies examining combat deaths on U.S. children – some in development
- Bereaved children vulnerable
- Increased risk for social impairment and psychopathology (Baker et al. 1992, Cournos 2001, Lin et al 2004, Cerel et al. 2006)
- Combination of parental loss and other traumatic events results in more severe psychopathology (Pfefferbaum et al. 2002, Silverman et al. 2000)
- Childhood traumatic grief – unique consideration (Cohen, et al. 2002)

