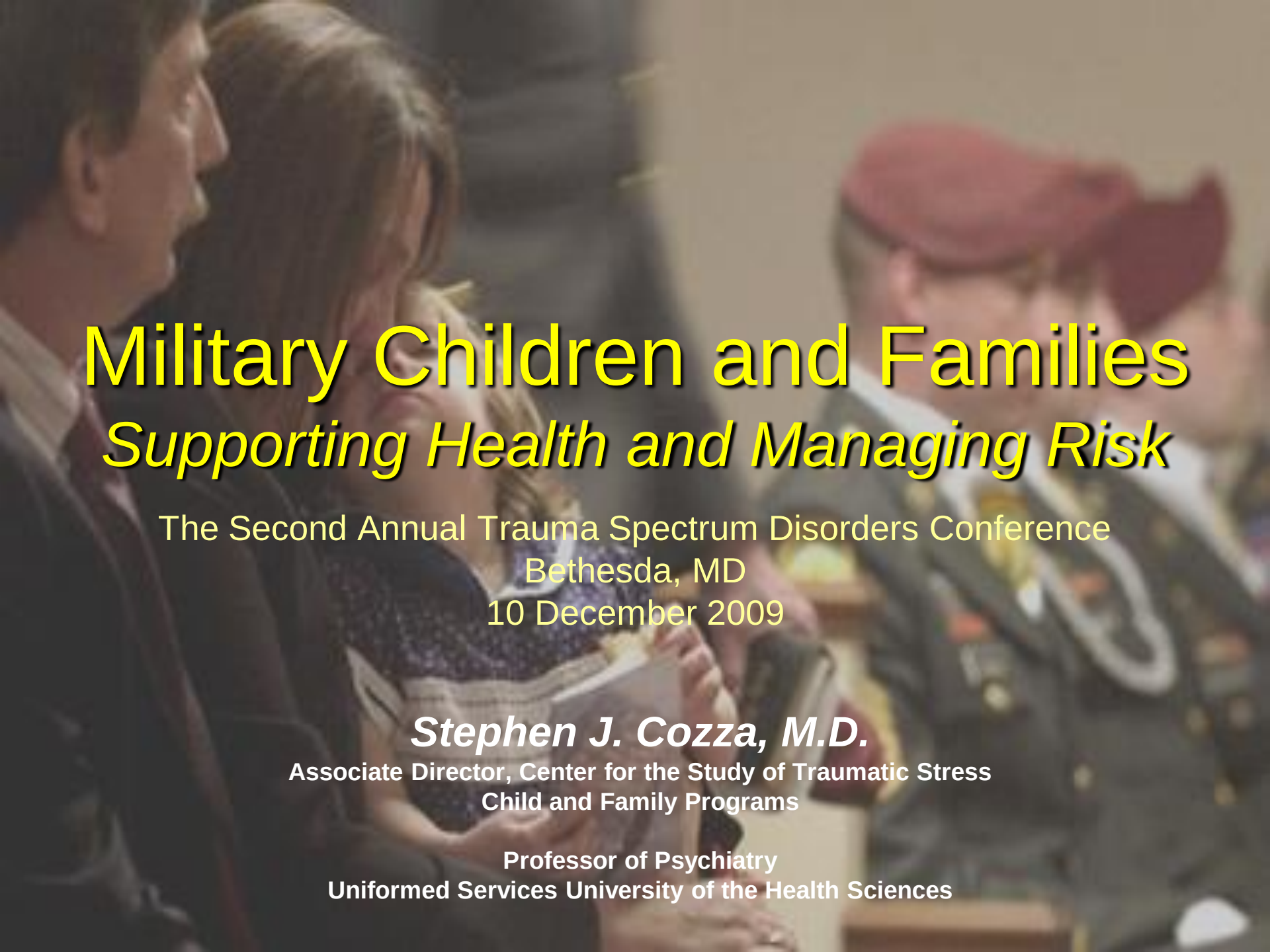

Military Children and Families

Supporting Health and Managing Risk

The Second Annual Trauma Spectrum Disorders Conference
Bethesda, MD
10 December 2009

Stephen J. Cozza, M.D.

Associate Director, Center for the Study of Traumatic Stress
Child and Family Programs

Professor of Psychiatry
Uniformed Services University of the Health Sciences

Collaborating Center NCTSN and DCoE

www.cstsonline.org

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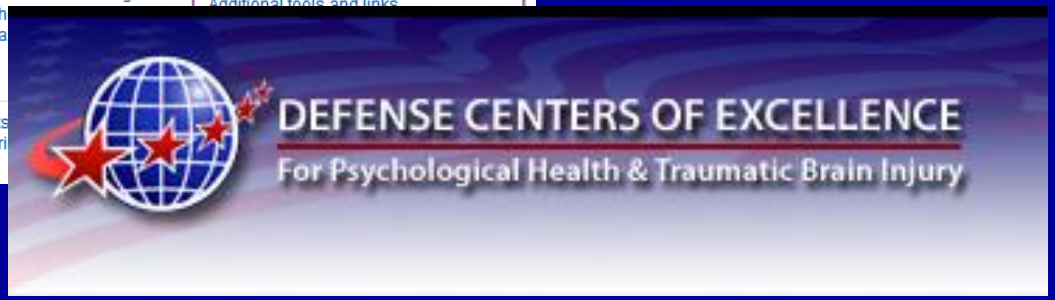


www.dcoe.health.mil

Our Military Community

Large military dependent population

44% AD SMs have children

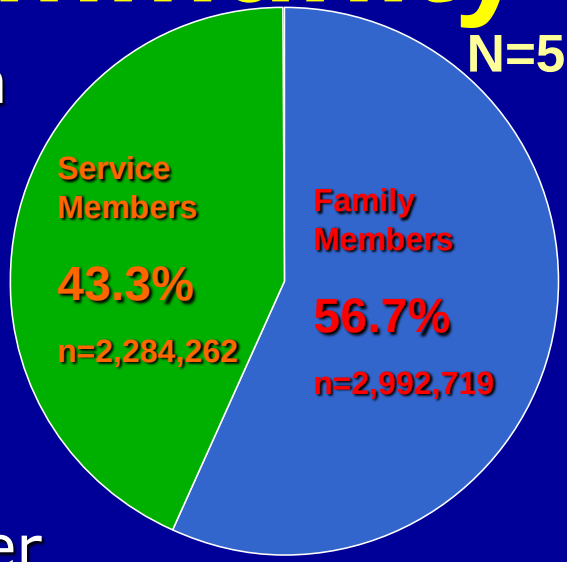
Two-thirds of children 11 and under

Forty percent of children 5 and under

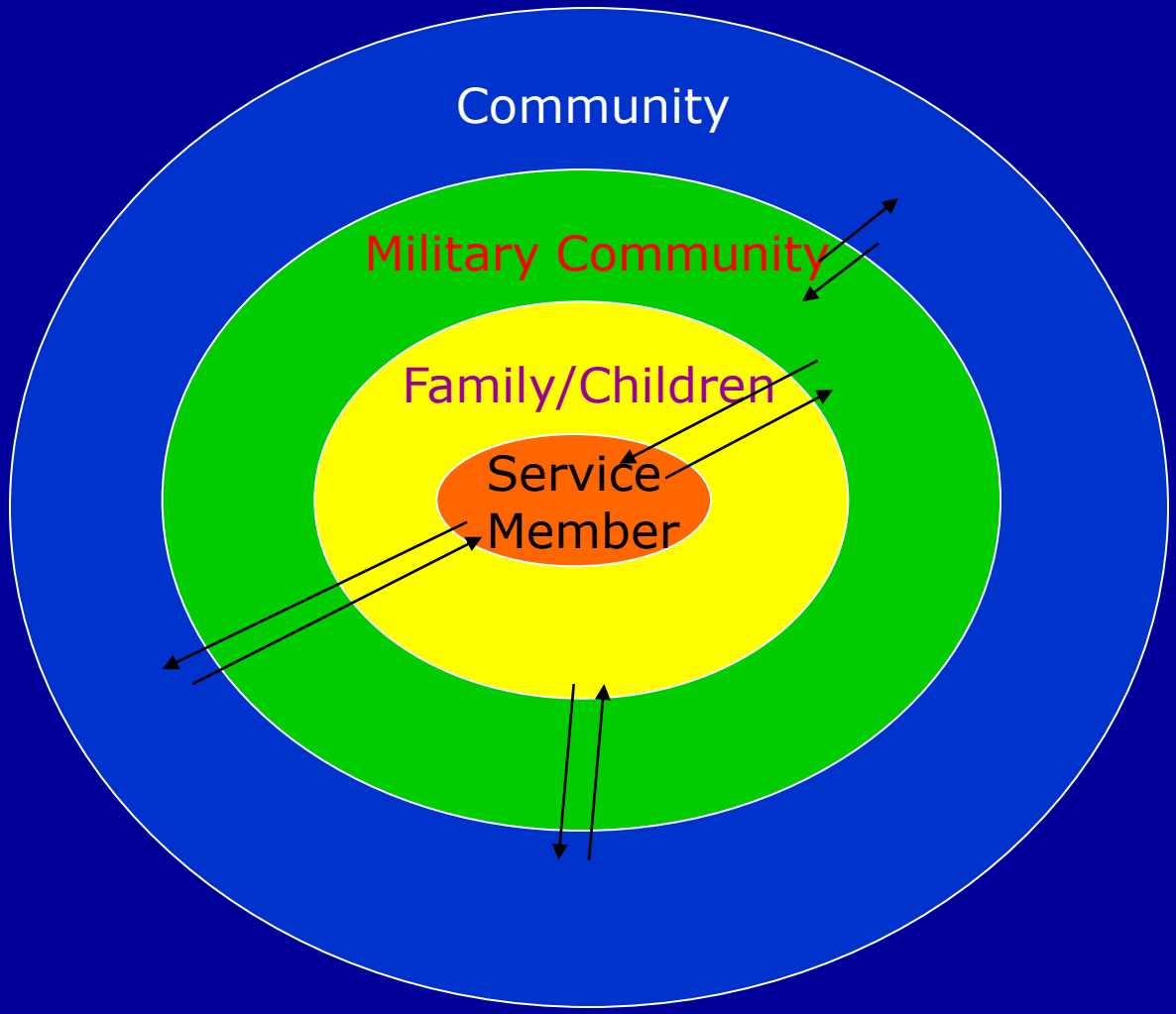
Military children are our nation's children

Military children are our future

Concept of military family relatively new



The Recovery and Social Environment



Military service member is contained within layers of support systems

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

Military Deployments

- Traditional Model: Stages of Deployment
  - pre-deployment, deployment, sustainment, redeployment, post-deployment (Pincus et al, 2001)
- Multiple and Recurrent Deployments
- Shift from occasional events to continuous
- Complicated deployments (parental illness, injury or death)
- Requires change to model of sustainment to support communities, families and individuals under stress

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

Corrosive Impact of Stress

- ***Multiple deployments during wartime***
- Distraction of responsible parties
  - many contingencies to address
  - manage anxiety and personal stress
  - potential impairment of role functioning
- Disruption of relationships, interpersonal strife, loss of attachments
- Most dependent are most vulnerable in the process
- Reduction of Parental Efficacy – the availability and effectiveness of the service member and spouse
- Impact on Community Efficacy – leaders and service providers

Child Maltreatment and Deployment

- **Rentz ED, Marshall SW, Loomis D, et al.,** Am J Epidem 2007
  - Time series analysis of Texas child maltreatment data in military and nonmilitary families from 2000-2003
- **Gibbs DA, Martin SL, Kupper LL, et al.,** J Amer Med Assoc 2007
  - Descriptive case series of 1771 Army families with substantiated child maltreatment
- **McCarroll JE, Fan Z, Newby JH, et al.,** Child Abuse Rev 2008
  - Tabulation of Army Central Registry 1990 – 2004
  - Elevated rates of child maltreatment during combat deployment periods
  - Greatest rise in maltreatment appears to be attributed to child neglect
  - Rates of child neglect appear highest in junior enlisted population

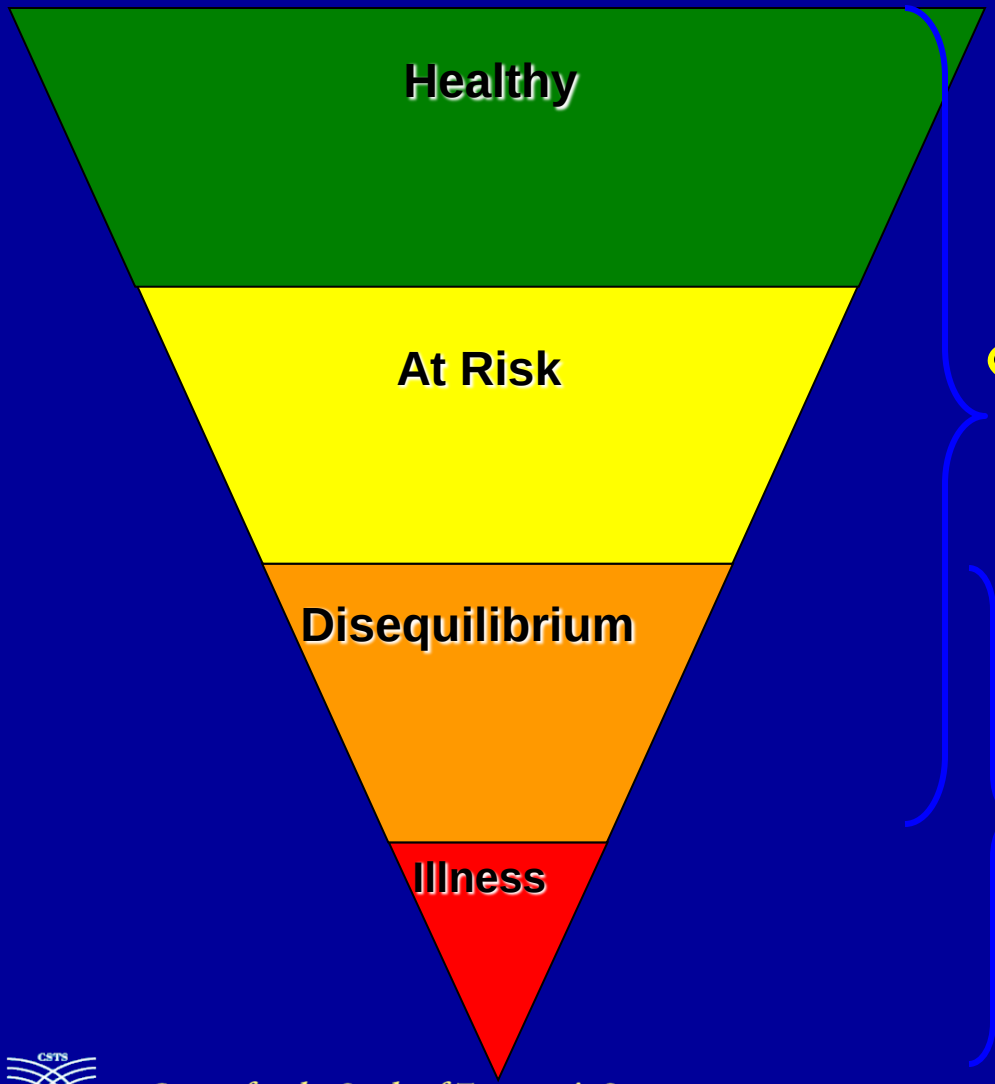
OIF and OEF Military Deployment Literature

- Studies have focused on children of varying ages pre-school (Chartrand et al, 2008) through school age and teens (Chandra, et al 2008, Chandra, et al 2010, Huebner & Mancini, 2005, Huebner et al, 2008)
- Impact of deployment length and nondeployed caregiver health on children (Chandra, et al 2010)
- No identified studies of impact on infants and toddlers
- Most studies evidence distress in children at all ages
- Evidence of anxiety, depression as well as behavioral/functional disturbances
- Teens demonstrated resilience and maturity (Huebner & Mancini, 2005)

Military Children – What Science Tells Us

- literature is limited, fewer combat exposed samples
- health of military children when compared to civilian counterparts - child and family strength
- elevated distress/symptoms in deployed families
- must differentiate and assess groups with risk factors based upon experience
    - (single parents, dual military parents, multiple combat deployments, injury, parental illness, death)
- need to identify mediating factors that contribute to child and family risk or health
- need to examine developmental differences
- longitudinal study needed to determine the course of distress resolution and developmental outcome

Range of Functional Responses



Community Support
- Command Actions
- Support services
- Education
- Self-help services

Mental Health Support
- Clinical Treatment
- Psychoeducation
- Skill Building
- Communication

Avoid complicating factors

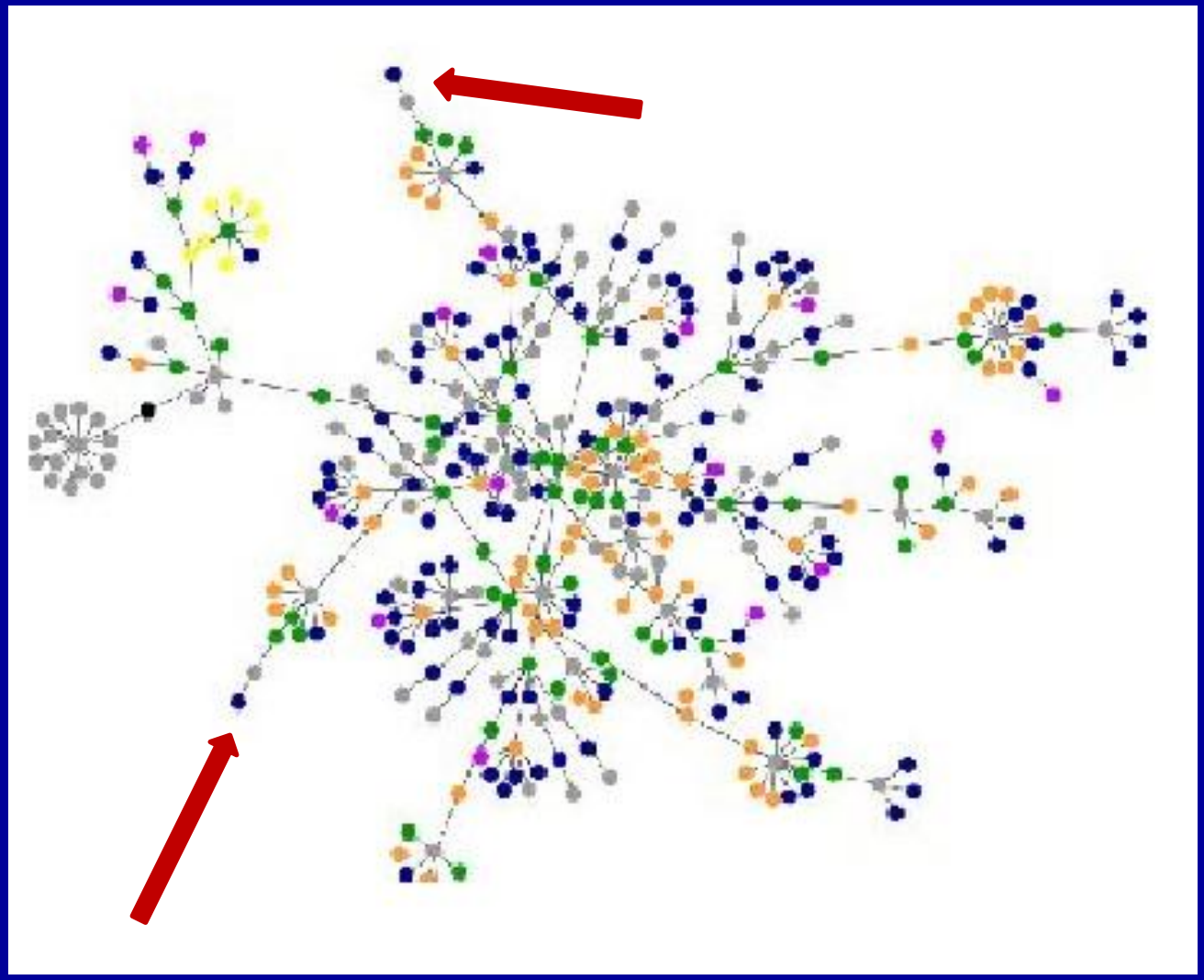
Support toward Resilience

Center for the Study of Traumatic Stress

Potential Risk Factors

- Pre-existing psychiatric or developmental problems
- Non-deployed spouses that exhibit higher distress or poorer function
- Higher exposure (multiple deployments, single parent or dual parent deployments)
- Complicated deployments (parental illness, injury or death)
- Lack of social/resource connectedness (NG, reserves, language barriers, off-installation housing, few friends/family available)
- Family and parenting risk factors (parental anger, disconnection, marital conflict, poor financial support)

Social Connectedness

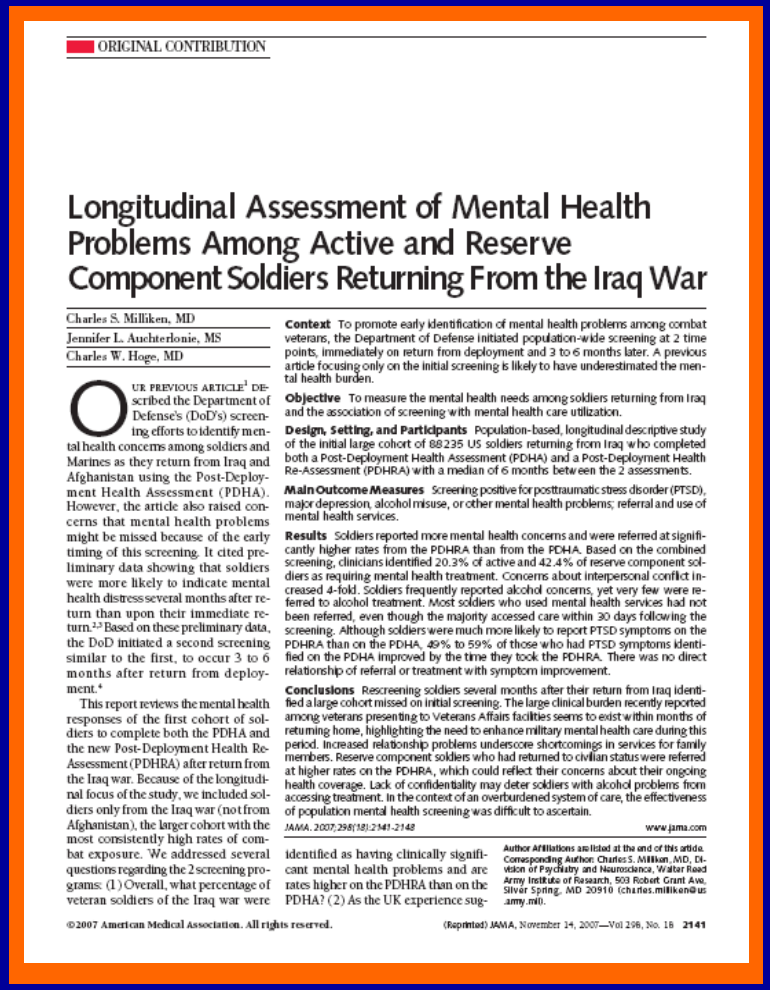


Unique Challenges in Theatre

Impact of Combat Exposure on Service Members

- high level of traumatic combat exposures (witnessing injury or death, exposure to dead bodies, hand-to-hand combat, blast injuries) Hoge et al. 2004
- resultant psychiatric sequelae and other morbidity (depression, PTSD, substance use disorders, cognitive disorders, physical injury) Hoge et al, 2004; Grieger et al, 2006, Milliken et al, 2007; Tanielian & Jaycox, 2008

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. Auchterlonie, MS
Charles W. Hoge, MD

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, 49% 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

IMPACT OF PARENTAL PSYCHIATRIC ILLNESS ON MILITARY CHILDREN

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 1, 2004 VOL. 351 NO. 1

Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care

Charles W. Hoge, M.D., Carl A. Castro, Ph.D., Stephen C. Messer, Ph.D., Dennis McGurk, Ph.D., Dave I. Cotting, Ph.D., and Robert L. Koffman, M.D., M.P.H.

ABSTRACT

BACKGROUND
The current combat operations in Iraq and Afghanistan have involved U.S. military personnel in major ground combat and hazardous security duty. Studies are needed to systematically assess the mental health of members of the armed services who have participated in these operations and to inform policy with regard to the optimal delivery of mental health care to returning veterans.

METHODS
We studied members of four U.S. combat infantry units (three Army units and one Marine Corps unit) using an anonymous survey that was administered to the subjects either before their deployment to Iraq (n=2530) or three to four months after their return from combat duty in Iraq or Afghanistan (n=3671). The outcomes included major depression, generalized anxiety, and post-traumatic stress disorder (PTSD), which were evaluated on the basis of standardized, self-administered screening instruments.

RESULTS
Exposure to combat was significantly greater among those who were deployed to Iraq than among those deployed to Afghanistan. The percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (15.6 to 17.1 percent) than after duty in Afghanistan (11.2 percent) or before deployment to Iraq (9.3 percent); the largest difference was in the rate of PTSD. Of those whose responses were positive for a mental disorder, only 23 to 40 percent sought mental health care. Those whose responses were positive for a mental disorder were twice as likely as those whose responses were negative to report concern about possible stigmatization and other barriers to seeking mental health care.

CONCLUSIONS
This study provides an initial look at the mental health of members of the Army and the Marine Corps who were involved in combat operations in Iraq and Afghanistan. Our findings indicate that among the study groups there was a significant risk of mental health problems and that the subjects reported important barriers to receiving mental health services, particularly the perception of stigma among those most in need of such care.

From the Department of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research, U.S. Army Medical Research and Materiel Command, Silver Spring, Md. (C.W.H., C.A.C., S.C.M., D.M., D.I.C.); and First Naval Construction Division, Norfolk, Va. (R.L.K.). Address reprint requests to Dr. Hoge at the Department of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research, 503 Robert Grant Ave., Silver Spring, MD 20910, or at charles.hoge@na.amedd.army.mil.

N Engl J Med 2004;351:13-22.

- Parental psychiatric illness
  - disrupts parental role
    - permissive parenting
    - negative/hostile engagements
    - reduction in positive parenting
  - disrupts child development
  - child confusion and cognitive distortion
  - increases risk behaviors
    - possible domestic violence
    - substance misuse
- PTSD
  - Avoidance – withdrawal of parental availability
  - numbing

Transgenerational Effects of PTSD In Vietnam Vet relationships/families

- Vietnam veteran families with PTSD evidence severe and diffuse problems in marital and family adjustment, parenting and violent behavior (Jordan et al .1992)
- Broad relationship problems/difficulty with intimacy correlated with severity of PTSD symptoms (Riggs et al. 1998)
- PTSD adversely effects interpersonal relationships, family functioning and dyadic adjustment (MacDonald et al. 1999)

Family Impact of PTSD in Vietnam Vets Mediating Factors

- *emotional numbing/avoidance* may be component of PTSD 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)

Family Problems Among Recently Returned Military Veterans

- Sayers et al, 2009
- Iraq/Afghanistan combat veterans referred to mental health
- Three fourths of married/cohabitating veterans reported family problem in past week
  - Feeling like guest in household (40.7%)
  - Children acting afraid or not being warm (25.0%)
  - Unsure about family role (37.2%)
- Veterans with depression or PTSD had increased problems

Impact of Parental Combat Injury on Children

- Little information on the impact on children due to injury of parent during wartime
- May extrapolate from studies done in other injured/ill parent populations
- Unique child responses based upon parental illness are expected
- Parental psychiatric illness also impacts negatively on children

Impact of the Injury on the Child

- The meaning of the injury to the child
- Child's developmental limitations of understanding
- Time of parental distraction and preoccupation with injury
- Confusion about "invisible changes"
- Child must modify the internal image of his injured parent
- Health requires developing an integrated and reality based acceptance of parental changes

Impact of the Injury on the Parenting Process

- Need for mourning related to body change and/or functional loss
- Self concept of “idealized parent image” is challenged
- Must develop an integrated sense of “new self”
- Parental attention must be drawn to child’s developmental needs
- Explore new mutually directed activities and play (transitional space) that allows parent and child to “try on” new ways of relating

Assessment of Concerns and Needs of Families Following Combat Injury

PGA-CI record review analysis

Stephen J. Cozza, M.D.*, Ryo S. Chun, M.D.**, Teresa L. Arata-Maiers, Psy.D.***, Jennifer Guimond, Ph.D.*, Brett Schneider, M.D.** 2008

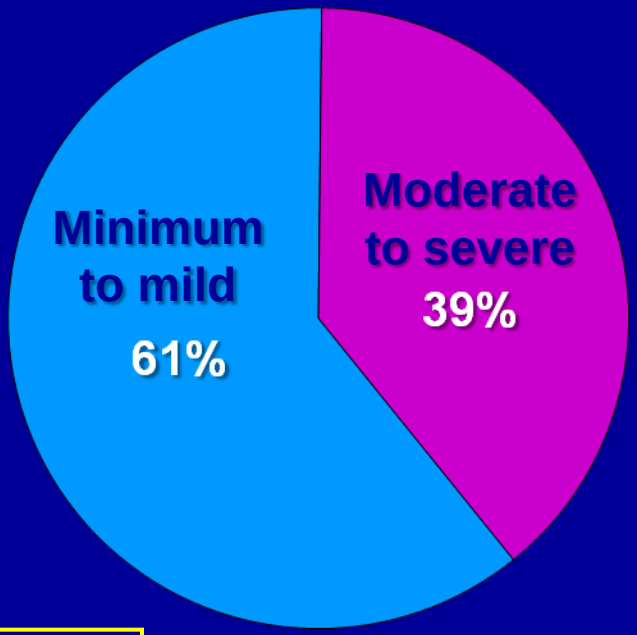
* Center for the Study of Traumatic Stress, Uniformed Services University, Bethesda, MD, ** Walter Reed Army Medical Center, Washington, D.C., *** Brooke Army Medical Center, San Antonio, TX

Family Disruption

- 80% reported moderate to severe impact on living arrangements
- 78% reported moderate to severe impact on child and family schedules
- 86% reported spending less time with children
- 48% reported moderate to severe impact on discipline

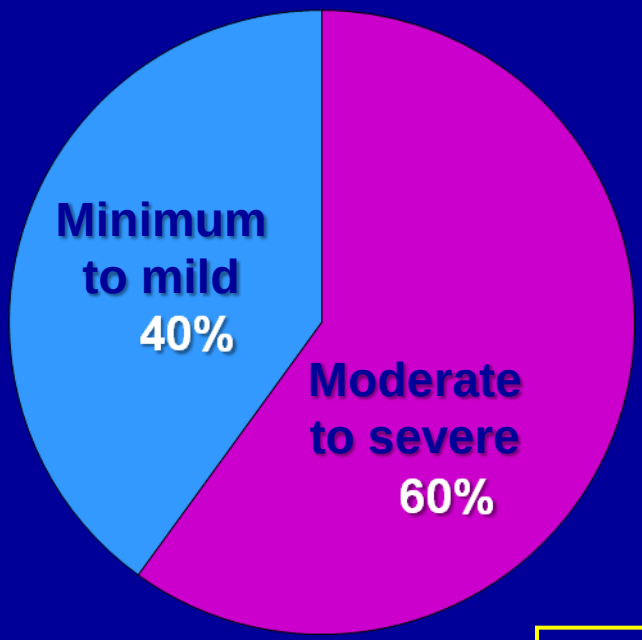
Impact on Children

Changes in Behavior



Scale: 1-5
Mean: 2.9
Std Dev: 1.4

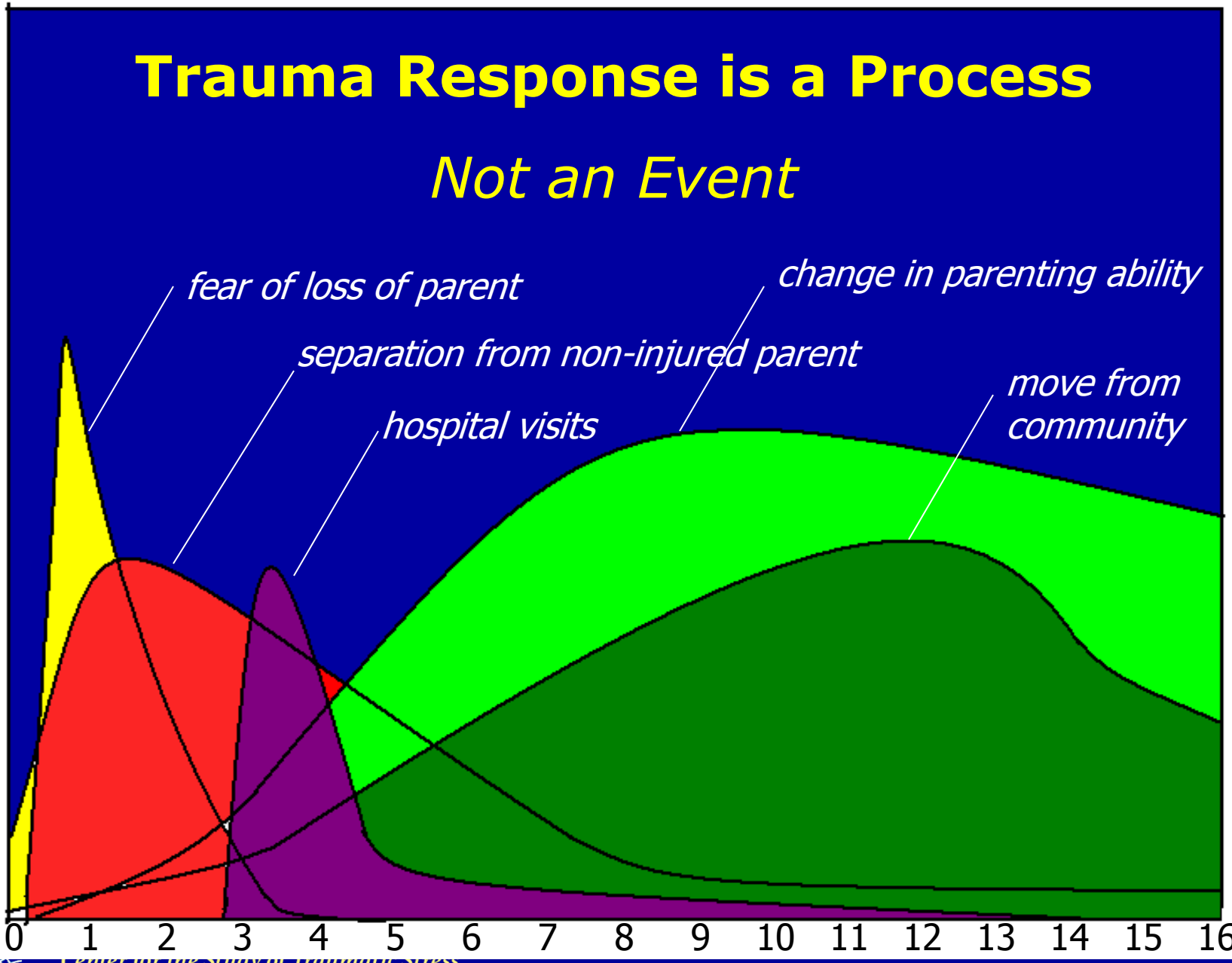
Emotional Difficulty



Scale: 1-5
Mean: 2.9
Std Dev: 1.4

Trauma Response is a Process

Not an Event



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
- Early parental death is a known contributor to compromised child outcomes

Children and combat parental death

- No reported studies examining combat deaths on U.S. children – some in development
- vulnerability in children as a result of parental death
- bereaved children more susceptible to PTSD than other populations of traumatized children (Pfefferbaum et al, 1999; Stoppelbein and Greening, 2000)
- 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 (Pynoos, 1992)

Building a national community of care and concern for our military families

Center for the Study of Traumatic Stress

www.cstsonline.org

scozza@usuhs.mil