Psychiatric Quarterly, Vol. 76, No. 4, Winter 2005 (© 2005)
DOI: 10.1007/s11126-005-4973-y

MILITARY FAMILIES AND CHILDREN DURING OPERATION IRAQI FREEDOM

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The general public has become increasingly interested in the health and well being of the children and families of military service members as the war in Iraq continues. Observers recognize the potential stresses or traumas that this population might undergo as a result of the military deployment or the possible injury or death of military family members. While such concern is welcomed, it is sometimes misplaced. Not infrequently, conclusions that are drawn are fraught with misunderstanding and bias based upon lack of understanding of the military community or a preconceived notion of the vulnerabilities of the population. This problem is compounded by the paucity of scientific study. In this article the authors review the strengths of military families as well as the unique challenges that they face. The authors also highlight parental deployment, parental injury and parental death as unique stresses to military children and families. Available and pertinent scientific information is reviewed.

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0033-2720/05/1200-0371/0 © 2005 Springer Science+Business Media, Inc.

Clinical observations of children and families during the ongoing war in Iraq are presented.

KEY WORDS: military family; military child; military deployment; combat injury; combat death.

MILITARY AND NON-MILITARY CHILDREN

Depending upon the social and political climate of the country, military children and families are often portrayed as stereotyped groups, rather than the complex and heterogeneous populations that they are. As an example, in the 1970's Lagrone (1978) coined the term "military family syndrome." He used this term to describe a set of traits presumably resulting from the noxious influence on children of growing up within autocratic military families and communities (1). Much more likely the result of post-Vietnam anti-military sentiment, this formulation was not based on valid empirical support. More recently, Ryan-Wenger reported findings that compared the children of active duty members, reservists and civilians, and found no difference among the groups in measures of anxiety or other psychopathology (2). An earlier study by Jensen et al. actually reported fewer behavioral and emotional symptoms in the military child population they examined, when compared to civilian counterparts (3). In many ways military children and families appear to be a robust and healthy group. However, this is not to say that they are invulnerable to the stresses that war or trauma may bring.

Current concerns related to military children, as a result of the war in Iraq, focus on three principal areas of wartime stress: deployment of military parents; injury or illness of military parents; or parental deaths. Increasing interest and concern is being raised about the impact of the war on military families and potential pathological sequelae. It would be destructive to assume either widespread pathology or uniform resilience as a result of these wartime experiences. Drawing such conclusions without supporting data would indicate again the intrusion of inappropriate social and political agendas on scientific process. The war in Iraq provides an unprecedented opportunity to study these phenomena.

PARENTAL DEPLOYMENTS

Separation of military members from their families during peacetime has been an increasingly common experience for military families, particularly for active duty families. With the onset of the war in Iraq,

reserve and National Guard families have had increasing experience with deployments, as well.

A number of studies have looked at the impact of parental deployment on military children during both peacetime and wartime. One study examining the impact of father absence on children during non-wartime deployment described increases in anxiety and depression in the study group children when compared to non-deployed controls (4). Pathological responses were more directly related to the effect of maternal psychopathology or other family stressors as mediating variables.

Most wartime deployment studies were conducted during Operation Desert Storm (ODS), a conflict that was relatively short lived and resulted in fewer casualties and deaths in comparison to the current war in Iraq. In at least two of these studies, moderate increases in internalizing and externalizing symptoms were noted in children whose parents were deployed to combat areas (4,5). Of note, Rosen reported that those children who actually demonstrated increases in symptoms rarely required clinical attention and those that did were more likely to have a past history of mental health treatment (4). Kelly further found that families of those deployed to combat areas demonstrated less cohesiveness than the control families of service members who were deployed to non-combat areas (5).

At the outbreak of ODS Jensen took the opportunity to compare data in a population of children that were involved in an ongoing study (7). As initial ratings had been completed prior to ODS deployment, the investigators were able to prospectively evaluate the impact of wartime deployment by comparing follow-up ratings between a wartime deployed group and the children of those who did not deploy. Similar to previous studies the authors measured increased levels of depression and anxiety in the children of the deployed group. These symptoms did not reach pathological levels, however. The authors also highlighted the important finding that boys and younger children appeared to be at higher risk for complication.

Peebles-Kleiger and Kleiger argued that deployment during wartime should be considered a “catastrophic” stressor to children and families, suggesting that wartime deployment would be traumatic in most or all circumstances (8). While these conclusions may be overstated, the recognition that deployment during wartime is different and likely more troubling than routine, non-combat deployments is realistic.

INJURIES AND PSYCHIATRIC ILLNESS OF PARENTS

There are few objective data that help us in our understanding of the impact on children of injury to military parents during wartime. The

authors' experiences during the current war in Iraq suggest that the impact is likely to be considerable in certain cases, although risk factors for vulnerability can only be postulated.

Scientific interest begins with the process of family notification of injury. While there have been improvements in this system of notification (e.g. often the injured service member is the individual who contacts a spouse or other family member), it is not uncommon that initial information pertaining to an injury may be incomplete or inaccurate, leading to greater anxiety. Once notification has been made, intense activity typically follows. Such activity may lead to disruption of the family schedule or structure. Spouses often join the injured service members who are likely receiving treatment at military hospitals distant from the family home. This may require that children either be left under the supervision of other adults (either at home or at the home of other family members or friends) or be uprooted to join parents at the hospital. Either option is likely to be unsettling, resulting in disruptions of schedules and relationships, as well as potential alterations in parental empathy, structure or discipline. Children who travel to hospitals will miss school and may move into treatment environments that are not prepared to meet the needs of younger family members. Of the utmost importance is that children be properly prepared before visiting the hospital to handle whatever clinical situation that they will face when visiting an injured parent. This is crucial when the injury is disfiguring or is of significant severity, such as amputation.

The nature of the information that parents share with children may or may not be developmentally appropriate and may be based more on the anxieties of parents, rather than the needs of the children. Not infrequently parents may choose to share either too much or too little information with children, making it difficult for them to understand the nature or seriousness of the injury and its realistic implications for the injured parent. The following clinical vignette provides an example.

> SGT R is a 27 year old father who sustained multiple fractures from a truck accident that occurred while he was driving in Iraq. He has two sons ages 7 and 8 who live with a former spouse. SGT R says that since the injuries were not sustained in battle he could not share the news of his injury with his sons for fear that he might disappoint them. SGT R stated that his boys continue to view him as a "war hero" so he chose to share no information about this non-combat caused injury.

This example shows how the meaning of an injury may keep a parent from sharing appropriate amounts of information related to the injury with a child. In the experience of the authors, several soldiers or their spouses have made the decision to withhold information related

to serious injuries from their children. This can be due to a variety of reasons, often related to a desire "not to worry them." Sometimes these uninformed children have been as old as 12 or 13 years and have demonstrated a full capacity to rationally understand the injury. In such circumstances clinicians have challenged assumptions that such "secrets" could be adequately kept, emphasizing that older youngsters usually have some awareness that something significant has happened. Clinicians highlighted that lack of appropriate information could lead to unnecessary worry or catastrophizing on the part of children. Clinicians must also work with parents to help them understand how the withholding of information may likely negatively impact on the relationship between parents and children in the future. These children may wonder "what else are they not telling me about," resulting in greater long term anxiety.

As some parents may provide too little information about the injury, others feel the need to share more than is necessary or force children to see an injury in a particular kind of way. In rare situations, a parent may actually demand that a child look at the injury site to fully appreciate the nature of injury sustained. When the injury is one of considerable trauma, is physically disfiguring, or results in amputation graphic exposure can lead to pointless and problematic anxiety. The clinical case below provides an example of a parent who forced his young son to integrate the injury in a way that was more reflective of his own needs than his son's.

> SPC S is a 23 year old father whose injury resulted in a below knee amputation. The service member was concerned that his 3 year old son Jim would be scared of his injury site and was relieved when, after a visit, Jim showed no concern regarding the stump. When Jim visited he was a curious boy who engaged his father actively and physically. At one point during the observation SPC S asked his son "where is Daddy's foot?" Jim pointed to his father's stump and SPC S replied "no, no, that's not it." When asked again where his father's foot was Jim, this time, went over and touched his father's stump. At this point SPC S became somewhat irritated and scolded "that is Daddy's foot" as he pointed to his prosthesis. When asked a third time where his father's foot was Jim hesitantly pointed to the stump again and walked away from his father.

In this example, the service member father's own sense of grief and loss related to his recent amputation likely played out within the context of the relationship with his son. While Jim appeared to be responding well to his father's injury, using the strength of the relationship with his father, the service member's own need to view his injury in a particular way were forced on the child. While this particular incident may not be representative of a typical interaction between this father and child,

it encapsulates how an injury can interfere with the normal availability a parent may have for a child as the child develops. In the clinical example that follows, an injured service member mother poignantly describes her anxiety about the impact of the injury on her ability to effectively parent her child.

> SGT T, the 32 year old mother of a 6 year old girl, sustained multiple serious injuries to include loss of right arm functioning. While she described that she was doing well, she was concerned about how her husband and daughter would respond to her when they visited, worrying that they might perceive her as ugly, mutilated or incapable of functioning. During the visit, SGT T reported that her daughter was gentle, loving and helpful. The fact, however, that she required her daughter's aid in some activities that she would have previously done on her own left her feeling sad and withdrawn. This was true despite the fact that her 6 year old appeared to enjoy the closeness and her ability to help her mother.

Physical injuries are not the only medical problems with which returning soldiers contend. Data indicate that many returning service members may suffer from unrecognized psychiatric illness, including post traumatic stress disorder (PTSD), depression, substance use disorders or other conditions (9). The impact of these conditions on families and children is unclear, but is likely to be significant. The multigenerational transmission of traumatic sequelae resulting from a variety of different exposures has been recognized and reported (10). Rosenheck and colleagues have described the negative impact of PTSD in Vietnam veterans on their children (11,12). Others have described the significant impact of PTSD (reduced family cohesion, decreased interpersonal expressiveness, greater interpersonal conflict, and reduced problem solving ability) in the families of Vietnam veterans with PTSD (13–15). Clinicians must strive to identify and treat these disorders that otherwise are likely to negatively impact on the children and families of returning Iraq War veterans.

DEATH OF SERVICE MEMBER PARENTS

As of January 2005, over 1400 service members have been killed in Operation Iraqi Freedom, resulting in over 900 children losing their parents. The impact of parental death on military children has also not been broadly examined. Studies that have more generally looked at the impact of any parental death on children identify that these youngsters are at higher risk for developing psychiatric disorders or other behavioral or emotional problems (16). No data report the specific impact on

children of war related parental deaths. It would not be unreasonable to conclude that given the likely intentional and aggressive nature of these deaths the psychological consequences would probably be more complicated and possible more problematic.

It is the impression of the authors that the media (particularly television) serves as military children's most significant source of stress related to potential parental death. Interviews with children suggest that they have a disproportion fear of the risk for possible death to their parent, given the reality that fewer than one percent of deployed service members has been killed. Children who live on military installations are exposed to more immediate knowledge of the death of a soldier due to informal communications, community activities, military news or memorial services. Knowledge of the death of a service member is typically followed by a pervasive sense of fear, until confirmation is received that the service member is not a particular child's parent. It is the experience of the authors that in situations where a parent has actually been killed, children are much more likely to experience pathological emotional responses if the surviving parent is so emotionally distraught that he or she is unavailable to care for the children. Supportive military communities may provide a helpful holding environment for stricken families that sustain family functioning and emotional health.

Similar to parental injury, the aftermath of parental death is likely to lead to even greater family disruption. As military families are typically assigned at a distance from their extended families, many may choose to relocate back to their homes of origin, leaving a supportive military community behind. The benefit or detriment of such relocation is unclear and may be case-dependent. Families typically lose access to government housing and, if they move to a site that is not close to a military installation, may lose access to military commissary, Post Exchange and health care facilities.

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