



POLICY BRIEF FALL 2013

Keeping the Promise: Maintaining the Health of Military and Veteran Families and Children

Colonel Stephen J. Cozza (U.S. Army, Retired), Ron Haskins, and Richard M. Lerner*

Deployment and its possible consequences, including a service member's injury, psychological trauma, or death, put considerable strain on military children and families. Most of them are resilient in the face of this adversity. Still, the psychological distress they experience can reverberate through the family, impairing the healthy functioning of parents and children alike. As a nation, we owe these families a system of care that emphasizes not just treatment but also prevention, helping them draw on their own resources for resilience, as well as those of their communities. We propose a shared national agenda to expand and rigorously test a system of treatment and preventive services for military children and families.

Colonel Stephen J. Cozza (U.S. Army, Retired) is a professor of psychiatry and associate director of the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences; Ron Haskins is a senior editor of the *Future of Children*, a senior fellow in economic studies and co-director of the Center on Children and Families at the Brookings Institution, and a senior consultant at the Annie E. Casey Foundation; Richard M. Lerner is the Bergstrom Chair in Applied Developmental Science and the director of the Institute for Applied Research in Youth Development at Tufts University.

To read the full report on military children and families, edited by Stephen J. Cozza and Richard M. Lerner, go to www.futureofchildren.org.

More than two million Americans have served in the post-9/11 wars in Iraq and Afghanistan, and nearly 45 percent of them have children. Although polls show that around 90 percent of Americans recognize and appreciate the sacrifice of service members who serve the nation, the public knows little about the actual costs imposed on the health and functioning of families, including children, of service members and veterans. Research on the effects of deployment on families is still in its infancy, but it already shows that deployment leads to distress and mental health problems among parents and that these parental problems are in turn associated with elevated rates of similar social-emotional problems in children. Though military families show remarkable resilience, given the stress most of them face, we argue that the sacrifices they make place a special obligation on the nation to help these distressed families and children. After all,

since 9/11, nearly 6,700 service members have died and 50,000 have been physically injured in a combat zone. Hundreds of thousands more suffer from traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD). After reviewing the evidence on both the elevated levels of emotional and behavioral problems experienced by deployed service members and their families, as well as evidence on their resilience, we discuss a shared national agenda to expand and evaluate the effectiveness of preventive and treatment services for these families.

Deployment and Its Effects

Even routine military life means that families must deal with conditions that, research shows, can cause problems. Members of military families are often separated from one another; children are forced to change schools frequently; and some families, particularly those of lower rank, may face financial problems. Members of the military usually have little choice about where they are stationed, which means that spouses and children cannot decide where to live and when to move. Deployment to a combat zone adds a layer of danger to this already formidable list. The stress that family members feel when their loved one (or loved ones, in the case of families with two military parents) is in harm's way can disrupt family routines, lead to conflict between parents, and cause worry and elevated distress.

Several investigators have surveyed military families and found that combat deployment is associated with higher levels of emotional and behavioral problems in children. Anita Chandra of the RAND Corporation and her colleagues used a computer-assisted telephone interview with more than 1,500 military children aged 11 to 17 and their caretakers. Controlling for family and service member characteristics, they found that older boys and girls of all ages with a deployed parent had significantly more problems with school, family, and peers than do children the same age in the general U.S. population. Longer deployments were associated with more problems. Patricia Lester and her team at UCLA reported similar results among 272 children aged 6 to 12. Importantly, both studies found a strong relationship between the mental health of parents or caretakers and the healthy adaptation of their children to deployment stress.

Alyssa Mansfield of the University of North Carolina and her colleagues also examined how combat deployment affects children's mental health, using outpatient treatment records from 2003 to 2006 of nearly 310,000 children aged 5 to 17 with at least one parent in the Army. They compared the pediatric mental health outpatient visits of children whose parents were deployed longer than 11 months, 1 to 11 months, and not deployed at all. After controlling for children's age, gender, and mental health history, they found that both boys and girls whose parents were deployed received higher-than-normal levels of mental health diagnoses (including acute stress reaction/adjustment, depression, and behavioral disorders). Children of parents deployed more than 11 months had especially high levels of these problems. These results should be interpreted with some caution, because they are based on the procedural diagnostic codes that clinicians must enter in health care records for insurance and other purposes. Although greater use of mental health services likely indicates higher levels of distress in these military children, it should not be equated with mental illness in most of these cases.

Deployment leads to stress that affects both parents and children.

Research also identifies an increased risk of child maltreatment among children with a deployed parent. Over the years, rates of child maltreatment in military families have been no greater, and perhaps lower, than among civilian families, and maltreatment rates in military families had been falling continuously until combat operations began in 2001. But at least three studies have now shown that parents are more likely to maltreat children during periods of deployment. A study by Deborah Gibbs of RTI International and her colleagues found that, based on confidential military records from 2001 to 2004, civilian wives of service members were four times as likely to neglect children during their

husband's deployment than when he was home, and nearly twice as likely to physically abuse them. Also looking at 2001 to 2004, James McCarroll and his colleagues at the Uniformed Services University of the Health Sciences found rising rates of child maltreatment in military families, following a decline in the 1990s; most of the increase was in neglect rather than physical abuse. Deployment may contribute to an elevated propensity for child neglect in a number of ways, for example, by temporarily creating the equivalent of a single-parent family, a known risk factor for child neglect.

We can draw two conclusions from these and similar studies on the effects of deployment on families. First, deployment leads to stress that affects both parents and children. Parental absence and parental distress are likely associated with diminished parenting capacity, greater risk for child maltreatment (particularly neglect), and greater parental dysfunction, and these in turn are associated with social-emotional and behavioral problems in children. Second, severity of exposure can make these child and family problems worse. For example, greater cumulative deployment time; a parent suffering from PTSD, as well as TBI or another injury; or a family member's death all increase the risk that a family will encounter trouble. These research findings justify concern and must lead to action by the public, by policy makers, and by senior military and other government officials.

Whatever action we take, however, we should remember that both experience and research show that combat deployment leads to a large range of reactions among military families and children. These reactions fall along a continuum from risk to resilience. Many parents and children handle the stress of deployment well, taking problems in stride and continuing to function normally. At the other end of the continuum, some parents and children struggle significantly with the challenges they face, resulting in dysfunction and risk. Most families are likely to be somewhere in the broad middle, distressed by the hardships but capable of adopting strategies that sustain their health and wellness. This range of responses suggests that we need a broad intervention strategy that supports health, screens for risk, and actively engages those who have the most trouble. To be sure, some children will need

behavioral health treatment, although most can be helped with modest and relatively inexpensive interventions. But what is resilience, and do military families possess more of it than do civilian families?

Resilience in Military Families

The Fall 2013 issue of the *Future of Children* (FOC) focuses on military families, and it contains ample evidence of resilience among military families and children. Two articles—one by Ann Easterbrooks, Kenneth Ginsburg, and Richard Lerner, and the other by Ann Masten—find that most military-connected children and parents have the attributes to be resilient in the face of parental deployment and reunification. One source of resilience is self-regulation, or a person's ability to intentionally alter her behavior, thoughts, attention, and emotions to react to and influence the environment; it is a key strength that helps people adapt and thrive in the face of adversity. A child's self-regulation is enhanced when other family members also possess self-regulation skills. For example, research shows that, when children must adapt to change, their resilience is related to their mother's adjustment and mental health. Therefore, just as in civilian families, positive relationships with close family members can help military children adapt to stress.

Other factors that protect military children and parents from stress include the perception that society appreciates the value of military service, pride in contributing to an important mission, a sense of belonging to a military culture, and awareness that networks of support don't go away when active service ends. In addition to providing a haven of safety and stability in difficult times, family relationships can help military-connected youngsters make meaning of adversity, affirm their strengths, feel connected through mutual support and collaboration, provide models and mentors, offer financial security, and frame the stressful circumstances in the context of family values and spirituality. The culture of the modern military gives families the capacity to help children see their experiences as a badge of honor rather than a burden.

What to Do

Military communities are diverse and rich with cultural heritage and resources that help sustain families and children. As a result, military communities,

service members, their families, and, more specifically, their children, possess a capacity for resilience that equals or exceeds that of their civilian counterparts. But when they face deployments or other consequences of war, service members and their families are at risk for higher levels of distress, emotional and behavioral problems, child maltreatment, as well as possible deterioration in parental and family functioning, particularly when parents come home with serious disorders such as PTSD or TBI.

Combat veterans have a significant risk of developing mental disorders as a result of their wartime exposure. However, we must avoid a tendency to employ an “illness” model to understand how military spouses and children respond to wartime deployments. Though some people may develop mental disorders, they are likely to be a minority. Most other affected adults and children will experience distress. Distress is not an illness, but it can still significantly affect individuals, families, and communities. In addition to the anguish it can cause, distress can undermine occupational, social, and emotional functioning. Distressed parents are less likely to be attentive to their children and may lose some of the parenting capacity that they previously possessed. Distressed children may become withdrawn, participate in fewer extracurricular activities, find it difficult to concentrate in school, or demonstrate behavioral symptoms that are unusual or that complicate their normal development.

Interventions for mental illness differ from interventions for distress. The most successful models for helping environmentally stressed, at-risk populations emphasize prevention, particularly when these groups have previously enjoyed health and wellness. In 1994, the Institute of Medicine (IOM) outlined a model of activities that promote and sustain health. It places prevention strategies along a spectrum of intensity: universal (helpful to all), selective (useful to those at higher risk), and indicated (targeted to those who exhibit symptoms of a disorder). Beyond prevention, the IOM intervention spectrum includes more intensive activities such as case (or illness) identification, traditional treatment, and health maintenance activities. Such a model is an excellent foundation for a national plan to support and sustain military children and families.

Two FOC articles—Harold Kudler and Colonel Rebecca Porter’s on communities of care and Easterbrooks, Ginsburg, and Lerner’s on resilience—define a spectrum of services that focus on effective prevention and treatment. Universal prevention in military communities is best achieved by programs that ensure social support and make resources readily available. Such programs should also help adults, children, and families develop resilience-enhancing skills—communicating, connecting with others, being flexible, taking on new and appropriate challenges, solving problems, resolving conflicts, and building a core sense of individual and family capacity and wellness. Such skills can prepare individuals, families, and communities and sustain them through challenging times. Universal prevention programs should be available in the many settings where service members, veterans, and their children and families are likely to be found—schools, child-care programs, youth services, faith-based organizations, and health care systems, all of which have the capacity to promote health and wellness. Many such prevention programs are available in military communities, but they are less likely to be found in the civilian communities where National Guard and Reserve families often live, or where veteran families move after their service ends.

In addition to universal prevention, we need programs that target the populations who face the greatest risk, for example, those who experience multiple deployments, PTSD, TBI, or a parent’s death. In their FOC article, Allison Holmes, Paula Rauch, and Stephen Cozza note that military and veteran families who face long-term disability are more likely to experience disruptions in individual and family functioning. Several new preventive interventions are helping families where deployment, illness, or injury have overwhelmed family resources, disrupted family schedules and routines, or undermined previously normative parenting practices. Though deployment distress may decrease as the wars wind down, military parents’ combat-related illnesses and injuries will continue to affect their families and children. Programs designed to help those who are at the most risk or are showing symptoms of distress or dysfunction are at varying stages of development, and they require further refinement and scientific study to better understand which ones are likely to be most effective, and in which circumstances.

One family-focused prevention program shows considerable promise, and it illustrates the kind of programs that should be available to all military and veteran families who need them. FOCUS (Families Overcoming Under Stress) was developed by a UCLA-Harvard team, which based its design on previous research and evaluations of programs developed to help children and families contending with parental depression, a parent's infection with HIV, and military deployment. Based on the previous research and evaluations, the UCLA-Harvard team worked with the Navy and Marine Corps to modify the program's family prevention strategies for use with military families. FOCUS includes these central elements: family education, structured communication through discussing deployment on a personal level, and development of family-level resiliency skills. This multi-session program (typically six sessions, but sometimes more) involves separate meetings with parents and children, followed by sessions with all family members, who participate in structured activities led by skilled family resilience trainers.

Military communities, service members, their families, and, more specifically, their children, possess a capacity for resilience that equals or exceeds that of their civilian counterparts.

FOCUS has been evaluated by checking participants both before and after they took part in the program (this kind of evaluation is called a pretest-posttest design). Data were collected over 20 months from nearly 500 participating families serving at 11 military installations. Before the program began, participating parents scored higher than community norms on measures of posttraumatic stress, depression, and anxiety, and children scored higher for emotional and behavioral problems. After 20 months, parents and children alike who participated in FOCUS showed

significant improvement in all these areas. They also showed improvement on measures of family functioning, such as communication, role clarity, and problem solving, all of which were targeted by the FOCUS program. These results suggest that the processes underlying family resilience can be bolstered by family-centered preventive intervention.

Pretest-posttest designs are less than rigorous, however, and evaluations that use such a design cannot be fully trusted. But some of the testing that FOCUS's creators carried out as they designed the program met the highest standard of evaluation design, and the program should continue, although it should undergo more rigorous and better controlled evaluation. Moreover, refining FOCUS specifically for families who are contending with TBI and PTSD would expand its usefulness to those who are likely to experience the highest and longest-term risk. We recommend that federal funding pay to expand, adapt, and refine the program. We also call for funding to rigorously evaluate FOCUS and similar programs, following participants for at least 10 years, to determine whether they make a long-term difference in the lives of adults and children who experience the stress associated with combat deployment and its consequences. Such a plan would require collaboration among the Department of Defense (DoD), the Department of Veterans Affairs, other federal agencies, and universities and other academic or research institutions.

We must also ensure that service members and veterans, as well as their spouses and children, can easily access evidence-based mental health treatments in the communities where they live when formal treatment is required. Since many of the disorders for which veterans are treated are chronic (for example, PTSD, substance use, depression, and TBI), treatment and health maintenance programs that support veterans' functioning and minimize relapses or complications are critical to the health and wellbeing of military and veteran families and their children. Researchers universally recognize that children's health is related to the health and wellbeing of their parents. Traditional individual treatments of service members and veterans must incorporate family-focused approaches that address the profound impact that diagnoses such as PTSD and TBI can have on families and children. Preliminary evidence suggests that such programs are helpful and well-received.

A national plan to meet the needs of military and veteran children and families will not come cheaply. As the nation debates the size of the national budget and the wars in Iraq and Afghanistan wind down, attention may shift from the needs of military children and families. This is not just an issue for the DoD. Though the DoD has developed many programs to help military children and families, civilian communities—where Guard and Reserve families live and where active-duty families will move when their service ends—remain less well equipped. An effective national plan would require us to expand and integrate systems and resources that exist outside the DoD. Families need access not only to DoD resources, but also to programs provided through other federal agencies (for example, Veterans Affairs and the Substance Abuse and Mental Health Services Administration), other health care systems (for example, TRICARE), and public mental health systems, as well as private providers and community-based

programs (for example, public schools, community colleges, child-care programs, and faith-based organizations). Optimally, such a system of care would include programs that coordinate their efforts with one another, that know and respect military culture, and that include the levels of service outlined in the Institute of Medicine spectrum of preventive and treatment interventions.

It is difficult to put a price tag on our recommendations for developing and testing effective prevention and treatment programs, but it will likely be in the tens of millions of dollars. Given the dramatic sacrifices that military families have made to defend the nation, policy makers and taxpayers should honor our promise to these families with the funds necessary to restore and sustain them. To do less would disrespect their service and discredit the nation's commitment to those who serve in harm's way.

**Stephen J. Cozza's views expressed herein do not necessarily reflect those of the Uniformed Services University of the Health Sciences or the Department of Defense.*

Additional Reading

Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics* 125, no. 1 (2010): 16–25.

Stephen J. Cozza and Richard M. Lerner, eds., "Military Children and Families," special issue, *The Future of Children* 23, no. 2 (2013).

Carol S. Fullerton et al., "Child Neglect in Army Families: A Public Health Perspective," *Military Medicine* 176, no. 12 (2011): 1432–39.

Institute of Medicine, *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families* (Washington: National Academies Press, 2013).

Patricia Lester et al., "Evaluation of a Family-Centered Prevention Intervention for Military Children and Families," *American Journal of Public Health* 102 (2012): S48–54.

Patricia Lester et al., "The Long War and Parental Combat Deployment: Effects on Military Children and Spouses," *Journal of the American Academy of Child and Adolescent Psychiatry* 49 (2010): 310–20.

Ann Masten, "Ordinary Magic: Resilience Processes in Development," *American Psychologist* 56 (2001): 227–38.

James E. McCarroll et al., "Trends in US Army Child Maltreatment Reports: 1990–2004," *Child Abuse Review* 17 (2008): 108–18.

Patricia Beezley Mrazek and Robert J. Haggerty, *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research* (Washington, DC: Institute of Medicine, 1994).

Sean C. Sheppard, Jennifer Weil Malatras, and Allen C. Israel., "The Impact of Deployment on U.S. Military Families," *American Psychologist* 65 (6), 599–609.

Senior Editorial Staff

Editor-in-Chief

Sara McLanahan

Princeton University
Director, Center for Research on Child Wellbeing, and
William S. Tod Professor of Sociology and Public Affairs

Senior Editors

Janet M. Currie

Princeton University
Director, Center for Health and Wellbeing, and Henry
Putnam Professor of Economics and Public Affairs

Ron Haskins

Brookings Institution
Senior Fellow and Co-Director, Center on Children
and Families

Cecilia Elena Rouse

Princeton University
Dean, Woodrow Wilson School of Public and International
Affairs, Katzman-Ernst Professor in the Economics of
Education, and Professor of Economics and Public Affairs

Isabel Sawhill

Brookings Institution
Senior Fellow, Cabot Family Chair, and Co-Director,
Center on Children and Families

Journal Staff

Associate Editor

Kris McDonald

Princeton University

Managing Editor

Jon Wallace

Princeton University

Outreach Director

Lisa Markman-Pithers

Princeton University
Acting Director, Education
Research Section

Outreach Coordinator

Stephanie Cencula

Brookings Institution

Communications Coordinator

Regina Leidy

Princeton University

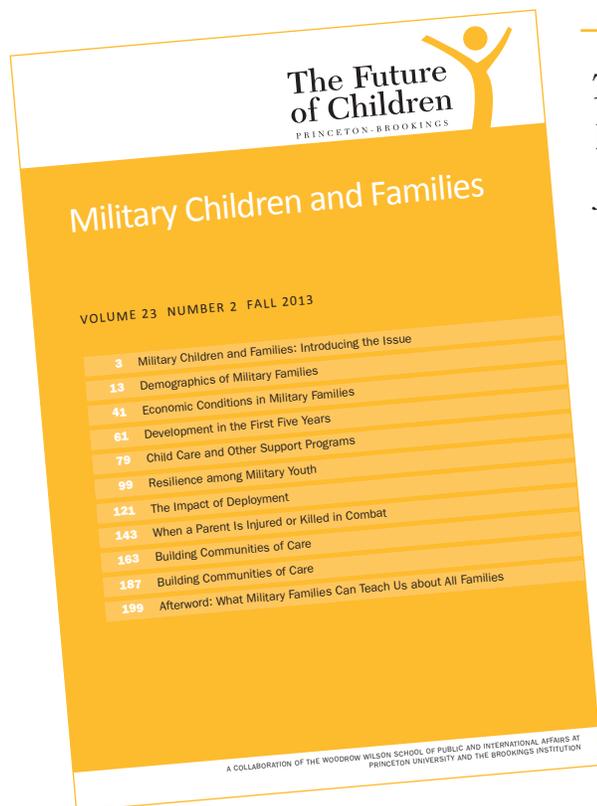
Administrator

Tracy Merone

Princeton University

The Future of Children
Princeton University
267 Wallace Hall
Princeton, NJ 08544

CHANGE SERVICE REQUESTED



This policy brief is a companion piece to Military Children and Families, which can be found at no charge on our website, www.futureofchildren.org. Print copies of Military Children and Families can also be purchased on our website. While visiting the site, please sign up for our e-newsletter to be notified about our next issue, Helping Parents, Helping Children: Two-Generation Programs, as well as other projects.

The Future of Children would like to thank the David and Lucile Packard Foundation, the William T. Grant Foundation, the Foundation for Child Development, and the Achelis and Bodman Foundations for their generous support for this policy brief. *The Future of Children* is a collaboration of the Woodrow Wilson School of Public and International Affairs at Princeton University and the Brookings Institution.

The Future of Children © 2013 by The Trustees of Princeton University, all rights reserved.