NCC Pediatrics Continuity Clinic Curriculum: **Military Family Issues** ***Faculty Guide***

Goals & Objectives:

To identify and address issues related to military life that may impact child and family health.

- Perform a military social history and identify challenges specific to military families.
- Explain the emotional cycles of deployment and provide anticipatory guidance.
- Identify available resources, including LWP, and understand how to refer families.

Pre-Meeting Preparation:

Please read/review the following enclosures:

- "Military Family Support" *(Pediatric Annals, 2003)*
- "Parental Deployment and the Use of Mental Health Services" *(Peds, 2010)*
- "Military Child" *(Online Article, 2012)*
- "Resident Guide to the Littlest Warrior Program"
- **Homework:** Scan "Military Family Resources" web-links *(last page)*. Pick one to review in-depth and present to your group at continuity conference.

Conference Agenda:

- *Review* Military Family Issues Quiz
- Complete Military Family Issues Cases
- **Round table:** Present the "Military Family Website" you reviewed to your group. What resources are available at this site? Would you recommend it to your families?

Extra-Credit:

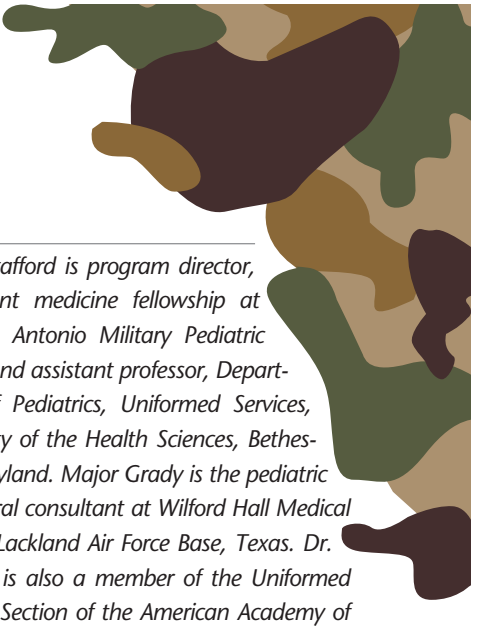
- **Littlest Warrior Resources**: Sharedrive in "Residents" Folder→ Access Database with resident assignments; LWP brochure; LWP Information & Enrollment Forms.
- "Wartime military deployment and increased pediatric mental and behavioral health complaints" *(Gorman, Pediatrics 2010).*
- "Military Children, Families, and Communities: Supporting Those Who Serve" *(2012)*
- Military Deployment Guide *(Military OneSource, 2012)*

Military

Today's military is faced with an increasing number of mission requirements including combat, peacekeeping activities, humanitarian relief, and disaster response, as well as the new requirements for homeland defense. This presents significant challenges for military families as they adjust to repeated and often lengthy periods of family separation. The 9/11 attacks on the Pentagon and the World Trade Center have also brought about heightened concerns for personal security at home and abroad for military families. This article provides an overview of the challenges that military families face, especially with service member deployment.

Deployment can be defined as the assignment of military personnel to temporary, unaccompanied duty away from the permanent duty station. There are predictable emotional

Elisabeth M. Stafford, MD, Colonel, Medical Corps, US Army; and
Beth A. Grady, LCSW, BCD, Major, Bio-Sciences Corps, US Air Force



Dr. Stafford is program director, adolescent medicine fellowship at the San Antonio Military Pediatric Center and assistant professor, Department of Pediatrics, Uniformed Services, University of the Health Sciences, Bethesda, Maryland. Major Grady is the pediatric behavioral consultant at Wilford Hall Medical Center, Lackland Air Force Base, Texas. Dr. Stafford is also a member of the Uniformed Services Section of the American Academy of Pediatrics. Address reprint requests to Elisabeth M. Stafford, MD, Col, MC, Brooke Army Medical Center, Department of Pediatrics, ATTN COL Stafford, 3851 Roger Brooke Drive, Fort Sam Houston, TX 78234-6200.

The opinions and views expressed herein are those of the authors and do not reflect the official policy or position of the departments of the Army, Air Force, or Navy; the Department of Defense; or the United States Government.

The authors have no industry relationships to disclose.

Family Support

responses that family members may experience with the expected or unexpected deployment of a military parent. For children, these responses vary with age and developmental stage. The knowledgeable clinician is in a position to provide anticipatory guidance regarding coping with the stresses of military deployments, to screen for maladaptive coping, and to make referrals to military family support services in place within all the uniformed services, as well as to local community services as needed.

Both military and civilian clinicians provide health care to children of military families, whether active-duty or National Guard and reserves. There are more than 1.2 million active duty service members serving in our armed forces at this time, with approximately 700 000 spouses and 1.2 million children of active duty members. Of these children, 39% are newborn and preschool age, 34% are ages 6 to 11 years, 24% are 12 to 18 years, and 4% are 19 years or older. The top 10 states where active duty members are stationed are California, Virginia, Texas, North Carolina, Georgia, Florida, Washington, South Carolina, Hawaii, and Kentucky. Military families move 2 to 3 times more frequently than their civilian counterparts. In addition, there are 1.3 million reserve component members and their families. The top 10 states where reservists are located are California, Texas, Pennsylvania, New York, Florida, Ohio, Illinois, Georgia, Alabama, and Virginia.[1] Most children in military families will have attended several different schools before they graduate from high school, often in different states and different countries as well.

Those who care for military children must be prepared to support our military families in times of crisis and routine deployments. This requires clinicians to be educated and knowledgeable about the challenges facing military families. Intermittent single parenting characterizes life in the military family, with repeated and often lengthy deployments of the service member. The nature of the deployment may put the service member in danger. Waiting family members, both spouse and children, must cope with worries about the safety of the service member. Media coverage that is real-time and often quite graphic reinforces and may intensify concerns for safety of the absent parent. With frequent moves, often every 2 to 3 years, the traditional community support systems of extended family, close-knit neighborhoods, and long-term relationships with a school or religious community may not be available fully to the family as it copes with service member deployment. An understanding of these struggles provides an impetus to use clinical encounters with military families to determine if there are deployment issues to address.

There are predictable patterns of emotional response that a service member, spouse, and children may exhibit with deployment, which can be characterized as the emotional cycle of deployment. The original construct for the emotional cycle of deployment is traced to Kathleen V. Logan's thesis, "Deployment Adjustment Model for Navy Wives."[2] This model was expanded upon by Pincus et al.[3] This cycle is divided into five distinct stages closely

EDUCATIONAL OBJECTIVES

1. Discuss the challenges faced by military families, especially with deployment-related separations.
2. Explain the "emotional cycle of deployment" with an emphasis on the responses of children to separation from the military parent during deployment.
3. Delineate support resources for military families.

Military Family Support Roles for the Pediatric Health Care Professional

- Providing anticipatory guidance about deployment/family separation issues during health maintenance visits;
- Making available in the pediatric clinic setting parent/patient educational materials that are relevant to military family life;
- Being knowledgeable of military installation's unit activities-increased operational tempo, and impending lengthy deployment, and proactively screening for and anticipating distress in the family;
- Counseling on strategies to assist parents to support the needs of their children in times of deployment, crisis, or disaster and to seek appropriate care and support for themselves;
- Assessing for mental health service needs and mobilizing timely support;
- Encouraging families to take advantage of programs such as unit's family support group, Army community services, and chaplain's family life programs as a preventive, health-promoting measure for the family;
- Educating medical colleagues, commanders, school administrators and teachers, and child/youth service providers as a subject matter expert on the support needs of military children.

corresponding to the service member's experience of deployment: predeployment, deployment, sustainment, redeployment, and postdeployment.[3] The onset of the predeployment phase begins with the warning order or notification of impending deployment. This period is variable and may encompass days to months in advance. The deployment phase covers the period from the service member's departure from the family through the first month. The sustainment phase covers the subsequent months until the beginning of the last month of deployment. The redeployment phase covers the month prior to return of the service member, and postdeployment phase covers approximately a 3 to 6 month period of readjustment on return.

Deployment factors that can lead to increased stress include sudden deployment, longer deployment, combat environment, and perceived nonlegitimacy of a deployment by the family. Family factors that may negatively impact on coping with deployment include history of poor adaptability, family conflict and dysfunction, and poor communication. High risk factors for spouses include young age, first time away from home, foreign born, and tenuous financial status.[4]

The emotions that children either internalize or exhibit are based on many factors. The age, personality, special needs, and external environment impacts how a child reacts to deployment-related family separations. Toddlers may exhibit extremes of behaviors such as temper tantrums, sullenness, or difficulty with sleep patterns. However, it is often how the primary caregiver reacts and exhibits coping to the deployment that is the critical indicator of the reactions of the toddler. Preschoolers may regress to earlier mastered behaviors and may be clingy, afraid to sleep alone, or afraid of being left alone. School-aged children may complain excessively, become aggressive, or place significance on missed events (eg, birthdays). Teenagers may exhibit irritability, attention-seeking behaviors, or other types of negative behaviors. As with all of these age groups, the key factor is not to recognize each and every possible reaction to a prolonged separation but to identify that most likely the child will be impacted to some degree and offer guidance and support.

In the predeployment phase (the variable period prior to deployment), children may feel anticipation of the loss of a parent and show fear, resentment, and hurt. Detachment and withdrawal can be coping mechanisms to shield the child from feelings of separation. Extreme emotions related to a sense of abandonment may surface. Children may feel that the deployed parent is going away because of their perceived misbehavior.

In the first month of the deployment, feelings of loss, disorganization, and anxiety may occur. Younger children may worry about their basic needs not being met, such as food and shelter. Older children may worry about the safety and well being of the deployed parent, and some adolescents begin to take on the role of the absent parent. During the period of sustainment, the family strives and works toward a state of equilibrium among the remaining family members. The acclimation to the service member's absence and the family process of onward movement may yield a new sense of adjustment and stabilization. In the month prior to the return of the service member, there is anticipation of return; however, a range of emotions from excitement to apprehension is common. Following the return of the service member, all family members begin the process of renegotiation of relationships and family roles.[3]

Clearly, clinicians who are aware of deployment-related separation issues when caring for a child in a military fam-

ily can play an important supportive role (see Principles in Providing Support to Children in Times of Deployment, page 114). They can inquire about children's reactions and coping mechanisms during the deployment of the military parent. If difficulties are identified, brief behavioral health interventions that focus on adjustment to separation can help the family system acclimate to the absence of the military member. For example, an Air Force pediatric clinic may be staffed with a behavioral health consultant who provides consultation on behavioral health issues, including coping with deployment. The Air Force Medical Operations Agency has recognized the need to address behavioral health issues, including coping with deployment, in primary care clinics. Because deployment-related reactions should not be viewed initially as psychiatric or pathologic mental health issues, the primary care clinic is a perfect area to provide short-term assessments, recommendations, and brief interventions for the child and family. Most often, children and adolescents are displaying anticipated, predictable behaviors associated with separation from the military parent, and helpful guidance regarding strategies to meet the child's needs can be provided for the parent or caretaker. Very often one or two 30-minute interventions to educate and provide recommendations that help to restore the family to the predeployment level of functioning is all that is necessary. If mental health or more significant adjustment issues are identified, appropriate recommendations are made to the pediatrician and family by the behavioral health consultant.

Children with underlying mental health problems or other special needs may have greater difficulties adjusting to the absence of a parent. In a study focused on the impact of mothers' military deployment during Operation Desert Shield/Desert Storm, "Children whose mothers were deployed did not, as a group, demonstrate more symptoms or stress than children whose mothers were not deployed." However, during the deployment it was found that children experienced more distress when mothers had difficulties arranging for their care, older children exhibited more symptoms of stress, stress was greater the longer the mother was away, and children of reserve and guard members demonstrated greater stress, especially with mother in the combat zone.[5] In a study of the impact of maternal deployment on Navy children, those whose mothers were deployed were no more likely to experience pathology than children of nondeployed mothers.[6] An analysis of psychiatric hospitalizations of Navy children concluded that, in vulnerable families, deployment of the father could precipitate children's decompensation.[7] Such studies can inform us regarding subsets of children and their families who may need additional support during deployment.

Clinicians can provide anticipatory guidance to parents and designated caretakers, outlining healthy coping strategies for the parent to care for themselves and their children better during deployments. It is helpful for the military providers to be aware of unit missions on the installation and of impending unit deployments to provide timely and targeted family support. The civilian pediatric professional providing care to military families may keep abreast of military installation activities and impending deployments through military installation and other community newspapers. If a child has a parent in the military, inquiry can be made about deployments during clinical encounters with brief assessment of how the family is coping while the service member is deployed.

Pediatricians have a mandate in the family support arena, as outlined in a recent position paper from the American

Developmental Stages and Children's Expression of Distress

PRESCHOOL OR KINDERGARTEN

- Clinging to people or favorite toy or blanket
- Unexplained crying or tearfulness
- Choosing adults over same-age playmates
- Increased acts of violence toward people or things
- Shrinking away from people or becoming very quiet
- Sleep difficulties or disturbances (waking, bad dreams)
- Eating difficulties or changes in eating patterns
- Fear of new people or situations
- Keeping primary care giver in view

SCHOOL-AGED CHILDREN

- Rise in somatic complaints
- More irritable, labile
- Problems at school (grades, attendance refusal, fighting)
- Anger toward at-home parent, siblings

ADOLESCENTS

- Acting out behaviors (trouble at school, home, law)
- Low self-esteem and self-criticism
- Misdirected anger (over small things, at parent/sibling)
- Sudden or unusual school problems
- Loss of interest in usual hobbies, activities

Principles in Providing Support to Children in Times of Deployment, Disruption

- Maintain as much a sense of normalcy as possible, including routine discipline;
- Reassurances of safety;
- Increased physical contact with the child;
- Answer questions as honestly as possible at child's level of comprehension;
- Project a sense of calm and control as the adult role model;
- Expect children to regress behaviorally;
- Take care of oneself as the parent/ adult caregiver (diet, rest, exercise);
- Expect expressions of separation anxiety whether toddler or teenager;
- Anticipate possibility of increased somatic complaints;
- Keep child engaged in routine activities and connected to social support systems;
- Encourage child to do something to help others;
- Facilitate communication with loved ones far away;
- Take seriously behaviors that persist and incapacitate function;
- Take all mention of suicidal thoughts/intent seriously and seek attention;
- Anticipate child with special needs/mental health/chronic illness to be more fragile;
- Do not neglect the support needs of adolescents.

Academy of Pediatrics. Thus they should be familiar with military community resources that are available routinely to support the needs of military families.[8] In the 1960s, the Army was in the vanguard of the military family support movement with the creation of the Army Community Service organization, with the Air Force and Navy following suit.[9] At the Department of Defense level, the Office of Family Policy was established and over time has crafted directives on family policy providing guidance to all branches of the service on responsibilities, standards, and procedures for implementing effective family support programs and policies worldwide.

Each branch of service has programs designed to maximize families' ability to cope with the unique aspects of military family life, including deployments. Military installations have Family Support Centers (Air Force), Family Service Centers (Navy and Marine), or Army Community Service Centers where a family can find a wide array of services. These include financial counsel and assistance, employment information for military spouses, emergency assistance, and guidance regarding other installation support services (eg, child development and family care centers, youth centers). Educational programs to introduce spouses to military culture and strategies for meeting the challenges of military family life, including deployments, are also offered. Examples of such programs include the Army Family Team Building and Operation READY (Resources for Educating About Deployment and You). Family readiness or support groups within the service member's work unit are also sources of information and support. Internet family support information resources have been developed for all the uniformed services and examples are listed at the end of this article. Carol Vandesteeg's *When Duty Calls* summarizes the various services available during a deployment to families of all branches of the military and their reserve components, as well as the Air National Guard and the Army National Guard.[10] *The Military Family, A Practice Guide for Human Service Providers*, is another valuable reference text for pediatricians, with specific chapters addressing family support during deployment.[11]

Every service member's military unit has a command structure. Pediatric health care professionals can always recommend that a family member contact the service member's command for guidance and direction to appropriate family support services and agencies. Facilitating full family support is a command responsibility, and commanders receive ongoing education regarding military family needs and available services. Chaplains are another resource for spiritual and life skills counseling. Military medical treatment facilities are also avenues to seek and request direction for family support during deployments.

Although separation can be an emotionally challenging time for children in military families, there are positive aspects that should be noted. Military children have the opportunity to experience and grow within a diverse and culturally rich environment, especially for those who live outside of the United States. These experiences add to opportunities for growth and maturation as children learn how to function and master their perception of the world. Independence and flexibility are important to healthy adjustment to military life; children's development of these attributes will help build resilience and strong coping skills as they continue to meet the challenges of military family life. Deployment-related family separations can be transformed into family and personal growth-promoting experiences when military families know what to

expect, understand the inevitable phases of emotional response, are educated about effective coping strategies, and are well supported as specific needs arise. In this setting, children have an opportunity to acquire new life skills, to feel a sense of pride in the contributions they make to the family, and to gain a sense of increased self-efficacy. Military pediatricians and their civilian counterparts who care for military families, active duty, reserve, and guard have a critical role to play in facilitating and supporting families as they meet these challenges.

Clinicians, both military and civilian, must be prepared to mobilize and intensify family support measures outlined above at the earliest signs of an unfolding large-scale crisis rather than waiting until multiple families are crippled by distress. This same paradigm applies to the family members of nonmilitary emergency responders as well, including police, firefighters, paramedics, and other disaster response personnel called to a crisis situation. Remember the impact of timely, proactive support of families on the ability of these military and emergency service providers to carry out critical missions at hand.

Resources for Military Families and Children

Air Force Crossroads-Family Separation and Readiness
http://www.afcrossroads.com/famseparation/pre_sec2_children.cfm

DOD Deployment Health Support Office and Assistant Secretary of Defense for Health Affairs.
http://deploymentlink.osd.mil/deploy/family/family_intro.shtml

Full text online for the "Emotional Cycle of Deployment"
http://www.hooah4health.com/environment/deployment/emotionalcycle.htm

LIFELines, Web-based quality of life services network for Navy, Marine, and Coast Guard personnel and families
http://www.lifelines2000.org

LifeWorks, a family support program for recruiting service personnel of Army, Navy, and Air Force
http://www.lifeworks.com

Mobilization and Deployment: Enduring Freedom Web site
http://mfrc.calib.com/Enduring_Freedom/mobiliz.htm

Military Children and Youth Web site (Military Family Resource Center)
http://military-childrenandyouth.calib.com/index.htm

Military Child Education Coalition Web site
http://www.militarychild.org

Providing Support for Families
http://www.ari.army.mil/Outreach/family_6.htm

The Guide to Reserve Family Member Benefits
http://www.defenselink.mil/ra/documents/family/benefits.pdf

The Help Guide to Guard and Reserve Family Readiness: A Key Component of Mission Readiness
http://www.defenselink.mil/ra/family/toolkit/pdf/helpguide.pdf

REFERENCES

1. Military Family Resource Center. Profile of the Military Community: 2000 Demographics. Available at: http://mfrc.calib.com/WordFiles/Exec_Summ_Intro.doc.
2. Logan KL. The emotional cycle of deployment. *US Naval Institute Proceedings*. 1987;113:43-47.
3. Pincus SH, House R, Christenson J, Adler LE. The emotional cycle of deployment: a military family perspective. *Journal of the Army Medical Department*. April-June 2001;PB 8-01-4/5/6:15-23.
4. Blount BW, Curry A Jr, Lubin GI. Family separations in the military. *Mil Med*. 1992;157:76-80.
5. Pierce PF, Buck CL. Wartime separations of mothers and children: lessons from Operations Desert Shield & Desert Storm. military family issues. *The Research Digest*. 1998;2:1-4.
6. Kelley ML, Hock E, Smith KM, Jarvis MS, Bonney JF, Gaffney MA. Internalizing and externalizing behavior children with enlisted Navy mothers experiencing military-induced separation. *J Am Acad Child Adolesc Psychiatry*. 2001;40:464-471.
7. Levai M, Kaplan S, Ackermann R, Hammock M. The effect of father absence on the psychiatric hospitalization of Navy children. *Mil Med*. 1995;160(3):104-106.
8. The Pediatrician's Role in Family Support Programs. *Pediatrics*. 2001;107:195.
9. Albano S. Military recognition of family concern: Revolutionary War to 1993. *Armed Forces and Society*. 1994;20:283-302.
10. Vandesteeg C. *When Duty Calls: A Guide to Equip Active Duty, Guard, and Reserve Personnel and Their Loved Ones for Military Separations*. Enumclaw, Wash: Winepress; 2001.
11. Martin JA, Rosen LN, Sparacino LR. *The Military Family: A Practice Guide for Human Service Providers*. Westport, CT: Praeger Publishers; 2000.

Parental Wartime Deployment and the Use of Mental Health Services Among Young Military Children

AUTHOR: Colonel (ret) Beth Ellen Davis, MD, MPH, FAAP

Medical Corps, US Army (retired); and Past Chair, Section on Uniformed Services, American Academy of Pediatrics, Elk Grove Village, Illinois

The views expressed in this commentary are those of the author and do not necessarily reflect the official policy or position of the Department of the Army, Department of Defense, or the US government.

www.pediatrics.org/cgi/doi/10.1542/peds.2010-2543

doi:10.1542/peds.2010-2543

Accepted for publication Sep 8, 2010

Address correspondence to COL (ret) Beth Ellen Davis, MD, MPH, FAAP, Department of Pediatrics, Madigan Army Medical Center, MCHJ-PPS, Tacoma, WA 98431. E-mail: bethellen.davis@amedd.army.mil

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: *The author has indicated she has no financial relationships relevant to this article to disclose.*

FREE

The wars in Afghanistan (2001) and Iraq (2003) have been raging for almost 9 years, and some would qualify the current conflicts as the longest in US history. There is growing evidence that the psychosocial burden of war extends beyond the military service member's combat time and includes effects on the spouse and children, perhaps unfolding years after combat exposures.

Recent study reports have described the health and mental health (MH) issues of US service members involved in wartime deployments,[1,2] including the toll on American lives. From October 2001 through May 2010, there have been 5473 American casualties and 38 076 wounded in action.[3] A recent study identified significant stress and MH problems in US Army wives whose husbands experienced deployments.[4] Evidence from that study, and a study of school-aged children,[5] suggests cumulative stress from subsequent wartime deployments for at-home parents and their children, and there are potential negative lifetime effects. Despite these challenges, the vast majority of US military children manifest considerable resilience. In fact, a colleague of mine genuinely refers to military families as "our heroes at home."

In this issue of *Pediatrics*, Commander Gorman et al[6] address parental wartime deployment and the use of MH services among military children aged 3 to 8 years. It is one of the first studies to capture data from a large number of military children representing multiple active-duty (AD) services during a period of high-intensity parental deployments. The authors should be commended for their ability to extricate important pediatric needs from a system of complex, multipurpose electronic resources. By using comprehensive claims data, they report increased outpatient visits for anxiety, behavioral, and stress disorders in 3- to 8-year-old children of deployed parents compared with nondeployed parents. More claims were filed for families in which the children were older, AD parents were married, and the deployed parent was the father.

In general, Tricare (the health care delivery system for US military and their family members) has a generous MH benefit for military families and does not require a consultation for the first 8 visits of behavioral/MH counseling. This study used an MH classification system (Clinical Classification System 5) to count health care utilization as *International Classification of Diseases, Ninth Revision* diagnoses according to pediatric providers, with respect to parental deployment status. To help guide primary care providers toward anticipatory and preventive strategies for common pediatric deployment-related MH/behavior problems, future studies need to build on this foundation and measure more directly the specific parental concerns and child psychosocial

impairments related to deployment (such as sleep problems, separation issues, and regressive behaviors in children).

Although there was a gender and marital-status effect in this study that implied more married AD fathers had children with MH problems, there may be an ascertainment bias by those who claimed Tricare health benefits while a married AD father was deployed. It is clear that a consistent finding across developmental studies is that child distress is closely linked to parental distress. It is possible that a greater proportion of AD "fathers" experience greater combat danger, which is reflected in at-home parent stress and anxiety and, thus, increased child symptoms. However, it is more likely that the Tricare system does not capture all of the health service utilization of single AD families, for which health care often occurs outside the military system. On the basis of my clinical experience, I would have as much (if not more) concern about child MH and behavioral problems in single AD parent and female deployed-service-member households.

Among the important findings from this study is that 65% of the services provided to children for MH and behavioral problems occur "outside the gate"—by civilian pediatricians and other child-serving providers. Along with numerous smaller studies that have sought to understand the effects of parental wartime deployment on children and youth,[6–9] this article should fortify general pediatricians, both civilian and military, in their primary care role of recognizing and responding to the MH/behavioral needs of military children. Recognizing childhood stress, anxiety, or behavioral problems that are interfering with school or family function has been a responsibility of pediatricians for generations. It is not uncommon for pediatricians to see a child for 1 purpose (school physical, immunizations, etc), only to uncover a more troubling problem. By simply asking, "I understand your daddy/mommy is deployed. How are you feeling?" pediatricians can uncover important stressors in a military family. Pediatricians should use acute and health supervision visits to:

- assess family stress and coping;
- provide anticipatory guidance for common reactions to the deployment cycle;
- know where to find appropriate resources (see below); and
- know when to refer for specialized services (death or injury of parent).

By understanding the military family and the experiences of parental wartime deployments, all pediatricians and other child-serving providers can be the "front line" for the health and well-being of US military children, especially in times of war.

Resources for families and pediatricians include:

- Military One Source (www.militaryonesource.com): 24-hour resources for all AD services, Reserves, and National Guard
- Military Home Front (www.militaryhomefront.dod.mil): deployment programs and resources
- Tragedy Assistance Program for Survivors (www.taps.org)
- American Academy of Pediatrics Military Deployment support Web site (www.aap.org/sections/unifserv/deployment)

REFERENCES

1. Thomas JK, Wilk JE, Riviere LA, MGurk D, Castro CA, Hoge CW. Prevalence of mental heath problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq. *Arch Gen Psychiatry*. 2010;67(6):614–623
2. Millikin CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*. 2007;298(18):2141–2148
3. US Department of Defense. DoD personnel & procurement statistics: personnel & procurement reports and data files. Available at: http://siadapp.dmdc.osd.mil. Accessed June 12, 2010
4. Mansfield AJ, Kaufman JS, Marshall SW, Gaynes BN, Morrissey JP, Engel CC. Deployment and the use of mental health services among U.S. Army wives. *N Engl J Med*. 2010;362(2):101–109
5. Lester P, Peterson K, Reeves J, et al. The long war and parental combat deployment: effects on military children and at-home spouses. *J Am Acad Child Adolesc Psychiatry*. 2010;49(4):310–320
6. Gorman GH, Eide M, Hisle-Gorman E. Wartime military deployment and increased pediatric mental and behavioral health complaints. *Pediatrics*. 2010;126(6):1058–1066
7. Flake EM, Davis BE, Johnson PL, Middleton LS. The psychosocial effects of deployment on military children. *J Dev Behav Pediatr*. 2009;30(4):271–278
8. Chartrand MM, Frank DD, White LF, Shope TR. Effects of parent's wartime deployment on the behavior of young children in military families. *Arch Pediatr Adolesc Med*. 2008;162(11):1009–1014
9. Chandra A, Lara-Cinisomo S, Jaycox LH, et al. Children on the homefront: the experience of children from military families. *Pediatrics*. 2010;125(1):16–25

Military Child

This essay, written in April 2012 by columnist Debra Rae to commemorate the Month of the Military Child, nicely summarizes the literature about the characteristics of children growing up in military families. Sociologists consider the life experiences of military children as unique and influential enough to qualify 'military brats' as an American subculture.

In her 1991 book, *Military Brats: Legacies of Childhood inside the Fortress*, Mary Edwards Wertsch isolated America's community of military children as an indigenous subculture with its own customs, rites of passage, forms of communication, and folkways. In doing so, she launched a movement for cultural identity through which adult military "children" began discovering the "secret family" they didn't know they had.[1]

Thereafter, in 2005, filmmaker Donna Musil released the first ever documentary made exclusively about military children. In it, Musil draws on many studies and interviews with counselors, psychologists, and military brats themselves. Her award-winning documentary, *Brats: Our Journey Home*, fingers this distinct American subculture, "an invisible tribe" comprising five percent of the population. Former military child, author Pat Conroy ends the film with a provocative observation: "We spent our entire childhoods in the service of our country, and no one even knew we were there."[2]

The Defense Department addresses this conundrum by earmarking April as the "Month of the Military Child." Given our nation's three extended military engagements (two in Iraq and one in Afghanistan), now is a great time to examine America's distinctive subculture of the military child—and to appreciate unique challenges faced by America's military families at home and abroad. We owe them that much.[3]

Linguistic Reclamation of "Brat"

Wherever organized warfare exists, military spouses and their children follow armies. The so-called "little traveller" is found in literature dating back to the early nineteenth century. Historically, military children were known as "camp followers." Though origin of the term, "military brat," is unknown, some evidence suggests that, originally, the label stood for "British Regiment Attached Traveler." American "military brats" date back to birth of the United States.[4]

In her research, sociologist Karen Williams used the term reluctantly in order to "follow the

"We spent our entire childhood in service to our country, and no one even knew we were there."

- Pat Conroy

the wishes of participants." You see, while non-military personnel find the term "brat" impudent, it has been reclaimed linguistically as a positive term of affection within the ranks of the military. Member of the United States Senate Committee on Armed Services, Senator Ben Nelson explains, "When the word 'brat' is used to describe someone, it is not meant as a compliment; but ... "military brat" [is] ... a term of endearment." It speaks respectfully of one who is a world traveller and, hence, a global citizen, graced with spunk and a spirit of adaptability.[5]

Third Culture Kids

In the 1970s, sociologist Ruth Hill Useem coined the term "third culture kid" (TCK) for the child of a soldier. TCKs integrate aspects of one's birth culture (the first culture) with a new and different culture to which he is exposed (the second culture). When merged, the two create a unique "third culture." Studies show that third culture kids move frequently, often hundreds or thousands of miles away from what's familiar.[6]

Sociologist Morten Ender conducted the largest scientific study to date on career military brats exclusively, specifically those who from birth through high school had at least one parent in military service. Of 600 brats studied, ninety-seven percent had lived in at least one foreign country (sixty-three percent in two; thirty-one percent in three), spending an average of seven years abroad. Brats averaged eight moves before graduating from high school. Over eighty percent were bilingual; and fourteen percent spoke three or more languages.[7]

Education Turntable

Unlike the public school system, a typical military school can experience up to fifty percent turnover every year; and base schools reach one hundred percent turnover in only two years. Recent studies show that mobility during the school year may be less traumatic than summer time moves. However, when required to move mid-year, the student is forced to join classes that have already begun. Social groups are even more difficult to break into, and previously enjoyed activities may be open to him no longer.

Even more, continuity in core curricula is interrupted, resulting in instructional gaps. A student who excelled at one school may feel inadequate upon entering a larger, more academically rigorous one; and, adding to the stress, previously completed coursework may fail to fulfill graduation requirements.[8]

Home and Family

The modern military has a larger proportion of married military members. For the "travelling child," home is where the family is. Although a significant percentage of military brats report difficulty forming strong relations with people or places, they typically experience tight bonds with siblings; and they often forge strong connections with (or, in some cases, aversion to) their military community. Military bases represent tiny, self-contained, government-subsidized towns defined by conformity. Even the areas immediately surrounding bases are highly influenced by the military culture.

Eighty percent of Cold War era military brats characterize their fathers as "authoritarian." Military households frown on non-conforming behaviors and dissent. Consequences for said misbehaviors are generally greater for brats than for civilian counterparts, perhaps because the brat's behavior likely becomes part of the military member's record. Patterns of misbehavior can undermine a parent's promotion or preferred duty assignment.

MILITARY BRATS
Stats

5% of the U.S. population

8 moves before high school

Lower divorce rate than U.S. average

97% have lived abroad

80% bilingual

Affinity for service careers as adults

As a general rule, military brats are better behaved than their civilian counterparts. It's typical for U.S. military families to display "duty rosters" on the refrigerator and to enforce parent-conducted room inspections. Tardiness and insubordination are unacceptable. Traditionally, military children address adults with "sir" or "ma'am," and they are expected to answer the family phone with extreme formality.

Because brats are pressured to conform to military culture, they sometimes are perceived as being more mature than peers. Paradoxically, having struggled with perfectionism and performance-control issues, a majority of military brats describe themselves as being successful.[9]

"Down" Side of Family Militarization

On the other hand, under the intense stress of always being on their best behavior, some military brats develop psychological problems; others rebel against military regimentation well beyond what is normally considered acceptable. Rather than develop problem-solving skills, there is a temptation simply to leave a problem behind without resolving it. If a brat does not like somebody, he knows that in short order the problem will likely disappear. Among a minority of military brats, there is a higher than average incidence of Avoidant Personality Disorder and Separation Anxiety Disorder. Some adult military brats fail at developing and maintaining deep, lasting relationships. One major study shows that thirty-two percent of military brats feel as if they are only spectators to U.S. life, and another forty-eight percent feel central to no group whatsoever. A significant minority exhibits symptoms of Post Traumatic Stress Disorder, Avoidant Personality and the like.

Long hours, frequent disruptions in lifestyles, and high levels of stress, sometimes war-related, can lead to abusive behaviors and alcoholism within military homes. Both are common themes in Wertsch's book and in Pat Conroy's *The Great Santini*.[10] However, because military culture offers more accessible help—i.e., health care, community, and family support programs—some report abusive behaviors (inclusive of alcoholism) are less prevalent among military families.

"Up" Side of Family Militarization

Anecdotal evidence compiled by Samuel Britten suggests that many children from military families are raised with a strong sense of patriotism. After all, at the close of each workday, the bugle call *To the Color* resounds on military installations while the flag is lowered. In my day, all activities ceased, even driving, while uniformed personnel saluted and all others placed their hand over their hearts. Lifeguards emptied pools of swimmers for all to stand at attention. Prior to movies at base theaters, patrons and staff alike stood for the National Anthem followed by *God Bless the USA* or its ilk.

Until recently, students at Department of Defense Dependents Schools (DoDDS) overseas and Department of Defense Domestic Dependent Elementary and Secondary Schools (DDESS) within the United States recited the Pledge of Allegiance every morning. Patriotic and militaristic songs were sung not only in schools, but also during military chapel services.[11]

Duty, Honor, Country

In the 1990s, the army officially adopted what have come to be known as "The Seven Army Values," summarized with the acronym "LDRSHIP"—namely, loyalty, duty, respect, selfless service, honor, integrity, and personal courage. Indeed, the motto "duty, honor, country" is the standard of the U.S. military. To some degree, brats are treated like soldiers, subjected to a warrior code of honor and service.

Training and preparing for war involve significant dangers, as do other military duties. Consequently, even when there is no active war, many military brats live with the reality of risk to one or both parents. A military brat understands and accepts that, in the line of duty, the service person within his family may be killed or maimed. Accordingly, a positive backronym (acronym-style derivation invented for existing words) identifies brats as "Brave, Resilient, Adaptable, and Trustworthy."[12]

Marine General Peter Pace, the Chairman of the Joint Chief of Staff adds, "There's no way, in my mind, that you can be successful in the military and have a family unless that family does, in fact, appreciate your service to the country. ... [Brats are] patriots and role models for us all."[13]

Lifestyle Quirks

Military brats have been studied extensively from the perspective of social psychology and as a distinct and unique American subculture, but less so in terms of long-term impact. Unlike civilian counterparts, military brats endure absence of a parent due to deployment, threat of parental loss or injury in war, stresses associated with the psychological aftermath of war, and militarization of the family unit. Studies show that growing up within the military culture can have overall, long-lasting effects—some positive, some not.

Due to a transient lifestyle, military

brats routinely forfeit friendship ties. However, in being exposed to a wide range of regional cultural differences, not to mention foreign cultures and languages while living overseas, brats tend to cultivate resilience, exceptional social skills, proficiency in foreign languages, and a high level of multicultural and/or international awareness.

"Suddenly military" reservist and National Guard families face isolation from other military-family peers, coupled with isolation within hometown communities. *Operation: Military Kids* is a program designed to help "suddenly military" children understand the military culture; and *Our Military Kids* provides monetary grants for National Guard and Reserve children, whose parents sometimes incur a lapse in income upon being called to active duty.[14]

Adult Brats

Remarkably, brats divorce at a lower rate. More than two-thirds of brats over forty years of age remain married to their original spouses. This applies even though military members can be deployed without their families for days, months, or even years at a time. In such cases, the children experience similar emotions as children of divorced parents.[15]

Having lived around the world, military brats can have a breadth of experiences unmatched by most teenagers. Sociologist Henry Watanabe showed that growing up in a mobile community offers opportunities generally unavailable to geographically stable families. Not only do they boast lower delinquency rates, military brats also achieve higher scores on standardized tests and rate higher median IQ scores than civilian counterparts. Furthermore, they graduate from college and earn advanced degrees at higher rates than the non-military population.[16]

Author of a well-known study on military brats, Mary Edwards Wertsch identified a curious pattern. Statistically, brats show a very strong affinity for careers that entail service to others—e.g., military service, teaching, counseling, police, nursing and foreign-service work. Adult brats who do not choose military service tend instead to favor creative and/or artistic professions that offer more independence. Hence, many elect to be self-employed.[17]

Recent studies show that, although brats move an average of every three years, they do not grow accustomed to moving. An adult military brat can never return and find old friends, neighbors, or even former teachers on military bases where they grew up. Feeling outside in relation to civilian culture is common for a majority of military brats. Studies show further that many adult military brats refuse any and all pressures from spouses or employers to move ever again. Still others report having "the itch"—namely, difficulty settling down in one geographic location.[18]

Military Classism and Racism

In recent years, military classism is rare among military brats. In fact, "social" rank discrimination among families is typically frowned upon. Most officer- and enlisted- clubs have merged into "All Hands" Clubs, and military children play together without recognition of parental rank.[19]

Decades before the civil rights movement, President Truman signed Executive Order 9981, thereby integrating the military and mandating equality of treatment and opportunity. The EO made it illegal for military personnel to make racist remarks. Fifteen years later, Secretary of Defense Robert McNamara issued Department of Defense Directive 5120.36 that opposed discriminatory practices affecting men and their dependents.[20]

Brats today aren't solely "non-racist"; they are commonly "anti-racist." According to the largest study conducted on nearly 700 third culture kids, eighty percent claim they can relate to anyone, regardless of race, ethnicity, religion, or nationality. A recent study, *Military Brats: Issues and Associations in Adulthood*, found that military brats can feel a "sense of euphoria" when connected to others who share this sense of transcendence.[21]

Conclusion

Limited studies on children who have lost a parent show that ten to fifteen percent experience depression, and a few develop childhood traumatic grief (inability to recall any positive memories of the deceased parent). Based on his experience, military psychiatrist Stephen Cozza speculates that wartime death of a parent is even more traumatic and difficult to deal with than typical causes.[22]

The U.S. Defense Department reports that there are currently two million American children and teenagers who have had at least one parent deployed in a war zone, and parents of over nine hundred thousand have been deployed multiple times. To complicate matters, both parents in about fifty thousand military families serve in the armed forces.[23]

With the advent of the Internet, family members can communicate with servicemen and women in combat zones. However, given CNN and Fox News, military families know that servicemen have died before official word reaches the family. Not surprisingly, a Pentagon study released in June 2009 shows that children of combat troops demonstrate increased fear, anxiety, and behavioral problems; and one-third of them experience academic

academic problems. For a year after the parent returns, some thirty percent of the military children exhibit “clinical levels of anxiety."[24]

Armed with awareness of their unique subculture, we do well to honor America’s approximately fifteen million military brats. Accordingly, at the Center for Changing Worldviews, we’ve implemented Operation Heartlift, which connects local communities with troops and their families. Our purpose is to to show in tangible ways that we appreciate them and care about them. Indeed, no military brat should feel as though he spent his entire childhood in the service of our country with no one even knowing he was there.[25]

-

1. Mary Edwards Wertsch. *Military Brats: Legacies of Childhood Inside the Fortress*. Saint Louis, Missouri: Brightwell Publishing, 2006, p. 350.
2. BRATS: Our journey home.
3. Rudi Williams. “Military Brats are A Special Breed.” Washington, D.C.: American Forces Press Service (US Department of Defense Publication), 2001.
4. Grace Clifton. Making the Case for the BRAT (British Regiment Attached Traveller).” *British Education Research Journal*, Volume 1, No 3: June 2004, p 458.
5. Senator Ben Nelson. “April is a Very Special Month for Children in Military Families,” 2005. Retrieved on March 18, 2012.
6. Ruth Useem, et al. “Third Culture Kids: Focus of Major Study.” International Schools Services. Retrieved on, 2006.
7. Morton Ender. "Military Brats and Other Global Nomads." Westport, Connecticut: Greenwood Publishing Group, March 2002.
8. "Despite the commonly held belief that summer moves are best for children, teens who moved during summer vacation seemed to experience particular difficulties... Their problem was that, with school out of session, it was very difficult to identify potential friends and begin to form relationships." (Tyler, 2002).
9. Morton Ender. "Military Brats and Other Global Nomads." Westport, Connecticut: Greenwood Publishing Group, March 2002.
10. The great Santini.
11. "We all stopped, no matter what we were doing. And no matter where we were, no matter what foxhole we were hiding in, ... we stopped. Retreat would blare out from the loudspeakers all over the base. We could never see the flag; it was miles away. But we knew where it was, and like facing Mecca, everyone turned around, and put their hand over their heart, and stood there until the music stopped.... There was never even a comment about it, no matter what was going on. It just happened everyday." (Truscott, 1989) "Whenever and wherever the National Anthem, To the Colors, or Hail to the Chief is played outdoors, at the first note, all dismounted personnel in uniform and not in formation, within saluting distance of the flag, face the flag, or the music if the flag is not in view, salute, and maintain the salute until the last note of the music is sounded... Vehicles in motion are brought to a halt. Persons riding in a passenger car or on a motorcycle dismount and salute." (Bonn, 2005)
12. Grace Clifton. "Making the case for the BRAT (British Regiment Attached Traveller)" in *British Education Research Journal*, Vol 1, No 3, June 2004, p. 458.
13. Marine General Peter Pace. “Sacrifices of Military Children.” American Forces Press, December 3, 2006.
14. Bob Roehr. “Families of Deployed Reserve, National Guard Soldiers Face Challenges.” Denver, Colorado: Medscape Today, Medscape Medical News, November 16, 2010.
15. Your children and separation.
16. Admiral Dennis Blair, Commander in Chief, U.S. Pacific Command. “The Military Culture as an Exemplar of American Qualities.” San Diego, California: Supporting the Military Child Annual Conference, Westin Horton Plaza Hotel, July 19, 2000. Retrieved December 3, 2006.
17. Mary Edwards Wertsch. *Military Brats: Legacies of Childhood Inside the Fortress*. Saint Louis, Missouri: Brightwell Publishing, 2006.
18. Kathleen Finn Jordan. "Identity Formation and the Adult Third Culture Kid." Westport, Connecticut: Praeger, 2002.
19. "Protocol is not intended to promote snobbery; it is a courtesy designed to recognize official status and give respect to those who, by their achievements, time in service, and experience, deserve it. And the exercise of that most certainly extends to spouses." (Cline, 1995)
20. Heather Antecol and Deborah Cobb-Clark, “Racial and Ethnic Harassment in Local Communities.” Unpublished working paper: October 4, 2005, p 8. Retrieved on January 1, 2007.
21. Mary Edwards Wertsch. *Military Brats: Legacies of Childhood Inside the Fortress* (first hardcover edition). Saint Louis, Missouri: Harmony, April 23, 1991.
22. Stephen Cozza. "Military Families and Children During Operation Iraqi Freedom." *Psychiatric Quarterly*, Vol 76, No 4, Winter 2005, pp. 371–378.
23. Elaine Wilson. "Military Teens Cope With Wartime Challenges." Fort Campbell, Kentucky: American Forces Press Service, Department of Defense, April 22, 2010
24. Troops' kids feel war toll
25, Operation Heartlift

Reprinted with permission by the National Capital Consortium Pediatric Residency at Walter Reed National Military Medical Center. The NCC Pediatrics Residency is the only tri-service military pediatrics training program.

Resident Guide to the Littlest Warrior Program

Intro: Wounded warriors are continuously arriving at WR-B for care. Their children often accompany them for some period of their inpatient and/or outpatient care. These children may require medical, dental, social work and/or behavioral care while in the area. The Littlest Warriors Program seeks to identify and provide care for these children. You are an integral part of that process.

What has been done before you are involved in the process? Ms. Lenora Freeman, CDR White, or Dr. Hoffman will have contacted a family member of the wounded warrior and completed an intake form. DEERS eligibility will have been determined prior to them being assigned a PCM. Referrals to a civilian provider are made for those not eligible for care in our facility (nieces, nephews, brothers, sisters). Records have been created in CHCS, if needed, so that appointments can be booked for the children who are eligible for care at WR.

How is PCM assignment determined? For those children requiring immediate appointments, a Resident on the Clinic rotation will most likely be assigned. For families not requiring immediate care, any resident is eligible. The goal is for every resident to have 1-4 LWP family members enrolled in his/her panel. Efforts will be made to assign a resident of the same Service.

What are we asking you to do?

1. Once you have been assigned as a PCM for a family member of a wounded warrior, you will receive a T-CON in AHLTA. You will then be required to Contact the wounded warrior's designated family member and complete the T-CON gaining any additional information, regarding children that are now or may in the future be in the WR-B area.*
2. Determine what medical needs the child(ren) have now or are likely to have in the future. See "Parent Medical Interview Sheet" (located on the ShareDrive).
3. Arrange an appointment (if indicated) with the primary care or specialty provider that is appropriate for the needs identified. Use your booking keys or contact front desk staff.
4. Ensure the family knows that you will be their PCM, what team you are assigned to (Green, Red, Blue), and that they have your contact information.
5. Return the completed T-CON (code as V6102 Family member returned from deployment) to CDR Mary White for Co-signature.
6. Continue to serve as the PCM for the child(ren) in this family until such time that they no longer need care in the WR-B area.

**If you are notified of a family in clinic and see them in clinic, you will still receive a T-Con for documentation and accountability purposes, please include information discussed with designated family member regarding LWP in T-CON and submit for Co-Signature as above.*

If you are seeing ANY patient in clinic and discover they are a Wounded Warrior Family Member, please enroll them in LWP with you as their PCM! At a minimum, complete LWP Enrollment form (in exam rooms or Share Drive) and return to CDR White.

Military Family Issues Quiz

1. Please complete this table for the **5 Stages of the Emotional Cycle of Deployment:**
(There is also an updated 7 Stage Cycle of Deployment Model).

Stage of Deployment	Time Period	Emotional Response
Pre-deployment	Varies—days-months	Anticipation of loss; fear, resentment; detachment & withdrawal as coping mechanisms
Deployment	1st month	Loss, disorganization, anxiety. Young children worry about basic needs. Older kids about safety.
Sustainment	2nd— last month	New routines established, new sources of support. Independence and confidence ("I can do this!")
Re-deployment	Last month	Anticipation of return. Excitement, apprehension. Burst of energy ("nesting").
Post-deployment	3-6mo after deployment	Renegotiating routines and family roles. Honeymoon period. Loss of independence.

2. According to Dr. Gorman's study, what are **risk factors for mental health issues** during parental deployment in children 3-8yrs old? What are other risk factors for increased stress on the family during deployment?

   * Older children, AD parents were married, father was deployed
   * Sudden deployment, longer deployment, combat environment; history of poor adaptability, family conflict and dysfunction, poor communication; young age of spouse, foreign-born spouse, tenuous financial status.

3. All of the following are true about **"Military BRATs**," except:

   A. As adults, divorce at a lower rate than civilian peers.
   B. Experience 20% turnover in their DOD schools each academic year.*
   C. Achieve higher standardized test scores and more advanced degrees than civilian peers.
   D. 30% exhibit clinical levels of anxiety for a year after a deployed parent returns.
   E. Decreased incidence of racism and classism when compared to civilian peers.

   * 50% turnover

4. **Discussion Q:** Consider the different representations of the "The Military Child"—"invisible tribe", "little traveler", "camp follower", "BRATs", and "third culture kids". How does this relate to your experiences as a provider for military children?

Military Family Issues Cases

Case 1: You are seeing a 3 year old boy for a chief complaint of tantrums and oppositional behavior. You discover that his mother is an active duty Army nurse and has been deployed for 3 months of a planned 12 month deployment. His father works full time as a general contractor. The patient attends daycare at the CDC and there are no extended family members in the area.

What elements of the patient's medical history, social history and family history would particularly help your evaluation of this child and his family?

- PMHx: Term? Any other medical issues? Any prior behavioral issues? Temperament?
- SocHx: How long have parents been married? Any marital conflict? Any other stresses at home? Prior deployments? Prior PCS moves? Other children? What is preferred method of discipline? How often does patient get to Skype or otherwise contact mom?
- FamHx: History of mental health or substance abuse disorders? Prior deployments for mom and history of injuries or psychological comorbidities?

What historical factors or current clinical factors would make you consider subspecialty referral for this family? *Answers will vary, but possibilities include:*

- Underlying medical or psychiatric disorders for 3 year-old *(special needs children may have greater difficulties adjusting to the absence of a parent).*
- Underlying medical or psychiatric disorders for parent *(at-home parent stress and anxiety is associated with increased child symptoms).*
- History of family conflict and dysfunction or tenuous financial status of family *(risk factors for deployment-related stress).*
- Always refer for specialized services for death or injury of a parent.

Who would you refer this family to and how would they be helpful? Consider both subspecialty providers and non-medically oriented family support organizations.

- Medical: More frequent "health maintenance" appointments in Gen Peds Clinic (*reading highlights that "the primary care clinic is the perfect area to provide short-term assessments, recommendations, and brief interventions".)* Could also consider Peds Behavioral Health depending on the results of H&P, as well as Adult Behavioral Health intervention for father depending on his stress/symptom level.
- Family support organizations: unit's family support group/family readiness group (FRG); Army Community Services (ACS) or Navy Fleet & Family Services (FFS) or Air Force Family Support Centers; chaplain programs; military installation's MWR site.
- Websites: *See resources on last page of module*
- Dr. Gorman's study, among others, showed an **increased risk of anxiety, behavioral, and stress disorders** in children of deployed vs. non-deployed parents.

Case 2: On routine screening you identify that the father of a healthy 2-month old has received orders to deploy for 12 months and will be leaving in 2 weeks. There are 3-year old, 8-year old, and 15-year old siblings at home.

What anticipatory guidance would you give these parents about each of their children in preparing for deployment? *See Developmental Stages & Children's Expression of Distress:*

- In general, maintain normalcy including routine discipline, routine activities; give reassurances of safety and increase physical contact; answer questions honestly.
- Preschool: May regress to earlier mastered behaviors and may be clingy, afraid to sleep alone, or afraid of being left alone; eating difficulties.
- School-aged: May complain excessively, become aggressive, or place significant on missed events (e.g. birthdays); rise in somatic complaints.
- Adolescent: May exhibit irritability, attention-seeking behaviors, or other types of negative behaviors; sudden or unusual school problems.

What historical factors (social or medical) might predict this family's risk or resilience in negotiating stress from deployment-related family separation?
From Extra Credit Article Supporting Those Who Serve:
"Protective factors include family readiness, "meaning making" of the situation, receipt of community and social support, acceptance of military lifestyle, ability of the at-home parent to develop self-reliant coping skills, and adoption of flexible gender roles. Children who have supportive child caregivers, school environments, and adults who understand their military situation are more able to effectively recruit coping skills that augment family supports."

When do you want to follow-up with this family? How will you assess coping in the 8 year-old and 15 year-old specifically? *Answers will vary:* may wait until next scheduled well-check to follow-up; some may invite family to return in 6mo to assess family stress and coping.

- **Ask: "I understand your dad is deployed, how are you feeling?"**
- Assess possible "expressions of distress" listed in Table.

10 months later you see the mother and now 12-month old infant again for a well visit. With your help, things have gone fairly well at home in the interim. The mother mentions looking forward to her husband's return in 6 weeks.

What anticipatory guidance would you give regarding the upcoming family "reunion"?

Discuss **re-deployment** and **post-deployment**. During re-deployment, there can be intense anticipation: excitement that the Solder is coming home, along with apprehension about the changes that this return may bring. During post-deployment, there is often a "honeymoon" period, after which the returning solder/spouse/parent may want to reassert their role or "make up for lost time", which can lead to tension.

For children, babies may not know the Soldier and cry when held. Toddlers may be slow to warm-up. Preschooler may feel guilty and scared over the separation. School-age children may want a lot of attention. Teenagers may be moody and may not appear to care. Children are often loyal to the parent who remains behind and do not respond to discipline from the returning Soldier/Parent. It is best for the Soldier not to try to make changes right away and to take time renegotiating family rules and norms. *(Excerpted from Hooah 4 Health)*

Military Family Resources

http://www2.aap.org/sections/uniformedservices/deployment/index.html *(AAP site dedicated to the effects of deployment on child and adolescent mental health; includes **videos** for all ages)*

- Military Youth Coping With Separation: When Family Members Deploy
- Mr. Poe and Friends Discuss Reunion After Deployment

http://archive.sesameworkshop.org/tlc/ *(Sesame Street resources for military families, including videos for military children on deployment and homecoming).*

- Videos on "Deployments", "Homecoming", and "Changes"

http://www.militaryonesource.mil/ *(Or call 1-800-342-9647. Review Military Life Topics.)*

- *Includes* "Coming Together Around Military Families" Toolkit and kids books such as "Over There", "I'm Here for You Now", and "Home Again"

http://www.zerotothree.org/about-us/funded-projects/military-families/ *(Zero to Three – early childhood resources; Military Family Projects)*

- Young Children on the Homefront: Family Stories, Family Strengths

http://www.defense.gov/home/features/2012/0412_militarychild/ *(Department Of Defense Office of the Military Child)*

http://www.ptsd.va.gov/public/web-resources/web-children-adolescents.asp *(National Center for PTSD – Links for Children and Teens)*

www.cfs.purdue.edu/mfri/index.html *(Military Family Research Institute)*

http://www.militaryfamily.org/ *(National Military Family Association. Toolkits for kids & teens.)*

www.militarychild.org *(Military Child Education Coalition)*