

# Chapter 31

## THE CHILDREN AND FAMILIES OF COMBAT-INJURED SERVICE MEMBERS

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## INTRODUCTION

As of July 2008, over 30,000 soldiers, sailors, marines, and airmen have been injured in ongoing operations in Iraq and Afghanistan.<sup>1</sup> A substantial number of these injuries have been serious, resulting in limb amputations, severe soft-tissue and orthopaedic injuries, traumatic brain injuries (TBIs), eye enucleations, and body burns.<sup>2</sup> The effect of these severe injuries on families, parents, and children is not easily ascertained, but will likely be determined by the functional consequences of the injuries. Even when physical recovery is complete, families can be profoundly affected by the injury of a parent. Because 40% of US service members (SMs) have children, averaging about two children per parent,<sup>3</sup> the authors estimate that approximately 24,000 military children have been affected by serious combat-related parental injuries within that same time period. These numbers do not reflect the many other nondependent children whose siblings or other military family members have been injured.

Case reports have described the anecdotal experience of combat-injured families and children.<sup>4,5</sup> The

effects appear complex, particularly with children. From the initial distress to the longer-term injury adjustment challenges, children and families face difficult emotional and practical problems. These phenomena have been described and are being addressed in several clinical treatment centers and studied through ongoing research. However, no empirical data have yet been systematically collected examining the effect of combat injury on families. Such investigation is required to inform intervention and treatment planning across the injury-to-recovery timeline. In addition, no family- or parent-focused interventions have been uniformly implemented and no evidence-based treatments developed and evaluated. This chapter describes the clinical experience and insights of mental health practitioners who have been involved with the children and families of the combat injured at Walter Reed Army Medical Center (WRAMC) in Washington, DC, a major military medical center that has been treating injured SMs since the start of global war on terror combat operations.

## BACKGROUND LITERATURE

Although no literature exists that systematically examines the effect of parental combat injury on military children, other areas of scientific literature help the understanding of this population. Several types of parental illness have been carefully studied, including parental cancer.<sup>6-9</sup> In these studies, children's emotional and functional responsiveness were affected by their age and gender. A recent study examined the influence of parental multiple sclerosis (MS) on the adjustment of children and adolescents as measured by parental report.<sup>10</sup> The authors found that children of MS parents showed greater difficulty in relating interpersonally and in managing their lives when compared to non-MS children. They also evidenced higher levels of distress, but did not show elevated levels of emotional or behavioral symptoms indicative of psychopathology.

Family function is central to the child's response to parental illness.<sup>11-14</sup> A family's capacity to maintain structure, to provide emotional support, and to diminish distress all appear to help children adjust to parental illness. The level of parental disability is also a principal factor affecting children's responses to parental illness.<sup>15-19</sup> As with many family stresses, children's responses tend to mirror the distress and functional capacity of the important adults in their lives. Whether the seriousness of the illness or resultant parental disability has a greater influence on child functioning and emotional response is less well

understood. In either case, these findings highlight the importance of adopting intervention models that improve family and parental functioning when parental health problems exist, to support the health and well-being of children.

Sudden health-altering events, such as combat injury, may have more profound effects on children and families than parental illness. Families have very little time to prepare for the consequences of sudden injuries. The noninjured parents must often make rapid decisions about childcare, or may be so preoccupied by the needs of the injured partner that they are too overwhelmed to address the needs of children.

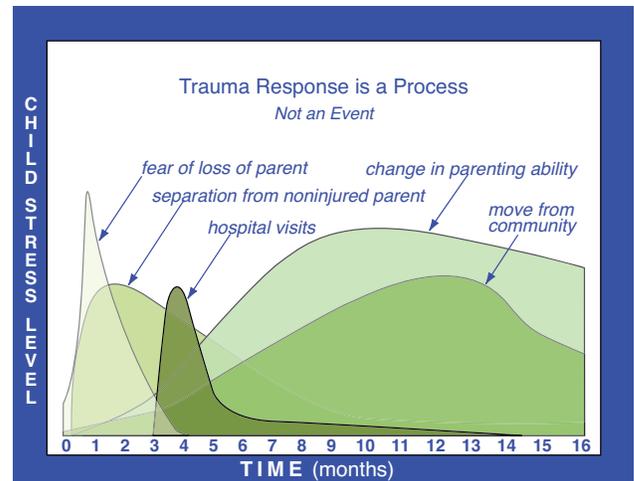
Of the few studies that have examined the effect of sudden medical events on families, those related to TBI are most instructive.<sup>20-25</sup> TBI often has a profound effect on children and families,<sup>25</sup> with greater difficulty in families with young children, those with lesser social or financial support, or where psychiatric problems are prominent. Elevated levels of emotional and behavioral symptoms in children of TBI patients correlate with compromised parenting in both the injured and noninjured parent, as well as depression in the noninjured parent, suggesting the importance of healthy family and parental functioning to protect children's mental health.<sup>22</sup> Strategies that support such outcomes appear warranted; however, no established family-focused interventions have been empirically studied in TBI populations. In addition,

there has been no scientific examination of the psychological effect of parental burns, amputation, or motor vehicle accidents on children that would help in the understanding of the experiences of combat-injured families.

From the initial distress to the longer-term injury adjustment challenges, the children and families of the combat injured face difficult emotional and practical problems. It is likely that the effects of combat parental injury on children are more complicated and potentially more challenging than nonviolent and accident-related injuries. Often immediate information regarding the nature and severity of the injury is limited, and sometimes inaccurate, causing further anxiety. Injuries sustained in combat are likely to result in sudden family distress and a flurry of urgent activity, leading to disruption of family roles, sources of care, and instrumental support. Over time, the consequences of parental injury and required treatment also include changes in the child's residential community, loss of military career by the parent, and changes in parenting capacity. The cascade of events following injury is graphically portrayed in Figure 31-1.

Any serious physical injury may result in the development of comorbid psychiatric symptoms,<sup>26</sup> as well as physical injuries. Longitudinal data suggest that combat-injured SMs may develop complicating psychiatric problems, such as posttraumatic stress disorder (PTSD) and depression.<sup>27</sup> Mental health symptoms may present a variable course, resolving or commonly worsening during the first year after hospitalization.<sup>2</sup>

In addition to moderate or severe TBI, researchers have voiced concern about the influence of milder forms of TBI that may not come to medical attention,



**Figure 31-1.** Child response to events resulting from combat injury.

Drawing courtesy of: Center for the Study of Traumatic Stress, Uniformed Services University of the Health Sciences, Bethesda, Maryland

but can result in serious dysfunction or sense of ill health.<sup>28</sup> When mild TBI is comorbid with other physical injuries, families may contend with the complication of dealing with a parent with psychiatric illness, cognitive or personality alterations, as well as physical injury. When significant changes in parental ability result from injury, parents and children must renegotiate family relationships and integrate the reality of the injury, whether physical, psychological, or both, and its consequences. Continued scientific investigation is required to develop effective preventive interventions that address both short- and long-term effects of these parental injuries.

## NOTIFICATION OF INJURY

SM families are faced with multiple challenges, beginning the day the SM receives notification about a combat deployment. These challenges continue through the deployment cycle and can include many changes within the family system resulting from the SM's absence (See Chapter 30, *The Impact of Deployment on Military Families and Children*). When SMs are injured, facing the threat of permanent bodily changes or reductions in their physical, cognitive, or psychological functions, greater distress is unavoidable.

Family stress begins with notification of the SM's injury. Although there have been improvements in the process of injury notification (eg, when possible, injured SMs may contact a spouse or other family member directly, relieving their loved ones of the worst fear of imminent death), it is not uncommon that initial information pertaining to an injury may be incomplete

or inaccurate, leading to even greater worry. Occasionally, information that a member of a military unit has been injured is communicated through informal channels, causing broad confusion and anxiety on the home front. Only when accurate information about the personnel involved and the details of the injury are known is some relief achieved. The manner in which the information of the injury is related to the spouse and family varies significantly from spouse to spouse and unit to unit. Typically, the accuracy and detail of available information, as well as the mode of its communication, reflect the unique circumstances of the injury. Injury notification may be conducted either in person or by telephone.

Several clinical examples help to illustrate. One spouse of an injured SM recalled that she had been visited at home by two rear detachment officers

dressed in Army combat uniforms. While the sight of these visitors at her door raised concern about her husband's health, she also noted with great relief that they were not dressed in the formal Class A uniform, indicating that they were not part of a death notification team. Another spouse spoke about how she received telephonic notification of her husband's injury while she was driving. Before relating the news of the injury, the caller made certain that she had pulled off the road, stopped the engine, and was in a safe area, to ensure that she was not in danger of having a motor vehicle accident as a result of receiving the frightening news. Another spouse spoke about having received three separate phone calls from three different offices that related different versions of her husband's injury. Even the simplest inaccuracies can undermine a family's confidence in the care that an SM may receive after an injury, and are often remembered and related by spouses or other family members in the hospital setting. Family members typically describe the most reassuring and trusted information coming from the face-to-face visits of familiar members of their injured SM's unit, rather than from telephone callers who are unknown to them.

### **Communicating With Children About the Injury**

Whether injury notification occurs on the phone or in person, children may be present when news of the injury is shared with adult family members. Children may witness the response of their non-SM parents or other adults, who may become extremely distressed, tearful, or emotionally volatile. When possible, children should be protected from viewing the raw adult emotional response to such news because it can be both confusing and overwhelming. Also, when possible, information should be shared with adults first, so that they can be better emotionally prepared for a discussion with their children that is based on accurate information.

Most adults understand that some information should be shared with children whose parents or close relatives have been injured in combat. It is recommended that all children should be given some explanation to better understand the emotions and behaviors that they see in the adults around them. Depending upon their age and psychological and cognitive abilities, children have different capacities to understand and tolerate sensitive and disturbing news. The amount and type of information that adults share should be based upon the developmental capacity of any given child. Older children and teens are generally capable of understanding and accepting more details, including the cause of the injury, the nature and degree of the physical wounds, the plan for treatment, and the

likely effect on the family (eg, expected family separations, visits to the hospital, and changes in childcare arrangements). Adults may be more circumspect about the details that they share with preschoolers or early elementary school children. In some circumstances, facts may be briefly withheld from young children until a parent's immediate survivability is determined. Although infants and toddlers are not cognitively capable of understanding the injury of a SM parent, they will quickly respond to perceived changes in the emotional climate of a household, changes in behavior or availability of any adult childcare providers, or disruptions in their daily schedules or routines. The most important communication to children of any age is that, despite the news of the injury, they will be cared for and that important adults will remain available to them.

It is not recommended that children over the age of 5 or 6 years not be told about an injury for an extended period of time because they are likely to overhear adult conversations or recognize changes in adult behavior that will cause them to worry that something is wrong. Adults should never conduct conversations about the injury within the earshot of children assuming they do not understand. Typically, children will listen and be interested in everything that is discussed. When children ask questions, they should be answered matter-of-factly and with the level of information that seems appropriate and desired by the child. Children should be given permission to ask questions and understand that those questions will be respected and answered truthfully, to the degree that is possible. Sometimes the questions that children ask do not have known answers, in which case adults should say that they do not know. Not uncommonly, children and teenagers may worry that their injured SM parent may die. When an injured SM has stabilized and is not at risk of death, children should be quickly reassured. In situations when health status is precarious, adults should be careful not to unrealistically reassure children. Adults can offer a hopeful message such as, "Dad was hurt very badly, but he is being given the best treatment possible to help him get better."

Often non-SM parents or other adults have trouble gauging what to tell their children. Adults sometimes struggle with their own emotional reactions, which may make it particularly difficult for them to determine what is appropriate to pass on to children. These adults may need help processing and calibrating the amount, content, and timing of the facts that they share. Their description of the injury and its consequences may be based more on their own anxiety than on the needs of the children. Some noninjured parents may choose to share either too much or too little, making it difficult for children to understand the nature or

seriousness of the injury and its realistic implications for the injured parent. Knowledgeable professionals should offer parental guidance when needed.

Some adults may choose to withhold important information related to serious injuries from children in an attempt “not to worry them.” In such circumstances, clinicians need to challenge the assumption that such “secrets” can realistically be kept from children. The clinician should communicate that even younger children can be given some explanation without causing them to become overly worried, and may help them understand the actions and emotions of the adults they see around them. Just as some parents may provide too little information about the injury, others share more than children are able to tolerate. This may frighten them by unnecessarily bringing up unknown future consequences. The foundation of the clinician’s helpful stance toward the families and children of the injured is to increase adult awareness and to help them notice and respond appropriately to children’s emotional signals.

All children require some patient adult assistance to better integrate their understanding of serious injuries. Psychologically minded adults implicitly understand this need and may demonstrate tremendous creativity and sensitivity in meeting the needs of young children. As an example, one mother made a thoughtful and developmentally informed decision not to bring her nearly 3-year-old son to visit his seriously injured father until he was no longer intubated, so that the boy could hear his father’s voice when first meeting him in the hospital. This sensitive decision enabled the young child to relate with his father in the ways he was accustomed to despite the seriousness of the father’s injuries.

### **Travel to Military Medical Facilities and Family Separations**

Once the family has been notified of the injury, a period of intense activity typically follows, often leading to disruptions in the family’s schedule or structure. Spouses usually join injured SMs being treated at military hospitals distant from the family home. When necessary, they leave their children under the supervision of other adults either at home or at the homes of other family members or friends in local or distant communities. Sometimes children are uprooted to join parents at the hospital. All these options are likely to be unsettling, particularly for young children, with resultant disruptions of routines and relationships.

Recommendations cannot be broadly made about where children should be cared for when family separations are necessary. When an injury is serious, military spouses might fly alone to join their injured

SMs at military medical centers. Spouses must plan for the care of their children and the maintenance of their households while they quickly arrange trips to distant locations, not infrequently overseas. Planning can be complicated as noninjured parents may not know how long they will be away from home. Some spouses make the choice to bring their children with them while others make interim arrangements for childcare with friends or neighbors, or send their children to stay with relatives in distant places for uncertain periods of time. In some cases, families must split the children, due to age, logistical requirements, or because of custody agreements (stepchildren). Siblings may stay with friends, while others move in with relatives. In such circumstances, children are not only separated from their parents, homes, and routines, they are also separated from their siblings, adding distress. Some families are fortunate enough to have their extended families move into their homes with their children, resulting in less disruption. Decisions about childcare and separations are never simple and often can result in parental confusion and guilt as they try to meet competing responsibilities. The following two vignettes provide examples of the complexity of military family situations and the solutions that families found.

**Vignette 31-1:** Shirlene, the mother of a seriously injured SM, was staying with her son at a military medical center across the country from her home in Washington state. She had been with her injured son since his admission and was torn between staying at the hospital or going home. Her younger daughter, Candace, who was living at home with her stepfather, had requested that Shirlene return home to celebrate the daughter’s birthday. Shirlene was hesitant to leave her son’s bedside, but was encouraged by the treatment team to visit with her daughter. During the few days that they visited, Candace had the opportunity to talk with her mother about some problems that she was having with friends. She didn’t want to burden Shirlene during their phone calls, and she didn’t feel comfortable talking with her stepfather about these problems. Shirlene’s decision to leave the hospital had been difficult, but upon her return she recognized the importance of this visit and was pleased that she had decided to make it.

Although the decision for children to stay with parents at the hospital can be a helpful way of maintaining the integrity and support of families, many families appropriately choose to have children remain at home. The following example describes how decisions are often complicated and emotionally difficult.

**Vignette 31-2:** John was injured in an improvised explosive device (IED) blast that resulted in multiple soft-tissue injuries, an upper-extremity amputation, and severe TBI. He and his young wife Miriam were parents of a 10-month-old

daughter, Sarah. Miriam had made the decision for Sarah to stay with her parents in Oklahoma during the hospitalization. John's initial prognosis was described as poor and he was not expected to walk or talk again. Miriam, his wife of 2 years, was quite devoted to him and made the decision to remain with him and be there for his ongoing therapies. She received criticism from hospital staff and from some other

patients' wives for her decision to leave their young child with her parents. However, she knew that her daughter was in a stable environment with people who loved her. Miriam wanted to provide ongoing support to her husband, something she felt no one else was able to do. The presence of Sarah would have made it hard to give John the care she felt he deserved.

## THE HOSPITALIZATION

Duration of hospitalization of combat-injured SMs can vary in length, based upon the type and seriousness of the injury. Critical specialty care services are available at most major military medical centers. Because many war-related injuries are extensive, the care of patients can be time consuming, often requiring months to years of hospital-based treatment and rehabilitative services. Within the hospital setting both formal and informal supports and services are available. Specialty care units, such as the US Army Institute of Surgical Research Burn Unit at Brooke Army Medical Center, San Antonio, Texas, provide specialized care. The course of treatment for the severely injured can be unpredictable, involving multiple surgeries, as well as other treatment procedures and intensive therapies. As a result, treatment plans must be fluid and can change, leading to disappointment in both patients and their families.

Injured patients cannot be effectively treated within the hospital setting without understanding and addressing the needs of families. Loved ones understandably want to spend time with their injured SMs, especially when their health status may be uncertain or when they are undergoing complicated or painful treatments. Some family members may choose to remain in hospital rooms for extended periods of time or even continuously. Although healthcare teams recognize the importance of family member involvement, and work to incorporate families into the overall treatment plan, their presence can also complicate the ability to provide effective care. Family members who have feelings of anger or frustration related to the injury may misdirect those emotions toward the treatment team. Families may also bring preexisting emotional conflicts and challenges or interpersonal difficulties into the hospital setting. It is essential that medical teams recognize and address family conflicts to find resolutions that support effective treatment.

Many military families are nontraditional in their composition. Marital separations and divorces, as well as the young age of many injured SMs, can lead to conflicts between spouses, former spouses, girlfriends, boyfriends, and parents, all of whom may visit the hospital. Due to the stress of the injury, conflict not uncommonly develops along these fracture lines and can lead to interpersonal clashes within the healthcare setting,

making treatment more difficult. In young SMs with serious injuries, disagreements can develop between the SMs' mothers, who respond to the regressive needs of their incapacitated sons or daughters, and young spouses who can feel like intruders to the parent-child relationship. Spouses may second guess their commitments to SMs who now are to be permanently altered by the injury. Marital dissolution and divorce are not rare. Sometimes parents, particularly mothers, can unfairly criticize spouses who they believe will abandon their injured children. Legal questions can arise as a result of these conflicts; for example, who in the family will hold medical decision-making capacity or who will be the recipient of insurance or government disability payments?

Marriages are not always healthy or functional prior to the combat deployment or injury. Military family members struggle with many of the same family challenges that all Americans face. Marital conflict, separation, divorce, and infidelity occur. When these problems are present prior to deployment, an injury only compounds them. The case below describes an example.

**Case Study 31-1:** Peter, a marine, was treated at a military medical center for a left-side below-the-knee amputation. While in Afghanistan he was called by his wife Diane on his birthday, 2 months before his injury. Peter was quite pleased until he heard a voice in the background saying, "Tell him you're engaged and wearing my ring. Tell him the marriage is over." It was in this way he learned that Diane was having an affair. She had also emptied their bank account and sold their home using the power of attorney Peter had provided when he began the deployment. Peter and Diane had a 4-year-old son and 18-month-old daughter. Peter was unable to get in touch with them and didn't know whether they ever learned of his injury. Having been served divorce papers and with no place to return, Peter left the hospital to live on his father's farm in Iowa. He said he would have liked his children to receive counseling to make sure they were handling their new life well but he didn't have the physical ability to pursue this nor did he have the financial ability to fight for custody.

Complicated family situations can affect children as well as adults. When the injured SM is divorced and a child resides with a former spouse with whom the SM sponsor has a conflict-laden relationship, hospital

visits or telephone calls with the injured parent become major events to negotiate. When the military parent is remarried, the discussions can become even more difficult because the current spouse, the divorced parent of the children, or other former in-laws may not get along. When families are unable to resolve these differences, clinicians should serve as facilitators to negotiate communication and visitation.

Military family situations can be complex even when relationships are not conflicted. Regulations governing marriage within the military are legally determined and therefore can lack the flexibility that families sometimes wish would be possible. The following case provides an example.

**Case Study 31-2:** Steven, a transportation driver in the Army, suffered a TBI in Iraq from an IED while he was driving in a convoy. Steven and his wife, Cathy, had divorced prior to his deployment but began working out their differences by e-mail and phone while he was in Iraq and planned to remarry upon his return. They had two children, ages 9 and 12 years. After the injury, Cathy and the children joined Steven at the hospital. However, Steven was listed as “divorced” on all his paperwork and Cathy, unlike other married military spouses, had no rights and was provided no financial compensation for her stay in a hotel close to the hospital. The medical staff members were reluctant to speak with Cathy because she and Steven were divorced. Steven was given written instructions and would lose them. He wanted to pass on information to Cathy but he would forget because of his TBI. Consequently, there were periods of time when he was considered noncompliant, and uninterested and unmotivated in his recovery. During the hospitalization the couple remarried, allowing Cathy and the children access to housing and her greater involvement in the medical care. Prior to the remarriage a well-meaning but misguided administrator counseled Steven that perhaps Cathy only wanted to remarry him because of the money he would be getting from military disability. The family found this to be quite inappropriate and unresponsive.

The following vignette provides another example of a stressful military family situation.

**Vignette 31-3:** Beth, a divorced mother of three, was injured as a result of crossfire during a small arms firefight. She was hospitalized for sustained injuries to her chest and upper extremities. Beth was injured 9 months into a 12-month deployment with a National Guard unit from the Midwest. Because of her medical treatment, Beth’s activation was extended well beyond the original 12-month period. In addition to two biological children, ages 10 and 12, she had a 13-year-old foster daughter. All three children remained with a caregiver in Beth’s hometown. Because Beth was the agency-approved foster mother, her ongoing medical care and extended deployment caused the foster daughter to be returned to the agency where another foster home had to be found. This loss was an additional disruption because the foster child had become an important member of the family.

The needs of a family can change dramatically during the course of hospitalization. Attendance to these needs can be extremely supportive to both the SM and family as treatment and rehabilitation progress. Families sometimes require help finding adequate housing, particularly when long-term family stays are required. Questions can arise and practical assistance may be necessary regarding childcare, family health, or educational needs. Familiarity with military regulations and coordination of appropriate paperwork to ensure financial support, adequate housing, and travel arrangements and support are all necessary for military family success during extended combat-injury treatments. Some families are able to demonstrate a tremendous amount of resourcefulness and identify independent ways to meet their own needs. Many others require help through the Family Assistance Center, social work services, or through active case management.

The Psychiatric Consultation Liaison Service (PCLS) at WRAMC has developed a system of care—Preventive Medical Psychiatry (PMP)—that includes ongoing clinical consultation to injured SMs and their families.<sup>29,30</sup> Through PMP, all injured SMs are seen without the need for traditional consultation from the primary treatment team. Patients are told that members of the PCLS routinely see all those who were injured and that PCLS is part of the trauma team. As a result, PMP is met with little patient or family resistance. The major goals of PMP are to place psychological reactions within an appropriate context, to support and encourage healthy defenses, and to monitor for development of psychiatric disorders. Identified posttraumatic symptoms are explained as expected responses to combat and injury, rather than being viewed as necessarily pathological. In addition, PMP serves secondary and tertiary prevention efforts through posthospitalization identification and treatment of at-risk or symptomatic SMs. (For more information see Chapter 16, Psychiatric Intervention for the Battle-Injured Medical-Surgical Patients Following Traumatic Injuries.)

In addition to PMP, PCLS social workers also provide family assistance. Family support services must be individually based, addressing the needs of any particular family in crisis at any given time. Many solutions are met through referral to resources in the surrounding civilian and military communities. Sometimes, effective interventions require more personal professional involvement using creative social work skills, a willingness to get personally involved, and a readiness to “work outside of the box.” As examples, WRAMC PCLS social workers have called Operation First Response for portable cribs and have found car seats for spouses who have precipitously flown into town without them. Social workers have arranged for

baby items for couples with newborns who were not financially prepared and needed to fully equip a new nursery. Most families are disorganized when they first arrive at the hospital. They may come to the hospital without their automated teller machine (ATM) cards, other bank cards, or their military or other identification cards. Some go months before they can access their pay. Medical treatment centers must expect these problems and attend to them as they would the medical care that is afforded the SMs.

The following vignette is an example of how family needs can arise during hospitalizations.

**Vignette 31-4:** Enrico, a US Marine from California, was injured by sniper fire to his eye and upper extremity, resulting in eye enucleation and arm amputation. Eventually, 6 months into the hospitalization, Enrico was able to arrange for his fiancée, Maria, to join him from Puerto Rico. They were married shortly thereafter and Maria became pregnant. She precipitously delivered a premature infant at 25-weeks gestation at a local civilian hospital after visiting their emergency room; the infant required a lengthy stay in a neonatal intensive care unit. Maria did not speak English fluently and, therefore, had difficulty communicating the complex healthcare needs of her family to civilian providers. Active military social work assistance was required to coordinate services between Enrico's treatment and the needs of the couple's newborn. Special arrangements were made for vouchers that allowed the couple to travel between the military medical center and the civilian hospital as they were unable to afford these costs. In addition, the social worker coordinated with Army Community Service to ensure that nursery equipment was delivered to Maria's temporary housing unit when their newborn eventually left the hospital.

Other innovative solutions have been developed by PCLS social workers. To help support the family members, a group—Girls Time Out (GTO)—has been meeting weekly since January 2005 at WRAMC. GTO's mission is to provide a forum to support the wives, mothers, sisters, female friends, and fiancées of injured SMs. Group members meet, talk, eat, and learn from one another. They occasionally invite guests who present pertinent information to the group. For the past several years, GTO members have gotten together during the holiday season and made cookies using kitchens available in both Occupational Therapy and Army Community Service. This activity has allowed the women to make and share their favorite seasonal treats while getting away from the hospital setting for

a few hours.

Finally, the importance of understanding and attending to family cultural differences cannot be overestimated. Recognizing how different races and ethnicities respond to trauma is quite important. For example, Latinos have been observed to be more "hands on" with their injured loved ones. Very often Latino family members touch injured patients and talk to them regardless of their seeming unresponsiveness. Family members will include the injured in prayers (eg, rosaries, novenas), instruct them, talk to them as they shave them, and give them the latest family news. For non-Latino healthcare providers, these cultural methods may seem foreign. Unfortunately, family members can inadvertently feel demeaned by their sense of the disapproval of the medical staff.

Relationships between family members and the healthcare team can become further complicated when language barriers exist. Some of the Latino family members may believe that their observations are not accepted because they do not speak English. It is as though their comments are tainted by ignorance simply because they are not bilingual. The following vignette provides an example.

**Vignette 31-5:** Geraldo was wounded by an IED in Iraq and was transported for further medical treatment while in a coma. His mother, Sonia, remained at his bedside and continued to talk to him and to pray out loud. There were times when she felt he was listening to her but was unable to respond. The medical staff continued to tell her not to expect too much and kindly explained that he could not hear her and had no awareness. Although Sonia did not speak English, she understood the looks the medical staff gave her and knew they did not believe her, but this did not deter her and she continued stimulating Geraldo throughout the day and late into the night. She was quite excited on the day after Christmas when she reported that Geraldo had whispered, "Feliz Navidad" on Christmas Eve, but no one believed her. The clinical social worker supported Sonia in her belief that Geraldo had spoken, despite the medical team's skepticism, and encouraged her to continue what she was doing. Ultimately, Geraldo came out of the coma and told his mother he knew she had been with him around the clock. He told her that he had sensed her in his "sleep" and stated that he recognized and was comforted by her perfume, one that she had used throughout his life. Geraldo was also able to relate conversations that had been held in his room while he was in the coma.

## CHILDREN IN THE HOSPITAL SETTING

Recognizing and meeting the needs of children within general hospital settings is complex. Most pediatric hospitals have developed effective ways

of engaging children and recognizing and meeting them at their developmental levels. Hospitals that provide care to adult populations have been much

less effective in planning for the presence of children. Because children are important members of military families, the identification of, and attention to, their unique developmental needs is key if engagement with combat-injured families is to be effective.

When the family of a combat-injured patient arrives at the hospital, the noninjured parent must navigate the medical environment and military system while being available to their injured military service member. Noninjured spouses often are inundated by the requirements they face, and thus the needs of their children can go unmet. When children arrive at the hospital, they can quickly become overwhelmed by the hospital's size and complexity. Young parents may have little understanding of how to best prepare their children for the hospital setting and how to prepare them for the visits with their injured parents.

Family members can have a difficult time with children's activity levels, leading to frustration and unnecessary harshness. Younger children can be loud and boisterous. They may get negative feedback from parents or hospital staff members, leaving them to feel that they are not wanted. Children may also be viewed as obstacles to care. Hospital and nursing personnel typically do not know how to engage younger children. They can benefit from simple recommendations that can make a child's visit much more pleasant. For example, one 4-year-old boy was repeatedly making loud noises and gestures in the hospital that were disturbing other patients and hospital staff members. His parents and grandmother were embarrassed by the behavior and became engaged in a heated and public emotional exchange. After a discussion with Child and Adolescent Psychiatry Service (CAPS) staff, they were helped to recognize that the child had his own ways of expressing worries and needed time to play and unwind outside of the hospital setting.

Children's presence within the hospital should be time limited and structured. Medical centers that provide care to injured service members should ensure that there are appropriate areas for family activities that are "child and family friendly." Specific plans need to be put in place that allow children to be present and involved in their parent's care, while preparing and protecting them from what they are likely to see in the hospital setting. Because of the many injured SMs being treated at military medical centers, children can not only be exposed to their own parent's frightening medical condition, but also the burns, amputations, and serious injuries of those other SMs receiving care. Recommendations for healthcare treatment facilities' support of families of the combat injured are outlined in Exhibit 31-1.

Parents can assist children to prepare for, and

comfortably participate in, hospital visits. When possible, it is helpful for parents to settle into the hospital routine alone, before children arrive. If children must accompany parents to the hospital at the first visit, it is best that children remain in the hotel or other living quarters while the noninjured parent gets to know the hospital environment. Parents can help their children understand what they may see or be exposed to. In order to do this, parents must first integrate the experience themselves. The opportunity for parents to describe what the hospital looks like, where it is located, who are the members of the treatment team, the appearance of the hospital room, and the names of individuals with whom the injured parent may share a room, will all help to orient a child to this new setting. When possible, parents can also show children pictures of the hospital, the ward, the hospital room, and their injured SM parent to best prepare them for what they will see when they come.

Preparation for the meeting with the injured parent is a continuation of the discussion that began with injury notification and continues throughout the hospitalization and recovery period. Children typically want to know what is happening and what they can expect when they come to the hospital. Noninjured parents can best accomplish this by gauging the appropriate amount of injury-related information (presence of bandages, casts, amputations, or medical equipment) and mixing the discussion with descriptions of less anxiety-provoking topics, such as the hospital cafeteria, the kind of food that they can eat while in the hospital, or the hotel or living quarters. With proper planning most children will feel comfortable when the time for the visit arrives. It is particularly important to carefully prepare children when dramatic changes in a parent's appearance occur, such as facial wounds or serious burns. The following vignette describes how one couple successfully met their young child's needs.

**Vignette 31-6:** Teddy was a 3½-year-old boy whose father, Bill, had been deployed to Iraq for 6 months when he was wounded in an IED explosion. The father sustained serious injuries to his face and upper extremities requiring unilateral facial bandaging and resulting in an inability to effectively use his arms and hands. On the day of Teddy's first visit with his father, his mother spent several minutes explaining the nature of the injuries and what he was likely to see upon entering his father's room, to include the presence of facial bandages, as well as his father's hoarse and somewhat unrecognizable voice. Teddy became very excited about the prospect of seeing his father. When they entered the room Teddy became silent and transfixed by his father's appearance. While his mother tried to reassure him, Teddy cautiously approached his father and carefully climbed on Bill's lap when invited. Instinctively, Bill began jostling Teddy between his legs, a game they had played often prior to

## EXHIBIT 31-1

### TREATMENT FACILITIES' SUPPORT OF FAMILIES OF THE COMBAT INJURED

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**Recognize the contributions of families as part of treatment and establish appropriate boundaries for involvement**

#### **Develop child- and family-friendly treatment environments**

- Welcome children and families
- Families don't VISIT, they PARTICIPATE in care
- Develop appropriate areas for family visiting: in room, on ward, off ward, dining area, family lounge
- Develop child-appropriate environments within the hospital
- Ensure adequate available family lodging
- Consider child life worker involvement within the hospital

#### **Protect children from unnecessary exposures**

- Educate healthcare providers about child developmental issues and exposure risks
- Develop a systematic methodology to prepare children for hospital visits
- Support parents in parenting role and encourage them to speak with their children about health status

#### **Develop family intervention strategies**

- Watch for and address intrafamilial conflicts
- Consider multifamily or spouse group involvement
- Recognize the role of bereavement in family transition
- Actively address expected role changes within the family, especially in TBI and polytrauma victims

#### **Monitor for "at risk" family situations**

- Traumatic brain injury
- Polytrauma victims
- Marital or intrafamilial strife/ domestic violence
- Substance use problems
- Signs of spousal or parental disengagement

#### **Rally resources to aid**

- Practical assistance
- Military Severely Injured Program
- Veterans Administration resources—Seamless Transition
- Military OneSource
- Military treatment facilities/TRICARE
- Self-help and other support organizations

the deployment. The familiarity of this activity eased Teddy, who immediately relaxed and began talking with Bill in a more natural and comfortable way. Recognizing the stress

that Teddy faced, his mother limited the amount of time that Teddy stayed in the hospital setting and ensured that he spent considerable time at the hotel pool.

### SUPPORT TO COMBAT-INJURED FAMILIES WITH CHILDREN

To better meet the needs of the families and children of injured SMs, the CAPS at WRAMC has established a system of care in which clinicians actively engage families of combat-injured SMs. CAPS staff members are informed of the pending arrival of the families of injured SMs by official notification. Clinicians provide an informational briefing to incoming families during their orientation at the Family Assistance Center, at which time they are given general information about CAPS services and how they can access care for identi-

fied problems. Families are also notified that they will be contacted by CAPS providers within the immediate future. This contact is typically made within 1 week of arrival at WRAMC.

Available CAPS services include anticipatory parental guidance to the injured SM and spouse, assistance in preparing children for their visit to the hospital (to include how and what they should be told in anticipation of seeing their wounded parent for the first time), supportive reassurance, anxiety relief, and connec-

tion to appropriate resources when required. CAPS staff members work collaboratively with WRAMC PCLS at the hospital bedside. CAPS staff members also provide therapeutic activities to the children living at the Fisher and Malone Houses, where families reside during SM treatment, and at the Military Advanced Training Center, where wounded SMs and their families participate in outpatient occupational and physical rehabilitation. Services are offered in an outreach or “preclinical” format to support healthy family recovery. The goals of the intervention are to assist the reunion of the injured SM family, to promote children’s mastery of the complex and stressful injury experience, and to facilitate and promote the rehabilitation process of the injured parent by acknowledging the integral and essential role of parenting in the SM’s life. By interacting with families from early in their arrival and developing trusting relationships, CAPS strives to assist families to avert potential difficulties and support their comfort in accepting additional services when indicated. When deemed appropriate, children and families requiring clinical assessment or treatment are referred to the outpatient mental health clinic for formal assessment.

At WRAMC and Brooke Army Medical Center, mental health clinicians have begun using the Parent Guidance Assessment–Combat Injured (PGA–CI) instrument as a mechanism to assist in conducting discussions with injured SMs and their spouses about the needs of their families (especially their children) in response to the combat injury. A copy of the PGA-CI is included in Attachment 1. This semistructured clinical interview is designed to assess family demographics, deployment experience, nature of the combat injury, intrafamilial communication about the injury, and the effect of the event on family members, and to initiate discussion about family expectations and future plans. Often, the PGA-CI interview is the spouses’ first opportunity to talk about their personal experiences and to describe the effect of this powerful event on the family. The PGA-CI affords the time to think about their children and to ask questions about how best to meet their children’s needs. Ultimately, the PGA-CI was designed to assist healthcare professionals in the formulation of family assistance strategies and plans, with specific interest and emphasis on the positive growth of children.

### CHILDREN’S RESPONSES TO COMBAT INJURIES

It is expected that all family members are likely to show some level of distress because of the sudden injury of a military family member. Clinicians have anecdotally observed that although most children do not initially demonstrate symptoms consistent with actual psychiatric disorder, many appear anxious, saddened, or troubled by the news. Parents do not always accurately recognize the emotional effect of the parent’s injury on children. Prior studies have shown that parent reports alone are not reliable in the determination of child behavioral and emotional problems and that cross-informant input from others, to include children, is required for accurate assessment.<sup>31</sup> Children who have been exposed to trauma similarly report different and much higher levels of clinical symptoms than their parents, highlighting the importance of direct child assessment for accurate evaluation.<sup>32</sup> No scientific investigation has yet systematically and directly measured the responses of children to parental combat injury. This section provides anecdotal descriptions of children with whom the authors have engaged.

When children first meet their injured parent, their understanding of the injury and the implication of the injuries can be limited. They may experience a broad range of emotional responses that can be confusing both to themselves and to the important adults in their lives. Some children become hesitant and afraid of

what they see. They are often distressed and unable to show affection to the injured parent. As a result, some injured SMs express feelings of hurt or disappointment by these reluctant responses. When this occurs, the uninjured parent or another relative may be overly forceful in pushing children, especially young children, to show affection for the injured.

When parents deploy, children are usually told that their parents will safely return home. After the injury, children realize that parents cannot always keep promises that they make. A few children have expressed confusion and anger toward authority, as if they have been wronged. Frequently this anger may be directed toward the caregiver or other adults. Alternatively, children may verbalize fear and ambivalence. They may look to blame others for their parents’ injuries or may feel guilty as if somehow they are responsible. After the immediate emotional response, children report feelings of relief and gratitude that the SM parent is alive and safe. However, emotions can fluctuate in character and intensity.

A developmental perspective is helpful when the expected responses of children to parental injury are considered. For example, although infants and toddlers (0–2 years) may be assumed to have little cognitive capacity to appreciate their parents’ injuries, they will respond based upon changes in the schedules and routines of their lives, and the physical and emotional

availability of important adults, as well as any changes in the emotional tenor (anxiety, interpersonal abruptness, irritability) of these individuals.

Young children (3–6 years) have greater awareness of the actual nature of the injury. However, this understanding is likely to be undeveloped and fragile. Young children use “magical thinking,” an immature cognitive process characterized by egocentric thinking, which can lead them to inaccurately take responsibility for events that occur. Young children’s cognitive processes become even less reality based at times of high anxiety, as occurs after a parent’s injury. For example, one 4-year-old son of an injured SM told his grandparent that he was responsible for his father’s injury because he did not remind his dad to be careful when the SM was deploying. The young child needed to be reassured that he did not cause his father’s injury.

The immature cognition capacity of young children can lead to an inability to gauge an accurate sense of time. For example, a 3-year-old boy, whose father had multiple injuries and was prescribed extensive bed rest after an amputation, gave his father’s wound a kiss and said, “It’s all better now, Dad. Let’s play.” He became confused and frustrated when repeatedly told that his father could not yet play with him. The staff worked with the boy and his parents to establish more circumscribed ways of playing that allowed the father and son to enjoy their time together. Because many serious injuries can result in months, if not years, of medical treatment and rehabilitative services, the patience of young children can rapidly dissipate. Professional intervention that assists parents in understanding the developmental limitations of children and in creating new means of interaction can be invaluable for the future success of the family.

The clinician must recognize how young children perceive and integrate the nature of their parents’ injuries. Not uncommonly, young children who see their seriously injured parents become disorganized and extremely anxious. They may wonder “if this powerful and important person in my life can be hurt in this way, what could potentially happen to me?” For example, the mother of two young sons of a seriously injured marine asked to talk with a WRAMC CAPS clinician about their behavior. The boys were becoming increasingly aggressive, impulsive, and active, especially when their father’s injury was discussed. While in the room visiting their father, the boys sat quietly and were immobilized, carefully watching him. After leaving the room, they became aggressive with each other and oppositional to their mother.

During the evaluation, each child was asked to “draw a person.” They were given no additional directions and were not specifically requested to draw their father. The younger child produced the drawing shown

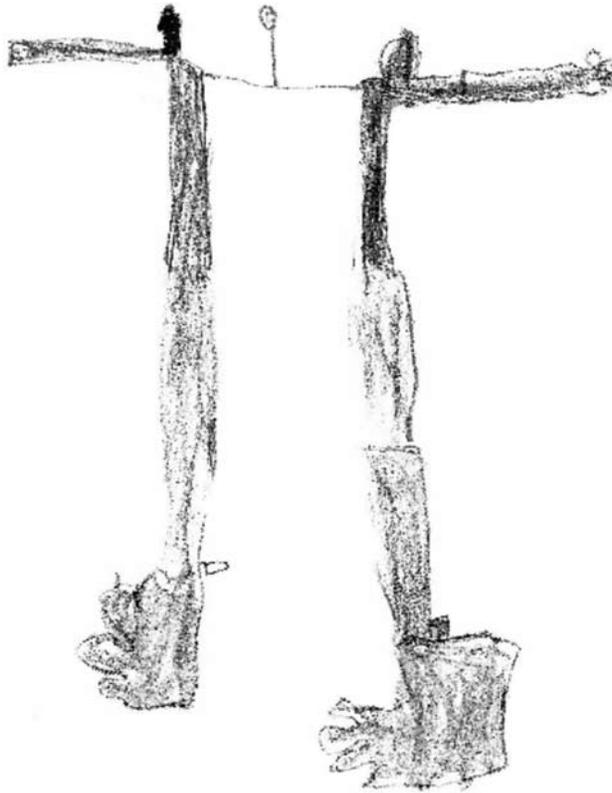
in Figure 31-2. He initiated the drawing as one would expect, completing the face first, but then proceeded to scribble erratically over and around the face. When asked what the picture represented, the young boy stated, “This is a man in an explosion.” After completing the drawing, the boy shifted to aggressive play with toy dinosaurs and jungle animals.

The older 5-year-old brother was also asked to produce a drawing of a person. His drawing is shown in Figure 31-3. Unlike his younger brother, he completed the drawing in a very careful and methodical fashion. However, different from his younger brother and the typical approach of other children, the boy started by drawing the figure’s feet, which were large and sturdy. He then added extended sections of leg bilaterally. After adding three sections of leg to the drawing, the 5-year-old drew a brace between the two legs to hold them together. The brace was later erased and is not present in the final drawing. This addition betrayed the older son’s anxiety about the body’s perceived instability that needed to be supported by an armature. He completed the drawing by adding arms, powerful shoulder muscles and a small head. There is no apparent torso and the body is joined at the shoulders.

The children’s drawings that appear in these figures give some view into their interior psychological worlds and their drive to process what they had seen and experienced. Their immediate choice to draw injured bodies indicated the psychological challenge that each faced. The younger son was clearly struggling to make



**Figure 31-2.** Drawing of 3-year-old son of severely injured service member. Image courtesy of Stephen J Cozza, MD.



**Figure 31-3.** Drawing of 5-year-old son of severely injured service member. Image courtesy of Stephen J Cozza, MD.

sense of his father's injury, but was finding difficulty in doing this in any organized way. In comparison, his older brother, while equally preoccupied with his father's injury, demonstrated greater capacity to organize his own thoughts and anxieties and develop his own solutions (as evidenced by the added brace). This greater ability probably indicates the older brother's greater psychological and cognitive capacities. The drawings are not presented as examples of psychopathology, but rather to highlight the challenges that face the young children of combat-injured SMs.

Older children have more mature developmental capacity to meet the stresses of parental injury, both cognitively and emotionally. Nonetheless, the school-aged child may still harbor similar anxieties to those of younger children. Fear, in combination with a sense of guilt and a desire to take responsible action, can complicate the school-aged child's response, as the following two examples illustrate. An 8-year-old boy, whose father had multiple severe injuries and was unconscious as a result of an IED explosion, expressed his reaction to a 4th of July celebration that occurred while he was visiting the hospital. During the celebration he was frightened by both the fireworks and low-flying helicopters. He worried that

his family was being targeted by missile attacks from "the bad guys." He imagined another 9/11 terrorist attack near the hospital. He was able to talk with the staff concerning his frequent worries about his and his family's safety. One 10-year-old girl confided that she was sad and missed her two cats that were given to a friend and was sure that she would never see them again. CAPS staff helped her raise these concerns with her parents, who were unaware of the impact of this loss.

Not surprisingly, children can be confused about expectations related to their responses to the injured parent. They may not understand what is or is not appropriate and may feel uneasy bringing up questions. One injured SM expressed concern that her children were reluctant to have physical contact with her. As they had always been affectionate, she could not understand why they no longer wished to be hugged. The mother's apprehension prompted a discussion in which the children described the fear that if they touched her, they might inadvertently add to her ongoing pain. This new understanding allowed the mother to reassure the children and to help them find ways to express their love and care without fear of increasing her pain.

Based upon their developmental stage, teenagers are faced with unique challenges related to parental injury. At a time when they are normally expected to become more independent and less reliant on family, they can be confused by a sudden need to once again be close to, and intensely involved with, their parents and families. Given their near-adult capacity, teenagers may also be asked to shoulder some of the greater demands that result from parental injury, including increased chores, care for younger children, or assistance in the care of the injured parent. Teenagers may be ambivalent and may voice wishes to be with their friends, rather than spend time with their families or injured parent. When visiting the hospital, adolescents have been observed playing electronic games or spending time on computers away from their parents. An adolescent's apparent lack of interest should not be construed as apathy. Clinicians should encourage parents to discuss their teenagers' fears about the injury and their ambivalence about the changed family. Parents may need to be reminded of the importance of remaining involved in their teenagers' lives, especially because this age group is at high risk for engaging in dangerous behaviors. Parents should be encouraged to be clear about their expectations, set appropriate limits on behavior, and consistently administer discipline, when appropriate.

Children and teens can also become activated in healthy ways in response to parental injury. One injured amputee parent proudly shared that his son

started a blood drive for a local hospital in appreciation of the care that his father had received. Clearly, this boy was able to redirect the unfortunate experience of his father's injury into altruism and leadership that supported his father's healing. Other children have channeled their energy and desire to help in positive ways within the hospital setting. For example, two preteenage children came to visit their single father who had serious upper extremity injuries as a result of an IED blast. These children cared for their father by bringing food and water and assisting him with some simple and age-appropriate activities of daily living. As a result, the children felt that they were part of their father's treatment and made important contributions to his progress. The clinical staff encouraged the father to include his children in these activities as they requested, while setting limits where developmentally appropriate.

Children whose situations must be closely evaluated are those with preexisting emotional, behavioral, developmental, or medical conditions of their own. For these potentially more vulnerable children, clinicians can expect that the stresses associated with parental injury may lead to greater distress or worsening of their underlying conditions. Healthcare providers should maintain a lower threshold for referral to appropriate clinical resources. At times, families that have children with preexisting conditions may move from their homes to live in the vicinity of the military hospital where the parent is being treated. These parents need to facilitate continuity of care from earlier treatment providers to newly identified clinicians at the military hospital site. Given a family's preoccupation in addressing the medical needs of the injured parent, children's healthcare or educational needs can go

#### EXHIBIT 31-2

#### GOALS FOR CHILDREN OF INJURED SERVICE MEMBER PARENTS

**Develop an age-appropriate understanding of what happened to the parent.**

**Develop an age-appropriate understanding of the injury and required medical care that can result in**

- family separations,
- lengthy hospitalizations,
- multiple procedures, and
- change in family structure/routine.

**Accept that they did not create the problems they may now see in their families.**

**Learn to deal with the sadness, grief, and anxiety related to parental injury.**

**Accept that the parent who went to war may be "different" than the person who returned, but is still their parent.**

**Adjust to the "new family" situation by**

- staying hopeful,
- having fun,
- being positive about life, and
- maintaining goals for the future.

unaddressed or inappropriately delayed. Ultimately, children must integrate the realities of the parent's illness over time and adjust to the changes that they face. Exhibit 31-2 highlights the goals of recovery for the children of combat-injured SMs.

#### EFFECT OF THE INJURY ON THE PARENT

In addition to the direct effect of the injury on children, it is important to consider the psychological effect of these injuries on SMs and on their various family roles. Depending upon the nature of the injury, SMs may have resultant physical, psychological, or cognitive changes that affect their abilities to function in virtually all areas of their lives, including parenting. Injuries can alter an SM's capacity to feel comfortable in intimate relationships, may create distance with those to whom they are married or emotionally close, and may undermine their sense of sexual capacity. Because the vast majority of injured SMs are young men, it is important to recognize the potential for narcissistic trauma that negatively affects their sense of competence as men, with resulting effect on spouses and children.

Injured SMs were likely physically active individu-

als who incorporated these traits in their parenting activities prior to the injury. Physical activities (hiking, backpacking, and camping), hands-on activities (playful wrestling), and athletic activities (ball throwing, skiing, and golfing) were all likely modes of interaction for young military parents with their children. Depending upon the nature of the injury, those modes of interaction either may no longer be possible or may require significant modification to their previous form. In such cases, injured SMs will need to alter their former idealized sense of themselves as parents, mourning any related body change or functional loss. Clinicians should encourage children and parents to explore innovative, mutually developed activities and play that allow parents and children to "try on" fresh ways of relating. The capacity for the parent-child dyad to reestablish enjoyable modes of interaction is

critical to future health and happiness. Candid parental discussions can allow injured SM parents to reframe their situations, develop new skills, and achieve greater strength in parenting. Within the hospital setting, occupational therapy and physical therapy services have incorporated children into therapeutic activities with parents in novel and creative ways.

### Principles of Caring for Combat-Injured Families

Recognizing that parental combat injury is a life-changing event for SMs, their families, and their children, the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences convened the Workgroup on Intervention With Combat-Injured Families. This workgroup included expert military and civilian clinicians and academicians from around the country, focusing on the unique needs of this special population. As a result of workgroup meetings, the Center published a fact sheet titled "Principles of Caring for Combat-Injured Families and Their Children" (Attachment 2). These 10 principles can be used by hospital- and community-

based professionals in military and civilian settings to support the healthy growth and recovery of this unique population. The principles of caring are summarized in Exhibit 31-3.

### Long-Term Rehabilitation and Transitions

Although most of this chapter has addressed the experiences and needs of the families and children of the combat injured during the immediate aftermath of injury, their long-term requirements can vary tremendously and must be planned for. Some data suggest that injured SMs may develop vulnerabilities as they transition back to their homes and communities.<sup>1</sup> When families leave the hospital setting they no longer have the intensive resources that were available. They can lose connection with the families of other injured SMs with whom they may have developed a

#### EXHIBIT 31-3

#### PRINCIPLES OF CARING FOR FAMILIES AND CHILDREN OF THE COMBAT INJURED

- Principles of psychological first aid are primary to supporting families of combat-injured service members.
- Medical care for the combat injured must be family focused.
- Service providers should anticipate a range of responses to combat injury.
- Injury communication is an essential component of care of the families of injured service members.
- Programs to assist the families of combat-injured service members must be developmentally sensitive and age appropriate.
- Care of the family of injured service members is longitudinal, extending beyond immediate hospitalization.
- Effective family care requires an interconnected community of care.
- Care must be culturally competent.
- Communities of care should address any barriers to service.
- Families, communities, and service providers must be knowledgeable.

#### EXHIBIT 31-4

#### RESOURCES

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2. Sesame Workshop Talk, Listen, Connect: Deployments, Homecomings, Changes—DVD and print materials. Available through Military OneSource at: <http://www.militaryonesource.com>, and by online streamed video at: <http://www.sesameworkshop.org/tlc>. Accessed October 14, 2009.
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sense of fellowship and camaraderie. Families may struggle with the realities of being home, having to face responsibilities and routines that no longer seem manageable. Often injured SMs require continuing medical or rehabilitative care. Access to needed services can be problematic or may require the scheduling of appointments at treatment facilities that are at great distance from home, adding more stress to family routines.

With the return of the injured SM, children may expect a return to the lives they remember. They may become disappointed with changes that they experience in the family. Older children and teenagers may have to pick up additional household responsibilities that the injured parent is no longer able to perform. When children are placed in a care-provider role to the injured SM, emotional challenges can be even greater. Teens may be asked to assist with wound care, self-care, or other activities of daily living that require intimate contact with the parent. This contact

can be confusing, emotionally upsetting, and lead to resentment and frustration. Such activities should be minimized.

Finally, longer-term consequences of severe combat injury can result in medical retirement from the military service, the loss of a cherished military career, and movement from homes in military communities to other locations or back to families of origin. Although such transitions may increase access to available resources, particularly when the extended family is supportive, these changes are likely to be stressful for both adults and children. Moves from known communities likely mean loss of friends, changes in schools, and possible elimination of enjoyable extracurricular activities. Moves also can cause relocations to communities that have little understanding or appreciation of military culture and the unique challenges that the family has faced. (See Exhibit 31-4 for additional resources available to help families of combat-injured service members.)

## SUMMARY

Combat injury can profoundly affect the lives of service members, their families, and their children. Upon injury notification, a cascade of events takes place that can result in distress and interpersonal turmoil for children and adults in the families of the combat injured. Disruptions in parental functioning and family structure are common. The effect on children of serious injury to a parent is likely to be profound, particularly when it leads to long-term or permanent changes in parents, or deterioration in their functioning. Immediately after the injury, noninjured parents are focused on the medical well-being of the injured SMs and may have difficulty recognizing and meeting

the needs of their children. Children's developmental and emotional capacities determine their abilities to understand and integrate the experience of parental injury. Parents and healthcare providers benefit from developmentally informed guidance to help children accept the injury, manage their distress, prepare for hospital visits, reengage the injured parent, and effectively communicate their needs. Family and child reactions to combat injury must be understood as a longitudinal process beginning with injury notification and continuing through longer-term rehabilitation and potential transitions to new lives and new communities.

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## ATTACHMENT 1: PARENT GUIDANCE ASSESSMENT—COMBAT INJURY



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### PARENT GUIDANCE ASSESSMENT – COMBAT INJURY (PGA-CI)

The PGA-CI is a semi-structured clinical interview for collecting preliminary family, child, and parent information from the spouse of recently hospitalized, severely injured service members to guide appropriate child and family interventions. The profound impact on combat injured families necessitates increased support and guidance to sustain parent and family function and child health.

The PGA-CI is a clinical interview to be administered *only* by experienced mental health professionals familiar with the unique issues and challenges of combat-injured soldiers and their families. The PGA-CI provides a selective but sufficiently broad summary portrait of injury-related issues from notification of injury through rehabilitation and recovery as it impacts the wounded service member, his/her children, spouse and other family members. The PGA-CI was developed to assist mental health professionals in the formulation of family assistance strategies and plans.

The PGA-CI is not a self-report questionnaire and therefore should not be used for self-completion by the spouse of combat-injured soldiers. In addition the PGA-CI does not provide prescriptive guidance concerning how the resulting information should be interpreted and utilized.

The PGA-CI is organized thematically and uses both open-ended and response-scale formats. The instrument is not intended to provide an interpretive score. The PGA-CI is not exhaustive in its coverage of these domains. Those who administer this instrument may need additional information to develop and provide appropriate interventions for parents, children and the family.

The PGA-CI is not intended for, but may have applicability, for other families with an injured parent such as might appear in a trauma center after a major motor vehicle accident.

#### **The PGA-CI assesses:**

- a) Family demographics
- b) Family deployment experience
- c) Nature of service member's combat injury
- d) Injury communication: notification of injury and parent-child injury-related communication
- e) Event impact on parent: parent behavioral and emotional responses and concerns
- f) Event impact on child(ren): child behavioral and emotional responses and concerns
- g) Understanding and preparation for future family needs

**FAMILY DEMOGRAPHICS**

**I would like to begin by asking some basic information about you and your family**

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Spouse Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Years married \_\_\_\_\_ Number of Children \_\_\_\_\_

Child Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Military Branch

	Army	Marines	Navy	Air Force	Coast Guard
Active Duty	<input type="checkbox"/>				
Reserves	<input type="checkbox"/>				
National Guard	<input type="checkbox"/>			<input type="checkbox"/>	

Where do you live? State: \_\_\_\_\_ City/Town: \_\_\_\_\_

Living situation/members – where? \_\_\_\_\_

Do you have access to the military community and services?  Yes  No

Do any members of your extended family live nearby?  Yes  No

Notes

**FAMILY DEPLOYMENT EXPERIENCE**

**I am going to ask you some questions about your spouse’s deployment**

Dates/scheduled length of deployment \_\_\_\_\_

How many times had your spouse been deployed to combat prior the current deployment ? \_\_\_\_\_

Current deployment: Location: \_\_\_\_\_ Date (mm/dd/yy) : // Duration: \_\_\_\_\_

Unit/MOS/Function \_\_\_\_\_

How would you characterize the family impact of your spouse's deployment prior to the injury?

	<b>Minimal Strain</b>		<b>Moderate Strain</b>		<b>Significant Strain</b>
On Children	1	2	3	4	5
On you personally	1	2	3	4	5
On your spouse	1	2	3	4	5

Can you give me some examples?

To what extent did you and your spouse discuss the possibility of combat injury prior to deployment?

<b>No Discussion</b>		<b>Limited Discussion</b>		<b>Significant Discussion</b>
1	2	3	4	5

To what extent did you or your spouse discuss the possibility of parental combat injury with your child prior to deployment?

	<b>No Discussion</b>		<b>Limited Discussion</b>		<b>Significant Discussion</b>
Child Name: _____	1	2	3	4	5
Child Name: _____	1	2	3	4	5
Child Name: _____	1	2	3	4	5
Child Name: _____	1	2	3	4	5

How about any differences in the level of detail you provided different children?

**NATURE OF INJURY**

**Now I am going to ask you some questions about your spouse's injury**

Date of injury (mm/dd/yy) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Nature of injury:  TBI  Amputation  Blindness  Multi-trauma  Burn  Other (Describe below)

Describe

How would you rate severity of your spouse's injury?

Minimal Long-Term Impairment		Moderate Long-Term Impairment		Severe Long-Term Impairment
1	2	3	4	5

How difficult has it been for your spouse to relate to you and your children about the injury?

Very Easy		Somewhat Difficult		Very Difficult
1	2	3	4	5

**INJURY COMMUNICATION**

**Notification Process**

Next are some questions about how you were told about the injury

How long after the injury were you notified? \_\_\_ Hours \_\_\_ Days

Who notified you about the injury? \_\_\_\_\_

How were you notified injury?  Telephone  In-person  Other \_\_\_\_\_

Was information passed through informal channels prior to formal channels?  Yes  No

Was the formal notification information accurate?  Yes  No

**These next questions concern children about the injury**

What have you or anyone else told your child(ren) about the injury? (exact wording)

Child Name \_\_\_\_\_

Child Name \_\_\_\_\_

Child Name \_\_\_\_\_

Child Name \_\_\_\_\_

Did you receive any guidance regarding how to share this news with your child(ren)?

No  Yes

From whom? \_\_\_\_\_

How helpful was this?

Not at All Helpful		Somewhat Helpful		Very Helpful
1	2	3	4	5

How comfortable were you speaking with your children about the injury?

	Very Comfortable	1	2	3	4	5	Very Uncomfortable
Child Name: _____		1	2	3	4	5	
Child Name: _____		1	2	3	4	5	
Child Name: _____		1	2	3	4	5	
Child Name: _____		1	2	3	4	5	

How helpful would it have been to have resources or professionals available to help you speak with your child(ren)?

Not Helpful	1	2	3	4	5	Very Helpful
	1	2	3	4	5	

Comments

**FAMILY AND CHILD DISTRESS**

**Typically after an injury a lot of things happen. May I ask you about that?** What things happened to your family immediately after notification?

Clinician please rate the level of organization with which the spouse describes the chain of events after Notification

Very Organized	1	2	3	4	5	Very Disorganized
	1	2	3	4	5	

What were the 3 most important decisions you had to make immediately after notification?

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

Did anyone come to be with you or support you and your family following the injury notification?

	Little or No Support		Moderate Support		Significant Support
Family	1	2	3	4	5
Friends	1	2	3	4	5
Neighbors	1	2	3	4	5
Clergy	1	2	3	4	5
Military	1	2	3	4	5

What were the 3 greatest stresses or strains related to this early chain of events?

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

What 3 three actions by others did you find most helpful to you and your family during this period?

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

How often have you been separated from your child(ren) in connection with hospital visits related to this injury and for how much time for each period?

	Days	Hours		Days	Hours		
Date	/ /			Date	/ /		
Date	/ /			Date	/ /		
Date	/ /			Date	/ /		
Date	/ /			Date	/ /		
Date	/ /			Date	/ /		

To what degree has your spouse's injury disrupted your family/children's lives so far?

	Minimal Disruption		Moderate Disruption		Significant Disruption
Family Routines	1	2	3	4	5
Children's Play Activities	1	2	3	4	5
After School Activities	1	2	3	4	5

Can you give me some examples?

**IMPACT ON PARENT**

How has this injury impacted on the amount of time you spend with your child?

<b>Minimal Impact</b>		<b>Moderate Impact</b>		<b>Significant Impact</b>
1	2	3	4	5

Can you give me some examples?

To what degree has this injury impacted the way you typically discipline your children?

<b>Significantly More Lenient</b>		<b>About the Same</b>		<b>Significantly More Strict</b>
1	2	3	4	5

Can you give me some examples?

**I would be interested in knowing how this injury has impacted you personally**

What has been the most challenging part of this injury for you?

What changes have you had to make to your schedule/life (e.g. job, etc)

What has been most helpful to you in dealing with this injury?

Combat injury is a life-changing event that impacts the entire family; at times it may be helpful to talk with a care provider about how your family is coping with your spouse's injury. Would this be helpful for you?

Yes  No

**IMPACT ON CHILD AND CHILDREN**

**Now I'd like to turn to what you think this experience has been like for your child(ren)**

Has your child developed any adjustment problems since being informed of your spouse's injury?

(check all that apply)

	School Problems	Social Problems	Behavior Problems	Sleeping Problems	Eating Problems
--	-----------------	-----------------	-------------------	-------------------	-----------------

Child Name: _____	<input type="checkbox"/>				
Child Name: _____	<input type="checkbox"/>				
Child Name: _____	<input type="checkbox"/>				
Child Name: _____	<input type="checkbox"/>				

How difficult has this experience been for your child from an emotional perspective?

	Not at all Difficult	Moderately Difficult	Extremely Difficult
Child Name: _____	1	2	3
Child Name: _____	1	2	3
Child Name: _____	1	2	3
Child Name: _____	1	2	3

Has your child witnessed any family conflict related to your spouse's injury?

No  Yes

If so, between whom \_\_\_\_\_

How would you rate the level of conflict?

Little or No Conflict	Moderate Conflict	Significant Conflict
1	2	3
4	5	

PATIENT IDENTIFIER \_\_\_\_\_ PGA-CI

Communication support is very important throughout the injured parent's treatment and recovery. Would it be helpful for a care provider to offer guidance on how to communicate with your child(ren) and/or for your child to talk directly with a care provider ?

**IMPACT OF HOSPITAL EXPERIENCE ON CHILD/REN**

**I would like to ask about what it has been like for your child/ren to visit the hospital.**

How much preparation did your child receive for his/her first hospital visit?

	<b>Did Not Visit</b>	<b>Minimal Preparation</b>	<b>Moderate Preparation</b>	<b>Significant Preparation</b>
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3

How distressful was it for your child to visit your spouse in the hospital?

	<b>Did Not Visit</b>	<b>Minimal Distress</b>	<b>Moderate Distress</b>	<b>Significant Distress</b>
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3

What comments/questions did he/she have about the injury?

Child Name: \_\_\_\_\_

Child Name: \_\_\_\_\_

Child Name: \_\_\_\_\_

Child Name: \_\_\_\_\_

How about your child's exposure to other combat injured soldiers?

	<b>No Other Exposure</b>	<b>Minimal Distress</b>	<b>Moderate Distress</b>	<b>Significant Distress</b>
Child Name _____	NA	1	2	3
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3
Child Name: _____	NA	1	2	3

Has your child participated in his/her injured parent's treatment?

- Child Name: \_\_\_\_\_  Yes  No

**FUTURE PLANS AND ISSUES**

**Now I'd like to turn to some questions about how you see the future**

Have you and your spouse considered long term plans after recovery?  No  Yes

Will he/she be leaving the military?  No  Yes  Unknown

Will you be moving from your current home?

- No  Yes  Unknown

If so, where to: \_\_\_\_\_

Do you anticipate any changes in your spouse's role as a parent or partner?

- No  Yes  Unknown

If so, what kinds of changes do you anticipate?

How significant do you think these changes will be?

<b>Minimal</b>	<b>Moderate</b>	<b>Profound</b>
1	2	3
4	5	

Comments

What impact do you see this injury having over the long-term?:

	<b>Minimal Impact</b>		<b>Moderate Impact</b>		<b>Profound Impact</b>
On you personally	1	2	3	4	5
On your spouse	1	2	3	4	5
On your children	1	2	3	4	5
On your family life	1	2	3	4	5

**FAMILY CHALLENGES AND STRENGTHS**

**As we close I want to ask if there is any other information you would like to share about this experience**

What has been the most difficult part of this experience?

What has been the most helpful part of the experience?

What do you wish you had more assistance with?

Of all the choices you have been faced with around this event, what has been the best choice you have made?

Have you developed any new methods of coping based upon this experience (e.g. in what ways have you grown)?

How would you rate your family's need for the following forms of guidance and assistance?

	<b>Little or No Need</b>		<b>Moderate Need</b>		<b>Significant Need</b>
Parenting guidance	1	2	3	4	5
Stress and coping	1	2	3	4	5
Transition planning	1	2	3	4	5
Family communication	1	2	3	4	5
Child counseling	1	2	3	4	5

**CLINICAL FORMULATION AND CONCLUSIONS**

Clinician: List any identified problems, areas of strength/weakness or need for potential referrals.

ATTACHMENT 2:  
PRINCIPLES OF CARING FOR COMBAT-INJURED FAMILIES AND THEIR CHILDREN

## Principles of Caring for Combat Injured Families and their Children

Combat injury is a life-changing event that impacts a service member, his or her children, as well as other family members and loved ones. Military children are our nation's children, and represent a vulnerable population within the injured family unit. Injury to a parent is a major threat to children of all ages and a challenge for even the most resilient of military families.

**Injury to a parent is a major threat to children of all ages and a challenge for even the most resilient of military families.**

Parental injury disrupts the family system — its routines, cohesion and sense of safety. Importantly, parental injury can alter the child's view of the wounded parent, and undermine the child's view of his or her own physical integrity. Combat injury also affects existing patterns of parenting, as both injured and uninjured parents experience their own emotional responses and face the complicated reality of medical treatment and

rehabilitation over time. Often, adults do not know how to speak to children about the injury, or how much and what kind of information to share.

As a result of parental combat injury, many family members may demonstrate initial distress that is likely to be temporary. Most

children will remain healthy in the face of this stress, but some children may sustain life-changing trajectories in their emotional development and/or their interpersonal relationships. The simultaneous use and study of the following principles of care for our combat injured families will foster evidence based approaches that can support their healthy growth and recovery. These principles can be used by hospital and community based professionals in military or civilian settings.

### Principles of Caring

- **Principles of *psychological first aid (PFA)* are primary to supporting Injured Families.** Care of injured service members and families should incorporate key elements of PFA: providing safety, comfort, information, practical assistance and connection to appropriate community resources — all serving to support healthy family recovery.
- **Medical care for the combat injured must be *family focused*.** Care of combat injured service members must attend to family needs and specifically should work toward relieving family distress, sustaining parental functioning, and fostering effective injury related parent-child communication.
- **Service providers should anticipate a *range of responses* to combat injury.** Serious injury will challenge our healthiest families. Most service members, their children and families will adjust to the injuries they sustain. But, others may struggle with the changes that they face. Some may even develop problems that require treatment. Service providers should expect this broad range of responses and be prepared to meet family needs as they are identified.
- ***Injury communication* is an essential component of injured family care.** Effective injury communication involves the timely, appropriate and accurate sharing of information with and among family members from the moment of notification of injury throughout treatment and rehabilitation. Communication should be calibrated to address patient and family anxiety and to sustain hope. Because families may be uncertain how to share difficult information with their children, they may benefit from professional guidance on what to say and how to say it.
- **Injured Family programs must be *developmentally sensitive and age appropriate*.** Services and programs must address the unique developmental responses of children of varying age and gender, and recognize that distress, care needs and communication ability will change with children of different ages.
- **Injured Family care is *longitudinal, extending beyond immediate hospitalization*.** Services need to be tailored to the changing needs of the combat injured family throughout the treatment and

*Continued*

*Workgroup on Intervention with Combat Injured Families*

Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences

rehabilitation process. Interventions must meet the family where it is within the recovery process, recognizing a family's unique strengths and challenges, as well as anticipate its future needs through transition to a new community or new way-of-life.

- **Effective Injured Family care requires an *interconnected community of care*.** Effective intervention requires collaboration and coordination of services between the family, the health care system, and military and civilian community resources. This collaboration fosters a community of care that reaches across traditional professional boundaries throughout rehabilitation and recovery.
- **Care must be *culturally competent*.** Healthcare and community professionals who interact with combat injured families need to possess the cultural and language competence to engage families that may be traditional or nontraditional in their composition and may be of broad ethnic and religious backgrounds. It is essential that all healthcare and community service providers understand and respect the unique experiences and traditions of military families.

- **Communities of care should address any *barriers to service*.** Barriers to intervention can complicate the healthy recovery of combat injured service and family members. These barriers may include a family's difficulty in accessing health care or community services. In addition, a community's lack of awareness or misunderstanding of the needs of a combat injured family or a family's reluctance to seek assistance (due to stigmatization) can also limit family intervention and recovery
- **Families, communities and service providers must be *knowledgeable*.** Individuals, families, professionals, organizations and communities all have a need for access to quality educational materials to address the challenges that confront combat injured families. Effective education leads to the development of skills in all parties, building empowerment in communities and families. Development of new knowledge is fundamental to better meeting the needs of this unique population.

PLACE LOCAL CONTACT INFORMATION HERE



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