

# Children and Families of Combat Veterans

*Joint Family Support Assistance Program  
September 15, 2008*

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# *Center for the Study of Traumatic Stress*

## *Uniformed Services University*

### **Focus:**

*Education*

*Consultation*

*Research*

*Training*

### **Topics:**

*Trauma*

*Disaster*

*Terrorism*

*War*

*Community Resilience*

***[www.cstsonline.org](http://www.cstsonline.org)***

# Consultation



talk,  
listen,  
connect

Deployments, Homecomings,  
Changes



# Public Education

## RESOURCES FOR RECOVERY

FOR FAMILIES

*Advancing the Health and Care of our Nation's Combat Injured Service Members, their Families and Children*

### *The Combat Injured Family: Guidelines for Care*

Your military loved one has been wounded and suddenly your world has been turned upside down. Combat injury is a life-changing event that impacts a family's routines and its sense of safety and wholeness. Combat injury especially affects children of all ages. Children worry about the effect of the injury on their wounded parent; how that injury will change their bond with that parent and the parents' relationship with each other. Often, caring adults do not know how to speak to children about the injury and its impact on their family, or how much and what kind of information should be communicated.

At this time, many resources of care and support will be extended to your injured service member, to you and to your family and children. Due to normal distress and anxiety, there



may be times when you will not hear, understand or accept all that you will be told.

Do not be shy about writing things down or having an important person in your life accompany you and take notes for you. When you have questions or forget important information ask doctors and healthcare professionals to re-explain or repeat themselves so you can better understand the information they have

provided. Good communication between you and your spouse's medical team and between you, your family and your children is essential for helping you cope and make important decisions related to the care of your injured loved one and to the care of your family.

# Participating Center NCTSN and DCoE

**NCTSN** The National Child Traumatic Stress Network

Home CTS Intro Trauma Types Resources En Español About Us Products Search

**Welcome to NCTSN.org**  
The mission of the National Child Traumatic Stress Network is to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

**Child Traumatic Stress (CTS) Introduction**  
What causes child traumatic stress? How does it affect a child? What can be done about it?

**For Parents and Caregivers**  
It's not always easy to know what type of support children and adolescents need, or how to offer it, but there is help available.

**Military Children and Families**  
Care of our nation's military children helps sustain our fighting force. Gathered here are resources about military families for caregivers, service providers, and children.

**For Educators**  
What are the effects of trauma on schools and learning? What can teachers, principals, and other school personnel do to help? How can they respond to a crisis?

**For the Media**  
Access NCTSN resources and expert press releases, and find tips for coverage.

**Public Awareness**  
National Preparedness Month (September 2008)  
September 11 Anniversary

**It's hurricane season!**  
Be prepared  
Tips for parents and teachers to aid children's recovery  
Additional tools and links

**Are you in crisis?**  
Does someone you know need help?  
Click here

[www.nctsn.org](http://www.nctsn.org)

**DEFENSE CENTERS OF EXCELLENCE**  
For Psychological Health & Traumatic Brain Injury

[www.dcoe.health.mil](http://www.dcoe.health.mil)

# Understanding War Trauma

- Children are affected by their parents' traumatic experiences as well as their own
- Equally dangerous to assume uniform resilience or uniform problems as a result of war exposure
- A real accounting of the trauma and its effects is an *opportunity* to honor the service and sacrifice
- War trauma is a primary source of difficulty for all military family members (combat experience, deployments, separations)

# Reality About Combat

1. The combat environment is harsh and demanding

2. Fear in combat is ubiquitous

3. Unit members will be injured and killed

4. Combat impacts every soldier mentally and emotionally

5. Soldiers are afraid to admit that they have a mental health problem

6. Deployments place a tremendous strain upon families

**Realities of Combat:**

- Combat is sudden, intense, and life threatening.
- It is the Soldiers' job to kill the enemy.
- Innocent women and children are often killed in combat.
- No Soldier knows how he will perform in combat until the moment arrives.

**Development of Battlemind:**

**What is Battlemind?**  
It is a Soldier's inner strength to face adversity, fear, and hardship during combat with confidence and resolution. It is the will to persevere and win.

**Objectives of Battlemind:**  
To develop those factors (focusing on Leader behaviors) that contribute to the Soldier's will and spirit to fight and win in combat, thereby reducing combat stress reactions.

**10 Realities and Battlemind Concepts:**

**Reality # 1: FEAR IN COMBAT IS COMMON.**

**FINDINGS:**

- Over 2/3 of other star recipients reported increased fear as battle progressed.
- Common symptoms of fear: violent shaking/trembling, losing control of bowels, feeling weak, cold sweats, and vomiting.
- Fear and anxiety are reduced in combat when Soldiers engage in actions used from training experiences.

**WHAT LEADERS CAN DO:**

- Drill and train Soldiers' specific actions to use in combat conditions—Tough training is the best preparation.
- Provide Soldiers sufficient physical and mental rest time.
- Admitting and talking about fear will release tension.
- Remember that fear is NOT a mental disorder.

**EVEN HEROES FEEL FEAR.**

**10 TOUGH FACTS ABOUT COMBAT**

*"The capacity of Soldiers for absorbing punishment and enduring privations is almost inexhaustible so long as they believe they are getting a square deal, that their commanders are looking out for them, and that their own accomplishments are understood and appreciated."*

GEN Dwight D. Eisenhower, 1944



**AND WHAT LEADERS CAN DO TO MITIGATE RISK AND BUILD RESILIENCE**



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This presentation contains a combination of research findings and recommendations, many of which are based on personal observations and experience. Therefore, the opinions and views expressed here are mine, and should not be considered representing the U.S. Army or the Department of Defense. OIF/OEF casualty figures are as of 17 November 2004.



# Unique Challenges in Theatre



# Unique Challenges in Theatre



# Unique Challenges in Theatre

# Combat Stress Reactions



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

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

### ABSTRACT

#### BACKGROUND

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

#### METHODS

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

#### RESULTS

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

#### CONCLUSIONS

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

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### ORIGINAL CONTRIBUTION

## Mental Health Problems, Use of Mental Health Services, and Attrition From Military Service After Returning From Deployment to Iraq or Afghanistan

Charles W. Hoge, MD

Jennifer L. Auchterlonie, MS

Charles S. Milliken, MD

IN MARCH 2003, THE UNITED STATES and its coalition partners launched Operation Iraqi Freedom (OIF), the largest sustained ground operation since the Vietnam War. The mental health effects in US military personnel returning from current deployments to Iraq and Afghanistan are of increasing importance to examine and have not been fully explored to date. Previous research has shown that deployment and exposure to combat result in increased risk of posttraumatic stress disorder (PTSD), major depression, substance abuse, functional impairment in social and employment settings, and the increased use of health care services.<sup>1-6</sup> A recent study showed that 17% of soldiers and Marines who returned from Iraq screened positive for PTSD, generalized anxiety, or depression, a prevalence nearly twice that observed among soldiers surveyed before deployment.<sup>7</sup>

Despite the high risk of mental health problems among veterans returning from Iraq and Afghanistan, there have been no systematic studies of mental health care utilization among these veterans after deployment. Such studies are an important part of measuring the mental health burden of the current war and ensuring that there are adequate resources to meet the mental health care needs of veterans returning from Iraq

**Context.** The US military has conducted population-level screening for mental health problems among all service members returning from deployment to Afghanistan, Iraq, and other locations. To date, no systematic analysis of this program has been conducted, and studies have not assessed the impact of these deployments on mental health care utilization after deployment.

**Objectives.** To determine the relationship between combat deployment and mental health care use during the first year after return and to assess the lessons learned from the postdeployment mental health screening effort, particularly the correlation between the screening results, actual use of mental health services, and attrition from military service.

**Design, Setting, and Participants.** Population-based descriptive study of all Army soldiers and Marines who completed the routine postdeployment health assessment between May 1, 2003, and April 30, 2004, on return from deployment to Operation Enduring Freedom (n=64 967), Health care utilization and occupational outcomes were measured for 1 year after deployment or until leaving the service if this occurred sooner.

**Main Outcome Measures.** Screening positive for posttraumatic stress disorder, major depression, or other mental health problems; referral for a mental health reason; use of mental health care services after returning from deployment; and attrition from military service.

**Results.** The prevalence of reporting a mental health problem was 19.1% among service members returning from Iraq compared with 11.3% after returning from Afghanistan and 8.5% after returning from other locations (P<.001). Mental health problems reported on the postdeployment assessment were significantly associated with combat experiences, mental health care referral and utilization, and attrition from military service. Thirty-five percent of Iraq war veterans accessed mental health services in the year after returning home; 12% per year were diagnosed with a mental health problem. More than 50% of those referred for a mental health reason were documented to receive follow-up care although less than 10% of all service members who received mental health treatment were referred through the screening program.

**Conclusions.** Combat duty in Iraq was associated with high utilization of mental health services and attrition from military service after deployment. The deployment mental health screening program provided another indicator of the mental health impact of deployment on a population level but had limited utility in predicting the level of mental health services that were needed after deployment. The high rate of using mental health services among Operation Iraqi Freedom veterans after deployment highlights the importance of ensuring that there are adequate resources to meet the mental health needs of returning veterans.

JAMA 2006;295:1022-1032

www.jama.com

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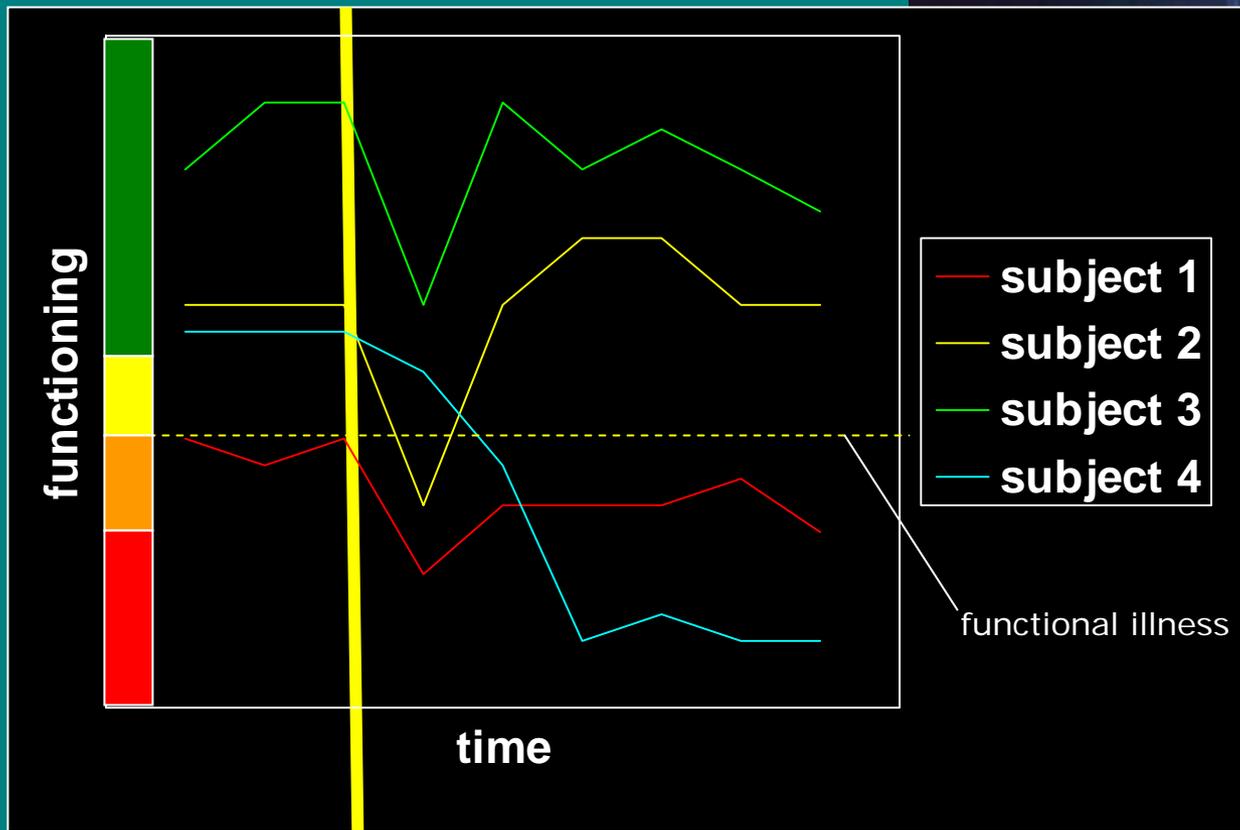
(Reprinted) JAMA, March 1, 2006—Vol 295, No. 9 1023

# Psychiatric Sequelae to Combat Exposure

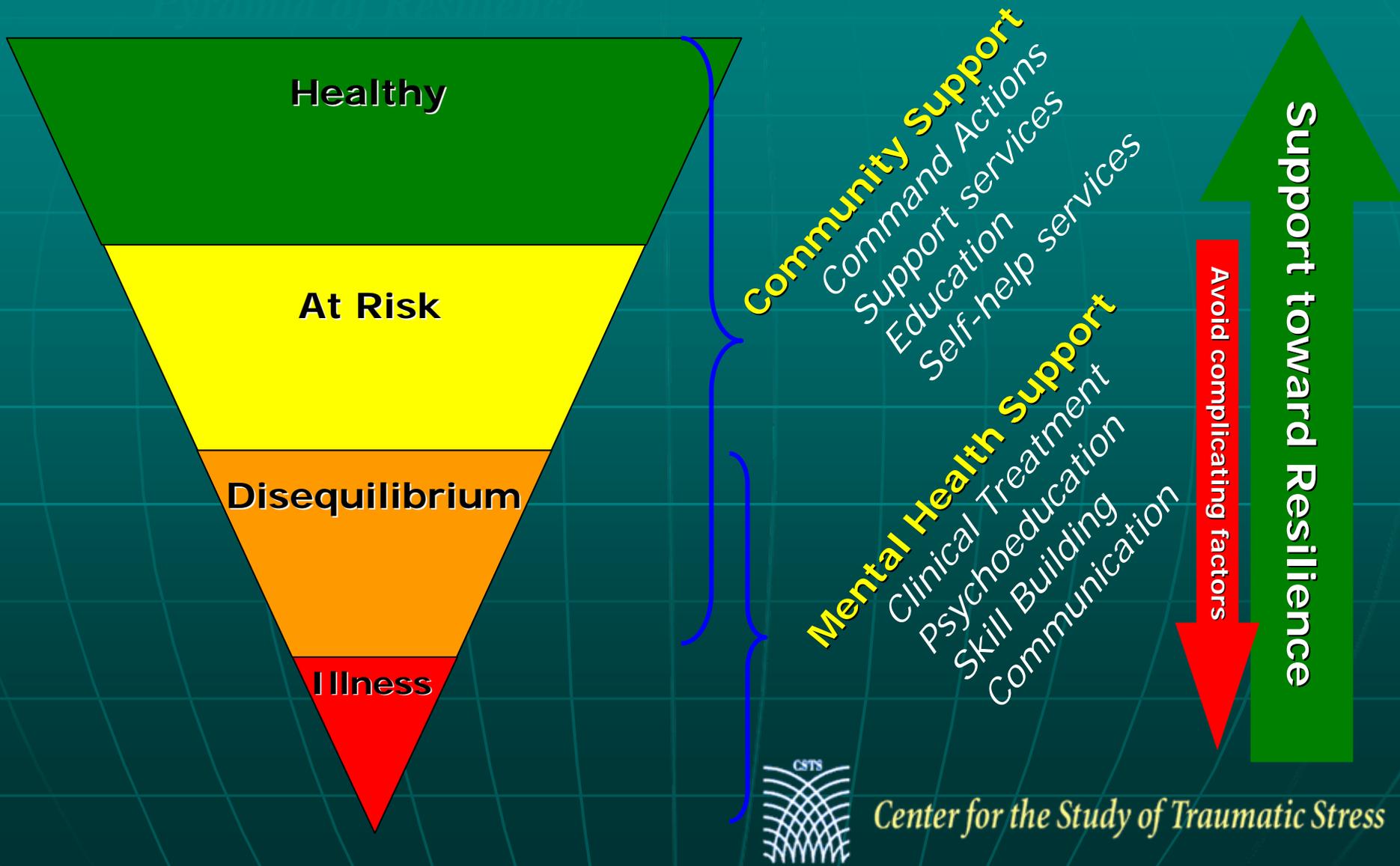
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Messer SC et al: New Eng  
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Hoge CW, Auchterlonie  
JL, Milliken CS: JAMA,  
1 MAR 06

# Resilience Variability in Trauma Response



# Graduated Tiers of Intervention



# Post-Deployment Health Re-Assessment (PDHRA) Results

- Sampled over 88,000 SMs
- Elevated rates of positive screening of PDHRA compared to PDHA
- Over 40% of combat veteran reserve and NG component referred to mental health
- Variability in persistence of PTSD symptoms between PDHA and PDHRA
- **Four fold increase in veteran concerns related to interpersonal conflict**
- Problems with mental health service access for non-active and family members

ORIGINAL CONTRIBUTION

## Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War

Charles S. Milliken, MD  
Jennifer L. Auchterlone, MS  
Charles W. Hoge, MD

OUR PREVIOUS ARTICLE<sup>1</sup> DESCRIBED the Department of Defense's (DoD's) screening efforts to identify mental health concerns among soldiers and Marines as they return from Iraq and Afghanistan using the Post-Deployment Health Assessment (PDHA). However, the article also raised concerns that mental health problems might be missed because of the early timing of this screening. It cited preliminary data showing that soldiers were more likely to indicate mental health distress several months after return than upon their immediate return.<sup>2,3</sup> Based on these preliminary data, the DoD initiated a second screening similar to the first, to occur 3 to 6 months after return from deployment.<sup>4</sup>

This report reviews the mental health responses of the first cohort of soldiers to complete both the PDHA and the new Post-Deployment Health Re-Assessment (PDHRA) after return from the Iraq war. Because of the longitudinal focus of the study, we included soldiers only from the Iraq war (not from Afghanistan), the larger cohort with the most consistently high rates of combat exposure. We addressed several questions regarding the 2 screening programs: (1) Overall, what percentage of veteran soldiers of the Iraq war were

**Context** To promote early identification of mental health problems among combat veterans, the Department of Defense initiated population-wide screening at 2 time points, immediately on return from deployment and 3 to 6 months later. A previous article focusing only on the initial screening is likely to have underestimated the mental health burden.

**Objective** To measure the mental health needs among soldiers returning from Iraq and the association of screening with mental health care utilization.

**Design, Setting, and Participants** Population-based, longitudinal descriptive study of the initial large cohort of 88235 US soldiers returning from Iraq who completed both a Post-Deployment Health Assessment (PDHA) and a Post-Deployment Health Re-Assessment (PDHRA) with a median of 6 months between the 2 assessments.

**Main Outcome Measures** Screening positive for posttraumatic stress disorder (PTSD), major depression, alcohol misuse, or other mental health problems; referral and use of mental health services.

**Results** Soldiers reported more mental health concerns and were referred at significantly higher rates from the PDHRA than from the PDHA. Based on the combined screening, clinicians identified 20.3% of active and 42.4% of reserve component soldiers as requiring mental health treatment. Concerns about interpersonal conflict increased 4-fold. Soldiers frequently reported alcohol concerns, yet very few were referred to alcohol treatment. Most soldiers who used mental health services had not been referred, even though the majority accessed care within 30 days following the screening. Although soldiers were much more likely to report PTSD symptoms on the PDHRA than on the PDHA, 45% to 59% of those who had PTSD symptoms identified on the PDHA improved by the time they took the PDHRA. There was no direct relationship of referral or treatment with symptom improvement.

**Conclusions** Rescreening soldiers several months after their return from Iraq identified a large cohort missed on initial screening. The large clinical burden recently reported among veterans presenting to Veterans Affairs facilities seems to exist within months of returning home, highlighting the need to enhance military mental health care during this period. Increased relationship problems underscore shortcomings in services for family members. Reserve component soldiers who had returned to civilian status were referred at higher rates on the PDHRA, which could reflect their concerns about their ongoing health coverage. Lack of confidentiality may deter soldiers with alcohol problems from accessing treatment. In the context of an overburdened system of care, the effectiveness of population mental health screening was difficult to ascertain.

JAMA. 2007;298(12):2141-2148

www.jama.com

identified as having clinically significant mental health problems and are rates higher on the PDHRA than on the PDHA? (2) As the UK experience sug-

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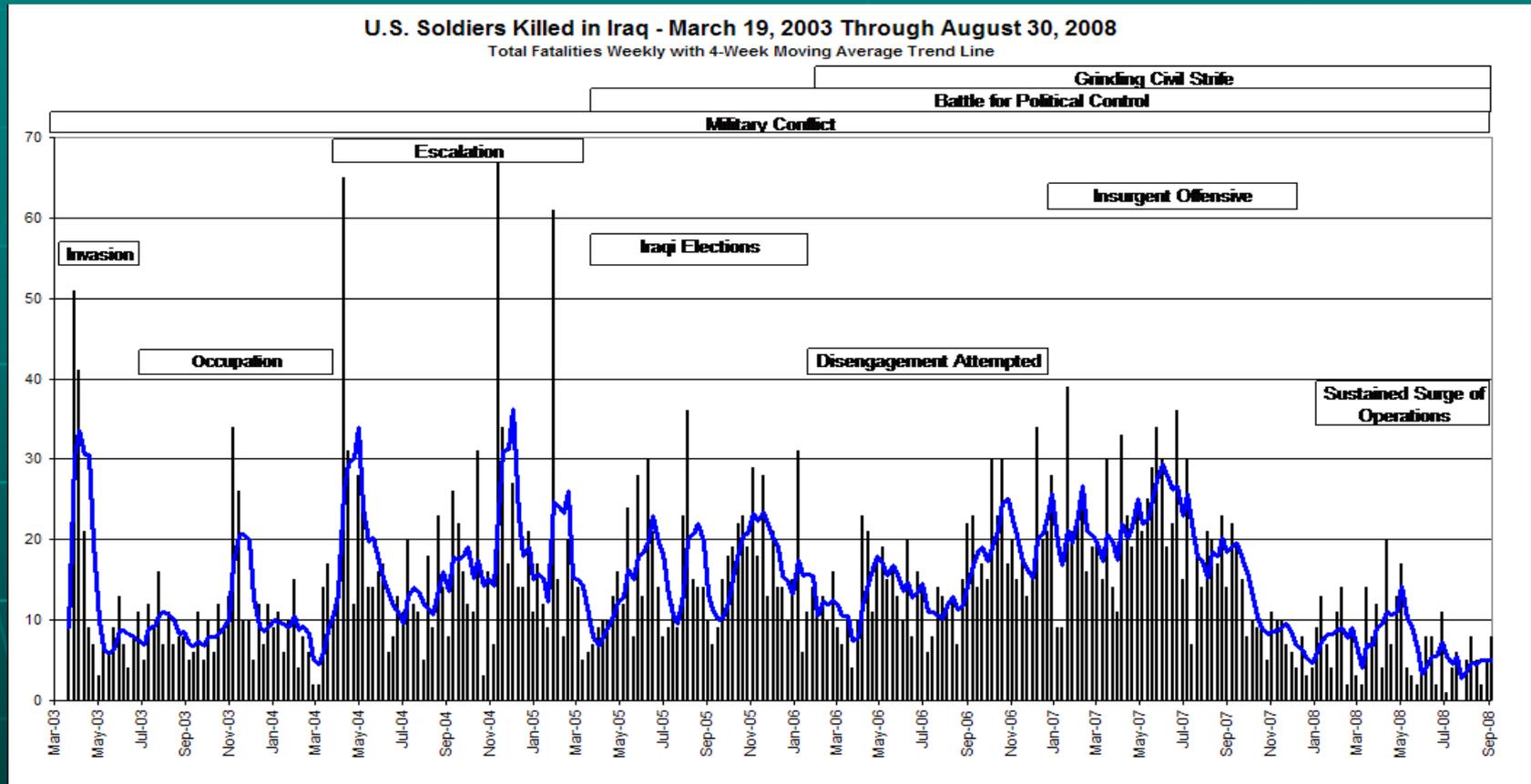
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# Rise in U.S. Army Suicide Rates

- Rising Army suicide rates
- 102 active duty confirmed suicides in 2006 – twice number in 2001
  - 72 not deployed
  - 27 deployed to Iraq
  - 3 deployed to Afghanistan
- Suicide rate per 100,000 soldiers spiked to 17.5 by the end of 2006, up from 12.8 at the start of the year
- Appears related to relationship problems, strain of multiple deployments, psychiatric illness (PTSD and substance use disorders)

# U.S. Fatalities in Iraq

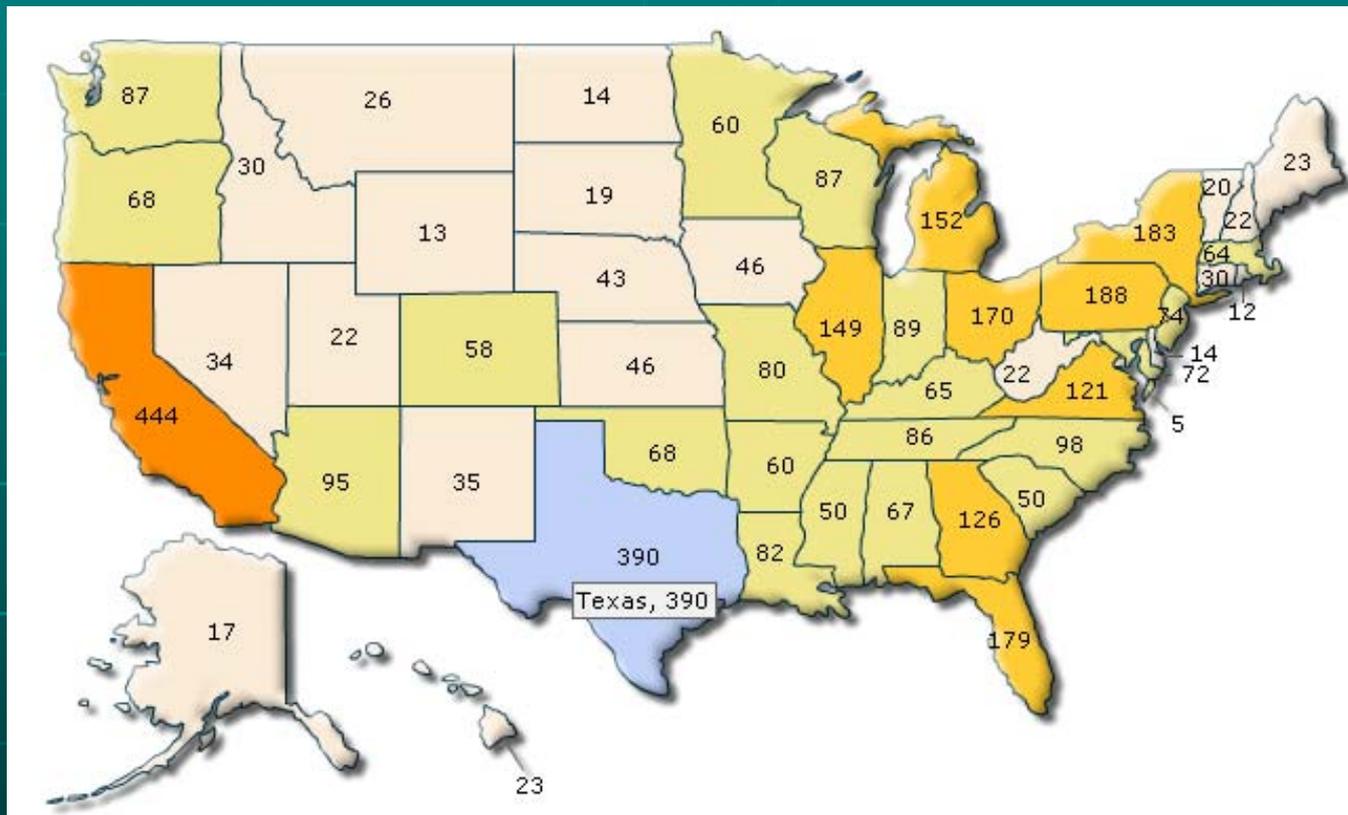


Reported 9 SEP 2008

source: <http://www.icasualties.org/oif/>

# Iraq Fatalities By State

(total n=4155)



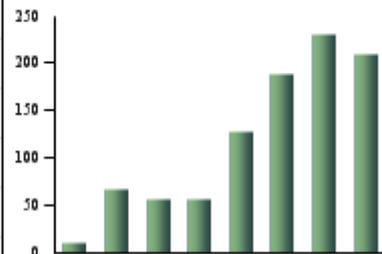
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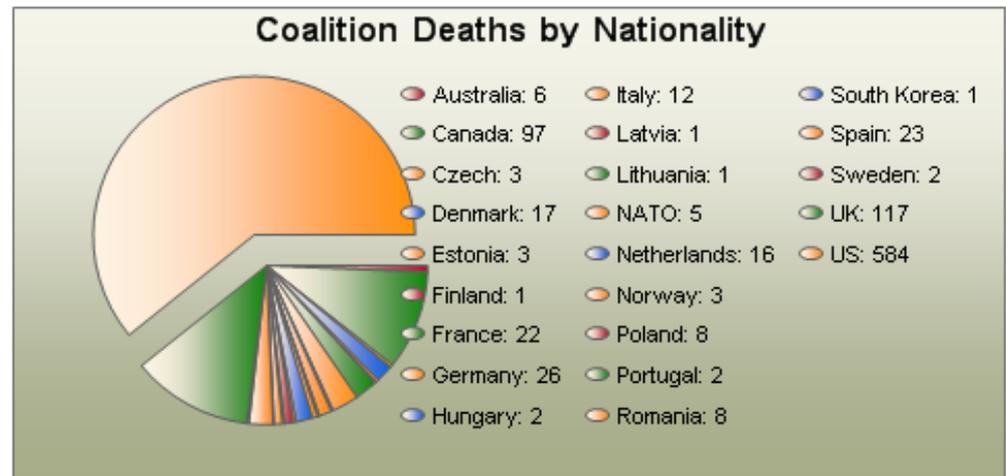
# Operation Enduring Freedom Fatalities

Coalition Military Fatalities By Year

| Year         | US         | Other      | Total      |
|--------------|------------|------------|------------|
| 2008         | 109        | 102        | 211        |
| 2007         | 117        | 115        | 232        |
| 2006         | 98         | 93         | 191        |
| 2005         | 99         | 31         | 130        |
| 2004         | 52         | 6          | 58         |
| 2003         | 48         | 9          | 57         |
| 2002         | 49         | 20         | 69         |
| 2001         | 12         | 0          | 12         |
| <b>Total</b> | <b>584</b> | <b>376</b> | <b>960</b> |



Fatalities By Country

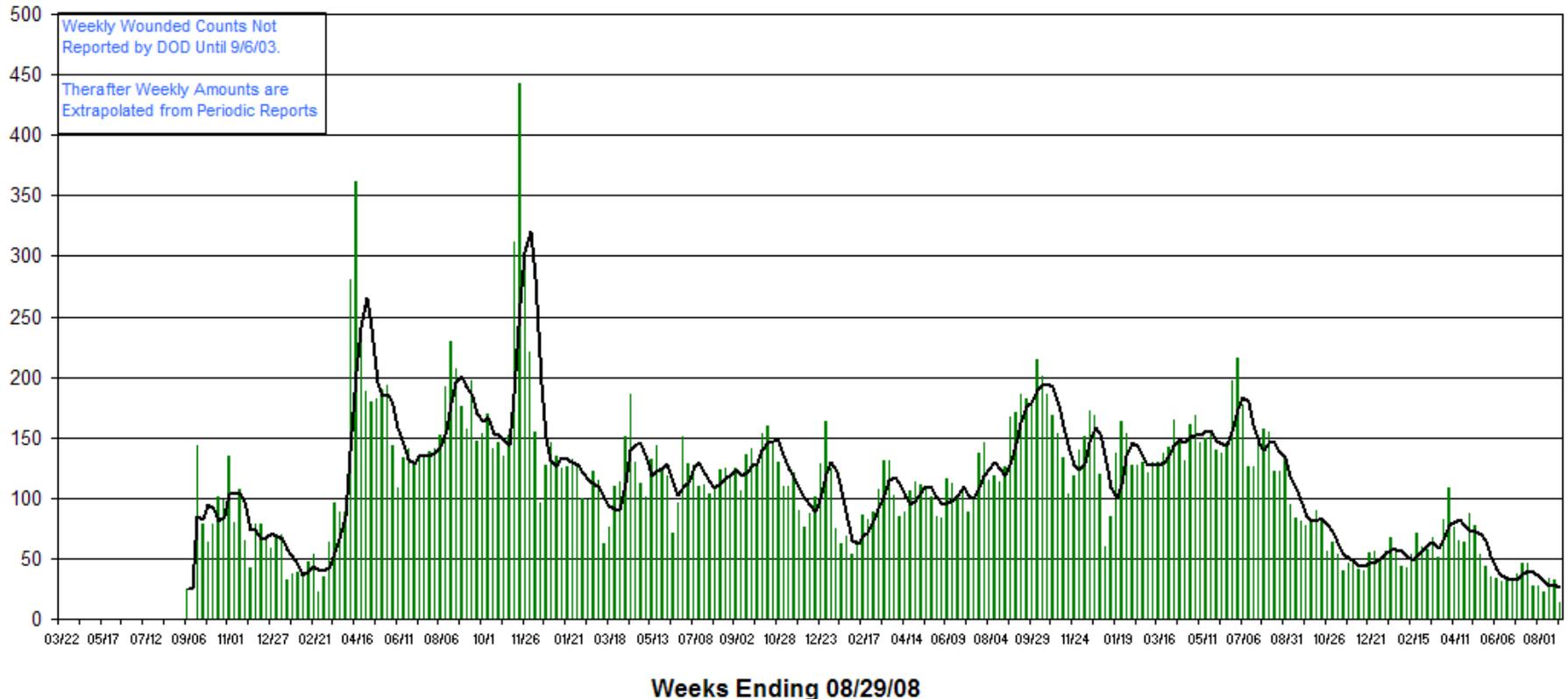


Reported 9 SEP 2008

source: <http://www.icasualties.org/oif/>

# U.S. Injuries in Iraq

## US Soldiers Wounded

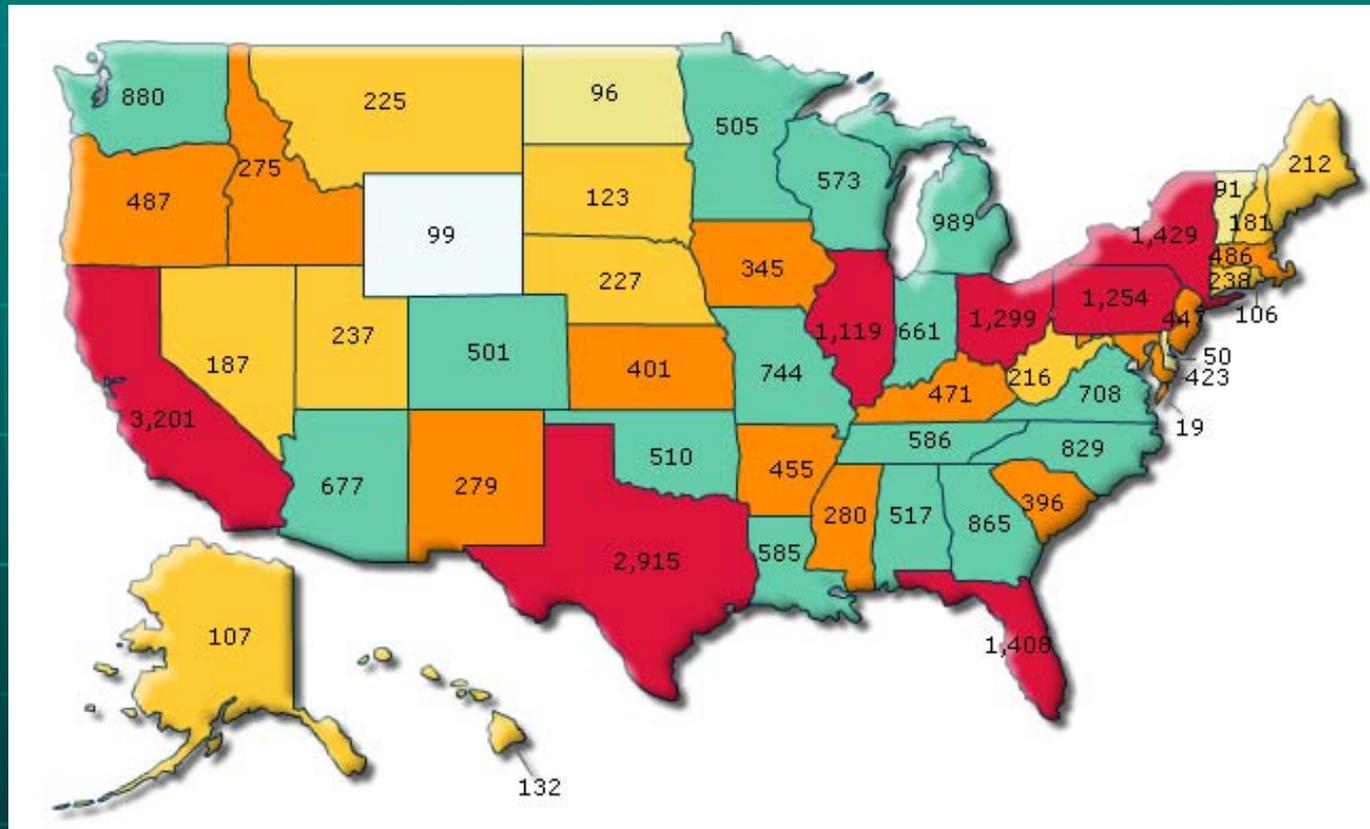


Reported 9 SEP 2008

source: <http://www.icasualties.org/oif/>

# Injured By State

(total n=30,324)

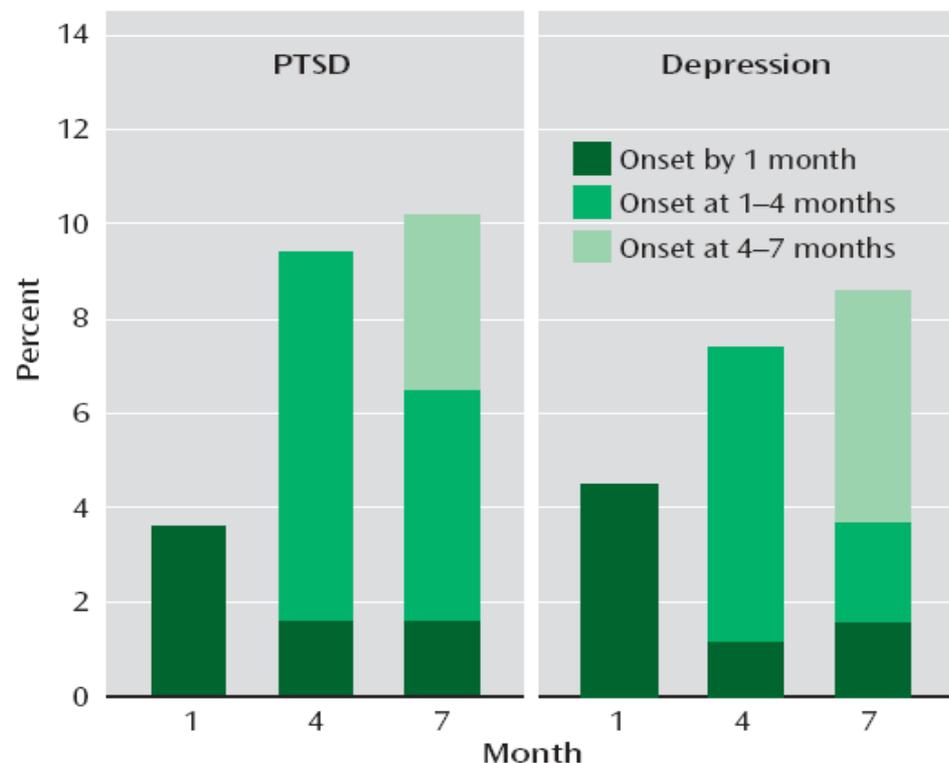


Reported 9 SEP 2008

source: <http://www.icasualties.org/oif/>

# Posttraumatic Stress Disorder and Depression in Battle-Injured Soldiers

FIGURE 1. Rates of PTSD and Depression at 1, 4, and 7 Months Among 243 U.S. Soldiers With Serious Combat Injuries Who Completed All Three Assessments



GRIEGER, COZZA, URSANO, ET AL *Am J Psychiatry* 163:10, October 2006

# Traumatic Brain Injury

- Traumatic Brain Injury- concussion- 10-20% (or more) of combat soldiers/marines affected
- 9.3% PTSD in TBI injured soldiers
- Headache - 38% acutely after moderate-severe concussion
- Post Concussion Syndrome- can persist months to years (change in personality, impulsivity, cognitive slowing)

Warden et al 2005, 2006

# Military Family Challenges

## **Deployment**

- \*transient stress*
- \*modify family roles/function*
- \*temporary accommodation*
- \*reunion adjustment*
- \*military commun maintained*
- \*probable sense of growth and accomplishmt*

## **Injury**

- \*trans or perm stress*
- \*modify family roles/function*
- \*temp or perm accommodation*
- \*injury adjustment*
- \*military commun jeopardized*
- \*change must be integrated before growth*

## **Psych Illness**

- \*trans or perm stress*
- \*modify family roles/function*
- \*temp or perm accommodation*
- \*illness adjustment*
- \*military commun jeopardized*
- \*change must be integrated before growth*

## **Death**

- \*perm stress*
- \*modify family roles/function*
- \*permanent accommodation*
- \*grief adjustment*
- \*military commun jeep or lost*
- \*death must be grieved before growth*

**STRESS LEVEL**

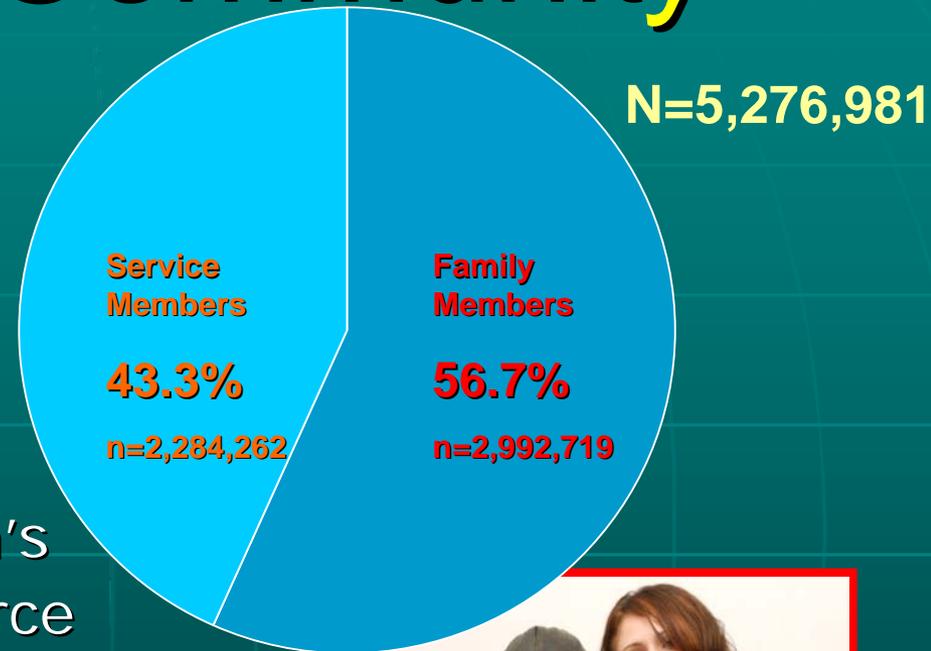
# Our Military Community

Health of military children and families

44% military members have children

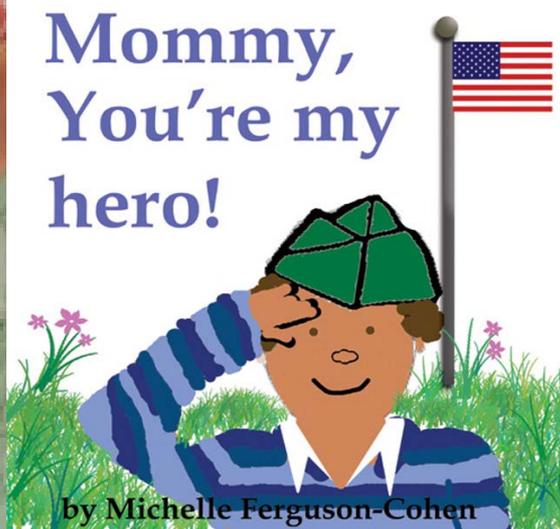
Military children are our nation's children, a national resource

Military children are our future



1<sup>st</sup> Quadrennial Quality of Life Review  
DoD, 2004

# Military Deployments



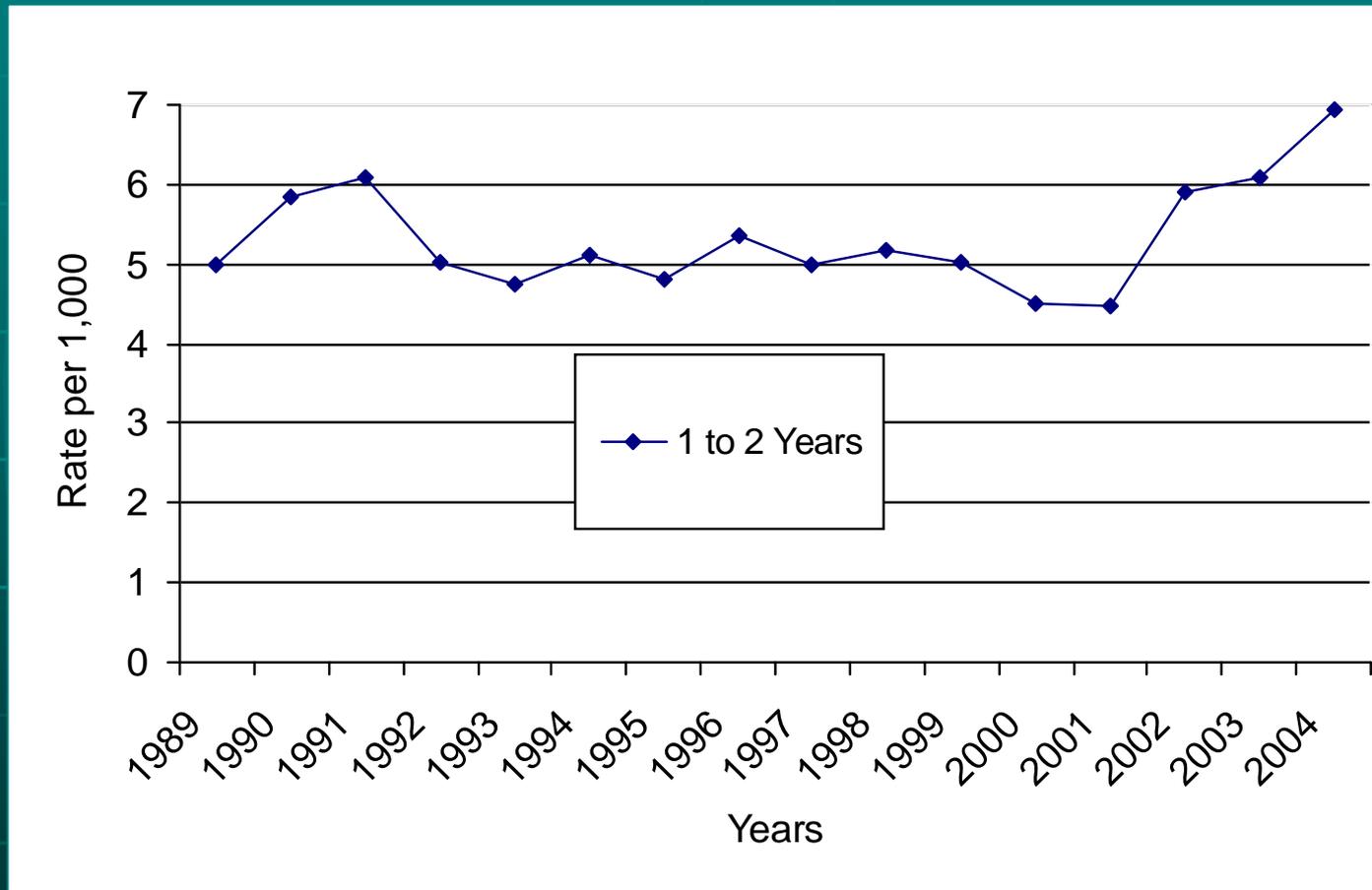
# Corrosive Impact of Stress

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

# Child Maltreatment and Deployment

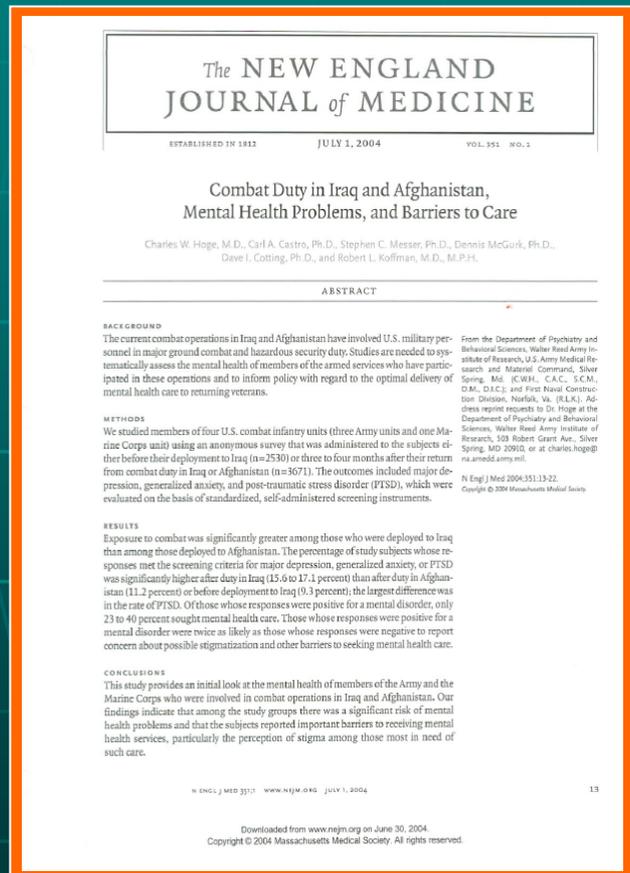
- **Rentz ED, Marshall SW, Loomis D, et al., Am J Epidem 2007**
- **Gibbs DA, Martin SL, Kupper LL, et al., J Amer Med Assoc 2007**
- **McCarroll JE, Fan Z, Newby JH, et al., Child Abuse Rev 2008**
  - Elevated rates of child maltreatment during combat deployment periods
  - Greatest rise in maltreatment appears to be attributed to child neglect
  - Rates of child neglect appear highest in junior enlisted population

# US ARMY CHILD NEGLECT RATES AGE 1-2 YEAR OLDS, 1989-2004



McCarroll J et al, 2005

# IMPACT OF PARENTAL PSYCHIATRIC ILLNESS ON MILITARY CHILDREN



- Parental psychiatric illness
  - disrupts parental role
  - modifies parental behavior
  - disrupts child development
  - child confusion and cognitive distortion
  - increases risk behaviors
    - possible domestic violence
    - substance misuse
- Avoidance – withdrawal of parental availability

# Principles of Caring for Combat Injured Families and their Children

- psychological first aid (PFA)
- family focused
- range of responses
- injury communication
- developmentally appropriate
- longitudinal care
- interconnected community of care
- culturally competent
- barriers to service
- knowledgeable

# Impact of the Injury on the Parenting Process

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

# Tasks for Military Children when Parents Return from War

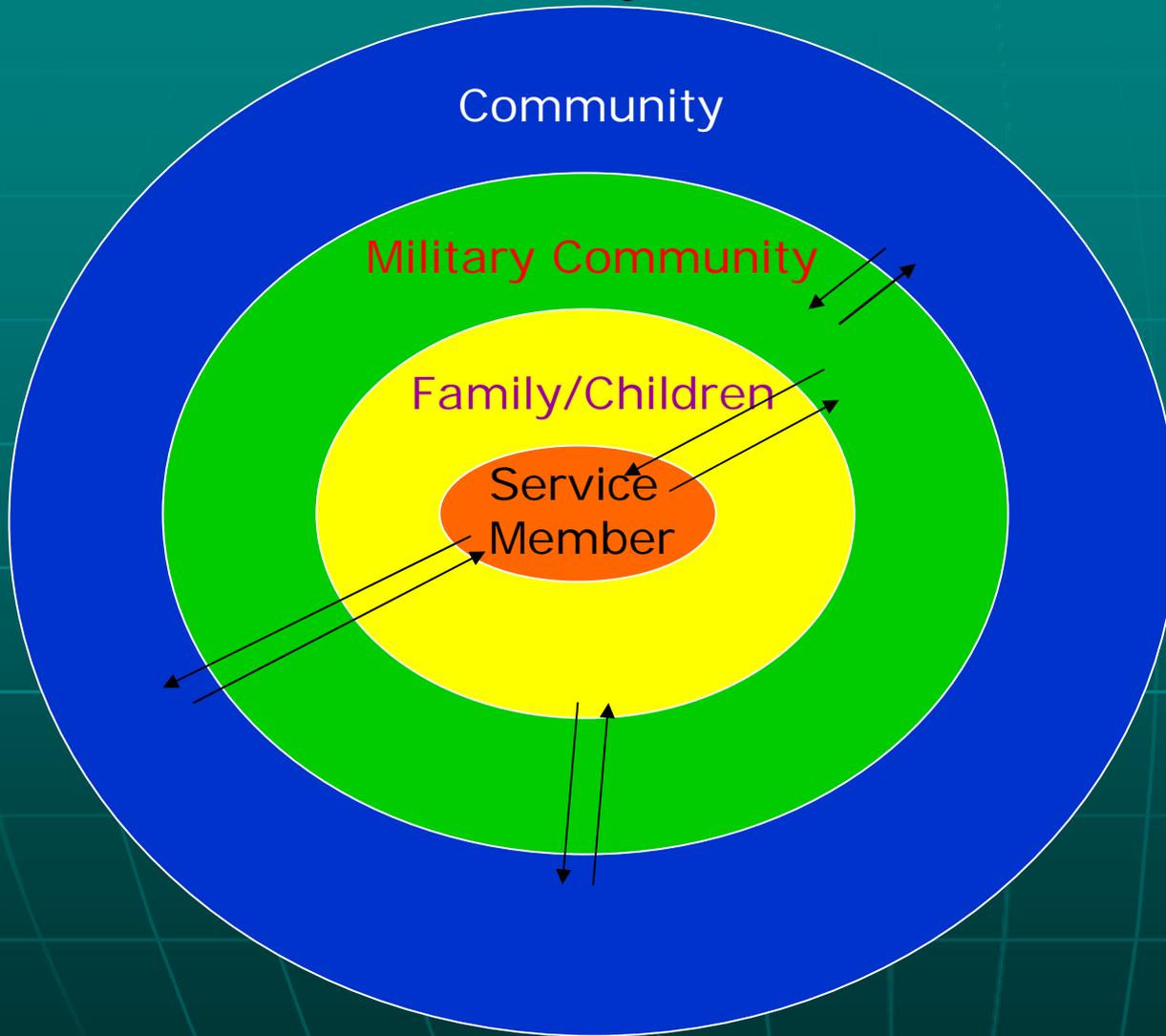
- Develop an age-appropriate understanding of what the parent went through and the reasons why
- Accept that they did not create the problems they now see in their families
- Learn to deal with the sadness, grief and anxiety related to parental injury, illness or death
- Accept that the parent who went 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*
  - *maintaining goals for the future*

# Parental Death in Military Families

- Family and child grieving
- Potential loss of military community support
- Probable family relocation
- Change of schools
- Services typically shift to the civilian community
- Early parental death is a known contributor to compromised child outcomes



# The Recovery and Social Environment



Military service member is contained within layers of support systems

Transactional interplay between layers

Interaction may be mutually helpful or disruptive

Family is the closest social support

Important to maintain function in all roles – spouse and parent

# Sustaining Community Capacity

## *“social ecology”*

- Sustain resources that meet the needs of combat exposed families
  - *Sustain leadership and services*
  - *Sustain a sense of mission and meaning*
- Increase access to services
  - *Decrease barriers to include stigma*
  - *Identify those who are having difficulty*
  - *Encourage help seeking behaviors within the communities*
- Educate to change attitudes and behaviors
- Coordinate and simplify agency efforts
- Collaborate with military/civilian counterparts

# A Coordinated Effort

## *Military Population In Flux*

Change of station  
between communities

Transition to civilian  
life

National Guard and  
Reserve units

Medical and psychiatric  
discharges

Know your role

Think about function  
across organizations



# Psychological First Aid



## PSYCHOLOGICAL FIRST AID

Field Operations Guide

2<sup>nd</sup> Edition



National Child Traumatic Stress Network  
National Center for PTSD

This work was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, opinions, and content are those of the authors, and do not necessarily reflect those of SAMHSA or HHS.

*calm reassurance*

*basic information about trauma response*

*safety*

*comfort and support*

*practical assistance*

*community connection*

*connection to resources*

# National Community Resilience

a recovery and social environment that would lend opportunities for the military family to re-equilibrate after redeployment or trauma event

an environment that acknowledged the multiple stresses that military families have experienced without minimizing nor pathologizing

a recovery environment that meets the broad basic support needs of all service members and families ranging in intensity from no-risk to high risk

# Community Resilience

- Honor the service and sacrifice of service members, their children and their families – *simply listen*
- Resilience may be best supported by monitoring and supporting individual and community “role” functioning
  - Recognize the role of the military child as unique and valuable – instills meaning
  - Acknowledge and support role of the military spouse
  - Provide parents with the support they need to their job – **Parental Efficacy**
    - Offer respite
    - Provide mentoring
    - Provide resources when necessary

# Community Resilience

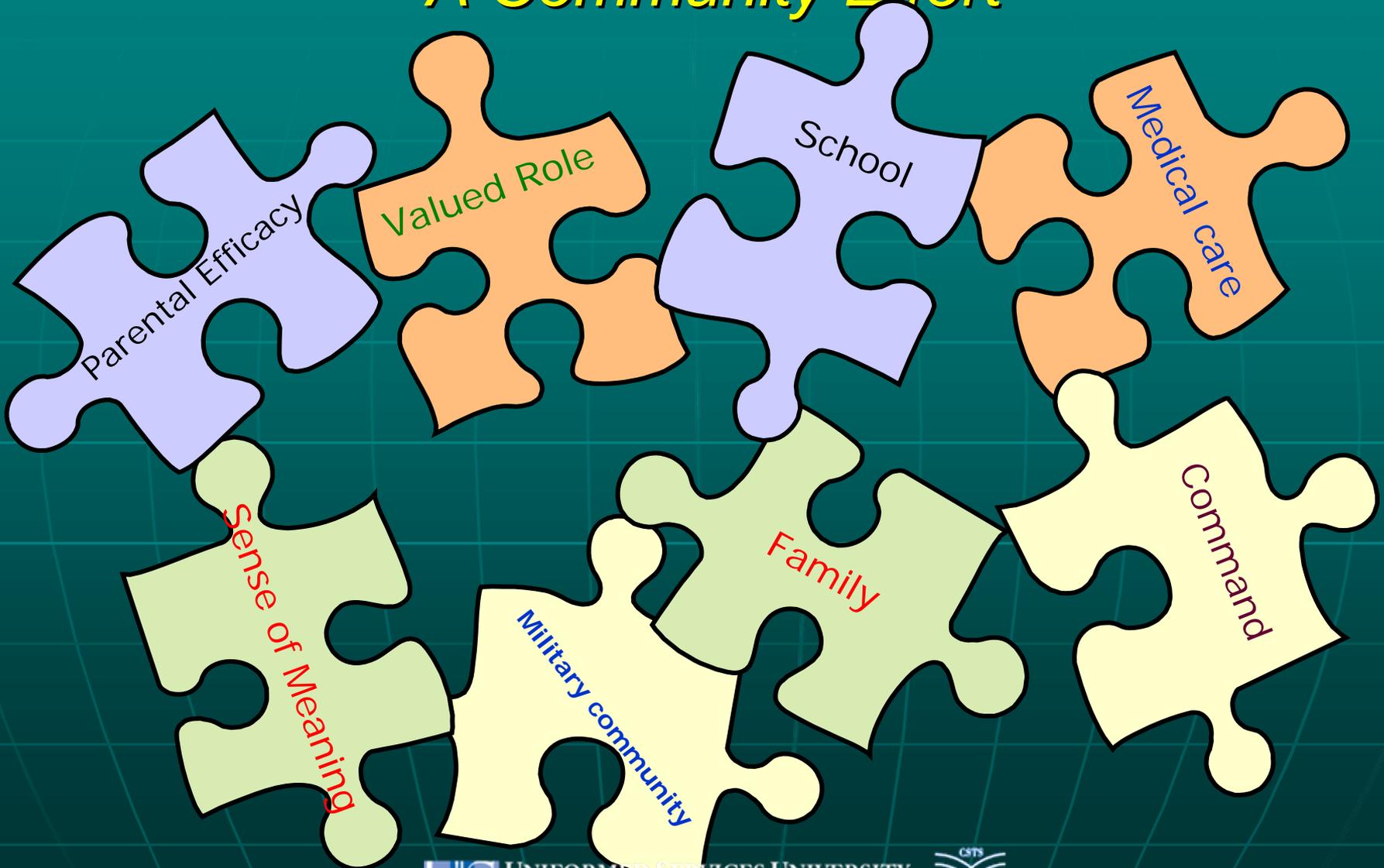
- **KNOW YOUR ROLE** – commands, educators, day care providers, medical communities
- Address those issues that serve as obstacles to effective role functioning – *including psychopathology*
- Identify and seek resources for those who are unable to function
- Work within the context of our military traditions – traditions of duty, responsibility, mission, courage and pride

# When Present – Identify More Serious Problems

- Build a safety net
- Look for the warning signs – high risk group
- Remember that a minority of individuals will develop illness – but some will
- Overcome barriers to care
- Destigmatize – illness is neither a source of embarrassment or source of alarm. Mental disorders are diagnosable and treatable medical illnesses
- Work across organizations to provide service and resources

# Military Child Resiliency Building Model

## *A Community Effort*



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