Combat-Related Injuries and Bereavement: Effects on Military and Veteran Families and Suggested Interventions

23

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Introduction

Since 1973, after the end of the draft in the United States and the start of the all-volunteer military force, the number of military families, including dependent spouses and children has grown considerably. As of 2018, there were over 1.5 million dependent family members of active duty service members, and over 1 million dependent family members of Selected Reserve members [1]. Since the start of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), these families have continually faced difficult challenges associated with military life, including repeated combat deployments. Some of these families have also been affected by combat-related injuries, including *visible* (e.g., musculoskeletal injuries, amputations, burns) and *invisible* (e.g., posttraumatic stress disorder [PTSD], traumatic brain injury [TBI]) injuries, as well as bereavement. These profound stressors typically include short-term and long-term challenges that affect all members of the family and their relationships with each other.

This chapter provides information for U.S. physical and mental healthcare providers who treat military service members, veterans, and their families who are dealing with combat-related injuries or bereavement. Combat-related injuries have the capacity to undermine the health and well-being of all family members. In addition, combat deaths or other sudden deaths could result in prolonged grief in family members, as well as changes to family structure and relationships. These life-altering events often lead to transitions in lifestyle, moves from military installations, and disruptions in established support and services, including health care,

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educational services, friendships, and a sense of community. It is important to be aware of the effects of visible and invisible injuries as well as bereavement on families in order to fully address the needs of patients. This chapter highlights how these events can affect the mental and physical well-being of patients and their families, and describes family-centered interventions that can assist families affected by military duty-related injury, illness, and death. *Resources* and *Actions to Take* are provided at the end of the chapter, in addition to several additional *Recommended Readings*.

Combat-Related Visible Injuries

Epidemiology

As of 2020, nearly 53,000 service members sustained non-fatal *visible* injuries in OEF, OIF, and Operation New Dawn (OND) [2]. Nearly 75% of all combat-related injuries from post-9/11 conflicts were attributed to explosive devices (e.g., improvised explosive devices, land mines) [3]. During 2001–2005, the most common combat-related injuries (54%) involved the extremities [4]. Injuries to the extremities required the longest average inpatient stay (nearly 11 days), were the most frequent cause of repeated hospitalizations, involved the greatest resource utilization during rehospitalization, and ultimately disabled 64% of those injured [5, 6]. Although considerable media attention was given to injuries resulting in amputations, they constituted a small portion of overall injuries (roughly 1,700 out of 52,000 wounded in action from 2002–2015) [7]. In addition to these *visible* injuries, service members and veterans may have experienced *invisible* injuries (described below), such as traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD). The combination of both *visible* and *invisible* injuries can worsen functional outcomes [8, 9].

Injury Recovery Trajectory

Recovery from combat-related injuries has been conceptualized as involving an *injury recovery trajectory* that consists of four phases: acute care, medical stabilization, transition to outpatient care, and long-term rehabilitation and recovery [10]. During each phase, families face multiple emotional and logistical challenges (see Table 23.1). *Acute care* involves the immediate, often life-saving medical attention provided to the wounded service member in combat theater, as well as their transportation via the medical evacuation system. During *medical stabilization*, military spouses and children often relocate to military treatment facilities to be closer to their injured loved ones. However, not all family members may be able to move, so individual family members are sometimes geographically separated, disrupting

Table 23.1 Injury recovery trajectory

Phase	Explanation
1. Acute care	Initiated at the time of injury by military medics and includes care provided in combat hospitals
2. Medical stabilization	Incorporates definitive medical treatment in U.S. stateside military medical centers
3. Transition to outpatient care	Relocation of injured service members to treatment facilities closer to home, transition to different treatment teams, and possible medical discharge from military service
4. Long-term rehabilitation and recovery	Ongoing care of the service member/veteran in order to maximize treatment benefits and long-term functioning

Sources: Cozza [11], Cozza and Feerick [12], Cozza and Guimond [10], Holmes et al. [13]

daily routines and adding stress to the family system. *Transition to outpatient care* involves other challenges: finding new housing, working with new health care providers, enrolling children in new schools, and leaving military friends and communities behind. After the injured service member leaves the hospital, family members (both adults and children) may be required to take on new roles and responsibilities (e.g., new household tasks), which may be confusing, upsetting, or frustrating. *Rehabilitation and recovery* is usually the longest period in the injury recovery trajectory, during which the service member/veteran and their family learn to adapt to the injury and become accustomed to a new life. It may also involve ongoing caregiving provided by both adult and child family members.

Injury Communication

The confusion and distress that results from combat-related visible and invisible injuries can compromise communication between family members. *Injury communication* is a term used to describe the exchange and impact of information about the injury [10]. Effective injury communication requires that family members are able to discuss information about the injury, its consequences, and required treatments within the family (including using developmentally-appropriate language with younger children), as well as with those outside of the family (e.g., friends, community professionals, service providers). Principles of effective injury communication (Table 23.2) have been detailed in *Courage to Care—Courage to Talk* (see www.courage2talk.org, Center for the Study of Traumatic Stress), a public health campaign that focused on the importance of injury communication both within the family and between the family and healthcare providers.

As illustrated in the following vignette about SSGT Jones and his family, the *acute care* and *medical stabilization* phases of recovery are distressing and chaotic for families. Each creates challenges for cohesion and effective communication. (Note—All vignettes within this chapter are constructed from clinical experience, but do not represent actual people or families).

Table 23.2 Injury communication

What is meant by the term 'injury communication'?	Injury communication is an essential component of injured family care. In its broadest sense, 'injury communication' refers both to the exchange of information (provision and delivery of information related to the injury), and to the impact of information (the capacity of the family and family member to process information). Injury communication also refers to the impact on the family's behavior. Effective injury communication involves the timely, appropriate and accurate sharing of information from the moment of notification of injury throughout treatment
What is the goal of injury communication?	Its primary goal, to be achieved over time, is helping family members integrate the injury experience through a process of shared understanding. To this end, ongoing dialogue about the injury and its implications are extremely important
Why is injury communication important for clinical providers?	Injury communication is both a process and an opportunity for healthcare providers. In the process of communicating with families about combat injury, there are multiple opportunities to educate and help families understand the importance of connectedness and availability—both within the family and within one' community Understanding the impact of injury on children, especially from a developmental perspective enables providers to guide families on how best to communicate with children to sustain hope, connection to both parents, and continuity with family and community routines. Ultimately, effective injury communication helps injured families learn the skills of self-advocacy, leading to protection from isolation, a sense of connectedness, the capacity for appropriate and timely help-seeking, and family problem-solving. Providing quality communication and compassionate outreach that supports injury recovery, family function and health are important goals that healthcare providers can advance using the educational resources of the ***Courage to Care Courage to Talk*** campaign
What are the implications of effective injury communication for families and children of the injured service member?	Family members of the injured will need to effectively communicate with each other, as well as with numerous military and civilian healthcare and social support personnel including nurses, doctors of diverse specialties, social workers, psychologists, case managers, chaplains and support service staff. As participants in the communication process, the ***Courage to Care Courage to Talk*** campaign can provide families with tips on talking about war injury, talking with children, and talking with healthcare providers

Used with permission, Courage to Care—Courage to Talk, Center for the Study of Traumatic Stress

Vignette #1

SSGT Mark Jones is a 35-year-old Army noncommissioned officer who was injured by an IED while deployed to Iraq in 2004. His wife, Annette, and their three children, Stephanie (age 14), Sam (age 9), and Jackson (age 3), were living in Killeen, Texas near Fort Hood where Mark had been stationed before deployment. Annette was notified of the injury and made arrangements to fly to Landstuhl Regional Medical Center in Germany where Mark was medically evacuated. Annette left her children in the care of a neighbor until her 60-year-old mother could join the family from her home in Ohio. Mark was then transported to Walter Reed Army Medical Center in Washington, DC where he remained for 9 months while he underwent a

series of surgeries (including bilateral lower extremity amputations) for multiple musculoskeletal injuries. Given her mother's own medical problems and need for treatment, Annette made the decision to relocate her two older children to live with her brother's family in rural Ohio, and to have Jackson join her at the Fisher House at Walter Reed, a hotel where family members often stay while visiting their hospitalized service members. Jackson accompanied his mother on visits to Mark in the hospital and was often perceived as a nuisance by nursing staff because of his "high energy" and disruptive behavior. When Annette was asked what she told her children about Mark's injury, she replied "I talked to Stephanie and Sam about his injuries. But I didn't know what to say to Jackson, since he is so young. I didn't think he would understand, so I just let him see for himself when he came to the hospital. He found out his Daddy lost his legs when he saw Mark in the bed."

Effect of Visible Injuries on Spouses and Children

The family's experience of a combat-related injury can be influenced by the type and severity of the injury, family composition, individual and family maturity, health or preexisting medical or psychological conditions, the ages of children, the course of medical treatment, and whether the injured regains satisfactory functioning [10, 13]. In addition, the effect of combat injury on the marital relationship can have far-reaching effects that reverberate throughout the family. For instance, disruption of the marital dyad, parenting, and parent-child relationships as a result of parental physical injury would likely affect child functioning [14–16]. Shared activities between a parent and child prior to the injury may no longer be possible, which can alter the way the parent connects with the child. It may be necessary for the injured parent to modify their previously-held vision of themselves as parents, as they acknowledge their bodily changes and loss of functioning [15]. In addition, the ability to co-parent effectively may be affected due to changes in parental responsibilities, disruption of household routines, strains in the marital relationship, and prolonged hospitalizations or rehabilitation [17, 18].

Few empirical studies have examined the burden of parental combat injury on military children. Hisle-Gorman et al. [19] described risks faced by young military children (3–8 years old) whose parents deployed and returned either uninjured or injured (both physically and psychologically) compared to children whose parents did not deploy. Children of deployed and uninjured parents were at elevated risk for child injuries, child maltreatment, and for increased mental health care visits compared to children whose parents did not deploy. Children with combat-injured parents were at even higher risk. A follow-up study [20] that included a broader age range of children also found that children of combat-injured parents had increased healthcare visits associated with maltreatment, child injuries, and mental disorders (including increased use of psychiatric medication), and decreased preventive care visits compared to children of non-deployed and deployed but uninjured parents. If the parent had PTSD, or comorbid PTSD and TBI, the impact on children's health was greater [20].

The following fictional vignette describing Mark, Annette, and their children highlights the challenges associated with *transition to outpatient care* and *long-term rehabilitation and recovery* (see Table 23.1). These challenges include discontinuity of healthcare, misuse of prescribed medication, and family conflict.

Vignette #2
Upon completion of medical treatment at Walter Reed and nearly 18 months after his injury, Mark was transferred to outpatient care at a VA Hospital in a rural area. Stephanie and Sam joined Mark, Annette, and Jackson there in a temporary three-bedroom apartment while the family looked for permanent housing that could accommodate Mark's physical needs. The family struggled with the transition in several ways. In contrast to appointments at Walter Reed, Mark now needed to be transported by Annette to appointments at the VA hospital which was 20 minutes from their apartment. Stephanie, who had become increasingly independent and thrived in school while living with her uncle, now had more babysitting responsibilities for her two younger siblings and caregiving responsibilities for her father. She had to manage these new responsibilities while attempting to make friends in a new high school. In contrast, Sam had struggled in school while living with his uncle due to the lack of the educational support services he had received from the Texas school district. Now that he was with the family, he also had become sullen and moody because his father was often sleeping and unable to engage him in the kinds of outdoor play that they had enjoyed prior to his injury. In fact, Mark's frequent sleeping generally affected his ability to parent effectively. One winter morning, Jackson was left under Mark's supervision while Annette was grocery shopping. Jackson left the apartment when Mark fell asleep after taking his prescribed pain medication. Child protective services was contacted when Jackson was found wandering unsupervised without a coat in the neighborhood.

Invisible Injuries

Invisible injuries, such as traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), depression, and substance use disorders (SUDs), can be devastating in a different, but no less life-altering, manner compared to visible injuries. Invisible injuries can present unique challenges.

Traumatic Brain Injury

Epidemiology
According to the DoD, between 2000 and the first quarter of 2018, there were nearly 384,000 cases of traumatic brain injury (TBI), making it the "signature injury" of conflicts during this period [21–23]. Although large, this number may be an underestimate of the true total number of affected service members and veterans, as it can be difficult to identify and diagnose TBI, especially mild TBI [24].

Effect on Spouses and Children

TBI can affect the health, wellbeing, and functional capacity of the non-injured spouse, as roles and responsibilities that were previously conducted by their partner may have to be incorporated into the spouse's ongoing tasks [25]. Spouses of TBI patients are at higher risk for psychiatric disorders, such as depression and anxiety [25], and poor marital satisfaction resulting from TBI may also affect co-parenting [25].

These negative influences on the spouse's health and the couple's relationship can affect children [26]. Children may show increased externalizing behaviors, emotional issues, and post-traumatic symptoms following parental TBI [27]. Children report feelings of loss, isolation, and loneliness due to changes they perceive in their injured parent [28, 29]. A substantial number (42–79%) of children of TBI-affected service members/veterans experienced a decline in their overall health and behavior [30], particularly within the first 2 years following the TBI. Although 17–27% of children experienced declines in health and behavior that were associated with parental deployment, there were additional declines subsequent to the TBI [30]. The severity of the TBI and the amount of disruption to a family's organization are other factors that affect children [25, 26]. Furthermore, if an injured parent withdraws from other family members, demonstrates communication issues, exhibits low frustration levels, manages anger poorly, and presents difficulty regulating emotions and behaviors, these behaviors may distress and alienate a child who cannot comprehend what they are witnessing [31].

TBI can cause unique challenges for families compared to those caused by other physical and non-neurological impairments [26]. For instance, certain TBI symptoms, such as personality changes and unexpected emotional reactions, that can be particularly detrimental to interpersonal relationships [32]. TBI's effect on families may also be long-lasting (as described in Table 23.1), and it may not improve over time [25]. Those with poor financial and social support are at greater risk for these long-term effects, which is why facilitating access to practical resources (e.g., financial, housing, social, etc.) and professional services are essential for these families [25].

Posttraumatic Stress Disorder (PTSD) and Comorbidities

Epidemiology

PTSD symptoms and comorbidity with other disorders can affect how families function. The PTSD symptom clusters of re-experiencing, avoidance, negative cognitions and mood, and arousal each have negative effects on normative family processes that support resilience (see description below) [33]. Substance use disorders (SUDs) are highly comorbid with PTSD, as 46% of a national sample of US veterans who met lifetime criteria for PTSD also met lifetime criteria for an SUD [34], and 22% of Veterans treated for PTSD in the VA across the nation had a concurrent SUD diagnosis [35]. Similarly, depression is often comorbid with PTSD [36]. Although depression and SUDs have been shown to negatively affect marital and

parent-child relationships [24, 37, 38], less is known about their specific effects in military families. In contrast, the effect of PTSD in military and veteran families has consistently been shown to be disruptive to family well-being.

Impact of PTSD on Spouses and Children

Spouses and partners of service members with PTSD report higher rates of distress, depression, and suicidal ideation, and poorer adjustment than spouses of service members without PTSD [39, 40]. In addition to affecting the psychological health of spouses, PTSD can negatively impact the relationship between the service member and spouse [41–46] by contributing to problems with intimacy, communication, intimate partner violence, reduced emotional and physical well-being, divorce, and relationship distress and marital satisfaction [43, 44, 47–50]. In particular, PTSD symptoms of avoidance, emotional numbing, and hyperarousal can negatively impact intimacy and are associated with relationship dissatisfaction, spousal abuse, and divorce [45, 51–54]. These effects on relationships appear to be specific to PTSD, rather than to trauma exposure, as divorce occurs at a higher rate in veterans suffering with PTSD compared to similarly trauma-exposed veterans without PTSD [48, 55].

PTSD can undermine parenting behaviors and parenting satisfaction [56–58]. Not only are parent-child relationships affected, but parental cooperation and coordination between parents can be negatively impacted. Given potential changes to previous ways of parenting, renegotiation of the co-parenting relationship may be required [47].

Children's emotional health can also be negatively affected by parental PTSD. General distress, depression, lower self-esteem, aggression, impaired social relationships, and school-related difficulties have been reported in children of service members with PTSD ([59]; reviewed in [57]). A child's reaction to a parent who has PTSD should be expected to vary by their age, maturity, temperament, and preexisting conditions. Children with preexisting medical, developmental, behavioral, or emotional conditions may experience greater distress or worsening of symptoms. Given the potential disruptions in lifestyle due to care for a parent with PTSD (e.g., geographical transitions, possible separations from established child care providers), children's healthcare may be neglected or inappropriately delayed. Parents and clinicians may need to use a lower threshold for referral to appropriate clinical resources for these more vulnerable children.

The following vignette of Lance Corporal Bradley and his family illustrates how military duty-related injuries and illnesses can affect the health and well-being of other family members (including children) across the injury recovery trajectory (see Table 23.1). Clinicians need to be attuned to evolving mental health needs in all family members.

Vignette #3

Lance Corporal Jim Bradley returned home to his wife, Mary, and their children, Mike (7) and Carrie (5) after a 6-month combat deployment. Many of his battle buddies were injured, and some didn't make it home. Images of his wounded and

dismembered friends continue to pop into his mind at unpredictable moments, and, as a result, Jim is jumpy and irritable. In addition, he feels extremely guilty that he survived combat unscathed, while so many did not. Since returning home, he often wakes up multiple times per night from nightmares. One morning, Mike gleefully jumps on his father's bed wanting to "play," however, Jim is startled from his sleep and pushes Mike off the bed. Jim feels alienated from his family because they do not understand what is "wrong" with him. He sleeps in his office so Mary doesn't find out about his nightmares and he relies on alcohol to fall asleep. Jim begins drinking a six-pack every night, often takes a shot of vodka in the middle of the night to get back to sleep, and experiences anxiety in the morning when the alcohol has worn off. As a result, Jim craves alcohol during the day, and he starts sneaking sips of vodka from a flask. Mary notices the alcohol purchases on their credit card statements. She asks him to cut back on the alcohol and Jim gets angry. They begin arguing often and, during one physical altercation, Jim shoves Mary to the floor in front of the children. Several days later Mary is called by Carrie's kindergarten teacher who stated that Carrie had soiled herself in the classroom, asking "Have there been any new stresses in her life recently?" As a result, Mary demands that Jim seeks treatment or she will leave the house and take the children.

Combat-Related Bereavement

Epidemiology

During the ten years following September 11, 2001, 15,938 service members died while on active duty [60]. The causes of death varied, but most were sudden and violent, resulting from accidents, combat deaths, and suicide (34.0%, 31.5%, and 14.5%, respectively). Fifty-five percent of these deceased service members were married, and their surviving spouses ($n = 9{,}667$) were young at the time of bereavement (mean age = 32.8, SD = 9.3). Thirty-one percent of service members who died from 2001 to 2011 had children, totaling 12,641 bereaved children whose young age (mean age = 10.3 years, SD = 7.3) reflected the youth of their parents. In addition, children younger than 10 years old were 3.8 times more likely to experience a service member's death as a result of sudden and violent causes than children above the age of 10 [60].

Impact on Spouses and Children

The death of a service member often results in secondary losses for surviving family members, including changes in their way of life and their associated identities (e.g., military spouse, military child, military parent/sibling), loss of housing (e.g., needing to move from a military installation), and loss of connection to the military community [61]. For spouses and children, it can feel like an "involuntary discharge" when they relocate to the civilian world, leading to feelings of isolation, disconnectedness, loneliness, confusion, and disenfranchisement [60].

In addition to distress caused by these changes, family members bereaved by sudden and violent deaths (which are commonly the cause of military service members) are at higher risk for adverse psychological outcomes than those bereaved by other types of deaths [62]. Although intense acute grief is an expected response to bereavement, those who have been bereaved by sudden and violent deaths are at higher risk for a condition of persistent and impairing grief that can continue for years after the death [63]. This grief condition, referred to as Prolonged Grief Disorder in the DSM-5-TR [64] and previously variably referred to as *complicated grief*, *traumatic grief,* and *persistent complex bereavement disorder*, often co-occurs with depression and posttraumatic stress disorder, but is distinct from these conditions and responds to grief-specific treatments [65, 66].

Researchers at Uniformed Services University (USU), Center for the Study of Traumatic Stress (CSTS) conducted the National Military Family Bereavement Study (NMFBS; www.militarysurvivorstudy.org) to examine the impact of U.S. service member death on surviving family members. Fifteen percent of NMFBS participants endorsed grief symptoms consistent with prolonged grief disorder [11]. This proportion is similar to non-military family samples that were bereaved by sudden and violent deaths [62]. An analysis comparing healthcare data of military widows and a matched sample of non-bereaved military wives indicated two to fivefold increases in prevalence of depression, PTSD, and adjustment disorder, as well as increased healthcare utilization in widows in the 2 years after the death [67, 68]. A separate analysis of these data that examined physical health conditions indicated increases in prevalence of ill-defined conditions, in addition to mental health conditions in years 1 and 2 following bereavement. Health care utilization was highest for widows with comorbid ill-defined conditions and mental health conditions [69].

Information about bereaved military children is scarce. However, children are likely to be strongly affected by the deaths of loved ones, though they do not grieve in the same manner as adults. Instead of crying and displaying sad expressions that are typically shown by adults, a child's expression of grief may be unfocused and may include playing, talking, questioning, and observing, [70, 71]. In addition, many children may feel sad, cry, or become withdrawn, but others may express their emotions by regressing to earlier behaviors (e.g., bedwetting, temper tantrums, withdrawing), or displaying behavior problems [71]. Sometimes a loss may lead to anxiety, depression, and posttraumatic stress symptoms in children [72–74]. However, in a study of 360 parentally-bereaved children compared to 110 depressed children and 120 community controls, bereavement was associated with increased psychiatric symptoms in the first 2 years after death, but with fewer symptoms compared to children with clinical depression [75]. Some of these psychological symptoms may be related to changes in the child's care following the death of a parent due to the absence of the deceased parent and the grief of the surviving parent. A parent's mental health can affect the mental health of their children, as poorer adult outcomes are associated with poorer child outcomes [76], and higher family socioeconomic status and lower depressive symptoms of the surviving parent are associated with better child outcomes [75].

The following fictional vignette describing Shannon, a military widow, illustrates the challenges associated with military family bereavement and the need for clinicians to be attentive to family members who may require clinical intervention.

Vignette #4

Shannon was working at home in her office while her twin sons (age 2) were napping upstairs. She had been thinking about her recent text exchange with her husband, SGT Dave Williams, when the doorbell rang. She glanced out the window and noticed a government vehicle parked outside and two uniformed men standing by her door. Even before speaking with them, Shannon knew that Dave had been killed.

After the acute stress of speaking to the notification team and the chaplain, and then figuring out how to tell her young sons and family, Shannon was faced with numerous decisions that had to be made quickly during the next few days. Although she had help from the casualty assistance officer that was assigned to her, she needed to decide on details surrounding the dignified transfer of remains, the burial process, managing media requests, and obtain information about benefits and other financial, legal, and military paperwork. After several weeks, things settled down and the reality of life without Dave began to sink in. She decided that it might be easier to manage her twin sons if they were closer to her parents in rural Michigan. However, after the move, she missed the closeness she had had with other wives at Fort Drum, NY, where they had been stationed. She briefly dated a few men she had met at her new job, but after receiving cool responses from Dave's mother and sister about dating, she stopped. Shannon became increasingly isolated and her grief for Dave persisted. There were numerous times in which Shannon wasn't able to give full attention to either her children or her job. She started drinking alcohol more frequently at night once the children were in bed. Two years after Dave's death, Shannon continued to struggle with intense longing for Dave. She stopped reaching out to friends they had enjoyed as a couple, because it brought up too many painful memories.

Family-Centered Care in Families Facing Injury, Mental Disorders, and Death

Although combat-related visible and invisible injuries and bereavement are distinct experiences, each can powerfully impact military and veteran families by generating distress that can undermine parenting and other family processes. However, several theorists have detailed how family processes can be targeted to support resilience. For example, Family Resilience Theory [77] highlights the importance of shared beliefs, constructive communication, and healthy patterns of organization within families as being critical to overall family health in traumatic circumstances. Saltzman et al. [78] recommended targeting family resilience processes in traumatically-affected military families by encouraging understanding, support, and forgiveness among family members; improving communication and cohesion within the family; coordinating parental leadership; ensuring defined but adjustable roles and responsibilities; and developing shared goals and beliefs among adults and children. These family resilience processes can be differentially affected by certain symptoms or conditions. For instance, specific PTSD symptoms can negatively affect some of these processes rather than others. Table 23.3 summarizes these negative effects and highlights opportunities for intervention.

Table 23.3 Negative effects of PTSD symptom clusters on family resilience processes

	Re-experiencing	Avoidance	Negative cognitions and mood	Arousal
Emotional closeness	↓	↓	↓	↓
Communication		↓		↓
Safety and impulse control	↓		↓	↓
Family leadership		↓	↓	
Family hopefulness	↓		↓	
Supervision of children		↓		
Authoritative discipline of children		↓	↓	↓

Source: Adapted from Cozza [11]
Note: Down arrows indicate a negative effect of a PTSD symptom cluster on the indicated family resilience process
Reproduced with permission National Academies of Sciences, Engineering and Medicine [79]

Greater appreciation of these intrafamilial effects of PTSD and other combat-related stressors has fostered both theoretical and clinical appreciation of family-centered approaches to military and veteran families that have been affected [15, 80]. For instance, the National Academies of Sciences, Engineering, and Medicine published *Strengthening the Military Family Readiness System for a Changing American Society* [79], a report focused on the well-being of military families, including those affected by high-stress events, such as combat-related visible and invisible injuries and bereavement. One recommendation within that report was to increase access for military families to "effective, evidence-based and evidence-informed family strengthening programs, resources, and services" [79].

Several evidence-based family-centered strengthening programs have been developed for use in military communities. For example, Families OverComing Under Stress (FOCUS) [81] and After Deployment Adaptive Parenting Tools (ADAPT) [82] share common core components, including a strengths-based approach, and an emphasis on emotion regulation, communication, problem solving, and understanding and addressing children's developmental needs. In addition, ADAPT highlights several positive parenting practices, including parental limit setting and monitoring and involvement in school and other activities. Other programs, such as Strong Bonds [83] and Strength at Home [84] focus on strengthening couple functioning within families.

Additional family-centered interventions have been developed specifically for families affected by TBI or bereavement. Family Focused Therapy for TBI (FFT-TBI) [85] and Brain Injury Family Intervention (BIF) [86] share common intervention strategies, such as increasing knowledge about TBI, enhancing family communication, and improving problem solving, emotion regulation, and goal setting [85, 86]. The Family Bereavement Program (FBP) incorporates positive parenting strategies and individual and interpersonal strengthening activities to support family grief outcomes [87].

Although these family-centered strengthening programs differ in their emphases and details of their implementation, they share common goals centered on

Table 23.4 Family-strengthening goals to promote family resilience and well-being

1.	*Maintain a physically safe and structured environment*, protecting against interpersonal aggression among adults and children, and ensuring that children have adequate structure and support, have consistency in routines and rules, and are effectively monitored
2.	*Engage required resources*, accessing instrumental and social support within and outside the family to support adults and children, dyadic relationships and the family as a whole, and teaching family members how to effectively use their support opportunities (friends, extended family, teachers, coaches, faith-based communities, etc.)
3.	*Develop and share knowledge within and outside of the family*, building shared understanding about stressors, including service members' injury or illness, as well as modeling and teaching effective communication strategies among adults and children
4.	*Build a positive, emotionally safe, and warm family environment*, including effective stress reduction and emotional regulation strategies for parents to engage in and model for children, as well as engaging in activities that are calming and enjoyable for all
5.	*Master and model important interpersonal skills*, including individual and relational problem solving and conflict resolution and incorporating evidence-based strategies
6.	*Maintain a vision of hope and future optimism for the family*, engendering positive expectations among family members and creating a hope-filled family narrative
7.	*Utilize competent and authoritative parenting*, encouraging consequence-based strategies that promote mastery and minimizing harsh disciplinary practices
8.	*Incorporate trauma-informed approaches to care*, recognizing that families faced with stress and adversity are likely to be affected by trauma and loss experiences that uniquely impact adults and children within families, their relationships, and their development
9.	*Promote security among adults and children*, strengthening parent-child relationships that are known to contribute to individual and relational wellness for both adults and children, and focusing on effective conflict resolution between spouses or partners
10.	*Highlight the unique developmental needs of family members*, helping parents and other engaged adults in the family recognize and respond to their family members' needs effectively at each developmental stage

Sources: Compiled by the Committee on the Well-Being of Military Families. Source for Goal #5 is Dausch and Saliman [85], Gerwitz et al. [82]; source for Goal #6 is Saltzman et al. [78] Reproduced with permission National Academies of Sciences, Engineering, and Medicine [79]

supporting family health and well-being, which were noted in a 2019 National Academies report (summarized in Table 23.4). Evidence-based approaches should serve as a foundation for clinical treatments offered to families affected by combat-related injury, illness, or bereavement. For example, in a family affected by PTSD, clinicians must ensure that adults and children understand the disorder and how it impacts behaviors and intrafamilial interactions (e.g., "It's not a good idea to jump on the bed and awaken Daddy because it frightens him."). As another example, clinicians can introduce problem-solving strategies, such as conflict resolution, within a family affected by TBI in order to minimize interpersonal arguments (e.g., "We know that talking about homework is stressful for Dad and Ebony, so let's wait until we are all calm to try to have that conversation."). Clinicians should also introduce skills for competent parenting (e.g., consequence-based discipline), ideas for activities that strengthen relationships (e.g., mutually enjoyable games or activities), and family hopefulness (e.g., "Although you miss your father, you are still a strong family that can manage.") into family-centered treatment strategies.

Conclusion

Because the health and well-being of each family member affects and is affected by the health and well-being of others in the family system, combat-related visible and invisible injuries and bereavement can each profoundly affect military and veteran families. As discussed in this chapter, combat-related injuries and combat-related bereavement are likely to affect family dynamics (e.g., roles and responsibilities, the functioning of the couple, parenting of children), social interactions with those outside the family, and logistical and practical concerns, such as residential moves and financial resources. It is vital that healthcare providers are aware of the challenges that these life-altering events can pose to family members of the identified service member or veteran patient. In addition, they must be familiar with the principles of family-centered care and the relevant and available interventions to treat their patients.

Additional Resources

- For resources related to injury communication visit *Courage to Talk*: https://www.courage2talk.org/
- *For Resources for Recovery* fact sheets for combat injured and ill families visit the Center for the Study of Traumatic Stress: https://www.cstsonline.org/fact-sheet-menu/fact-sheet-list
- For resources specific to bereaved military family see the *Stepping Forward in Grief* resource pagel: https://steppingforwardstudy.org/resources/
- For a comprehensive list of military family resources
  - The Rand Corporation's ***Additional Health-Related Resources for Service Members, Veterans, and Military Families***: https://www.rand.org/well-being/social-and-behavioral-policy/projects/veterans/resources.html
  - Military One Source: https://www.militaryonesource.mil/benefits-and-resources

Clinical Pearls

- Acknowledge that even though you are treating an individual patient, combat-related visible and invisible injuries are likely to affect all family members. Your patient's health and well-being are interconnected with the health and well-being of their family members.
- Ask your patients to describe their families: Who are their family members and how do patients relate to each of them?
- Document the entire family's military service histories, including combat-related injuries or traumatic losses.
- Expand your clinical focus to include the impact of visible and invisible injuries on functioning within interpersonal relationships (i.e., with adult and child family members), in addition to symptom resolution (i.e., reducing flashbacks or nightmares).

- Recognize that family relationships are dynamic and change over time. Sometimes they will improve, but they also may worsen. Do not assume that a marriage is "good" or "bad."
- Listen for indications that your patients' children or spouses are having difficulties and may need to be referred for interventions of their own.
- Become familiar with family processes (e.g., effective communication, problem solving, emotion regulation, goal setting) that support resilience, and encourage your patients and their families to incorporate such practices.
- Refer your patients and their families to family-centered interventions that are designed to encourage resilience processes and strengthen family well-being. These interventions will likely also support your patients' treatment progress.
- Screen bereaved patients for persistent and impairing grief symptoms (i.e., ongoing yearning or longing for the deceased) that indicates problems with grief adaptation and possibly the presence of prolonged grief disorder that requires evidence-based, grief-focused treatment.

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