

Article 6

Secondary PTSD in Children of Service Members: Strategies for Helping Professionals

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Military deployment affects not only the military service member, but also individuals surrounding the troops. Upon initiating the writing of this manuscript, the three authors discussed their various counseling efforts in relation to working with military members and their families. It is of note that although all the authors have worked with family members at various stages of deployment, and two have facilitated deployment groups for children, the services for families tended to focus on pre-deployment concerns and issues arising during deployment. None of the authors had facilitated groups for children *after* the deployed parent had returned. This is of particular significance because secondary post-traumatic stress disorder (PTSD) develops in the post-deployment stage. Additionally, service members are often completing multiple deployments (Huebner & Mancini, 2008) and therefore services need to be continued for children throughout deployment and long after post-deployment. This article will review the deployment cycle, define PTSD and secondary PTSD, discuss possible impacts on children, and review strategies and resources recommended for practitioners working with this population.

There are approximately 49,000 U.S. troops currently deployed in Iraq and approximately 103,700 U.S. troops currently deployed in Operation Enduring Freedom in Afghanistan (Defense Manpower Data Center, 2011). The impact of these long separations is of increasing concern with 55% of soldiers now married and 43% having children under the age of 18 (Huebner & Mancini, 2008). Combat zone deployments cause a great deal of stress not only for the service member, but also for the family that is left behind (Young, 2007).

A deployment is a military related relocation of an individual or entire military unit to an overseas location in order to accomplish a specific task or mission. The mission may be as routine as providing training or as dangerous as combat duty in a warzone. Military deployments consist of three phases, pre-deployment, deployment, and post-deployment/reunion (U.S. Department of Education, 2007), although other researchers state there are five stages, adding sustainment and re-deployment prior to post-deployment (Johnson, n.d.).

During a deployment the military family lives in a continuous state of readiness that is heightened during times of national emergency or war (Packman, Paone, LeBeauf, Smaby, & Lepkowski, 2004). There are approximately 150,000 active duty Soldiers, 85,000 Sailors, 90,000 Airmen and 65,000 Marines that have been deployed more than once to Iraq, Afghanistan and surrounding countries (Military Advantage, 2007). Humanitarian missions and peace enforcement have sent our troops to Somalia, Cuba, Haiti, Bosnia and Kosovo (Pincus, House, Christenson, & Adler, 2001).

The emotional cycle of an extended military deployment, 6 months or greater, can be divided into seven distinct stages. These stages are comprised of: anticipation of departure, detachment and withdrawal, emotional disorganization, recovery and stabilization, anticipation of return, return adjustment and renegotiation, and reintegration and stabilization (Morse, 2006). Each stage is differentiated both by a time frame and emotional challenges.

The anticipation of departure stage is when spouses may alternately feel denial and anticipation of loss. With multiple deployments, this stage may begin again before the family has even had time to complete the reintegration and stabilization stage from the last deployment (Morse, 2006). In the detachment and withdrawal stage, service members become more psychologically prepared for deployment by focusing on the mission and their unit. Sadness and/or anger may occur as families attempt to protect themselves from the hurt of separation. During the emotional disorganization stage, spouses may be experiencing fatigue from the last deployment and feel overwhelmed at starting this stage again (Morse, 2006). In the recovery and stabilization stage, spouses realize they are fundamentally resilient and able to cope with the deployment. They develop increased confidence and a positive outlook. The anticipation of return stage is generally a happy and hectic time spent preparing for the return of the service member. In the return adjustment and renegotiation stage, families must reset their expectations and renegotiate their roles. The key to successful adjustment and renegotiation is open communication, which may be more difficult for a soldier coming home with PTSD. The reintegration and stabilization stage can take up to 6 months as the family stabilizes their relationships and negotiates a possible Permanent Change of Station (PCS) move. Back to back deployments create stress as families stabilize only to begin Stage 1 once again (Morse, 2006).

According to a study released in February, 2008, conducted by the Army Surgeon General's Office, approximately 3 in 10 service members on their third tour admit to having mental health problems (Zoroya, 2008). The survey collected anonymous responses from 2,295 soldiers serving in Iraq in October and November of 2007. According to the study about 15 to 20% of U.S. soldiers in Iraq have signs of depression or PTSD and about 30% of soldiers on their third or fourth tours have experienced emotional illnesses. The survey also found that 27.2% of the Sergeants who led soldiers into combat in Iraq experienced mental health problems during their third or fourth tours, compared with 18.5% during their second tours and 11.9% during their first tours. Furthermore, the research found that symptoms of some mental illnesses may become more intense as soldiers prepare to return to Iraq.

Post-Traumatic Stress Disorder (PTSD) is an incapacitating condition that occurs after an individual experiences or witnesses a terrifying event (American Psychiatric Association [APA], 2000). In a survey by the Walter Reed Army Institute of Research, of the 21,822 personnel who had served in Iraq and had screened positive for PTSD, 79.6% said they either saw someone being killed or wounded, or took part in combat in which they fired their weapons and potentially inflicted death or injury (Cogan, 2007).

PTSD is the most common mental health disability affecting troops who have served in combat. Symptoms of combat related PTSD include re-experiencing of the traumatic event, often through flashbacks or nightmares; difficulty sleeping and concentrating; irritability; and avoidance of anything associated with the trauma; they may also feel emotionally numb, especially with people they were once close with (APA, 2000). PTSD can develop at any time after exposure to a traumatic event. For veterans, it often emerges several months after they return to civilian life (Newhouse, 2008). These symptoms may disrupt the service member's life, making it hard to continue with daily activities.

Unfortunately, the biggest problem with PTSD is not that there are no treatments that the soldiers can seek, but that soldiers do not accept treatment. It has been shown that recent military returnees experience a strong stigma against disclosure of PTSD and other psychiatric problems (Hoge et al., 2004). Ironically, those who are most symptomatic are most sensitive to such stigma and, consequently, least likely to seek mental health treatment. The mentality among many service members is that if they admit that they have mental health problems, it will adversely affect their career, making promotion difficult or will cause their fellow soldier's to look at them as being weak. Tanielian et al. (2008) identified several obstacles that discouraged service members from seeking mental health services, including fear that confidentiality would be breached which would damage respondents' career and promotional prospects, and that medications may have aversive side effects. Furthermore, Galovski and Lyons (2004) found that veterans were reluctant to include their family in treatment and may be defensive regarding the idea that their mental health may be negatively impacting the health of their children. For these reasons, when service members are suffering from mental health problems, they are very reluctant to seek help for the problems they are experiencing.

When service members do not seek assistance for their mental health concerns, serious issues can arise. For example, the Army Suicide Event Report (ASER) for 2006 revealed that there were at least 97 cases of suicide among Army personnel the previous year; the highest recorded since 1991, when the stresses associated with the first Gulf War against Iraq contributed to the suicide of 102 army personnel (Cogan, 2007). At least 948 suicide attempts by Army personnel were also reported, 52 of which did not involve actual self-harm but were cases of hospitalization due to suicidal ideation. The statistics contained in the ASER report also suggest serious deficiencies in how the U.S. Army deals with soldiers attempting to cope with mental illness. Soldiers with a history of using psychotropic medication accounted for 26% of deaths and 37% of attempts. Cogan (2007) stated that more than 20% of attempts and 21% of completed suicides had a history of substance abuse and 12% had diagnosed personality disorders.

Upon returning to the U.S., military service members face several psychological challenges, including the shift away from an adaptive, continuous, combat-ready, hypervigilant state. After many months of deployment to a war zone in which the threat to life and limb is continually reinforced by surprise attacks, direct assaults, deaths of colleagues, inadvertent civilian casualties, and narrow escapes, it can be quite difficult to settle quickly into quiet

domesticity (Friedman, 2007). As soldiers return to their home and family, they inevitably find things have changed: their children are older, taller and perhaps have different interests; their spouses are more independent, roles have changed, and family dynamics are more complex (Uniformed Services University of the Health Sciences, 2004).

As stated previously, deployment does not only affect the service member, but clearly also affects those close to the service member – particularly the family members. If soldiers return from combat with a mental illness, they may not be emotionally available to their family members, which can strain family relationships at a time when open communication is sorely needed (Cosgrove, Brady, & Peck, 1994). Pearrow and Cosgrove (2009) stated, “Exposure to combat can lead to excessive anxiety and disabling symptoms that present not only in the veteran but that can be transmitted to persons close to him or her such as partners, children, and friends” (p. 77).

The transmission of trauma to others, including children, can be referred to by many terms including secondary PTSD, secondary traumatic stress, secondary traumatization, vicarious trauma, empathic trauma, or compassion fatigue (Pearrow & Cosgrove, 2009; Waysman, Mikulincer, Solomon, & Weisenberg, 1993). The term secondary traumatization was first discussed by Figley, in 1983, to “indicate that people who come into close contact with a trauma victim may experience considerable emotional upset and may, over time, become indirect victims of the trauma themselves” (Waysman et al., 1993, p. 104).

The family is a system and the actions of the combat veteran directly influence other family members (Galovski & Lyons, 2004). Therefore, keeping parental trauma history in mind when working with a soldier’s family is an important consideration (Rosenheck & Fontana, 1998). For example, a Croatian study of 56 wives of combat veterans concluded that 39% of the sample met the DSM-IV criteria for secondary traumatic stress. Based on these results, it was recommended that “any treatment offered to veterans with PTSD must address the traumatization of their family” (Frančisković et al., 2007, p. 177). Dinshtein, Dekel, and Polliack (2011) and Dekel and Monson (2010) additionally emphasized the importance of family evaluation for PTSD victims.

Not all family members who live with veterans diagnosed with PTSD will experience secondary PTSD. Kaplan (2002) reported the three most important factors for children’s development of PTSD to be “1) severity of the trauma, 2) parental reaction to the trauma, and 3) the temporal proximity of the trauma” (Risk Factors section, para. 1). Dekel and Goldblatt (2008) distinguished between direct transmission of trauma where PTSD symptoms such as anxiety are directly impacting the child, versus indirect transmission when the PTSD symptoms “impact or shape the child’s distress, based on evidence that children who grow up in a violent and/or stressful family atmosphere might experience negative implications” (p. 284). Other factors to consider may include the child’s gender, age, developmental level, mental health of the parent(s), and general family functioning (Kaplan, 2002). The symptoms of the veteran can be frightening to children who witness them, and if the soldier is unable to discuss his/her symptoms and rather pull away from those close to him/her, children may feel their parent does not care for them (Price, 2009).

Symptoms of the child will depend on his/her particular response to a parent’s PTSD. Price (2009) reported children can respond in three ways: become *over-identified* and feel and behave in ways similar to the soldier as a way to connect with them, become the *rescuer* and take on the roles of the parent when they are unable, or become *emotionally uninvolved*. All responses need interventions to offset potential problems in the near future as well as later in life.

According to the National Institute of Clinical Excellence (2005), children who do develop secondary trauma present with symptoms similar to those experiencing general PTSD, such as hypervigilance, dissociation, irritability, and behavioral outbursts. Klarić et al. (2008) found that children of soldiers diagnosed with PTSD had more night fears, more difficulties in school, and more depressive problems than children of veterans without PTSD. Overall these children had more developmental, emotional, neurotic, and dysfunctional behavior. Several studies have reported the effects of a parental soldier's PTSD on their now adult children. For example, Dinshtein et al. (2011) reported that adult children of PTSD veterans exhibited greater psychiatric distress, higher levels of avoidance and intrusiveness, and had lower capacities for intimacy than the control group whose fathers participated in warfare but did not have PTSD. Furthermore, children of veterans who participated in abusive violence, particularly acts toward children, were found to have more behavioral problems 15-20 years later than children of other Vietnam veterans (Rosenheck & Fontana, 1998). From these studies it is clear that a veteran's PTSD potentially has severe effects on his/her children.

Possible symptoms to watch for in preschool-age children include regression activities such as thumb sucking or bed wetting, whereas older children may withdraw from peers, compete for the attention of parents, have a drop in school performance, become aggressive, or have difficulty maintaining friendships (Substance Abuse and Mental Health Services Administration Center on Mental Health Services, 2007). Possible symptoms for adolescents include depression, negative behavioral adjustment, poor academic performance, increased irritability and impulsiveness, hyperactivity, and increased anxiety (Huebner & Mancini, 2008; Price, 2009).

Although all military children need to be supported in their everyday lives by people in their immediate surroundings, this need is heightened for children experiencing secondary PTSD. Military connected youth can be supported by: maximizing understanding of deployment-related matters; strengthening recognition of indicators of depression and stress; and encouraging connection with supportive peers and adults (Huebner & Mancini, 2008).

When addressing the needs of a child exhibiting behavioral problems in school, it is crucial that the approaches used are uniquely tailored to the child, circumstance, and school (Nader, n.d). Parents can play a pivotal role in securing constructive interventions for their child. If the child's symptoms are serious enough to impede learning, a parent might find it beneficial to request a consultation with the school counselor, school psychologist or private therapist; locate a therapist specializing in PTSD; evaluate present and long-term needs; remain mindful of other family members; and engage in appropriate self-care. Huebner and Mancini (2008) emphasize "Support for youth can be best accomplished by supporting the adults in the family, insuring that those adults have the necessary skills, characteristics, and personal efficacy to guide, support, and protect their children" (p. 13).

School professionals can assist by assessing the child to determine the best placement alternatives, identifying students coping abilities, evaluating personal and community resources, establishing support systems, recruiting supportive peers, and offering small peer support groups, as appropriate (Nader, n.d). Specific school intervention strategies for teachers include maintaining routines and a predictable schedule, avoiding articulation of personal political views, focusing on safety, being prepared to decrease student assignments as necessary, being approachable and open to students, acknowledging student's feelings and being conscious of cultural values (Johnson, n.d).

As children often freely express themselves through play, classroom teachers are in a unique position to notice changes in a child's behavior that may indicate the need for formal assessment. Professional services are critical for a child exhibiting symptoms of PTSD. If not detected and treated, issues may eventually resurface with increased intensity (Grosse, 2001). The Department of Veterans Affairs Department of Defense (2010) has recommend several therapies for treatment of adult PTSD including Cognitive Behavioral Therapy (CBT), exposure therapy, Stress inoculation therapy, and Eye Movement Desensitization Reprocessing (EMDR). To date, the authors found few studies on the long-term repercussions of parental post-combat PTSD on military children. This compels the helping community to extrapolate results from other populations to the children of service members. Education is a recommended element of treatment for all individuals diagnosed with PTSD and their family members.

While, PTSD is largely an *invisible injury*, post-combat veterans may have other co-morbid disorders as well as physical injuries. When dealing with the additional stress of a visible injury, communication is key. Children should be informed about an injury before they are confronted with the reality of seeing a parent with an alarming disfigurement (Center for the Study of Traumatic Stress, n.d). While it may seem prudent to suppress negative events, it may cause confusion for children when they sense something is amiss and children often imagine things are much worse than they actually are. It is believed that educating children about trauma beforehand may serve to inhibit their potential of acquiring PTSD and that hearing about individuals who have survived life's adversities and flourished provides ideals and an optimistic future outlook (Grosse, 2001).

Parents need to realize that their behaviors affect their child's well-being (Huebner & Mancini, 2008). "For parents who are struggling with their own emotional responses, it may be particularly difficult to evaluate what information their children are able to process and to calibrate the amount, content, and timing of the information they provide" (Cozza & Lieberman, 2007, Combat Injury section, para. 5). The American Psychological Association (n.d.) offers the following suggestions for fostering resilience in your child: talk with your child often and answer their questions truthfully, help your child feel safe at home, limit exposure of media war coverage, develop and maintain a routine, and instill a sense of hope for the future. Information must be shared with children in a developmentally appropriate manner; in particular, parents must use language their child can understand and be aware that younger children may not be ready to know as many details as older children (Center for the Study of Traumatic Stress, n.d).

Regardless of the severity of the issues, counselors can serve a key role in linking families with mental health resources to help assist children suffering from secondary traumatization in response to a veteran parent's PTSD. Some beneficial and easily accessible resources for families with members experiencing PTSD include:

- **Army Behavioral Health** – provides information and resources related to a soldier's mental health, including information on post-deployment adjustment issues with sections specifically for Guard and Reserve: www.behavioralhealth.army.mil
- **Camp C.O.P.E.** – a program designed to help children cope with the effects of war and deployments: <http://campcope.org/>
- **Center for the Study of Traumatic Stress** – focuses on the impact of war and its effects (including deployments, injury, and loss) on parenting and family function: <http://www.centerforthestudyoftraumaticstress.org/>
- **DoD Deployment Health Clinical Center (DHCC)** – provides information and links to other sites addressing a wide variety of deployment-related issues. The site includes a

Reserve Component Resource Center with information on health care, stress, and family support: www.pdhealth.mil

- **FOCUS: Family Resiliency Training™ for Military Families** – FOCUS Project addresses concerns related to parental combat operational stress injuries and combat-related physical injuries by providing state-of-the-art family resiliency services to military children and families: <http://focusproject.org/>
- **Gifts from Within** – an international nonprofit organization for survivors of trauma and victimization: <http://www.giftfromwithin.org/>
- **Marine Corps Community Services** – provides downloadable booklets on combat and operational stress, one for Marines and the other for their family and friends. Click on "Deployment Support": www.usmc-mccs.org
- **Military OneSource** – a free 24-hour service available to all Guard and Reserve members and their families regardless of activation status. Services include consultation by phone or online with referrals for free face-to-face counseling sessions in your community. Privacy is assured and no one knows you reached out for support unless there is a threat of harm to yourself or others. Contact Military OneSource by calling toll-free 1-800-342-9646: www.MilitaryOneSource.com
- **Military Youth on the Move** – designed to assist military children and parents to navigate topics such as dealing with deployment, moving to a new location, and everyday topics such as dealing with divorce: <http://apps.mhf.dod.mil/pls/psgprod/f?p=MYOM:HOME:0>
- **National Center for PTSD** – provides fact sheets, videos, and more about trauma for veterans and the general public to help answer questions about PTSD and related issues: <http://www.ptsd.va.gov/>
- **National Child Traumatic Stress Network Services** – has the mission to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States: <http://www.nctsn.org/>
- **National Institute of Mental Health Post Traumatic Stress Disorder** – provides information that explains what PTSD is, treatment options, and how to get help: <http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>
- **National Military Family Association's Operation Purple** – the mission of the Operation Purple program is to empower military children and their families to develop and maintain healthy and connected relationships, in spite of the current military environment: <http://www.militaryfamily.org/our-programs/operation-purple/>
- **National Military Family Association's Operation Purple Healing Adventures** – a family camp experience for active duty or medically retired service members who were wounded or experienced emotional trauma or illness related to their service in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF): <http://www.militaryfamily.org/our-programs/operation-purple/wounded-warriors-families/>
- **Operation Military Kids** – the goal of this program is to connect military children and youth with local resources in order to achieve a sense of community support and enhance their well-being: <http://www.operationmilitarykids.org/>
- **Sesame Workshop** - provides tips on how to manage the fear and anxiety often associated with frightening or traumatic events: <http://www.sesameworkshop.org/>
- **Sidran Traumatic Stress Institute, Inc.** – designed to help people understand, recover from, and treat traumatic stress (including PTSD), dissociative disorders, and co-occurring issues, such as addictions, self injury, and suicidality: <http://www.sidran.org/>

- **Vet Wives Living With PTSD** – a support site for wives and significant others living with PTSD: <http://livingwithptsd.yuku.com/>

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