

Center for the Study of Traumatic Stress

PROCEEDINGS WORKGROUP ON INTERVENTION WITH COMBAT INJURED FAMILIES



Sponsored by the Center for the Study of Traumatic Stress, part of the
Department of Psychiatry of Uniformed Services University and a partnering center of the
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PROCEEDINGS

Workgroup on Intervention with Combat Injured Families

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Workgroup Sponsored by:

Center for the Study of Traumatic Stress
Department of Psychiatry
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WORKGROUP ON INTERVENTION WITH COMBAT INJURED FAMILIES

Editor's Note: This transcript has been edited, however, as in most transcripts some errors may have been missed. The editors are responsible for any errors of content or editing that remain.

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PROCEEDINGS
Workgroup on Intervention with
Combat Injured Families

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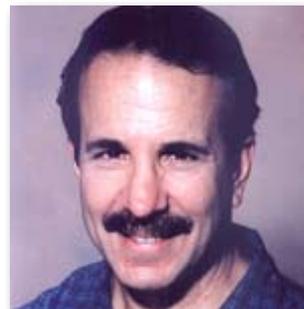
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Combat injury is a life-altering event that impacts not just the service member but his/her family and children.

Executive Summary

Workgroup on Intervention with Combat Injured Families

Introduction: Addressing the Needs of Combat Injured Families

Combat injury is a life-altering event that impacts not just the service member but his/her family and children. The affected population is significant in number and in terms of the unique challenges that include the short-term disruptions of individual and family routines and sense of safety, to longer-term issues around parenting and family health.

On December 11th and 12th, 2007, a number of prominent clinicians and researchers in the fields of child and adolescent psychiatry, military medicine and family trauma met to conceptualize the hitherto unaddressed needs and challenges of the combat injured family. This expert consensus gathering, referred to as the *Workgroup on Intervention with Combat Injured Families*, included six Chiefs of Psychiatry from major military medical centers and a renowned Children's Hospital, and the Child and Adolescent Psychiatry Consultant to the U.S. Army Surgeon General.

The Workgroup's primary objective, which was met, was to develop and disseminate a set of core *Principles of Caring for Combat Injured Families and Children* (see appendix). These principles would serve to guide simultaneous endeavors of scientific research and evaluation, and clinical interventions to mitigate family distress and dysfunction, and to improve communication around the injury within and between the healthcare, family and community settings. Other products were to include an edited transcript (attached), an Executive Summary, and a scholarly article initiating a scientific community dedicated to achieving the highest level of care for our nation's combat injured families and children.

Day One, *Clinical Problems and Core Principles of Intervention with Military Families*, provided an expert presentation on the scope, nature and unique challenges of combat injured families and children followed by presentations from Walter Reed Army Medical Center, Brooke Army Medical Center, Naval Medical Center San Diego and Madigan Army Medical Center. Participants described their sites' experiences providing care to combat injured families in the context of identifying and developing a Core Principles of Care document. Day Two, *Integration and Programmatic Intervention*, examined existing family trauma interventions to refine programmatic strategies for a manualized intervention to improve care and outcomes with this population.

The Center for the Study of Traumatic Stress (CSTS), part of the Department of Psychiatry of Uniformed Services University Medical School, spon-

It is not only the pain that they are dealing with, but it is part of that whole transition of the combat mindset complicated by the injury process.

sored the Workgroup. CSTS is the academic arm and a partnering center of the newly established Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury. CSTS conducts research, education and consultation around the psychological effects and health consequences of exposure to war, natural disasters, terrorism and public health threats. The Center's Associate Director and head of its Child and Family Program, Dr. Stephen Cozza, spearheaded this initiative. Dr. Cozza is the former Chief of Psychiatry of Walter Reed Army Medical Center and a leading scholar, educator and consultant to public and private sector stakeholders on understanding and meeting the needs of families and children affected by combat injury, loss of life, as well as the larger needs of families and children affected by trauma.

Scope and Nature of Problem

So many service members invest so much of themselves in being in the military, and then they are injured. It is not only the pain that they are dealing with, but it is part of that whole transition of the combat mindset complicated by the injury process. We need to recognize the necessary work that allows them to once again be available to their families and children.

Since the start of OIF and OEF, there have been close to 40,000 injuries of which 16,000 have required medical evacuation. These injuries include amputations, Traumatic Brain Injury (TBI), burns and other serious injuries. Since forty percent of U.S. service members have children, averaging approximately two children per parent, some 24,000 military children have been affected by serious combat related parental injuries. These numbers do not reflect the non-dependent children whose siblings have been injured, nor the parents of non-married and married soldiers, many of whom leave their communities and jobs to attend to their injured children in hospitals and rehabilitation centers across the country.

The incidence of mental health problems is high amongst this population further complicating treatment and recovery. Between 10–40% of service members who suffer severe physical injuries develop depression or post traumatic stress disorder (PTSD) after hospitalization. The literature suggests that combat injured veterans are at greater risk for developing PTSD when compared to non-injured counterparts.

A deployment that results in a severe combat injury is likely to have profound effects on the service member's spouse and children. From the initial distress to the long-term injury adjustment challenges, children and families face difficult emotional and practical problems. Severe parental injury disrupts the family system — its routines, cohesion and sense of safety. Combat injury also affects existing patterns of parenting, as both injured and uninjured parents experience their own emotional response and face the difficult reality of medical treatment and rehabilitation over time.

Combat Injury Unique Challenges

The injury inherently disrupts the constellation and function of the family and adds stress to the family unit. It tends to widen splits in families that are already present, and add conflict when the dust has settled. Suddenly you have this injury event that just complicates things. Even when families pull together closely, the impact of the combat injury on families is more likely to disorganize than to organize families.

The injury inherently disrupts the constellation and function of the family and adds stress to the family unit.

Serious parental injuries, particularly those that lead to disability and/or compromise in parental function, are likely to result in child and family behavioral or emotional problems, as well as family dysfunction. Drawing upon their experiences, Workgroup participants catalogued some of the unique challenges that combat injury inflicts upon service members and their families, and the implications of these challenges on parenting, child development and providing care.

Injuries to a service member are likely to result in a flurry of urgent activity and anxiety, leading to disruption of family roles, sources of care and instrumental support. Often immediate information regarding the nature and severity of the injury is limited, and sometimes inaccurate, causing increased anxiety in families. Complicating matters further, adults often do not know how to speak to children about the injury, or how much and what kind of information to share. *Injury communication* is a new term that refers to both the provision of information and the manner in which it is delivered. Injury communication is a significant challenge that occurs from the outset of the injury process and over time, and involves the healthcare setting to patient family, family to children, and to the outside community.

Spouses face the dual challenge of supporting their injured service member and sustaining their parenting role. Upon being notified of the injury, many spouses travel abroad and stateside leaving their children in the custody of family or friends for indefinite periods of time. Preoccupation with serious medical issues can reduce their awareness of their children's needs, not necessarily in a punitive or a toxic way, but may certainly lead to change in their availability and a very real disconnect between the parent and the child. The spouse's most frequently reported concerns about their children include: 1) changes in parenting style and in their children's routines; 2) the emotional health of their children; and, 3) concerns about continuing to be effective parents.

Spouses also can be the recipient of the frustration and angst of the injured soldier. According to one participant, *"Oftentimes the anger that the service member is experiencing is directed at the spouse, and sometimes at the children. We have found an increase in the potential for abuse and we have encountered several cases of spouse and child abuse."*

The impact of a parental injury on a child is profound and potentially leads to long-standing consequences. Children must integrate the meaning of the injury within their own developmental understanding, possibly requiring them to modify the internal images of their injured parents. Ultimately, a child must develop an integrated and reality based acceptance of those changes. According to one participant who works with burn patients, *"the extent of a facial injury may be difficult for a child, from a developmental perspective, because the parent looks so very different. We have children who talk about knowing that this is their parent but it may take months for them to realize that this is really their parent."* In addition to fear, young children often blame themselves for the parent's injury. Adolescents may react by engaging in risk behaviors that express anger, sadness or a sense of invulnerability.

Children are variably prepared for hospital visits. In addition, hospital clinical staff is frequently not educated about the developmental needs of children, the risks of traumatic exposure, and the fact that parents might benefit from guidance about the needs and likely reactions of their children in this context.

Remaining culturally minded, military families often pride themselves on their self-sufficiency. They do not necessarily like seeking out or demanding things.

The impact of combat injury on a service member can be devastating to his/her personal identity and parental role. For many Marines and Army soldiers who identify with physicality and athleticism, the enjoyment of parenting is also linked to physical activities such as wrestling, tossing a ball, running and playing games. To lose one's physical ability complicates the transition to post-injury health and it may also require learning to parent in new and different ways. One Workgroup participant describes "a *Special Forces service member who had lost his eye and a limb and anticipates that he will not be able to shoot or run, and he feels so lost. He is 29 years old and...feels he cannot be a father to his three-year-old son...Only after he was able to talk about his losses and his trauma could he begin to think about his role in a different way. He decided that he was going to be a teacher; as he was teaching his physical therapy exercises to his children, he realized that he could turn those teaching skills into an occupation as a teacher.*" The capacity to shift one's sense of identity and to incorporate alternate pleasurable ways of parenting is a key to the healthy transition of families and children, as well. The multiple challenges unique to combat injury coalesce to have high

Barriers to Care

Remaining culturally minded, military families often pride themselves on their self-sufficiency. They do not necessarily like seeking out or demanding things. It is important to develop or shift the model from one of dependency to self-sufficiency or self-care.

Diminishing individual and family distress and fostering parental function and family health is a critical component of creating a recovery environment for the combat injured and his/her family. While the trajectory of combat injury care involves both the acute hospital setting (Stabilization Phase) and long-term care (Sustainment Phase), a number of barriers exist that must be acknowledged in developing family-based interventions.

Combat injured families tend to self-organize, caring for each other's children and families through the acute hospital ordeal. This can diminish provider opportunities to educate and work with families around sensitive issues that may exist or will exist over time. Working through parents may be the only way to address the needs of children who may not be present at the hospital, but many parents in acute hospital settings are too preoccupied and overwhelmed to address the needs of their children while attending to the medical needs of their spouse. Some military and Veterans Administration (VA) hospitals recognize the need and are better resourced to treat combat injured families, and others may or may not be.

Many injured service members may leave the military and enter communities that lack military healthcare facilities or have VA hospitals and centers whose staff has limited clinical knowledge of working with families of the injured. The community itself is an important support network for combat injured families. In the words of one participant, "*When the injured service member re-integrates into the community, the community reacts positively or negatively to seeing the injured person and the family is aware of those reactions... How does the family navigate through the community system and when the community responds, how does the family handle the response?*" There are unique and multiple challenges that result from combat injury. Common to many of these are challenges involved in reducing child and family distress,

The 10 core principles form the basis for comprehensive, sensitive and military-appropriate interventions of care for combat injured families and children.

sustaining parenting roles, fostering effective communication, and addressing barriers to care.

Core Principles

Ten “Core Principles of Care” were created as a result of the expert consensus discussion. These principles form the basis for comprehensive, sensitive and military-appropriate interventions of care for combat injured families and children. The simultaneous use and study of these principles will foster greatly needed evidence-based approaches that can support healthy family growth and recovery. These principles may be utilized by military and civilian hospital and/or community professionals to effectively manage clinical programs. Common to all is recognition of individual and family strength and resilience in the face of profound change and challenge. The ten principles are described below:

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

There is an urgent need for research to develop effective family focused intervention strategies that may better meet the short and long term needs of combat injured families.

process, recognizing a family's unique strengths and challenges, as well as anticipate the future needs of families as they transition to a new community or new way-of-life.

- Effective injured family care requires an *interconnected community of care*. Effective intervention requires collaboration and coordination of services between the family, the health care system, and military and civilian community resources. This collaboration fosters a community of care that reaches across traditional professional boundaries throughout rehabilitation and recovery
- Care must be *culturally competent*. Healthcare and community professionals who interact with combat injured families need to possess the cultural and language competence to engage families that may be traditional or nontraditional in their composition and may be of broad ethnic and religious backgrounds. It is essential that all healthcare and community service providers understand and respect the unique experiences and traditions of military families.
- Communities of care should address any *barriers to service*. Barriers to intervention can complicate the healthy recovery of combat injured service and family members. These barriers may include a family's difficulty in accessing health care or community services. In addition, a community's lack of awareness or misunderstanding of the needs of a combat injured family or a family's hesitation to seek assistance can also limit family intervention and recovery
- Families, communities and service providers must be *knowledgeable*. Individuals, families, professionals, organizations and communities all have a need for access to quality educational materials to address the challenges that confront combat injured families. Effective education leads to the development of skills in all parties, building empowerment in communities and families. Development of new knowledge is fundamental to better meeting the needs of this unique population.

● **Interventions: Goals and Strategies**

While the problems facing families of combat-injured individuals have been described and are addressed in clinical treatment centers, no empirical data has been collected on the impact and severity of combat injury on families to inform intervention and treatment planning (Cozza, Chun & Miller, in press). Thus, there is an urgent need for research to develop effective family focused intervention strategies that may better meet the short and long term needs of combat injured families.

On Day Two, *Integration and Programmatic Intervention*, participants deconstructed the challenges of combat injury on children and families to identify actionable intervention strategies, goals and proposed outcome measures. The three identified domains that interventions should target were identified as *individual and family distress*, *individual and family function* and *injury communication*. Many of these strategies were drawn from Project Focus (Families OverComing Under Stress), a program initiated by UCLA, and used in military communities around the country to address deployment cycle family stress. There was consensus around the following points.

Interventions should also foster effective injury communication.

Intervention in the acute hospital setting to foster parental function should:

- Be flexible, modifiable and strength-based (vis a vis family function) versus pathology-based.
- Include both a brief model and more comprehensive model focused on parent and/or child mastery sessions.
- Acknowledge family anxiety and distress, and help parents to acknowledge its impact on the family and children.
- Incorporate a family system perspective that paves the way for altering family function and a caring recovery environment.
- Anticipate child development issues, i.e. adolescent risk behavior in reaction to parental injury.
- Have applicability in the civilian population for children exposed to traumatic parental injury or illness.

Interventions should also foster effective injury communication. Injury communication, in its broadest sense, refers to the provision and delivery of information related to the injury. It is a process that encompasses notification, the acute hospital phase (provider/patient information), the family itself (parent to children to extended family) and community (friends, schools, social support systems and the media). Effective injury communication facilitates connectivity within and between hospital, family and community.

Interventions to foster injury communication should address:

- The type, role and effectiveness of communication (what is enough/too much/what should be shared/not shared/in what ways and with whom).
- Calibrating the message to foster realistic hope, appropriate involvement and reduced stress.
- The importance of helping a family construct an injury narrative that will provide meaning for the family and children, and a way of communicating their experience to friends, schools, and the community.
- The role of communication in community reintegration. As families reintegrate into the community, effective communication allows them to advocate for themselves through appropriate and timely help-seeking as well as to engage in family problem-solving.
- Health communication materials and resources are needed to educate combat injured families, community healthcare providers and the community at large about the unique challenges and needs of military families and children impacted by parental injury.

Conclusion/Summary

The recovery of an injured service member's family and children is a process and not an event. The injury experience itself is unique to the family and varies significantly depending upon the nature of the injury, the structure of the family, the developmental level of the children and the expected outcome, treatment, and rehabilitation process.

Military families and children of the combat injured are a diverse and geographically dispersed population living in military and civilian communi-

Taking care of military families, especially as a result of serious injury, can foster recruitment and retention and sends an important message to the nation that those who have sacrificed for our national security deserve the highest level of care at the time of the injury and throughout what may be an extensive period of recovery.

ties across the United States. Their care needs are complex, unique and entwined, and necessitate informed involvement from healthcare professionals, community service providers, and family and friends. Importantly, care must be delivered with sensitivity and skill from the acute in-hospital phase and throughout the long and arduous road to recovery, which includes transition back to one's home and one's community.

While many children will remain healthy in the face of this stress, some may sustain life-changing trajectories in their emotional development and/or their interpersonal relationships. Parental injury can alter the child's view of the wounded parent, and undermine the child's sense of his or her own physical strength. Indeed, it is likely that the effects of combat parental injury on children are more complex and potentially more challenging than non-violent and accident related injuries.

Intervention strategies need to include a longitudinal perspective. Good post-injury care is not just about the injured service member. Health care facilities need to include children and families as part of the treatment plan and process. Family members are not outsiders or visitors to the health care facility; they are participants in the care plan. Hospitals should develop child and family friendly treatment environments, incorporate children into rehab activities, protect them from possible traumatic exposures and monitor at risk family situations. Such efforts are likely to have a positive impact on the combat injured parent, family and children, as well as the health care team.

The Workgroup intends to formalize techniques to measure and address the challenges of the combat injured family to be sure that interventions and programs are helpful and evidence-based. While the process will be iterative, developing interventions will correlate with the core set of *Principles of Caring for Combat Injured Families*. Research and evaluation will require resources and environmental support, to include funding as well as active application in healthcare settings.

It is important to recognize that the next generation of the U.S. military is coming from the children of the current generation of military service members. Taking care of military families, especially as a result of serious injury, can foster recruitment and retention and sends an important message to the nation that those who have sacrificed for our national security deserve the highest level of care at the time of the injury and throughout what may be an extensive period of recovery.

SESSION ONE:

Clinical Problems and Core Principles of Intervention with Injured Military Families

Introduction of Workgroup Participants

- DR. COZZA: Welcome to our *Workgroup on Intervention with Combat Injured Families*. We, at the Center for the Study of Traumatic Stress (CSTS), have been planning this Workgroup for some time and are very pleased to be hosting it today. It is good to have everybody here to address the concerns that *combat injury is having on children and families of our service members*. This topic has been important to me and in my work for many years now. The impact of combat injury on military families and children is also a topic of tremendous significance to you, and to our Nation. Let's begin by introducing ourselves to each other.
- LTC PETERSON: I am Chief of Psychiatry at Madigan Army Medical Center (MAMC) and the Child and Adolescent Psychiatry Consultant, to the Surgeon General of the Army. I was born and raised in Tacoma, Washington. I am glad to be here and I am very interested in doing research and supporting our military children. I completed my adult residency and child and adolescent psychiatry training at Walter Reed Army Medical Center (WRAMC).
- DR. LESTER: I am a child and adolescent psychiatrist and serve as the Director of a Child and Adolescent Trauma Psychiatry Clinic. I also work at a research center, the Center for Community Health at University of California at Los Angeles (UCLA). Bill Saltzman and I have developed Project FOCUS. I am the Director of the Project FOCUS Initiative for the Marines and Navy, and I will talk about this project this afternoon.
- MS. MARTINEZ: I am a retired Army nurse who is now working with Dr. Cozza and the Workgroup on Intervention with Combat Injured Families at CSTS. I had the pleasure of working with Drs. Cozza, Chun and Wain, and his staff, at WRAMC where I worked on the *Post Deployment Health Assessment Tool Project* completing initial and follow-up assessments on selected, battle injured service members.
- LTC SCHNEIDER: I am the Chief of Child and Adolescent Psychiatry at WRAMC, and an adult, child and adolescent psychiatrist as well as a forensic psychiatrist.

Everybody here will address the concerns that combat injury is having on children and families of our service members.

DR. COZZA: And, an Iraq War Veteran. We are pleased to have a number of combat veterans at this Workgroup meeting.

- DR. RICHTERS: I am local, and was trained as a child psychologist. My research and writing for the past 20 years have been in the area of child and adolescent psychopathology focusing on children who are living in high-risk environments exposed to violence. I was at the National Institute of Mental Health (NIMH) for most of those years. I have recently joined the staff at the CSTS *Workgroup on Intervention with Combat Injured Families*.
- DR. ARATA-MAIERS: I am the Child and Family Coordinator for our Warrior Resiliency Program at Brooke Army Medical Center (BAMC). I have been working with military families for about 12 years. I am working with Steve on a couple of projects related to military families.
- DR. SALTZMAN: I am part of the Project Focus Team at UCLA with Trisha Lester. I am also a child psychologist, a Professor, and run a Family Therapy Program at California State University at Long Beach. I have been developing programs for children and families for a long time. John reminded me that it was 20 years ago that we developed the survey for children exposed to violence.
- DR. FULLERTON: I am the Scientific Director at the CSTS. I am also a Professor in the Department of Psychiatry of Uniformed Services University of the Health Sciences (USUHS). I work closely with our Center's Director, Robert Ursano. As a developmental psychologist, my interest in our disaster, trauma and terrorism projects has been related to children and families. At CSTS, we initiated some of the first research on spouses of disaster workers, and have studied a wide range of disasters and traumas. I have known Steve for many years and I am glad that he has joined us at the CSTS.
- DR. CHUN: I am working on the Child and Adolescent Psychiatry Service at WRAMC. I have been working with children and families since the 9/11 terrorist attacks when we ran our Family Assistance Center at the Pentagon site. With the start of Operation Iraq Freedom (OIF) and Operation Enduring Freedom (OEF) in 2003, the Child and Adolescent Psychiatry Services at WRAMC added a new service called the Psychiatric Consultation and Liaison Service, part of the Walter Reed Child and Family Service Center. The Center's service model is based upon the DoD Family Assistance Center and the principles learned from 9/11. The Psychiatric Consultation and Liaison service provides preventative psychiatric consultation to combat injured service members' families and children recognizing that they are under a great deal of stress and at risk for traumatic responses.
- LCDR KANE: I have been the head of Child and Adolescent Psychiatry at Naval Medical Center, San Diego (NMCSD) for about three months. Prior to this assignment, I was a Fellow at WRAMC working with Dr. Schneider and Dr. Chun.
- MS. WILLIAMS: I am a clinical social worker at Zero to Three, which is a national nonprofit organization dedicated to the needs and interests of infants and toddlers. Within the Zero to Three Program, we have a Military Projects Division that performs a variety of initiatives. I work with the 'Coming Together around Military Families Initiative', and have experi-

As a result of this Workgroup, we would like to: 1) develop a set of core principles that would inform the intervention with injured families; 2) catalogue family problems associated with combat injury; 3) describe the evidence-informed interventions that are appropriate to address those problems...

ence with family advocacy and a home visitation program. Zero to Three is supporting 12 military installations and two medical centers around the country focusing on stress, trauma, grief and loss. I am also a Marine Corps spouse who has always supported military families.

- MS. KAUL: I am with the Substance Abuse and Mental Health Services Administration (SAMHSA). I am a Federal Project Officer for the National Child Traumatic Stress Network (NCTSN), an organization that has a strong interest in serving this particular population. We recently entered into an agreement with the CSTS to bring the Center into the NCTSN as a non-funded Category II network site. I want to keep current on Workgroup activities to facilitate collaboration with other members of our NCTSN across the country.
- MS. VINEBURGH: I work at the CSTS as Director of the Office of Public Education and Preparedness. I have been in the field of health communication and mental health communication for nearly 30 years. I am here because of our Center's interest in developing information for behavioral health change. We have completed many different projects and publications around that focus. We developed *Courage to Care*, an electronic fact sheet campaign that is distributed to military healthcare leadership, and last April, our team led by Steve, developed a campaign for the military child called *Courage to Care for Me*. Our public education work is very innovative. On page nine of *Center for the Study of Traumatic Stress, 2007 Report*, there is a very nice description of our Center and the very important role that Steve played in a Sesame Workshop and public education initiative, as well as the *Courage to Care for Me* initiative.
- DR. MCCARROLL: I work at CSTS and oversee our Family Violence and Trauma Project; my work area is in family violence research.

DR. COZZA: We will be spending the next day and a half together and I look forward to being your host. For clarification, this meeting is *not* a conference. It is a workgroup. Because of that, there are some products that we expect to create from this Workgroup meeting. There are some other people who will be participating at some level. Dr. Bill Beardslee from Children's Hospital Boston will join us soon. Bill was a major participant in the development of the FOCUS intervention and he has a great deal of experience working with families with parental mental illness. Dr. Robert Ursano, Chairman of the Department of Psychiatry at USUHS and Director of the CSTS, will join the group tomorrow. Dr. Doug Zatzick from University of Washington who has developed collaborative care models of intervention for the injured will be participating in future Workgroup efforts. Dr. John Newby, one of our CSTS doctoral level social workers will be joining us as an observer. COL Bruce Crow, Chair of Behavioral Health at BAMC and Capt. Warren Klam, Chair of Psychiatry at Naval Medical Center, San Diego, were not able to attend, but did send representatives.

● Workgroup Aims and Agenda

DR. COZZA: I will now review the information that was passed out. There were several electronic attachments that I hope you all had an opportunity to peruse, the *Workgroup Agenda*, *Participant List* and a copy of the *Psychological First Aid Field Guide*, Second Edition, which was published by the NCTSN. In this guide, you will notice the core *Principles of Psychological First Aid*.

“The impact of a parental injury on a child is profound and potentially leads to longstanding consequences. Children must integrate the meaning of the injury within their own developmental understanding, possibly requiring the child to modify the internal image of the injured parent. Ultimately, a child must develop an integrated and reality based acceptance of those changes.”

As a result of this Workgroup, we would similarly like to: 1) develop *a set of core principles* that would inform the intervention with injured families; 2) catalogue family problems associated with combat injury; 3) describe the evidence-informed interventions that are appropriate to address those problems; and, 4) refine programmatic strategies for a manualized intervention.

The Workgroup process will be *product focused*. We will develop an edited transcription text and an Executive Summary of this meeting. We will have a strategic discussion focusing on the objectives. Thinking about core principles that would apply to these families in any setting is important. We also want to be thinking about intervention strategies that are appropriate in the acute hospital setting (Stabilization Phase) and in long-term care (Sustainment Phase). We will be working to manualize this intervention (to create an intervention manual) leading to scientific study and evaluation. Using a tiered model, we will start with *core principles* and narrow them down to protocolized interventions recognizing that scientific study may not occur at everybody’s site, but that the *core principles should apply at every site*.

As noted, several Workgroup products will come out of this meeting, and others will continue to be developed beyond this meeting. In addition to developing group consensus on what are the core principles of intervention with combat injured families, and developing intervention strategies for use with combat injured families, this Workgroup can be viewed as an opportunity to develop a scientific community where everybody participates and assists in developing a scientific paper with multiple authorship. This paper will describe the clinical problems, core principles and the intervention strategies to use with combat injured families.

To start, *we* will describe the experiences that we have had with injured families, and then have an opportunity for the different clinical sites represented here, which include Walter Reed Army Medical Center (WRAMC), Brooke Army Medical Center (BAMC), Naval Medical Center, San Diego (NMCS), and Madigan Army Medical Center (MAMC) to provide ten-minute presentations about their work with injured families. The focus will be on *identification of core principles*. Please address your five most important lessons learned, and include the most important things that you are doing with injured families that could inform our *core principles*.

In the afternoon, we will talk about intervention strategies. Bill Saltzman and Tricia Lester will discuss the FOCUS Model. We will then review different intervention models and their applicability to injured families. Then we will do a round up and have dinner. In the evening, our Planning Committee will get together to digest and integrate today’s discussion materials and develop the agenda for tomorrow. We wanted to have an opportunity to pull things together, bring the results back to the group, and then address those distilled ideas with the group participants.

Introductory Presentation: The Impact of Combat Injury on Military Families and Children, Dr. Cozza

“The impact of a parental injury on a child is profound and potentially leads to longstanding consequences. Children must integrate the meaning of the injury within their own developmental understanding, possibly requiring the child to modify the internal image of the injured parent. Ultimately, a child must develop an integrated and reality based acceptance of those changes.” — Dr. Cozza

We need to remember that any identified core principles or intervention strategies may be used by both military and civilian health care professionals in either hospital or community settings, and plan accordingly.



Figure 1.1: Range and Prevalence of Combat Injuries.

COZZA: While there are a host of military family challenges, our main focus today is on *combat injury* and the *unique needs of military families* related to these injuries. Using a power point presentation, I will discuss the CSTS experiences and work in this area. Also, some of this work was done at WRAMC when I was the Chief of the Department of Psychiatry.

Figure 1.1 presents a description of the *range of combat injuries*. Injury severity may vary depending upon your clinical site, however most of the military medical center sites are receiving service members who have received serious injuries including *amputations, Traumatic Brain Injury (TBI) and burns*. Given the range of combat injuries, any intervention should be applicable to these different clinical populations.

Figure 1.2 is a summary slide of casualties that have been reported since the start of the war. There are close to 40,000, although most of them did not require air evacuation. About 16,000 service members suffered injuries that were serious enough to require air evacuation (combat and non-combat related combined). Many of the injured will leave the military and return to communities where there may not be military health care facilities. Some combat wounded service members may return to communities that have a Veterans Hospital whose staff may have limited clinical understanding of the impact that the combat injury has on a service member's family and children.

We need to remember that *any identified core principles or intervention strategies may be used by both military and civilian health care professionals in either hospital or community settings*, and plan accordingly. In work that was done at WRAMC, Pat Martinez and her staff used the *Post Deployment Health Assessment Tool (PDHAT)* with combat injured service members to assist clinicians with the management of their care. The PDHAT as distinguished from the *Post Deployment Health Assessment and Reassessment (PDHA and PDHRA)* tools, which are purely screening instruments for detecting mental disorders in returning soldiers over time, is a more comprehensive instrument

As we consider core principles, the importance of family cannot be underestimated.



Figure 1.2: Reported Casualties Since the Start of IOF.

used for research purposes. These purposes may include collecting information about combat exposures, prior trauma history, as well as screening for posttraumatic stress disorder (PTSD), depression, alcohol abuse and other anxiety disorders.

The rates of PTSD and depression in this combat injured population were retrospectively examined using these screening tools, and results were published in the October 2006 issue of the *American Journal of Psychiatry*. One of the most interesting findings was the fluctuating status of PTSD and depression. The findings suggest a population at risk, where the development of symptoms can occur at various times during injury recovery and for unclear reasons. We can hypothesize that illness development is related to stress, and for our purposes and considerations are related to family stress. The combat service member's injury and subsequent psychiatric symptoms or illness impact the service member *as well as their family and children*. As we consider core principles, the importance of family cannot be underestimated.

There is little if any literature examining the impact of parental combat injury on children. Some scientific literature reports the impact of parental traumatic brain injury (TBI), spinal cord injury and chronic illness on children and families. There are probably unique child responses resulting from combat related parental injury. Existing literature does recognize that the impact of any parental injury on the family and children relates to the nature of the injury and resulting parental dysfunction. This is another important consideration for our deliberations.

Child and adolescent psychiatry staff members at WRAMC have piloted the use of the *Parent Guidance Assessment Inventory (PGAI)*, which was recently modified to the *Parent Guidance Assessment-Combat Injured: PGA-CI*, with selected families and children of combat injured service members. The instrument, developed by the CSTS in conjunction with WRAMC, attempts to foster a working relationship with injured families. It assesses when there

Hospital clinical staff is not particularly well educated about the developmental needs of children, the risks of traumatic exposure, and the fact that parents might benefit from guidance about the needs and likely reactions of their children in this context.

is significant distress in parents or children, and encourages parents to think through the complex needs of children resulting from parental injury. It also helps parents make appropriate decisions to meet those needs. Recently, the *PGA-CI* has been expanded to include items that provide quantifiable data responses.

As not all children of the injured service members were able to visit their injured parent in the hospital, parental reports were generally used in the assessment of children. Given the reality that many children do not come to treatment facilities we need to consider the importance of developing interventions that meet those children's needs by working through their parents. In looking at anecdotal information collected from WRAMC, we see that most parents did not report elevated symptoms in children. This may indicate child health, or the possibility that the parents were so impacted by the injury that they were not attentive to the impact of the injury on their children. Often parents were so preoccupied that there was less time for their children.

Frequently, parents reported that they did not know how much information to share with their children about the injury. Additionally, there were often major disruptions in the lives of the children due to the length of hospitalization, the distance from the medical center to the family's home, the absence of the non-injured parents, or the dislocation of children from their homes to live with relatives or friends in different parts of the country. Any or all of these could impact school, home and peer relationships. Children seemed to have fears or concerns about the nature of their parents' injuries.

Children who visited the hospital were *variably prepared for the hospital visit*, and their meeting their injured parent remains a significant concern to the clinical team. At times, some older children in the family were talked to about the injury while younger children were not. Some parents also might assume that their children would figure it out when they walked into the injured parent's hospital room, clearly representing a potentially destructive decision. In addition, hospital clinical staff is *not particularly well educated about the developmental needs of children, the risks of traumatic exposure, and the fact that parents might benefit from guidance about the needs and likely reactions of their children in this context.*

Additional anecdotal information collected from non-injured parents (spouses of combat injured service members) indicated their most frequently reported concerns about their children included: 1) changes in parenting style and in their children's routines; 2), the emotional health of their children, and: 3) concerns about continuing to be effective parents. The impact of a parental injury on a child is profound and potentially leads to longstanding consequences. Children must integrate the meaning of the injury within their own developmental understanding, possibly requiring the child to modify the internal image of the injured parent. Ultimately, a child must develop an integrated and reality based acceptance of those changes.

The drawing in Figure 1.3 was completed by the five year old son of a combat injured father who had bilateral lower extremity amputations. The son was asked to draw a picture of a person, not to draw a picture of his parent. But his initial reaction was to draw a picture of a man with artificial legs. Although most children his age would start with the head and work down, this child started with the two feet (which he was profoundly interested in) and then added segments of legs up to the shoulders including no torso. When the

There are many challenges that military families face... including financial concerns, interpersonal family issues, concerns about continuation of military service, the nature of health care decisions, and disruptions to children's lives by family moves, changes in schools and loss of peer relationships.

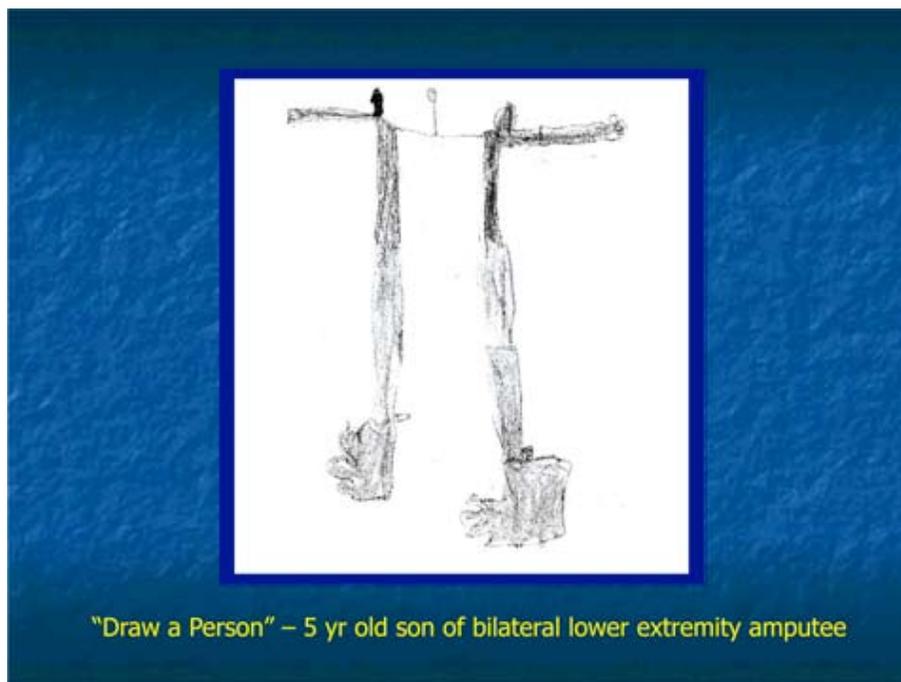


Figure 1.3: The drawing of a child of a combat injured service member.

child reached the second segment, the legs must have felt wobbly or unstable to him because he drew a line between the legs, a supporting beam to provide stability to the drawing. In his own mind he likely was questioning how a person can remain an integrated being when they have suffered that level of injury. The son then drew large deltoids on the figure suggesting some semblance of remaining strength. In the ankles of the figure he drew (with great interest) small computer chips that represented prosthetic devices. Clearly, this five year old was working hard to integrate his emotional reactions to his father's serious injury.

A three year old son of a lower extremity amputee father was asked to draw a picture of a person. He started by drawing the head, but then scribbled around the head and said that his was a picture of a person who had been in an explosion. His father had been injured by an incendiary explosive device (IED). Again, this child's drawing reflects great effort in integrating an emotional understanding of his father's injury. Both drawings clearly demonstrate the powerful organizing effects of parental injury on these children and their healthy struggle to appropriately integrate these events.

There are many challenges that military families face as a result of combat injury. Some of these include financial concerns, interpersonal family issues, concerns about continuation of military service, the nature of health care decisions, and disruptions to children's lives by family moves, changes in schools and loss of peer relationships. We have talked about disruptions to family structure, but need to specifically mention the impact on the injured service member's own sense of his or her capacity to parent. For many Marines and Army soldiers who identify with physicality and athleticism, the enjoyment of parenting is also linked to physical activities such as wrestling, tossing a ball, running and playing games. To have lost physical ability can complicate their transition to post-injury health as it may also require learning to parent in new and different ways. Their capacity to shift their sense of identity and

“Sometimes the children, although they feel very lonely, anxious and depressed, are not ready to share their own need and pain with their parents when their parents are in this turmoil. Young children want to protect their own parents.”

to incorporate alternate pleasurable ways of parenting is a key to the healthy transition of families and children, as well.

We have discussed some of the goals of health care providers, which include (but are not limited to) working with the injured family to promote mastery and facilitating the rehabilitation process, both of which are collaborative efforts. This leads us to an additional core principle and an important consideration in working with injured families: *recognizing the importance of staying involved longitudinally*. The recovery of an injured service member’s family and children is a process and not an event. *Intervention strategies need to include a longitudinal perspective*. Doug Zatzick’s Early Collaborative Care model is helpful in that regard. Good post-injury care is not just about the injured service member. Health care facilities need to include children and families as part of the treatment plan and process. Family members are not outsiders or visitors to the health care facility; they are *participants in the care plan*. Hospitals should develop child and family friendly treatment environments, incorporate children into rehab activities, protect them from possible traumatic exposures and monitor at risk family situations. Such efforts are likely to have a positive impact on the combat injured parent, family and children, as well as the health care team.

● **Introductory Presentation Discussion**

“Sometimes the children, although they feel very lonely, anxious and depressed, are not ready to share their own need and pain with their parents when their parents are in this turmoil. Young children want to protect their own parents.”
— Dr. Chun

*“One of the themes we are going to hear about is **injury communication** — how much do children hear (both what is appropriate and inappropriate) and understand about what this injury experience is about? How much are they able to talk to their parents about what has happened to them? How can the parents talk with the children in a way that supports the family integrity and family communication?”* — Dr. Cozza

LTC PETERSON: Something that resonated with me regarding the lack of parental insight is that they are often so preoccupied with their own injuries that they do not pick up on what is going on with their children. Some of the literature about mothers with severe PTSD reports that the more these mothers are not in tune with their own anger and aggression, the more that anger is being perceived by the children and actually increases the rates of these children’s depression and anxiety. Are you getting the same kind of resonance with the parents who are so preoccupied with their own issues that it is having a negative impact on the children?

DR. COZZA: There are several short and long term issues to consider. In the short term there are many decisions that are made by the spouse in particular. One of the things we cannot forget about injured parents is that they are combat veterans as well. They come back from war with acute stress reactions; some are probably related to the injury, but also are likely related to their combat experience. This frequently can make them distant and unavailable to their families. If a spouse is particularly worried about the level of injury, this

It is important to better understand the unique characteristics of the different types of injuries and their impact on families.

preoccupation can cause lack of awareness of the children's needs, not necessarily in a punitive or a toxic way, but almost a neglectful way. The spouse may be unaware or have to defer those child-specific responsibilities to others. They may make choices to put the children in the custody of other family members or friends who may or may not understand or have the capacity to care for those children. This can lead to a very real disconnect between the parent and the child. In the longer term the service member and the parent spouse must integrate the realities about the impact of the injury. Emotional responses can vary considerably and oftentimes go unmentioned within the family. One of the themes we are going to hear about is *injury communication* — how much do children hear (both what is appropriate and inappropriate) and understand about what this injury experience is about? How much are they able to talk to their parents about what has happened to them? How can the parents talk with the children in a way that supports the family integrity and family communication?

DR. CHUN: Our experience is that there are different ways that parents demonstrate their lack of awareness of what their children's symptoms or experiences are. Sometimes the children, although they feel very lonely, anxious and depressed, are not ready to share their own need and pain with their parents when their parents are in this turmoil. Young children want to protect their own parents. Parents cannot always deal with children's risk behavior and the degree of their activity levels. I had an experience with a 16 year-old boy who used a lot of humor to deal with chaos. His father had been in the Intensive Care Unit for weeks. When the 16 year-old visited his father, he would crack jokes. Neither of his parents could deal with that. Telling jokes was how the son dealt with his stress. He kept telling jokes hoping that his parents were going to say, "Stop!" and then set some limits. But the parents were too preoccupied. The father was too sick and the mother was too focused on her spouse. They ignored their son and sent him out of his father's hospital room, but could not say, "Stop!" Here we see miscommunication between the son and the parents. In some cases, parents, especially fathers, have been away so long, some for many months, or in other cases for about a year. They do not understand that in their absence the children have grown and changed, as has the non-military parent. There can be real isolation. Sometimes children are isolated from their parents even when they are physically present.

DR. SALTZMAN: It is important to better understand the unique characteristics of the different types of injuries and their impact on families. I know there is commonality, but what are the distinct injury presentations and how do they variably impact parenting and communication in the family? An article by Collins provided an approach to adaptive interventions that are really tailored to specific needs. There are many dimensions that could be adapted to individual family needs.

DR. ARATA-MAIERS: Over time, we have noted that families benefit from a great deal of work to help them adjust to the changes and emotions surrounding the injury. Often there is initial fear and then relief that the injured family member survived. These families tend to return to BAMC a year or two later as the children enter another developmental phase. Not uncommonly the issue then is the *caregiver role that the child is placed in*. There is minimal literature addressing the *challenges to children as caregivers*, especially in families dealing with amputations, burns and other profound inju-

“What we learned is that families have the support of other families of injured service members.

ries. We are concerned for both the children and the parents. It is difficult for the injured service member who has a child and does not have any family or other support available to assist with their care except for the child. The child can become the longer term treatment solution, assisting the parent in dealing with chronic problems that he or she will be dealing with for the rest of the service member’s life.

DR. LESTER: Is that true for school age children as well as adolescents?

DR. ARATA-MAIERS: Yes, in some instances, school age children are also providing care for their injured parent. If the child is capable of doing personal care and the child is the only person in the home, the child may be enlisted to do that.

DR. CHUN: My experience with the children is that that they have mixed feelings helping their parents versus seeking other activities. At WRAMC, children want to go out and do sightseeing in D.C., but then part of them wants to be helpful and take care of their wounded parent. Often children do not know how to respond to or help the injured parent. For instance, the child who comes to visit the amputee parent and hugs him and it creates pain. The child and parent both have emotional responses to this. It is very complicated and creates conflicted feelings.

LCDR KANE: Working with the families of injured service members, I was struck by the fact that in addition to the parent service member who was injured there were situations in which the *injured service member had a younger brother or sister*. In those cases, we did not usually receive a referral to visit with the injured service member. We just stumbled into it. That is probably a larger population than we are aware of. Obviously, this sibling has been somebody who has been involved in the life of the injured service member in profound ways. This situation may have as much impact as a parent being injured, but maybe in a different way and is worth thinking about if we are looking at whole families.

Clinical Problems and Core Principles: Medical Center Participant Presentations

Walter Reed Army Medical Center (WRAMC)

“What we learned is that families have the support of other families of injured service members. They help watch each other’s children when they have appointments or need to run errands. They use their own network, rather than going to what the military creates for them. How can we support those kinds of activities at our facilities?” — LTC Schneider

“Injured service members know they have to be parents; they cannot escape being parents. Cognitively, you can think to yourself that you may not be able to be a service member anymore because you have lost your arm; however, you can never abdicate your parental responsibilities.” — Dr. Chun

DR. COZZA: Our Workgroup participants who represent the different Medical Centers will now give a ten minute presentation highlighting their experiences in working with the siblings, families and children of combat injured service members. Again, let’s focus on recognizing clinical family problems and highlighting core principles for intervention. We will start with WRAMC.

What we have learned at WRAMC is that families form their own support groups within their own support system, rather than depending on us to preside over the support group.

DR. CHUN: I will share some case examples and programs that we introduced at WRAMC. Since 2003, the Preventive Medical Psychiatry Team has provided care to about 2,570 combat injured service members. As of November 2007 about 1,658 injured service members had children. We started a Parent Education Group that included three modules of classes on *how to parent the children of combat injured service members*: Module One dealt with parenting children when one parent has been combat injured; Module Two covered parenting children when the parents are distant due to the hospitalization of the injured parent, and; Module Three covered how parents can help children deal with loss.

DR. COZZA: Please frame your presentation within the context of core principles. One core principle involves understanding our knowledge (or lack of knowledge) related to the impact of injury at the parent level, the provider level, and the facility level.

DR. CHUN: Parent Education Classes were cancelled because the attendance was poor even after we changed the time and the site of the class. The classes were set up on the premise that if you come, we will give you educational information.

DR. RICHTERS: Do you know whether the parents did not attend the classes because they were too busy with other things, or might they have felt they understood the topic well so as not to need such classes?

DR. CHUN: Parents were too busy to come to the locations where we presented the classes.

LTC SCHNEIDER: As Ryo-Sook talks about the content of the classes, I also believe we need to think of the focus. We must focus on the family in the process of treatment and meet them where they are at. If the family is with the injured service member in one of the clinics such as Physical Therapy, we have to forward deploy (to use a military term) our personnel to where the family is at.

DR. RICHTERS: Focusing on where the family is at, within the course of treatment, is very important; we might also think of this within the larger principle of barriers to intervention.

DR. CHUN: We also tried to provide a Parent Support Group. Again, we tried to make it palatable, but we were not successful.

LTC SCHNEIDER: What we have learned at WRAMC is that families form their own support groups within their own support system, rather than depending on us to preside over the support group. How do we facilitate helping that process go forward, helping them do what they would do naturally? At a meeting with the families of the injured service members, the families complained that there was no child care facility available for their children. We created free childcare for the injured families at Walter Reed. It is staffed well and is very close to the hospital, but there are usually only two to three children there. What we learned is that families have the support of other families of injured service members. They help watch each other's children when they have appointments or need to run errands. They use their own network, rather than going to what the military creates for them. How can we support those kinds of activities at our facilities?

DR. CHUN: One of the most poignant things that we have learned is how important a skill self-advocacy is. For example, injured service member parents who have lost a limb; you can help them to continue to be successful

By focusing on parenting skills and helping them to see how they can do those better, it actually helps their whole recovery process.

parents by giving them examples of different ways that they can accomplish some of their parenting responsibilities. By focusing on parenting skills and helping them to see how they can do those better, it actually helps their whole recovery process. Injured service members know they have to be parents, they cannot escape being parents. Cognitively, you can think to yourself that you may not be able to be a service member anymore because you have lost your arm; however, you can never abdicate your parental responsibilities.

We also tried to conduct classes for the nursing staff about important concepts to consider when interacting with the injured service member's children, and we were not successful. Classes set up for the Child Development Center staff were also not well received. We then tried an individual approach and discussed specific cases with the staff. Again, this kind of organized effort did not get the kind of reception we were anticipating.

What we continue to do, and believe is helpful, is to meet with injured service members and their spouses at the bedside. One of the things that we learned is that discussing their concerns about their children is not what they may want to deal with during the initial treatment period. Of course, they are worried about their children, but they are also concerned about their own pain and their loss, and they want to deal with their own trauma first. We have changed our approach and we meet the injured service member parent where the parent is at, both physically and emotionally. We have to be willing to hear what they have lost and the despair they are feeling.

A case example is a Special Forces service member who had lost his eye and a limb and anticipates that he will not be able to shoot or run, and he feels so lost. He is 29 years old and he is dealing with the challenge of what will he do for the rest of his life. All he knows how to do is to be a Special Forces sharpshooter. When meeting with this service member, we talked first about his losses and then about his concern, feeling he cannot be a father to his three-year-old son, which of course he can. To be a father to his son, he does not need to be running around or to have a sharp shooter's eyesight. We talked and focused on what he could do to be a good father to his three year old son. This service member began to think about what he could do as a parent. Only after he was able to talk about his losses and his trauma could he begin to think about his role in a different way. He decided that he was going to be a teacher. As he was teaching his physical therapy exercises to his children, he realized that he could turn those teaching skills into an occupation as a teacher.

DR. COZZA: So many service members invest so much of themselves in being in the military, and then they are injured. It is not only the pain that they are dealing with, but it is part of that whole transition of the combat mindset complicated by the injury process. We need to recognize the necessary work that allows them to once again be available to the family and children.

DR. ARATA-MAIERS: A number of these service members stay in and return to a military position after they recover from their injuries. They transition into and out of their 'battlemind'. Knowing that they are going to remain in the military may be a factor if they are not able to return to the job duties they had with their former unit. The adult providers must differentially handle the therapy with the service member who returns to a new type of job or a new military unit compared to the service member who is re-integrating back into his former unit.

Given the tendency of young children, they are making attributions in the face of ambiguity; making attributions about why their parent would choose to redeploy and not stay with them.

DR. RICHTERS: What proportion of the combat injured service members are going to be redeployed?

LTC SCHNEIDER: Of the combat injured service members who were in patients at WRAMC, hardly any of them redeployed.

DR. RICHTERS: Is that because their injuries were so severe?

LTC Schneider: Yes, but of the 16,000 and some who do not have severe injuries, a significant percent will return to their unit and redeploy.

DR. ARATA-MAIERS: The Institute of Surgical Research (ISR), which is the Burn Center, indicated that about 33 percent of this subpopulation's injured service members redeployed. Many of them return to the military to a clerical/administrative job and they are in a non-deployable status.

DR. CHUN: Another issue that I wanted to bring up is *recurring redeployment* and what it means to the parent and the children. The service members have been asking for assistance with how to tell their children that they are going to re-deploy.

LTC SCHNEIDER: It's important to note that there is a choice involved. Most of these service members have the option to stay on active duty. Most of them could opt to have a medical board and be released from active duty. If you are saying, "I am going to stay in and go back," you are making a conscious choice to put your family and yourself back into that position again.

DR. CHUN: One issue that I am also faced with is that the children come and say, "Will my dad go back and if he does, what kind of injury is he going to get?" That adds more uncertainty.

LTC SCHNEIDER: Military injuries in combat are so much more complex, cognitively and emotionally, than civilian injuries. Civilian injuries are typically accidents. While what has happened to somebody is traumatic and unfortunate, a military injury is much more complex. It is easier in a civilian injury to say that the cause of the injury was accidental or, for example, the fault of a drunk driver. In the military, it is much more complicated. Do you blame yourself because you were injured? Do you blame your injury on the military or not blame anything or anyone? How you handle the fact that you were injured while deployed is complex.

DR. RICHTERS: It is similar to the role that a police officer or fireman is in. They choose that occupation and the risk of injury is high.

DR. FULLERTON: We know from the literature that in all disasters *attribution* plays a large role in the recovery process. Whether it was a motor vehicle accident or an airplane crash there was always a searching for attribution. I think that is critical and very important.

LTC SCHNEIDER: However, it is much more complex with military related injuries.

DR. RICHTERS: Given the tendency of young children, they are making attributions in the face of ambiguity; making attributions about why their parent would choose to redeploy and not stay with them. I would think they might tend to sink to the most negative attribution with reference to themselves.

DR. CHUN: One issue that may come up is that children want the parent to get better, but they are also scared that when their parent has recovered from the injury they may redeploy. What this is doing to the children must be so complicated.

LTC PETERSON: I do not think that we have looked at tailoring our

Families are often told that things will get better. However, families report that they do not get better; they just get different, and that type of reassurance is bothersome to a lot of them. Everyone in the family misses their lives and everyone has been affected.

treatment for children whose parents must redeploy. How do we tailor our interventions to make them appropriate for that child or adolescent who has to watch their dad or mom redeploy, even though they have had an injury of some sort. How do we help when the child has been impacted just by deployments? There may not be an injury and Dad or Mom is doing fine, but there is the impact of that redeployment. How do you get the children ready to have their Dad or Mom redeploy multiple times? Five redeployments are not unheard of, and the impact on the children may be detrimental even if the parent is doing fine.

● **Brooke Army Medical Center**

DR. ARATA-MAIERS: I am going to go over the types of injuries of the service members for whom we provide care. One thing that is unique to us is that we have the *Institute for Surgical Research (ISR)* for burn patients. We have both inpatient and outpatient treatment settings. We provide care for both civilian and military burn patients. Civilian burn cases are primarily caused by accidents, while the military burn cases are war-related. We also provide in-patient and out-patient care for amputees. The outpatient care is provided at the *Center for the Intrepid* that opened in the last year, and also provides care for selected burn patients. Additionally, we provide care for medical and surgical patients who oftentimes get forgotten due to the less critical nature of their wounds — wounds caused by gunshots for example. Psychological disorders such as PTSD, cognitive and other clinical disorders are usually treated on an outpatient basis unless the service member also has a medical or surgical problem that is being treated with an inpatient stay. In that case, all of the service member's problems would be treated during his inpatient hospitalization. Service members who have mild to moderate TBI are usually transferred to us to be treated as outpatients.

Specific concerns that we observed during the *service member and family acute injury recovery phase* include: family's roles, other factors affecting the families and their training needs in the area of clinical problems (see Figure 1.4). We have talked about the shift in the focus of treatment over time from the adjustment to the caregiver role, and the emotional reactions that change over time. Families are often told that things will get better. However, *families report that they do not get better; they just get different*, and that type of reassurance is bothersome to a lot of them. Everyone in the family misses their lives and everyone has been affected. The service member is often the one whose changes have been identified, but everyone in the family is taking on different roles. Service members and their families and children tire of being identified as Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) veterans. They want simply to be service members again. Families also tire of the focus on the service member and the service member's injuries. Families and children want to live other parts of their lives and enjoy activities that are age appropriate or appropriate for the spouse.

The children have difficulty with the caregiver role. There is anger about the chronic nature of the impairment and the loss of that service member's role as a parent. Since 2001, the schools at Fort Sam Houston have reported an increase in the number of students who have been identified as academically at-risk, which represents one step before you are placed in a special educa-

When the injured service members are discharged from the hospital, the spouses may have difficulty with the caregiver role. They may spend up to five hours a day providing wound care, which can be very demanding and draining physically and emotionally.

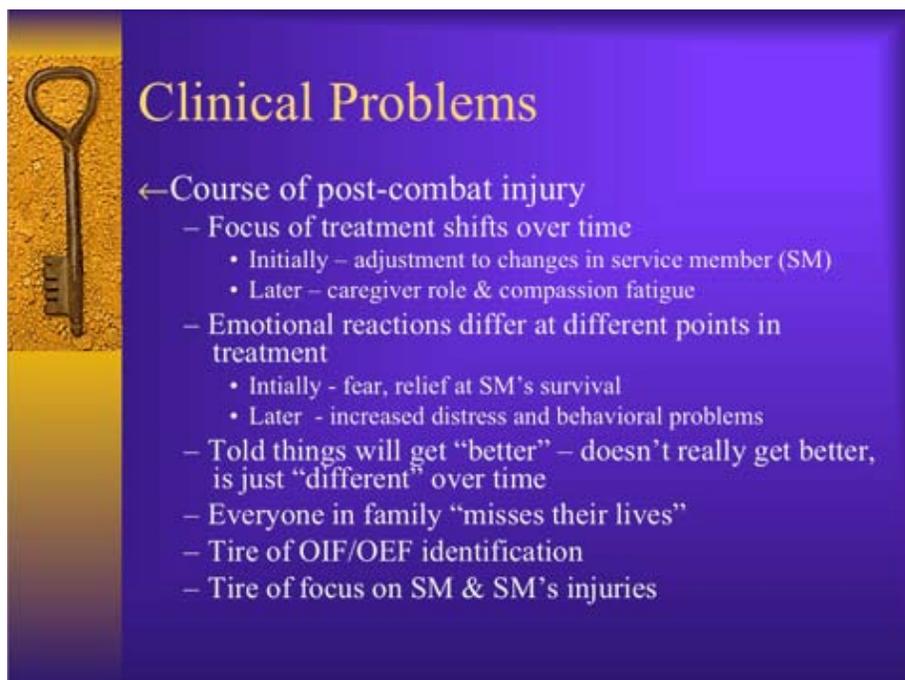


Figure 1.4: Emotional Reactions to Acute Injury Phase.

tion program. As clinicians we find that there are more children with unclear diagnoses. A six year-old may be referred to you because of problems that the child is having. Is it an adjustment issue, a learning disability that is just now being identified, a clinical disorder like Attention Deficit Hyperactivity Disorder, or is it some combination thereof with post-traumatic implication? It is difficult for us to assess and evaluate these children and difficult for the pediatricians who are providing medication for them.

LTC SCHNEIDER: Are these Department of Defense schools?

DR. ARATA-MAIERS: No, they are public schools on the Fort Sam Houston installation and we have good relationships with the staff who work there. I worked in the schools for about six and a half years for a half day a week at each site until we had to discontinue that service. We are now starting to offer those services again.

LTC Schneider: What percentage of the population at Fort Sam is typically deployed? Is it similar to WRAMC where the percentage of service members who deploy is not large?

DR. ARATA-MAIERS: No, at BAMC both the deployment factor and the fact that we are a referral center for sick children have an impact on the school system. However, the largest impact is the number of children of injured service members because when the injured return and they are at the guest house or the Fisher House, their children attend Ft. Sam schools. We also have a large number of families who have children enrolled in the Exceptional Family Member Program. In addition, we provide care for children who have cancer or are diagnosed with hemophilia, and their families usually accompany them. However, the combat injured service members are probably more prominent.

When the injured service members are discharged from the hospital, the spouses may have difficulty with the caregiver role. They may spend up to five hours a day providing wound care, which can be very demanding and drain-

Although, the types of injury do not seem to be a problematic factor for the burn patients, the extent of a facial injury may be difficult for a child, from a developmental perspective, because the parent looks so very different.

ing physically and emotionally (see Figure 1.5). This can contribute to the spouse being overwhelmed and less responsive. The injured service member often becomes very irritated that his wife is both the caregiver and the spouse, a situation that can create significant frustration. There is also a subpopulation of dual military families. In these families the military spouse who is also a service member is treated as a spouse. They are not treated as service members. Often their PTSD, or other combat related conditions, is overlooked because they are viewed as in the spouse role. This may be true even though they may have experienced more combat than their service member spouse who was injured. This is something that can be overlooked.

I want to focus on the changes that symptoms such as anger and forgetfulness can cause, and the effect that the symptoms can have on parenting. Oftentimes the anger that the service member is experiencing is directed at the spouse, and sometimes at the children. We have found an increase in the potential for abuse and we have had several cases of spouse and child abuse. It has been difficult to find data on the increased potential for abuse in the injured service member population. I know there is some data on deployment related abuse cases. I believe that Dr. McCarroll is in the process of publishing an article on that topic, but the potential for abuse in the injured service member population is an area in need of attention. Is this issue a large or a small problem?

DR. FULLERTON: There is also a concern regarding the neglect of children of combat injured service members.

DR. COZZA: I think the issue for the neglect is specific to the absence of the parent during the deployment in the young military families. The situation described by Dr. Arata-Maiers sounds more anecdotal. You may not have the data, but are we talking about physical abuse or neglect?

DR. ARATA-MAIERS: We are talking about physical, emotional and verbal abuse.

Clinical Problems

← Spouse of SM

- Difficulty with caregiver role
 - Significant amount of time in wound care post-hospitalization
 - Spouse overwhelmed
 - Non-responsive to children
 - SM wants wife in spouse role
- Military spouses' military role overlooked

Figure 1.5: Complex Role of Spouse of Injured.

The girls tend to watch over their dads and if someone refers to their dad in a negative manner, they stand up for their dad. They also check to find out if their fathers need assistance when they have to move around or get out of bed.

DR. COZZA: More active maltreatment as opposed to passive withdrawal of parenting.

DR. ARATA-MAIERS: Yes, when I spoke to a Spouse Group and a Service Member Group on the Burn Unit about anger symptoms that they might be experiencing and how it can affect their parenting, everyone in the group was nodding. We were talking about the severity of the anger and how it can be destructive to their child. We discussed the need for assistance in dealing with their anger such as the availability of counseling services to help with anger control, and in some cases the need for medication to help control the anger. One of the service members who was very forthright, said, "Yeah, been there, done that. We are all in therapy and on medications because we are all dealing with the anger and our response to it." Some of the parents' stress behaviors, substance abuse, numbness, or trauma triggers seem to put the children at physical and emotional risk.

Although, the types of injury do not seem to be a problematic factor for the burn patients, the extent of a facial injury may be difficult for a child, from a developmental perspective, because the parent looks so very different. We have children who talk about knowing that this is their parent but it may take months for them to realize that this is really their parent. The burn patients tend to understand. We also have amputee patients, but it is usually the children whose parents are burn patients who seem to have more difficulty over the long term with the changes in their parents. In talking about developmental stages, the adolescents are the ones who do not seem to be interested in group activities. They also become really tired of being identified as OIF/OEF Service Members' children; they want to be seen as teenagers.

We have very little information about *what role the gender of the child or parent plays in this process*. We also don't know the impact of *culture or ethnicity* on the family and children of injured service members. We are finding that there are a lot of protective behaviors that the daughters of the injured service members are displaying (see Figure 1.6). Since most of the injured parents are males, they prefer to have their sons perform any personal care that is necessary. We have little information about daughters of the injured male parent performing any personal care. There is minimal information about the impact on the family and children if the injured service member parent is female. I believe that the gender of the injured service member may affect how that injury is experienced by the family and children. Several of the Hispanic families who relocated to the Fort Sam Houston area to be with their injured service member have school age and young adolescent children who were not given any information about their father's injury. We do not know if this type of communication is based on a cultural dimension about a desire to be more protective of their children or not.

DR. LESTER: When you say protective behaviors, can you explain that in the girls?

DR. ARATA-MAIERS: The girls tend to watch over their dads and if someone refers to their dad in a negative manner, they stand up for their dad. They also check to find out if their fathers need assistance when they have to move around or get out of bed.

DR. COZZA: Girls are protective of their dads?

DR. ARATA-MAIERS: Correct, also the girls that we are talking about tend to be school age and their behavior may be developmentally driven as it

We want to provide treatment that is based on resiliency rather than a pathology model. People are unique. Everyone does not have the same problems or the same level of reactions to problems.

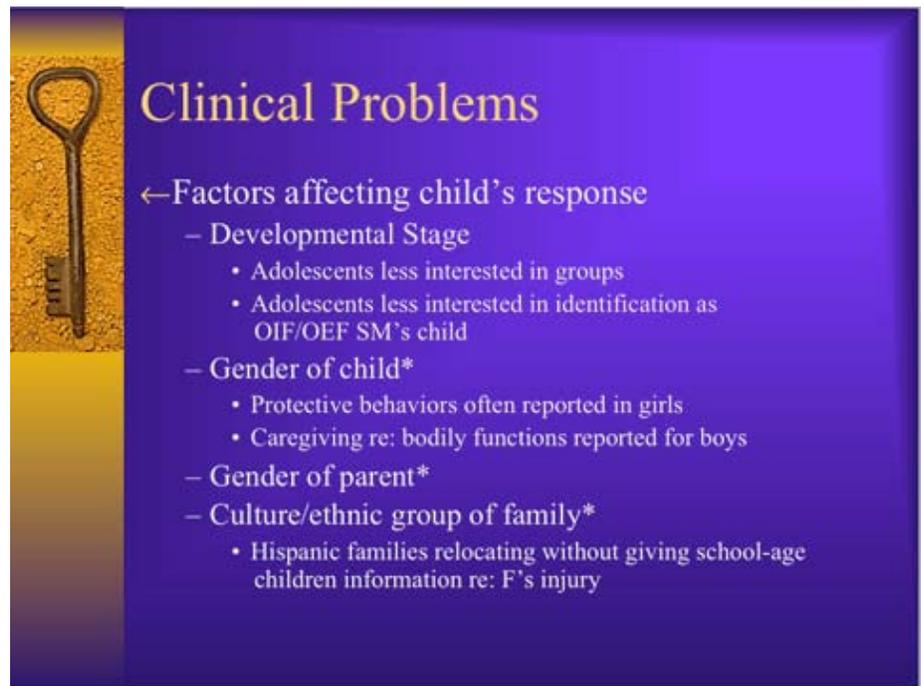


Figure 1.6: Psychosocial Issues for Children of Combat Injured.

is primarily with their dads. The communities need additional training and information on the impact of combat injury on military families and children. One of the lovely things about working in San Antonio is that people are much attuned to the military. We have injured service members who are from Oregon retiring to San Antonio because the community knows about the military and wants to be very responsive. The hospital staff needs additional training and information on the impact of combat injury on the families and children, and we are trying to accommodate their needs. Some of the barriers we have encountered included challenges within the hospital. There is a lack of developmentally appropriate information about the impact of parental injury on a child that is available to the staff and family. The severity of the service member's combat injuries and the difficulty in accessing the spouse makes it complicated to obtain information about the spouse and children. It is also difficult to talk with the injured service member and spouse when the children are present.

Another challenge to meeting the family's needs is the immediacy, the primacy, and the time consuming nature of the service member's medical needs. This reality can sometimes mean that meeting the family's needs may have to be delayed. Reference childcare issues, in addition to the problems with the availability and accessibility of child care services, the mothers' comfort level with leaving their children is an important issue. When mothers have recently almost lost their husbands, they are skeptical of leaving their children and want their children to be at their side and that makes marital therapy more problematic.

We have also found that there is a process of crisis referrals in which families are referred to us when there is a crisis. Then there is a lack of follow-up by the family after the referrals are made and the crisis has passed. Other challenges include the paucity of research to guide our interventions, staff shortages and new staff training needs.

It speaks to the fact that even if you have developed helping relationships in the health care setting, once the family has moved back to the community you are not in a position to be able to support that family over time. They become disconnected.

Regarding the core principles, it is important to focus on the needs of the family, not just the injured service member. We are trying to institute a systematic, proactive service provision rather than a service that is provider-driven and reactive (see Figure 1.7). We want to ensure that we meet all the injured service members who have families and children and be viewed as part of the treatment team. Hopefully that will reduce the stigma that is associated with mental health services. We want to avoid the impression that one is being referred to a psychologist because the family is broken, in addition to everything else that is going on. *It's better if our intervention is seen as part of the treatment that every injured service member receives.*

We want to provide *treatment that is based on resiliency rather than a pathology model*. People are unique. Everyone does not have the same problems or the same level of reactions to problems. There are a lot of factors that have a contributing role. In addition to current family and individual stressors, previous stressors, including the child's relationship with both of the parents, must be considered. Some of the children have parents who have deployed multiple times and may have missed significant developmental milestones. If the deployment occurs during the very early period of a child's life, the returning parent may actually have to develop a relationship with that child becoming familiar with their personality and coping repertoire.

Cooperation with other departments in your health care facility and the availability of community resources is important. We collaborate within the hospital with ISR Case Management Analysts and the Pediatric staff and with school and community agencies. We are also involved with a Substance Abuse and Mental Health Services Administration (SAMHSA) Grant and visit local hospitals to provide information on military families and combat injury. The number of our staff limits additional outreach activities.

MS. VINEBURGH: Something that you said reinforced a concept of strength that Dr. Chun had discussed. One of the most powerful comments that you made was that oftentimes hospital services that are organized are not well received, and that families have been shown to self-organize. Would you consider that a strength of the family? To what extent, when you are in the process of developing interventions and principles of intervention, might you want to think about recognizing and acknowledging a family's strength in response to such stress?

DR. ARATA-MAIERS: It seems like people have to identify having a problem that is large and pressing enough to take time away from everything else in order to attend a free standing group meeting. We had the same problems with providing deployment groups. Everyone was saying that they needed these, but when you set the groups up nobody comes.

DR. COZZA: It really is the way you said it, Brett, in terms of meeting the family where it is at in a particular time of treatment. The important idea is that interventions must be offered *on the family's terms* as opposed to the clinician provider or service delivery system's terms. I do think that this is a core issue here, and in trauma responses as well. One of my friends who was involved in Operation Just Cause put out a mental health sign for his mental health clinic to support soldiers during the war, but nobody came. He realized that the best way to work with them was by spending time where they ordinarily worked — in the gym or in the emergency room where they came in, a similar concept to providing services in a forward deployed area.

In the Navy, and to a certain extent the Marines, there is an expectation that the Chaplains are really on the front line. In the fleet and on the Marine bases, the Chaplains are embedded, and the families feel very comfortable going to them.

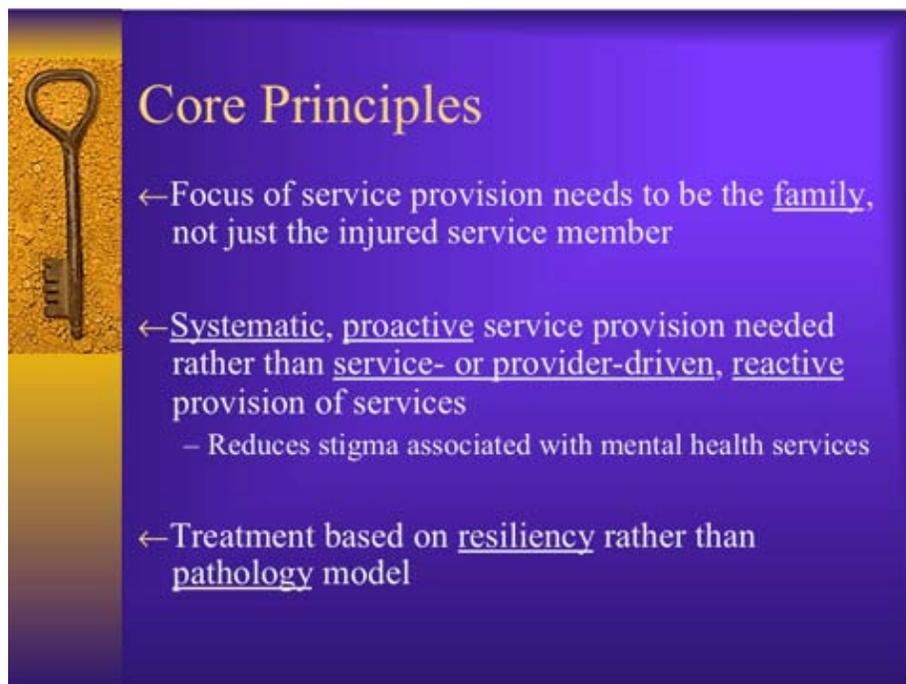


Figure 1.7: Core Principles of Combat Injury Care.

LTC SCHNEIDER: If you do not do that, you cannot get access to the resilient because they do not come to us. They do not come to see a mental health provider. If they know me as Brett, then they might happen to ask me a mental health question, but if they know me as a psychiatrist with no face, no name, they are never going to interact with me.

MS. WILLIAMS: That speaks to the transition needs of a family when they leave the health care facility. When those who have self-organized and found that kind of peer support at the hospital move to the civilian community again, they need to redevelop that linkage and support.

DR. COZZA: That is a really good point. It speaks to the fact that even if you have developed helping relationships in the health care setting, once the family has moved back to the community you are not in a position to be able to support that family over time. They become disconnected. Even when you do the best you can in passing a case off, there are a lot of disconnects when that service member or family moves onto the community. They may not feel comfortable talking with people that they do not know.

DR. CHUN: You have identified a real issue, especially when the service member goes back to a community that is not very military-oriented. You may have a family who is specifically requesting to see a military provider because of their fear of rejection and stigmatization, but none may be available in the community that they are moving to.

I also want to comment about meeting the family where the family is at. When new injured service members and their families arrive at Walter Reed, all of the spouses are invited to get together for an administrative briefing. We participate in that briefing and provide the families with information about our services. We are also trying to familiarize them with resources that are available both in the hospital and in their communities and to be a resource for their needs and as a mental health provider. If the family identifies a particular need that their child has, we will direct them or take them to the

As we are seeing more and more families due to redeployment and issues related to that, there seems to be a normalization of the symptoms families can experience. If families begin to feel their stress is a normal response in our culture, they may become more accepting and reluctant to contact the health care provider.

service that can best help them. In a case where a parent remarked, “Oh, my child is going to have a birthday, but I am stuck here,” we brought the parent to the Red Cross so they could provide some help connecting the parent for this special event.

DR. COZZA: *That also speaks to the principles of Psychological First Aid.* Often, simply connecting people with resources can be tremendously valuable.

DR. ARATA-MAIERS: There is one other small piece that I think is important: the literature we have available for burn patients is for siblings of burn patients because prior to OIF and OEF our patients were primarily children. We do not have any prepared literature that describes the potential impact of a burn injury on a service member’s family and children. We are conducting literature searches to find similar information.

DR. COZZA: That also speaks to a certain type of neglect, an awareness of a kind of medical traumatization that occurs to children in children’s hospitals, and a lack of understanding on how these powerful parental events can affect children. There has been very little literature related to how to prepare a child for a visit to a seriously injured parent. There are a couple of articles that nurses have written about interventions for children in the Intensive Care Unit or Coronary Care Unit setting, but a lot of work needs to be done here.

Navy Medical Center, San Diego Presentation

LCDR. KANE: I would like to reference what Dorinda has talked about, which is that this model of being a referral center does not necessarily result in a lot of appropriate patients. In Child and Adolescent Psychiatry at the Navy Medical Center in San Diego, I have noticed that families are being assessed outside of our facility and then referred to us. We do not really see a lot of referrals related to combat injured families. When I was invited to attend this workgroup and talk about our clinical problems and core principles, I needed to find out how the children we provide care for are referred to us.

The information I am going to relate is not based upon my experience, but on the experiences of other providers with whom I work. This includes Captain Klam, our Navy Psychiatry specialty leader and head of the Directorate of Mental Health for NMCS D and one of our Clinical Psychologists in our C-5 program, our equivalent to WRAMC’s Wounded Warrior Care program. Captain Klam emphasized that the family is as equal and important as the service members. We want to ensure their access to care. It is true when families with children do come to us they get excellent care, however we are not seeing the high volume that we had expected to see.

NMCS D realized that there was disparate care for the combat casualty group. They created a C-5 Center that recently opened and provides comprehensive, complex combat casualty care for the combat injured service members. Services include Physical Therapy (PT) and Occupational Therapy (OT). They also hired two mental health providers, a neuropsychologist and a clinical psychologist. I met with Dr. Kim, our clinical psychologist who echoed exactly what we are talking about: the family members do not come to see the clinical psychologist. When the clinical psychologists were in the Mental Health Building, families did not come to see them there either.

Dr. Kim now meets the families when they come with their injured spouse for PT and OT appointments. *When the mental health providers are recognized*

Sometimes the task is just trying to diffuse a conflict between the family members. During the acute and sustainment phases of the injury recovery process, we need to incorporate the core principles.

as part of the team, the injured service member and his/her family opens up and starts talking about issues related to the impact their injury is having on the entire family. However, the emphasis is not on the family. The clinical psychologist knows the importance of including the spouse who is invited to some of the meetings where they educate the spouse about PTSD, etc.

The mental health providers are doing some marital counseling, which I do think represents a hierarchy of needs such as helping the couple maintain connectedness and modeling for their children. How the family goes through recovery in a manner that fosters developmentally appropriate changes may also address those needs. Only about 20% of the injured Marines and Sailors have children. I do not know if there is a focus on the families and children of the combat injured service member, but certainly we are available.

The other area that Captain Klam discussed was the involvement of the Chaplain Corps. *In the Navy, and to a certain extent the Marines, there is an expectation that the Chaplains are really on the front line.* In the fleet and on the Marine bases, the Chaplains are embedded, and the families feel very comfortable going to them. Using this model of the deployment operations, the Chaplains are involved in the pre-deployment, deployment, and the post-deployment assessments. Theoretically they are also referring if the family is in need. The Chaplains do not always refer to Child Psychiatry or Mental Health and instead probably make referrals to the Fleet and Family Services, which is a major area of support in the Navy. This organization provides basic education about parenting, social work level counseling on parenting, individual counseling for children and access to family advocacy for any kind of abuse. I did not have a chance to talk to with the Fleet and Family Service staff, but I believe that this is an avenue for a lot of work that is going on. It is not psychiatry-based, but it does provide services at the social work level. One of the reasons to include a Chaplain as a resource on the traumatic injury team is the issue of stigma that exists in saying, "I am going to talk to the psychiatrist." The other change at Camp Pendleton is the establishment of a Marine Corps Community Service Program (MCCSP) that is hiring 24 new social workers. They want to establish the equivalent of the Navy's Fleet and Family Services and offer services closer to where the families live, particularly since the existing Navy program is about an hour away. The MCCSP will offer basic educational services, outreach and therapy services for families.

In terms of core principles, the family is as important as the service member, and access to mental health care is available by referral. All families are now treated within a seven day access standard, as a result of recommendations from the DOD Mental Health Task Force that CAPT Klam served on. Additional personnel are being hired, and more outreach services should be available.

From the Navy's perspective, if we want to increase the amount of money that is allocated for psychiatry related programs we need to demonstrate efficacy. If we do not have outcome measures, evidence of our productivity and effectiveness is limited. Timeliness of care is an additional problem. With a classic tiered system, Child Psychiatry is often the last service to be involved. This makes it difficult to inform Navy and Marine families of combat injured service members about the developmental needs of their children. An increased emphasis on longitudinal care is needed to know if the interventions provided to the family are effective over the course of time.

We try to tackle the issues that the service member and his/her family want to address while they are in-patients on the ward and receiving treatment.

In our system, there is a great deal of reliance on specific reports. In our C-5 Center when the report references how the children are doing, a child psychologist may report that the children are doing well and then they move on to the next issue. There does not seem to be an incentive to find out what the impact of the parental injury on the child is. If we have an opportunity to meet with the parents and educate them, we might discover many more issues we might be able to assist with.

As we are seeing more and more families due to redeployment and issues related to that, there seems to be a normalization of the symptoms families can experience. If families begin to feel their stress is a normal response in our culture, they may become more accepting and reluctant to contact the health care provider. No one is going to request assistance if they feel their responses are considered normal. As the whole community shifts to an acceptance that there will be a great deal of redeploying service members who are dealing with PTSD issues, providers may be less inclined to feel, “we should do something about this.”

Medical Center Presentation Discussion

DR. MCCARROLL: To what extent are you seeing involvement of the parents of the injured service member?

LCDR KANE: We are not seeing parents of the injured service members.

DR. COZZA: The Preventive Medical Psychiatry Service/Psychiatric Consult Liaison Service at WRAMC provides assistance to the parents of the service members at WRAMC.

DR. ARATA-MAIERS: We as the Child Psychiatry Service do not see the parents of the injured service members. The case managers seem to be involved in the process of assisting and/or referring the parents of the injured service members for additional services.

DR. MCCARROLL: Do you find that there is enough established literature and practice to deal with this issue or is this a new area?

DR. ARATA-MAIERS: I do not know because I do not work with the parents of the injured service members. From what I’ve been told, there does not appear to be much literature on that particular topic.

DR. COZZA: From my experience on the Consult-Liaison Service and working with Dr. Hal Wayne and his staff at WRAMC, families can be tremendously complex in terms of both their constellation and their relationships. You can have parents who are in conflict with each other and/or with the spouse or significant other of their injured service member. It becomes a very complicated process as you forge a relationship with the family members and significant others who may be providing support to the injured service member, particularly when the spousal relationship is where efforts should be directed.

Sometimes the task is just trying to diffuse a conflict between the family members. During the acute and sustainment phases of the injury recovery process, we need to incorporate the *core principles*. An injury disrupts the constellation and function of the family inherently and adds stress to the family. It tends to widen splits in families that are already present and add conflict where the dust has settled. Suddenly you have this injury event that just complicates things. Even when families pull together closely, the impact of the combat injury on families is more likely to disorganize than to organize families.

In terms of developing relationships in the community, I could speak for a long time about the shortages in the military, however there are also national shortages of child and adolescent psychiatrists.

DR. FULLERTON: I also think about the impact that injury has had on siblings of the injured service member, and do not know if there is much research on that. I know there has been research on the impact that children's long-term illnesses have had on the family, but how does the response of siblings to this current injury of their family member harken back to the original family interactions, and how is this handled when the siblings no longer live in the same house? I think that is important not just for parents but also the siblings.

DR. ARATA-MAIERS: Dysfunction within the families is one of the other things that are sometimes revealed during this injury period. On the Burn Unit, the case manager discussed concerns that were raised during which time the wife of the service member found out that there was a pregnant girlfriend in her husband's life. The injury event brought the relationship to light when this individual, who was notified of the service member's injury, came to the hospital to visit him.

LCDR KANE: I would like to clarify what I meant by (services that are) 'not available', and provide examples. One involves first-degree relatives of the injured service member. If there is a child who has been negatively impacted, that child has access to mental health and medical care. The child can be identified as needing individual therapy when the family comes in for Family Therapy. We can refer the child to the Child and Adolescent Clinic for services. However, if the parent of the injured service member needs assistance, you can do some work at the service member's bedside and do some counseling. If you say that person needs a referral because of the impact that their son or daughter's injury is having on them, there is no mechanism for that because the parents are not usually covered for their medical care by the military. The same would be true for the siblings. These are first-degree relatives who may not have access to that larger military health care system, but who are part of the service member's family and have concerns that we have previously discussed.

LTC SCHNEIDER: At WRAMC, the Command has allowed for a family member exception policy to occur when we bring families to WRAMC while their injured service member is being treated. If something happens and a health care provider has determined that a family member needs health care services, we allow the family member to be treated. This includes parents who may not ordinarily be eligible for care. If we made arrangements for the family member to come to WRAMC, and they are displaced from their own system of care, there is a system in place that allows us to do what is right, rather than referring to an outdated procedure book for guidance.

In the outpatient Behavioral Health Clinic, the policy that OIF/OEF service members are evaluated within 72 hours has impacted the availability of providers to see family members. To provide assistance in this area, I have unofficially renamed our service. Instead of being called the Child and Adolescent Psychiatry Service, I now refer to our service as the Child and Family Psychiatry Services. I have explained that child psychiatrists are also adult psychiatrists, and, when the situation warrants it, I have allowed our service to start seeing adults who are the primary patient rather than always focusing on children.

LTC PETERSON: From my experience, I would underscore what everybody else has already said. In terms of our patient populations, there is a slightly different mix at Madigan. Madigan is more of a deployment platform

From the military side, there is recognition that we should be out there providing care for the families and children of the combat injured service members, or the care will not be provided.

with about 30 percent of the population deploying at any one time; 30 percent coming back, and; 30 percent gearing up to go. We see less of the service members who have medical-surgical, amputee, or orthopedic injuries. We see and treat service members who have PTSD and moderate TBI related issues. We also treat service members who have deployment cycle related issues. We are primarily providing services to the 'walking wounded'. We also provide services to families of service members who were killed during their deployment; we see that the children who are dealing with the death of a parent receive some assistance before their family moves from the installation. In most instances, the family moves out pretty quickly.

We try to tackle the issues that the service member and his/her family want to address while they are in-patients on the ward and receiving treatment. Trying to get them to return for follow-up appointments can be problematic. As Chief of the Psychiatry Department at Madigan, my primary challenge has been to meet the needs of the active duty population in terms of access to care, and this has been to the detriment of services for the family. We want to provide services to the families of the injured service members but we do not have the necessary staff. In terms of the *core principles* I was trying to ensure that we had adequate resources to execute programs looking at lessons learned and interventions that were needed while having interventions provided downstream to execute programs. What I see happening Army-wide is that the emphasis is on screening programs. It is doubtful that we would have sufficient staff available to treat the service members if all the service members who screened positive tried to access our facilities for care at the same time. At Madigan we plan to hire an additional general psychiatrist so the child psychiatrists can do child psychiatry. In the Army we have about 50 child psychiatrists in the inventory and probably ten, not including trainees, who are practicing child and adolescent psychiatry. The remainder of the child and adolescent psychiatrists are practicing adult psychiatry. It is challenging because we have some of the resources and solutions within our system to provide care to the children of the injured service members, however doing that would take a significant toll on providing psychiatric care to the adult population. Madigan is known for their screening programs. The Service Member Wellness Assessment Pilot Program (SWAP) is touted as being, and is, a very good program. It will be important however to ensure that there will be the necessary resources downstream in the military, as well as in the community to provide the services that will be needed.

In terms of developing relationships in the community, I could speak for a long time about the shortages in the military, however there are also national shortages of child and adolescent psychiatrists. There is also a shortage of civilian child and adolescent psychiatrists who will accept the Military TRICARE insurance payment. In the short term, we are looking at what can be done to augment resources currently in place, such as ancillary support staff and nurse practitioners in order to extend the services that our providers can offer. Longer term we need to find the means to expand resources in the network and in the military to focus on military issues such as recruitment, retention, and matriculation.

Research is ongoing at Madigan, therefore we want to capitalize on developing partnerships for research. We are looking at the possibility of doing a research study with Drs. Lester and Saltzman on the impact of deployment on

The family focus applies not only to the intervention but also to the institution. Unless the institution has a family focus, it will become problematic to provide services.

children. The core principle is to partner with those who know how this research works and learn from them. We cannot do this type of research on our own because we are trying to meet the core missions that are changing and present to us at a very rapid pace. If we bring the experts in our area on board who are willing partners for research activities and who can teach us and help us to obtain resources, we would be in a win /win situation.

In reference to school-based programs, Dave Callies has implemented a Resiliency Program at Madigan. Dr. Faran at Tripler Army Medical Center (TAMC) has done a very extensive integration of mental health and child and adolescent mental health into the school systems there, leading to a very fine synergy between the community and the military. This is a model that should be looked at and rolled out in other places depending upon available resources. The Madigan Resiliency Program consists of a psychologist going out and teaching resiliency to school counselors. The TAMC Program is resource heavy with psychiatrists, child psychiatrists and other providers who are partnering with the school systems and doing everything from preventative work to running clinics at the school. This requires a coordination of efforts. Unfortunately, pediatrics and adolescent medicine are thought of first when people think of child mental health issues, and that just defies reason.

When Nancy Pelosi had her summit on America's Children, Child and Adolescent Psychiatry was not invited to the table. We were eventually invited to the table, but the people who were there speaking on the panel did not include one child and adolescent psychiatrist. When this was brought to their attention, they were quick to include us. We have to do more in terms of advertising and capitalizing on the existing partnerships, leveraging the lobbyists from the professional organizations, and leveraging our professional organization, the American Academy of Child and Adolescent Psychiatry (AACAP), to speak for us at the Congressional level about issues such as retention.

Deployment and redeployment is another issue that concerns me. For example, how do we ensure access to care and appropriate interventions to treat the service members and their families to include their children? When you look at the impact of deployments, there are children who are being affected by this. The active duty population may be looking fine and there may not be any issues of concern for the service member who has deployed five times, e.g., he is hard charging, making rank and he is doing everything he needs to do. *Behind that service member you have the child, the brother, the siblings, and the spouse, many of whom are suffering.* If the service member is doing fine, there is a sense that there are no problems. We have to re-tailor what we are doing and try to reach the family members in some way without asking directly if they have problems and then not having the needed services. This approach risks a loss of faith and trust. This goes back to what everybody has been saying: focus on services for the family not just the injured service member. We need to work to leverage partnerships, amplify what we have got, synergize where we can, but fundamentally we have got to be asking for more at all levels — Congress, the military and the community.

DR. COZZA: From the military side, there is recognition that we should be out there providing care for the families and children of the combat injured service members, or the care will not be provided. When we talk about the impact of parental injury, I have not seen it tackled anywhere. Workgroup members and military participants should feel very good and em-

Understanding and mobilizing resources within the individual, the family, the extended family, the care system, the church, the military and the larger community will eventually result in an effective and healthy adjustment.

powered to be contributing not only to the health and well being of military children, but potentially the health and well being of civilian families and children of parents who face serious injuries. There is very little information available on the impact parental injury has on a child. This group is in the process of developing and refining the scientific information in ways that will answer some of the questions and provide information on interventions that are evidence-based.

Discussion and Revision of Core Principles

DR. COZZA: Now that we have heard from the presenters about the clinical problems they have been experiencing, and are getting a better understanding of the challenges families and children of the combat injured service members face, we may want to think about expanding or changing the five categories of general problems that are listed in your folder and updating the *core principles*. The kinds of core principles we have discussed include: 1) the topic of family health and wellbeing as central to the recovery of the combat injured service member. Additional core principles that we want to consider are: 2) injured family care is longitudinal; 3) the needs of injured families change over the course of treatment and recovery; 4) education at multiple levels is needed; and, 5) barriers to interventions exist, therefore when we think about understanding the health of the family as integral to combat recovery, there is information to support that.

DR. COZZA: Regarding the *core principles*, we want to make sure that we are comprehensively addressing the needs of the children and families of combat injured service members. We have the following core principles that we will review and discuss:

1. Combat injury is a challenge to our healthiest families and requires support at varying levels in the health care system and community.
2. Interventions need to be longitudinal and tailored to the changing needs of combat injured families throughout the treatment and rehabilitation process.
3. Family health and well-being are reciprocally connected to the health of the combat injured service member.
4. An integral component of effective intervention includes a family focus.
5. Interventions must engage the family “where it is at” and respect the family’s unique differences and strengths.
6. Children of varying age and gender are likely to have unique developmental responses to the injury that must be addressed.
7. Effective intervention requires collaboration and coordination of services between family, health care, military and community resources so as to develop a community of care.
8. There is a need for awareness and consideration of the unique military and ethnic contributions that need to be addressed as part of combat injury intervention.
9. Education is required at the individual, family, professional, and facility or institutional level to best meet the needs of injured families.
10. There are multiple barriers to interventions that include access to care and stigmatization, which can limit family involvement and effective intervention.
11. Additional scientific study is required to better understand the needs of

Our National Guard and Reservist service members may receive some of their mental health services in their home communities. Community education will become vital to their well being. An informed community will be better equipped to address the challenges that confront the injured service member and his family.

combat injured families and to study the effectiveness of the proposed outcomes.

DR. ARATA-MAIERS: The family focus applies not only to the intervention but also to the institution. Unless the institution has a family focus, it will become problematic to provide services.

DR. COZZA: Would that fall under our educational requirements?

DR. ARATA-MAIERS: It might fall under barriers to care because it is a barrier to care that has not been acknowledged.

LTC SCHNEIDER: Our own preconceived notions and perceptions are as big a barrier to care. An example of this would be stigma.

MS. VINEBURGH: The intervention should be able to be communicated beyond the specific setting in which you envision it.

LTC SCHNEIDER: Do you mean it cannot be so specialized it becomes inaccessible to people when they get back to their community?

DR. FULLERTON: In a broader sense the issue is, "how do we address this in terms of public education?"

DR. ARATA-MAIERS: Perhaps the education principle should have "community" added to it. Education is required at the individual and family level as well as at professional, institutional and community level to best meet the needs of injured families.

DR. CHUN: We found that we needed to reframe our services in a way that was not going to create more patients or require additional resources. If we were going to provide this type of service, it would require resources whether we were resourcing it up front or later. Otherwise, we were not only creating more patients, but we were going to use the same resources that we had. That was how it was when we started our service at WRAMC.

DR. FULLERTON: One of the important points that a couple of people touched on is this issue about indebtedness, and the chaplain was an example of this, i.e., working with someone already in the system who has the trust factor. Service members will come to a Chaplain. Additionally, using buddies and spouses is an example of a natural resource.

LTC PETERSON: The issue is the ambivalence and risk of adverse stance that the Command has regarding service members who need mental health assistance. This sometimes interferes with our endeavors in terms of programs and research. At the Corp's level, the Commander's view of mental health is so essential for the success of mental health programs in terms of expansion, intervention and research. Commanders have the ability to approve or disapprove your requests.

DR. COZZA: I want to make sure that we are thinking about the *core principles*. Is the ambivalence of the service member's Commander a barrier to mental health intervention? We could put that into education, but we are looking for anything uniquely present, absent or overlapping that we need to be considering in terms of intervention.

DR. LESTER: Is it the concern about making mental health patients or generating a need for which there are no resources?

DR. CHUN: Both are concerns.

DR. LESTER: If it is framed as prevention then it is not about patients at all. Could we call it *resilience training*? If it can be framed for what it really is, it could be focused on secondary prevention.

The audiences can vary but the wording of the core principles needs to be generic enough that it can be similar to the approach that was used in developing the Psychological First Aid principles. If it is broad, families and professionals will be able to read it.

LTC SCHNEIDER: My experience with Commanders is that you have to put things *in their terms* for them to understand it. If you explained it in terms of a Humvee that is leaking some oil, you might suggest having to check the oil more frequently. Prevention and preventative maintenance is what you are looking at. Otherwise you are going to end up with a dead lined Humvee if you do not do what you need to keep it running. We are looking at an at-risk group of service members, and we want to make sure they are functioning properly so they do not become victims. If you communicate your need in that manner that has much more traction than by saying we want to create another service.

DR. COZZA: So the wording here is in terms of prevention and keeping everything in the prevention framework.

DR. LESTER: I do not think it is just semantics. It is actually what you are doing.

DR. BEARDSLEE: And then you could also add a statement about *healthy adjustments; something like, adjustment is a longitudinal process that involves all family members. Understanding and mobilizing resources within the individual, the family, the extended family, the care system, the church, the military and the larger community will eventually result in an effective and healthy adjustment. The adjustment results in healthy functioning in the face of this adversity or this injury.*

DR. COZZA: What if we said injury recovery is a longitudinal process that involves all family members and mobilizes resources within the individual, the family, extended family and community.

DR. BEARDSLEE: Many people could recover without receiving services if they had access to resources. I am sure many people do, but then you are positioning the interventions as fostering resiliency and prevention. Does that make sense? That is the way we have done it working in related areas.

DR. ARATA-MAIERS: We should add what Nancy said earlier about education to the education-based core principle, and we should include education at the professional, institutional and community level. Our National Guard and Reservist service members may receive some of their mental health services in their home communities. Community education will become vital to their well being. An informed community will be better equipped to address the challenges that confront the injured service member and his family.

DR. FULLERTON: The school systems also need the education component.

DR. COZZA: Nancy, you had discussed targeting the helpfulness of education materials. The target is the communication.

MS. VINEBURGH: We need to be able to disseminate the principles at other levels that may be points of entry for an injured service member.

MS. KAUL: It is more the way it is perfected or developed so that it is accessible, useful and targeted.

DR. COZZA: We just want to get the idea out that it is available and makes sense to the population.

LTC SCHNEIDER: The Battlemind program gives service members a vocabulary that is in their own words enabling them to talk about and deal with the impact that their deployment is having on them and their family. The vocabulary facilitates talking about the Battlemind skills that helped them to survive in combat and how they are trying to adapt those same skills to the home and community environment. They can also provide more buddy care

By using our core principles to develop family-focused interventions that will address the needs of the families and children of our combat injured service members and following this cohort, we will be better equipped to provide care for the families and children of our next combat operation.

if they have the vocabulary to help them explain what is going on and what action needs to be taken.

LTC SCHNEIDER: How would you do the same thing with regard to children and family?

DR. FULLERTON: A similar thing happens when children are at a developmental stage where they can put a word to something, versus not being able to articulate or say it.

DR. COZZA: Acting out if they cannot express their feelings.

DR. FULLERTON: Or using play as a method of expression.

DR. LESTER: We need to address the unique military considerations. The military culture piece needs to be included in all of these interventions. You also brought up the cultural differences around communication, how people handle difficult information. Roles of families are going to be different across different communities. In our Latino sample, the older children were a great source of self-efficacy. They took responsibility when a parent was ill and helped with family tasks that needed to be accomplished. Do you want to include that in the cultural piece?

DR. COZZA: Yes, there is a need for awareness and consideration of unique military and ethnic contributions.

DR. ARATA-MAIERS: I was also concerned about gender effects.

DR. COZZA: Gender effects are included in the *core principle: Children of varying age and gender have unique developmental concerns that need to be addressed.*

DR. ARATA-MAIERS: Are the parent characteristics included?

DR. FULLERTON: Yes, but we do not know much about that. It may be a factor.

LCDR KANE: When you pluralize genders that may invite the idea that we are talking about sexual orientations as well. In this group we do not mean that.

DR. COZZA: Varying age and gender are included in the developmentally appropriate core principle.

DR. COZZA: Should the *core principles* be framed in an active voice? Do we want the principles to communicate a concept or is the principle something that directs the intervention? Here is an example of phrasing an intervention in the active voice: "This intervention must engage the family where it is at." Here is an example of phrasing it as a concept that directs the intervention: "Services need to be tailored to the changing needs of the combat injured family throughout the treatment and rehabilitation process." Do we want to mix these? We will be using an umbrella type of formatting for the core principles and the core principle will be bolded and in color with one or more paragraphs underneath that will outline what that principle incorporates. The principle itself does not need to have all of the specifics included in it.

DR. NEWBY: From a marketing perspective and to consider the use of terms that the Commanders are familiar with I noticed that we do not use the word 'service member' or 'service members.' I do not know whether that is intentional. I do not see specific places where I would put it, but I am wondering whether it could be incorporated.

LTC SCHNEIDER: That is a good point because it asks the question, 'who is the audience?'

DR. COZZA: The audiences can vary but the wording of the *core princi-*

...A great deal of the principal work is done by the peers, supervisors of service members, and non-mental health care providers. This concept of resiliency is really fostered when the military community has the expectation that the families will function together.

ples needs to be generic enough that it can be similar to the approach that was used in developing the *Psychological First Aid* principles. If it is broad, families and professionals will be able to read it.

LCDR KANE: One core principle that may not be addressed concerns the Navy's very narrow definition of 'family' as spouse and child. If we use 'family', it might be worthwhile to use a broader definition to include parents, siblings, children and spouse of the service member. We can then get the service member into the family definition, and the constellation around the service member is what the family is. The use 'family' is then implied.

DR. SALTZMAN: Do you want to extend that to the care of the child?

LCDR KANE: How 'family' is defined is a very sensitive topic that we need to discuss. However, it needs to be broader than how the Navy defines it. If we try and expand it too far and start including the whole larger community of the uncles and godparents, it could become too expansive.

DR. COZZA: We could use the words 'immediate' and 'extended'. People would understand that.

LCDR KANE: I want to include siblings and parents.

DR. COZZA: You could have non-traditional kinds of constellations in the family, i.e., where a grandparent is primarily the parent.

MS. KAUL: I would include parents and caregivers.

DR. ARATA-MAIERS: Siblings. The younger siblings are especially affected.

DR. ARATA-MAIERS: In the Workgroup literature, we talk about family intervention, but when you read most articles, the content concerns the care of the children. It is not about the spouses, siblings or the parents. The absence of the spouse part concerns me because if we do not address the concerns of the spouse who is overwhelmed and who is usually the person bringing her injured husband to his medical appointments, we will not be addressing the concerns of an important family member.

DR. FULLERTON: There is literature on that topic, but the impact combat injury has on the spouse addresses different issues that I think are important; issues such as anger.

DR. MCCARROLL: There is a need to consider the use of an epidemiologic framework of collecting new information. Wars always end up with either a new diagnosis or a new constellation of problems. To avoid concluding that we have all solved the problems and all we need to do is provide the interventions, some thought needs to be given to collecting information that is going to inform us where we need to go; using an epidemiologic framework that will detail the needs, problems and issues, and using a standardized data collection system. When you are looking for new information, you develop an epidemiologic framework of what has been done on a large scale in the communities and in the hospitals. You are looking for new information that is going to populate different positions on how to deal with these issues as opposed to what we are doing now. Now we take interventions that we know of and that are being used, which is great, but now consider collecting information that would be used to develop a framework leading to interventions that would better meet our future needs.

DR. COZZA: The use of our *core principles* would serve as the framework we would use to facilitate the development of interventions that we would use for the families and children of the combat injured service members.

We are talking about a broader primary prevention role, which is to consult with other community and health care service providers who work in various health and psychosocial related fields, but not necessarily limited to other mental health care.

For example, our leadership at the Army or facility level would use these principles when developing services or programs that would include interventions for caring for combat injured families and children. The *core principles* would then become actionable at the level that they were applied. The military could also apply them if they wanted to develop a system *to measure* the health and well-being of combat injured families. While at hospital level, they may want to measure the effectiveness of a particular intervention that they were using at their facility. What we have been talking about is collecting new information that is core to what we think needs to happen, but that may be enacted upon in different ways depending upon the level of implementation.

LTC SCHNEIDER: It has been over 30 years and we still talk about the Vietnam War and the Vietnam veterans, and 15 years later we are still talking about the Gulf War. Years from now we will be talking about OIF and OEF veterans and their families. We are now recognizing that the family and children of the OIF/OEF combat injured service members and veterans have been an important part of the OIF/OEF deployment cycles. Developing a way to include them in our body of knowledge is important. By using our *core principles* to develop family-focused interventions that will address the needs of the families and children of our combat injured service members and following this cohort, we will be better equipped to provide care for the families and children of our next combat operation.

DR. COZZA: We will have an opportunity to advance to the level of application; however, right now we are at the concept level of developing the *core principles*. Additional scientific study will be required to better understand the needs of our combat injured families and to study the effectiveness of our interventions.

DR. FULLERTON: There is more than just assessing and evaluating the intervention or a program, which gets back to Ed's discussion about using an epidemiologic framework.

DR. COZZA: Using an epidemiological framework to collect information to advance the knowledge of military children and families.

DR. BEARDSLEE: The key issue here also, to go back to what Ed said, is that this is an evolving problem. There are more and more families that are being affected. We do not know a great deal about them but we probably know more than anybody else. That is another reason to gather data.

And then your point is, even if there were no more families being injured, there would be much to be learned by following these families over the long term. These are two different points, but both are very important. This is a problem you have that is growing and it is epidemiologic.

LTC SCHNEIDER: And a much more utilitarian issue is that with a volunteer Army at war, the leadership has to recognize that unless the family is attended to, people are going to vote with their feet. The quality of the Army will degrade if we do not incorporate dealing with the needs of families and spouses into how we deal with retention issues.

LTC PETERSON: I underscore that point. The next generation of the Army is coming from the children of this generation of Army soldiers and their families. If we want to recruit and retain service members, we need to take care of their families.

DR. SALTZMAN: Yes, we should incorporate that concept as justification

There are collaborative pieces such as the public education piece, but public education does not necessarily refer to the general public. It may also include the military public.

of why it is important to care for the families of injured service members, but not necessarily as a core principle.

DR. COZZA: Military children are a national resource.

DR. SALTZMAN: I want to address the importance of the mental health practitioners being forward deployed and the importance of primary care physicians developing an early and ongoing relationship with the service member and the family. These relationships will improve the likelihood of service members and their families receiving mental health services.

DR. RICHTERS: They would kind of naturally migrate to you when they come back in a crisis.

DR. SALTZMAN: Right. And the key would seem to be, and it is in Doug Zatzick's work as well, talking about this long-term relationship that starts with the primary care but then is handed off to mental health when services are needed. It becomes an easier transition to mental health.

LCDR KANE: We might consider including the concept of the military community and the importance of the family. In other words, a great deal of the principal work is done by the peers, supervisors of service members, and non-mental health care providers. This concept of resiliency is really fostered when the military community has the expectation that the families will function together. Then when the family is separated from their service member, their ability to overcome setbacks and obstacles may be less likely to be challenged. Military communities can bolster the family's resiliency, and that could be a core principle. Within the military there is resiliency fostered by those who have been through it before, who can assist those who are new. We do not need to immediately refer families and children to their pediatricians and the mental health providers for assistance. This is just how it works, e.g., when you are with the Navy Seals you look out for each other's families — this is part of our military community of care. To be able to say that as a principle would be helpful.

DR. COZZA: We need to be framing this for the injured families specifically. So how could we frame that?

DR. MCCARROLL: Do you think a *core principle* might be the development of consultation models to be able to pass the knowledge on to all the providers who are out there in the caring community such as Family Life Consultants and Chaplains. There are not sufficient mental health providers to meet the access standards in all communities. One of the models for providing care might be through consultation to other providers by passing on new models of care that they can use.

DR. COZZA: Let us look at the *core principle: Collaboration and coordination of services between health care and community resources*.

DR. MCCARROLL: A consultation model would be different though.

DR. COZZA: Would it be to develop a community of care?

DR. MCCARROLL: You can say that, but the idea is to be able to pass off, pass on, or consult with to develop resources that can be provided by others, rather than solely by mental health people. Consultation is a model.

DR. SALTZMAN: It is really consultation upstream rather than downstream. The first service provider who contacts the injured service member's family should be knowledgeable in the area of providing services for the family.

DR. RICHTERS: Ideally you would want to ensure that the first time the

The use of the core principles we are developing should foster evidence-based approaches that can be used to support the family's healthy growth and recovery.

family is faced with the reality that their spouse has become an injured service member. The individuals who contact the spouse need to have the appropriate information about what services and contact sources are available to help the family.

DR. COZZA: This is in the education principle. We are talking about baseline knowledge, sort of universal knowledge. Effective care is informed by existing knowledge and seeks new knowledge

DR. BEARDSLEE: You are looking for a broad public health principle that is applied to healthy recovery and to recognizing the difficulties of recovery.

DR. FULLERTON: And to an understanding of the military environment.

DR. BEARDSLEE: Within the military environment, within the military context.

DR. COZZA: Ed, I want to make sure we do not lose this point about consultation, which is an equally important point.

DR. MCCARROLL: We are talking about a broader primary prevention role, which is to consult with other community and health care service providers who work in various health and psychosocial related fields, but not necessarily limited to other mental health care.

DR. RICHTERS: I know there are different variants of it, but is it sensitizing people who work in various front line positions to know when to recognize problems in order to refer them appropriately?

DR. COZZA: You are talking about developing an informed system of care that can broadly meet the needs of these family members.

LTC SCHNEIDER: Yes, a collaborative relationship that is based on you as a resource person, someone who has some knowledge and experience to offer possibly in the area of implementing interventions, who can assist combat injured families. Additionally this would be someone who will share their knowledge and experiences with you over the next six months and follow up with you to check on your progress and to offer guidance where needed.

DR. ARATA-MAIERS: That fits under the collaboration principle.

LTC SCHNEIDER: Yes, that is reaching across traditional boundaries. I think a lot of people here have contributed to that in a number of different ways and it will continue to develop, but I just wanted to put the idea in place.

DR. MCCARROLL: That is important, but the relationship is not part of the core principles.

MS. KAUL: Are we talking about the systems that people come into, e.g., school systems, medical systems, groups of faith, Lions Clubs, and you want the intervention to do something, and the consultation model to be set up so that it can flow either way? I look at it as pertaining to professional and para-professional staff, not just from a disciplinary perspective. Most of the systems that families will initially interact with will be the school systems, their faith-based communities, and their primary care providers who have physician technicians. Your point is that the consultation model is different than just rolling out a teacher who is going to teach and who then is going to promptly leave. There has to be some way of integrating, particularly for the injured families who are leaving the hospital system and going back to their home communities, but I do not know.

DR. CHUN: There are collaborative pieces such as the public education

As we develop the intervention, we want to look at the evidence-based information that we have available and start to think about the strategies that would be useful in linking clinical problems to strategies.

piece, but public education does not necessarily refer to the general public. It may also include the military public. The Casualty Assistance Officer receives information that the service member was injured, and he or she will call the family and notify them about injury. The Casualty Assistance Officer needs to have some basic information about the injured service member such as marital status and living arrangements. For example, are there any children and what are their ages? Who are the children living with, and where do the children live? Usually it is the Mom who is receiving the call, and will she be able to handle the call? The kind of sensitivity and information that is needed before contact with the spouse is made is nowhere in this notification protocol.

DR. COZZA: Are you saying that the casualty notification process needs to be more descriptive?

DR. CHUN: Yes, the process needs to be more descriptive.

DR. FULLERTON: We participated in a study within an Air Force community that lost seven squadron members. This loss affected the entire community. There was a very strong spouse group that assigned some of their members to accompany the Base Commander's wife, the Casualty Assistance Officer, the Chaplain and other individuals to inform the spouses that their husbands had been in one of the planes that went down in flames. The importance of that spouse group is that they had a folder that contained information that would prepare them for the visit, which included a checklist of helpful things to offer assistance with. It was a list of supportive services that were available, military related activities that needed to be accomplished, a script to assist them with what they were going to say, and information on how many children each spouse had and their ages. This was not an all inclusive list.

DR. ARATA-MAIERS: That is triggering something in me. I do not know if it is a barrier to intervention, but the information on family members within the military typically has to be searched out. It is difficult to access. Whether or not service members have children and whether or not the children are present or not present is information that is not standardized anywhere. The information usually comes through a case manager whom you want to have a good relationship with in order to obtain the information that you need. An additional challenge is trying to identify which family members are here and who needs assistance. These challenges would probably fall under barriers to care in military hospitals.

● Intervention Strategies Discussion

DR. COZZA: We are going to refine our *core principles* now. We are developing a certain level of depth and specificity to them. We need to further define some of the principles and determine *which principles can stand alone, and which principles may be combined*. We have principles which refer to systems of care, education, and barriers to care. There is some crossover between them, but they probably need to stand independently.

DR. SALTZMAN: As I am listening to the course of injury treatment and recovery, it seems to me that there are critical windows in which different interventions or target interventions are more or less appropriate. I am talking about interventions or different components within them that are appropriate for different phases of the treatment and recovery process.

LTC PETERSON: I would not dispute that, but it is pretty blurry in terms of which interventions are appropriate for which window of time. There may

Whatever intervention we develop, the training received should be broad enough to enable the provider to work with children and to recognize where the parent is at and what the parent's psychological needs are.

be different windows of time during the deployment cycle, but many have gone through the windows multiple times. It is the series of windows that they are going through.

DR. SALTZMAN: Some interventions like *Psychological First Aid* and even *Battlemind Training* may be appropriate for the acute phase or the very early stages whereas the FOCUS interventions may be not appropriate to use during the acute phase.

DR. RICHTERS: That is an excellent point. Refining the principle pertaining to interventions, which may be used to assist families with some of the challenges they will face during a particular phase of treatment or recovery would make that clear.

DR. COZZA: We will refer to the *Session 1 Information and Worksheets*, and we will review the injured family challenges and intervention strategies. The intervention strategies should reflect the core principles of intervention that demonstrate our current understanding of the injured families experience and needs. The use of the core principles we are developing should foster evidence-based approaches that can be used to support the family's healthy growth and recovery. This review is going to get us into an actual discussion of the clinical problems and intervention strategies. Page one of this document describes several evidence-informed interventions, which provide the background and important strategies of intervention that this workgroup will be developing. The worksheets really get into clinical problems. We may divide the clinical problems or challenges for the families and children of the combat injured service member into three major domains: 1) Family Distress and Recovery, 2) Parental Functioning; and, 3) Injury Communication.

We have been talking about *core principles*, and we are now ready to start discussing specific interventions which could be used in medical center facilities. We want to develop general strategies. Remember the plan for this project is to develop core principles, general strategies that can be applied, and to develop a manualized treatment intervention. Only a couple of people in this room are going to be participating in the research study and using the intervention; however, you all are now involved in helping us to refine programmatic strategies for the manualized intervention. As we develop the intervention, we want to look at the evidence-based information that we have available and start to think about the strategies that would be useful in linking clinical problems to strategies. We may come back to look at our core principles, but now we will review the list of combat injury related family problems and the adapted evidence-informed interventions. They do not always match up perfectly one to one, but the purpose was to begin developing a way to approach the problems we were seeing. Page 3 is an overview of all the problems and interventions. The combat injury related problems are: 1) acute parent and child traumatic stress symptoms, 2) reduced parent availability and awareness, 3) parent-child communication problems, 4) disruption of children's lives; and, 5) the long-term impact of injury on child, parent, and family function.

We will look at the problem side and determine whether it needs to be integrated into the core principles, and we will then send it out to the workgroup for comment. As we focus on the broad categories of clinical problems, we need to ensure we are inclusive. Do we need to add more problems? Also, because care of the injured family is a complex, we need to decide if there

There are young children who have only seen their parent as injured, and they are on a unit where there are a lot of injured service members. When they meet people who are not injured, they are afraid. They are not afraid of injured people.

are other evidence-informed interventions we need to be thinking about or incorporating into our existing interventions.

DR. LESTER: At whatever stage of treatment or recovery you are in, would the core principles guide whatever interventions you use?

DR. COZZA: Yes, the *core principles* will always guide our interventions.

DR. LESTER: But your goal is to develop a manualized protocol for the immediate hospital setting. Is that accurate or not?

DR. COZZA: Yes, we are now identifying the clinical problems. In the afternoon we will look at the evidenced-informed interventions that we recommend using in different sessions to address the specific needs of the injured families. For example, we have child mastery sessions that would use different adaptive interventions during different sessions in the stabilization and sustainment phases. We want your input to ensure the sessions have the right mix of activities in them to be able to do the job that we are asking.

DR. SALTZMAN: Is the time frame we are considering more for the hospital stay and the immediate period after that, or are we also including the long term phase?

DR. COZZA: We are talking about both, but we are talking about it from the health care facility vantage point; not every health care facility is going to provide these interventions. We anticipate medical centers may offer these interventions in the acute and sustainment phases. We have models of follow-up with our injured service members where there is telephone contact, such as calling service members post discharge and checking in with them. The focus for the family at that point would really be at the time of transition: how are they transitioning and integrating back into their communities and are they receiving the care they need?

We want to think about the child and family, and the impact combat injury is having on them in what we have identified as potentially challenging areas. Are the following problem areas that we identified the right problems to be thinking about? We conceptualized the problem areas as falling into five major clinical categories: 1) acute child and parent traumatic stress symptoms; 2) reduced parental availability and awareness; 3) parent-child communication problems; 4) disruption of children's lives; and 5) the long-term impact on injury on child, parent, and family function.

DR. ARATA-MAIERS: They seem to be the right categories, however, my concern is that there should be some mention about the child as the caregiver, and I do not see that addressed. The long-term rehabilitation care for the parent comes close to that, but it seems more focused on the parents.

DR. COZZA: You are right. Would you see that included in the disruption of children's lives category?

DR. LESTER: The disruption in the child's life affects his or her developmental trajectory.

DR. ARATA-MAIERS: The child as a caregiver does not occur during the parental absence.

DR. COZZA: The disruption of children's lives category was actually intended to mean children who are placed in the care of other parenting figures, however, there may be some crossover here, but the child as caregiver is an important problem to consider.

DR. CHUN: A concern that I have is that once we develop a model to follow, additional requirements such as training will be mandated. Flexibility

There are a set of enormously challenging developmental tasks for the spouse who learns their partner is so severely injured as to require hospitalization. There are also a huge set of environmental tasks for the person who is injured. And then on top of those two, there is some responsibility to the children.

is another important concept to consider. Whatever intervention we develop, the training received should be broad enough to enable the provider to work with children and to recognize where the parent is at and what the parent's psychological needs are. That type of flexibility needs to be emphasized.

DR. COZZA: We are talking about embedding that type of flexibility in the use of the intervention. The intervention would be adapted based upon a number of different factors such as the needs of the family and the presence or absence of family members. What you are referencing is the presence or absence of resources, and the concern about being placed in the position of being asked to do things that an institution may not be able to provide resources for.

LTC SCHNEIDER: There is a concern that if the intervention becomes manualized, it may become a program that requires additional resources. However it is more likely to be accepted if the intervention is introduced as an evidenced-based approach that will provide us with interventions that assist us in supporting the family's and children's healthy growth and recovery, and is presented as looking at what we really do and the outcomes. The result will be providers feeling empowered to study the interventions and the stages, sessions, and challenges they will address. Then this is not a barrier for professionals. On the other hand if you require the providers to learn and use these interventions, it may communicate that someone is not capable of doing this on his/her own.

DR. COZZA: It is the distinction between the clinical application and the science application.

DR. COZZA: We are now moving from principles to general strategy. The strategies will be general and the interventions will be specific. We are shifting now to intervention strategies that are problem-based strategies as opposed to general principles.

DR. ARATA-MAIERS: Are we looking at interventions with the families rather than interventions within the settings?

DR. COZZA: At this time we will look at interventions that will effectively address problems arising during the injury stabilization phase, which is the acute phase that occurs during the service member's hospitalization and discharge from the hospital. That is the information on page 3 of the Session 1 Information and Worksheets handouts. This is family-focused. We may need to do some things within the hospital setting such as educating the staff.

LTC SCHNEIDER: This would assume that some of the core principles underlie the care for the combat injured families and children.

DR. COZZA: Yes, your assumption is correct.

DR. CHUN: When I was reading articles about caring for the service members who had TBI there were no references to what impact the injury had on the family and children, or the care that you would provide to support the injured service members' families and children in their recovery. We do not want to do the same thing here. We want to provide care for combat injured families and their children.

DR. ARATA-MAIERS: The other thing about that literature is that it provides information and descriptions about the problems, but there is very little about the interventions with those families. We want to move beyond that point.

LTC PETERSON: Does that speak to the lack of depth of the interven-

When you think of Psychological First Aid, the first thing we think of is safety. For example, are the children in a safe place? Is the spouse in a safe place? You want to make sure that the family constellation is safe, and then begin discussions of their more acute needs followed by longer term issues.

tions that are available?

LTC SCHNEIDER: What we have are actually specific treatment goals that have a specific intervention that will apply to a specific problem.

As a group, our consensus is that these are the kinds of goals that need to be attained if a particular issue or problem is identified such as the difficulty the parent has in appropriately sharing or modeling emotional responses to injury. There will also be a recommended, evidence-informed intervention, and this type of information will be addressed in the manual. There could be other interventions, but this is a nice way of studying and manualizing it while still communicating that the goal is, for example, to prepare the child to visit the injured parent.

DR. LESTER: I do not work primarily in an in-patient hospital setting. I am wondering how much reactivity to loss and trauma reminders are actually interfering in that acute phase. It is generally referenced as fear, anxiety, or behavioral disturbances related to trauma, but I wonder about loss reminders for the injured and even for spouses in the community. My sense is that it is fairly pervasive. People are reacting to loss and children are aware that their parents lost a buddy, but nobody is talking about it very much.

DR. ARATA-MAIERS: And then there are oddities. We have burn children who are afraid of normal looking adults, but who are comfortable being around adults who have been burned.

LTC SCHNEIDER: Where does that transfer to?

DR. ARATA-MAIERS: There are young children who have only seen their parent as injured, and they are on a unit where there are a lot of injured service members. When they meet people who are not injured, they are afraid. They are not afraid of injured people.

DR. COZZA: Are you referring to a problem that is not listed here such as protecting children?

DR. BEARDSLEE: In reference to my visit to WRAMC and my work with you, there are a set of enormously challenging developmental tasks for the spouse who learns their partner is so severely injured as to require hospitalization. There are also a huge set of environmental tasks for the person who is injured. And then on top of those two, there is some responsibility to the children. The first thing one wants to do is to have a set of psycho-educational information or cognates which would describe for the spouse the kind of things people wrestle with and the uncertainty of what to do about the children. You are also thinking about how the initial contact occurs and then presumably the spouse coming to the hospital with children for the first time. This is a different situation than the spouse who is returning with her children for a repeat visit. We are talking about the facilities. One of the points you have made is that facilities may not have places for children to stay when spouses come to visit the injured service member. Trying to think about it that way will explain the possibility for parent anxiety and child distress after that initial contact. You may want to frame this as a potentially normal developmental experience that is also enormously challenging. If I were a spouse in this situation, I would be bewildered by the amount of information I am receiving and not understanding it at all. I might be given a detailed explanation of the nature of the wound, the nature of the surgery, or the nature of the recovery process, but I would not know what to ask about my children, or any of the other things parents usually ask as they are trying to figure it out.

There is a hierarchy of need that dictates the need of the parent to come to grips with what the injury situation is, to plan on how to talk to the child about the parent's injury, to plan a visit to the injured service member spouse, and then maybe to bring the child to visit the injured parent.

To go back to your list, what I am saying is things like anxiety, distress or trauma reminders come in the process of coming to grips with this experience.

DR. LESTER: I was thinking about disclosure and notification. Is there something in that process that needs to be attended to? Are there any important medical disclosures at pivotal impact points or when the spouse is first notified about the injury event?

DR. COZZA: Yes, however we are now focusing specifically on the health care environment. The education needs to be inclusive to include education of the health care system employees about the needs of the combat injured service members and their families and children. Assuming that you have the availability and willingness of the institution to participate, what are the types of problems that you might encounter within the health care setting?

DR. BEARDSLEE: And you were thinking of the parent here as the non-injured parent or both parents?

DR. COZZA: Both.

DR. BEARDSLEE: As was previously stated, one might encounter the re-enactment of trauma or the stirring of past traumas. Everybody sees the part of the elephant that they work with. For example, I work with depression, and I think there would be a great deal of depression with both the injured service members and their spouses. Assessing for that or at least being aware of its possibility is probably important.

MS. VINEBURGH: It would be critical in this first early stage to have the health care system understand the basic needs around the security of the actual visiting of the parent, e.g., does the spouse have a place to stay? Did family and children accompany the spouse?

DR. BEARDSLEE: Saying that, an assessment should include whom the family is or who the stakeholders are from the patient's perspective.

LTC SCHNEIDER: This includes the family demographics including who they are and where they are living?

LTC PETERSON: That is going to be a moving target because there are family and close friends who will be coming and going. In some ways it is refining who you are targeting, and you will have limited resources. Therefore it is important to identify whom we are going to target in terms of intervention and identifying those individuals.

DR. FULLERTON: And the first step is why they should be there.

DR. BEARDSLEE: You also need to identify how many children are there and their ages because you are going to do something different for a three year old than you are going to do with a ten year old.

LTC SCHNEIDER: The information discussed is in the Parent Guidance Assessment-Combat Injured (PGA-CI) interview tool. The issue with the PGA-CI is not the questions. The problem is having sufficient resources to complete the assessment. It is a question of priorities, and that will need to be discussed with the department chief.

LCDR KANE: What do we do first? When you think of *Psychological First Aid*, the first thing we think of is safety. For example, are the children in a safe place? Is the spouse in a safe place? You want to make sure that the family constellation is safe, and then begin discussions of their more acute needs followed by longer term issues. When you initially meet with a spouse, they are dealing with all the medical/legal decisions; therefore, family oriented con-

There are some things like getting the information, speaking up, taking care of yourself, and thinking about your children that help people through this experience. This will be the beginning of the tool kit, and then you have more measured responses after that.

cerns may need to be prioritized and addressed during follow-up visits.

DR. ARATA-MAIERS: One of the things that we are instituting at Brooke Army Medical Center (BAMC) is the use of the PGA-CI that we are calling the “Pegasus.” This is a parent-child assessment that we complete with the spouses of injured service members. The need for an intervention in the hospital setting is what I discussed earlier. We have tried to implement the use of this PGA-CI “Pegasus” assessment since November 2006. We conducted a needs assessment in January 07, and we are now inaugurating the systematic use of the PGA-CI “Pegasus.” It required a lot of refocusing of resources in order to have a policy in place that mandated completion of the PGA-CI “Pegasus” with all spouses of the injured service members. We coordinated with case managers to set up appointments that work well for the spouses when they have the time and emotional availability to meet with us and complete the assessment. The PGA-CI “Pegasus” is both a setting and a family intervention.

LCDR KANE: The service member’s prognosis is another decision point. Is he or she ever going to regain consciousness and be cognitively intact? If the prognosis is poor we will use different kinds of interventions than we might use with the spouse and family of a service member who had an orthopedic, eye or soft tissue injury and whose cognition is intact. The child will be able to interact with the parent and see that their Dad or Mom may be injured but will recover. This would be a hospital intervention, and the type of family intervention will depend on the prognosis of the injured service member.

DR. COZZA: Our intention now is not to develop a longitudinal intervention strategy but to understand the problems and the disruption to the family and children in broad ways. I know as clinicians, we would be interested in how we approach the problem, starting at Time A. This table was not set up in that way. It was set up to catalogue the types of problems families are likely to have that would need to be addressed in some kind of way. We would then identify our intervention goal and the components of our intervention in order to ensure our core principles are addressed and look at problems in a time driven and flexible format. In other words, we have a broad understanding of what those problems are likely to be for any given family. The fact that problem 1.1 is “acute parent and child traumatic stress symptoms” does not necessarily mean it is the first thing we deal with. We do have broad categories of problems within families that can be assessed and treated using evidenced- informed interventions. Problems may not be addressed in any particular order. It may not even be feasible to address all of them based upon the resources that we have. Do we have the categories of problems addressed? Are we missing big chunks of material?

DR. BEARDSLEE: That was very helpful. Somewhere you may want to say that each of these problems is preceded by some awareness of the dimensions. In other words, who is in the family and what is the nature of the injury? Is the service member in the Intensive Care Unit (ICU), on the Neurology Unit being treated for a severe TBI, or is the service member’s condition listed as ‘very seriously ill’? What you are going to do is going to be different depending upon the extent of the service member’s injuries and prognosis.

There is a larger issue for me: taking problem 1.3, parent-child communication problems and the sub-problem relating to the inability of the parent to offer developmentally appropriate notification of the injury to the child. How do you communicate notification information? You can frame that as a diffi-

We want to have information available. Providing information about how to communicate with children can be anything from providing a sheet of paper to optimal discussion. There are lots of different ways to educate parents.

culty, or you can frame that as a developmental challenge. The developmental challenge is what any parent would face in trying to describe a very serious injury of a service member who is being treated at WRAMC. There is a hierarchy of need that dictates the need of the parent to come to grips with what the injury situation is, to plan on how to talk to the child about the parent's injury, to plan a visit to the injured service member spouse, and then maybe to bring the child to visit the injured parent. There are a set of strategies that will guide this intervention. It is a question of whether you frame these as developmental challenges, and the problems are then the situations where it does not go well.

DR. COZZA: This is an important point. Is it a language problem?

DR. BEARDSLEE: It seems to me that every family in this situation is going to be challenged by how to explain the injury notification to the children. But it seems to me that by saying 'communication problems,' you believe there is a subset of families that are going to get into real difficulties or difficulties that are other than the norm, such as an inability to offer developmentally appropriate notification, or difficulty in sharing or modeling emotional response. And then there are other families who may be able to do this. That is how I understand problems.

DR. RICHTERS: There are a number of things that we do not necessarily think of as problems. If we thought of them as needs, what are the normal ranges of needs in the injury situation? You would think of a number of other things to do preventively that you might not otherwise think about.

DR. BEARDSLEE: You can do it either way. You can put a definition at the top that says, "These refer to responses that are beyond the range of normal in this situation." I just want to pick up on something that Patricia said. I try to think about the mental model of the parent who is having this experience. The mental model will be conditioned by having lived on the Army base where many families may be experienced in living with an injured service member.

DR. COZZA: The emphasis on challenges is an important one to be thinking about, and it is almost self-explanatory. If challenges go unnoticed and unaddressed, they become problems. Keeping it within a prevention context is important. To phrase it as developmental challenges or symptom challenges, some of those things in some ways are expected, and then some of them are problems. Do we need to think about the relationship between challenges and problems as we develop this? In other words, there are certain things we are going to provide that we think are important in developing strategies within the hospital setting. How should we consider the range of responses? Should it be within each of these subcategories, or should it be in its own category in terms of when problems develop?

LTC SCHNEIDER: It is like the *Battlemind Training* where the issues are identified. For example, 'emotional control versus detachment,' and under that 'what worked well in combat,' and why that same skill set will not work well in the home, i.e., transitioning the combat skill to the home environment.

DR. BEARDSLEE: You could easily do a paragraph or two about the huge, expectable and normal developmental challenge it is for a family to adjust to a service member spouse and parent who is hospitalized for a period of time. That is the challenge; some families do this on their own and others do not. You frame it as a normal reaction, namely that it would be normal to be heavily challenged by this.

Ultimately, getting information to parents in a way that helps them meet the immediate needs of their children in the hospital setting and then beyond is very important.

DR. LESTER: It is the self-care approach that Doug's model rolls out too. Similarly to the medical tool kit we use for everybody who goes through a physical injury and is hospitalized. There is an assessment piece embedded in it. Then somehow you have some decision-making point for who gets followed over time. Maybe everybody does, because maybe the risk is high enough that everybody gets followed over time, but then there are points where some will receive additional modules.

DR. BEARDSLEE: Nancy really engineered this piece (a brochure) that we wrote for National Depression Screening Day, entitled *Can a Depressed Parent Be a Good Parent? You Bet!* BET stands for *believe* in yourself, *educate* yourself, and *talk* to your children. And it took a huge amount of work to reduce the information to two, eight and a half by eleven sheets of paper. I think the public health intervention would be to generate a knowledge set, and then put it in some format available to a parent that says that this is enormously challenging and here are the things that families wrestle with. There are some things like getting the information, speaking up, taking care of yourself, and thinking about your children that help people through this experience. This will be the beginning of the tool kit, and then you have more measured responses after that.

DR. CHUN: I was just going to say that we present the situation to families in just this way. Otherwise we are going to overwhelm the family and become more of a barrier. We let the family know that this is an enormous challenge and that we are here to answer any questions they have and to support them. Those are the kinds of statements that we use before we do anything. We do repeated visits to give the family an understanding that, 'this is a normal response to an extremely challenging situation,' and we will support them in using the coping resources they have and be there if additional assistance is needed.

DR. COZZA: The lunch break will help us as we shift to the idea of challenges and the relationship between challenges and problem development, which is important. We will then discuss the intervention goals and strategies. The strategies could be anything from handing a spouse a fact sheet with information on it versus engaging in more conversations. There will need to be some flexibility in how this intervention is integrated at the particular health care facility.

DR. BEARDSLEE: I would agree. The piece that Nancy and I did was to be given out as a stand-alone document on National Depression Screening Day. We had no control over it other than to make it as good as possible. Your point is that this is probably better than a face-to-face interview in which one is very careful about not overwhelming the parent.

DR. RICHTERS: It is getting the information down and how it is going to be used that is different.

DR. COZZA: Although there are some settings where the resources may not be available, we do not want to develop an elitist strategy that can only be implemented in a very well resourced place. We want to have information available. Providing information about how to communicate with children can be anything from providing a sheet of paper to optimal discussion. There are lots of different ways to educate parents.

LTC PETERSON: I want to underscore what Dr. Cozza said. My concern is when there are no resources to implement programs like this. We are one

Providing information about how to communicate with children can be anything from providing a sheet of paper to optimal discussion. There are lots of different ways to educate parents.

provider deep for Child Psychiatry and Child Psychology. You are not going to go after the parent who is not eligible for care to begin with, even though it is the right thing to do. You are not going to go after the multiple, no-show family. You are going to go after the person who is presenting in trouble.

DR. COZZA: If it was a stratified strategy where there were multiple ways that goal could be achieved, it might work.

LTC PETERSON: That would help here. It needs to be able to be used in a manner that the providers, who are under-resourced, can utilize it in an effective manner.

DR. RICHTERS: It should be communicable at all levels from the level Bill was just talking about where they were required to reduce the information to two eight and a half by eleven sheets of paper to increasingly more detailed and more complex forms of communication.

DR. COZZA: That is the reason why we need to have a complete problem list. Then we understand and can come up with multiple strategies to approach the problems or challenges on a varying number of levels.

LTC PETERSON: As this manualized intervention gets rolled out, it will be very important in the deployment of this intervention to include an information sheet that will identify the phases, the session worksheet functions, and the participants for the various sessions. Will there be specific instructions for the use of this intervention at medical centers versus community hospitals? The sessions are intended to be combined flexibly, which will allow an appropriate mixture of meetings with parents and children in varying formats to address the specific needs of a family during injury recovery.

LCDR KANE: Another thing that would be helpful is to include information about how to obtain additional resources if you want to expand your program. This is helpful because sometimes when you are given funds; you are trying to prioritize what programs to implement and where to obtain resources.

MS. WILLIAMS: I just wanted to bring out the possibility of another challenge or problem, which is the post-hospitalization transition that should be addressed while the family is still in the acute care setting in order to prepare the family for their next phase of treatment. For example, if the family has been together in this very artificial environment, what is it going to look and feel like when they are trying to go about doing the everyday tasks of being a family when they have not seen their child in a year or more because the child has been watched by another provider?

DR. COZZA: You are referring to reintegration issues. We can probably put that in the problem or challenge section that addresses the long-term impact on child, parent, and family function.

DR. MCCARROLL: Bill commented on providing knowledge to parents as part of a tool kit. It seems to me that we are talking about two, different things. I thought this conference was organized to provide information for providers. If we have information for providers and we are also trying to develop information for parents, are we saying these are two separate topics or can they overlap?

DR. COZZA: The intention was that the product roll-out would not necessarily be the immediate outcome of the Workgroup, although I expect that would eventually be where activities would go. The Workgroup was not broadly defined as core providers only, and it was more narrowly defined as

Ultimately, getting information to parents in a way that helps them meet the immediate needs of their children in the hospital setting and then beyond is very important.

we got to the point about what to do in the immediate hospitalization setting and post hospitalization setting. However, that would also include the providers and the parents. It is really more related to the parents and the engagement of the parents, and we will want to make sure, based upon our core principles, that the hospital and health care providers are educated and everybody is saying the same thing. Ultimately, getting information to parents in a way that helps them meet the immediate needs of their children in the hospital setting and then beyond is very important.

I believe we need to add another core principle: combat injury is a challenge to our healthiest families and requires support at various levels in the health care system and community.

SESSION TWO:

Practical Application and the Components of Effective Intervention

From Clinical Reality to Family-Focused Intervention

DR. COZZA: Regarding our previous discussion and Bill's comments, I believe we need to add *another core principle: combat injury is a challenge to our healthiest families and requires support at various levels in the health care system and community*. We need to acknowledge the nature of the challenge. If we neglect that, then we move immediately into illness-based models. The focus on prevention is extremely important. Without concerning ourselves about how the interventions are carried out, do the categories we have identified on the Session One worksheet reflect all of those challenges and problems? Terry, I thought your comment about the care-giver status is an important one.

LCDR KANE: One area we should include is spouse communication. How is the relationship between the parents? At some level we need to assess how the parents are communicating.

DR. COZZA: We might change that to family communication challenges.

LCDR KANE: That would be broader and help us to assess how the parents are functioning, i.e., the marital relationship.

DR. COZZA: Can you give a succinct example of that? What is the challenge?

LCDR KANE: I encounter families where one parent has one parenting style, and they use it as a battle or conflict between the two of them. They need time to reintegrate into the role of parenting so they are not stepping on those boundaries.

DR. COZZA: Can we specify it a little bit more for the injured party?

DR. LESTER: Could you talk about sustaining parenting and maintaining the injured parent's role while away or while injured?

LCDR KANE: My concern is about marital conflict and its implications. Many of our interventions at Walter Reed are spouse focused. If we are intervening with the spouse, we want to make sure we assess how the marriage is doing. A great deal of the parenting work falls out because of that. If we are doing a family paradigm, you really want to do a marital assessment.

DR. COZZA: I like keeping it at a pre-clinical level. *The goal and challenge is sustaining the marital relationship through injury, treatment, and recovery*. The goal is helping couples recognize the challenge and some specific

It can be a slippery slope when you go down the road of marital conflict and marital therapy. Sometimes it is more than you can do in the circumscribed context. You have to assess it, acknowledge it, and set it to the side and get people to focus on the task at hand.

approaches to dealing with communication or relationships during the period of treatment and rehabilitation.

DR. LESTER: It can be a slippery slope when you go down the road of marital conflict and marital therapy. Sometimes it is more than you can do in the circumscribed context. You have to assess it, acknowledge it, and set it to the side and get people to focus on the task at hand. Or, focus on parenting per se, because they may be able to come together around children, or around injury recovery. The marriage is something that is a longer-term issue.

DR. ARATA-MAIERS: Do you want to look at the spousal communication as a part of the family, or the spousal communication as it relates to the ability to parent?

DR. COZZA: These are really challenges to the family. I think it is reasonable to just recognize the injury-related stressors on marriages.

DR. CHUN: We have a menu that lists situation examples identifying periods of time during which the family and the spouse expect almost a breaking point. Soldiers being deployed many times have drawn out narratives. When they come back with the injury, there is that issue of the communication. Our approach has been to focus more of the communication around the parenting, but we do have to address the marital situation. An example is a soldier that comes to us with an injury and when he opens his eyes, his wife is signing divorce papers. This creates another level of complexity. We could work with his family around parenting, but their marital conflict is something they need to address later on with someone else.

DR. COZZA: If we are talking about the family in terms of how they function, it might be helpful to keep it communication based as opposed to relationship based.

MS. VINEBURGH: What if the injured parent cannot communicate?

DR. COZZA: That is part of the challenge through injury treatment and recovery. It is also sustaining parenting through injury. For example, one of the difficulties is that some parents who have traumatic brain injury think they are parenting acceptably, and they want to be involved. Part of what you must teach them is that it may be better to defer to the healthy parent at this point in time.

DR. ARATA-MAIERS: There are two things I would like us to look at. Under 1.2, reduced parent availability and awareness, we have parental problems related to the injury. Do we have parental lack of availability and awareness related to the care-giving responsibilities? That might be included under reduced parental awareness of child's emotional needs. We may want to fit the child's distress related to encountering reminders of trauma in the hospital such as seeing other injured folks or medical procedures related to combat injury.

DR. COZZA: We might want to add child traumatic exposure under 1.6 and not leave it as 1.1. This idea of exposures being a challenge to the child in the hospital setting is important.

DR. ARATA-MAIERS: There are many triggers within the hospital settings, not necessarily gruesome medical trauma. Children could see a nurse and get concerned about shots when they are young. So coming into the hospital setting and seeing or hearing that their parents are going to have surgery and connecting that to the time when they had surgery.

LTC SCHNEIDER: Yes. Some are counter-intuitive, like children with

Reintegrating a deployed member is a challenge for any family. It may be even more challenging if the context of reintegration is an injured family member.

burned parents who react negatively to those that are normal-looking.

DR. CHUN: The really important issue is about reintegration.

DR. COZZA: Are we talking about 1.5, long-term impact?

DR. CHUN: Say Dad has been in Iraq for fifteen months. His three year old becomes a five year old and the first time they see each other is in the hospital. There are a lot of reactions or adjustments. In some instances the child has been told in the picture, "This is your Dad," and the child comes to visit Dad, and says, "He is not my Dad." This could fit under disruption of a child's life.

DR. ARATA-MAIERS: In your initial remarks, you talked about the child's integration of the change in the parents. That seems to be what you are discussing now.

DR. COZZA: It is not just the re-connection, but the long-term change in injured child-parent interactions, activities, or function under 1.5.

LTC SCHNEIDER: Reintegrating a deployed member is a challenge for any family. It may be even more challenging if the context of reintegration is an injured family member.

DR. BEARDSLEE: You asked us to think about difficulties at different levels. How much do you see existing conditions exacerbated by either disruptions in routine or other associated child needs? An example is the child who has ADHD and needs the structured setting, medication at a certain time of day, and so on. Then, the person who is doing that is not available and the condition becomes exacerbated. I think that belongs under either disruption of children's lives or long-term impact exacerbated by preexisting difficulties.

LTC PETERSON: Our patient population is the same as before, but the intensity of need is greater having been exposed to the stress of parental injury, i.e. the ADHD child whose attention worsens. It is also a reflection of the stress of the parent who remains behind and not having that co-parent, co-pilot thing.

DR. ARATA-MAIERS: We are having difficulty also with identifying whether this is a pre-existing condition, a new condition that is an adjustment response, or a co-morbid condition. Because we see them at the point of injury, we don't know. Oftentimes they are young enough that they are just entering a time period when you would identify them as ADHD or ODD, so you don't have a good history to depend upon.

DR. RICHTERS: It raises interesting questions. Would it have relevance to how you would intervene, or would it have relevance as a possible rule-out? For example, if this is a continuation of a pre-existing problem, do we concern ourselves with it during the intervention?

DR. ARATA-MAIERS: We have found that our pediatricians are assuming this is a reaction to stress. If we deal with just the stress and not the ADHD, and then you put them together, you've got chaos, such as kids being thrown out of school, or academic problems. So not identifying what may be a prelude to a behavioral disturbance exacerbates it and creates more problems for the family.

DR. RICHTERS: Granted, they may have many problems. The question is what do you do in this intervention from the best practice standpoint? We talked about core principles. A good strategy in the hospital setting is to be aware of children or families that were at risk prior to the injury taking place. That's not a core principle, but it's an important strategy to get our hands around.

We have not talked about how to help the child deal with the loss of the physical function of his/her father. It could be just appearance, it could be body parts, or it could be other things. For example if the father used to be big and now is a bilateral amputee, he is small.

DR. COZZA: I think it is reasonable. It is an informing part of trauma work that at risk populations are going to have worse outcomes.

DR. RICHTERS: Co-morbidity is going to be the rule rather than the exception.

DR. LESTER: There is another problem that comes from the network medical trauma toolkit. It is helping children plan for communication with others. There is the potential stigma experienced when going back to school or going back to their community. They can actually model and practice what they want to say about it. They don't have to tell everybody everything.

DR. COZZA: Can we put that under family communication challenges?

DR. LESTER: Yes. It could be helping your child communicate about the parent's injury to others.

DR. SALTZMAN: In terms of 1.2 and 1.3, it might seem a little narrow. Parent-child communication does not speak to some of the broader family communication issues.

DR. COZZA: We have changed it to family communication challenges.

DR. SALTZMAN: Excellent. In 1.2, there is more than reduced parental availability and awareness. We are seeing a change in parenting styles, i.e. becoming more rigid. Is this subsumed in 1.2?

DR. COZZA: No, and that is a good idea. What we should say is changed parental availability awareness and style. For example, some parents do not prescribe to disciplining their children. They feel the situation is hard enough on them already so they will just ease up on them.

DR. ARATA-MAIERS: Is that different from what is in 1.5 in terms of the change in injured parent-child interactions or activities in the parenting function?

DR. COZZA: The part of this table intended to have a temporal sense is 1.5 as opposed 1.1 to 1.4 being more short term. We may want to adjust the table to reflect that especially if we are thinking about the idea of stabilization and sustainment phases of treatment and intervention. As we have redefined this table the distinction between family based challenges, as opposed to systems based challenges, becomes evident. We may want to define certain systems based challenges separately, and use 1.7(the blank page) to do that.

DR. CHUN: We have not talked about how to help the child deal with the loss of the physical function of his/her father. It could be just appearance, it could be body parts, or it could be other things. For example if the father used to be big and now is a bilateral amputee, he is small.

DR. COZZA: Could we add that to childhood stress?

LTC SCHNEIDER: Perhaps we should consider a key frame, child reaction to injury, as a heading of 1.1, and then bereavement or loss could become a point under it.

MS. KAUL: I am wondering about the issue of a defined lack of role for a child, not in the acute phase, but in the early rehabilitation. When is it appropriate and helpful for a child to have a role? Would that create some sense of stability?

DR. COZZA: Yes, disruption of children's lives, 1.4.

MS. KAUL: Instead of normal routine disruption, this is a new activity and concern going on in this family. For many children, depending on the setting, there is no role for them. There may be ways of creating an adaptational role for even smaller children so they feel part of this process.

We need to think about developmentally sensitive challenges to the individual child. There may be a difference between a school aged boy being pulled back into the family to be helpful versus a teenager being pulled back who is searching for independence.

DR. COZZA: A sense of self organization, safety and security.

MS. KAUL: Can you link the injured service member to a sense of efficacy about parenting?

DR. COZZA: In the disruption of children's lives, we may want to incorporate loss of a sense of safety, role, and efficacy. We talk about loss of parental efficacy.

LTC SCHNEIDER: The challenge may be maintaining connectedness through treatment from the child's perspective.

DR. COZZA: Yes. Should 1.3 just be communication, or should it be communication and connectedness?

DR. LESTER: What about communication and connectedness challenges?

DR. COZZA: Yes, that makes sense.

MS. VINEBURGH: Building on what Pat said, another challenge is the external communication problems. Helping families regulate this as they are assaulted by so much communication.

DR. BEARDSLEE: This would be regulating external information. I was trying to think about the challenges that are different at different developmental stages for children. I'll give two made-up sexist examples. The first involves a family with an older girl who is caretaker. We see this with the depressed families all the time — tremendous pressure on that child to step in and do things for the parent. And then, imagine a family with a younger boy who is active, and the pressure on him to be quiet and passive. Both examples are expected. The challenges for different children are going to be different depending on their ages and roles in the family. But the roles will change and the demands on them will change. Or the expectations about them will change.

DR. RICHTERS: It is also a role redefinition. From parents, injured parent, spouse, and child, those things are going to be redefined by the nature and extent of the injury.

DR. BEARDSLEE: They push children into areas because there is no one else to do it or because there is a tremendous premium on behaving.

DR. RICHTERS: An interesting piece just came out this year on the phenomenon of parentification.

DR. BEARDSLEE: I have written about children who become caretakers in families with depression. It is not a bad thing as long as they have some choice about it. The natural response, if somebody in your family is ill, is to take care of them.

DR. LESTER: We have six year outcome studies showing that children who took on parentification roles experienced some initial distress, but six years later they were actually doing better than written about in Judith Stein's article.

DR. RICHTERS: There should be a distinction between a functional and emotional parentification role.

DR. LESTER: That may be important in a family with an ill or injured parent.

DR. COZZA: We need to think about developmentally sensitive challenges to the individual child. There may be a difference between a school aged boy being pulled back into the family to be helpful versus a teenager being pulled back who is searching for independence.

DR. BEARDSLEE: Developmentally sensitive changes in roles. The roles are going to be different at different developmental epochs or stages.

Pre-discharge, there is a set of issues relevant to planning and preparation for the transition. With discharge imminent, the non-injured spouse may wonder, "What if I have to be the bread winner and a care taker?"

DR. ARATA-MAIERS: Under reduced parental availability and awareness, you may need to put in something about the parents' distressed or clinical behaviors that impact the family, for instance substance abuse, parental numbness and avoidance. Substance abuse can endanger a child in many ways

DR. COZZA: That probably should be included in 1.1. We have child trauma-related psychiatric disorders, but there are also parent trauma-related psychiatric disorders and stress symptoms.

MS. VINEBURGH: What if the uninjured spouse is disabled?

DR. RICHTERS: Would that be subsumed under the parenting role? What if one of the kids is disabled?

DR. COZZA: Somewhere in 1.2 we need to include change in parental availability, awareness and/or efficacy.

LTC SCHNEIDER: There may be more instances where the other parent is disabled with psychiatric issues.

DR. COZZA: We need to add changes in parental ability, awareness, style and challenges to at-risk parents, such as prior illness or disability.

DR. ARATA-MAIERS: Are we talking about both the service member and the spouse?

DR. COZZA: Yes.

LTC SCHNEIDER: Where do we put that?

DR. COZZA: Under 1.2, change in parental availability, awareness and style.

LCDR KANE: Another problem relates to long term financial loss and career issues.

DR. COZZA: Yes, change in a family's financial status.

LCDR KANE: Financial resources.

DR. ARATA-MAIERS: And vocation as they are related.

DR. CHUN: When they get injured they also lose their combat pay, which is a double whammy.

DR. COZZA: So there is change in family constellation, roles and financial status.

DR. RICHTERS: Pre-discharge, there is a set of issues relevant to planning and preparation for the transition. With discharge imminent, the non-injured spouse may wonder, "What if I have to be the bread winner *and* a care taker?"

DR. COZZA: How about putting transition and long term impact under 1.5?

LTC SCHNEIDER: Would a program like this focus on the anxiety related to financial issues?

DR. ARATA-MAIERS: I believe that is somebody else's responsibility.

DR. COZZA: We are not focusing on the intervention, but rather on understanding the broad problems that families address.

LTC SCHNEIDER: Should our role include connecting them with resources?

DR. RICHTERS: Should we advise or give guidance on how to be proactive as resource seekers and recipients?

DR. ARATA-MAIERS: Regarding the vocational implications, if a National Guard member is injured, and their former employment involved physical activities, they are going to face a lot of change. Those who stay in the military may face job changes also. Both create anxieties and stressors for the family.

I added a fourth principle: combat injury is a challenge to our healthiest families requiring support at varying levels in the healthcare system and community.

DR. COZZA: I have included change in family financial/vocational status; changes that take place long term.

DR. COZZA: We can discuss barriers to care later. We have talked about four principles. I added a fourth principle: *combat injury is a challenge to our healthiest families requiring support at varying levels in the healthcare system and community*. This is kind of a PFA type principle. We also have discussed core problems for the families. We have not talked about specific strategies, just broad strategies to address them. Some methodologies have strategies within them, like PFA, the Parent Guidance Assessment Instrument, and FOCUS. Many of you have said you would be more interested in core principles and strategies as opposed to specific interventions that would obligate you to implement them.

LTC SCHNEIDER: Sometimes they are 100 percent necessary if they have outcome evidence to apply to a new population and can be validated in another. I am not saying it should not be part of what we are looking at, but it should not be a barrier to going forward.

DR. COZZA: It is not an obligatory intervention. It is a development of an intervention that would be available for use and study, but would depend on resources and resourcing.

Project FOCUS: UCLA and NCTSN

DR. COZZA: I would like to shift to project FOCUS and use it as a jump-off point for discussion of intervention for injured veterans.

DR. LESTER: Bill and I are going to present this together. Project FOCUS, with its own version of core principles and components, is the collaborative effort of the UCLA Center for Community Health, UCLA Trauma Psychiatry, and the National Child Traumatic Stress Network (NCTSN). Bill and I work at the National Center developing a work group on family-centered interventions for child trauma. We worked with Bob Pynoos to develop and adapt this intervention from our existing ones. The UCLA Center for Community Health develops, evaluates, and disseminates prevention and treatment interventions for high-risk and traumatized children and families. We have a large profile in families affected by HIV as well as other kinds of high-risk children. We work with communities, international and national, to adapt and integrate these interventions to make them relevant to their communities.

You are familiar with NCTSN, and the SAMHSA funded Traumatic Stress Network. Over the last four or five years, working closely with the National Center, we have integrated some of the strategies and methodologies into our work at UCLA Division of Child Psychiatry. UCLA Trauma Psychiatry, originally developed by Bob Pynoos, has done consultation and intervention services nationally and internationally. We have collaborated to integrate some of the traumas, like the medical trauma toolkit, developed for physically injured children and their families into our services. I run a Child and Family Trauma Clinic, and Bill co-runs it with me one third of the year. Our trainees go through this clinic. While they circulate on our service, they are trained to use the trauma toolkit. They do psycho-education for all physically injured children including those felt to have high levels of traumatic exposure, such as transplant and cancer children. Those who are experiencing high levels of distress are referred to the clinic to receive more intensive evaluation and services of which FOCUS is one. When I give this talk, I usually have to set the

We developed this intervention with a specific interest on how trauma affects parenting and family functioning. So, it is applicable for physically injured parents with co-morbid psychiatric problems, or people just dealing with combat operation stress.

context for the challenges facing military children and families.

We developed this intervention with a specific interest on how trauma affects parenting and family functioning. So, it is applicable for physically injured parents with co-morbid psychiatric problems, or people just dealing with combat operation stress. It is not just a deployment support intervention. The military does those things, for example the Fleet and Family Service, very well around the deployment cycle. We were really interested in what we could bring to families at higher risk.

I normally summarize that we do not know a great deal about the impact of wartime deployment. We know that military children look good compared to non-military children in the study, a community based sample. Military children usually experience some level of transient distress around one war-time deployment cycle. Certain groups appear to be at higher risk — boys, younger children, children with prior mental health or developmental problems, particularly children with caretakers who have high levels of distress.

One of the most interesting findings from Doug Zatick's work is that among children who sustained physical injuries, one of the strongest predictors of PTSD is prior trauma in the parent. Parent functioning, their prior mental health functioning and their experience with trauma, are relevant factors to how their children are going to do long term. There is also the emerging data about child maltreatment, primarily an elevation in neglect, from the impact of repeated deployments.

We really looked at what we knew about parent emotional distress and child adjustment, which is that they typically track together to tease out what are the aspects of parent adjustment? We know parental depression, in particular irritability, important in PTSD, has a strong negative predictive affect on child adjustment. Then we looked at the literature on non-combat traumatic stress and parent and child adjustment. We are still doing some of this work around one of my community-based samples and finding that it is not avoidance or re-experiencing that predicts parent and child conflict, but rather symptom severity across domains. In my HIV positive and neighborhood moms with trauma, parent and child conflict seems to be the most powerful predictor of poor child adjustment in the family.

We tried to develop an inventory of the components of PTSD and its impact on parenting. Avoidance and emotional numbing have been talked about in the literature, and there are separate studies to support them. It is difficult literature because everybody uses a different family measure, draws upon different parenting literature, and finds slightly different variations. The idea exists that parents can be either highly authoritarian and over-protective or avoiding with poor monitoring. Both things can occur.

This is our model. To some extent there are baseline moderators — the events that happened to the military personnel and the kinds of problems we have talked about today such as parenting challenges, changes in family atmosphere and roles, financial problems, relational changes. Our interventions are targeted at those mediating factors with the hope of having an impact on child, spouse, and service member adjustment over time.

We collected a great deal of data when we went to Camp Pendleton three or four years ago. The research revealed that people would be more likely to seek services for their kids than for themselves. Even divorcing parents might be willing to do a parenting intervention. This is a gateway to getting people

Dr. Beardslee's intervention for parents with a serious mood disorder is the only family-centered intervention in SAMHSA's National Registry of Evidence-based Programs and Practices. Its results, based on long-term longitudinal randomized control outcome data, show it increases understanding of parental illness in the family.

in to be assessed, to do some early intervention and do prevention for the family.

To Chris's point, this is not just a recovery model. It could be used to support ongoing readiness and is useful for multiple deployments. How do we need to change and shape our interventions with that in mind? This may be less relevant for the injured population as many of these people are leaving the service or not going to be deployed again.

Dr. Beardslee's intervention for parents with a serious mood disorder is the only family-centered intervention in SAMHSA's National Registry of Evidence-based Programs and Practices. Its results, based on long-term longitudinal randomized control outcome data, show it increases understanding of parental illness in the family.

DR. BEARDSLEE: I had two active interventions; one with lower intensity and one with higher intensity.

DR. LESTER: Yes, and both groups got better to some extent. The intervention I have worked with is called Project TALC, an intervention for parents with HIV and their adolescent kids, which has been used with children of different ages in different countries. A randomized control trial in New York that took place early in the HIV epidemic, when it was thought to be a fatal illness, had a bereavement component. There are many similar issues such as dealing with the parent's chronic illness, change in function, change in roles within the family, and hospital exposure to parental physical decline.

This was a 12 week family intervention involving parent groups, kid groups, and then combined meetings. We had positive outcomes in parent and child emotional adjustment, risk taking behaviors, self-esteem, and a decrease in early child bearing in the adolescents as they aged into young adulthood. At six years, the adolescents were more likely to be in school, to hold a job, less likely to abuse alcohol and more likely to be satisfied with romantic partners. We even enrolled the grandchildren in this intervention, and we found they were doing better also.

DR. COZZA: Did you have a specific model you used around protecting from medical exposures?

DR. LESTER: In its original incarnation, TALC was not trauma informed. It had Irwin Sandler's bereavement modules in it and integrated some of Bob's work, but it was not trauma informed regarding the exposure to medicine. We have integrated that because we found, in terms of mental health problems, PTSD was the biggest problem for those teenagers. Now we have a rigorous assessment for it. It is less of an issue now as parents are not hospitalized very much.

DR. COZZA: Did you have educational materials around exposure?

DR. LESTER: We do now. We also have educational materials on how traumatic reminders may interfere with treatment adherence, going to the hospital and taking medications. Project FOCUS itself used to be called 'Families Overcoming and Coping Under Stress'. We learned that coping was a little low-functioning for some of our military partners and that the term overcoming was better. Our group, NIMH, and Mary Jane Rotheram who developed Project TALC, spent a lot of time on the NIMH intervention core component workgroup for preventive interventions. We agreed that you cannot replicate the manual everywhere to make sure it is truly evidence-based. We cannot do that with HIV because it is a changing epidemic. When you go to another

If we learn that Dad is barking orders and treating his children like little Marines, we address that. We do a lot of problem solving with the family, developing a family plan that addresses their specific difficulties, and building support within the family and within their community.

country, you cannot do the same intervention. So, how can we know what is robust and what really works about our interventions? They reviewed all the RCT, having at least one RCT in positive outcomes, and came up with a list of what they considered the robust components of preventive intervention. They called it ‘framing the problem’. It is putting the issue in a context, doing cognitive behavioral skill building. You see our list: Communication, Problem solving, Goal setting, and Emotional regulation skills, Dealing with environmental barriers, and Building social support. I believe I am missing one. We took those and integrated them very systematically with Bill Beardslee’s intervention and tried to change it from a group model to an individual family model. With these issues, we felt groups would be problematic, especially in the military.

We took trauma-informed, developmentally appropriate psycho-education, much of which is embedded in PFA and in the work from the network. We do family level skill building, which are typical CBT skills, but done at a family level, taught both to the parent and the child, and then done together. These are integrated across all the sessions, as needed by the family. The systematic piece is that the family develops a narrative time-line that Bill will demonstrate. We agree that parents can not do this work with their children until they have reflected on their own experiences.

The first two sessions are parent sessions in which they are asked to reflect on what this experience has meant to them, how it has affected their parenting, their relationship and their functioning. Only then can they turn and attend to the family issues. We linked skills to the family’s particular experience. This is not handing them information, rather linking specific skills and information to what they are experiencing. We do an assessment piece before we start. If we learn that father is having reactivity to reminders such as driving fast, and swerving whenever there is bag in the road, we will spend time talking about reminders. If we learn that Dad is barking orders and treating his children like little Marines, we address that. We do a lot of problem solving with the family, developing a family plan that addresses their specific difficulties, and building support within the family and within their community.

DR. SALTZMAN: As Patricia said, the architecture of this is based a lot on Beardslee’s work. We have a series of parent-child, parent and family sessions. We start by engaging and assessing the parents to learn their concerns, what they want and what they are the struggling with. We have great tools to help them develop very specific goals that they would like to achieve through participation in the program. It is important to frame what is doable in this brief span of time and what they hope to accomplish later. We also start the parent piece of work. We want to help them process what this experience has been like. The separation in the deployment situation creates many opportunities for different experiences on the home-front and in the field. Frequently there are not mechanisms or opportunities in the family to talk and bridge those differences.

In the first couple of sessions, we provide opportunity for parents to graph out their individual timelines, their experiences of pre-deployment, deployment, and post-deployment. It is a graphic means of mapping these experiences in terms of their reactions and levels of distress. It is an important first step to getting these parents to lock arms, so they can work more effectively as parents. By the time we finish those first sessions, we have the parent narra-

Key events we have learned from the parents constitute the flow, and the methodology we use to get these narratives is based upon their developmental level.

tives and goals. Then we move to the child sessions. In those sessions, as with the parents, we are weaving together psycho-education about the program, but also about normative reactions to the difficulties they are contending with — multiple deployments, combat related mental health problems, or injury. We are working with the children to get a sense of what their experience has been across these multiple deployments as well.

DR. LESTER: We have a developmentally different task for younger children versus older children. As every child provider knows, children do not have the greatest timeline in their head for events. We actually do this timeline on the floor. It looks like a game board with pre-mapped-out pathways and nodes of critical moments that we have learned from the parents. We have them do it that way around eight or less, depending on their developmental level.

DR. COZZA: Prompting the child based upon the parents' input into the family's experience?

DR. LESTER: Yes. It is mostly chronological, i.e., your Dad's first deployment to Iraq, your Dad's hospitalization.

DR. SALTZMAN: Key events we have learned from the parents constitute the flow, and the methodology we use to get these narratives is based upon their developmental level. We have this Candy Land-like track in which the key events are linked. They can put in the ones that were important to them, but they also have the opportunity to draw pictures of the different experiences and incorporate that into their graphic representation of what this experience has been like for them.

This is geared towards preparing for family sessions in which parents can share appropriate portions of their experience. It is important for the kids to talk, share their experience, their concerns and their questions, and even the artwork they have done. Sometimes we do these child sessions individually especially if there is big spread in terms of the age, special issues, or sensitivities that individual children might have. Or we can do them together, which presents some real advantages.

DR. FULLERTON: Did you ever do it where the child mapped it out, and looked to see what was salient in the child's memory?

DR. LESTER: We do, if they grasp the chronology. If you do it with teenagers they can do that. When you map them together, it is very informative.

DR. SALTZMAN: Yes, and often there is a difference between what the children and the parents consider important or traumatic. The next piece is getting back with the parents, so they're not blindsided by any of the questions that might arise in the family session. Our goal is to empower the parents so they can take a leadership role and respond appropriately to their children's questions and concerns.

DR. RICHTERS: When you have the child-only sessions, what age ranges are we talking about?

DR. LESTER: Six up through eighteen.

DR. RICHTERS: How do you deal with confidentiality?

DR. SALTZMAN: It is with the child's permission. We make it very clear, and we ask for permission for which parts they feel is okay for us to share with their parents. Sometimes they do not want to talk about some of the things that are important to them. We go with what they're comfortable with. After a couple of sessions with help and structure, they able to share some things they

The question of confidentiality is really important. What you're modeling for the family is that different people can have different experiences and they can choose to share them or not. If they do choose to share them, it's probably because they mastered them somewhat, or they feel safe to share.

initially felt uncomfortable about.

DR. LESTER: Most of the younger children want to talk to their parents. I do not think we ever had anybody say, "No, I don't want to."

DR. COZZA: Is it because they do not know how, or they just need somebody to facilitate it?

DR. LESTER: My sense is there are a lot of unwritten rules about secrets in families. There was an eight-year-old girl who said, "I know my Daddy's sad, and I'm really afraid." We then asked, "What are you most afraid of?" Her response was, "I'm afraid he's going to get mad, and he's going to hit me." She didn't feel permission to say that to him, but she drew it on her map, and she wanted to share it with him. He was stunned that was actually on her mind. He had never hit her, but he was able to think about it and respond to it.

DR. BEARDSLEE: That is a good illustration. The question of confidentiality is really important. What you're modeling for the family is that different people can have different experiences and they can choose to share them or not. If they do choose to share them, it's probably because they mastered them somewhat, or they feel safe to share. Very simply, what does it take for a family to be able to have a meaningful conversation that ends well about an event that is potentially very difficult or traumatic whether about deployment or depression.

DR. LESTER: There are things that we do not want the military member to be talking about with their kids. Part of the parent conversation is making those decisions in a thoughtful way about what makes sense in their family.

DR. COZZA: A structural element should be part of this too, in terms of appropriate boundaries, i.e., what could be talked about, what the roles are and who takes care of whom.

DR. BEARDSLEE: In our original work, we would say to parents, it is not as important *what* you say as it is that you decide to *say the same thing together*. You are sharing with them the idea that parenting involves working out these differences and then it involves thinking about the child and how to present it.

DR. SALTZMAN: It is a type of boundary making within the family that is important. From a structural family point of view, we are helping to comprise the parent subsystem so there are certain things that are appropriate to discuss, and in a way such that they support each other and are clear. Then we decide together what they bring to the family session.

DR. BEARDSLEE: One other point. When I started to do this work in the late 80s in Boston, I thought that families always had meals together, that they talked about everything, and we were adding in a little bit of a conversation about depression. Then we found that many families, particularly with adolescents, do not have meals together and do not talk about anything. When you raise the question about permission, it may be that there is no occasion to talk about any of these things because everybody is busy. It is hard to talk about certain things. So the occasion arises to have a meeting, and it becomes an important event.

DR. SALTZMAN: All along the way there is homework that is assigned to try to start building in some of the types of interaction that we think will be supportive to the family being able to have conversations together. This can be family assignments, having meals together, or doing certain activities and certain specifically structured, fun things that we have in our appendix.

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DR. RICHTERS: Are older adolescents alright with these exercises?

DR. LESTER: We have not had many older adolescents doing it within the military. We have older adolescents doing it in our clinic around other kinds of issues. Yes, they will do it, if they choose. Our approach with all these interventions is to provide the facilitator, trainer, or counselor, with a variety of tools they feel comfortable with that fits this family, but that also fulfills the core principles, and that the family chooses. It is not like everybody has to do this assignment. I do not think that works very well.

DR. COZZA: Do you include younger children, under the age of six?

DR. LESTER: When families have brought them and there is nowhere else for them to go, we have included them and they have done just fine. We give them some role or activity. They have been part of the conversation in their own way, but we find we cannot really do a narrative timeline with them in the same way.

DR. COZZA: Even just sitting with siblings, even if they do not necessarily participate. For example, if you have a younger sibling, like a five year old or four year old, with a seven or eight year old.

DR. LESTER: As long as they are not really distracting,

DR. SALTZMAN: We have done some of that in which the younger children are witnessing and watching the family have a conversation. That type of modeling and interaction of a supportive and appropriate way of talking to each other is not lost on them.

DR. FULLERTON: Or simply the fact that they are included and not left out regardless of what they understand.

DR. COZZA: In relation to the population we are considering, there are so many issues like child care that impact decisions like who gets brought to the appointments. The other question related in terms of structure is, do you ever see parents alone?

DR. LESTER: Individually? Yes, because in some families there is only one parent.

DR. COZZA: If there are two parents, do you do that?

DR. LESTER: If our assessment reflected that somebody had, for instance, a high level of traumatic stress or severe depression, we would see him or her alone.

DR. COZZA: I understand the importance of seeing the parents together and the strengths that it builds toward developing the parenting relationship. As we think about the injured, and the availability both cognitively and practically, we think about how to apply these principles to this population.

DR. BEARDSLEE: That is a very good point. There are the important issues about transparency and confidentiality. They are going to be working with two parents inside and I am going to see this parent alone. Whether availability or medical treatment precludes the other, the aim is to include the whole family. But then you make practical decisions based on what is possible. Where you get into trouble is working with one parent when the other parent either does not know, or know what it is about. We had some amazing experiences including younger children. We let parents bring whomever they wanted. We measured kids eight to fifteen, and I do think young children are enormously attentive to feeling tone. They know when people are irritated and they know when people are trying to communicate well. They can pick up on that so they can gain a lot. I agree with Tricia. What does not work is having

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someone (not to be sexist) like a young, hyperactive boy who just cannot sit still. We just finished a Latino adaptation for our project. One of the families had an older girl and a very lovely, but very hyperactive, boy. We ended up doing an individual family meeting with the girl and the mother first, and then including the boy, the mother, and the girl second. The communication was different, but it worked. The second meeting was a little shorter because the boy was about six.

LTC SCHNEIDER: Are these weekly?

DR. LESTER: We do them weekly. I think that is best because there is an opportunity to integrate. When the family can only come a few times, we had two people. One met with the kids, one met with the parents, and then we bring them together.

LTC SCHNEIDER: With Steve's plan of a hospital-based intervention for injured families, eight weeks for that age group might not be possible.

DR. COZZA: Yes. The challenge is how to integrate the core principles as it applies to this population recognizing the logistics of specific populations.

LCDR KANE: How were these military families selected? Do you just do it for redeployed families?

DR. LESTER: We did this at Camp Pendleton. Either there was a parent who was in treatment for combat stress or whose wife felt he needed to be in treatment for combat stress, or a pediatrician who was worried about a child's reactions.

LCDR KANE: Were they clinically flagged?

DR. LESTER: Yes.

DR. FULLERTON: What about alcohol or drug use?

DR. LESTER: We did not exclude people for that. If they had active substance abuse making it made problematic for them to do this work, they would be referred for treatment. Getting back to the issue of skills, we think families enjoy the skills. When we use timelines, we introduce them to 'feeling thermometers.' We introduce children to them. It is a very safe and structured way for them to talk about their fears, worries, and feelings. As they are building their timeline, they are actually doing it on some indicator of stress. We teach them awareness of their emotional and physical reactions. That is one of the ways emotional regulation skills are integrated.

LTC SCHNEIDER: This does not sound like your typical model of consultation. What you are describing is very problem oriented and skills based, rather than diagnostic using RVUs and CPT codes.

DR. LESTER: This is like our community-based prevention. There is a risk group with whom we do skill building and resiliency building. Certainly there are people with diagnoses who participated in the intervention, but that wasn't our goal. We are going to do this for the Marines and Navy at four Marine installations and three Naval sites. Once we have done that, we will have a better sense of uptake based on referrals. We had very few dropouts. One, who could not come for one session because of having no gas money, came the following week. Engagement is the challenge.

DR. BEARDSLEE: We also had relatively few dropouts. Two things may account for this. One is that it really is strength-based and not pathology-based. It's about people acquiring skills and recognizing strengths. Emphatically, for most members of the family, it is preventative. It is prevention for the children, the spouse and even for the person who is identified as having a

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problem. Working with non-dominant cultured families, we have found that a prevention-orientation and strength-orientation is perceived as more tolerant.

DR. SALTZMAN: Once the parents are on board with the family session and the children are prepped, we come into a series of family sessions in which the centerpiece, especially for the initial couple of sessions, is the sharing of the mutual marriage goals in whatever format they were developed. This can be a wonderful experience for the family, and this has been Bill's experience also. There is a sharing of things not shared before, an appreciation of the individual differences and the individual who has been struggling. In the process, the family is identifying the current issues with which they having difficulty. Through that, we map out the remaining family sessions in which we focus on the family skills.

We are doing this throughout, but this is a good opportunity to have the whole family together, to problem solve, to identify mutual trauma, or loss reminders. Then there is a list of specific skills on more of a menu basis that they can select from and spend a flexible amount of time addressing. That way, we have some characteristics of an adaptive intervention in that we can mix and match, and go with what they need.

We have adapted this program for multiple populations. One of the populations we will be working with is the Naval Special Warfare Group, the Navy Seals in Coronado Beach and in Virginia Beach. Because of their rapid deployment cycling, and their huge training demands, it is unlikely they could go through all eight sessions. We are looking at these clusters of sessions as pieces of work that can be done independently.

DR. BEARDSLEE: In the latest interventions we did with Latino families, we described the work in modules rather than in sessions. So they could take a couple of sessions to do module one, which was family history and psycho-education. Module three might be seeing the child. Doing the pieces in different order gave us more flexibility. You might have a family that work with for a couple of months, and then a couple of months after that.

DR. SALTZMAN: We have both adapted this approach working with first responders in the Hurricane Katrina area. Using funding through Robert Wood Johnson, each of the sessions has to be almost stand-alone or a piece of work. We were not sure if they could continue. That is how their training works. As Bill was saying, a module can be delivered that focuses on initial engagement, assessment and goal setting with psycho-education. Then you can do just another piece or module and focus on coping skills. If there is time, you can do a separate piece which is more of the narrative work from both the parent and child standpoint. It can be flexible, although, the sequence does have value to it. Some things can be lost, but given the circumstances, it still can be a good piece of work.

The figure on this slide (see Figure 2.1) is what we call just the timeline. On the horizontal we have the key events. In this case, we have multiple deployments, plus the time in between in which they rotated. On the vertical dimension is the degree of the intensity of the stress that the event had in terms of their individual reactions to the different events.

DR. COZZA: When you use the thermometer, do you say, rate your stress, or what do you?

DR. LESTER: We call it a 'feeling thermometer'. In this case we ask how stressful the event was.

After this third deployment, and coming home, the first thing we see is an up-tick in the distress as reported by the parents. This was also accompanied by pronounced marital conflict. By the time they are coming to see us, there is also talk about possible divorce.

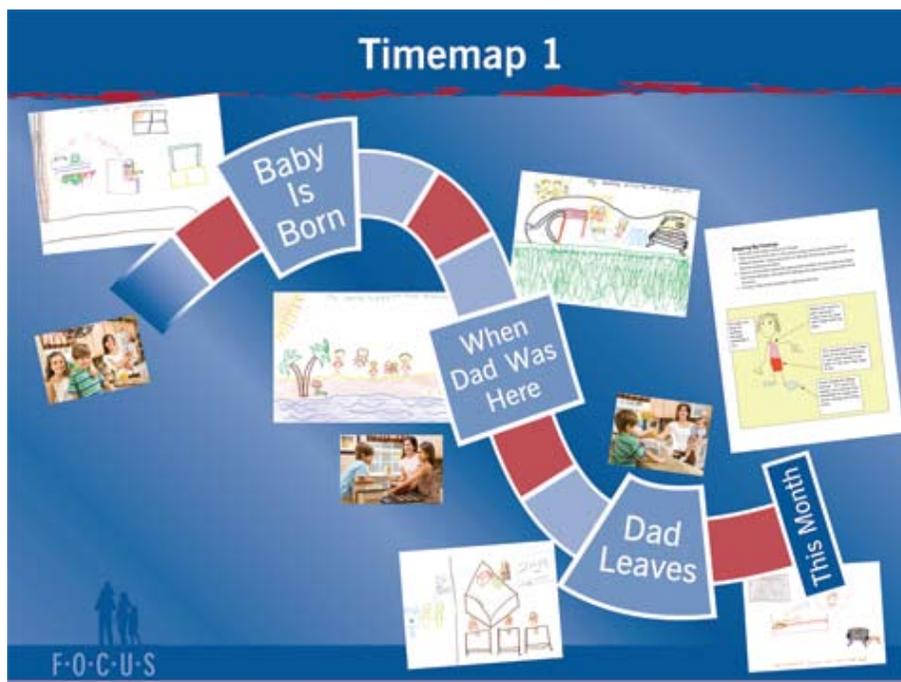


Figure 2.1: Timeline of Key Family Events.

DR. SALTZMAN: In current versions of the timeline, we actually have a thermometer on the left side of it, so they can rate it in terms of low, medium, or high level of stress. So for the first piece, this is a composite of both parents own narrative. In the initial sessions we get individual narratives from each parent. The interesting part is to work out the differences between them. We want them to be able to discuss the differences, and then have a shared understanding and experience of what the multiple deployments were like.

What you are seeing now (see Figure 2.2) is a more simplified version of the shared experience between the parents. So, pre-deployment with this composite family involved some stress, and some of it was happy stress with the birth of a new baby. The difficulty was that just two weeks after the baby was born, the father was called for his first deployment. It was a WESTPAC training tour, so he was in communication. It was not a huge wartime deployment at that point. He came home, and things were great until a few weeks later when the war started. He was called up. He came home tearfully saying, "I am going to war in two weeks."

DR. FULLERTON: So that was at the point where he knew he was going. What about the anticipation two weeks before leaving?

DR. SALTZMAN: Exactly. The stress for the parents was really ramped up tremendously in the preparation. There was, in fact, a painful goodbye in which the part that was most salient to the Dad was when they went to the bus. When they get on the bus, his son, Adam, would not look at him. He just turned away, and he interpreted that as he hates me. So that was what he carried. During the deployment, he was out of touch by and large. Mom watched the progression of events on CNN, which was stressful for everybody. Mom told the kids that Daddy had a desk job when in fact he was a Marine on patrol going outside of the Green Zone.

Coming home, after that wartime deployment, you see a little up-tick in terms of the initial stress. That is because he delayed his homecoming. He vol-

We asked one family to make a family plan. They said, "We don't plan. We are going strawberry picking this afternoon. We know that at any moment he/she may be redeployed, so we wake up and appreciate every day."

DR. LESTER: She was worried that her house could not be safe or truly protected without her Dad there.

DR. SALTZMAN: Those are some of the main differences from the children's point of view that could be brought into the family sessions. This is not an exact science, but rather a tool to graphically show the differences for the family sessions. This is subjective looking at broad global differences between their experiences. In terms of therapeutic outcomes, sharing these individual experiences can increase the appreciation of each person's challenges, such as the parents appreciating what was stressful for their children.

This intervention certainly supports more open communication and sharing of worries and fears. For many families, not just military families, there is a culture in which you suck it up and you do not talk about things. Here, we want to provide a structured and safe way for the family to talk about concerns, worries, and fears with the expectation that it is okay to do that with their family. If the family together can identify individual cues, triggers or reminders that are difficult for them, and which can prompt Dad being irritable or the kids having a difficult time, that helps them to anticipate these things and to plan ways they can support each other appropriately. Parents work together to monitor their interactions and maintain consistent routines. Mom can track Dad when he starts using his voice that upsets the children treating them like they are little Marines and coming on too strong. Or, Dad can stop Mom from leaning too much or confiding too much in the older child, which was the case here, so she can pull back from doing that. The overall approach is to develop positive coping skills to address challenges and to mobilize the family to support each other and to build a team approach to dealing with these challenges. This is a key part of hardiness and family resilience.

DR. RICHTERS: Does the photograph at the end depict a victory?

DR. LESTER: They are not throwing up their hands in despair.

DR. SALTZMAN: All of our families end up in that same position.

LTC SCHNEIDER: Is it mostly Marines that you have worked with so far?

DR. LESTER: We have done it with military and other families.

LTC SCHNEIDER: If it was with Marines, most of whom were young and male, my guess is that they took to this model pretty readily because it utilizes the military team building and training focus. That would be very much inculcated into the military culture of a training module and a team building module. Kind of like, you got your war experience; well, this is my family's war experience. We have our own war story.

DR. RICHTERS: Is that not also true of Army?

LTC SCHNEIDER: Yes, but Marines are notorious for pooh-poohing any kind of treatment based stuff.

DR. SALTZMAN: In fact, we decided to call our counselors "trainers."

DR. LESTER: Our Marine partners felt that we should call them their RTs, Resiliency Trainers.

LCDR KANE: When you involve the Marines, is it going to be with everybody who is deployed or is it going to be clinically indicated?

DR. LESTER: It is a service program, not a research protocol, so we will take who they refer to us. But the indication is somebody is having higher levels of distress.

MS. WILLIAMS: Going back to how to incorporate the younger children,

We ask them to reflect on their child's experience of the deployment cycle or the traumatic event, which they can do.

I wonder about the possibility of going through a timeline with the parents to get the child's perspective of the events.

DR. LESTER: That is absolutely the way to go with parents of younger children. Sometimes we do that with parents who are so conflicted and angry they are not able to reflect on their own experiences in front of each other. We ask them to reflect on their child's experience of the deployment cycle or the traumatic event, which they can do. With Shelly McDermott's group in Indiana, we have a proposal to do this with the National Guard for couples.

DR. ARATA-MAIERS: Did you have a group of service members who were again going to be redeploying, and did you notice if there was any difference in the things that you addressed with that group?

DR. LESTER: Yes. One family stands out. We asked one family to make a family plan. They said, "We don't plan. We are going strawberry picking this afternoon. We know that at any moment he/she may be redeployed, so we wake up and appreciate every day." In a way, it was a kind of plan. For those of us who treat child trauma, what is different now is that we are focused on recovery. This prevention skill model helps families become better at dealing with their ongoing challenges.

DR. SALTZMAN: It puts in place certain skills that they can really draw upon to help with readiness. This provides support and is appropriate.

Practical Application and Components of Effective Interventions

DR. COZZA: We will now address the following questions:

- How do you take these principles and apply them in the unique injured population?
- What modifications do we need to be thinking about?
- How do we address the lack of consistency in terms of family presence?

Refer to the handout, *Session Two, Practical Application and Components of Effective Interventions*.

The conclusions that we have drawn have been based largely on the work with colleagues at Walter Reed, directly or in collaboration. It is helpful to leverage our developing intervention on much of the family FOCUS work that was just discussed recognizing that the injured population is a very unique population. We feel there are multiple distinct and different problems that need to be addressed, and in many ways are more complicated than those that are addressed as part of the regular deployment cycle. This is a complicated deployment with profound family effects that are disorganizing and disruptive, and the families need significantly more support to manage their injury experience. The injury experience itself is unique to the family and varies depending upon the nature of the injury, the structure of the family, the developmental level of the children and the expected outcome, treatment and rehabilitation process.

When we submitted a grant proposal with Bill and Trisha last year, we had developed an intervention model that was focused upon the similar, session-based approach family intervention. We realized that we needed an intervention that is modifiable and allows for an individual and appropriate structure for the family at any particular time.

The other qualities are that we are constructing the model based on specific sessions that may have varying modules within them, but are more related to the timing of the intervention as well as the participants of the intervention.

The injury experience itself is unique to the family and varies depending upon the nature of the injury, the structure of the family, the developmental level of the children and the expected outcome, treatment and rehabilitation process.

So you will see that we have an engagement and assessment session that is a parent only intervention. We use the Parent Guidance Assessment Inventory (PGAI) as part of that to frame the understanding and to develop the relationship with the family. You have a copy of the PGAI in your packet as well. In addition to that, there are several other sessions. One is a child mastery session to engage children of the injured service person and others individually. We need to recognize the fact that many children do not come to the hospital. When they do come to the hospital, it may be at times when they are not clinically available, such as on weekends or during holiday periods, which makes it difficult to engage them.

There is also a parent guidance session. The idea is using a session and leveraging much of the family focused activity into parent guidance approaches, as opposed to necessarily working directly with the children or with the family because they may or may not be available. The other question is within the context of the narrative and the use of the narrative: at what time is it appropriate to be considering that? Is it post deployment or between deployments that it is stabilizing in its ability to organize the event? Part of the question would be, in the midst of the experience and the hospitalization, would it be similarly organizing or would it be overly anxiety provoking for the family or for the children? These are the sorts of issues we are struggling with. How to pull it together in a way that is effective for this particular population based upon the problems discussed this morning. Would a family mastery or family transition session focused on the near discharge timeframe, and then family sustainment sessions, address the specific needs of families in the longer term? I am particularly interested in how we would apply the principles Bill and Tricia described to develop our intervention.

DR. SALTZMAN: Our work can also map onto your architecture — your parent session, child mastery session, and the family mastery.

DR. COZZA: We do not want to develop so specific a treatment that we limit it to 20 percent of the population who are there with their children and not enlist the injured service member parent to participate like the earlier example of the recently deployed parent. How do you then pull it together in relation to parent guidance approaches? Let us look at the PGAI to see those discussions and how they are developed. Much of it is information gathering, but it is also information gathering within the context of the clinical relationship. It gives the clinician the opportunity to help organize the experience for the spouse of the injured service member.

DR. LESTER: What level person is going to be doing this?

DR. COZZA: We have had independent clinicians with at least a master's level. Child trained independent clinicians have been implementing this.

LTC SCHNEIDER: They are social workers in a specific Child and Family fellowship.

DR. ARATA-MAIERS: We are doing it at BAMC. We call it something different. We are having the pre-doctoral interns do it who are on a child rotation. They may not have an extensive background in child psychology, but we train them beforehand and supervise them as well.

DR. SALTZMAN: Would you administer this or have your clinician administer it, and what are the next pieces of work?

DR. CHUN: The critical period, the window, is something that applies to this work. After a few sessions with the parents, I suspect that the family feels

The critical period, the window, is something that applies to this work. After a few sessions with the parents, I suspect that the family feels comfortable and safe enough to open up some of these painful experiences.

comfortable and safe enough to open up some of these painful experiences. You have to have a significant amount of therapeutic lines already developed. When we introduce this assessment, it is not about assessing them. It is for us to develop skills. They are teaching us about their own experience.

DR. COZZA: It is not an assessment in the sense of a quantitative measure. It is aimed at getting a sense of a parent's sensitivity and the needs of the child. For example, just simply asking a parent if they have talked with their child about this injury and what was said can be an important way of understanding, not only the way they integrate the experience for themselves, but how they organize it and present it to a child. All of this reflects a level and kind of parenting capacity under stress. That is an example of this assessment.

There is also an opportunity to engage them educationally and guide them. You have talked with your 12 year old, but you decided not to talk with your five year old. What were your thoughts? I did not realize that that was something that they needed to hear. It opens up the opportunity for the clinician to talk with the parent about the needs of the child; what that five year old may or may not already know and what they've picked up on. Are they at the hospital? What is happening in the family? It is intended to help broach sensitive subjects with a parent in a way that allows them to continue to parent effectively or to be able to engage that child in an effective way. This helps to open up conversations around the following questions. Where do you think this is going? Have you talked with your child about coming into the hospital? Have you thought about what they might see? Can you insure that they will be protected in the hospital setting? It is clinically driven, but it has a structure to it.

DR. SALTZMAN: Over multiple sessions, multiple meetings?

DR. COZZA: It can be.

DR. ARATA-MAIERS: In terms of selling this as something we are going to be doing systematically in the hospital setting, we did not emphasize the assessment aspect of it to the other providers and to the patients. The reason is that they are being assessed extraordinarily for everything. If it is just another assessment to be filed away somewhere and someone is going to write a study on it, their investment in getting involved is significantly less, and the investment of the various services in letting us do it is less. So even though it is an assessment, we should present it as a clinical instrument primarily, even though it has other dimensions to it.

DR. LESTER: My impression is that when you administer this and hear the responses, you are integrating guidance for them as well?

DR. COZZA: Yes. It is not a structured interview from which you cannot deviate. It is intended to bring up topics that would require some awareness of how to address them apart from what is listed on these pages.

DR. LESTER: That is the ancillary piece that requires expertise and experience to know how to answer or highlight, so that it can be translated?

DR. COZZA: Yes. We would start with instructions. They do not fill it out. It is a guide to the clinician in engaging the family.

MS. VINEBURGH: Knowing that the ultimate goal is to engage the parent/family, and knowing the tremendous anxiety level that families have initially, might there be consideration to creating the PGAI in a way that it becomes a family plan? While we are gathering this information, this is also for you. That is creates a stepping stone to obtaining resources for the family.

We have heard from a number of people that this is the first time they have had a chance to just talk about what has happened. Up to then, it has all been about what happened to him, as opposed to what has happened to me and to the family.

DR. RICHTERS: We have discussed this, and there are some questions at the very end that specifically ask about what the family needs.

LTC SCHNEIDER: Part of the reason this was initially created at Walter Reed was for us to help the families understand what was going on. Rather than rushing in and presuming we knew what people needed, we were trying to go in and understand what people were really experiencing. That way, we could tailor what they needed to what was actually going on. But we found there are interventions that go on in the process of doing this.

DR. COZZA: One of the most interesting findings is that it really does serve as a way for the spouse to organize the experience for himself/ herself. We have heard from a number of people that this is the first time they have had a chance to just talk about what has happened. Up to then, it has all been about what happened to him, as opposed to what has happened to me and to the family. I like the idea of thinking about how you can translate administering the PGAI, both as an observation and respect for the experience, into some sort of skill building opportunity for the spouse.

DR. NEWBY: Often when you see families of injured soldiers and you are trying to engage them, they are under so much stress and anxiety they do not hear a great deal of what is being said. Therefore it would be helpful if there were some kind of a take away from this. If it is summarized in some way then they could have a chance to read through it and reacquaint themselves with what may have taken place during the course of the interview that you had with them.

MS. VINEBURGH: Or that it becomes the first stage for them to consider their own plan. The interviewee becomes a partner. This is your plan, as well. We can build this together.

DR. COZZA: Family goal development is part of the goal setting.

DR. BEARDSLEE: Two things. The way you described it, it is very important that it is done in a window of opportunity, very sensitively in the context of a relationship with a lot of support. If any of the questions stump or upset the person, you stop and deal with that. That is exactly as it should be. It is a wonderful instrument for that. The observation that many of these parents have not had the chance to have a conversation about themselves and their children because it has been about the wounded warrior is a very important observation. Just giving people a chance to speak and talk about what they have been through often is very therapeutic.

People who have depression do not have good memories. They do not remember things very well, particularly positive things. We found ourselves being the historians for the families, i.e. we would have elicited something around how excited they were when the child was born or something that the child did, and could bring that back. You could do the same thing here. You could pick out positive parts of the story and highlight them.

In our latest iteration of our mandate for this Latino version, one question we did find useful at the beginning of each session was asking the family, "How are you doing right now; what's on your mind right now?" It is like a check in. "Is there anything you want help with right now, anything you're very concerned about?" It is another variant of being a partner with the family. You might think about a question somewhere in here, along the lines of, "Do you need help with something right now? What is your concern?"

My next comment is about a different developmental process. How do

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you go about finding an intervention that works? And you do it exactly this way, by starting on the ground with families. What is their experience? And then, if you went ahead and did a parent guidance session, that would be about psycho-education or the basic knowledge we have about how to guide parents through this experience. It would be like the first and second sessions of either what Bill and Tricia presented or what we do initially. You would be thinking about that as both reflecting the best of the best practices wisdom about how to guide parents, and then fitting it to their individual circumstances, such as their needs, the ages of the children, the circumstance of the spouse, and the time that you have, and whether somebody was leaving soon or not.

One of the things we found very valuable was to have two interventions of different intensity. We have a two-session intervention and a six or seven session intervention. In the two-session intervention, we just do groups of parents. Oftentimes you are not going to have time to do a six or eight session intervention with families, but there are going to be concerns about getting a history, recognizing strengths, and doing guidance.

DR. SALTZMAN: That is interesting. You said groups with the parents, getting multiple families together?

DR. BEARDSLEE: Yes. In our randomized trial, the comparison condition, which was an active condition, was two sessions with groups of parents doing basic teaching about what is depression, what is resilience, how do families cope with it, and asking and answering questions? We showed sustained effects from that intervention, as well. What I am saying is you try to get at what the family's experience is and how you can join with it in multiple ways. That is what you are doing by framing these sessions.

DR. MCCARROLL: It is really important to give people something to take away. This would be a marker where they were at that time, which people are not going to remember later. If somebody asks, "What did you tell the doc," they would say, "Well I do not remember," so being able to have something to take away is important.

DR. CHUN: It is also important to ask what they are concerned about right now, and something that possibly happened this week.

DR. BEARDSLEE: I agree, but I think there are actually some positive questions in here. We found the question that was the easiest and that people responded to the most positively was, "Tell me something good about your child. What are some of your child's strengths?" We have also found in working with a depressed parent, nobody asked them what was going on with their children. They can often rally and see some strength in a child when they cannot see any strength in themselves and certainly no strength in their spouse.

DR. SALTZMAN: Is the PGAI administered just to one spouse? Have you ever administered it to the service person?

DR. COZZA: Ryo-Sook, have you ever used the PGAI with the injured service person?

DR. CHUN: I have done it when they both are present.

DR. BEARDSLEE: Good, so they are both sharing in the experience.

DR. ARATA-MAIERS: We experienced that as well. The service member had seizures and the spouse was the non-medical attendant. We could not administer it unless the service person was present. What we found is that they started talking about their experience similar to what your narrative did. They started talking about how their experiences were different on certain

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parts of it. Comparing the experience of the service member and the spouse was therapeutic.

DR. SALTZMAN: So you would be able to compare notes in the session and find they have very different experiences in some cases, different views.

DR. ARATA-MAIERS: Yes. There was a sense of, "Oh, that is what you were going through," and, "Oh, that is what was happening with you," sort of thing.

DR. BEARDSLEE: When we started developing this I thought everybody had family meetings or meals together; however they do not. We were amazed that couples would have gone through these very powerful experiences such as hospitalization and never have talked about it, never have talked about what they shared in common and what was different. We cannot make the assumption that people have conversations about these things that are very much in the foreground, that separated them for months at a time, that people often do not talk about as a couple. It is very important and therapeutic to provide a context to do that safely.

DR. MCCARROLL: They probably do not because talking about trauma is difficult. The soldier does not want to expose the spouse to what they have gone through. Sometimes the spouses do not want to hear it. It is a very difficult ordeal.

DR. BEARDSLEE: I would agree with that. On the other hand, raising children together puts them in a situation where they do need to talk to each other.

DR. MCCARROLL: All I am saying is it is a very difficult barrier to overcome, particularly in trauma. There is the issue of protection and people who do not want to be exposed to it. So you have to break that down.

DR. BEARDSLEE: Right. I think the lane in here is what degree of conversations about these experiences is going to help the children? The lane in is not all about *my* experience, but rather *what part of my experience and what part of our shared experiences* might help?

DR. SALTZMAN: That is an important boundary: that you do not fall into the deep well of marital therapy, because you will never get out of it. It is a constant reframing about what you are doing. *This is for the children.* We are not here to solve their relationship issues. Then to keep framing it: how does this impact the kids? What do you think is important for them?

DR. MCCARROLL: They still have to feel that you are doing something. The spouse has to feel that you are doing something for them too. You cannot just put it on the service member or the child or the spouse. Everybody has to get something out of it.

DR. SALTZMAN: Yes, and they do. That process of just sharing their experience is a win/win because they are experiencing being heard by their spouse. That is huge. But then, they might want to start talking about all the things that they are really angry about, and it can evolve or deteriorate.

DR. COZZA: At some point, the injured are typically available to participate, although it may take some time. What becomes complicated with the injured is the issue about the timing of the intervention, especially around protective issues related to parent guidance about child decisions. If both parents are not available to participate and the spouse is available to talk about the child independently, and then have a conjoint discussion.

Another challenge is the non-injured spouse who does not want to share

Another challenge is the non-injured spouse who does not want to share things because of the amount of difficulty, pain, or medical problems of their spouse. A spouse may be extremely reluctant to come in and start talking about the degree of pain they have and the worry their family has while dealing with major illness or injuries, such as amputations, TBI.

things because of the amount of difficulty, pain, or medical problems of their spouse. A spouse may be extremely reluctant to come in and start talking about the degree of pain they have and the worry their family has while dealing with major illness or injuries, such as amputations, TBI. The non-injured spouse is concerned about overwhelming the other spouse with the information, rightly or wrongly. I think there is another issue: not just, I'm worried that I'm going to upset him, but a need to be in charge. How can we be helpful with all of this?

DR. BEARDSLEE: Also, the non-injured spouse may need both a forum to talk and guidance about what to do with the children before the injured spouse can participate. You all are very sensitive to the experiences of these families. The fact that you are aware of these areas that are difficult to talk about is a very important clinical skill to reflect on as you construct an intervention. If you begin to feel that there are taboos or things people are not ready to talk about, the thing to do is not talk about it in front of your kids. Rather, it is to step back and ask what is going on here and where can there be an activity that engages these parents in coming together around helping the child.

DR. COZZA: Correct. Parent guidance through an engagement or assessment session with the non-injured spouse is appropriate throughout the injury experience, focused on the health of the spouse. It can include couples mastery or a parent mastery session in which the injured service member is at a point to participate in the discussion. It can address their independent experiences by focusing on what part would be helpful in terms of helping their children.

DR. RICHTERS: And the family.

DR. COZZA: Does it make sense to include family mastery or child components given the limited amount of time there?

DR. CHUN: It is very seasonal. During a holiday period, there are more children around, so we get to see those children at least a couple times during the hospitalization.

DR. RICHTERS: In what proportion of families are children present when the spouse first visits?

DR. CHUN: That depends on the seriousness of the injury. If it is a serious injury, some parents bring the children.

DR. RICHTERS: During the school season roughly what proportion are present — 10 or 20 percent?

DR. CHUN: I believe it is higher. At least half or 50 percent of the children come and see their parents briefly, one or two days.

DR. RICHTERS: With the non-injured spouse for the initial visit?

DR. CHUN: Right.

DR. RICHTERS: As many as half?

DR. COZZA: Not necessarily for the initial visit. Did you say 50 percent for the initial visit?

DR. CHUN: When they first arrive, they are allowed to have at least three traveling together — one non-injured spouse and a couple of children get to come. Many children do come for a weekend or a couple days, and that is usually the missed opportunity for us because we do not get to see them. The children come back for subsequent visits like holidays or extended weekends. The decision parents make to bring the children or not, really depends on

A poignant comment made by a spouse in response to the question, "What is the best thing you did during this period," was, "The best decision was to leave the children behind." Then, I asked, "What is the most difficult decision you had to make?" Her response was, "Leave the children home."

their resources and the backing of the community. They can even leave their children with friends, but not many people do that. If they have extended family available, they leave the children with their in-laws and their own parents. Other than that, they tend to bring the children, often out of necessity.

DR. RICHTERS: The military will cover expenses to bring children here, but not to cover childcare back home?

DR. CHUN: Exactly. A poignant comment made by a spouse in response to the question, "What is the best thing you did during this period," was, "The best decision was to leave the children behind." Then, I asked, "What is the most difficult decision you had to make?" Her response was, "Leave the children home."

LTC SCHNEIDER: That highlights how complicated and conflicted a lot of these decisions are, like your example of the soldier who decided to stay longer in Iraq. There are a lot of conflict-based decisions that military families have to make routinely.

DR. ARATA-MAIERS: There is a great deal of guilt and anger. In terms of who comes, our situation at BAMC is a little different because we have outpatient services — the CFI and the burn outpatient services. We may have a lot more families there for longer periods of time. Often, the children come later during a semester spring break, or over the summer. They actually move to San Antonio and Fort Sam, which has its own attendant, disruptive problems. As clinicians, we may have a larger group to work with because the length of time that most of those people stay in San Antonio is several years.

LCDR KANE: The same is true for San Diego. If they are going to San Diego, it is because their family is there, so a family oriented intervention does make more sense.

LTC PETERSON: It is the same for Madigan.

DR. COZZA: And this is true for Walter Reed. The major medical centers for the seriously wounded will be where they congregate.

DR. CHUN: Right. Parents usually will get a call about the injury. The next stop is Germany. When the soldier arrives in Germany, they have an idea of when they are going to come to Walter Reed. Walter Reed is usually the first stop in the States, so the parents come here. Some bring their extended families and grandparents. They arrive, and then quickly they return. Because there is only one room assigned to one family, they have to share a room with children and extended family.

MS. VINEBURGH: Where is the room?

LTC SCHNEIDER: Some are on the post and some are off post in hotels up the street. It is interesting how they organize themselves. Many of these families come with extended family members. If there is a child, they might organize the childcare into shifts and sleep in this one hotel room. It is like being on a Navy ship. You can spend time from 8:00 a.m. to 4:00 p.m.; I have from midnight to whatever. They incorporate childcare and attending to the wounded service member into a schedule that is very well orchestrated. It is amazing what some of them do.

MS. WILLIAMS: Sometimes there are even babies born there.

DR. CHUN: These families are so resilient and strong. It really touches all of us. They do talk beforehand about the possibility of getting injured or getting killed. They have to because they have SGLI, and they have a power of attorney. So they do talk, but, perhaps not in a medical way.

Each of these families has some very complex issues. What holds it together is the integrity of the intervention: its focus on the family and the health of the family; its focus on the support of the parent and supporting parental efficacy so they can take care of their children; and, understanding where the children are coming from through this very difficult time.

DR. COZZA: Developing an intervention with all of these moving variables is what this is about. In a manualized treatment, it can be difficult to address every possible scenario. Our charge is to think about a model and a schedule of preventive intervention that focuses on the family's experience through the treatment and recovery period, and to have a family mastery session with certain goals around the experience at particular times by incorporating the availability of those children when they come while not knowing what the particular issues for that family will be at that time. It requires a tremendous amount of flexibility in how it is done and with clinical acumen. A non-trained person trying to do this kind of training or intervention would find themselves lost very quickly because of the sensitivity and the complexity of the problem.

Each of these families has some very complex issues. What holds it together is the integrity of the intervention: its focus on the family and the health of the family; its focus on the support of the parent and supporting parental efficacy so they can take care of their children; and, understanding where the children are coming from through this very difficult time. That is how I would summarize it.

There are specific kinds of interactions that would be appropriate. These include skill building, speaking to strengths, and addressing problems as they change over time realizing that the family is going to be moving. Examples are the parent is leaving the military, a TBI that is not going to get better, or return to their community. Part of the reason there is an interest in sustaining the involvement is recognizing that many of the families do better in the hospital setting than when they return to their communities. The longevity of involvement is what we want to integrate into these principles and their use. John and I are going to work on the timing — what parts of the intervention are appropriate at what particular times and what decisions determine when they are eligible to participate in a particular component of the session.

DR. SALTZMAN: The way you are mapping this out for a flexible approach makes sense. When you talk about being extended throughout the recovery period, are you talking about beyond the transition to home? There are a great deal of emotional issues that come once you leave the hospital, perhaps even in the hospital. It is like trying to hit a moving target.

DR. COZZA: Yes, that is why we are setting up these sessions.

DR. SALTZMAN: The follow-up work that was done with the injured soldiers four and seven months after was based upon the fact that they knew the person they were talking to on the other end of the phone. It was not just a cold call from someone they had never heard of before. It was an opportunity to re-engage them, to talk with them about the transition, to talk about how their health care needs were going, to talk with them their sleeping, their alcohol use and the nature of relationships in their family. It provided an opportunity to understand what the problems would be and to direct them to resources in the community. It was not necessarily an intervention that attempted to solve those problems, but to think with them about how to gain resources for themselves so that they could solve the problems they were experiencing. They can use the skills they have acquired for new types of challenges they will encounter.

DR. COZZA: That is why one component needs to address the concept around transition including self-advocacy, the capacity to pull resources into

That is why one component needs to address the concept around transition including self-advocacy, the capacity to pull resources into themselves and to self-identify and seek out assistance. This would allow them to get help in the future and to ask for help at the institution where they came from if they were having difficulties.

themselves and to self-identify and seek out assistance. This would allow them to get help in the future and to ask for help at the institution where they came from if they were having difficulties.

DR. LESTER: Could you make this something that people other than highly skilled, highly trained people would use? Considering shortages of child providers and child psychiatrists, there might be a way to put some of this into a manual that would enable Master's level people to do it if enough decision making points and skills were integrated and the structure were simple. There are a lot of highly skilled Masters level clinicians who can administer trauma focused CBT dealing with really difficult family and child issues.

DR. COZZA: Yes. We accept that Master's level clinical social workers will be able to do this, just not lay people.

DR. LESTER: The challenge is making the rules of your intervention and your session explicit and deciding the key skills people need. Once they have learned it in one context, they can face new things that cannot be anticipated. Another question is how to train both a parent and the child on comparable skills and strategies so they can support each other. It sounds hokey, but our children and parents will sit and talk about, "What is your feeling thermometer, Mom? You need to take a time out before we can talk. You need to be at a 30 before we can do that."

DR. COZZA: Do you have exclusion criteria for distressed families?

DR. LESTER: For our intervention codes, we have very few exclusion criteria. One is active psychosis.

DR. COZZA: Can people who feel depressed and are falling apart or struggling in interpersonal relationship problems use these tools?

DR. LESTER: We would refer most of the people you are talking about to individual treatment, but then hope that they might still be able to use it. Sometimes you have somebody who is so distressed that they cannot.

MS. KAUL: Did you say that active substance abuse might be an excuse why the project would fail?

DR. LESTER: It might be. Another is family violence.

DR. SALTZMAN: Yes. On a family based approach, especially. We use different approaches in non-military situations. We have done parts of the model in which domestic violence is present. We are usually working just with the mom and the kids. It is a different scenario, but also has value.

LTC SCHNEIDER: If you referred someone for individual treatment, would you do your portion concurrently?

DR. LESTER: Yes, we would as would Bill.

DR. BEARDSLEE: In our situation, we often had someone treating the parent's depression. We would not work with the family unless we had permission to talk to that person and make sure that we were going to work together and support one another. We had three big exclusion criteria — active psychoses, fulminant substance abuse, and legal actions for divorce.

DR. SALTZMAN: Fulminant substance abuse?

DR. BEARDSLEE: In other words, really abusing substances and denying it. They are coming in under the influence. The other requirement we had is that if we were going to work with a family, everybody had to consent to be involved. And we had lots of families where that would not happen initially and we would never say no. We would say, "Let us work with you until we understand why your adolescent will not come or why your husband will not."

Sometimes families will tell you, "I cannot go any faster or I am not ready." I have two larger questions. What is the normal developmental course of that kind of adjustment (having a combat injury) within the individual and within the family?

We also worked with a lot of families with the same number of sessions, but over a longer interval. For example, there were families who said they could come only once a month. It was a long time ago in the 80's, but we were very careful to be very respectful of the families and say what we were going to do. This is a six or seven session intervention; we are going to get a history, we are going to do some teaching, we are going to see your children, and we are going to meet with you and talk about having a meeting. Each time we could, we would orient the family to that contract guidance agreement we had made and place them on that. They found that very helpful.

DR. SALTZMAN: Did you feel like something was lost though, when you stretched it out that much?

DR. BEARDSLEE: It depended upon the reasons for stretching it out. If there were good reasons in the family such as their coming from far away or somebody was recovering from an illness, it was okay. Obviously, we would try to do things once a week or once every other week and move it along. Sometimes families will tell you, "I cannot go any faster or I am not ready." I have two larger questions. What is the normal developmental course of that kind of adjustment (having a combat injury) within the individual and within the family? And then, how do you position your intervention to try to maximize the likelihood of that for all families? The kinds of things you were observing about the remarkable resilience of these families. In intervention development, what you want to do is find some families that you can do the intervention with. Most people would say you select people that are seriously enough ill that they really need it, but are strong enough that they can actually do it within a time frame that you could do it with them and learn from it. Having done that, you then mix-match and strategize about the situations. So you would consider someone who would only be at Walter Reed for six weeks or eight weeks before returning to the community. You might choose them to do some parent guidance as well as a session with the couple together, and then at some later point, you may wish to do this in the family.

DR. COZZA: Using the parent as a means to develop the skills in the child, or is that a little too difficult in terms of stretching?

DR. BEARDSLEE: The issue is whether the parent could both be the parent and the coach for developing skills in the child. I wrote a book for parents about how to formulate difficult matters, saying the kinds of things that are helpful based upon your own experience, what you have been through, what you have been through together, and what you think are the concerns of your child. Now you have wonderful narratives where the girl is afraid there is going to be an earthquake and the tree is going to fall over. You have these examples where people have experienced the same powerful thing, but they had different experiences. And they come together. We want to create the climate where that can be respectfully discussed.

There are certain basic principles that people endorse, like 'do not try to talk in the midst of a crisis,' 'be able to listen,' 'plan to talk more than once,' and 'try to have the experience end on a positive note for everybody.' The parents often say they could never do that, that it is too much. My response would be, "You don't have to. Wait and see what part of that you can do."

When I visited Walter Reed, there was a group following up with people after they left Walter Reed. That was very powerful in their report. After our interventions with families, we did an outreach every six to nine months, for

The simple fact that in a preventive intervention someone is going to call in six to nine months and not say what is wrong, but instead say, 'How are you doing? How are you using the skills you learned? What are the issues now? This is where you were last time.' This follow up was enormously helpful because it let people know there was both a resource and a chance to practice their skills and have follow up.

several years. We called them. Sometimes they would come back in. Sometimes we would do it over the phone. The simple fact that in a preventive intervention someone is going to call in six to nine months and not say what is wrong, but instead say, 'How are you doing? How are you using the skills you learned? What are the issues now? This is where you were last time.' This follow up was enormously helpful because it let people know there was both a resource and a chance to practice their skills and have follow up.

DR. LESTER: There is some evidence to show that at least some effects of our intervention wear off after two years. That suggests you need some "boosters" or "refreshers." We invite people back in quarterly. Most people do not take you up on it, but they appreciate the contact. Some people come in every chance they can get.

DR. FULLERTON: Can they reach out to you?

DR. LESTER: Yes, of course.

DR. BEARDSLEE: Absolutely. We have a 24-hour, seven-day hotline, and we provide additional support as part of our intervention.

LTC PETERSON: What was the context of the guidance provided, and were there limits?

DR. BEARDSLEE: That is a good question. Let me give you the model. I was working with a strength-based model, but also with a common disease management model. The illness most like chronic depression is rheumatoid arthritis. Because there are flare-ups and because it is chronic, people get various kinds of preventative strategies. When you have a long term relationship with your rheumatologist, you are going to go in for regular visits and in crises. Because this intervention is for families, we will do a burst of intervention, be available for anything that comes up, but obviously we will make referrals or route things. Strikingly, we did not have a great deal of abuses of this availability. People were very respectful when they called. They called because they were worried that their kids had become depressed, which is a big issue as kids go through adolescence. They wanted to figure that out and we were able to help them with that. The other reason they called was they might want to have another family meeting because a crisis had come up. I think the limits were clear. This was not open-ended therapy. This was not couples therapy. We were going to work with families for six to eight sessions around a piece of work about shared responsibility for children and the conversations with them.

DR. LESTER: What is important is making it clear what this is and is not, and setting the parameters at the outset.

DR. BEARDSLEE: There is also an issue around available resources. We believe that people with chronic depression need a regular physician to deal with it, so there was somebody who had that assignment. The issue about not getting overwhelmed is very clear... that this is a limited piece of work.

LTC PETERSON: When you stumbled into a marital issue or something more, did you limit yourself?

DR. BEARDSLEE: We approach it several ways. If I was working with a couple and thought they were about to get divorced, I would stop the intervention and say, "I wonder if what you need to do is some work on your marriage before we go on with this?" They would often then say 'yes' or 'no'. When you start working with depressed people, they often go into an episode. We also did the intervention with people who were bipolar, and they would go into episodes more rapidly. Part of our work was teaching families how to

The hardest part about this population is they represent a family in transition where bigger problems are likely to come later. How do you build the skills in there to prepare them to address this at a later date?

recognize that and how to help one another. If our team was working with someone they thought was getting acutely depressed, we would tell them that and make a referral for them. So we were modeling not only that there were limits to what we would do, but there were other resources that they could access.

DR. COZZA: That is helpful. It might indicate our ending with a transition session rather than a sustainment session. We might consider a check-up phone call or a follow-up phone call. The hardest part about this population is they represent a family in transition where bigger problems are likely to come later. How do you build the skills in there to prepare them to address this at a later date?

I like the idea of doing a parent guidance that focuses on a parenting role including availability — to let them know that they can talk with their child and to make them aware that the child is likely experiencing something similar. A parent guidance to educate them about the way children may express that, not through words, but through misbehavior or whatever, so the parent can identify it. Some of it is hearing, making good decisions, building skills, but some of it is watching yourself and watching how you do, over time. It would be interesting to know what is a good disease model for that, in terms of identifying when you are about to get into trouble?

DR. SALTZMAN: You know enough to help them anticipate the challenges and difficulties they might have after they transition out. To have an early warning system so they can see when they are getting in trouble. What are some of the red flags that can be built into your intervention around identifying and when to seek out help?

MS. VINEBURGH: This is one of the greatest challenges this intervention might encounter. In Bill's intervention there was a baseline, namely you know when the family is experiencing an absence of depression because it was built around 'breaking the silence,' getting the family communicating, making sure the health of the family was defined as the absence of depression, the management of depression, and the prevention of depression in children.

What is the baseline and goal of this intervention? How would you define what you would ultimately want that family to be experiencing once they leave such that the family knows what to put their hands around in terms of knowing they are functioning in a healthy way?

LCDR KANE: I remember meeting at least one family on the ward who was functioning really well. I was impressed with how they adapted. We know that not necessarily one size fits all treatment. Something else to think about is that there might be some families where you want to emphasize progress and for others there are different kinds of emphasis. You do want to know the goal you are headed for is something that can be achieved in this level.

MS. WILLIAMS: According to whose perception, yours or the families?

LCDR KANE: Yes, this is definitely something that you want to know.

DR. SALTZMAN: You have to build in the possibility that the parents can check in together or the family can check in together to see how their progress is going. You are right.

MS. VINEBURGH: Should criteria be set that they can check on?

DR. SALTZMAN: Right. And not just for one as it could be unique for each family, and how they define a good level of functioning for them. That comes out of the initial engagement and goal setting and assessment period.

The biggest finding of our work was that families can be remarkably resilient in the face of very difficult stresses. If you take a strength-based, positive, but fairly prescriptive approach that gives structure and a narrative to someone, they can find a lot of strengths within themselves.

What do they see as a good level of functioning and what are the concrete markers of that level of functioning?

DR. BEARDSLEE: In our experience, with replications in European countries and in this Latino situation, it is important to redefine terms with their culture in mind. What is depression? What is resilience and what is good parenting? When you find a family that is coping well, they can teach us all a great deal about how people deal with this naturally — how they are resilient. I think it is very important to characterize that. If you could do this intervention, five or six sessions, with a number of families, in which you had the time to do it and they could consent and say yes, it would teach you a lot about what the eventual doses or levels of intensity you would do.

The biggest finding of our work was that families can be remarkably resilient in the face of very difficult stresses. If you take a strength-based, positive, but fairly prescriptive approach that gives structure and a narrative to someone, they can find a lot of strengths within themselves. You need to think about how to describe the resiliency, but I am sure it is there.

DR. COZZA: There is a unique part that is a bit different than some of the FOCUS model. For the most part, we are talking about transition, especially for families where there is injury the consequences of which are not going to go away. There is integration and a transition that is required. How do you get a family to a point of re-equilibrium and acceptance that is healthy? There are probably families that struggle with this indefinitely. We are dealing with people who have experienced an almost life ending event or what appeared to be a minor injury, but now they are completely different than before.

MS. VINEBURGH: The concept of equilibrium and balance might be some of the criteria that a family would be able to think about.

MS. KAUL: That is unique to each family.

DR. SALTZMAN: When we developed this kind of goal setting technique working with the Navy Seals, we had certain domains and family function that we think are important such as communication, cohesion, time together, these sort of things. The family identified key goal areas that are important to them and then identified specific behaviors that are either on target or off target. These are your warning signs that mark you are achieving and moving towards your goal. Then they rate themselves on a progressive basis. For the sustainment period, that can be helpful because they already have a map of what does it mean to be moving towards our goals and when are we moving away from our goals.

DR. LESTER: I am not sure our bull's-eye is going to be a traumatic reminder. The Seals are into peak performance, which is the origin of this metaphor. But it is actually kind of a feeling.

DR. COZZA: Instead of making it a silhouette, just make it a bulls-eye.

DR. ARATA-MAIERS: One of the important issues we hear with this population is their difficulty defining equilibrium, given all the changes in their lives. They do not have a reference point because the past is no longer possible. Part of the therapeutic intervention is about defining that for them now, in their new circumstances, so they are not going to revert.

DR. COZZA: What are reasonable expectations given the injury that has been sustained?

DR. FULLERTON: They might not know that.

DR. ARATA-MAIERS: Right, and that is part of the issue.

One of the important issues we hear with this population is their difficulty defining equilibrium, given all the changes in their lives. They do not have a reference point because the past is no longer possible. Part of the therapeutic intervention is about defining that for them now, in their new circumstances, so they are not going to revert.

DR. COZZA: And part of the intervention.

LCDR KANE: In some of families I met with, the service member was bound and determined for full recovery. Any effort that was not aimed at that was wasted effort including adapting the parenting style around his limitations because his view was those limitations will not be there in seven months. With any intervention, you need to understand where the family is before you structure how you are going to change them. Yes, it is a dose response. For example, there is the service member who is cognitively impaired and the extent of his recovery unknown.

DR. RICHTERS: You have a point. We need to respect there could be some families that are very self-rising and very resilient naturally and we do not want to disturb that.

DR. COZZA: How do you balance optimism with reality especially early on in the injury recovery? We have not talked about the fact that Pat Martinez and John Richters are new to our team, which we are building to assess these issues, help develop the core principles and refine the intervention with the input of the work group. We plan to develop a work group product that provides a unified response to this challenge. We will be meeting this afternoon and preparing our agenda for tomorrow, based upon today's discussion.

Summary and Reflection: Day One

DR. COZZA: Before we end, I would like to go around the room again and get people's last minute or end of day thoughts. Tell us what you think would help in summarizing our experience today. We have moved from principles to general strategies to very specific intervention foci, which was our intention. I am impressed by the challenges that we face in doing this and how helpful it has been.

DR. SALTZMAN: We also came full circle. We are back to principles.

DR. COZZA: Yes. Scott, would you start.

LCDR KANE: I liked how we started out very broadly and tried to think about as many principles and things as possible. In the afternoon, we talked about how to define the FOCUS and how that intervention will help with the clinical problems we discussed. My suspicion is there are a lot of clinical problems not addressed that are important with the family intervention we are discussing. We talked about financial resources as an example, and how you address those particular needs. How would this intervention address that? There are many clinical problems families might need to address.

DR. COZZA: We have a good sense of the core principles and need to refine them. Our Center's job will be to digest it and then get it back to you all for comment. The other part we are struggling with and need to figure out is to define the specific intervention in a narrow way that could become a *gold standard model* using general strategies for families that are less specific than using a feeling thermometer or the family narrative. What are the best ways of approaching strategies in the clinical sense while thinking about the core principles? We may want to be more specific about parent guidance approaches, i.e. protecting children in these environments and assisting parents in developing skills for themselves and their families around identifying problems in the future. Those kinds of strategies can be used independent of an intervention. We may want to spend some time focusing on those tomorrow.

I am quite excited about the fact that what we have been doing conceptually and also structurally could be replicated in another place and could be broader. While we are considered a research field, our struggle is to take the power from some other places to do what we have been doing.

LCDR KANE: What do we do when our resources are narrow? Can we be very specific as to what we can do? When I came here, Captain Clem wanted to know if I could hire somebody who may not be at the full child psychiatry level to make some of these implementations. The other part is doing an assessment to see where the family is at, so the importance of an initial assessment as compared to a one size fits all.

DR. CHUN: While I am a bit overwhelmed and near having reached a saturation point, I am quite excited about the fact that what we have been doing conceptually and also structurally could be replicated in another place and could be broader. While we are considered a research field, our struggle is to take the power from some other places to do what we have been doing. The other struggle is when patients leave Walter Reed I know we kind of lose them, which is another kind of dilemma. But that is where the families usually struggle most. So how are we going to extend our mission of service?

I very much like the idea of using the parent guide assessment as that starting point. The lessons learned provide the family with a plan. Although we kept that in mind, we have not used it in any more of a specific way. If we could just focus that a little bit more, it would be more helpful.

DR. FULLERTON: The core principles that we have talked about are invaluable. We were able to build upon a few things, get those down and now they are there to build upon. Regarding the assessment of outcome, as a researcher I have been thinking about some of the outcomes that you are not looking at. There have been some comments about not making this seem like another set of forms to fill out. The way I have worked with Bob Ursano is gaining entrée. Whether it is a plane crash, a disaster situation, Katrina, working with the Tsunami, the CDC, we try not to embed ourselves, but in a way yes, so there is a face there for them. We have been up in Mortuary Affairs in Dover and they know us. When we say to an adolescent, "You can help us," they love this. We did an MVA study of adolescents and engaged them with the approach; "Only you can help us better understand this so people in the future can deal with this." If you design something for people who have been through what you've been through, what would you do, that type of thing?

While I have not read his book, I loved the way Dr. Beardslee used the term developmental as in the developmental tasks of the spouse, the developmental tasks of the injured soldier, the developmental tasks of the children. Being a developmental psychologist, you were using those terms in a different way, which represented action and movement.

DR. SALTZMAN: I have enjoyed being here today. I have learned a lot about staging an intervention of this kind, and I appreciate the thoughtfulness that has gone into preparing these materials and selecting people and pulling this together. The next steps though will get harder and harder in terms of specificity. Although the research is not solid, you have a lot of knowledge, intuition, and wisdom about what types of intervention components are most useful for different types of people at different stages of this recovery and sustainment process.

Collin's article has a great template for thinking about not only those components but discerning those tailoring variables and how would you pick which to apply in different types of dosages. I assume you selected that because you like the model. There are some real challenges, but we are happy to work with you on this.

With this particular population we have a great deal of expertise and experience in working with these families. In identifying the problems, we are dealing with people who were actually working with individuals who have done this. It is not just theoretical.

DR. ARATA-MAIERS: With this particular population we have a great deal of expertise and experience in working with these families. In identifying the problems, we are dealing with people who were actually working with individuals who have done this. It is not just theoretical. We are also looking at the differences in characteristics between your setting and our setting, which impacts what we are going to be able to do in terms of interventions. It has also been helpful to look at the core principles because those are what we are going to implement and operationalize it. And there will be other things we do based upon our settings, our types of injuries, how long the people are there, etc. The briefing on FOCUS was also helpful to get us thinking how we make this practical. I come away wanting to read this memo — this literature about the TOG project.

I would like to flesh out, not only the topics that we started today, but also the methods of engaging the family. Whether we are looking at the need for this to be primarily psycho-educational or to have a clinical activity associated with it, we need to determine the structure.

DR. RICHTERS: I am struck by, in Brett's words, the importance of deploying resources when and where they are needed and what types are needed. This is kind of the central theme of discussion. Also valuable is the emphasis Bill and everyone has articulated regarding the importance of capacity building, resilience building, rather than a problem focused intervention. The principles we have discussed and some of the front line observations about the realities involved all ring true and will be indispensable in ironing out the details.

I was thinking about that old *New Yorker* cartoon of a scientist in front of a blackboard where on the left side is this complex set of formulas and algorithms, and on the right side is the solution. In between them it says, "Something magic happens here." It feels qualitatively different to be in a room full of people who are on the front lines and know the phenomena well, as opposed to a traditional meeting of scientists and colleagues. There is a story about a ferocious game hunter who goes on a safari and is unable to shoot anything for the two weeks he is there. On his way back to base camp at the edge of the woods he spots a ferocious lion 50 yards away, who spots him at the same time. The hunter instinctively pulls up his rifle and shoots, and it misfires. He drops to his knees, bows his head in prayer, but nothing happens. In about five seconds, he looks up and the lion is next to him. He said, "My God, my prayers have been answered. The lion has joined me in prayer." And the lion looked up and said, "I don't know about you, but I'm saying grace." Things are not always what they appear from a distance. I bow to all of us. I took more notes today than I typically take in a week of meetings. Thank you, all.

LTC SCHNEIDER: The experience here has the opportunity to have some synergistic outcomes. I am excited that we are creating something that can be generalized and has a good chance of actually getting buy-in by families, clinicians, and command. Our challenge now as a group is to allow ourselves to trust Steve to carry this forth. We have to focus specifically on what he wants, which is this particular module for a particular group of people. To have that manual does not necessarily meet the needs of everybody who came here. The connections and the thoughts generated here have the capacity to be more than just the outcome of the meeting.

The experience here has the opportunity to have some synergistic outcomes. I am excited that we are creating something that can be generalized and has a good chance of actually getting buy-in by families, clinicians, and command.

DR. COZZA: Our outcomes are broader than that. There is a development and a consensus, core principles.

LTC SCHNEIDER: We did that today.

DR. COZZA: Having these core principles that will drive this intervention is important as well as having it available to a group of professionals who can bring it back to institutions. It is also vital to have broader strategies that can be implemented regardless of the setting and to be able to evaluate its effectiveness in a particular context.

LTC SCHNEIDER: Yes. What we give you we get back by having data that supports everything we all want to do, ultimately.

DR. BEARDSLEE: This day has been a very exciting day for me. I have had the privilege of developing interventions with many groups and learning a great deal from Tricia and Bill in the development of Project FOCUS. There are several points I would like to make. One, this notion of developmental challenge and resiliency is important. What does it look like in a family that comes through this okay? Where do they find it? They can teach us a great deal. Second, I think the question of specificity of intervention versus order constructs go hand in hand. You put yourself on the line when you say I know enough to do an intervention with families that six other people are going to in the same way and we are going to see what we find out. It is not an intervention that answers all the questions. It is an exercise in trying to think about how you will eventually answer the questions by asking, "What could we do now that looks like other things?" Off of the top of my head, I would probably think about two interventions: the one you described in which some of you would find families and do five or six sessions and a briefer intervention when you only had two weeks.

DR. RICHTERS: We just had the interview session.

DR. BEARDSLEE: Yes, when you had only the assessment session and could give some guidance, for example 'take care of yourself', 'reach out for help', 'think about your children's experience', 'think about how you and your spouse can find common ground', etc. When we were able to follow these 100 families, many of them for as long as 10 years, we found there were longer term processes of healing and coming to grips with things. Many of these families have been alienated from church because of their illnesses. As they recovered from their depression, they found their way back into the mainstream of the culture. I think that window is important because you do not want to say we have to get it all done in six weeks or eight weeks or whatever. With Project FOCUS, the idea is to give people skills that they can use over years.

No one should view this exercise as trying to do far more than they can possibly do or go way beyond resources. It is exactly the other way around. With resource constraints, one must ask what might be something worth doing whatever it would be.

We did not talk about changing systems to make them more family friendly. What if the core principles became part of the care process? Whether someone was cared for at Walter Reed or at another facility, there would be concern about the family as essential for the soldier's recovery and the experience of the children and parents coming together around parenting. That is a systems change issue. We have worked at trying to get systems to track families and what has happened to them. Medical records do not do this. It is a different level and order for which there is a lot of interest. I will not be with

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you tomorrow because the Institute of Medicine is starting a committee on which I am part of to study parental depression, my area of interest.

Whatever you develop and disseminate, it must be evidence-based and clear. There is always the possibility people misunderstand what you do. It is important to have, as do I, a conviction that people who are parents want help with parenting regardless of whether they are depressed or regardless of whether they are in the military. Public education is a different kind of intervention, but it helps you think about the core principles.

Ms. Vineburgh: I have some copies of the brochure. I would just like to add that “public relations”, a term not readily endorsed in academic settings, is an important part of public education and communication. Bill may recall that Children’s Hospital had only endorsed public education materials at the department level, but that was such a powerful piece that Children’s Hospital endorsed it at the institutional level. Talking about promoting systems change, public education is a level at which you can do something here.

DR. LESTER: This has been informative, and we have appreciated this collaboration and your time. There are still many pieces to be resolved. It is like a five dimensional puzzle. The assessment piece is very important because we talked a lot about families’ assessments of where they are, but it would be helpful to come up with a model diagram of what we think is our assessment. What would it look like if our intervention is working? Is it less distress? It is better functional outcomes? Are there other indices of resiliency? And then backtrack, What do we think the family components are that are going to get us there, and what are the risk factors that may come up that we would have to address? This would help us shape what components and what topics we choose. One module might deal with medical problems and the education around that. What are the core skills needed around dealing with pain and recovery? I am feeling in need of diagrams, but maybe that is where we are.

DR. COZZA: As long as some of them have overlapping skills.

DR. LESTER: We have made great progress. I share your feeling that there are at least two clear pieces here: a short-term guidance phase with educational intervention, even if it consisted of one session; the other would be a more intensive skill building intervention.

DR. COZZA: So feeling good about that PGAI and its use in a single session?

DR. LESTER: Yes for providing the backside of the decision-making processes and the guidance woven into it.

DR. COZZA: Skills in goal setting?

DR. CHUN: Your comment validates what we are doing, so it makes us feel good. Not every family we see could do six full sessions.

Ltc SCHNEIDER: Right. Even if we had the resources, sometimes the families just are not ready for this or they leave before an intervention can be done.

DR. BEARDSLEE: Regarding a previous comment made by Carol, we ask people all the time, and it is very powerful, “What would you advise us if we were developing a program for other families?” Oftentimes people disclose their needs by talking about what other families need because they do not have to personalize it. That is another question we included as part of our regular session and it also builds a nice relationship with the family.

DR. LESTER: We will probably be taking some of these pieces and run-

Oftentimes people disclose their needs by talking about what other families need because they do not have to personalize it. That is another question we included as part of our regular session and it also builds a nice relationship with the family.

ning them with some families. It may give us a good feel for how it might fit together and how to get it down on paper in order to make someone else be able to use it.

LTC PETERSON: Among the positive things I will take away was not looking to pathologize as much as looking at the normal developmental process and looking to elicit help from family members regarding the next generation of people. Then in taking this paradigm and shifting it to a system of being family friendly, the intervention becomes a recruitment tool in its most fundamental form or a deployment enhancer. One of the top two things soldiers say bother them when they are deployed is the family back at home. We are looking at deployment enhancement and recruitment retention. To temper some of the optimism that I feel is that magical thing. What happens in between the problem and the solution is resourcing. It is important when this is rolled out is to emphasize it is in modules and is flexible and can be tailored for the patients and the staff. Saying this up front inoculates the providers from saying here is yet another program. Also, we can take it back to the command and say this is what I need to be able to do if we want such a program.

DR. COZZA: Yes, this is what we want. We can focus on a specific intervention, but the purpose of this is to infiltrate the system with knowledge and information that will shift the way we think about these injured families. To assume that there is only one kind of narrow way of addressing them is inappropriate. We want to provide information in a way that is usable and very flexible. It helps people understand these families have certain experiences that need to be addressed in some way, that those issues are valid, and that this is not the only thing that will work for what we do.

Ltc PETERSON: That has to happen to be able to be useful.

MS. KAUL: From our perspective at SAMHSA, the collaborative cooperative focus of this meeting and also the approach going forward, will increase capacity particularly if one expands as mentioned. Collaboration and cooperation go beyond disciplines. Going to peer professionals and using the families as resources extends capacity, which we are going to be struggling with for a long time. Knowing that these principles can be generalized and are portable is exciting. Once we start nailing down what the interventions are, how they work, and showing some evidence or efficacy, we can start generalizing that. I have always been interested in strength-based approaches. If the model could be tailored in which every session could almost be a stand-alone that also could be useful. So if this is the last time the patient sees you, they still got something out of it.

MS. WILLIAMS: I am excited about the possibility of taking these very core concepts, tools, and strategies and engaging the civilian community more. We could be supporting our families once they leave these settings. I think it is critical we cast that safety net widely.

MS. VINEBURGH: Everybody in the room, in addition to their specific role, is an educator. This is a great opportunity. This topic is desperately in need of being addressed. As the intervention develops, you are educating someone and it has been my experience that people love to learn. I am referring not just to the patient or the patient's children, but also to other institutions and settings.

The goal is to develop a more comprehensive intervention model that would include a number of different session modules to be used in a variety of ways, depending upon the needs of the family.

SESSION THREE:

Integration and Programmatic Intervention

Summary of Proceedings

DR. COZZA: I would like to introduce Bob Ursano, our Department Chair of Psychiatry at the Uniformed Services University and Director of the Center for the Study of Traumatic Stress. I appreciate the opportunity of your being here today, Bob.

We are going to summarize the work from yesterday. Today I want to re-frame this as we move forward. Our group met yesterday afternoon before dinner to think about how our Workgroup might best use our time. We developed a list of our core principles of intervention with families yesterday. Our job at the Center is to digest those and to flush them out a little bit. We will then provide a document to the Workgroup members in a draft format to get input. Then we will finalize a list of core principles — consensus principles — that the Workgroup agrees upon in terms of addressing the needs of children and families of injured service members. This list will be useful in a number of ways for professionals who are trying to manage clinical programs and may need information that would support interventions, as well as underlying principles of the interaction with the families. It would also be useful in thinking about where we go forward with strategies and future intervention models.

The second thing our small group did was to talk at great length about the intervention. We heard from Trisha Lester, Bill Saltzman and Bill Beardslee about the FOCUS model and the family-focused intervention that has been developed. The work that has been done has a tremendous amount of applicability to what we are doing. But we really need to be thinking more specifically, especially in the sensitive population that we have, about how pieces and parts of that can be put into place. We discussed the importance of developing an intervention that is flexible and modifiable for a number of different reasons; largely though, to address the changing needs of the family and also the changing presence of family members. Bill Beardslee's recommendation that we consider a brief intervention model as well as a more flushed out intervention model is a good one. We are going to take a look at the PGAI and think about how we can modify that in ways that speak to family strength, which was another suggestion, skill development and also using the instrument as a way for families to develop their own survival skills. These would include how they move forward into the future and be equipped to advocate for themselves, especially if we are only able to interact with the family on a single oc-

When the war ends, the question will not only be, "Can we help the soldiers?" but "Have we helped the nation?" The work that you all are doing has the opportunity for both of those.

casation. The goal is to develop a more comprehensive intervention model that would include a number of different session modules to be used in a variety of ways, depending upon the needs of the family. The model would include the initial engagement and assessment, similar to this brief model, but then would also include a parent-mastery session. How do we support parent skills in the work with the families? We would use a parent-mastery and potentially a child-mastery model. We want to develop a number of different pieces that could be used based upon both the skill and interest of the clinician.

We also developed a comprehensive list of family challenges rather than family problems, reconsidering the verbiage to indicate that we are shifting this to a strength model as opposed to a pathology model. Today, we would like to look through these again and begin thinking about goals and strategies that the Workgroup would develop and guidelines for intervention around these models that can begin to inform clinical interventions that are being used at the clinical centers represented here. I would now like to ask Dr. Ursano for his thoughts and comments.

DR. URSANO: I heard from Steve and Dr. McCarroll about the marvelous work that was done yesterday. One of the pieces that I wanted to underline for the group is that the goal of such work is also to test it. As Harry Holloway would say, "Ideas are free; they are everywhere." Ideas are free but are not the same as accomplishing something. What accomplishes something is when you can test it, show that it works, and then test it and refine it again. The work of this group, which is so very important, has to move into phase two and phase three evaluation because evaluation and assessment allows one to produce a product that is actually useful and shown useful, and that you can be sure is not doing more harm than good. There is a tremendous amount of work happening and very much more to come. The route to follow that has already been done is that of Psychological First Aid. Phase two looms as well for this group to tackle to be sure that its work does not go off into the vapor, but in fact becomes a solid contribution that can be used not only in our military populations, but also in other trauma exposed populations. The issue is that trauma centers around the nation do not always have ways of helping children of those who are in those trauma centers. When the war ends, the question will not only be, "Can we help the soldiers?" but "Have we helped the nation?" The work that you all are doing has the opportunity for both of those.

Programmatic Application and Future Study

DR. COZZA: I would like to pass out a reformatted list of family challenges that we had looked at. If you remember the packet that you all had yesterday, there was a column on the right-hand side that had a number of different interventions along with, parenthetically, models that we would be using to inform those interventions. Based upon the discussion we had yesterday, it would be useful now to shift to a goal-oriented approach to who we would address and what would the goals of any sort of interaction or intervention with these families be without getting into the weeds of specifically what exactly we would do. *What are the goals that we want to see in these children and families if we address the challenge areas that we had identified from the family's perspective? What would we want the family or the child, based on those challenges, to accomplish?*

We are talking about family and parental approaches. We want the parent to acknowledge a child's distress. There may be some clinician or health care system acknowledgment of the child's distress, but we also want the parent to serve that role.

In our first area is 'acute parent and child response to injury'. We discussed a number of those being anxiety, distress and child distress. What would we want to see in the family?

LTC Peterson: The counterpart of it would be the reduction in stress.

DR. COZZA: It is important to first acknowledge the family anxiety and stress.

DR. RICHTERS: It is not just reducing anxiety, but helping channel it because a certain amount of anxiety is called for, which is consistent with this idea of normalization. Assuming they are within normal range in their functioning, we want to help them channel that and through that channeling and the actions they can take, reduce their anxiety through their own efforts.

LCDR KANE: You start with acknowledgement and then you help them with toleration. In the last step, you help them to put it in some perspective, meaning, 'Yes, there is a lot going on.' Acknowledge it and the whole perspective is, 'what he is going through is difficult and hard but that the family, in the interval, will heal at some time.' During the acute stage, it is not necessary to do all of the healing, but to see that the healing process has begun.

DR. COZZA: We are talking about family and parental approaches. We want the parent to acknowledge a child's distress. There may be some clinician or health care system acknowledgment of the child's distress, but we also want the parent to serve that role.

MS. WILLIAMS: There is recognition from the parent's perspective perhaps about how that distress appears in terms of behavior, etc.

DR. COZZA: Also, think about the developmental differences and the parents' understanding of different children's presentation of anxiety.

DR. RICHTERS: With a normal range of presentation and developmental differences.

DR. COZZA: What came out of the discussion yesterday is the need to develop some clear goals. What do we want to have happen in these families if we are going to be successful with an intervention? What are the strategies for doing that?

DR. ARATA-MAIERS: We also want to look at the child's developmentally appropriate understanding of their anxiety in the course of responding to the acute stress.

DR. COZZA: To develop an age-appropriate understanding of one's own stress?

DR. ARATA-MAIERS: Perhaps this needs to be a separate one about how it is not just the developmental processes of the child but is also the developmental process of the response. There is a developmental progression of a response to trauma. Understanding this can help them get the type of perspective that Dr. Kane was talking about.

DR. RICHTERS: It is the parent's understanding of the normal range of anxiety and reactions to these kinds of stressors and sensitizing them to signs of their own manifestations of stress that they haven't recognized as being normal and the development differences in the way these things play out within any given child or parent. There is a development trajectory across the course of the parents' injury, recovery, and transition home.

LCDR KANE: One thing about this particular problem is the acute parent-child response to injury. Some of our goals are a little bit theoretical, whereas in this particular group, we might get very practical like Psychological First

A parent's capacity to tolerate children's expression of anxiety may be a good outcome. They are not yelling at their children, they are not overly disciplining them, etc. They are able to tolerate reasonable levels of anxiety.

Aid. The goal here is to try to establish safety amongst the family. Are the kids in school? Can we address the disruption issues? In my opinion, this category is primarily 'Psychological First Aid'.

DR. RICHTERS: We have been talking about establishing the alliance with the parent and getting a sense of where they think things are.

LCDR KANE: I meant practical things such as, 'Do you have a hotel room?' 'Are the kids in school?' 'Do you have money for food while you are here in the hospital?' These are routine things, thinking of Psychological First Aid first. Before we ask 'How is your level of stress?' we ask, 'Do your kids have a place to sleep tonight?'

DR. COZZA: We want the parents to re-establish their role as supporters and comforters of their children.

DR. CHUN: We want to provide a safe environment for children and family in a time of crisis. A safe environment can mean a lot of different things.

DR. RICHTERS: Immediate needs in a triage sense, or as Maslow said, 'First things first.'

DR. COZZA: Parents will establish or re-establish themselves as comforters and supporters of children.

MS. VINEBURGH: This may be the spot where you want to identify any risks that may not be associated with the injury? For example, what if somebody has a parent who is dying? What if the parent has a mother who is dying? What about the identification of risk in a child that may have exceptional needs? Consider the identification of other risk factors.

DR. COZZA: We definitely want to do that. I am trying to remember where we had included those at previous risk somewhere else. The idea is that we have disruption and it has an impact on children's lives. There may be some overlap with these as we think about them. This is the acute nature of stress reactions in the parent and child. It is the need to identify and provide treatment and to refer to clinical resources when needed.

DR. CHUN: Providing families and children with accurate and developmentally appropriate information about the immediate medical situation is important.

DR. COZZA: We want to be careful about the difference between goals and strategies. We want a reality-based understanding of the nature of injury considering all family members.

DR. LESTER: It might be helpful to add a column of outcomes after goals and strategies. Thinking about this measurement evaluation piece, we have a lot of goals for what might be a single session. We may have to choose what we are going to focus on. It might help if we knew which outcomes we were driving at. Sometimes it helps me to think about what the end point is and then to back it up from there. In the first session, we may want to focus on increasing people's knowledge and understanding of developmental issues and impact of the injury. They may not get a lot of emotional regulation and skills in that one session.

DR. COZZA: How would a goal be different than an outcome?

DR. LESTER: The module appears to focus on mental health. Reducing emotional distress might be the main objective. There is a focus on decreasing behavioral disturbance and there is also a knowledge aspect, too.

LCDR KANE: We are not quite at the point where this is like module one, but because this is the acute initial issue it is likely the first thing we will do.

The ultimate hope is for better emotional regulation and better understanding. They also have decreased distress and anxiety. In many ways, these are strategies to reach positive adjustment.

DR. LESTER: If you had broken it apart this would just be the first one or two sessions.

DR. RICHTERS: For some families, there will be pre-existing problems not related to the injury that will trump other things that might otherwise be addressed in that initial meeting. It requires stabilizing them. That is an issue of intervention, flexibility, etc.

DR. COZZA: We may find that knowledge and understanding should be its own problem area. We may shuffle areas around.

A parent's capacity to tolerate children's expression of anxiety may be a good outcome. They are not yelling at their children, they are not overly disciplining them, etc. They are able to tolerate reasonable levels of anxiety.

LCDR KANE: Another outcome might be parents' establishment of a safety plan or a safe environment for the family. They should have a plan for how they are going to get their family to a safe environment.

DR. COZZA: The idea is for the parents to develop and communicate a safe plan regarding children.

DR. LESTER: These may be goals. Outcomes should be measurable. Could we develop an 'understanding' or a 'knowledge' outcome? Bill Beardslee has an interview that measures kids' understanding of parental illness.

DR. RICHTERS: A goal might be to assess and recognize the normal range of child responses. We might reflect on how to recognize and cope with them. We want the parents to be tolerant of the child's varying responses. A knowledge goal could be used to convey information in ways to inform the parent and arm them with the capacity to tolerate. It would be the knowledge goal. We would design it in ways that facilitate their acceptance of this.

DR. URSANO: Pat, do you have major categories that you would put there, such as knowledge, symptoms, behaviors, cognitions. Do you have some frame that you are operating under?

DR. LESTER: It is usually reduced to something less sophisticated than the conversation here. It is social, emotional, behavioral adjustment, and sometimes, another indicator of positive adjustment in both the parent and the child. Knowledge and understanding are important when you have a primarily psycho-educational intervention.

DR. RICHTERS: This may be time to discuss the parent's capacity for advising and clarifying information for their children and outlining what the implications may or may not be. The child's possible cognitive distortions should be implicitly addressed at this time.

DR. LESTER: The ultimate hope is for better emotional regulation and better understanding. They also have decreased distress and anxiety. In many ways, these are strategies to reach positive adjustment.

DR. RICHTERS: Minimally, we want to make sure that the information gets through to them. That is measurable enough.

DR. COZZA: What would be an outcome measure for safety in a family?

DR. LESTER: Ask them if they have a safety plan. However, you cannot see change on a yes/no outcome.

DR. RICHTERS: At the beginning of the session, they should have adequate answers for questions such as, 'Where are the kids? Who is taking care of them? Do any of them have special needs that need to be addressed? Are these needs being addressed?' If they did not have answers, initially, we would help them think those things through.

In the initial meeting, we are attempting to assess the capacity of the family to mobilize and their own ability to manage these things. Do they just need a little nudge, are they doing it on their own, or are they unable to do it and need a lot of help?

DR. COZZA: It is an interesting question. How do you measure principles of first aid?

DR. ARATA-MAIERS: It may be stability of housing, schooling, and other family routines. For instance, at BAMC, they are going to have a room but the question is going to be, where is it? Are they going to be moved quickly from place to place? There may be issues related to that setting to cause them to feel unstable.

DR. COZZA: I like the idea of using categories. We have social, emotional, and behavioral, and cognitive, to include knowledge and understanding.

LCDR KANE: Many of the ideas around safety and the parent securing a safe place for the family to reside falls under the social category.

DR. RICHTERS: The children may be left behind at their residence or they may come to the hospital. Some children may stay with a caretaker. Are the children out of school? Considering all of these things, is there a plan? Do we intend to get them back to school to help normalize their lives as much as possible?

LCDR KANE: In the outcomes, it is not necessary to state every possible contingency. We will recognize it when we see it.

DR. COZZA: If we throw some of these out on the table, it will help us conceptualize it. What are the most important ones?

DR. LESTER: Is the creation of a safety plan an intermediate outcome or a mediating outcome? In other words, is it a primary outcome or is it a vehicle to reduce child and parent distress? Is there a primary outcome to improve parent and child functioning and adjustment?

LTC SCHNEIDER: The development of a safety plan is a strategy with an outcome of re-stabilizing the family.

DR. LESTER: You could frame it that way. It anchors you and it allows you to choose what your measures are going to be and think about it as a model.

DR. URSANO: The making of a family plan becomes a strategy.

DR. LESTER: The outcome becomes decreased child distress. They feel safe.

DR. RICHTERS: We should consider the literal conditions of their daily life, for example, children being in school versus being with a caretaker. At some point you are going to test these interventions and compare them to families who are not getting an intervention. Presumably, you would see differences in those basic kinds of things and that is crucial to our foundation.

LTC SCHNEIDER: In the initial meeting, we are attempting to assess the capacity of the family to mobilize and their own ability to manage these things. Do they just need a little nudge, are they doing it on their own, or are they unable to do it and need a lot of help? An outcome might be the family's capacity to mobilize. Can they show that they know how to engage the system and meet the needs of the family plan? It could be as simple as that.

DR. COZZA: That is part of a family assessment.

LTC SCHNEIDER: Part of our job would be to assess whether the family is able to meet these goals and if they have done so.

DR. RICHTERS: You may learn through that initial intake interview, for example a PGAI-type interview, that they have adequately thought through these things, made necessary arrangements and are thinking forward.

LTC SCHNEIDER: In a strength-based model, I would assess their capacity to actually do so.

DR. COZZA: That is overarching for all of these. Are they able to employ

Our purpose is strength-based. It is to not pull away the parenting role and to engage children independently unless they are really struggling. The purpose here is to help the parent reassume that role if they have lost the capacity to do that.

these strategies? Are they able to reassure their children? The ability to develop a family plan would be an indication of their capacity to address this challenge.

LTC SCHNEIDER: We are just priming the pump that exists, not building the engine from scratch.

DR. CHUN: We often say that parents do not recognize the level of distrust of children or they deny or avoid it. The process of acknowledgment should be accomplished in the beginning.

LTC SCHNEIDER: Once you bring it up to them, can they incorporate it into how they look at things? That is the capacity part. We can to bring it into their awareness.

DR. COZZA: We may want to do this for each of the challenge areas and look at whether the family can independently demonstrate the capacity to do this prior to our discussing it with them. Some families may be available or interested but were disorganized by the experience, and when prompted are readily able to do it. Some families are interested and understand but, based upon the disorganization, have difficulty implementing it. Lastly, some families are completely disorganized. Think of it as an organizational level, in terms of the family's organizational and emotional capacity. I like the idea of including that as an assessment for how the family manages the different challenge areas.

LTC PETERSON: Conceptually, would we assess the outcomes for each family member? You might have somebody in the family (e.g. a parent) who is successful in negotiating these goals and getting outcomes, but a child or an adolescent might fail miserably. Would an assessment be done for each member of the family or would we look at the family collectively?

DR. COZZA: Conceptually, we are talking about this as a family intervention. It is the family's capacity to do these things. If an individual is having extreme difficulty, we want a mechanism to be able to notate that and address it in some way. Approaching the family as a unit is the idea.

Our purpose is strength-based. It is to not pull away the parenting role and to engage children independently unless they are really struggling. The purpose here is to help the parent reassume that role if they have lost the capacity to do that. If they are distressed, we assist them with their distress. They calm their own children and help manage and develop a sense of safety in the house. That is the purpose of it and then we measure the family's capacity and the parent's capacity to do that. That hangs together well, conceptually, in my mind. What would be an indication of a parent's capacity to effectively communicate and to relieve the anxiety of the children?

DR. URSANO: Reading a bedtime story.

DR. CHUN: Set a routine like reading at bedtime or calling about the same time every day when the kids are away. Some parents say that their kids will not talk to them on the phone and so the parents stop calling. They do not have to say that. You could encourage them. That kind of encouragement may help them to maintain that routine and structure.

DR. URSANO: The things you are collecting will eventually cluster into parental nighttime behaviors. This involves teaching them about these behaviors.

MS. VINEBURGH: One area of importance at this stage is hope.

DR. COZZA: Instilling hope is Psychological First Aid.

DR. LESTER: There are a number of hope measures.

The outcome is the family's capacity to manage challenges and their success at a number of levels. The family challenge assessment gives you a sense of the family's capacity to manage challenges independently, the family's capacity to manage challenges with some instruction, or the family's inability to manage challenges due a level of family disorganization that makes them unable to participate, despite being willing.

MS. VINEBURGH: Hope is something that has to be communicated. It is something that a parent can communicate to a child.

DR. URSANO: I think the goal would be phrased as feeling hopeful and having realistic hope. Then, the questions would be how you get there and what the outcome measure may be.

DR. CHUN: The strategy for instilling hope might be having fun with the kids or by having the injured service member get out of their bed to take a five minute walk outside.

DR. LESTER: We might look at goals for the entire family that are unrelated to the injury.

DR. RICHTERS: We should move forward on various fronts to gain self-efficacy.

DR. COZZA: It is about not allowing the injury to get in the way of normal activity and maintaining development. This is an example of a problem area.

DR. ARATA-MAIERS: The structured parental engagement sounds like it applies to young, school-aged children. I do not know many adolescents who want you to play with them. We need to figure out if there is something different for the adolescent age group.

DR. LESTER: The general category might be maintaining or building family routines. Routines might be different based on developmental age.

DR. ARATA-MAIERS: Reading a bedtime story would be developmentally appropriate for younger children.

DR. URSANO: The shorthand of your categories is the problem, the goal (is) the intervention, and the outcome. That might be an operational way to approach this. What is the problem? What is the goal? What is the intervention you will use? Finally, what is the outcome you will measure?

DR. LESTER: These outcomes might be for your long intervention or the combined intervention.

DR. COZZA: The outcome is the family's capacity to manage challenges and their success at a number of levels. The family challenge assessment gives you a sense of the family's capacity to manage challenges independently, the family's capacity to manage challenges with some instruction, or the family's inability to manage challenges due a level of family disorganization that makes them unable to participate, despite being willing.

LTC SCHNEIDER: This does not necessarily fit under 1.1, Acute Response. To measure resiliency and how effectively people have responded to a challenge, you can look at the lack of negative outcomes. Was the family referred to ASAP? If the answer is no, they may not have been at risk for that. It is a positive outcome that this family was not referred to FAP (Family Advocacy Program), ASAP (Alcohol and Substance Abuse Program), etc. This shows that this particular family had some form of resiliency. A lack of negative outcomes, which is measurable, is an indicator of a positive outcome.

DR. RICHTERS: Ultimately, that is the kind of outcome the system will care most about.

LTC SCHNEIDER: When you talk about a prevention program, you are preventing negative outcomes. You cannot necessarily correlate one-to-one, but as a group these people are experiencing less stress. That would be an indicator that some kind of intervention might be helping.

DR. URSANO: In the family assessments, the corollary to that would be family strengths. We treat and assess the strengths. There is an organization

From a family systems perspective, one is looking for the avenue for altering family function and the recovery environment. In working with the family, you may choose to target the adolescent child as a way to change the family because that is the one with the most strength, the most activity.

here which is almost in each category of child-parent-family. Underneath, think of the outcome section in particular, you have child outcomes, parent outcomes, family outcomes, even though one's intervention is family directed or parent directed. Similarly, in the problem area we would have child problems, parent problems, family problems, even though one's intervention may be parent directed and family directed. The issue of the evaluation and the intervention are really separate concepts. When you are thinking about the problems, the goals, the interventions, and the outcomes, there may be child/parent/family levels to think through. Eventually, some of those may collapse in terms of the measurements they use.

LTC SCHNEIDER: There is some ambiguity regarding who we are targeting and for which particular thing. There should be more clarity about what to do when a certain person is or is not there.

DR. URSANO: One of the unique things is the focus on the question of parental and family function as the intervention and to not remove the child for treatment. It fits our system level issues and what is practical and possible. You are trying to alter the family function. That does not mean one is assessing at different levels and measuring at different levels.

DR. COZZA: The problem may be a child problem, but the intervention is a parent solution. The strategies may be more parent-directed.

DR. LESTER: The theory behind this is that we are driving the intervention through the family system. It is by targeting the parent-child relationship and conflict that we are going to get improved outcomes for the family, the parent, and the child. The same theory drives the intervention no matter who shows up to participate.

DR. COZZA: We want to build an intervention in families where we may not see the child and still be effective in the way we do it.

LCDR KANE: We also have families where the injured soldier's parents are the family. It is the reverse. We have another group where it is the siblings that are part of the family intervention. Today's framework is the traditional one but it would be nice to throw in an asterisk to explain that the intervention could be modified to deal with atypical family arrangements.

DR. COZZA: The challenge is that the roles and responsibilities of siblings or adult parents of adult children are different. The question is, how much can it be adapted and in what ways?

● **Family Systems Perspective**

DR. URSANO: What you are driving here is a family systems perspective. From a family systems perspective, one is looking for the avenue for altering family function and the recovery environment. In working with the family, you may choose to target the adolescent child as a way to change the family because that is the one with the most strength, the most activity. Most of the discussions will be targeted towards them or the parent. It might also be the parent outside.

If I were thinking about how to invite corollary to it, it would be adapting a family systems program for Marines whose parents are not in the service. How can one develop a care giving response and environment for them? There would be a way of working through that. This fits with a family system orientation and creating a caring recovery environment for the entire family, not just for the injured soldier.

This calls for a broader definition of family. We are locked into the traditional family definition with the mom, dad, two kids, and a dog. We do not look at in-laws, older parents, girlfriends, etc. We are in the context of the reality of relationships today rather than what would be considered a traditional family.

LCDR KANE: It is alright to go with the traditional model and talk about ways that it can be shaped for those other types of family situations.

LTC SCHNEIDER: That fits with Dr. Beardslee's discussion yesterday about the developmental challenges of being injured and the developmental challenges of being a parent who comes in to deal with their injured adult child. The process of development is always unfolding.

DR. URSANO: That is an important outgrowth of what you are doing. Given all this discussion, how can I apply it in different settings and leave the other spin-offs?

DR. CHUN: We have seen many younger siblings. For example, a five-year-old sister joins her injured older brother and their mother must take care of both children. The five-year-old child may have regressive symptoms. In other instances, we see a teenaged younger brother who is feeling devastated. When we visit patients, we see the whole family. We do not say 'you are not qualified' or 'you are not amicable.' We face the whole system.

DR. NEWBY: This calls for a broader definition of family. We are locked into the traditional family definition with the mom, dad, two kids, and a dog. We do not look at in-laws, older parents, girlfriends, etc. We are in the context of the reality of relationships today rather than what would be considered a traditional family.

DR. CHUN: Lately, the military has been relying on those extended families for non-medical attending. They need someone else besides medical staff to care for these people for 24 hours. They allow these family members to care for the injured service member and provide financial support and travel arrangements to ensure that it takes place. It is just that they are not included in this family concept.

DR. COZZA: They can be included. It can be challenging to meet the needs of different family members individually. What becomes more difficult is doing it in a family context if some members are not there. How do we develop family strength or implement family-focused intervention in a situation where the sister of the injured service member comes in from out of town and the parents are away in California? We need to modify it. It has to be developed in a way that is respectful of those non-traditional families.

DR. ARATA-MAIERS: One of the issues, no matter what type of family constellation you have, is helping to define the roles within the family. If you have an adult parent of an adult injured person, that role is going to be different than parents of a younger child. If you have a grandparent who is functioning as the parent of the children who are there, then they are going to have more of the parental role in the family. What is the role of a younger sibling who comes to visit? What is an appropriate role for them to take on within that capacity and what is not appropriate? That is part of our job. We are helping the families to define roles for themselves because these roles shift as they come into the hospital environment.

DR. COZZA: Have you applied FOCUS to families where the service member is the child as opposed to the parent?

DR. LESTER: We have not. It would require a lot of adaptation because our model is really focused on the impact of trauma on parenting. Most of the conversations we have had here have been about the developmental impact, child reactions, etc.

One strategy may be teaching how to communicate via e-mail. What is the appropriate parent-child, child-parent communication, including with the injured parent? Should the injured parent be telling the 12-year-old that the pain is bad on a particular day?

It is one thing if you are using the principles and making clinical adaptations where needed, but it is another thing if you are trying to evaluate it. You might have to say that it is an intervention that requires a child under 18 to be part of it.

DR. URSANO: That is why we have an inclusion and exclusion criteria for the evaluation phase.

DR. LESTER: It does not have to be a traditional family; you could include other caretaking adults. It seems that the intervention is a child intervention to improve their functioning.

Family Communication and Connectivity

DR. COZZA: Today is not so much about solving the problem; it is a matter of understanding what needs to go *into* the solving of the problem. Recognizing the fact that we cannot get through all of these challenges, we should pick two. Two useful areas to address are *family communications and connectivity*, and *parental efficacy, availability, awareness, and style*. We can look at the identified challenges and also think about goals, strategies, and measurable outcomes.

DR. MCCARROLL: Almost everybody depends on some kind of electronic communication medium. It ties people together no matter where they are, present or not. The amount of this material that is suitable for some kind of electronic communication or distribution might be a really important issue to work with. This would be a strategy.

MS. MARTINEZ: The strategy may be ways of transmitting material and communicating.

DR. COZZA: We want to maintain connectivity.

LTC SCHNEIDER: On the topic of connectivity, when you are in Iraq, most use the phone, e-mail, or web cameras. I did that every day. I had a routine with my kids. I used a web camera and saw them as a group when they came home from school. I wonder how many injured service members are able to re-establish that connectivity if their kids are not there or if there are too many barriers and they do not think of it or do not know how to do it.

DR. CHUN: The hospital actively supports that. The problem is that very few get to use web cameras. Security issues may be a problem. Most of the service members have a laptop. They are donated by a company so they do have access to a laptop.

DR. ARATA-MAIERS: Some of the injured are given a BlackBerry. The idea is that it helps them to keep up with their appointments. It may become the means of communicating with the children.

LTC SCHNEIDER: I do not know if the Fisher Houses have access to free wireless internet, but all should.

DR. URSANO: One strategy may be teaching how to communicate via e-mail. What is the appropriate parent-child, child-parent communication, including with the injured parent? Should the injured parent be telling the 12-year-old that the pain is bad on a particular day? If he or she does say that, what should be the follow-on to it? He or she may say, "But I'm taking my medication to help." What is the protocol? What is e-mail protocol that may facilitate family strengthening and what are those principles? Communication offers opportunities for problem solving. In couples where the communication breaks down, I tell them to start sending e-mails. It can be a way to solve family conflict.

What is the role of communication connection in the family and what is the type of communication? What are the roles and the effectiveness of communication? How much is enough? How much is too much? What information should be shared, in what kinds of ways, and with whom?

DR. COZZA: There is this issue of communication and also connectivity across family separations. How do you keep people connected and together? I have often told parents that it is helpful to take pictures of a hospital and e-mail them to the children so they can see where they are at and what that is like.

MS. VINEBURGH: When we were in Baltimore at the International Traumatic Stress Society Meeting, there were many military presentations. The Veteran's Administration is doing quite a bit of interventions through videoconferencing technology. There may be possibilities to deliver this beyond the face to face contact. This is something to think about in terms of the communication component.

DR. URSANO: It also deals with the resources available. There is the issue of teaching about where the resources are. There may be three that you want to include in the package and teach people how to find information to help them. Examples may be the National Child Traumatic Stress Network (NCTSN), the Veteran's Administration (VA), etc.

LTC SCHNEIDER: We are still not all that great at our capacity to get things across appropriately face-to-face, much less think of the impact of the media on connectedness.

DR. COZZA: What is the role of communication connection in the family and what is the type of communication? What are the roles and the effectiveness of communication? How much is enough? How much is too much? What information should be shared, in what kinds of ways, and with whom?

DR. URSANO: Specific to the picture of your intervention, is there going to be a website for families to access that answers specific problems, so that there will be a sequenced course of information. It might be organized around frequently asked questions. For example, "three-year-old children do such and such during this time". It becomes an avenue for delivery of information subsequent to their leaving the hospital.

DR. ARATA-MAIERS: There is a website that is being developed involving at least the Air Force and the Army and we may want to find out more about it. It concerns deployment with injury being a part of it.

DR. URSANO: It is a database but it becomes an avenue. Will there be things to send out? Is there a form of e-education to go out to the family? Will the target be by child's age or the particular challenges? There is a whole sequence of things to think through in the area of communication to the families and between the family members.

DR. COZZA: A goal would be to support appropriate communication within the family.

DR. LESTER: We talked about the need for the parents to reflect on their own experience prior to communication with the child.

DR. COZZA: This is similar to the first two sessions of FOCUS with the idea of encouraging the parents to get their act together. There is an expectation that the parents should be capable of pulling it together in order to be the parent, and figure out what they are going to share or not share with that child.

LCDR KANE: The next step is making sure that they have a mutual respect and understanding. It is important that they have a unified presentation to the kids. They are a parental unit leading their children.

LCDR KANE: Marital counseling becomes important. If there is a total breakdown between the parents and they are battling each other for some

It is important to figure out how parent surrogates in the community should communicate with the children. This may include either passing on information or directing them in terms of how much information they should or should not share. There are multiple caregivers.

reason, it is hard to move forward with other things. I recommend a goal for the parents to come together in agreement about how their parental styles will be shared to help them move forward together.

DR. COZZA: This is where there is a separation between the marriage and the parenting. I will tell parents to agree upon two ground rules and not to talk. If they talk, the kids may suffer. We are not there to solve marital problems at that time. We are there to help them be good parents. This is important because sometimes you can get dragged into these marital situations. If you can at least get them to recognize that the purpose of any interaction with us, above and beyond having a nice conversation together, is to get the parents to figure out how to take good care of their kids. If, in trying to fork out the rest of the problems, it makes things worse for them, then you should not do it at all.

DR. URSANO: This is really one of your strategies of intervention, which might include appropriate neglect of couples' problems and focusing on the parenting task as distinct from the marital problems.

MS. KAUL: We are focusing a lot on the interaction between the parents, so a strategy could be to help them determine what the key kind of anxiety or sources of anxiety are for their children. Sometimes they miss that. They do not understand that the worry is really 'x' and they are assuming it is 'y'.

MS. WILLIAMS: It is also important to be mindful in these particular situations of strategies when another caregiver is involved, i.e. a child is being watched by a relative. We want the communication of messages to be unified and consistent with what the primary caregiver communicates and how he or she does it. We need to problem solve around that. You know, how do we address that?

DR. COZZA: It is important to figure out how parent surrogates in the community should communicate with the children. This may include either passing on information or directing them in terms of how much information they should or should not share. There are multiple caregivers. You get grandparents, aunts, and uncles involved too. There are multiple ways that information can be communicated that may be overwhelming to a child.

DR. URSANO: *Your primary outcome measures are improved parenting; everything else is secondary.* The example where couple interaction may be unsatisfactory is a good one. The parents may be diagnosable and in treatment, but the child still has symptoms. The target is to change the parenting function, goals, and tasks with the picture that over time you will have a sustained impact on the child. In thinking about the evaluation of this type of intervention, the sustained impact on the child is the one thing you are going to evaluate. Everything else becomes a secondary hypothesis. Your primary question is going to be how they are able to make parental decisions. Your evaluation might include scenarios that assess parental decision-making. Do the parents talk with each other about a particular problem? Is there a change from beginning to end where initially, they do not talk to one another but in the end the two parents are talking? In the end, they may not be able to talk about anything else, but they are able to talk about this particular problem for their child.

LTC SCHNEIDER: It is the demonstrated capacity to do these things together as good parents.

MS. WILLIAMS: Regarding connectivity, the person that you bring into the fold (i.e. a parent surrogate) should maintain that connectivity as well.

Sometimes, the injured service member feels that he is a second option to his children at home. When the children are home and Mom is out, they call Mom on her cell phone instead of asking Dad about daily things. The injured service member father then feels left out. What does that do? There are multiple layers getting involved.

DR. URSANO: You cannot measure everything that exists. You are going to have to choose something that is important and it does not mean that you do not care about the other things.

DR. COZZA: How do you measure communication? You could do that from the parent's side or ask if the child knows enough information, too much information, etc. That is an indication of communication.

DR. URSANO: Does the child know how to make use of available parenting? Does the child feel he/she could go to both parents instead of just one? There are many indices one could use for those kinds of changes in the system that will be present over time. That is the primary focus and it does not mean the others are not important or secondary outcomes.

DR. LESTER: The other piece is parent-child communication. In our findings, this issue of parent-child conflict is critical in terms of child outcomes and is something that a parent's traumatic stress symptoms seems to influence. We think a lot about teaching parents and children how to resolve conflict and how to communicate more effectively about their emotional life. Several skills are involved with that.

DR. URSANO: We need to make sure not to confuse interventions with outcomes. Interventions can be very broad and outcomes can be very narrow. They are not one-to-one.

DR. COZZA: The capacity for conflict resolution or the capacity for conflict avoidance might be domains of an outcome. It is the idea that parents need to know that this may not be the best time to scream at their kids over the phone in Arkansas because they are not unloading the dishwasher. What is a good measure of that? It is a sense of connectivity and it is the amount of information and quality of information that gets passed.

DR. ARATA-MAIERS: We should not focus only on the parental side. We need something in here from the child's side.

The younger the child is, the more often they need to be encouraged to verbalize when they get to be older.

DR. COZZA: It would be nice to structure a strategy around daily check-ins between parents and child. It reminds me of a discussion with Trisha about children diagnosed with HIV and helping them find ways to ask the questions that they need to ask. How could the parent or the parent surrogate encourage that in a child? The child may need to write it down or need help asking the question.

DR. LESTER: The activity creates a structured and safe way for children to communicate. Children can engage in the activity because it is an activity outside of them. We are not just asking them to talk about their feelings. They are actually describing what worked, what did not, what was hard, and they are doing it in this very active way.

DR. COZZA: That is an intervention strategy. If you are putting out information, how do you help parents help their children to ask some of the questions that they need to ask?

DR. LESTER: There is a great deal of information about helping children label feelings, talk about their feelings, etc. There is psycho-education for parents. It is important to give them ways to do it that lifts it off the paper.

DR. CHUN: Often children in this situation do not want to burden the parent. Even younger children do not want to call Mom or Dad to talk about how upset he or she feels when they are away from home. We need to look

The concept of communication can be looked at as a strength model. The family can build a story around what has happened to them, a story that they understand as a family and one that incorporates everyone's understanding. Then, they can communicate that to other people.

at ways to encourage that kind of a communication. Sometimes, the injured service member feels that he is a second option to his children at home. When the children are home and Mom is out, they call Mom on her cell phone instead of asking Dad about daily things. The injured service member father then feels left out. What does that do? There are multiple layers getting involved.

DR. LESTER: There might be different strategies for a family to choose from that can work individually for them.

DR. COZZA: There is communication with a parent and then there are the unique challenges of communication with the injured service member. And we may want to just talk about that for a second, too.

MS. VINEBURGH: We are in the domain of communication and the point about having a protocol for talking to your children is an important one. Bill Beardslee's intervention helps the family build a story. The concept of communication can be looked at as a strength model. The family can build a story around what has happened to them, a story that they understand as a family and one that incorporates everyone's understanding. Then, they can communicate that to other people.

Family Meaning and Connectivity

DR. LESTER: This is at the heart of Dr. Beardslee's intervention. Our adaptation is *to create a shared sense of family meaning and experience around a stressful or difficult event in the family's life by first regarding the individual and then bringing the family together.*

DR. MCCARROLL: How do you help a family to have a meaningful conversation? At a practical and concrete level with measures, you may see if they can identify problems. Can they set goals? Can they meet a goal? How many did they do? How many are short-term? How many are long-term? How many concern the children? How many have to do with relationships? You can measure many things that go into the elements of making up a meaningful conversation. The key word is meaningful if the goal is a task outcome and you set it in terms of task as opposed to processes. You may ask, 'what tasks do you feel that your family has to accomplish or what problems do you have to deal with your child?' You can set those up to have a measurable quantity that is oriented toward the task and not necessarily toward the relationships. Although, you would expect the relationship to improve as a result of working on tasks together.

DR. COZZA: The measurement could be the successful completion of establishing of family goals. The idea is communication to facilitate connectivity. The purpose of the communication is to connect people by way of meaningful conversation, i.e., a family story, narrative, etc. The communication between the injured service member and the child is still an important challenge for families that we need to reflect on in our discussion. At CSTS, we have had discussions about goals for military children and having some capacity to engage the parent and also a connection with the parent. It is the capacity to recognize and accept the changes in the parent and still realize that they are their parent.

DR. ARATA-MAIERS: It is important for them to be able to converse about developmentally appropriate topics beyond the injury.

DR. CHUN: Moving beyond the injury is the core of what we are trying

Along with fear, some children feel blame; they feel that they caused it. This is so unique for the young children. For example, there may be a little boy who says that because he misbehaved or he did not say 'Daddy, be careful,' he caused the explosion.

to do here. We want to help the injured service member who feels shattered get back to the role of parenting that is still intact. We hope that this role is still intact.

DR. URSANO: What are the four or five topics that you are thinking about? For example, we have a soldier with a missing leg and a five year-old child. What should be the communication? What are the barriers? We have the same soldier with a 14 year-old. In one example, the child is a girl and in the other, the child is a boy. What is it that we think is impaired and what do we think should happen?

DR. COZZA: We can give examples and distill out the core elements. This was the whole issue with the Sesame Street project. The child's feelings about the injury should be validated. For example, Rosita's father is in a wheelchair and the character's response is anger. The producers came up to me and asked if I thought she was too angry. I said no because that is what you really want to see because she is angry. It was powerful. A child can feel any way they need to feel about the injury and the parent needs to understand that. Then, the child needs to be able to resolve it. This gets into the idea of free associations. It reminds me of Judy Cohen's balloon exercise. When a parent dies, the child writes those things that they no longer have and things that you can continue to have, and then they let those things go with the balloon. Concretely, it is the ability to give up those things that you no longer have, recognize realistically what you can continue to be able to do, and then be able to integrate that change and move on. The challenge to the child is integrating the parent's serious injury.

DR. URSANO: The case may be that the child was not able to express their anger during the initial meeting. You see the child at a lighter range of affect expression. Afterwards, the parent is able to tolerate and assist. We are looking for something measurable but also how it looks from the outside perspective.

DR. ARATA-MAIERS: Eventually, another aspect may be emotional modulation when there are extremes of emotions expressed by the child. Another thing we see with the younger children is fear, which keeps them from approaching the parent. The child needs to be able to approach the parent. You want the child to be able to modulate as time goes on so that they can continue to be in that relationship.

DR. CHUN: Along with fear, some children feel blame; they feel that they caused it. This is so unique for the young children. For example, there may be a little boy who says that because he misbehaved or he did not say 'Daddy, be careful,' he caused the explosion. There is a lot of self-blame and also, the anger toward the enemy or the 'bad guys.'

DR. LESTER: Are there certain pieces of information that the injured parent needs to communicate to the child? Some information could come from an outside person or a therapist and some could come from the other parent. Are there important aspects that are unique and should come from the person who has the injury?

DR. RICHTERS: There may also be anger towards the parent for redeploying. In the case of the very young child and, arguably older ones too, some explicit acknowledgment of the fact that the children are not to blame for the injury is necessary. Let them know that there was nothing they could have done to stop it. If the injured parent is capable and cognitively intact, he or she

Some children blame the parent for getting injured and some blame the Army or the President. I know a seven-year-old who wanted to write President Bush in every session and had a strong opinion. Everything that was being said on CNN, the seven-year-old was saying in his language.

is the best source for hearing that information. Otherwise, the spouse should relay that message to the child.

DR. URSANO: One of the goals could be for the parent to be able to develop an injury narrative to tell their child as a way of opening the discussion. It is the parent that is going to open this discussion, and therefore the parent has to develop some ability, skill, facility, comfort, self-esteem, etc. in order to say, 'Yes, I lost my leg...and sometimes kids feel...'

DR. COZZA: That gets back to the idea of 'getting it together' as a parent and doing some self-reflection.

DR. LESTER: Is this something that would happen in your brief intervention? Would this need to develop a clear narrative and make decisions about what to share with the child occur early on in the process?

DR. COZZA: This would not occur in a single session but it would occur early on in the process. If there was a parent mastery session, it would be helpful for that to happen with both parents. There should be a capacity to talk with the child. It allows the spouse and the injured to share the experience together in a narrative and then decide the appropriate way to share it with the children. It requires a certain amount of thinking and processing.

DR. URSANO: Talking about the injury with children is an entire module for an intervention. You would develop it for different aged children. That would be a core component of the parental intervention.

DR. COZZA: The goal may be to come up with two or three things that are important for this child to hear. Communication to the child should be distilled and processed. The parents need to decide what the child needs to hear from them.

DR. MCCARROLL: You need to know what the child wants to hear, as well as what the child might be afraid to hear and what their concerns are. There is going to be a domain including what you know how communicate and a domain of things you may not know how to communicate.

DR. URSANO: This should be a dialogue, not just a one-way narrative.

DR. ARATA-MAIERS: Some children blame the parent for getting injured and some blame the Army or the President. I know a seven-year-old who wanted to write President Bush in every session and had a strong opinion. Everything that was being said on CNN, the seven-year-old was saying in his language.

DR. LESTER: There should be a list of topics for the child that is separate from the parents, otherwise, you are going to run into the things that the child is too afraid to say.

DR. COZZA: There may be a problem if the child is not present. How can you direct the parents and their discussions with the children regarding how much information needs to be shared? Does that need to be determined by a clinician?

DR. RICHTERS: You may not need to know what the child is feeling or thinking to make an absolute statement about, for example, the case of blame or guilt that the child may experience. You should state this in whichever format that is comfortable for them. Feeling guilty and somehow responsible for the injury can be a normal reaction for a lot of children. It is not always obvious when the child feels guilty because it can show up in different ways, or possibly not at all.

There are certain absolutes. The form of the dialogue is different for differ-

The focus of your intervention is on injury communication and parenting function. The list of challenges can be categorized under these two areas. Which of these problems have to do with impaired parenting and which have to do with difficulties related to injury communication?

ent children and the child's family would know the best way to communicate to the child.

DR. LESTER: If the child is not present, you could ask the parents to reflect on what they feel their child's experience has been. That is a step towards that reflection.

DR. ARATA-MAIERS: The parents can look at the child's current behaviors as well as what has been already said to figure out what is going on. Sometimes the child is unable to verbalize what their experience is because they are so involved in the acting out the behaviors.

Parenting Function and Injury Communication

DR. URSANO: The focus of your intervention is on injury communication and parenting function. The list of challenges can be categorized under these two areas. Which of these problems have to do with impaired parenting and which have to do with difficulties related to injury communication? Problems occurring over time could be their depression, a new medication's side effects, their inability to throw the ball with their son, etc. You have injury communication and parenting function with particular sets of problems and strategies directed towards them.

DR. RICHTERS: To address parent functioning effectively, they need to be stabilized and their distress levels need to be controlled.

DR. URSANO: What creates a very strong focus here is the idea of neglecting certain problems. There is a whole area in brief psychodynamic psychotherapy that has to do with maintaining the focus. How does one focus? There is a reasonably well-known article that talks about benign neglect in order to maintain one's targeted focus on what is your goal. Your goal is parent functioning and injury-related communication. What causes problems in these areas and which strategies can alter these?

DR. ARATA-MAIERS: Many challenges fall under injury communication between the service member who has been injured and the child. We should also consider issues around the child communicating with individuals outside of the family including their teachers, peers and friends.

DR. RICHTERS: We discussed preparing the child on how to react when people ask about their injured parent.

DR. MCCARROLL: You could construct a number of 2 x 2 tables. One axis lists what the injured service member wants the child to know and what he or she does not want the child to know. The other axis lists what the child wants to know and what the child is afraid to know. In each of the four boxes, you would have targets that would be fairly easy to talk about. An easy one would be information that the service member wants the child to know and that the child wants to know.

It can become more complex though. Does what the service member does not want the child to know conflict with what the child wants to know and if so, how do you resolve that problem? This could join injury communication and some aspect of parent functioning because if you do not address the elephant under the table, as they say, you are going to have an issue that is going to go unresolved and may impede some aspect of functioning.

DR. URSANO: During a parent assessment, you would be able to ask the parent what things they want to tell their children and what things they are too frightened to tell them. What are the things that they probably want to

We would like the parents to acknowledge that a difficult thing has happened and that they may be worried or sad but as a family, they will get through it and will be okay. It takes some work on the parent's part to get to that point.

know? What are the things they are frightened to know? That would create an interesting grid between parent and child for a targeted focus.

DR. COZZA: The intervention is reworking the boundaries because sometimes the child wants to know information that a parent may be afraid to talk about. The parents need to be reassured that this could be information that the child should know. They may need to switch to a different box when both the parent and the child can handle it.

DR. CHUN: We are getting quite a few injuries that are not only accidental but also self-inflicted. Some feel that a parent cannot tell a child about what happened and some parents want to maintain a certain image of their father being hero even when it is not a heroic battle injury.

DR. LESTER: There may be child-driven reasons for not sharing a lot of information. We think secrets are bad and that it is better for families to talk but on the topic of HIV disclosure, studies showed children actually did worse in the initial year after being told about their parent's HIV illness. Children who knew their own HIV diagnosis were not necessarily doing better than those who had that information withheld. When we are providing guidance, we have to consider how parents make these complex decisions based on their community, their cognitive styles, their child's impulsivity, etc. There may be times when the children are told too much.

DR. COZZA: Parents may even have the child look at the amputated leg in order to accept the reality of the injury. We have seen parents who have told their children nothing and brought them to the hospital to introduce them to the injury without words. This could be a parental anxiety response. The parent is unclear about how to inform the child. The parents need to digest it and go through the important process of reflection first. We expect parents to organize the experience in some capacity for the children and model that organization. We would like the parents to acknowledge that a difficult thing has happened and that they may be worried or sad but as a family, they will get through it and will be okay. It takes some work on the parent's part to get to that point.

DR. LESTER: This is the beginning and the initial meetings will hopefully launch the family towards a series of conversations.

MS. KAUL: A statement of the intervention should assess the communication norms and keep with the core principles of the family culture. The norms may be to talk less about very unpleasant things or to be more protective. We need to assess what they do in a normal situation and see how that fits with the current issue. How do we really help them without taking them so far away from their norms?

LCDR KANE: I would use the words values in that case.

DR. COZZA: If the family's culture is not to talk about anything, we want to respect that as their norm but we also want to help them to recognize that under difficult circumstances, it may put them at greater risk. You have to understand where the family is coming from and where they are.

MS. KAUL: You may pace your intervention accordingly. We should ask about their communication norms in the beginning.

DR. URSANO: We have to organize the information into baseline versus change. We might measure present family communication and then see how it changes afterwards, both in content, process and competencies.

DR. COZZA: To switch gears, the parental reflection idea relates to the

A major goal here is the capacity for self-advocacy. We expect that this is a population whose needs will continue in a larger sense than the average family. It is the idea of recognizing the importance of being able to engage the community in appropriate and effective help-seeking and self-advocacy.

intervention of the PGAI. It is about having the parents think about what has happened. What has the child's experience been? How do you understand it? What has it been like for you? How do you figure out what to say to your child about this? It is an attempt to help the parent organize the experience in preparation for effective parenting. The parent should also be sensitive to the child's cues. This involves the idea of injury communication as a method of thinking and developing principles of injury communication as we consider what parents should or should not share. It is a nice integration of issues. For the extended intervention, we shift towards the protocol for when the child comes in. We now have the opportunity to develop an injury narrative.

DR. ARATA-MAIERS: Families come to us at different points in the recovery process. They may have already gone through some of these initial aspects. We have to assess where they are and may want to move immediately into the development of the narrative.

DR. COZZA: It would be helpful to look at transition and long-term impact. We are now talking about longer term goals when the children, parents, and the family return to their communities post-hospitalization. One goal is to maintain the connection to resources and support.

LTC SCHNEIDER: Another goal may be for the family to feel competent in their ability to deal with injury communication and parenting challenges as they change during the post-hospitalization phase. Can they demonstrate the capacity to utilize the set of communication skills learned while in the hospitalization phase of the injury? In the hospital, the parents practice how to talk to their three-year-old about the fact that his father lost his leg but when they return home, depression may get in the way of that. The parent may ask the question, 'how do I communicate with my child about impact of my depression and how do I continue to parent effectively?' If we can help them to continue to communicate effectively post-hospitalization, then we have succeeded.

DR. COZZA: The goal is to continue to effectively communicate with children and relay adequate amounts of information.

DR. NEWBY: There is a systems response providing a continuity of care to ensure family functioning over a long period of time or after the family transitions, for example from active duty status to civilian status. That seems to be incorporated in the elements here.

DR. COZZA: A major goal here is the capacity for self-advocacy. We expect that this is a population whose needs will continue in a larger sense than the average family. It is the idea of recognizing the importance of being able to engage the community in appropriate and effective help-seeking and self-advocacy.

DR. ARATA-MAIERS: The process at BAMC can take years actually. They are in the hospital for anywhere from a couple of weeks to a year or more, and after that they may remain on post and go to the hospital nearly every day for another period of time. After moving out to the wider community, they still visit the hospital to get their medication. Then, they may be VA or go back to active duty. This can be a very long process and there are going to be different needs of varying intensities over that time. Self-efficacy is important but there is also specificity to it.

DR. MCCARROLL: They carry those principles of self-efficacy with them

The fact is that most of the amputees demonstrate war resilience. Most of the amputees at Walter Reed, when they can, choose to wear shorts. It is a badge of courage. It demonstrates the ability to overcome the injury.

and they are sort of independent of the conditions.

DR. ARATA-MAIERS: As time passes, their issues become more related to the larger community versus the family. Part of the self-efficacy needs to be around negotiating and interacting with the community.

DR. LESTER: Are there interventions for injured service members without children, which would help support those long-term rehabilitation goals? There are goals for everybody who has been physically injured and transitioning back to the community. Case management becomes important in helping ease the transition.

DR. ARATA-MAIERS: There are people who negotiate those pieces for the service members, for example case management personnel or Defense and Veterans Brain Injury Center.

DR. COZZA: There is system interest in maintaining continuity of care and we should also look at the family aspect of that. Relapse prevention activities are of importance to the family. This may move towards another goal. This may not be part of the formal intervention because it does not move into the sustainment phase but the development of a narrative is something for VA colleagues to think about. A sense of family continuity pre- and post-injury is very important. It may be helpful to describe experiences before the injury or deployment. What has happened and where are they now? Are there ways of identifying threads of continuity that give the family a sense of integrity? That is a concern.

LTC SCHNEIDER: That is a great idea for a Department of Defense-Veterans Administration grant.

Community Reintegration

DR. ARATA-MAIERS: When the injured service member re-integrates into the community, the community reacts positively or negatively to seeing the injured person and the family is aware of those reactions. If the father goes into the school setting, the child may experience concern about him meeting his/her friends. There needs to be communication and a consideration of the developmental aspects. How does the family navigate through the community system and when the community responds, how does the family handle the response?

DR. URSANO: We discussed the hospital discharge and the concern about caring for the injured soldier and the anxiety over the caregiver burden. It is important to consider the transitions of care giving that fall on both the adult and the children. The child indirectly experiences the care giving of the injured parent and may possibly participate at times. How can we effectively manage this burden?

LTC SCHNEIDER: The fact is that most of the amputees demonstrate war resilience. Most of the amputees at Walter Reed, when they can, choose to wear shorts. It is a badge of courage. It demonstrates the ability to overcome the injury.

LCDR KANE: We could include this injury situation in the developmental roles of the parent and children and look at how the family accommodates for the physical limitation of the injured member. The long-term goal is being able to adapt and accommodate with this new injury and accept that it has become part of the family: we can make it a visible part; we can look at it; we can talk about it.

An individual with a disfiguring injury is going to have to deal with the shock people may experience and communicate throughout their life. Whereas the amputee may put on a pair of pants and a lot of people may never realize the extent of the injury. TBI involves primarily the family who must deal with the injured parent's potentially inappropriate behaviors in public. These are all very different types of challenges specific to the injury of the service member.

DR. NEWBY: It has to be incorporated into the community and reflected in the services that the community provides. With a lot of soldiers coming from rural communities and communities that don't have a lot of services, it is really important that we consider that.

DR. ARATA-MAIERS: It is not just an issue of adjusting to the limitations; it is the changes. It is not just what they cannot do; it is the fact that they look so different than other children's parents, or the parent they used to be. Parents who have burns that you cannot see have different issues within their families than those who have visible burns. Sometimes it is easier that they are visible. There are a lot of issues around the change and not just the limitations.

DR. CHUN: It may apply to TBI, too, because it is often unseen.

DR. COZZA: Remember this thinking is from the health care system perspective and not the community at large. What are the issues either just pre-discharge or within the receiving health care organization that would assist with some of the challenges faced by the family? What would be the strategies to facilitate a sense of comfort and belonging in the community and to manage family care giving burdens?

DR. CHUN: We could stay on the theme of injury communication.

LTC SCHNEIDER: If a service member has a disfiguring injury and their family comes together, their story becomes an example of how you can deal with this experience. An individual with a disfiguring injury is going to have to deal with the shock people may experience and communicate throughout their life. Whereas the amputee may put on a pair of pants and a lot of people may never realize the extent of the injury. TBI involves primarily the family who must deal with the injured parent's potentially inappropriate behaviors in public. These are all very different types of challenges specific to the injury of the service member.

DR. URSANO: The challenges in the transition show up in the categories of parenting function and injury communication. What is Johnny going to tell his best friend next door about his parent's injury, and how has the parent noticed that or addressed that? What are the child's challenges that the parenting function should be dealing with at that time?

DR. RICHTERS: It is helpful to have the two bearings of parenting function and injury communication because they tell us when we are venturing beyond reasonable intervention goals. In order to help them in this transition phase, we would give them a layout of the land and show them the kind of things they will be facing in some form or another including the potential reactions of other people. The child deals with the reactions of their friends after seeing them for the first time since their parent has returned home. Beyond that, the injured parent is exposed to the public and people's reactions. We need to forewarn them about the things they will be going through. Help them to think about the types of things they are going to experience in advance and guide them through some strategies.

DR. COZZA: There is this idea of self-efficacy within the injured population. The strategy would be getting parents to ask for help based upon the injury's effect on the family who may have been completely self-sufficient in the past and pre-injury.

DR. ARATA-MAIERS: One of the major things you see happen to TBI and burn patients is social isolation due to exhausting care giving responsi-

Remaining culturally minded, military families often pride themselves on their self-sufficiency. They do not necessarily like seeking out or demanding things. It is important to develop or shift the model from one of dependency to self-sufficiency or self-care.

bilities and fear over how the TBI or PTSD patient is going to behave. Whereas for the burn patient, it would be fears about how the community will respond. Part of the focus needs to be to help the family avoid social isolation.

DR. COZZA: Some of this is psycho-educational. It is identifying family social isolation.

DR. LESTER: It is reactivity to reminders and relapse risk as they are engaged in health care systems. We do a lot with our medically ill moms about assertive communication skills with providers and systems of care and accessing support. There may not be room or time to do that, but they seem to get a lot out of it.

DR. ARATA-MAIERS: With this review, you might want to add communication with schools and other institutions about parenting and child issues related to the injury.

DR. COZZA: Remaining culturally minded, military families often pride themselves on their self-sufficiency. They do not necessarily like seeking out or demanding things. It is important to develop or shift the model from one of dependency to self-sufficiency or self-care.

DR. ARATA-MAIERS: One woman that we worked with said people have been asking her for months if they could help and by the time she realized she needed help and was ready to accept help, they stopped asking.

LTC SCHNEIDER: For most injuries, it is going to be about overcoming and adapting to the injury. In the case of severe and moderate to severe TBI patients, we have to focus more on the *other parent's management* of the injured service member.

LCDR KANE: We have not discussed when a parent dies. There is grief and a great loss. Our group is focused on injuries that are recoverable and allow the injured individual to regain parenting roles. For example, you talked about an earlier goal that the child will recognize the parent and see this role in them. Much of that has to do with clear cognitive abilities. When you talk about the impact of TBI, the service member is not who he used to be. It is different and you might think of it in the area of grief and loss as opposed to the service member being able to return to the developmental pathway that had been there before the injury.

DR. ARATA-MAIERS: Grief is a large part of the whole process. Unless they are regaining full functioning, they are losing certain abilities that may impact the parent functioning. Some abilities may never be regained, whether it is cognitive or physical, so there must be an adjustment to those losses.

DR. URSANO: Sometimes also, the issue about not focusing on the child's symptoms. A child's depression might be a very appropriate outcome. By focusing on the child's symptoms or targeting attempts to change the child's symptoms, you may miss the fact about whether or not they are being appropriately managed and parented. Depression would be very appropriate for that study.

DR. CHUN: When the parents allow their children to do socially and developmentally appropriate things like sleep over at a friend's house or have friends over to their house, they are maintaining social and developmental norms as a family.

DR. COZZA: It is that continuity and shows that not everything has changed. There are still some things that they have that they had in the past and those can be sustaining. This is also related to marking holidays. Holiday

What about the adolescent with a parent who lost a leg who goes home and their response is to drive fast or to drink as a way to ensure their own sense of integrity and their sense of strength and power?

traditions, celebrating birthdays are things that are a normal part of their family life and they are not giving those up. Those are deployment based issues. It is the idea of regularity to life that is reassuring.

DR. URSANO: Taking that to the picture and next stage of adolescence, the idea of anticipating problems comes up. What about the adolescent with a parent who lost a leg who goes home and their response is to drive fast or to drink as a way to ensure their own sense of integrity and their sense of strength and power? The goals should include this picture. We should be anticipating both the challenges and the times when help may be needed so that there is knowledge about future child developmental responses. What is going to be measured that indicates the intervention itself had done what it said it was going to do; not that it cured all of life, but that it carried this one issue through?

DR. COZZA: The way I am viewing this is to inform our thinking earlier on. This could turn out to be important information for families. It may not be part of an intervention, per se.

DR. URSANO: You could track how often the parents access your email information system afterwards. This could be a way to see whether or not they tune in every six weeks and whether or not they respond to your communications to them with boosters.

DR. RICHTERS: At this phase, we are not giving them a fish dinner; we are teaching them how to fish. All bets are off once they leave the hospital. We can follow-up and make contact, but this is our last certain chance to arm them with certain proactive skills.

● Outcome Measures

DR. URSANO: Brainstorming about possible measurements will keep us targeted, so what would you measure six months later? As John said, life goes on. There are many things that will happen in the next six months that you did not anticipate, plan for, and that were not involved in your intervention, but what piece do you think might be sustained six months from now? It is not going to be symptoms, it is not going to be 'life is great,' and it is not going to that finances are good. What might it be? It might be parental communication about child problems. It might be that they have a new way to talk about what the present injury problem is.

DR. COZZA: It could be the development of discharge goals. Three months later, you might call them to check in.

DR. URSANO: Ask how the first PTA meeting went.

LCDR KANE: Ask if they are still talking at dinner each night.

MS. VINEBURGH: The family story concept gives the family a sense of self-efficacy with the knowledge that they can construct their own story. The categories of injury communication and parenting function are defined in a language that can be shared. They both provide a metaphor for a family but they give some structure to their own measurement. Are they communicating well? Is the communication meaningful to the injury? The idea of the parenting function is a self-alerting mechanism and is an ideal. We have created some language that could be very adaptable to public education.

DR. URSANO: An assessment can include general items and family specific items. There would be an injury communication score with seven generic items and three items developed for the specific family and their unique chal-

It is not the narrative itself. The narrative is merely an indicator that a process has gone through. If you are going to measure something, you have got to measure that piece, not the narrative. The fact that the family developed the narrative is not the outcome.

lenges. Similarly for parenting function, there would be a total of ten items. Seven are generic, defining the usual problems, and three are very specific to what you have learned about this family. Then, they score themselves on that. It becomes both a booster shot, as well as an assessment as to how are they doing in these areas that again is focused to the intervention. Are they remembering this particular area, which is unique to their family as an injury communication problem? Are they remembering this particular issue of parenting function that their particular family has problems with, and how do they score themselves on a scale of 1-5, on each one of those?

LTC SCHNEIDER: It would be good to have a module that includes a narrative with the whole family, and in one session you could look at the outcomes and see whether the family came together to share the narrative. It is important to have the whole family share in the development of the narrative. It helps to overcome the isolation that the service member feels about the injury; being something that he went through while his family was not there and therefore they cannot understand it. It could be seen as a copout to say, 'you were not there so you cannot understand it.' It is important to encourage people to develop their own story as a family unit.

DR. URSANO: It is an operational outcome. I am a little concerned about too much focus on the narrative itself because there are many studies that have looked at that. Many adult studies have looked at whether an individual is able to develop a cohesive picture of their illness, their disease and their life, and if that predicts better outcomes. The answer is, it does not. As a psychoanalyst, I have a big investment in that process, but it is not the goal nor the mechanism nor the outcome. That happens to be one of the sidebars. The outcome may be that there is a decreased avoidance that has occurred. It is not the narrative itself. The narrative is merely an indicator that a process has gone through. If you are going to measure something, you have got to measure that piece, not the narrative. The fact that the family developed the narrative is not the outcome.

DR. COZZA: We are seeing the narrative more as a strategy.

DR. URSANO: It is an integrated way of pulling together your interventions.

LTC SCHNEIDER: Does that strategy facilitate improvement in that particular outcome goal of reducing avoidance?

DR. LESTER: The narrative allows you to hang on to some of the skills that would appear to be irrelevant to a family unless they are revealed as connected to their issues. It is a strategy. If you are going to teach emotional regulation skills, which reduce stress, it is better to do it in a way that appears relevant to the family.

DR. COZZA: Returning to the categories of *Parent Function* and *Injury Communication*, have we identified a third one around the idea of self-advocacy? It goes beyond parent function. It is a family function and the expectation that the families should be able to care for themselves in the future in spite of the injury. It is a matter of the child asking the parent for help appropriately when needed. It is the parents who recognize when they are running into trouble, and seeking out health services appropriately, rather than engaging in risk behaviors such as alcohol misuse. Again, it is a family function and family self-efficacy within the community and not just within the medical environment.

We should arm them with skills that encourage them to anticipate and approach future challenges in ways that are healthy and successful as opposed to breaking down into substance abuse, repression, denial, family conflict, etc.

DR. URSANO: The family function might fit with the idea related to the way the family is operating.

DR. MCCARROLL: How about the idea of self-surveillance or self-monitoring as tools? Would you construct a method that most individuals could use to monitor themselves and their functioning? You could probably extend that to the family, as well.

DR. URSANO: Nearly all family measures are means of asking the child, asking the parents, and then adding it all together. The only place where that may not be true nor possible is where you actually videotape the interactions of the family.

DR. RICHTERS: We have done some diagnostic work with young children and the discrepancies between parent and child reports. They are notorious for their disagreements, but it turns out that a lot of them are not really disagreements. We interviewed some of the kids independently in a room for a section of the DISK (Diagnostic Interview Schedule for Kids), and simultaneously one of the parents in the other room was going through the same questions about the kid. Then there was a debriefing session, and often the child would say that she did not have symptoms, and the parent would say she has a great deal of symptoms. Although they actually agreed during the session, they disagreed in their individual reports. You had to know what was going on. There appeared to be a lot of disagreement, which is probably why some people have gone to these composite measures that are psychometrically more reliable even though they do not tell you anything. For the kinds of things that an intervention has to confine itself to, the only outcomes that we could reasonably rely on would be much more objective.

DR. COZZA: Maybe it is family problem solving instead of family efficacy. It is an important idea to include because our biggest concern for these families is what happens to them when they leave the health care setting. We should arm them with skills that encourage them to anticipate and approach future challenges in ways that are healthy and successful as opposed to breaking down into substance abuse, repression, denial, family conflict, etc.

DR. URSANO: The type of measurement that comes to mind is to ask the family to solve a medical-related problem. You could videotape the interactions and derive scores based on certain questions. Did the family communicate emotions about the event? Did the family communicate negative emotions about the adventure? Did the family problem solve about the event? Were they able to express varying emotions about different topics? You would try to also get a sense for the flow of the session. Then you would somehow score the family on their responses. That brings up the measurement issue. Measurements for this do not exist.

DR. COZZA: It could be done in a way to determine whether they followed up with their health care provider three months later. What type of problems with continuity of care and compliance did they have? What were the challenges related to community reintegration? They may look at a list of community reintegration challenges and tell whether they occurred in their own experience, and how and in what way they managed those specific challenges. We want to get a sense for how they tackled the real problems.

DR. URSANO: You could certainly look at what they accomplished, what the tasks and problems were, and how they did it. Did they do it through family function? Did they do it through one parent who was shown to be capable

One of our roles could be to assess their risk before they leave the hospital.... This assessment would be based on our evaluation of how they went through the hospital stay, their progress throughout, and finally, an evaluation of how well we thought they were going to do upon leaving.

of handling it? Did they do it through a child who took on that role?

LTC SCHNEIDER: Your outcomes are not one-to-one with your families.

DR. CHUN: You can measure the absence of negative outcomes.

LTC SCHNEIDER: One of our roles could be to assess their risk before they leave the hospital. We assessed one family as not being at high risk and we assessed another family as a minimal concern based on our interaction. This assessment would be based on our evaluation of how they went through the hospital stay, their progress throughout, and finally, an evaluation of how well we thought they were going to do upon leaving.

DR. RICHTERS: Would you then have done a study of clinical judgment?

DR. NEWBY: Are there measures of family problem solving?

DR. LESTER: The McMaster Family Assessment Device (FAD) has a problem-solving scale. There are also reasonable measures of family conflict.

LCDR KANE: We are starting to get into lofty goals and long-term goals in family function. We are perhaps getting ahead of ourselves. We have a three month window, for instance, where a family is going through a very uniquely challenge experience and we would like to provide the family with resources and help to get through so that when they look back, they can see that the military helped them to get through the ordeal. That is a very measurable outcome. The families can look back at the process and see that they were included, sending the message that the family is important to the military. In terms of the outcome goals, we will do better if we focus first on the short-term things that we are doing here. The long-term will evolve over time. We are struggling over the measures of our long-term goal because we are looking ahead, but there are still areas, 1-4, where we have very reasonable, focused, outcome goals that are more applicable to what we are going to get out of this topic.

DR. COZZA: The transition out of the hospital is important and is a factor in the experience that looms large. The question is whether in the short-term, there is a way to build in certain information to the families in an intervention that may be useful as they transition. Whether we eventually measure it useful or not, and regardless of how difficult it is to organize, it is important to prepare the families. We know these families are going to meet multiple challenges upon their transition out of the hospital. It is important to include a method for preparing the families even if it is a 15 minute conversation or connecting them with resources that will be useful in the future to address reasonable problems. Then we can measure the impact of our preparing them.

DR. URSANO: Is the family self-efficacy a process that you are trying to change, or is this an intuitive process that you think leads to an end result? Let us think of the perfect study only because it highlights your question. The perfect study is to have families randomized so you know they are exactly the same. You do not have to worry about other pre-variables. They are randomized to different interventions. They have your intervention and they have another intervention. One of your outcome measures might be the number of times they contact the hospital after they leave. You would expect that people from your group might have made more contact because they are more effective and they are capable of problem solving, etc. You might decide that was due to family self-efficacy. That would be your construct for explaining this

Family self-efficacy might be the broad construct and the two areas of impaired family self-efficacy in this set of families are parenting function and injury communication.

outcome. The outcome you are measuring is whether they made more follow-up contacts. Did they make more visits? Were they happier with the outcome of care? The group with your intervention would be higher than the other group. The family managed the problems better, but you would not necessarily measure family self-efficacy. You would be saying that efficacy was the explanatory construct by which you understood how the parental function and the injury communication were resulting in a better functioning family and, therefore, this was your outcome. In contrast, if you want to change family self-efficacy, then you have to be able to measure it during this study. You have to be able to show that it was there initially and that it changed in the end after the family was exposed to your intervention.

DR. RICHTERS: You should be able to show that it was not a measurement of some other component. e.g. parenting function or injury communication, but it was its own measurement.

DR. LESTER: It is hard to know because you would probably do five things at once, for example, the education piece, the narrative piece, the skill piece, etc.

DR. RICHTERS: If you have a sample size that is large enough and you have these components organized, you can keep track of all of it if you measure each piece.

DR. URSANO: Family self-efficacy might be the broad construct and the two areas of impaired family self-efficacy in this set of families are parenting function and injury communication. The family self-efficacy may have another 10 or 12 components to it. You are targeting these two dimensions of family self-efficacy as areas that become impaired in this set of families, and therefore, your intervention is targeted to these. But construct-wise, you are always thinking of family self-efficacy.

DR. COZZA: Family self-efficacy may be too broad. It may be more of the idea of effective problem solving. It is not an injury-communication issue. You could describe it as a parent function issue but it is not just the parents. It is the family's capacity to problem solve. We expect that they are going to face multiple problems in the transition that are related to the child, the injury, and the family function, which also impacts the child.

DR. URSANO: I would be cautious. Remember that you are now launching these people off into the world. There are a thousand variables you cannot control, for example, how many providers there are and where they are. The idea that the family will be able to solve all the problems that are out there assumes that the system is functional and consistent no matter where they go. If you say they are going to solve all of the problems related to the injury and seeking health care, you are assuming that the system out there is very good, and the same everywhere. Are they able to solve a problem around injury communication or parenting? Problem solving within parenting function may include how the parents decide how much allowance to give their children or how to decide whether to let them get a car.

DR. RICHTERS: There is another level of complexity. Suppose you decided to look at ultimate outcomes of how many and what kind of health services the families seek out. How do you interpret that? Do you use that as index of how a family is doing because they need to seek psychiatric care or they may have a child hospitalized? In other words, are those positive outcomes of family communication because they are dealing with problems they might

It is the idea of preparing individuals for uncertain times. It is not just a matter of telling the family that they are going to experience this or that problem. We want to help the family figure out how to recognize when they are in trouble and how to approach those issues.

otherwise not have? They become complex issues and the worst thing to do is to think we can approach them simply.

DR. COZZA: It may be difficult to study but if we are going to engage in any kind of intervention, there is an obligation to help these families prepare for what they are going to face. There is an obligation to do this in a way that is evidence-based. How do you construct it and how do you study and measure it?

DR. RICHTERS: Those things are easier to think about than what you use as outcomes. It is a lot easier to get consensus on what components ought to be in there.

DR. ARATA-MAIERS: When the family comes to the point where they are being discharged and going out into the community, there are three things that seem to be very important. The first one is that they should have a sense of what is going to happen next in the recovery process. Often, the doctors focus on the medical things and what is happening right now, and they do not prepare them for afterwards. The parents, who often experience issues later on, feel like they were never prepared for the other things that occur during the long-term recovery process. Anticipating what the future is going to be like is important for them so that they are prepared. The other part is problem identification. It is helping them to identify problems within the family, knowing that the two-year-old who starts to say 'no' all of the time is not related to the injury, but rather should be identified as a developmental problem. The adolescent who starts getting angry may be a developmental problem or it may be something beyond that. We should help the parents identify when this behavior is developmentally appropriate and when is the point in time where they need to seek additional help for that child. Another example might be helping to identify when the father's drinking becomes a problem to address. It is the ability to identify the problems as well as figuring out how to master them. That is the first step in problem solving. That may be something that you can do, at least in a psycho-educational way, with families before they leave the hospital. The third part is identifying challenges they might face in the larger community. How do they interact with the community and what are their concerns with this interaction, around the issue of the injury?

DR. RICHTERS: Given our interests, I cannot imagine a coherent intervention without this component of preparing them for what they are going to be face in the future.

DR. COZZA: We need to see if there is a way to consider the model a little tighter. It is the idea of preparing individuals for uncertain times. It is not just a matter of telling the family that they are going to experience this or that problem. We want to help the family figure out how to recognize when they are in trouble and how to approach those issues. *It might not be a matter of solving the problems as much as it is identifying and addressing each of them.* I have two question marks next to that.

DR. NEWBY: We might consider fostering resilience to achieve that, in addition to the notion around problem solving.

DR. COZZA: We should all agree on the definition of resilience.

DR. URSANO: Resilience is defined as good parenting and ability to communicate many of the problems.

DR. LESTER: It might be the ability to anticipate and problem solve.

As a result of this meeting, the group agrees that there is a core set of principles that should guide the intervention with injured families. We need to be thinking about family communication, the health of the family and its impact on the injured service member, etc.

Closing Comments

DR. COZZA: For those who have survived and stayed the course, your contributions are appreciated. A great deal of information has been exchanged, and it will be tremendously helpful to us. Our plan is to organize this information to clarify *core principles* with feedback, and to distribute them as a comprehensive list of consensus core principles. Understanding how we will develop the intervention around guideline-specific strategies will be an iterative process. We need to understand guidelines in a construct that generally informs the population, and in a way that helps us to define a specific intervention that can be studied and evaluated using measurements.

Now there is an opportunity for final statements.

LCDR KANE: Is the PGAI, which we are using at Walter Reed, ready to be rolled out? Is that something that a clinician might use to be able to do a one-time assessment to inform what is going on? We will look forward to the FOCUS-oriented module program that will be piloted at some point. I also look forward to presenting the ideas here to Captain Klam outlining the sort of things we could do for a one-time intervention and then a modularized intervention. He will want to know what level person to hire to do these types of things if we're going to implement these ideas, which can be stratified beginning with a one-time intervention. So, how do we operationalize all of this? How do I help the Navy to start incorporating our ideas?

DR. URSANO: There is nothing to implement yet. There are some principles of guidance on how to provide care and that is what one can communicate. There is nothing here that says what to do or how to do it. There is nothing here that says this works or this does not work. One can communicate about this wonderful discussion, which indicated core principles that we need to be sure *are present* in our ongoing programs. In talking to Dr. Klam, one might want to ask if parenting function and injury communication challenges are being addressed. The Workgroup is working on formalizing techniques to address and measure these challenges to be sure that interventions and programs can help. Those are important issues and they ought to be at the core of our thinking about our providing care. We should look at our present treatment programs to see whether or not we are addressing parenting and injury communication.

DR. COZZA: As a result of this meeting, the group agrees that there is a *core set of principles that should guide the intervention with injured families. We need to be thinking about family communication, the health of the family and its impact on the injured service member, etc.* There is a challenge for the person on the ground in terms of using that information. That is a strategic issue. There can be some leveraging at the medical center level to see how other people are using the information. It is a tool for the executive at the health care facility site to be able to organize a response.

DR. URSANO: "Tool" is being used metaphorically. It is a concept.

LTC SCHNEIDER: It is similar to the level of the DSM. *It is an organized way for us to be communicating in the same way about the issues and asking the same kind of questions.* The PGAI offers some guidelines and it is a tool in that way. It helps us all to be looking at the same issues and thinking about it with the same focus in mind but it is not an intervention with outcomes.

DR. URSANO: The other thing to ask your colleagues is whether there are things that our focused ideas of parenting and injury communication do not

You have taken a knowledge base and incorporated it into child clinical thinking. It does not represent all of the clinical thinking, and it is not meant to be the only thing collected.

address and if there are dangers in this. What do you think has been forgotten?

DR. COZZA: Returning to the PGAI, there is an interest in incorporating concepts about strength, and developing core skills in families. We also want to predict family challenges. The instrument may be modified as we develop a better understanding of the problems.

DR. LESTER: Do we feel comfortable with somebody using it without training for how to respond to a family? It is a detailed, structured interview that seems to elicit a comprehensive summary.

DR. RICHTERS: Currently it is an information-eliciting interview, which has no built-in guidance even though it is used clinically.

DR. LESTER: There is guidance woven into it. The question is whether you would hand it to somebody and feel comfortable that they would be able to use it effectively without information about how to respond and give feedback to the family.

DR. URSANO: Training is an important part of implementing the program.

DR. ARATA-MAIERS: Is utilizing this instrument in and of itself a program? At Brooke Army Medical Center, we are working with clinicians who have a certain level of clinical skills and a knowledge base. We are orienting them to the instrument and preparing them to respond to the potential tangents from the interview. These are clinical trainees under supervision so they always report back to supervisors. We are setting up an organized context in which they use it.

LTC SCHNEIDER: We have the ability to collaborate with the other institutions and utilize what is available now. Most people who have used the PGAI have seen some value. The PGAI is not yet developed at a level where it will provide certain outcomes or a sense of security in knowing what will come from it, but that does not mean it is not useful.

DR. URSANO: Someone may come back one year from now to say that we instituted and supported the development of a program that in fact totally neglected Z and we now know that Z was the most important component of intervention for injured soldiers. We should be careful about that even if it is benign neglect. You have organized concepts that a group of thoughtful clinicians have indicated as important to review programs for. Each group needs to have its own thoughtful clinicians to think about where the instrument works, where it does not work, where its holes might be, etc. because it is not a complete tool. We need to be cautious.

DR. COZZA: This came up in our discussion yesterday as an encouragement of the use of this, or a similar approach within the context of development to understand how effective it was.

DR. URSANO: You have taken a knowledge base and incorporated it into child clinical thinking. It does not represent all of the clinical thinking, and it is not meant to be the only thing collected. It supplements the usual assessments done on this population. You are advising clinicians to think about these things and that is different than instituting a program.

DR. COZZA: It is just a way of organizing thoughts in a useful way when talking with the spouse. We might make the PGAI available for a clinician at a particular site, and within the context of their clinical programs, they can decide what is helpful and how it could be integrated into the way they do their

The reason why some interventions, which are shown to be effective in testing, no longer work is because there are important components that enable the intervention to work in one setting but not in another.

work. They can decide what is reasonable. There is agreement that this is going to be an iterative process and there may be changes. It is not an evaluated instrument. In terms of clinical experience, we found that spouses find it helpful to be given the opportunity to speak about their experience. It is a way for the clinician to organize their approach with spouses so that they cover important areas related to child preparation, child education, psycho-education, etc. The next step is to address any pieces that are missing from the instrument.

DR. CHUN: We have to use qualifiers because this is an interview guide.

DR. URSANO: When the PGAI reaches Camp Lejeune, and it is administered by the Sergeant who just came back from Iraq, to the wife of an injured soldier, will it collect reliable information and lead to appropriate interventions? When it reaches Fort Stewart and is administered by the 91-G in the outpatient clinic to the soldier who is there in medical care, and his spouse, will it generate accurate information and lead to accurate interventions? This is the way a program needs to be and that has to do with training and who is qualified to do it.

LTC SCHNEIDER: The SCID (Structured Clinical Interview for the DSM) had important study components to it, but was it good for everybody in every situation, and can you roll it out and have everybody do it? You cannot.

DR. URSANO: The SCID actually had an advantage over the PGAI. The proposal of the PGAI implementation requires high-level skills in the assessment.

DR. LESTER: I train child psychiatrists, and given that they do not have experience with this, I would be worried handing that interview to trainees. They may not know what to say or what to do with the information. Do they have the developmental knowledge, though, to respond to parents about some of the developmental issues?

LCDR KANE: It requires somebody who has this knowledge to supervise them.

DR. ARATA-MAIERS: These are very legitimate concerns and we need to address them, but there is a danger that these concerns stagnate and prevent us from responding clinically to the patients we have. Some families will end up gathering information from outside of the healthcare and military community, perhaps from individuals who have even less experience dealing with the family challenges. Their health needs may not be addressed adequately because help is not coming from knowledge or evidence-based interventions. We currently have patients coming in and we have to respond to them clinically. How do we do so in an informed fashion until we move this intervention further along? One possible answer is to make sure that our principles correlate with our developing interventions. I do not want to lose sight of the reality that we will continue to treat combat injured families and we need to improve our response to them.

DR. URSANO: We should remember that what is being built is something that will require resources and support from the environment around it in order to function. If you were to take what you have designed and you moved it to Fort Huachuca, Arizona, the presence of additional support services for injured people changes dramatically compared to what exists at Walter Reed Army Medical Center, Brooke Army Medical Center, and Bethesda Naval Medical Center. Would you expect the same outcomes? The resources provided by the surrounding community relates to whether or not an out-

This needs empirical study to define when, under what conditions, how given and in what ways can interventions on parenting and injury communication help, or in some cases impair, restoration of family function. The system requires a definition around which this particular set of lenses or flashlights may be helpful.

come is possible. We were talking about the question of looking at long-term outcomes in one of the interviewing variables and whether or not this type of intervention will have any impact on certain other variables. What happens when you put a person in a setting in which they have no access to care, no car, and nobody is available to help them with it, and by the way, many in the community are not sympathetic to anyway? The reason why some interventions, which are shown to be effective in testing, no longer work is because there are important components that enable the intervention to work in one setting but not in another. Not only do you jump over evaluation, you jump over the step to generalization. You have yet to show its effectiveness when you generalize it to other places. You have to show that it works somewhere before you can even assume that it might work everywhere.

LTC SCHNEIDER: The PGAI is really just like a flashlight. It allows us to shed a little light on the situation and see where we are going. Now we are moving on to the next phase of trying to figure out what we saw in the dark, and bring some clarity to that without stepping in the trap.

DR. URSANO: It is a generic issue, but it also has some specificity. If we hone to it, there are some important pearls to be found. The pearls are the importance of *injury communication and parenting function*. The opportunity with the PGAI is to focus on the importance of injury communication and parenting function. If there is already support for family problem solving within the family and within the community, then these two issues become central to *family resilience and function*. If family problem solving is not present because of family deficit and/or lack of assistance, then injury communication and parenting may be *minor contributors to outcome*, swamped by the larger problem solving needs.

Regarding problem solving and family resilience, there is a great deal of help in the system directed towards problem solving in general. So, better defining *how assistance in injury communication and parenting can assist is important*. This needs empirical study to define *when, under what conditions, how given and in what ways* can interventions on parenting and injury communication help, or in some cases impair, restoration of family function. The system requires a definition around which this particular set of lenses or flashlights may be helpful.

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Appendix

1) Principles of Caring for Combat Injured Families and their Children

Principles of Caring for Combat Injured Families and their Children is a product of the Workgroup on Intervention with Combat Injured Families that took place in December, 2007 in Bethesda, Maryland. The document communicates ten core principles of care intended to guide simultaneous endeavors of scientific research and evaluation, and clinical interventions aimed at mitigating family distress and dysfunction, and at improving communication around the injury across multiple settings: healthcare, family and community.

2) Resources for Recovery

Resources for Recovery is a product of the Center for the Study of Traumatic Stress of Uniformed Services University of the Health Sciences. *Resources for Recovery* is a public education campaign to educate military healthcare leadership and civilian health professionals who work with and treat military families affected by combat injury. *Resources for Recovery* is disseminated to healthcare professionals as well as military families to enhance injury communication from the acute hospital setting (Stabilization Phase) throughout long-term care (Sustainment Phase). Current and future installments of *Resources for Recovery* can be accessed at www.cstsonline.org.

Principles of Caring for Combat Injured Families and their Children

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

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

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

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

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

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

Principles of Caring

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

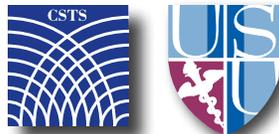
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Workgroup on Intervention with Combat Injured Families

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

- rehabilitation process. Interventions must meet the family where it is within the recovery process, recognizing a family's unique strengths and challenges, as well as anticipate its future needs through transition to a new community or new way-of-life.
- **Effective Injured Family care requires an *interconnected community of care*.** Effective intervention requires collaboration and coordination of services between the family, the health care system, and military and civilian community resources. This collaboration fosters a community of care that reaches across traditional professional boundaries throughout rehabilitation and recovery.
- **Care must be *culturally competent*.** Healthcare and community professionals who interact with combat injured families need to possess the cultural and language competence to engage families that may be traditional or nontraditional in their composition and may be of broad ethnic and religious backgrounds. It is essential that all healthcare and community service providers understand and respect the unique experiences and traditions of military families.
- **Communities of care should address any *barriers to service*.** Barriers to intervention can complicate the healthy recovery of combat injured service and family members. These barriers may include a family's difficulty in accessing health care or community services. In addition, a community's lack of awareness or misunderstanding of the needs of a combat injured family or a family's reluctance to seek assistance (due to stigmatization) can also limit family intervention and recovery
- **Families, communities and service providers must be *knowledgeable*.** Individuals, families, professionals, organizations and communities all have a need for access to quality educational materials to address the challenges that confront combat injured families. Effective education leads to the development of skills in all parties, building empowerment in communities and families. Development of new knowledge is fundamental to better meeting the needs of this unique population.

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The Combat Injured Family: Guidelines for Care

Military families and children represent a heterogeneous population and live in geographically diverse settings: on military installations, in civilian urban and suburban communities, and in rural areas across the country. While military families are generally robust and resilient, the stress of war (combat deployments, combat injury, illness or death) challenges the healthiest of families, be they active duty, National Guard or reserve.



Combat injury is a life-changing event that impacts the service member, his or her children, as well as other family members and loved ones. Parental injury disrupts a family's routines, cohesion and sense of safety. Existing patterns of parenting undergo change as both injured and uninjured parent cope with complex emotions and the

complicated reality of medical treatment and rehabilitation. Children are particularly vulnerable and often adults do not know how to speak to them about the injury, or how much and what kind of information to share.

Many military families and children will demonstrate initial distress in response to combat injury that is likely to be temporary. However, a number of children may sustain life-changing trajectories in their emotional

development and their interpersonal relationships. Experts in military medicine and the traumatic effects of combat injury on families and children have developed the following principles of care to guide the outreach of hospital and community-based professionals in military and civilian settings.

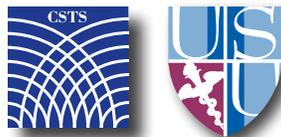
Principles of Caring for our Nation's Combat Injured Families and Children

As health care professionals, your role is invaluable and needed in caring for the families of combat injured service members. Your understanding and implementation of these principles of care can profoundly impact the health and recovery of injured service members and their loved ones. Remember, there is no such thing as a combat injured service member — think combat injured family.

Care and services should be delivered in a manner which:

- Provides a sense of safety, comfort, information, practical assistance and connection to appropriate community resources that can foster the combat injured family's healthy recovery.
- Is family focused to help relieve family distress, supports parental availability and effectiveness as much as possible, and helps guide a parent's efforts in communicating with their children about the injury.
- Reinforces a family's natural resilience while addressing special problems that might arise and require further help and support.
- Is sensitive to the unique responses of children of varying age and gender, and recognizes that distress, care needs and communication ability will vary according to the age of a child or children.
- Is tailored to the family's changing needs throughout treatment and rehabilitation recognizing the family's unique strengths and challenges, as well as anticipating future needs in their transitions to a new community or new way-of-life.
- Fosters the collaboration and coordination of services between the combat injured family, health care resources and treatment — military and civilian — reaching across traditional professional boundaries and levels of care.
- Respects the family's unique background including culture, language, composition (traditional or nontraditional), ethnicity, religion and the traditions of military families.
- Helps the combat injured family access care and addresses any barriers to service that can complicate the healthy recovery of its service member and his/her family members. These barriers may include a family's difficulty in accessing health care or community services or a community's lack of awareness or understanding of the needs of combat injured families.
- Is informed by knowledgeable service providers, professionals, organizations and communities, which have access to and provide quality educational materials that address the challenges confronting combat injured families.

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*CSTS is a partnering center of the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, and
A component site of the National Child Traumatic Stress Network*

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.

Principles of Caring for our Nation's Combat Injured Families and Children

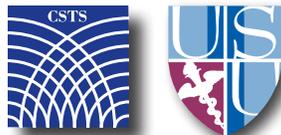
Despite the uniqueness of your family's situation and your loved one's combat injury, there are certain principles that should inform the care you receive. Understanding these principles of care can assist you in recognizing what you require and in seeking appropriate services to support your family's long-term health and wellbeing. Care and services should be delivered in a manner which:

- Provides a sense of safety, comfort, information, practical assistance and connection to appropriate community resources that can foster your family's healthy recovery. While the major goal of the health care facility is to provide treatment to your loved one, there will be people on staff who can assist in solving some of your family's practical needs.
- Is family focused and understands that you, your family and your children are all profoundly affected by the injury. Treatment should help relieve family distress, support your ability to be available to your children during the stress of injury recovery, and help guide your efforts in communicating with your children about the injury.
- Reinforces your family's strengths and resilience while understanding that each family may respond in a different way to the challenges it faces. Healthcare professionals must be responsive to the unique impact of the injury on your family and provide appropriate help and support.
- Is sensitive to the unique responses of children of varying age and gender, and recognizes that distress, care needs and

communication ability will vary according to the age of your child or children.

- Is tailored to your family's *changing needs* throughout what may be a long course of treatment and rehabilitation; anticipating future needs as the recovery process unfolds including discharge and transition to a new community or new way-of-life.
- Encourages a partnership and bringing together of services between your family, treatment providers (both military and civilian), as well as community services. Quality care reaches across traditional professional boundaries and levels of care.
- Respects your family's unique background including culture, language, composition (traditional or nontraditional), ethnicity, religion and the traditions of military families.
- Helps your family access care and addresses any *barriers to service* (unnecessary roadblocks that get in the way of good care), which can complicate the healthy recovery of your loved one and family members. These barriers may include a family member's difficulty in accessing health care or community services, his or her reluctance to seek needed help, or a community's lack of awareness or understanding of the needs of combat injured families.
- Is informed by knowledgeable service providers, professionals, organizations and communities that have access to and provide quality educational materials to address the challenges that confront combat injured families.

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