Parental Wartime Deployment and the Use of Mental Health Services Among Young Military Children

The wars in Afghanistan (2001) and Iraq (2003) have been raging for almost 9 years, and some would qualify the current conflicts as the longest in US history. There is growing evidence that the psychosocial burden of war extends beyond the military service member’s combat time and includes effects on the spouse and children, perhaps unfolding years after combat exposures.

Recent study reports have described the health and mental health (MH) issues of US service members involved in wartime deployments, including the toll on American lives. From October 2001 through May 2010, there have been 5473 American casualties and 38,076 wounded in action. A recent study identified significant stress and MH problems in US Army wives whose husbands experienced deployments. Evidence from that study, and a study of school-aged children, suggests cumulative stress from subsequent wartime deployments for at-home parents and their children, and there are potential negative lifetime effects. Despite these challenges, the vast majority of US military children manifest considerable resilience. In fact, a colleague of mine genuinely refers to military families as “our heroes at home.”

In this issue of Pediatrics, Lieutenant Commander Gorman et al address parental wartime deployment and the use of MH services among military children aged 3 to 8 years. It is one of the first studies to capture data from a large number of military children representing multiple active-duty (AD) services during a period of high-intensity parental deployments. The authors should be commended for their ability to extricate important pediatric needs from a system of complex, multipurpose electronic resources. By using comprehensive claims data, they report increased outpatient visits for anxiety, behavioral, and stress disorders in 3- to 8-year-old children of deployed parents compared with nondeployed parents. More claims were filed for families in which the children were older, AD parents were married, and the deployed parent was the father.

In general, Tricare (the health care delivery system for US military and their family members) has a generous MH benefit for military families and does not require a consultation for the first 8 visits of behavioral/MH counseling. This study used an MH classification system (Clinical Classification System 5) to count health care utilization as International Classification of Diseases, Ninth Revision diagnoses according to pediatric providers, with respect to parental deployment status. To help guide primary care providers toward anticipatory and preventive strategies for common pediatric deployment-related MH/behavior problems, future studies need to build on this foundation and measure more directly the specific parental concerns and child psychosocial

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The views expressed in this commentary are those of the author and do not necessarily reflect the official policy or position of the Department of the Army, Department of Defense, or the US government.

www.pediatrics.org/cgi/doi/10.1542/peds.2010-2543
doi:10.1542/peds.2010-2543

Accepted for publication Sep 8, 2010

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The author has indicated she has no financial relationships relevant to this article to disclose.
impairments related to deployment (such as sleep problems, separation issues, and regressive behaviors in children).

Although there was a gender and marital-status effect in this study that implied more married AD fathers had children with MH problems, there may be an ascertainment bias by those who claimed Tricare health benefits while a married AD father was deployed. It is clear that a consistent finding across developmental studies is that child distress is closely linked to parental distress. It is possible that a greater proportion of AD “fathers” experience greater combat danger, which is reflected in at-home parent stress and anxiety and, thus, increased child symptoms. However, it is more likely that the Tricare system does not capture all of the health service utilization of single AD families, for which health care often occurs outside the military system. On the basis of my clinical experience, I would have as much (if not more) concern about child MH and behavioral problems in single AD parent and female deployed-service-member households.

Among the important findings from this study is that 65% of the services provided to children for MH and behavioral problems occur “outside the gate”—by civilian pediatricians and other child-serving providers. Along with numerous smaller studies that have sought to understand the effects of parental wartime deployment on children and youth,6–9 this article should fortify general pediatricians, both civilian and military, in their primary care role of recognizing and responding to the MH/behavioral needs of military children. Recognizing childhood stress, anxiety, or behavioral problems that are interfering with school or family function has been a responsibility of pediatricians for generations. It is not uncommon for pediatricians to see a child for 1 purpose (school physical, immunizations, etc), only to uncover a more troubling problem. By simply asking, “I understand your daddy/mommy is deployed. How are you feeling?” pediatricians can uncover important stressors in a military family. Pediatricians should use acute and health supervision visits to:

- assess family stress and coping;
- provide anticipatory guidance for common reactions to the deployment cycle;
- know where to find appropriate resources (see below); and
- know when to refer for specialized services (death or injury of parent).

By understanding the military family and the experiences of parental wartime deployments, all pediatricians and other child-serving providers can be the “front line” for the health and well-being of US military children, especially in times of war.

Resources for families and pediatricians include:
- Military One Source (www.militaryonesource.com): 24-hour resources for all AD services, Reserves, and National Guard
- Military Home Front (www.militaryhomefront.dod.mil): deployment programs and resources
- Tragedy Assistance Program for Survivors (www.taps.org)
- American Academy of Pediatrics Military Deployment support Web site (www.aap.org/sections/unifserv/deployment)

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Pediatrics; originally published online November 8, 2010;
DOI: 10.1542/peds.2010-2543

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