

Military Children, Families, and Communities: Supporting Those Who Serve

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ABBREVIATIONS

AAP—American Academy of Pediatrics
DoD—Department of Defense
SOUS—Section on Uniformed Services
WWII—World War II

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More than 2 million children in the United States live in military families and 90 000 infants are born to these families each year. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, third edition,¹ a publication of the American Academy of Pediatrics (AAP), outlines an approach to comprehensive care for the individual child in the context of his or her family, as well as the community. Understanding the unique concerns of military families, such as the stress of parental wartime separation, and the specific resources available to these families, can help prepare all pediatric providers to meet the needs of this population regardless of where a medical home is established.

Although military pediatricians are subject matter experts on military children and family needs, military pediatricians are not the sole providers of care for military children. Up to 50% of children in military families obtain their primary care outside of a military medical facility.² Some service members' families leave military installations and return "home" during deployment and obtain local pediatric care. National Guard and Reserve members often use established local resources, rather than switch to active-duty services during their "activation." The Department of Defense (DoD) direct health care system is not large enough to care for all military children. Therefore, all pediatricians should be familiar with the population of American children who live in military families. A review of the historical perspective and the current demographics of the US military family is helpful when framing the challenges faced by military children and those who care for them. Military and civilian pediatricians are better prepared to articulate the concerns of military children and support their needs if they understand the child within the context of his or her family and community.

MILITARY COMMITMENT TO FAMILIES

For most of its history, the provision of family support was not viewed as a primary responsibility of the US military, although spouses, children, and significant others have certainly been woven into the fabric of soldiers' and sailors' lives for centuries.^{3,4} By the 1950s, however, with the unprecedented growth of the peacetime military and the changing demographics of military members who increasingly brought family members with them from assignment to assignment, the sheer numbers of children needing access to health care resulted in the landmark passage of the Dependent Medical Care Act in 1956, officially ensuring care to all dependents of active-duty service members.⁵ The foundation for comprehensive modern military family support, however, was solidified with congressional passage of the Military Family Act of 1985. This legislation codified the formalized commitment of the larger military

organization, and indeed the nation, to military families. The DoD Office of Family Policy, launched in 1988, set the stage for a modernized responsive engagement by the US armed forces to critically evaluate and address evolving military family support requirements.

Today, all of the active-duty services have centralized military family support centers on military installations. New Parent Support Programs are present in all services. The active-duty Exceptional Family Member Program addresses the special medical and educational needs of family members to ensure access to appropriate services at service member duty locations. These programs, among others, provide testament to the commitment to enhanced, optimized support at both the family and community levels, given the challenges faced by today's military family. Most recently, President and First Lady Obama introduced a national campaign to support military service members and their families called "Joining Forces."⁶

DEMOGRAPHICS

Similar to the general population of the United States, family patterns within the military, both active duty and selected reserves, have experienced significant changes since the 1970s. During the Vietnam era, 85% of military service members were drafted, not planning a military career, and unmarried. Currently, 100% of all service members volunteer for service, 50% plan on military careers, and 55% of all active-duty service members are married. In addition, 40% of military spouses are employed and 21% of those who are employed are in the military themselves.⁷ The percentage of children younger than 18 is also greater in the military compared with the general population—35% vs 25%^{7,8}; half of these children

are younger than 7.⁹ Military service members are more likely than their civilian peers of similar age to be married and to have children. Active-duty service members typically marry younger than their civilian counterparts and have their first child by an average age of 25, 2 years younger than US civilian parents. In summary, at any given time, military families include a higher proportion of young parents and children compared with the greater American population.

CHALLENGES OF MILITARY FAMILY LIFE

In addition to issues common to all American families, there are many aspects of military family life that are unique: frequent geographic relocations, forced adaptations to new communities and schools, living in foreign countries, peacetime separations, remote unaccompanied assignments of parent and spouse, and wartime deployments. At least 60% of military families have relocated at least once in the past 3 years.¹⁰ In a recent survey of active-duty families with deployed service members, 47% reported 3 or more moves in the past 5 years,¹¹ significantly more than Reserve and National Guard families, and certainly more than the general US population. Active-duty military families often live outside the continental United States. These sites include US locations such as Alaska, Puerto Rico, and Hawaii, in addition to foreign countries such as Germany, England, Korea, Japan, and Italy. Installation housing, medical care, and DoD schools are typically provided at overseas sites.

Many military family support resources are devoted to helping family members prepare for separation and deployment. Research has confirmed that families who feel prepared for a deployment cope better during and after deployment.^{9,12} Several factors pose

increased risks for poor family adaptation during deployment, including younger age of both spouse and service member, having young children, having a family member with prior psychopathology, predeployment marital or financial problems, being a spouse for whom English is a second language, living overseas, and lack of a predictable return date of the service member from deployment.¹³

Although there are common characteristics among many military families, it is important to appreciate some of the demographic differences between various aspects of the military, such as active-duty versus reserve components, assigned service branch (Army, Navy, Air Force, Marine Corps, and Coast Guard), and rank (officer versus enlisted). The Army has the largest active-duty force in the DoD with 502 790 members, followed by the Navy and Air Force with 345 098 and 344 529 active-duty members respectively. The Marine Corps consists of 180 252 and the Department of Homeland Security Coast Guard currently has 39 980 members. Overall, the US active duty force is 32.4% smaller than in 1990, with all services having decreased in size. There is a ratio of 5 enlisted service members to every 1 officer. Thus, 80% to 85% of military personnel are enlisted and ~15% are officers.⁷

The US military and its families represent a significantly greater proportion of minority members compared with the general population. More than one-third of all active-duty members (36.6%) identify themselves as an ethnic minority (African American, Hispanic American, Native American, Alaska Native, Asian American, Pacific Islander, or multiracial). For example, although African Americans comprise about 14% of the general civilian US population, they currently represent 22% of active-duty and 23% of reserve military positions. When further assessed by gender,

African American women comprise 37% of all women in the active duty Army.⁷

There are a number of demographic differences between the families of active duty service members and those of Reserve and National Guard members (see Table 1). Reserve and National Guard service members are made up of 7 components, of which the Army National Guard is almost twice as large (346 288) as any other component. Air National Guard, Air Force Reserve, Navy Reserve, Marine Corps Reserve, and the Coast Guard Reserve comprise the remaining components. In addition to these demographic differences, however, there also tends to be a difference in access to military-specific services and community support, as most Reserve and National Guard members live in nonmilitary communities where these services are not as readily available or accessible. This difference can have implications for how service member families experience not only deployment, but military life in general.

WARTIME DEPLOYMENTS

The issue that has affected military families more than any other in the new millennium is the need for lengthy, recurrent, and dangerous wartime

parental and spouse deployments. Emerging research is beginning to inform our understanding of the impact of our current wars on military families. Deployment starts when the service member is notified of pending departure. Before actual departure, months of training include weeks away from home. The actual departure is sometimes a relief to all, because of the frequent higher priority given to deployment preparation over routine family activities. After months of adjustment, with parents often missing birthdays, holidays, and births, the anticipation of a reunion again assumes center stage to all other life events. As cogently stated by Cozza et al,¹⁴ “To assume either widespread pathology or uniform resilience to the stresses of wartime deployments would be superficial and harmful to children and their families.” During wartime deployments, there is no question that stress is present; it is the extent to which stress affects individuals and families that needs recognition and response. The way an individual or family responds to a given stressor is characteristically dependent on the following:

- the individual’s previous experiences with stress,
- the meaning of the specific stress,

the family context where the stress is experienced, including how the at-home parent is coping, and the intrinsic as well as extrinsic resources available to deal with the stress.

In the past, the image of military families often evoked a stereotypical profile sometimes referred to as the “military family syndrome,”¹⁵ which described a rigid, authoritarian active-duty father who left home regularly, a stay-at-home submissive mother and wife, and “out-of-control” children with rootless identities who exhibited severe psychological problems. Subsequent research, including prospective studies of military compared with nonmilitary children, failed to validate this profile and found no inherent psychosocial differences between military and nonmilitary children.^{16–18} In fact, the experience of parental separation in one study of Navy families, where routine 6-month “sea duty” deployments have been a way of life for years, indicated that children demonstrated increased responsibility, independence, and confidence compared with their peers without deployment experiences,¹⁹ suggesting that children of deployed service members often develop a paradoxically stronger parent-child relationship during their separation.

Although the events of 9-11 changed the lives of all Americans, the children of deployed service members have faced particularly unique and stressful challenges. Some of the earliest research on military families and how they cope with postwar settings can be traced back to 1949 when Hill²⁰ looked at World War II (WWII) veterans and how their families adjusted to their return. He proposed that the actual wartime separation needed to be considered in the context of family resources and the meaning the family placed on the war to predict positive versus negative adaptation. Subsequently in

TABLE 1 Demographic Features of Active-Duty and Reserve and National Guard Personnel⁷

	Active Duty	Reserve and National Guard
Total no.	1 406 221	836 256
Ratio of officers:enlisted	1:5.1	1:5.6
Women, %	14.4	17.6
Minorities, %	35.9	29.9
Located in United States, %	85.3	99.1
≤ 25 y old, %	52.5	38.8
BS degree or more, %	17.7	19.7
Married, %	55.2	49.0
Dual military, %	6.7	2.6
No. of family members	1 864 427	1 114 900
No. of spouses	679 738	415 548
With children, %	43.2	41.9
Average age with first child	24.8	27.3
Kids age 0–5 y, %	39.8	24.8
Single parents, %	5.2	8.4

1983, Patterson and McCubbin²¹ examined families of Vietnam veterans and concluded that a “pile up” of pre-war, war, and postwar stressors “added up” to the degree of maladaptation, if present, and there was a cumulative effect of stress that could not be explained only by the effects of wartime deployment. The concept from previous wars that the contextual factors of a family influence coping and adaptation to stress should help primary care providers consider a list of preexisting situations or conditions that may place a family at higher risk for poor response to separation, as well as reunification stress.

Clearly, the deployment of a parent to a combat environment would be expected to be more stressful to most children than having a parent deploy in a noncombat situation. The most informative wartime deployment studies on children before the current era were conducted during Operation Desert Storm between 1991 and 1992. Although this was a short-lived war resulting in much fewer casualties than current conflicts, Desert Storm was the single-largest deployment of US troops since Vietnam. Studying family members of deployed service members during Desert Storm, Rosen et al²² found moderate degrees of increased internalizing symptoms in children, such as depression and anxiety, although most did not seek clinical attention for these symptoms. Kelley²³ compared features of deployed versus non-deployed families and found less cohesiveness in the deployed families. Most notably, Jensen et al²⁴ prospectively looked at families before and during deployment and showed somewhat increased levels of anxiety and depression symptoms compared with control families without a deployed member, although there was no increased incidence of pathology. At-risk groups included boys, younger

children, individuals with preexisting psychosocial issues, and children for whom the at-home parent had psychopathology. One study specifically looked at how gender of the deployed parent affected children and did not find significant differences in child adaptation between fathers versus mothers who were deployed.²⁵ Strong coping skills during deployment predicted greater adaptation after deployment.

One of the ongoing concerns with wartime deployment is understanding the impact of posttraumatic distress in service members as they attempt to reintegrate with their young families after a prolonged deployment. Families report that the first 6 months following a deployment can be very stressful. Recent studies suggest that as many as 20% to 30% of soldiers have posttraumatic symptoms in the initial 6 months following deployment.^{26–28} Postdeployment emotional and behavioral responses by a service member can range from typical short-term distress responses, such as change in sleep, decreased sense of safety, or social isolation, to the development of more serious psychiatric conditions such as posttraumatic stress disorder or depression. A recent study of clinically depressed new fathers has shown that paternal depression can negatively affect their ability to tend to their infant’s needs.²⁹ In a recent study of Army wives, a correlation was found between length of spousal wartime deployment and the incidence of their own mental health diagnoses.³⁰ Long-term generational effects of war have emerged from the Vietnam era and suggest that children of veterans tend to have the same mental health problems as their fathers.³¹

Recent research, some completed by military pediatricians on military installations, has helped create the current

profile of military children and their families coping with parental wartime deployments. In 2008, Chartrand et al³² studied preschool children with and without a deployed parent and found increased behavioral symptoms in the preschoolers experiencing parental deployment. Flake et al¹¹ found increased psychosocial morbidity in more than one-third of school-age children with a deployed parent. At-home parental stress was reported as very high in this group. Aranda et al³³ queried military adolescents with and without a deployed parent and both the teen self-reports and the parental reports revealed increased stress in the deployed subgroup. Lester et al,³⁴ Chandra et al,³⁵ and Barker and Berry³⁶ each provide evidence of cumulative effects of deployment experiences, as well as risk to children, associated with psychological stress of either parent. At a population level, Gorman et al² analyzed care received both on and off military installations by military children and found increased rates of mental health, behavioral, and stress problems in children during parental deployment. Although infants have yet to be investigated, a recent study found there is increased maternal stress related to pregnancy and childbirth when a service member partner is deployed.³⁷ Slowly and systematically, the extent to which wartime deployments affect military children and their families is being compiled across the life span.

No specific or consistent pediatric diagnoses have emerged as indicators of the severity of chronic wartime stress; however, recent testimony to Congress indicated increases in military preteen inpatient mental health stays³⁸ and 2 studies suggested that military families experiencing repeated deployments and/or prolonged deployments, especially in young marriages with young children, were at risk for

child maltreatment, specifically neglectful home environments.^{39,40}

Resilience appears to play a major factor in all phases of deployment. Protective factors include family readiness, “meaning making” of the situation, receipt of community and social support, acceptance of military lifestyle, ability of the at-home parent to develop self-reliant coping skills, and adoption of flexible gender roles. Children who have supportive child caregivers, school environments, and adults who understand their military situation are more able to effectively recruit coping skills that augment family supports.⁴¹

Even in the midst of ongoing deployments, many military families, regardless of service or component, appreciate the numerous benefits of military life, including adequate free housing; an “on-post” community with shopping, accessible child care, and schools; low-cost or free medical care; community services, including free behavioral counseling; military-sponsored activities; access to recreational facilities; subsidized educational opportunities; relatively stable family income; shared identity and mission with peers as well as senior leaders; and a feeling of patriotic contribution both within individual families and throughout the community.

MILITARY LEGACY: A VEHICLE FOR SOCIAL CHANGE FOR A NATION

Military policy can affect national policy regarding children, families, and communities. For example, WWII led to the “birth” of employer-based health insurance for the nation, as an employer’s only opportunity to compete during the war-based salary freeze was via payment of benefits, such as health insurance.⁴² The educational benefit of serving in the military has been clear for enlisted to senior officers. Post-WWII GI benefits helped to develop a larger middle class with unprecedented so-

cial and cultural impact on our nation. Indeed, the recognition during the Johnson administration of the poor health status of many draft-aged men that prevented conscription during the Vietnam War led to the creation of early periodic screening and diagnostic treatment for eligible US children. A universal electronic medical record, not without its significant challenges, has been in use in military hospitals since 2005, and the integrated military/civilian health care program, known as TriCare, has established regionalized, private-government partnerships to provide an integrated health care delivery system to benefit military children, families, and communities. Perhaps no population or health care system is better positioned to study and be studied than the US military health system. At the very least, lessons learned from the military health care system and its single-party payer approach should be considered as a new era of health care reform emerges.

FUTURE CHALLENGES

Insurance Reform

TriCare is the umbrella military health entitlement program that encompasses health care services in both military treatment facilities and in the civilian community. It is a single-party payer system that allows compilation of all billing information regardless of whether health care occurs within or outside the military. Pediatricians and the AAP can work to ensure that appropriate benefits, patient- and family-centered services, and medical home-centered reimbursement are implemented and maintained for its military constituents and those who care for these children, families, and communities. A full explanation of services available to service members and their families can be found at www.tricare.mil.

Seamless Communities

Because care of military children is not exclusive to either direct military or civilian health centers, all providers taking care of these children should have some familiarity with military systems, culture, benefits, and resources. Understanding how to access military-specific information in a timely manner is important for quality care of these children. Community service organizations where military members are present must be sensitive and knowledgeable about specific military needs and programs. Conversely, military health care providers must be aware of available civilian services that may be preferred at times by military family members. Military programs, as well as many partner civilian programs, attempt to reduce isolation; improve networking and connectedness; promote resiliency; and provide primary, secondary, and tertiary care and prevention for many personal and public health issues. The integration of resources from both the military and civilian communities in the support of military families is the vision behind the “Joining Forces” campaign initiated by Michelle Obama and Dr Jill Biden.²

Generation Next

Probably the most exciting opportunity of the next decade is to build on the strengths and attributes of a new generation of young parents who comprise more than 85% of military families. They have been referred to as “generation next,” bringing with them many solutions for the future.

Generation nexters (also referred to as millineals or gen Ys), born between 1980 and 2000, comprise close to 30% of the current US population,⁴³ as well as the vast majority of the current US military force. As readiness, retention, and resources are considered for service members and their families, it is important to acknowledge the

strengths and weaknesses they bring to the military health care system. For example, telemedicine, which provides subspecialty services to remote locations, is an ideal medical tool in the military, and is especially suited to a generation that values the application of media and technology in a wide variety of areas to include health care. Military pediatricians practicing in remote areas of Alaska, or the high desert of California, are trained to perform newborn echocardiography and relay the information to pediatric cardiologists thousands of miles away to determine triage status of infants with heart murmurs. Numerous newborn transports have been circumvented through the use of these and other technological tools that have been pioneered in the military health care system. Likewise, research is under way to use webcam-based behavioral assessments, including autism assessments, to provide families in remote military settings the fullest range of medical care. Gen Y parents bring technologically advanced communication to the kitchen table. They welcome computerized kiosks to perform risk assessments, behavioral profiles, demographic updates, and often request a “Web site” for reference rather than a text.

Specific Programs

As people and policy change, there are many considerations in the future for military families:

Portability of medical care is a must for this large international workforce. Electronic medical records are routine in active-duty medical care, and additional mechanisms to cross services and into the civilian community of care are needed.

Transportability and accountability of the military health system and its contractors will provide the nation with important information in its larger health care reform initiatives.

Establishment and maintenance of the “medical home,” regardless of portal of entry (Reserves, National Guard, active duty) needs to be individually tracked. For example, when a child with special needs has established health care providers and the parent is called to active duty from the Reserves, a mechanism must be ensured to maintain current care rather than change solely because of temporary military duty.

The needs of at-home parents during long deployments will certainly include respite and child care. Creating accessible and affordable options regardless of family location is already being addressed and will continue to be a challenge.

Optimization of current technology (Web, e-mail, text-messaging), as well as evolving technologies, will need to be increasingly used to provide up-to-date pediatric care and anticipatory guidance for parents.

Advocacy

The AAP membership at large, in collaboration with the Section on Uniformed Services (SOUS) and Uniformed Services Chapter East and West, has been at the forefront of policy change with Annual Leadership Forum resolutions in 2005, 2007, and 2009 to support education, training, resources, Web site development, and research projects in support of military children, families, and communities. SOUS and the Uniformed Services Chapters have leveraged resources and educational venues to assist all pediatricians in caring for military children, families, and communities. Some of the awareness and educational resources sponsored by the AAP SOUS include a pediatrician-focused Web site for deployment issues (www.aap.org/sections/unifserv/deployment/index.htm), an AAP PREP Audio (3) 8: 2008 titled, “The Effect of Deployment on Children”, and

review articles and commentaries.^{44–46} With a specific focus on the impact of parental deployment on military children, larger longitudinal studies, similar to those for adult military members, must be completed to guide our practice and policies over a life span. Indeed, a closer look at some initiatives within the military health system may provide benefit and insight as our nation continues to improve health care for all children in the context of their family and communities.

CONCLUSIONS

All pediatricians, whether military or civilian, are challenged to achieve the AAP motto, “the best for all children.” As trusted members of every child’s support system, pediatricians are in the unique position of providing individual care, as well as constructing policy for universal common child needs. All pediatricians have a role in sustaining obligations our nation has made to military members and their families, who have selflessly served to ensure our liberty and security. As child advocates, we need to educate each other, future generations of providers, families of the children we care for, and their communities. We are obligated to perform research, define specific concerns, and create interventions for these children, families, and communities, as well as to appropriately apply innovations and lessons learned to all children in America and beyond. The SOUS has had a proud first 50 years of benefiting from and contributing to a partnership with the AAP, and looks forward to many new opportunities and challenges in the next half century.

RESOURCES

The AAP SOUS, as well as Uniformed Services Chapters East and West, are valuable clearinghouses for information specific to care of military children and

families, as well as an excellent resource for providers, parents, and children:

AAP Uniformed Services Section (includes deployment Web site), www.aap.org/sections/unifserv/deployment/index.htm

Military One Source, www.militaryonesource.com

Military Homefront, www.militaryhomefront.org

ZEROTOTHREE, www.zerotothree.org/military

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