ABSTRACT

Objectives: Operation Building Resilience and Valuing Empowered Families (OBF) is a preventive, preclinical program that was developed by the Walter Reed National Military Medical Center’s Child and Adolescent Psychiatry Service to form a working partnership with families of wounded warrior parents from the war in Iraq and Afghanistan. The OBF staff helps to identify the families’ needs and collaborates with many organizations at Walter Reed National Military Medical Center to provide assistance. This article describes OBF, offers a case description, reviews current preventive programs for children exposed to trauma and disaster, and compares and contrasts OBF to these programs. Methods: A literature review was performed, searching Ovid MEDLINE(R) for keywords, such as post-traumatic stress disorder, child and adolescent, family, prevention, and disaster. Results: There are an increasing number of preventive programs for children and adolescents throughout the country, especially over the past 10 years. These programs build upon past prevention models. There are few services that offer primary prevention. Conclusions: OBF is a military treatment facility–focused preventive program that can serve as a program model for other military treatment facilities and civilian hospitals with the mandate to care for the family members and children of parents who are trauma victims and require long-term care.

INTRODUCTION

According to MilitaryTimes and the U.S. Department of Defense, there are 6,364 total casualties of Operation Iraqi Freedom and Operation Enduring Freedom and 48,296 wounded in action confirmed by the U.S. Central Command. Given that there are close to two million children of active duty military parents with 44% under the age of six, it is reasonable to suggest that many families are directly and indirectly affected by the trauma of the war. Because the families of the soldiers are an important part of their support system and recovery, they assume the role of a caregiver to the wounded warrior. This is a daunting task as the entire family is in a state of transition after an injury has taken place. The children of wounded warriors thus face the dilemma of having to provide support for their parent while they, too, are experiencing their own reactions to their parent’s injury.

The literature suggests that the child’s response to trauma, to include disasters of war, terror, and nature, can be lumped into a “disaster syndrome” that includes symptoms of post-traumatic stress disorder (PTSD), anxiety, dissociation, depression, and grief. A child’s cognitive and emotional reactions result from different kinds of losses: of people, support systems, normal routines, and basic assumptions concerning safety and regularity. The severity of a child’s response to a disaster usually correlates to the severity of his or her parents’ reaction through social referencing cues and role modeling, and the presence of adults providing care during and after a major stressor is considered the most important protective factor. Individual factors that affect the severity of response to a disaster or trauma include prior anxiety or mental illness, negative coping strategies, and past traumatic experience.

It is clear that children’s exposures to trauma can be through secondary means, after a disaster has already occurred. Children of military parents may be studied from this perspective since a parent may return from a war zone with emotional injuries and physical wounds. Although the children have not been directly exposed to the trauma that caused their parent’s injury, they must learn to cope with the effect it has created in their parent and their living environment. Therefore, the parent’s trauma often is perceived as a direct, primary trauma from the child’s point of view.

The majority of soldiers who return from wartime operations, despite exposure to traumatic events, will have transient symptoms of PTSD. The same is true for the majority of children who survive a disaster; when routine and stability return, their symptoms subside. However, there are populations of soldiers and military children who are at higher risk for anxiety and depression after such an exposure. The increased operation tempo of the recent war has caused more and more frequent separation of family members for long periods of time. This situation has led to more than just transient symptoms of depression and increased anxiety for the children involved. The length of deployment for the...
U.S. Army was recently shortened from 12 to 9 months, and the amount of time between deployments was recently increased from about 1 to 2 years. The changes that have been made have resulted from recognition that these factors had an impact on the amount of mental health challenges faced by soldiers. These separations also served as a predisposing factor that put military children at increased risk for developing further symptoms if their parent was injured. These separations also served as a predisposing factor that put military children at increased risk for developing further symptoms if their parent was injured. These separations also served as a predisposing factor that put military children at increased risk for developing further symptoms if their parent was injured.

Clinical treatment for children of military families has been available through Child and Adolescent Psychiatry Services (CAPS) on military treatment facilities before and since the start of the war to address these clinical behavioral health needs. Nevertheless, there is a growing realization that many more service members and their families will require treatment from providers in the civilian behavioral health community because of the length of the war and the fact that many active duty soldiers are exiting the service. As a result of several years of working with wounded warrior families and the acknowledgment of the impact of preclinical secondary trauma on the soldiers' children, the CAPS at the Walter Reed National Military Medical Center (WRNMMC) decided to address the special needs of families of returning wounded warriors by establishing Operation Building Resilience and Valuing Empowered (BRAVE) Families (OBF). OBF was created because of the empirical needs of families who migrated to WRNMMC to support their wounded warrior. Stigma regarding accessing behavioral health services in the military has been well defined. The preventive nature of OBF, providing assistance to military families before disabling symptoms arise also works to overcome problems with stigma that are often a barrier to treatment. This preclinical focus of OBF targets these family needs before they reach the point of need for clinical treatment, but if anxiety, depression, and other symptoms are identified, a referral for the child and/or adults is made. OBF mainly targets families of wounded warriors, those who have had an amputation or other severe injury, and their spouses and children, especially young children. These families will spend about a year and a half up to 3 years on the campus of WRNMMC by the time their treatment, rehabilitation, and administrative requirements have been completed.

Understanding the Post (Wartime) Injury Family and Its Needs

Although military families share many defining characteristics of American families in general, they take on an exceptionally unique set of challenges during their stay at WRNMMC. These families not only have parents serving in the military but also they are facing, what is in many cases, a traumatic assault on the family as a function of the parent’s emotional and physical injuries. There are many different types of military families. Some may have one parent who deploys frequently while the family remains at a large installation. Others may have never experienced a deployment before. In turn, National Guardsmen or Reservists and their families may have never have been linked into a military installation. Just as there is no one type of military family, there is also no one type of family response to trauma. There are, however, trends in how family members of service members adjust to the injury of a loved one.

Role Shifting to Accommodate the Injury

The most obvious change in the family constellation comes from the wounded warrior’s status change from child caregiver to receiver of care. This places added stress on the child’s parent who accompanies the wounded warrior because that parent is placed into a dual caregiver role. In fact, WRNMMC formalizes this role by putting caregivers on official orders as nonmedical attendants.

Adjustment to WRNMMC From Previous Routines

The comfort and safety of these families’ existing life patterns that are found in predictable routines and familiar surroundings are significantly disrupted. To address these stressors, WRNMMC has accommodated these families’ basic needs through the creation of housing and parking garages and corroboration with many organizations to include the Red Cross. There are many caring staff and numerous resources from the community and government agencies in addition to many opportunities for family members to engage in social and recreational activities. Nevertheless, families must be extremely flexible in approaching day to day household chores and completing tasks. For example, few families have kitchens to prepare meals or private areas to engage in routine family activities.

Learning How to Operate Within WRNMMC

Military family members quickly learn where and how to meet their needs as they move to new geographical locations about every 2 to 3 years through permanent changes of station. These families are also faced with frequent temporary duty, during which the parent works away from home for a short time. Since many military families are now staying at WRNMMC with the injured parent, they begin to identify with the military system. However, families that are new to the military, such as families of newly recruited service members and activated National Guardsmen and Reservists, likely will be less experienced in accessing services and adjusting to a new way of life. The role of OBF is to ameliorate the needs of these families and empower them in their journey of regaining normalcy in their lives.

OBF: Filling the Gap to Mitigate Secondary Trauma

OBF is a system of care which provides clinicians an opportunity to assist families of wounded warriors on multiple levels in an attempt to ameliorate the effects of secondary trauma and accelerate adjustment to their new surroundings. It is an outreach-based component of CAPS, which was engineered to serve spouses, children, and extended family members of warriors, those who have had an amputation or other severe injury, and their spouses and children, especially young children. These families will spend about a year and a half up to 3 years on the campus of WRNMMC by the time their treatment, rehabilitation, and administrative requirements have been completed.

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members of wounded warriors who are receiving treatment at WRNMMC. It is a proactive, prevention-based program that emphasizes resiliency and empowerment, offers a broad range of services, and conducts multiple and diverse tasks. It employs a collaborative and educational approach aimed at addressing and reducing myriad stressors that may cause or exacerbate problems or illnesses (be they physical, psychological, emotional, familial, interpersonal, social, vocational, or existential) in the returning injured parents and their families. Much of the work OBF accomplishes is directed most specifically toward the families of wounded warrior parents.

The staff of OBF attempts to form a working partnership with the families of wounded parents to address the families' needs. Education is provided in a nonpatronizing manner based on the family members' report of their responses to war-related injury or illness. A special emphasis is placed on helping to prepare children of wounded warriors as they learn about and cope with the parent's injury. Psychological first aid is provided individually and in groups to the children and families through family, individual, therapeutic art, and therapeutic play sessions. OBF provides support and training to professionals who serve military families, conducts research about the impact of war on families and professionals, and assesses its service effectiveness. Training for professionals is accomplished through weekly rounds with OBF and other services such as psychiatry consult-liason service (PCLS). These are among the core services provided by OBF that are delineated in its manual. Additional core services include a needs assessment, surveillance of symptoms and conditions that evolve, therapeutic activities such as art and play activities, individual and group parent guidance classes, and adult groups. The OBF program also provides outreach, participatory seminars, research, and development through dedicated annual meetings. A process improvement instrument is being developed, which will likely take the form of a satisfaction questionnaire similar to the 45-Item Outcome Questionnaire. A semistructured interview, using the Parent Guided Assessment Instrument (PGA-I), is one of the methods the staff uses to conduct a needs assessment for those who choose to participate. The PGA-I uses a 5-point Likert scale to assess child distress before and after injury as well as perceived family distress.

The process for family work used by OBF is based on the framework delineated by Hoagwood, and it includes identifying, engaging, and staying connected with the family. First, wounded warriors and their family members are identified. The planning for service provision begins when the OBF staff is informed of the pending arrival of the families of wounded warriors, which is before they are in transit to the hospital. This is facilitated by the Department of the Army sending the travel and transportation orders of the family members directly to WRNMMC, CAPS via the Travel and Transportation Office so staff can prepare to meet the wounded warriors and their families.

There are two major entry points into the OBF program. Staff members of OBF make themselves available and provide information packets to the Fleet and Family Service and the Soldier Family Assistance Center, where weekly orientation meetings are held for family members of wounded warriors who have just arrived at WRNMMC. Family members are provided with brochures, resource materials, and contact information, and these staff members give notice to families to expect to hear from an OBF provider at a later date. The preparation for a child to come visit usually includes a discussion about seeing the wounded parent for the first time. Another point of entry and access to new families is through the PCLS daily rounds where all wounded warriors are offered preventive medical psychiatry services and those who have children are identified. This point of entry helps OBF identify many other family members who have joined the injured parent through means other than military travel channels, and the information gathered is relayed to OBF professionals who attend these rounds twice weekly. Once the wounded warrior family is identified, OBF staff begins engaging with the family and focuses on establishing a connection.

The OBF staff meets the injured parent and family in their inpatient setting within 1 week to inform or remind them of available services and OBF's potential role in helping them. Families are provided with anticipatory parental guidance and a specially developed educational brochure. The family is offered the opportunity to participate in a screening assessment using the PGA-I, which is similar to other screening measures used with children who are experiencing medical trauma. There is an emphasis on learning from the family about their foremost needs and concerns. Practical assistance, such as how to set up child care on post or how to find a local health care provider, etc., is readily provided or a referral is made to resources that exist to provide this assistance. This meeting with the child and parents enables OBF staff to start an assessment and observation of behavior. Then a preliminary plan is formed and structured activities are provided. Families who choose to participate with the supportive services are followed throughout the course of their loved ones' hospitalization and care at the WRNMMC. Certainly one of the goals of OBF, which is similar to identifying and engaging wounded warriors and their families, is to stay connected with families and empower them to mobilize their energies, resources, and strengths.

To stay connected and foster relational empowerment, OBF staff must help the injured parents and their families to reduce or overcome barriers such as decreased motivation, grief over loss, depression, apathy, withdrawal, anxiety, feelings of worthlessness, and loss of personal freedom because they are bedridden. Part of this work is done through mental health professionals who work in tandem with OBF staff, many of them serve as primary therapists or psychiatrists. OBF strives to increase the sense of strength of injured parents and their family members. Acute symptomatology is addressed in a prompt and yet comprehensive manner.

**Case Study**

The following case illustrates some challenges faced by the wounded warrior parent, family, and child and showcases some
ways that OBF provides preclinical engagement. All identifying information has been removed to protect confidentiality.

In July 2009, Staff Sergeant (SSG) John Jones, a 29-year-old infantry soldier, was admitted to the Surgical Intensive Care Unit (SICU) after sustaining injuries from an improvised explosive device blast, which included a fracture of his right femur and an above the knee amputation of his left leg. He was in critical condition, and his physicians were uncertain as to whether or not he was going to survive. When members of OBF became alerted by the PCLS that SSG Jones had a child who would be coming to visit, an OBF social worker approached the family to provide information about services that were available and to assess how the family could be assisted. The soldier’s wife, mother, and sister were present. His wife was shocked by her husband’s injuries and wondered how to explain them to their only child, a 3-year-old daughter named Emily. The social worker discussed with SSG Jones’ family how to talk to Emily in an age-appropriate language that she could understand, being careful not to give too much information that would overwhelm her.

A couple of weeks later, after Emily had arrived at WRNMMC and spent some time with her father, the OBF social worker introduced herself to Emily in the waiting room of the SICU and stopped by weekly to check in with the family. Eventually SSG Jones’ injuries improved and he was moved from the SICU into a room on the general medical floor. During this time, the OBF social worker continued to meet with Emily and her grandmother in the Soldier Family Assistance Center to play games. One play session was at the outside play area of a hotel on base with Emily’s maternal grandmother and paternal grandfather. Emily and the OBF social worker went to play on the swing where they talked to one another and then played hide and seek. One day Emily met individually with the OBF social worker to play with toys and she focused on the doll house. Emily’s play reflected her desire for her mother’s support and for her mother to be more emotionally available to her. One of the dolls she played with was a man in a wheelchair. Emily’s play indicated reservations about the man in the wheelchair and what he could and could not do for himself or others.

Emily’s mother and grandmother expressed concern that Emily was demanding and difficult, especially during periods of transition of care from mother to grandmother. They were provided with information about stress and how it is manifested to children in her age as well as strategies to reduce the stress. In addition, ways to encourage and improve her relationship with her father were discussed.

SSG Jones and Emily were both hesitant to interact because he had an external fixator on his leg, making it difficult for Emily to get close to him, and he had some injuries to his arms and fingers that made it hard for him to reach out to her. The OBF social worker provided a book for SSG Jones to read to Emily and discussed possible ways for her to get close enough to see the pictures. Both parents felt that Emily became more interactive when the external fixator came off and the bed could be lowered for them to hug each other. Emily’s mother also became more relaxed despite her own anxiety about his severe injuries.

Emily’s mother planned to return to work when SSG Jones was discharged from the hospital. He began living independently in an apartment just outside of the base. SSG Jones had been spending weekends and holidays at his apartment and reported that everything was going well. Emily’s parents attended other functions offered by OBF, including a coffee group at the MATC while Emily stayed at daycare where she developed relationships with peers. After a couple of months, Emily and her mother returned to their permanent home so that her mother could resume work while SSG Jones continued his recuperation at WRNMMC. He decided there was no need for continued involvement at that point, but OBF left contact information and offered to help should the need arise for ongoing support.

This case study typifies how the family volunteers, or elects, to receive services in this preclinical model. Because of the fact that they are not official patients, the goal of the service can appear vague, but the family must still provide social consent to receive OBF’s involvement in their lives at WRNMMC.

METHODS

An Ovid MEDLINE(R) search was conducted for keywords such as PTSD, child and adolescent, family, prevention, and disaster. The goal was to find programs with a similar focus of OBF: preventive programs and, if possible, programs with preclinical engagement to compare and contrast them to OBF.

RESULTS

There was a relative paucity of these programs that were found, but there have been an increasing number of preventive programs in recent years that have been created in response to terrorism, war, and natural disasters. The Cohen-Harris Center’s Tel-Aviv model was implemented in Israel after attacks by SCUD missiles in the 1991 Gulf War. An acronym that describes the theory behind this program is AREST (anticipate, redifferentiate, empower, supervise and assess, and treat and follow-up). This approach was found most helpful after assessment of the local government structure and evaluation of how the existing services could be unified, although there is no data that assesses this efficacy. Lauer asserts that systems are difficult to change after the stress of a disaster, and this systems-based, ecological approach makes available resources accessible to the victims. Another preventive program is the University of California, Los Angeles public mental health model for treatment of children and adolescents traumatized by disaster. This model was implemented in 1995 as a postwar trauma and grief intervention program for adolescents in Bosnia-Herzegovina. It includes three levels of organization: governmental response, school community programs, and intervention teams. There
are also three tiers of interventions: a broad-scale school-based intervention, specialized school-based intervention, and a highly specialized community-based intervention through referral. These models form a back-drop to the formation of more recent child focused programs for addressing disaster and terrorism in the United States.

The Child and Adolescent Trauma Treatments and Services Consortium is a program that came into existence to provide services necessitated by the unprecedented World Trade Center terrorism attacks on September 11, 2001.19 It received referrals of children who saw their school counselors but who needed a higher level of care from the Federal Emergency Management Agency (FEMA)-sponsored Project Liberty.20 When the Child and Adolescent Trauma Treatments and Services Consortium was created, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), a treatment modality with proven efficacy in child sexual abuse, was selected for use with the children who were exposed to the attacks on the World Trade Center. In addition, it implemented a modified form of Trauma/Grief-Focused Group Psychotherapy Program with positive treatment outcomes for adolescents (a decrease on the reaction index total score from 31 to 14 at 12 months in one case). In the next step of evolution, TF-CBT, group therapy, and a systems approach were used after the disaster of Hurricanes Katrina and Rita in August and September of 2005 in New Orleans through the program called Project Fleur-de-Lis.21-25 The project used a three-tiered school-based mental health system to identify, triage, and refer children to more specialized, evidence-based treatment. The first tier was classroom-based interventions. The second tier is school-based interventions, using Cognitive Behavioral Intervention for Trauma in Schools, a primarily group-focused treatment modality. The third tier, using TF-CBT, was community-based interventions.

These programs share some similarities in that they show innovation and creativity in using the best existing treatment modalities available, which are then adapted to provide services that would otherwise not have been available. OBF is similar in this regard as there was a need for preventive services focused on providing outreach to children and family members of wounded warrior parents. However, the preclinical nature of OBF places it in a unique position because assistance can be offered in conjunction with existing medical services without a referral, in a nonintrusive way, to families who may not perceive a need for assistance.26 In addition, its preclinical nature overcomes some of the barriers of stigma that are often associated with seeking care from behavioral health. Similar to the described programs, OBF identifies patients using a screening measure, uses general treatment modalities such as various groups, and uses the existing structure and culture of the hospital, helping to unify many hospital services.13 In addition, the OBF program uses a somewhat tiered system: making itself available and identifying those at risk, providing psychoeducation and assistance, and making clinical care referrals when needed. It provides a microecological model within the structure of the military’s flagship hospital and could serve as a model for other military treatment facilities and civilian facilities that have the mandate to adjust existing services to meet the needs of children and family members of injured parents. OBF is a program that has adapted to the wounded warrior demographic and serves as a model for secondary and tertiary prevention. It may eventually move towards a primary prevention model, collaborating with the Families OverComing Under Stress project that targets the military family before a parent deploys.27

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REFERENCES


