When a Parent Is Injured or Killed in Combat

Allison K. Holmes, Paula K. Rauch, and Colonel Stephen J. Cozza (U.S. Army, Retired)

Summary

When a service member is injured or dies in a combat zone, the consequences for his or her family can be profound and long-lasting. Visible, physical battlefield injuries often require families to adapt to long and stressful rounds of treatment and rehabilitation, and they can leave the service member with permanent disabilities that mean new roles for everyone in the family. Invisible injuries, both physical and psychological, including traumatic brain injury and combat-related stress disorders, are often not diagnosed until many months after a service member returns from war (if they are diagnosed at all—many sufferers never seek treatment). They can alter a service member's behavior and personality in ways that make parenting difficult and reverberate throughout the family. And a parent's death in combat not only brings immediate grief but can also mean that survivors lose their very identity as a military family when they must move away from their supportive military community.

Sifting through the evidence on both military and civilian families, Allison Holmes, Paula Rauch, and Stephen Cozza analyze, in turn, how visible injuries, traumatic brain injuries, stress disorders, and death affect parents' mental health, parenting capacity, and family organization; they also discuss the community resources that can help families in each situation. They note that most current services focus on the needs of injured service members rather than those of their families. Through seven concrete recommendations, they call for a greater emphasis on family-focused care that supports resilience and positive adaptation for all members of military families who are struggling with a service member's injury or death.

www.futureofchildren.org

Allison K. Holmes is a developmental research psychologist at the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences. Paula K. Rauch, a child psychiatrist, is the family team program director for the Red Sox Foundation and Massachusetts General Hospital Home Base Team and an associate professor of psychiatry at Harvard Medical School. Colonel Stephen J. Cozza (U.S. Army, Retired) is a professor of psychiatry and associate director of the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences.

Since the U.S. military began fighting in Iraq and Afghanistan in 2002, approximately two million military children have seen a parent deploy into harm's way at least once, and many families have experienced multiple deployments.[1] Most deployments end with a parent's safe return home, but more than 50,000 service members have been physically injured in combat, and even more are later diagnosed with traumatic brain injury (TBI) or posttraumatic stress disorder (PTSD). In the worst case, deployed parents don't return at all. In this article, we examine the impact on dependent children of deployments that result in visible or physical injuries (for example, amputations or burns); invisible injuries, including TBI and PTSD; and a parent's death.

Few researchers have studied how military children adapt to a parent's injury or death in the conflicts in Iraq and Afghanistan. But military and civilian accounts describe profound effects on parents' mental health (including that of injured, uninjured, and surviving parents), parenting capacity, family organization, and community resources. Where there are gaps in the research, we present data from studies of civilian parents or of service members from previous conflicts who faced similar challenges. These studies can help us understand what military-connected children are likely to experience, and what the affected children and their families will need in the long run. Of course, their needs will change as they move from the initial notification of injury or death and on to treatment, recovery, and reintegration into civilian communities. Clinical and nonclinical providers alike must be aware of these evolving needs and make a long-term commitment to the children and families who, in serving our nation, have paid a particularly high price.

Combat-Related Injury

Since fighting began in Iraq and Afghanistan, more than 50,000 men and women have been physically injured and required immediate medical attention.[2] Other combat-related conditions, including PTSD and TBI, may not be recognized or treated until service members return home. Thus injuries can be categorized as visible or invisible. The distinction is important, because visible and invisible injuries have different effects on children, families, and their relationships. Visible injuries are those easily identified by others, such as amputations, blindness or eye injuries, auditory damage, burns, spinal cord injuries, and paralysis.[3] TBI and PTSD are called invisible injuries because there is often no immediate external bodily indication of trauma; the symptoms appear as changes in cognition, behavior, and social functioning.[4]

Because service members wear body armor that protects their vital organs, most severe physical injuries affect the arms and legs (54 percent) or the head and neck (29 percent). Advances in medical care mean that severely injured service members are more likely to survive today than they were in previous conflicts.[5] Multiple physical injuries are common, and physical and psychological injuries often occur together.

An array of variables affects the way families experience a service member's combat injury. They include the type and severity of the injury, family composition, the children's developmental age, individual or family characteristics, the course of required medical treatment, and changes that occur as the injured parent regains function and the family copes and adapts. The course of recovery can be thought of as an injury recovery trajectory, with four phases: acute care,

medical stabilization, transition to outpatient care, and long-term rehabilitation and recovery.[6] In each phase, children and families face emotional and practical difficulties.

Injuries can be categorized as visible or invisible. The distinction is important, because visible and invisible injuries have different effects on children, families, and their relationships.

During *acute care*, the injured parent receives life-saving and life-sustaining medical interventions. When families are notified, children may be exposed to unfiltered information about the injury and raw emotional responses. When families are reunited, children may hear medical providers talk about injuries or medical procedures, and they may see other ill or injured people in the hospital; they may also have to take on some caregiving responsibilities.

Medical stabilization includes surgery and other medical care that prepare the injured service member to leave the hospital. How long this phase lasts depends on the severity of the injury. Stabilization typically occurs in a facility far from the family's home, and the other parent may need to travel to be near the injured service member, with or without the children. In a 2007 report, 33 percent of active-duty, 22 percent of Guard and Reserve, and 37 percent of retired service members reported that a family member or friend relocated temporarily to spend time with the injured service member while he or she was in the hospital.[7] Whether children come with their uninjured parent or are left in the care of others, their daily routines are disrupted. Separation from parents, exposure to an injured parent, or exposure to an uninjured parent's emotional distress may cause children to feel sadness, anxiety, or confusion.

Younger children commonly express what they're feeling through behavior, such as aggression, greater dependency, or regression to behaviors more typical of a younger child. Older children may display the same kinds of symptoms; they may also either assume caregiving or household responsibilities or disengage from the family.[8] Children who lack social connections, as well as those who already suffer from a psychiatric illness, are more likely to experience emotional and behavioral problems.[9] Research in other contexts has shown that children with behavioral problems are more likely to be maltreated, and this may be true in the families of injured service members as well.[10]

Transition to outpatient care begins before discharge from the hospital, when follow-up care and rehabilitation are arranged. Families prepare to meet everyday needs (such as housing, financial planning, transportation, child care, and schooling) as they adapt to new medical demands (rehabilitation appointments, the service member's daily care) that add new emotional challenges for parent and child alike. The responsibility for coordinating these old and new demands falls mostly on the uninjured parent. In fact, family members or friends often must leave their jobs to care for the injured service member full time.

Rehabilitation and recovery is when service members learn to adapt to their injuries and settle into their new lives. During this phase,

families often move to new communities and seek new health-care providers. New homes, new neighborhoods, new schools, new friends, new child-care providers, and new daily routines add instability to children's lives. If schools, peers, and community providers don't know how to support children of injured service members, or if they are unfamiliar with military children in general, the readjustment may further tax a child's ability to cope.[11]

Visible Injuries

Severe injury often requires extended treatment, which is especially difficult for families. Periods of medical stability may alternate with periods of instability, when complications occur, progress is limited, or additional treatments (such as multiple reconstructive surgeries) are needed.[12] The family's living arrangements may change, and months or years of recurring hospital-based treatments and outpatient visits may disrupt their connections to the community. Moreover, when service members suffer multiple injuries, or when visible and invisible injuries occur together, treatment grows more complex and family adjustment more difficult.[13] A long and disruptive recovery can take its toll on children, 15 percent of whom exhibit clinical levels of emotional and behavioral problems several years after their military parent's injury.[14]

Parents' Mental Health

In addition to physical changes, combat-injured service members are at significant risk for invisible injuries or psychiatric problems, such as PTSD and depression.[15] These problems may not appear until long after the injury. In fact, one study found that nearly 80 percent of combat-injured service members who screened positive for either PTSD or depression seven months after their injury had screened negative for both conditions six months earlier.[16] When injured service members have poor emotional health, they may not be able to engage fully with their children, which affects the children's ability to cope.

A long and disruptive recovery can take its toll on children, 15 percent of whom exhibit clinical levels of emotional and behavioral problems several years after their military parent's injury.

Parenting Capacity

External events can disrupt both relationships between couples and the entire family system, as well as individual wellbeing. A family systems framework explains how a parent's physical injury can affect a child's wellbeing by disrupting the parenting of both the injured and uninjured parent.[17] For example, among children of parents suffering from stroke, the uninjured parents' stress and depression were associated with anxiety and depression among their children.[18]

One critical way that combat injury can influence an injured parent's ability to engage with his or her children is through changes in physical function. Amputation, musculoskeletal injuries, burns, or eye injuries are likely to produce temporary or permanent loss of function, requiring prosthetic assistance or rehabilitative care. Before their injuries, many young military service members are physically active, and, especially among

fathers, parenting activities are often physical, "hands-on," or athletic.[19] After the injury, those activities may no longer be possible, or they may need to be modified significantly. In turn, injured service members must modify their ideas of how to be a good parent at the same time that they are mourning their own bodily changes or loss of function. The injured parents' physical absence during hospitalizations, and their emotional unavailability due to physical condition or treatment effects, can also seriously limit their ability to effectively interact with their children.[20]

The uninjured parent may also find it hard to be available for the children. For one thing, if the injured service member can't take part in routine activities, the uninjured parent (as well as the children) has to take on new responsibilities. Similarly, the uninjured parent may be less available while caring for the injured parent. Either of these circumstances can limit the parent's ability to engage in warm, nurturing interactions with children. As multiple sources of stress spill over into the parent-child relationship, children have fewer resources, and their risk for maladaptation increases. Thus, supporting the children of injured service members means bolstering the parenting relationships of both injured and uninjured parents.

Family Organization

We know from studies of families dealing with combat injuries, multiple sclerosis, or stroke that when an injury or illness produces significant changes in parenting ability, parents and children alike must renegotiate family relationships and come to terms with the injury and its consequences. When service members remain impaired and can't resume their former parental and household responsibilities, uninjured parents and children are likely to see their own roles change. In these circumstances, children may act out if the family becomes disorganized or dysfunctional.[21] Likewise, relationships between parents and children, or between spouses, may grow strained, and children may experience emotional problems.[22] If the family's organization was poor before a combat injury, the injury is likely to make things worse, undermining family members' capacity to negotiate the challenges they face. In one small study of hospitalized injured service members, children from families where the stress from deployment was high even before the injury suffered greater emotional distress after the injury than did other children.[23] Because children's wellbeing depends on how well the family functions after a combat injury, service providers may need to work with such at-risk families more intensively.

A combat injury generates confusion and fear in the family, and better communication between parents and children can help children cope.[24] Injury communication refers to communication about injury-related topics both within the family and with others in the civilian and military communities.[25] Effective injury communication requires open dialogue about the injury and its consequences among many parties: the injured service member and the uninjured parent; family members, including children; friends; and medical personnel and other community professionals and service providers. Parents need sophisticated guidance about how to talk with their children about medical conditions; professionals need to know how to offer this support to parents.[26] Just as some parents may tell their children too little about the injury, others share more than the children can handle, or frighten them by unnecessarily bringing up unknown future consequences. Thus adults may need help calibrating the

amount, content, and timing of the facts they share. But even young children should be given some explanations to help them understand the actions and emotions of the adults they see around them.

Community Resources

Families who are dealing with combat injuries need support and services from the community, and these needs change and evolve as recovery from the injury progresses. For example, families may need help finding adequate housing, particularly when they expect long-term visits from extended family members. They may require assistance with child care, family health or schooling, or help navigating military regulations and paperwork, transitioning to civilian medical care, or finding a job.[27] Guard and Reserve families, who often live far from military communities and their associated support services, may require additional help. And when injured service members leave the military system and move to communities around the country, military families may find that service providers, teachers, and others are unfamiliar with their unique needs.

Traumatic Brain Injury

The number of service members who return home with combat-related TBI is not entirely clear. Estimates differ depending on the source of information, the screening criteria, and the threshold of diagnostic clarity, as well as the severity of the injury (that is, mild, moderate, or severe). The military health system reported that more than 250,000 cases of TBI had been diagnosed in military service members from 2000 through 2012.[28] Others have estimated a significantly higher incidence, for example, 320,000 cases among returning Iraq and Afghanistan combat veterans through 2007.[29] Overall, 33 percent of service members who return from combat are reported to suffer from TBI, PTSD, or depression, and 5 percent meet the criteria for all three diagnoses.[30] When such injuries occur together, they are likely to have cumulative effects on children and families.

The impact of parents' traumatic brain injuries in military families has not been well studied. But evidence from nonmilitary families shows that this type of parental impairment can have profound effects on children. Children living with a parent who has suffered a TBI display more behavioral and emotional problems, feelings of loss and grief at the change in the injured parent, and a sense of isolation. They also exhibit more posttraumatic stress symptoms, and 46 percent meet the criteria for PTSD.[31] Interestingly, when compared with children of parents with diabetes, children of parents with TBI report higher levels of posttraumatic stress but no differences in behavioral problems, depression, or anxiety; this suggests that a parent's TBI may be uniquely traumatic for children.[32]

Parents' Mental Health

The symptoms of TBI and PTSD overlap, and the prevalence of co-occurring diagnoses among service members returning from Iraq and Afghanistan varies depending on the definition of TBI. When the TBI is moderate (for example, producing loss of consciousness), the incidence of co-occurring PTSD was higher than when the TBI was mild (for example, producing alteration of consciousness) or severe (for example, an open head wound).[33] Compared with those with TBI only and those who screened negative for either condition, service members with both TBI and PTSD engaged in more high-risk behaviors like reckless driving, binge

drinking, and heavy smoking.[34] Because TBIs are not always immediately identified or treated, families may not know what is causing the changes they see in a returning service member. Problems related to undiagnosed TBI or PTSD may continue for months or years, eroding a family's bonds.

Parenting Capacity

TBI poses unique challenges to parenting. Its psychiatric effects tend to be more distressing to family members and more disruptive to family functioning than those of other physical and nonneurological impairments.[35] These effects include altered personality, emotional problems (for example, irritability, a low frustration threshold, poor anger management, or apathy), difficulty with behavioral regulation, cognitive problems (for example, a short attention span or intolerance for overstimulation), lack of energy, substance abuse, thrill-seeking behavior, disrupted sleep, communication problems, and difficulty with personal engagement.[36] To cope with such TBI symptoms, injured parents may withdraw from the family to protect children and other loved ones.

Children are likely to be confused and distressed by these behaviors and may blame themselves for their parents' outbursts, loss of control, or emotional aloofness. In some cases, children and families are left with a troubling sense that the injured service member bears little resemblance to the person they knew before the injury, resulting in a sense of sadness and loss. As one 12-year-old girl said: "I basically just feel sad, because he's there physically. I suppose I've got a Dad, but he's not my Dad."[37]

Uninjured parents are also likely to be affected. They often must care for the injured parent, and they are at high risk for depression and anxiety, either of which can undermine their parenting capacity.[38] Compromised parenting in either the injured or the uninjured parent, as well as depression in the uninjured parent, correlates with higher levels of emotional and behavioral problems in children of TBI patients.[39] Thus, visible and invisible injuries prevent injured and noninjured parents from engaging in the warm, nurturing relationships children require after trauma. Supporting and intervening through parenting relationships can help children cope and adapt.

Because TBIs are not always immediately identified or treated, families may not know what is causing the changes they see in a returning service member.

Family Organization

Unlike those of other physical injuries, the effects of TBI on children and families may not improve. In one study, families disrupted by a TBI still needed professional help 10–15 years after the injury, and young families with the least financial and social support were at the highest risk.[40] The initial severity of the TBI was not the greatest predictor of how the uninjured parent and children would fare; rather, it was the degree to which the injury affected the victim's cognitive and interpersonal functioning. In particular, the uninjured parent's experience was heavily affected by whether the couple was still able to have a reciprocal emotional relationship and communicate effectively.

For families of long-term TBI sufferers, the study concluded, social support from friends, family, and professionals alike was critical.

Community Resources

The common delay in diagnosing TBI, as well as the injury's long-term effects, can damage job performance, earnings, and the sufferer's military career. Because of the long-term effects, community providers will be seeing more cases of TBI as injured service members return to civilian life, and they will need to recognize the symptoms and provide appropriate treatment. Uninjured parents will need support of many kinds—practical, logistical, emotional—and they may also need temporary relief from caregiving. Similarly, the long-term impact of TBI means that children will need expanded community support from schools, clinicians, and therapists long after the injured parent leaves military service. Some younger children affected by a parent's TBI can be expected to exhibit disruptive behaviors, poor academic performance, and substance abuse years later, in middle school and high school.

PTSD is a signature injury of the post-9/11 conflicts.

Combat-Related Stress Disorders

Psychological injury is another invisible wound that affects children's health and well-being. Combat-related stress disorders can include PTSD, depression, anxiety disorder, and substance abuse. Recent reports indicate that up to one-third of service members deployed to Iraq and Afghanistan experience some sort of mental health disorder within three to four months of returning home.[41]

PTSD is a signature injury of the post-9/11 conflicts. Since 2000, 66,935 new cases of PTSD have been diagnosed among service members who have deployed, as well as 21,784 new cases among service members who have never deployed; the overall prevalence of PTSD among military personnel is variously estimated to be between 6 and 25 percent.[42] The disorder is associated with a range of problems, including occupational and social impairment, poor physical health, neuropsychological impairment, substance use, and risk of death.[43] Any of these complications can slow service members' recovery, affect children and families, disrupt reintegration into the community, and impair service members' ability to resume their former roles at home.

Unfortunately, only half of returning service members who meet the criteria for PTSD or depression seek treatment. Many are worried about job security; for example, they fear that they could lose a security clearance, or that their coworkers will lose trust in them. They may also fear the treatment itself.[44] Even among those who seek treatment, half receive only minimally adequate care. The children of these service members are affected as well. In studies from the Vietnam War and the second Iraq War alike, children of soldiers with PTSD showed higher levels of anxiety, depression, and posttraumatic symptoms themselves.[45] The children's symptoms may best be accounted for by disruptions in the parenting relationship and repeated exposure to the symptoms that the affected parent displays.[46]

As with visible injury, the way a parent's PTSD affects children depends on a child's age, developmental level, temperament, and preexisting conditions. Because their cognitive and emotional skills are less developed,

younger children may struggle more than older children to cope and adapt to changes in a parent's behaviors and the parenting relationship. Very young children may have an especially hard time coping with the disorganized parental behavior that can result from PTSD, such as overreaction or disengagement. These inappropriate responses can lead to an emotional disconnection between parents and very young children, resulting in a nonnurturing parent-child relationship that can mimic the dysfunctional relationships seen in early childhood abuse.[47] Definitive mental health treatment, mental health education for parents and children, developmental guidance, and supportive therapeutic assistance, such as parent-child interpersonal therapy, may all be tremendously useful in such situations, both on return from deployment and throughout the recovery.

Parents' Mental Health

Invisible stress-related injuries can harm the spouse's mental health along with the injured service member's. In studies from several conflicts, spouses of soldiers with PTSD were more likely than others to show traumatic stress symptoms themselves and to experience general distress.[48] Moreover, a spouse's mental health problems were more likely to harm children's functioning than were a service member's own, making spouses' mental health a critical target for treatment.[49] Clearly, attention to the mental health needs of both parents is essential to the health of their children.

Parenting Capacity

Studies of how parents' combat-related PTSD affects children and families come largely from work with American, Australian, and New Zealander Vietnam War veterans and their families. Within these populations, PTSD has been associated with poor intimate relationships, impaired family functioning, greater family distress, higher levels of family violence, and disrupted parenting and parent-child relationships.[50] The complex interaction of risk behaviors and psychological symptoms that characterize PTSD—including emotional numbing, avoidance, and anger—make it difficult for those who suffer from the disorder to engage with their families. Ayelet Meron Ruscio and colleagues, writing about male victims of PTSD, say that "the disinterest, detachment, and emotional unavailability that characterize emotional numbing may diminish a father's ability and willingness to seek out, engage in, and enjoy interactions with his children, leading to poorer relationship quality."[51] In turn, spouses may see service members with PTSD as unreliable and inadequate caregivers, further alienating them from their children. The way that spouses' emotional health affects children's wellbeing suggests that the traditional approach to treating a veteran's PTSD—individually, without providing primary mental health support to spouses and children—is inadequate.

Family Organization

Through their effects on marital and parenting relationships, combat-related stress disorders make it harder for families to readjust after deployment. Up to 75 percent of service members who screen positive for postdeployment mental health disorders report marital conflict, and service members with PTSD symptoms show higher rates of conflict with spouses and children, as well as more difficulty with parenting.[52] Spouses and children often struggle to avoid triggering negative or explosive responses from affected service members. As PTSD symptoms become more severe, rates of interpersonal violence rise and the burden

on caregivers increases.[53] When families experience stress and conflict, the potential for child abuse is higher.[54] But military families and children have great capacity for resilience, and targeted individual and family treatments can harness these skills.[55]

Community Resources

Given the prevalence of combat-related stress disorders and their far-reaching effects on children and families, service members, spouses, children, and families need several levels of support. Moreover, services must be available in both military and civilian communities.

Identifying and treating stress disorders early can prevent long-term family exposure and reduce family stress. Unfortunately, lack of understanding, concern for career, and stigma regarding treatment prevent many service members from seeking diagnosis and help.[56] Thus we should encourage and train people to identify children affected by combat-related stress disorders in schools, community organizations, sports teams, and religious groups, as well as during pediatric visits.

In addition to promoting mental health and family resilience, programs that work with families affected by stress disorders must consider their practical needs, such as employment, finances, and housing. Help with meeting basic needs can diminish stress, particularly for spouses who bear the burden of running the family. Comprehensive support promotes overall family health and increases the likelihood that mental health treatment will succeed.

Combat-Related Death

We define combat-related deaths as deaths that occur during combat deployment, as well as suicides that occur in combat zones or after return from combat deployment. Since 9/11, more than 16,000 uniformed service members have died on active duty. Approximately one-third of these deaths occurred in combat; more than 97 percent of those killed have been male.[57] Another 14 percent of all service members' deaths are self-inflicted. Though we know a great deal about how a parent's death affects children in the civilian population, little empirical research has been done on how a parent's death, especially a parent's death in combat, affects children in the military.

We hypothesize that a parent's death in combat has a more immediate impact on military children than do visible or invisible injuries. However, death during combat deployment is not wholly unanticipated. Military families, as well as families in other line-of-duty professions (law enforcement, firefighting), do not necessarily focus on the ultimate sacrifice.[58] But these high-risk service professions carry mechanisms, such as a professional culture and a sense of mission, that may help children who are coping with loss.[59] For example, one study showed that Israeli children with a relative who died in combat reported fewer psychiatric symptoms and greater general wellbeing than children with a relative who died in a motor vehicle accident.[60] However, military deaths may be experienced differently in Israel, where nearly all adults serve in the armed forces. Nonetheless, the military culture and its support systems can bolster families as they grieve and adjust. Critical to understanding any family's response to combat death is their perspective on the death (for example, whether they see it as meaningful or meaningless), the events that surround the death, and their experience following the death of family and community cohesion and support.

A warm, nurturing, and effective relationship with the surviving parent promotes positive coping and interactions.

Parents' Mental Health

Evidence from civilian families shows that a spouse's death can affect the surviving spouse in a variety of ways: increased vulnerability to physical and psychological illness, reduced happiness, and feelings of social isolation and meaninglessness.[61] While spouses grieve, children of all ages may display a variety of healthy, developmentally appropriate grief responses: playing, talking, questioning, and observing. Many children feel sad, cry, or become more withdrawn; others express their emotions through reverting to earlier behaviors. When the surviving parent was already struggling with depression, anxiety, or sleep or health problems before the death, children are less likely to adjust well, and young children are more vulnerable as well.[62] Some children develop childhood traumatic grief, which is marked by trauma-related symptoms (for example, hyperarousal, psychological distress, and avoidance) that can make it harder for them to mourn appropriately.[63] No studies have examined the incidence of childhood traumatic grief in bereaved military children, but combat death shares many of the characteristics (such as sudden loss) that contribute to its development in other populations.

Parenting Capacity

A child's response to a parent's death is related to the surviving parent's response. According to George Tremblay and Allen Israel, "Children appear to be at risk for concurrent and later difficulties primarily to the extent that they suffer a higher probability of inadequate parental functioning or other environmental support before, as well as after, the loss of a parent."[64] Therefore, the parenting relationship can support or undermine a child's adjustment after a parent's death. A warm, nurturing, and effective relationship with the surviving parent promotes positive coping and interactions.[65] Lax control (for example, inconsistent discipline practices), which is more common after one parent dies, as well as children's fear of abandonment, can increase problem behaviors, depression, and anxiety in children.[66]

Family Organization

Research has shown repeatedly that the surviving parent's competence helps ensure the bereaved child's positive adjustment, as does family cohesiveness.[67] The relationship between family cohesion and positive adjustment is significant, given that many military family members describe tension and alienation within the family after a service member's death.[68] If the death produces a large number of additional stresses and changes to routine, children are likely to show lower self-esteem and feel less in control of their lives.

For spouses, the death of a service member leads to a series of compounding losses. In addition to losing a husband or wife, bereaved military spouses may lose their identity as a "military spouse" and their way of life as a "military family." They may lose on-base housing and friends, as well as the feeling of being connected to the greater military community. Spouses may blame the military and the government for the death and for the

negative consequences that they and their families face, particularly if they have trouble navigating the bureaucracy. Thus, although the military culture and its support systems can provide avenues to resilience, they can also become painful reminders of a life lost, or a source of stress.

Community Resources

Following a service member's death, families must immediately make arrangements. Some of these are familiar to all families—for example, the funeral. Others are specific to the military, such as determining financial benefits and entitlements. Later, military families may have to make decisions about housing: qualifying military dependents may remain in on-base housing for one year after a service member's death, but after that they must leave. Each military service branch has created a casualty assistance program to aid families from the time they learn of the death, helping them get through military administrative processes and connecting them with survivor services.[69]

Importantly, providing practical and emotional support to surviving families both immediately and over time produces the best outcomes. A service member's combat death is likely to bring a cascade of events that can undermine the family's connection to practical support, communities of care, and military culture. Though many families remain close to military communities, where they can continue to access military services, others move great distances to be closer to extended family or friends. Like bereaved military families in the Guard and Reserve, these families may find themselves in communities that lack an understanding of their experience or sacrifice, leading to a sense of isolation or disconnection. National community support services such as the Tragedy Assistance Program for Survivors (TAPS), Gold Star Wives, Gold Star Mothers, and the Army Survivor Outreach Services (Army SOS), among others, can help provide continuity across communities to ensure that families stay connected and effectively engaged.

For children, schools can play an important role. For one thing, children who do well in school are likely to have fewer behavioral problems.[70] Moreover, self-esteem plays a key role in how children experience and respond to stressful events. Self-esteem also promotes academic success. Thus educators can promote resilience by fostering self-esteem and academic competence.

Conclusions and Recommendations

For the post-9/11 conflicts in Iraq and Afghanistan, we do not have enough scientific evidence documenting how visible and invisible injuries or bereavement have affected military children. But the long-term effects are likely to be substantial in this high-risk population. Certainly, we need more research both to guide policy for future wars and to more effectively serve the current population. In this review, we have extrapolated from studies of the civilian population and of families from past wars. We know that the effects of combat injury and death are not limited to children's emotional, psychological, behavioral, or academic functioning at the time of the incident. We do not know how today's military children will evolve over time, nor how or whether this evolution will differ from that of civilian children, but we do know that families will be affected for years to come.

Clearly, the family's structure and function are critical to individual and familial health.

Injured, uninjured, and bereaved parents affect children directly and indirectly through their own mental health, their parenting abilities, the family's organization, and their place in the community; all of these factors can be sources of either risk or resilience.[71] Most current services emphasize the needs of the injured service member. But deployments that result in injury or death profoundly influence all members of the family and increase the risk for maladaptation both immediately and in the long term. Supporting parents' physical and mental health, bolstering their parenting capacity, and enhancing family organization can help children cope and thrive. Throughout the family's recovery, the most effective community support services and resources are those that emphasize family-focused care and resilience.

Based on our review of the evidence, we offer seven recommendations for service providers and policy makers.

1. Stabilize the family environment throughout recovery by ensuring access to basic needs, such as housing, education, health care, child care, and jobs. Families need basic resources, not only as they make immediate adjustments to a service member's injury or death, but also as they transition later to new communities. Many families must profoundly alter their lives. They move, changing schools and doctors and jobs. Their income may fall, and they may lose access to community resources such as child care, youth activities, and sports programs. To succeed, families need support both inside and outside the military system as injuries heal, stress disorders are identified and treated, and bereaved spouses and children adjust and reorganize. Some families are likely to be more affected, for example, younger families, families who have trouble making ends meet, and families in which a parent has a disability that impairs parenting capacity. Even families who live on military installations or obtain treatment in the military or VA health-care systems will eventually transition to civilian communities, where understanding of military culture and expertise in working with military families is likely to be limited. Programs and services that foster a secure and stable environment for families of service members who are injured or killed are more likely to meet their multiple needs and, in turn, promote their children's wellbeing.

2. Identify and promote services that support family organization, communication, coping, and resilience. A parent's injury, illness, or death can powerfully disorganize families, contributing to distress and dysfunction. Families must effectively reorganize and rethink their activities and goals if they are to successfully overcome the challenges they face. Such family growth requires parents to exhibit strong leadership, fortitude, and patience, modeling positive adaptation and coping for their children. Professional assistance should support families in reaching these goals.

Another critical component of healthy family functioning is communication, particularly to help children understand the nature of an injured parent's condition at an age-appropriate level. Communication is also necessary for problem-solving and planning. Families must cope with real and perceived losses in all family members, and they must accept various emotional responses from everyone, including children. Conditions such as TBI or PTSD may complicate this process through heightened conflict, family disorganization, emotional problems, or interpersonal isolation. People who work with military families affected by these conditions need careful

strategies to support better understanding among family members, encourage parents and children to build their skills, and help families come to terms with perceived losses to recover meaning and hope. This article has used two-parent families as illustrations, but family-centered care should also recognize and incorporate the needs of blended families and single-parent families, as well as families that include the younger siblings of service members.

3. Incorporate family-centered care models into clinical and community practice to provide basic parenting intervention and education about the challenges of a service member's visible or invisible injuries, or a surviving parent's bereavement. A family-centered care perspective supports the physical and mental health of all family members, especially children, by acknowledging and ameliorating how combat-related injuries affect parenting. A service member's physical limitations, changes in cognitive ability, and psychological or emotional distress may affect parenting capacity; an uninjured or bereaved parent may be affected as well. Impaired parenting capacity may be the immediate result of a combat injury, or it may occur later as adversities accumulate in the injury's wake. Comprehensive family-centered care helps family members understand the broad impact of combat-related conditions on everyone in the family, and it suggests parenting strategies that can effectively promote children's wellbeing during the recovery. There is an urgent need to develop and evaluate evidence-based programs that reduce the impact of deployment stress, PTSD, and TBI on the extended family system.

4. Identify and treat mental health problems—including depression, anxiety, and PTSD—in uninjured parents and children. Clinicians who work with combat-injured service members or veterans can help their patients' families and children in simple ways. Clinicians can learn about the members of a patient's family and how the patient relates to the uninjured parent and children by asking how the illness or injury affects the marriage and parenting. For example, irritability, avoidance, or loss of interpersonal connectedness can decrease marital satisfaction and parental engagement. Clinicians should listen to uninjured parents and children for signs of distress and, when appropriate, get help for them. Uninjured parents and children who had psychiatric or developmental problems before the combat injury are at risk for greater problems. Clinicians who identify problems in the family can request a patient's permission to invite other family members to a clinical session to discuss the nature of family relationships and to assess the impact of combat-related injuries or illnesses. Such proactive attention to the clinical needs of all family members will boost the family's resilience, both together and individually.

5. Tailor services to families' individual risks and strengths. Children and families who were already functioning well may need only shorter-term support. On the other hand, children and families who had medical or mental health problems even before a combat injury or death can be expected to need more help. But in either case, strength-based approaches are more effective than deficit models. We can promote families' resilience by 1) reducing their distress, 2) educating them, 3) helping them plan for future needs, 4) linking them to outside resources, and 5) creating a sense of hope. Recognizing the variability among recovering families and adapting to their needs to promote resilience will help create cost-effective programs and services.

Clinicians should listen to uninjured parents and children for signs of distress and, when appropriate, get help for them.

6. Educate clinical and community service providers about the unique needs of families of service members who have been injured or killed in combat. Children and families who face combat injury and death should be able to get competent and well-informed medical, mental health, social, and educational care in any community in the nation, even and perhaps especially when they live far from military installations or in rural areas. Thus we need national programs to teach clinicians and community service providers about the unique needs of military children and families; the White House's Joining Forces campaign, for example, helps communities, businesses, clinicians, and schools learn about military families' needs. We also must evaluate such programs to make certain they deliver essential care efficiently and cost-effectively.

Building broad access to health care and community support programs is likely to be challenging, however. Professionals need incentives to participate in these programs. Because military children may need extensive and complex help after a parent's injury, illness, or death, children may be underserved. Or they may receive duplicate services or inappropriate treatments in overlapping systems. Policy must target efficient and formal coordination of care across multiple systems—education, health care, mental health, youth services—to facilitate recovery and to minimize the burden on already stressed families.

7. Commit to sustaining systems of support for these families, who may need help for decades. Policies and programs should recognize that a family's recovery after combat-related injury, illness, or death is likely to be prolonged, and families will have different needs at different times. Services from military, VA, and civilian providers should be supplemented, integrated, and coordinated to meet families' needs during their many years of recovery and healing. Increasing the use of web-based models of care may be a promising way to do this.

Ultimately, we need to do more research, evaluate the effectiveness of existing programs, and disseminate the findings so that we can expand resilience-based family programs to providers in the communities where families live and receive care. In the absence of strong, evidence-based programs to support these high-risk families, however, both contemporary practice and future research hypotheses should be grounded in sound clinical judgment.

ENDNOTES

1. Department of Defense, "Report on the Impact of Deployment of Members of the Armed Forces on Their Dependent Children," report to the Senate and House committees on armed services, October 2010, http://www.militaryonesource.mil/12038/MOS/Reports/Report_to_Congress_on_Impact_of_Deployment_on_Military_Children.pdf.

2. Iraq Coalition Casualty Count, "Military Fatalities by Year," accessed September 1, 2012, www.icasualties.org.

3. Edwin A. Weinstein, "Disabling and Disfiguring Injuries," in *War Psychiatry*, ed. Franklin D. Jones et al. (Falls Church, VA: Office of the Surgeon General, U.S. Army, 1995), 353–81.

4. Karyn D. Jones, Tabitha Young, and Monica Leppma, "Mild Traumatic Brain Injury and Posttraumatic Stress Disorder in Returning Iraq and Afghanistan War Veterans: Implications for Assessment and Diagnosis," *Journal of Counseling and Development* 88 (2010): 372–76, doi: 10.1002/j.1556-6678.2010.tb00036.x.

5. Atul Gawande, "Casualties of War—Military Care for the Wounded from Iraq and Afghanistan," *New England Journal of Medicine* 351 (2004): 2471–75, doi: 10.1056/NEJMp048317.

6. Stephen J. Cozza and Jennifer M. Guimond, "Working with Combat-Injured Families through the Recovery Trajectory," in *Risk and Resilience in U.S. Military Families*, ed. Shelley MacDermid Wadsworth and David Riggs (New York: Springer, 2011), 259–77.

7. President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors* (Washington, 2007).

8. Stephen J. Cozza and Margaret M. Feerick, "The Impact of Parental Combat Injury on Young Military Children," in *Clinical Work with Traumatized Young Children*, ed. Joy D. Osofsky (New York: Guilford Press, 2011), 139–54.

9. Daniel S. Pine and Judith A. Cohen, "Trauma in Children and Adolescents: Risk and Treatment of Psychiatric Sequelae," *Biological Psychiatry* 51 (2002): 519–31, doi: 10.1016/S0006-3223(01)01352-X.

10. Jocelyn Brown et al., "A Longitudinal Analysis of Risk Factors for Child Maltreatment: Findings of a 17-Year Prospective Study of Officially Recorded and Self-Reported Child Abuse and Neglect," *Child Abuse and Neglect* 22 (1998): 1065–78.

11. Stephen J. Cozza, "Meeting the Wartime Needs of Children and Adolescents," in *Caring for Veterans with Deployment-Related Stress Disorders: Iraq, Afghanistan, and Beyond*, ed. Josef I. Ruzek et al. (Washington: American Psychological Association, 2011), 171–90.

12. Elizabeth J. Halcomb and Patricia M. Davidson, "Using the Illness Trajectory Framework to Describe Recovery from Traumatic Injury," *Contemporary Nurse* 19 (2005): 232–41.

13. Greta Friedemann-Sanchez, Nina A. Sayer, and Treven Pickett, "Provider Perspectives on Rehabilitation of Patients with Polytrauma," *Archives of Physical Medicine and Rehabilitation* 89 (2008): 171–78, doi: 10.1016/j.apmr.2007.10.017.

14. Stephen J. Cozza et al., *The Impact of Combat Injury on the Adjustment of Military Service Members, Spouses, and Their Children,* poster presentation at the annual meeting of the International Society for Traumatic Stress Studies, Baltimore, MD, November 2011.

15. Danny Koren et al., "Increased PTSD Risk with Combat-Related Injury: A Matched Comparison Study of Injured and Uninjured Soldiers Experiencing the Same Combat Events," *American Journal of Psychiatry* 162 (2005): 276–82, doi: 10.1176/appi.ajp.162.2.276.

16. Thomas A. Grieger et al., "Posttraumatic Stress Disorder and Depression in Battle-Injured Soldiers," *American Journal of Psychiatry* 163 (2006): 1777–83.

17. Lisa Armistead, Karla Klein, and Rex Forehand, "Parental Physical Illness and Child Functioning," *Clinical Psychology Review* 15 (1995): 409–22, doi: 10.1016/0272-7358(95)00023-I; Lisa A. Gorman, Hiram E. Fitzgerald, and Adrian J. Blow, "Parental Combat Injury and Early Child Development: A Conceptual Model for Differentiating Effects of Visible and Invisible Injuries," *Psychiatry Quarterly* 81 (2010): 1–21, doi: 10.1007/s11126-009-9116-4.

18. Anne Visser-Meily et al., "Children's Adjustment to a Parent's Stroke: Determinants of Health Status and Psychological Problems, and the Role of Support from the Rehabilitation Team," *Journal of Rehabilitation Medicine* 37 (2005): 236–41.

19. Cozza and Guimond, "Working with Combat-Injured Families."

20. Beth A. Kotchick et al., "The Role of Parental and Extrafamilial Social Support in the Psychosocial Adjustment of Children with a Chronically Ill Father," *Behavior Modification* 21 (1997): 409–32.

21. Stavroula Diarme et al., "Emotional and Behavioural Difficulties in Children of Parents with Multiple Sclerosis: A Controlled Study in Greece," *European Child and Adolescent Psychiatry* 15 (2006): 309–18.

22. Anne Visser-Meily et al., "When a Parent Has a Stroke: Clinical Course and Prediction of Mood, Behavior Problems, and Health Status of Their Young Children," *Stroke* 36 (2005): 2436–40.

23. Stephen J. Cozza et al., "Combat-Injured Service Members and Their Families: The Relationship of Child Distress and Spouse-Perceived Family Distress and Disruption," *Journal of Traumatic Stress* 23 (2010): 112–15, doi: 10.1002/jts.20488.

24. Duncan Keeley, "Telling Children about a Parent's Cancer," *British Medical Journal* 321 (2000): 462–63.

25. Stephen J. Cozza et al., *Proceedings: Workgroup on Intervention with Combat Injured Families* (Bethesda, MD: Center for the Study of Traumatic Stress, Uniformed Services University, 2009).

26. Anna C. Muriel and Paula K. Rauch, "Suggestions for Patients on How to Talk with Children about a Parent's Cancer," *Journal of Supportive Oncology* 1 (2003): 143–45.

27. Francis M. Weaver et al., "Provider Perspectives on Soldiers with New Spinal Cord Injuries Returning from Iraq and Afghanistan," *Archives of Physical Medicine and Rehabilitation* 90 (2009): 517–21, doi: 10.1016/j.apmr.2008.09.560; John E. Zeber et al., "Family Perceptions of Post-Deployment Healthcare Needs of Iraq/Afghanistan Military Personnel," *Mental Health in Family Medicine* 7 (2010): 135–43.

28. Defense and Veterans Brain Injury Center, "DoD Worldwide Numbers for TBI," accessed September 1, 2012, www.health.mil/Research/TBI_Numbers.aspx.

29. RAND Center for Military Health Policy Research, *Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans* (Santa Monica, CA: RAND Corporation, 2008).

30. Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008), xxi.

31 Nella Charles, Franca Butera-Prinzi, and Amaryll Perlesz, "Families Living with Acquired Brain Injury: A Multiple Family Group Experience," *NeuroRehabilitation* 22 (2007): 61–76.

32. Rikke Kieffer-Kristensen, Thomas W. Teasdale, and Niels Bilenberg, "Post-Traumatic Stress Symptoms and Psychological Functioning in Children of Parents with Acquired Brain Injury," *Brain Injury* 25 (2011): 752–60, doi: 10.3109/02699052.2011.579933.

33. Jennifer J. Vasterling, Mieke Verfaellie, and Karen D. Sullivan, "Mild Traumatic Brain Injury and Posttraumatic Stress Disorder in Returning Veterans: Perspectives from Cognitive Neuroscience," *Clinical Psychology Review* 29 (2009): 674–84, doi: 10.1016/j.cpr.2009.08.004.

34. Amanda M. Kelley et al., "Risk Propensity and Health Risk Behaviors in U.S. Army Soldiers with and without Psychological Disturbances across the Deployment Cycle," *Journal of Psychiatric Research* 46 (2012): 582–89, doi: 10.1016/j.jpsychires.2012.01.017.

35. John R. Urbach and James P. Culbert, "Head-Injured Parents and Their Children: Psychosocial Consequences of a Traumatic Syndrome," *Psychosomatics* 32 (1991): 24–33.

36. Linda J. Resnik and Susan M. Allen, "Using International Classification of Functioning, Disability and Health to Understand Challenges in Community Reintegration of Injured Veterans," *Journal of Rehabilitation Research and Development* 44 (2007): 991–1006.

37. Franca Butera-Prinzi and Amaryll Perlesz, "Through Children's Eyes: Children's Experience of Living with a Parent with an Acquired Brain Injury," *Brain Injury* 18 (2004): 83–101.

38 Jeffrey S. Kreutzer et al., "Caregivers' Well-Being after Traumatic Brain Injury: A Multicenter Prospective Investigation," *Archives of Physical Medicine and Rehabilitation* 90 (2009): 939–46; Jennie Ponsford et al., "Long-Term Adjustment of Families following Traumatic Brain Injury Where Comprehensive Rehabilitation Has Been Provided," *Brain Injury* 17 (2003): 453–68.

39. Linda F. Pessar et al., "The Effects of Parental Traumatic Brain Injury on the Behaviour of Parents and Children," *Brain Injury* 7 (1993): 231–40.

40. Sofie Verhaeghe, Tom Defloor, and Mieke Grypdonck, "Stress and Coping among Families of Patients with Traumatic Brain Injury: A Review of the Literature," *Journal of Clinical Nursing* 14 (2005): 1004–12.

41. Karen H. Seal et al., "Bringing the War Back Home: Mental Health Disorders among 103,788 US Veterans Returning From Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities," *Archives of Internal Medicine* 167 (2007): 476–82, doi: 10.1001/archinte.167.5.476.

42. Fischer, *Casualty Statistics*.

43. Jeffrey L. Thomas et al., "Prevalence of Mental Health Problems and Functional Impairment among Active Component and National Guard Soldiers 3 and 12 Months following Combat in Iraq," *Archives of General Psychiatry* 67 (2010): 614–23, doi: 10.1001/archgenpsychiatry.2010.54; Lydia A. Chwastiak et al., "Association of Psychiatric Illness and All-Cause Mortality in the National Department of Veterans Affairs Health Care System," *Psychosomatic Medicine* 72 (2010): 817–22, doi: 10.1097/PSY.0b013e3181eb33e9.

44. Tanielian and Jaycox, *Invisible Wounds*, xxii.

45. L. E. del Valle and J. Alvelo. "Perception of Post Traumatic Stress Disorder Symptoms by Children of Puerto Rican Vietnam Veterans," *Puerto Rico Health Sciences Journal* 15 (1996): 101–6; Joseph R. Herzog, R. Blaine Everson, and James D. Whitworth, "Do Secondary Trauma Symptoms in Spouses of Combat-Exposed National Guard Soldiers Mediate Impacts of Soldiers' Trauma Exposure on Their Children?" *Child and Adolescent Social Work Journal* 28 (2011): 459–73, doi: 10.1007/s10560-011-0243-z.

46. Keith D. Renshaw et al., "Distress in Spouses of Service Members with Symptoms of Combat-Related PTSD: Secondary Traumatic Stress or General Psychological Distress?" *Journal of Family Psychology* 25 (2011): 461–69, doi: 10.1037/a0023994.

47. Melissa Hakman et al., "Change Trajectories for Parent-Child Interaction Sequences during Parent-Child Interaction Therapy for Child Physical Abuse," *Child Abuse & Neglect* 33 (2009): 461–70, doi: 10.1016/j.chiabu.2008.08.003.

48. N. Ben Arzi, Zahava Solomon, and Rachel Dekel, "Secondary Traumatization among Wives of PTSD and Post-Concussion Casualties: Distress, Caregiver Burden and Psychological Separation," *Brain Injury* 14 (2000): 725–36; Rachel Dekel, Zahava Solomon, and Avi Bleich, "Emotional Distress and Marital Adjustment of Caregivers: Contribution of Level of Impairment and Appraised Burden," *Anxiety, Stress & Coping* 18 (2005): 71–82, doi: 10.1080/10615800412336427.

49. Herzog, Everson, and Whitworth, "Secondary Trauma Symptoms."

50. David S. Riggs et al., "The Quality of the Intimate Relationships of Male Vietnam Veterans: Problems Associated with Posttraumatic Stress Disorder," *Journal of Traumatic Stress* 11 (1998): 87–101; Ann C. Davidson and David J. Mellor, "The Adjustment of Children of Australian Vietnam Veterans: Is There Evidence for the Transgenerational Transmission of the Effects of War-Related Trauma?" *Australian and New Zealand Journal of Psychiatry* 35 (2001): 345–51; Carol MacDonald et al., "Posttraumatic Stress Disorder and Interpersonal Functioning in Vietnam War Veterans: A Mediational Model," *Journal of Traumatic Stress* 12 (1999): 701–7.

51. Ayelet Meron Ruscio et al., "Male War-Zone Veterans' Perceived Relationships with Their Children: The Importance of Emotional Numbing," *Journal of Traumatic Stress* 15 (2002): 351–57.

52. Steven L. Sayers et al., "Family Problems Among Recently Returned Military Veterans Referred for a Mental Health Evaluation," *Journal of Clinical Psychiatry* 70, no. 2 (2009): 163–70; Abigail H. Gewirtz et al., "Posttraumatic Stress Symptoms among National Guard Soldiers Deployed to Iraq: Associations with Parenting Behaviors and Couple Adjustment," *Journal of Consulting and Clinical Psychology* 78 (2010): 599–610, doi: 10.1037/a0020571.

53. Candice M. Monson, Casey T. Taft, and Steffany J. Fredman, "Military-Related PTSD and Intimate Relationships: From Description to Theory-Driven Research and Intervention Development," *Clinical Psychology Review* 29 (2009): 707–14, doi: 10.1016/j.cpr.2009.09.002.

54. Cindy M. Schaeffer et al., "Predictors of Child Abuse Potential among Military Parents: Comparing Mothers and Fathers," *Journal of Family Violence* 20 (2005): 123–29.

55. Shelley M. MacDermid et al., *Understanding and Promoting Resilience in Military Families*, report prepared for the Office of Military Community and Family Policy in the Office of the Secretary of Defense (West Lafayette, IN: Military Family Research Institute at Purdue University, 2008).

56. Charles W. Hoge et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," New England Journal of Medicine 351 (2004): 13–22, doi: 10.1056/NEJMoa040603.

57. Iraq Coalition Casualty Count, "Military Fatalities by Year"; Fischer, *Casualty Statistics*.

58. Elaine Willerton et al., "Military Fathers' Perspectives on Involvement," *Journal of Family Psychology* 25 (2011): 521–30, doi: 10.1037/a0024511; *Cheryl* Regehr et al., "Behind the Brotherhood: Rewards and Challenges for Wives of Firefighters," *Family Relations* 54 (2005): 423–35, doi: 10.1111/j.1741-3729.2005.00328.x.

59. Shelley MacDermid Wadsworth and Kenona Southwell, "Military Families: Extreme Work and Extreme 'Work-Family,'" *Annals of the American Academy of Political and Social Science* 638 (2011): 163–83, doi: 10.1177/0002716211416445; Regehr et al., "Behind the Brotherhood."

60. Eytan Bachar et al., "Psychological Well-Being and Ratings of Psychiatric Symptoms in Bereaved Israeli Adolescents: Differential Effect of War- Versus Accident-Related Bereavement," *The Journal of Nervous and Mental Disease* 185 (1997): 402–6.

61. Jeffrey G. Johnson et al., "Stigmatization and Receptivity to Mental Health Services among Recently Bereaved Adults," *Death Studies* 33 (2009): 691–711, doi: 10.1080/07481180903070392.

62. Kirk K. Lin et al., "Resilience in Parentally Bereaved Children and Adolescents Seeking Preventive Services," *Journal of Clinical Child and Adolescent Psychology* 33 (2004): 673–83; J. William Worden and Phyllis R. Silverman, "Parental Death and the Adjustment of School-Age Children," *OMEGA—Journal of Death and Dying* 33 (1996): 91–102, doi: 10.2190/p77l-f6f6-5w06-nhbx; J. William Worden, *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner*, 4th ed. (New York: Springer, 2009), 231.

63 Robert S. Pynoos, "Grief and Trauma in Children and Adolescents," *Bereavement Care* 11 (1992): 2–10; Judith A. Cohen et al., "Childhood Traumatic Grief: Concepts and Controversies," *Trauma, Violence, & Abuse* 3 (2002): 307–27, doi: 10.1177/1524838002237332.

64. George C. Tremblay and Allen C. Israel, "Children's Adjustment to Parental Death," *Clinical Psychology: Science and Practice* 5 (1998): 424–38, doi: 10.1111/j.1468-2850.1998.tb00165.x.

65. Victoria H. Raveis et al., "Children's Psychological Distress following the Death of a Parent," *Journal of Youth and Adolescence* 28 (1999): 165–80.

66 Sharlene A. Wolchik et al., "Stressors, Quality of the Child-Caregiver Relationships, and Children's Mental Health Problems after Parental Death: The Mediating Role of Self-System Beliefs," *Journal of Abnormal Child Psychology* 34 (2006): 212–29.

67. Neil Kalter et al., "The Adjustment of Parentally Bereaved Children: I. Factors Associated With Short-Term Adjustment," *OMEGA—Journal of Death and Dying* 46 (2002): 15–34, doi: 10.2190/nt8q-r5gb-x7cw-acn2; Phyllis R. Silverman et al., "The Effects of Negative Legacies on the Adjustment of Parentally Bereaved Children and Adolescents," *OMEGA—Journal of Death and Dying* 46 (2002): 335–52, doi: 10.2190/ac8p-7cay-lf55-yxkr.

68. Jill Harrington-LaMorie and Meghan McDevitt-Murphy, "Traumatic Death in the United States Military: Initiating the Dialogue on War-Related Loss," in *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*, ed. Robert A. Neimeyer et al. (New York: Routledge, forthcoming).

69. Douglas H. Lehman and Stephen J. Cozza, "The Families and Children of Fallen Military Service Members," in Ritchie, *Combat and Operational Behavioral Health*, 543–62.

70. Irwin N. Sandler, "Quality and Ecology of Adversity as Common Mechanisms of Risk and Resilience," American Journal of Community Psychology 29 (2001): 19–61.

71. Ann Masten, "Ordinary Magic: Lessons from Research on Resilience in Human Development," *Education Canada* 49, no. 3 (2009): 28–32.