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PSYCHOTHERAPY ROUNDS

Psychiatric Effects of Military Deployment on Children and Families: The Use of Play Therapy for Assessment and Treatment

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ABSTRACT

Deployments in the United States military have increased greatly in the past 10 years. Families and children are psychiatrically affected by these deployments, and recent studies are clarifying these effects. This article focuses on the psychiatric effects of deployment on children and uses a composite case example to review the use of play therapy to treat children who are having psychiatric issues related to the deployment of one or both parents.

COMPOSITE CASE

Coy was a three-and-a-half-year-old son of an active duty Army father and an Army reservist mother. He was referred to our clinic for "play therapy." The mother sought treatment for Coy's increase in aggression and anger for the past year. During initial intake, Coy's mother reported concerns for Coy "being too aggressive toward his 11-year-old sister and the family puppy." The mother gave examples of Coy "getting so angry he would kick his older sister in the face or kick the dog." The mother also reported Coy being "aggressive with his younger 10-month-old brother, pushing him once." The mother became more concerned when Coy began making statements, such as, "Mom, if I kill you I would not have to follow your rules," and "Mom, would I be in trouble if I cut the family dog into little pieces." The mother reported that Coy had never injured his two siblings or the puppy and denied that Coy had access to or used a weapon to hurt anyone.

The mother described Coy as a "very smart, willful child." He was often defiant toward her and especially toward his father over the past year. The mother stated, "Coy refuses to follow the rules in the home despite being fully aware of the consequences." Coy was often disciplined with "time outs" or positive incentives by mother. When these approaches did not work, the mother reported "spanking Coy on the butt as a last resort." The mother mostly attributed Coy's behavior to the father's frequent absences that had been occurring since Coy's birth. The father volunteered for frequent military deployments, temporary duty assignments, and career training over the past four years. The mother stated, "Coy and his dad do not get along with each other and have unpleasant interactions even when Dad is home for short periods." The mother reported, "Dad seems to expect Coy to act more mature than his age and to

do what he is told. When Coy refuses, Dad will get tough with Coy, raising his voice demanding obedience or spanking him." The mother explained that Coy had never responded positively to this approach from his dad and would act out as if saying, "Who are you to tell me what to do when you're never here." Other times, if the father was play wrestling with Coy, the mother said she would typically intervene out of fear of Coy's anger flare ups toward the father, which would lead to a tense interaction between the two.

The mother reported having a normal pregnancy and delivery with Coy, who was healthy at birth. She reported that Coy had no health issues and was meeting all milestones early. He always had imaginative and social play and played well with other children. Coy was very attentive to book reading, and he could complete color patterns in the lines or a workbook assignment given to him by his part-time nanny. The mother denied, and patient did not indicate, any physical, sexual, or emotional abuse history or exposure to violence in the home. The mother reported a family history of depression in her family but denied personal history.

The mother reported that Coy seemed to feel sorry for what he did and had remorse after aggressive acts toward his older sister, younger brother, and the dog. Coy stated in the room, "I would never hurt anybody." Coy had never expressed suicidal ideation. He would randomly slap himself in the face after getting the mother's attention to watch him. The mother denied any other history of intentional self-inflicting behaviors.

DEPLOYMENT AND ITS EFFECTS

Deployments for military members in the United States have increased in both frequency and length over the past 10 years. As a result of these deployments, many children from military families have experienced absences of one or both parents. More than two million United States children have been affected directly by a parent's deployment.[5]

The effect of parental deployment in previous wars has shown children having an increase in behavioral problems.[1,2] More recent findings with deployed service members with children have shown problems with sleeping, higher stress levels and anxiety, declining grades, an increase in maladaptive child behaviors, and increased rates of child maltreatment. A survey showed 20 percent of military spouses reported increases in problem behavior exhibited by their children at home in response to parental deployment, and 21 percent reported increased levels of fear and anxiety with their children.[3] Another study showed that mental and behavioral health visits increased by 11 percent in children of deployed military members, behavioral disorders increased by 19 percent, and stress disorders increased by 18 percent. Rates especially increased in older children.[4]

The evidence is clear that deployments are stressful on families and that children can be affected by these deployments. A study by Chandra et al[5] shows that caregivers and children from military families report child emotional difficulties at higher levels than have been observed in the general United States population. The total number of months of parental deployment in the previous three years was strongly related to the number of challenges that children faced. Thus the greater total months a parent is deployed the more stressors the child faces. This study also found that girls had more problems with reintegration—the time when the deployed parent returns to the home—than other boys. Older children and particularly those in middle or later adolescence experienced more problems with parental deployment and parental reintegration.[5]

A study of Army spouses with a deployed service member with children aged 5 to 12 years showed one-third of the children were at high risk for psychosocial morbidity. The most significant predictor of child psychosocial functioning during the deployment was parenting stress.[6]

Children of deployed personnel experience higher levels of depressive symptoms. Families of deployed personnel report significantly more intervening stressors; however, deployment rarely provokes pathological levels of symptoms in otherwise healthy children. Although older children and girls have more problems with reintegration, boys and younger children appear to be more vulnerable to the effects of deployment itself.[7]

Wives with school-aged children were examined before, during, and after military deployment of their husbands to the Persian Gulf War. They reported more internalizing and externalizing symptoms in children than those whose husbands' deployment was routine.[8] Children whose fathers had been absent one or more months during the previous 12 months experienced significantly higher self-reported depression and anxiety.[9]

Researchers have looked at the effect of deployment on different age groups.[10,11] Children aged 3 to 5 years with a deployed parent experience greater behavioral symptoms than children with a deployed parent. Children aged between 18 months and 3 years react differently to having a parent deployed than those aged 3 to 5 years. The 3-to-5-years age group showed significantly higher internalizing, externalizing, and total symptom scores on the Child Behavior Checklist. The highest reported behavioral symptoms were those aged 3 to 5 years; however, children aged 18 months to 3 years had lower externalizing symptom scores. The authors hypothesized that at this age when attachment relationships are forming they may have more time with the primary attachment figure who is typically the mother. Thus, the child may have a continuous secure base for them during the parental separation.[10] Young children with a deployed parent showed increased behavior problems during deployment and increased attachment behaviors at reunion compared with children whose parents had not experienced a recent

deployment. The behavior problems were related to many individual child and family characteristics, such as child age and temperament, length of the deployment, total time the deployed parent was absent, number of moves, and number of stressors reported by the parent. Child attachment behaviors were related to the length of the deployment, number of deployments, and the number of stressors faced by the parent.[11]

Parental stress is believed to play a critical role in child maltreatment, and deployment is often stressful for military families. The Gibbs maltreatment study[12] showed a 42-percent increase in risk of maltreatment during a combat deployment. In addition, the severity of maltreatment was worse during deployment times. The rates of neglect were nearly twice as great during deployment.

Larger longitudinal studies are needed to look at children's behaviors before deployment, during deployment, and at the time of reunification. This information will be beneficial to guide providers who are serving military families with evidence-based anticipatory guidance and clinical intervention.

COMPOSITE CASE, CONTINUED: OBSERVATIONS OF COY IN THE ROOM

During the initial intake, Coy was observed playing quietly in the room with the doll house and doll family figures while also listening to his mother. When the mother spoke about him watching science fiction horror movies with his 11-year-old sister, Coy began to pretend he was a scary monster attacking his mother's belly. He stated, "You're in for a scare." The mother reported having to ban Coy from watching such age-inappropriate media, including violent cartoons involving animals being cut into pieces. Coy then commented, "I would never kill Mom. I love Mom. I want her to pay attention to me but I don't like what she tells me." As the mother began to continue speaking, Coy was then observed forcefully shoving the "mommy" toy figure through the window of the dollhouse and smashing the adult male figure in the groin area. Coy was quite attentive and articulate for his age, which was evident in the room. Play therapy was recommended to the mother as treatment to help Coy work through his underlying aggression.

PRACTICE POINT: DEFINING PLAY THERAPY

One common feature that has been recognized by past and current play therapists is the unique meaning of play to children and the importance of understanding the symbolism of children's play language. The six following features have been identified as being common purposes to all play therapies, assuming the child will express and work through emotional conflicts within play: 1) aids diagnostic understanding; 2) helps establish the treatment relationship; 3) provides a safe place or "holding environment" of the playroom for the child expressing his or her feelings in fantasy, working through defenses, and handling anxiety; 4) assists child toward greater verbalization of feelings; 5) helps the child act out unconscious material and relieve the accompanying tensions; and 6) enlarges the child's play interests for eventual use outside of therapy.[13]

Each child's situation is unique; therefore, work with the child will have different emphases, depending on the child's problem. Nevertheless these common features allow the child the experience of acceptance, catharsis, redirection of impulses, a corrective emotional experience, and assistance with removal of impediments to the child's development. Bettelheim stated, "the child's play is motivated by inner processes, desires, problems, and anxieties…play is the royal road to the child's conscious and unconscious inner world; if we want to understand his inner world and help him with it, we must learn to walk this road."[14]

COMPOSITE CASE, CONTINUED: PLAY THERAPY SESSION

Coy: Dr. J, are you going to be my doctor?

Psychiatrist: Yes, Coy, I will be your doctor, and I help children and families with their problems and their worries. Sometimes we talk and sometimes we play.

Coy: Will my mom be in the room whenever we play?

Psychiatrist: No, Coy. Mom will not be present for our play time. I will have to talk with her before we play, and then meet with her each week about any questions or concerns.

Coy: Alright, I guess that is OK...as long as I can stay in here and play and she isn't in the room very long...Will you be my doctor the whole time?

Psychiatrist: Yes, Coy. What does "whole time" mean?

Coy: Just, will you be my doctor for a long time or a short time?

Psychiatrist: I don't know how long it will be. Is that something that you're worried about?

Coy: No. Now can we play? I don't want to talk about that anymore.

ESTABLISHING THE THERAPEUTIC RELATIONSHIP

Play frequently serves as the means for establishing the therapeutic relationship. During the initial interaction in play therapy session, Coy needed reassurance that this would be a safe place to express his worries and troubles. Play would serve as a safe refuge for him when anxiety mounted and he could retreat from talking about his own life. Explaining to Coy the psychiatrist role as his doctor, and the options of talking sometimes and playing sometimes, gave him permission to use talk or play according to his own ability and comfort level.

The role of therapist in this relationship is complex. In addition to playing with the child, the therapist is simultaneously trying to understand the themes and underlying meaning of

the child's play. Various roles have been identified for the therapist to thoughtfully consider, as follows: 1) participating—play along with the child, being careful to follow the child's lead and not jump ahead of the child; 2) limiting—serving as an auxiliary ego, attempting to strengthen the child's own ego- functioning by emphasizing rules, encouraging frustration tolerance, and setting limits; and 3) interpreting—gently make connections between the child's symbolic play and the child's own life. This approach must be used cautiously and only after a positive therapeutic relationship has been established over time.[15]

Practical ways to carry out these roles would include observing the child's play, asking the child to describe the play, suggesting feelings in the context and metaphor of the play, focusing on the child's affect or behavior, becoming part of the play itself, and setting limits when the need arises. The therapist can either take a passive observing role or an active, participating one depending on the child's need.

COMPOSITE CASE, CONTINUED: PLAY THERAPY SESSION

Coy was seen for numerous subsequent play therapy sessions. He was occasionally observed in play, but he routinely invited therapist to join him in play. Coy would give therapist the words to use in his play commentary. On occasion, Coy would use plastic toy kitchen utensils, such as a knife, to act out a play scenario involving the therapist:

Coy: Now, poke your mom in the eye. Here, I'll show you how. Take the knife now, and you poke her!

Psychiatrist: You want me to take this knife and poke my mom in the eye?

Coy: ...takes the play knife and begins to poke it near the psychiatrist's eye then touches his hand with play knife... Now you came back to life. Whoever you poke, they came back to life....*then Coy takes play knife gesturing with hands in the air touching army figures...*If I poke you again you disappear. Ha Ha Ha! I wanted to make him disappear and he did! He disappeared! He disappeared! Ha Ha! ... Pause the game for a minute. Help me put this glove on...keeps my hand from not scraping...*Coy indicates the power of the knife and that the glove would protect his hand from it. He begins to poke the play knife near the psychiatrist's eye again and touches the psychiatrist's face with it...*Is that painful? Can I poke you all the way inside? Do you not like it? Does that hurt? ...*as he slightly pushes knife...*

Psychiatrist: Are you concerned about the knife hurting me?

*Coy: ...then tries to bend the play knife in half...*That's not good if I break this knife. Is this somebody's? But I don't want to break it. Nobody wants to break anything.

PLAY AS A MEANS OF MASTERY

Erikson viewed play as a child's means of achieving mastery of traumatic experiences. The atmosphere of play and make believe allows the child to have power of stressful experiences that rendered the child helpless, afraid, and impotent. The child is able to transform this passivity experienced into activity. Coy often chose to play with his favorite small toy Army figures and medieval warriors who had hatchets and missing arms. He would occasionally use an ambulance to pick up Army figures that were hurt. For example, Coy was given the option of playing with various family doll figures to act out scenarios using a play house or legos built to resemble a house. He would act out scenarios of figures yelling in the house or laughing. He would also act out figures running from someone and getting caught with a net or being run over by a large vehicle. He would often use the larger male figures to speak harshly to the smaller toy figures or take the smaller toy figures and run them over with the car. He would smash the car into the groin of the smaller male figures and usually stand up holding his groin area making a surprised or painful face.

PRACTICE POINT: PLAY THERAPY IN CRISIS SITUATIONS

The make-believe element in play does two things. First, it eliminates guilt feelings the child would have if his action resulted in real harm. Second, it allows the child to be victorious over influences above his capacity. For this reason, a therapy office should not have multiple toys in view, because not only is this over-stimulating to a child but it inhibits therapy, in that it restricts the child's use of his or her own imagination.[17–19]

In this example, Coy has been subjected to the painful experiences of deployed parent(s), intense and threatening interactions with his dad who is in and out of his life, and physical pain from punishment. In this case, the child has experienced fear resulting from the frequent verbal and physical threat of punishment from his father. The father demands him to obey the rules or to face harsh consequences. He likely had received discipline from breaking something of value, which he commented about with the knife. Through replay of these experiences, it is postulated that the child transforms the passivity and helplessness he has experienced into activity and power during play.[20]

COMPOSITE CASE, CONTINUED: PLAY THERAPY SESSION—THE IMPORTANCE OF TIME TOGETHER

Coy: Dr. J, Why can't we have more time to play?

Psychiatrist: Your time here with me is important to you.

Coy: I like you, Dr. J....Last night I dreamed that this fan on your desk was in my dream. The fan was talking to me while I fought this big robot and defeated it. Ha Ha Ha!

Psychiatrist: What else happened in the dream?

Coy: Well, you were in it later, standing behind me.

Psychiatrist: How did you feel in the dream?

Coy: Scared at first but then okay when you were talking to me.

Psychiatrist: What did I say?

Coy: I don't know...*looking into a mirror on the desk with me...* Dr. J, can our faces come together?

Psychiatrist: You wish we could have more time together.

Coy: I don't like it when we have to stop. What is that buzzing sound?
Psychiatrist: My watch.

Coy: What does that mean?

Psychiatrist: It means we are at the end of playtime today.

During the next play therapy session, Coy was observed removing the batteries out of the desk clock in the room and hiding them. He would usually avoid saying goodbye, often leaving the room in a rush. He later stated when he went home he would pretend he was just taking a break from playing in our sessions so they never ended for him. Often he reported fantasies about a "shrinking therapist" so he could take him home. He did not want the sessions with the therapist to end and became more aware of the limitation of time during the sessions.

The activity of the therapist has a profound effect on the development of the relationship. Activity refers to the therapist's ability to be alert to the messages the child is sending and to move the process in response to those messages. It is defined in terms of responses, therapeutic conditions, and the awareness of mutual influence.

The therapy resulted in recommendations to the parents that Coy have quality time with both parents and some predictability as far as the presence of his father. In addition, strategies, such as focusing on more positive reinforcement and consistency with a reward system, were developed, including rewarding the child with more one-on-one time with his parents for good behavior.

CONCLUSION

This case illustrates how deployment of military personnel can have an effect on a child's behavior and functioning. Children in Coy's age group (3–5 years) typically show more externalizing symptoms as was illustrated in this composite case. Treatment included play therapy to help Coy feel safe in expressing his feelings and working through them. Family education was also a large part of this case and is in most child therapy cases.

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