



# Military Caregivers

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Published online: 3 May 2018

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## Abstract

Military caregivers provide essential services for their veteran or military service members who have serious injuries or illness. Of the estimated 39.8 million Americans who provide care for an adult, 1.1 million care for a post 9/11 veteran or service member. Caregivers may experience greater physical or mental health concerns including stress, depression and/or chronic illness, and have greater financial burden than their non-caregiving counterparts. Policy shifts such as the Caregivers and Veterans Omnibus Health Services Act of 2010 (2018) have created and expanded programs to support caregivers. Practitioners working with injured or ill military service members or veterans and their families should include a comprehensive biopsychosocial assessment of the whole family, utilizing several interventions, such as support groups, peer support, psychoeducational programs, training, individual and family counseling, and/or respite care services, to improve family function and reduce caregiver burden.

**Keywords** Caregivers · Military · Veteran

## Introduction

Veterans experience a wide variety of medical concerns, some of which require a caregiver. These caregivers perform essential functions in maintaining the health of the veteran but have only recently begun to be recognized for their efforts. Prior research on caregivers predominately focused on caregivers for older adults, a population that differs in important ways from caregivers for veterans, particularly after the wars in Afghanistan and Iraq. The signature injuries of the wars in Afghanistan and Iraq—post traumatic stress disorder (PTSD) and traumatic brain injury (TBI)—have created a new younger generation of veterans that must utilize friends and family members as informal and formal caregivers. Furthermore, service members in these conflicts are more likely to survive deployment than those from previous generations due to advances in battlefield medicine (Goldberg 2010), though they survive with more extensive injuries. Chronic pain and medically unexplained symptoms are also significant health concerns in this generation of veterans (McAndrew et al. 2016). Importantly, the “invisible”

nature of these injuries add another layer of complexity for both the veteran and the caregiver (Tanielian and Jaycox 2008). Caregivers for these veterans often face unique challenges, as providing part- or full-time care for an injured family member or friend who may have a visible or invisible injury was an unanticipated challenge at this point in their lives. They frequently provide care simultaneously for their veteran as well as dependent children or older adults, and must balance these responsibilities with other obligations, such as employment or education.

## Description of the Population

Caregivers of military veterans are a varied group and include both caregivers of older veterans and caregivers of younger injured or ill veterans. The wars in Afghanistan and Iraq have created both a younger generation of injured and ill veterans and a younger generation of caregivers of those veterans. Tanielian et al. (2013) have estimated that as many as 1 million people may be providing caregiving for the newer generation of veterans of Afghanistan and Iraq. The average caregiver for a veteran of any generation is a 30–40 year old woman with dependent-age children, usually the spouse or partner of the veteran (Tanielian et al. 2013; National Alliance for Caregiving [NAC] 2010). This differs

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significantly from caregivers of other adults in the general population, who are generally caring for parents; only 6% are providing care for a spouse or partner, and few are cohabitating (23%) with the person for whom they provide care (NAC 2010). Caregivers for Afghanistan/Iraq veterans also differ from caregivers of veterans of other generations. In this group, the veterans' children, parents, and other family members may also provide caregiving, particularly if the veteran is not married or does not have a partner. In fact, in a recent study, the majority (59.4%) of the caregivers of severely injured Afghanistan/Iraq veterans were the parent of the veteran, compared to only 34.2% who were spouses or romantic partners of the veteran (Van Houten et al. 2012).

## Caregiver Tasks

Caregiving in prior studies has meant assisting with activities of daily living (ADLs), often for veterans or older adults with physical injuries preventing them from completing these tasks on their own. With the younger generation of Afghanistan and Iraq veterans, however, the injuries are often invisible, and caregiving requires different tasks. Caregivers complete multiple complex tasks, depending on the need and the abilities of the veteran. They often provide minor medical care, such as administering medications, observing for efficacy or side effects, making and providing transportation to medical appointments, and assisting with rehabilitation therapies. Caregivers may also assist with ADLs such as bathing, dressing, feeding, toileting, and mobility, and instrumental activities of daily living (IADLs), including housekeeping, meal preparation, and transportation to and from appointments. A majority (64%) of caregivers of veterans of all generations provided help with ADLs, and nearly all provide help with IADLs (NAC 2010).

An area of particular difficulty for caregivers is navigating multiple complex systems where veterans receive care. This system navigation can be challenging and time consuming, and the burden isn't noticeably reduced even with the provision of a formal case manager (Tanielian et al. 2013). Furthermore, it has been reported that caregivers report not knowing what to expect medically or where to turn to obtain needed services and information (NAC 2010). In addition, caregivers of combat veterans with mental illness, such as PTSD, report distress and burden similar to the caregivers of people with dementia and schizophrenia in the general population (Manguano-Mitre et al. 2007). In the veteran population with PTSD, there is an additional burden for the caregivers in that caregiver must cope with hypervigilance and uneasiness of the veteran; caregivers are often the only person trusted to provide care, which offers few opportunities for respite. In addition, the injuries of TBI and PTSD are highly

comorbid; the majority of caregivers (80%) report that their veteran had two or more diagnoses (NAC 2010). Providing care for these veterans is subsequently complex and could include a dual diagnosis of PTSD/TBI and other injuries, such as hearing or vision loss, or other physical injury. Finally, the younger age of the veterans and caregivers means that the care must be provided for many years into the future, sometimes decades. Caregiving for a younger veteran is not temporary but is a "new normal" that shapes the remainder of both the veterans' and caregivers' lives.

## Compassion Fatigue

Caregivers for veterans of all generations, not just Afghanistan/Iraq veterans, often suffer from Secondary Traumatic Stress (STS), also referred to as Compassion Fatigue (Figley 1995). This can be true for social work clinicians providing mental or behavioral health care as well as for friends and family members of veterans providing formal or informal caregiving tasks. For clinicians working with clients who have experienced trauma, Bride and Figley (2009) recommend close self-monitoring and creating a balance between professional and personal lives, which can be difficult for informal caregivers. Caregivers, especially spouse caregivers who live with the veteran, often have a difficult time creating a boundary between personal care and providing caregiving for the veteran.

As a result of these unique circumstances, caregivers of veterans report greater distress and burden than do caregivers of adults in the general populations. Almost 40% of post-9/11 caregivers meet clinical criteria for major depression, but only 34% of those who meet criteria receive treatment (Tanielian et al. 2013). NAC (2010) reports many caregivers of veterans report very high emotional stress (68%) and physical strain (40%), high financial hardship (50%), and interference with other aspects of life (such as stopping employment to provide caregiving; 47%). Van Houtven et al. (2012) report that 62.3% of caregivers of Afghanistan and Iraq veterans depleted assets or accumulated debt in caregiving and 41% left the workforce before they intended; these percentages are 2–4 times as high as caregivers of adults in the general population. Caregivers in general, and especially caregivers for veterans of any generation, have higher rates of physical strain, greater incidence of chronic illness, and higher mortality rates than non-caregivers (Bass et al. 2012; Schulz and Beach 1999). Caregivers of any disabled, injured or ill adult may report social isolation (Cameron et al. 2002), particularly if the veteran or military member for whom they are caring has a mental or behavioral health diagnosis such as PTSD (Calhoun et al. 2002; Jakupcak et al. 2010).

## Policy

As a result of the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163) (Civic Impulse 2018), the Veterans' Administration (VA) has implemented the VA Caregiver Support Program that provides a number of services. First, caregivers assisting seriously-injured post-9/11 veterans may also be eligible for the Comprehensive Assistance for Family Caregivers program that provides stipends, travel expenses, health insurance, mental health care and respite for the caregiver. Caregivers of other veterans—not only severely-injured post-9/11 veterans—have access to a support line for caregivers, monthly telephone education groups, peer support mentoring, and online training for caregivers provided by Easter Seals.

Military Caregiver Leave, enacted in 2013, is an extension of the Family and Medical Leave Act (FMLA) that allows caregivers of a military member up to 26 weeks of leave from their employment to care for a military member or veteran who is injured or ill. This rule change also allows military family members unpaid leave from employment to manage financial or legal arrangements for a pending deployment, address childcare or adult dependent care arrangements, attend military events and activities, spend time with a service member on Rest and Recuperation leave or attend post-deployment activities (US Department of Labor 2013).

As awareness of military caregiving grows, resources to support caregivers and their families also grows. As demonstrated in Table 1, there is a growing list of resources, organizations, and programs to support the needs of military caregivers. These resources provide outlets for conversation and informal support among caregivers, a centralized resource directory for programs that may provide assistance, and a number of online training opportunities for military caregivers. Recently, the VA announced plans to create a new research center of excellence on caregivers among other programs (Shane 2017). These expand the existing programs, such as the National Family Caregiver Support Program, that have provided grant funding to states to fund programs assisting caregivers (Administration for Community Living 2017).

## Treatment Modalities

Caregivers experience multiple consequences of providing care, including poorer mental and physical health than non-caregivers (National Alliance for Caregiving (NAC) 2015), social isolation (Cameron et al. 2002), and financial costs (Van Houtven et al. 2012). Because military

caregiving, particularly for veterans with “invisible injuries”, is complex, varied, and often time consuming, it is critical to assess multiple aspects of caregiving. These known issues, and other identified areas of stress, including marital strain, intimate partner violence, substance abuse, effects on children of caregivers/veterans, and caregiver resources (Patel 2015) should be assessed with caregivers. As Adelman et al. (2014) report “risk factors for caregiver burden include female sex, low educational attainment, residence with the care recipient, high number of hours caregiving, depression, social isolation, financial stress, and lack of choice in being a caregiver” (p. 1053). Assessments should also include detailed information about the family system, including the impacts caregiving has on each family member—spouse, parents, children, and other friends and family members important to the family. Being spiritually oriented and having spiritual support are also associated with lower caregiver burden (Torabi Chafjiri et al. 2017), therefore spirituality and spiritual orientation is an important aspect to include in assessment.

Social work intervention with military caregivers may take several forms, such as links to resources such as caregiving groups, support groups, links to financial resources, or other programs, such as those listed in Table 1. Interventions often used to reduce caregiver burden include psychoeducation, caregiver training, support groups, behavior therapy, individual counseling, and respite (Cooke et al. 2001; Brodaty et al. 2003). Caregiver training reduces caregiver burden for older caregivers (Grant et al. 2002). Support groups and psychoeducational interventions have shown modest reductions in caregiver burden in caregivers of adults with dementia (Adelman et al. 2014). Caregivers who received individual or family counseling showed reductions in depression, a common caregiver concern (Mittleman et al. 2008). Dam et al. (2016) studied social support interventions in caregivers and found that individual peer support and support groups had significant qualitative but not quantitative support. There was, however, some evidence to support the efficacy of remotely delivered interventions. Regardless of the delivery of the intervention, multi-component social support interventions demonstrated more efficacy than single component interventions. Most research and interventions for caregivers, however, have been aimed at caregivers of older adults, such as caregivers of adults with dementia, rather than the younger generation of caregivers providing care for post-9/11 veterans; research remains to be done on interventions effective with this diverse population.

## Case Study

Natasha is a 37 year old Caucasian military caregiver for her husband, 39-year-old Bill. Natasha and Bill have been married for 15 years and Bill has recently been medically

**Table 1** Caregiver resources

Resource	Provides	Website
Caregiver resource directory	Centralized information about resources/programs to support veterans and their caregivers	<a href="http://warriorcare.dodlive.mil/files/2016/01/00212-2480_Caregiver-Resource-Directory-January-2016_508-Compliant.pdf">http://warriorcare.dodlive.mil/files/2016/01/00212-2480_Caregiver-Resource-Directory-January-2016_508-Compliant.pdf</a>
Blue star families	Operation Family Caregiving Coaching Program; Caregivers Empowering Caregivers Workshops; Video and Virtual Caregiving Training	<a href="http://www.operationfamilycaregiver.org/">http://www.operationfamilycaregiver.org/</a>
Military OneSource <sup>a</sup>	Military Caregiver PEER forums (in person and virtual); Non-medical counseling (face to face, via phone, video, or chat); Military and Family Life Counseling, Financial counseling; health and wellness coaching	<a href="http://www.militaryonesource.mil/web/mos/caregivers">http://www.militaryonesource.mil/web/mos/caregivers</a>
VeteranCaregiver.com	Online training, information, and resources for military caregivers on a variety of topics; Caregiver Meetups	<a href="https://veterancaregiver.com/">https://veterancaregiver.com/</a>
Military families learning network	Caregiving webinars, publications, blogs, resources	<a href="https://militaryfamilies.extension.org/military-caregiving/">https://militaryfamilies.extension.org/military-caregiving/</a>
Caregiver action network	Caregiving education, peer support, and resources for family caregivers	<a href="http://www.caregiveraction.org/about">http://www.caregiveraction.org/about</a>
VA caregiver support	Caregiver Support Coordinator; Caregiver Support Line. Mentoring, online caregiving training, Comprehensive Assistance for Family Caregivers program; Caregiver Toolbox; Caregiver PEER Support programs	<a href="https://www.va.gov/">https://www.va.gov/</a>
Elizabeth dole foundation	Dole Caregiver Fellows Program; Hidden Heroes Foundation	<a href="https://www.elizabethdolefoundation.org/">https://www.elizabethdolefoundation.org/</a>
Easter seals	Caregiver education and training; adult day programs; respite care	<a href="http://www.easterseals.com/explore-resources/for-caregivers/military-veteran-caregivers.html">http://www.easterseals.com/explore-resources/for-caregivers/military-veteran-caregivers.html</a>
Hearts of valor	Retreats; support groups; online forums; social media; newsletters	<a href="https://www.heartsvalor.org/">https://www.heartsvalor.org/</a>
Department of Labor	Guide to Military Caregiver Leave	<a href="https://www.dol.gov/whd/fmla/2013rule/FMLA_Military_Guide_ENGLISH.pdf">https://www.dol.gov/whd/fmla/2013rule/FMLA_Military_Guide_ENGLISH.pdf</a>
National Alliance on Caregiving/ National Center on Caregiving	Research, public policy, and services for caregivers; Family Care Navigator, an online guide to government, nonprofit, and private caregiver support programs	<a href="http://www.caregiving.org/">http://www.caregiving.org/</a> <a href="https://www.caregiver.org/national-center-caregiving">https://www.caregiver.org/national-center-caregiving</a>
Caring.com	Caregiving advice; peer support; directory of services	<a href="http://www.caring.com">http://www.caring.com</a>
Well Spouse Association	Support groups; mentorship; collects resources; respite weekends and conference; advocacy for individuals caring for a spouse/partner	<a href="http://www.wellspouse.org">http://www.wellspouse.org</a>
Vet centers	Readjustment Counseling for veterans and family members	<a href="https://www.vetcenter.va.gov/">https://www.vetcenter.va.gov/</a>
Next step in care	Guides for family caregivers working with health care providers	<a href="https://www.nextstepincare.org/">https://www.nextstepincare.org/</a>

<sup>a</sup>For active and reserve service members and families only

retired from the Marine Corps after 17 years of service. They have two children, 13 and 11 year old boys. During his last tour in Afghanistan, 2 years prior, he sustained injuries that aggravated previous medical concerns in his knees and low back. He did not want to be removed from his unit, so he was not medically evacuated, but returned with the rest of his unit. Upon his return, he completed post-deployment health assessments, during which he noted the knee and back pain. He was assigned to the Wounded Warrior battalion, and then medically retired.

Since his return from that deployment and his assignment to the Wounded Warrior battalion, Natasha noticed he became increasingly irritable and restless, and frequently stayed up all night and napped during the day. They both attributed this to the chronic pain from his injuries and did not report it to their care team. Six months after his assignment to the Wounded Warrior battalion, he woke Natasha up in the middle of the night by grabbing her arms, sitting on her and screaming in her face while he was experiencing a nightmare. His yelling woke their boys up, and they witnessed the encounter. He was horrified at this behavior and reported it the next day to his care team, and after an interview and assessment, was diagnosed with post traumatic stress disorder (PTSD). Over several months, the PTSD symptoms seemed to worsen, with more frequent angry outbursts and new memory concerns. Natasha worries that he has a traumatic brain injury (TBI) in addition to PTSD and chronic pain.

The family has had a difficult transition out of the military. Bill is restless, does not sleep at night, and naps during the day. He sometimes combines his pain medication with alcohol so that he can sleep. He strongly identified as a Marine and has had difficulty with losing that part of his identity. Bill is able to drive, but Natasha accompanies him to all of his appointments because of his memory concerns. Natasha has left her full-time employment for free-lance, part-time work because of her caregiving responsibilities.

Maintaining their typical school and sports schedule became impossible with Bill's appointment schedule, so the family chose to withdraw the boys from their school in favor of an online homeschooling program, and a neighbor takes them to and from their sports practices. Natasha supervises their homeschooling when she is not accompanying Bill to appointments. The older boy, Anthony, has taken on more responsibilities around the house, things Bill used to do, and he and Bill have frequent conflicts over these responsibilities and how they are done. The younger son, Billy, who used to be close to his father, is upset about leaving his school and friends, and spends most of his day in his room, except when leaving for practice.

Natasha is somewhat involved in her Baptist church, although her involvement has lessened as she has begun caring for her husband. She is afraid to leave him alone, and he

becomes irritated and anxious in the crowd at services, so she does not often attend, but still keeps in touch with some of her friends from her Bible study group. They had planned to "move back home" once Bill retired, but all of Bill's doctors are near their last duty station, so they have decided to stay there until the family is stabilized. This decision means, however, that their family support (grandparents, siblings, and extended family) are hours away and unable to help with day to day tasks. Natasha finds herself becoming attached to her smartphone as her only connection to friends and family members—the only people she sees in person are her immediate family, doctors, and an occasional neighbor.

At one of the VA appointments for Bill, Natasha tells the social worker that she is "very tired" and can't remember the last time she slept well. She is frequently worried about Bill's behavior, particularly when he mixes alcohol and pain medication, and because he is restless at night, she doesn't sleep well either. She has not been to see a doctor for herself in over 2 years. She finds the VA system confusing and frustrating and has been having a very difficult time coordinating all of his appointments. She says, "I was not expecting this at this point in my life. We were going to retire and then it was supposed to be my turn for a career. Now I will never have that." She had been attending school to finish her master's degree during Bill's last deployment, but left school when he came home injured. They are struggling financially because of the loss of her employment income, but they are expecting once Bill qualifies for disability benefits, things will be better financially for them.

## Potential Interventions

The social worker meeting with Natasha could begin using a family systems approach with a comprehensive assessment that includes a detailed picture of the family system and the impacts of the injury/illness and caregiving needs on each family member (Weiss et al. 2013). They should also include biological, psychological, spiritual and social supports and resources that already exist. The social worker would recognize the family's strengths and the supports that Natasha has already put into place, such as her bible study friends and her neighbors that take the children to sports practices. Concerns about substance abuse, the potential for intimate partner violence and marital discord should also be addressed.

Using the family systems approach, the social worker may have several opportunities for intervention for this caregiver that would in turn benefit the entire family—Natasha, Bill, Anthony, and Billy. The social worker can provide Natasha with psychoeducation or access to caregiving training or psychoeducation on navigating the VA healthcare system, and what to expect when caring for a person with PTSD, potential TBI and chronic pain. The

practitioner could link Natasha to some of the programs available through the VA, such as the Comprehensive Assistance for Family Caregivers, the Caregiver Support Line, caregiver training, or peer support. These could assist the family financially as well as increased social support and psychoeducational training. They may also connect Natasha with some of the other caregiver programs listed in Table 1. Natasha may be referred to her primary care physician for a health checkup and screening for depression. The social worker may work with Natasha to identify ways she could increase her social supports, either through using her current network of friends, family, and neighbors, or by connecting with caregiver support groups or peer support and mentoring. The provider could also work with Natasha to identify respite opportunities, either formal respite care or informal sources, such as asking one of Bill's trusted friends to stay with him for a few hours while Natasha attends her church services.

The social worker could also use theory-based approaches to support the subsystem of the marital relationship between Bill and Natasha, to support the family as a whole. For example, a relational approach, focusing on developing a stronger relationship between Natasha and Bill, could enhance each person's emotional well-being. Their roles in the family and in the relationship have shifted significantly in the past few years, and they may benefit from an approach based on role-exit theory. Role-exit theory focuses on the experiences of individuals who depart from a role that is a primary focus of their self-identity and proposes that these individuals experience four stages—first doubts, seeking alternatives, turning points, and creating the ex-role—in adjusting to their departure from that role (Gambardella 2008). A developmentally-focused approach would examine the developmental stage each person is in and work to support the successful navigation of developmental crisis. Bill and Natasha would likely both be in Erikson's stage of Generativity versus Stagnation (Erikson and Erikson 1998). A social worker using this approach would note that the injuries may have derailed the couple's efforts to contribute to society and successfully establish generativity. The social worker could then help Natasha and Bill both identify how they have already contributed to society and how they can continue to do so within their new roles. Other theory- and evidence-based therapeutic approaches that may be useful with this family include Support and Family Education (SAFE Program), Behavioral Couple/Family Therapy, the K'oach Program, the Lifestyle Management Course, Emotionally-Focused Couple Therapy for Trauma, Strategic Approach Therapy, and Cognitive-Behavioral Conjoint Therapy for PTSD (Monson et al. 2012). Regardless of the theoretical approach, the social worker should focus on how improvements in one area of the family system, whether an individual or a subsystem, can enhance the whole family's functioning.

## Social Work's Role

As a profession rooted in the person-in-environment perspective and well-versed in family systems theory, social workers have long known that an injury to one member of a family inevitably impacts the other members of that system. The intensity and depth of that impact, though, is magnified in caregivers. Social workers engaged with this population should work to support the family as a whole by identifying the ways the medical concerns of one member can significantly impact the other system members. It is also critical to point out how supports in one area can also support the other family members simultaneously. This is especially important in work with caregivers who use their energy and resources to provide care to another member of their family system often without gaining that energy or resources back through support of their own. The trajectory of caregivers' lives is irrevocably changed when their military member is injured or ill, and the injury or illness will continue to shape both caregiver's and military member's life for years.

A social worker's role, therefore, is to continue to advocate for the entire family system, both injured or ill service members and veterans and their caregivers, whether those caregivers are spouses, parents, siblings, friends, or other family members. This may be advocacy at the macro level, continuing the policy work evidenced in the Caregivers and Veterans Omnibus Health Services Act of 2010 (Civic Impulse 2018). Research into effective caregiver interventions for the younger generation of post-9/11 veteran caregivers is needed. At the micro level, social work practitioners should work to assess and intervene to prevent and reduce caregiver burden, linking caregivers with effective resources, providing psychoeducation and training, and providing individual and family counseling to support the entire family system.

## Conclusion

Recent and ongoing conflicts and military deployments have shifted the demographics of caregivers for U.S. military service members and veterans. This shift in demographics has also shifted the needs and challenges of military families and caregivers impacted by ill or injured service members, requiring a complementary shift in services and advocacy. Clinical social workers can assist these families by assessing the family system as a whole, using theory-based approaches that impact multiple family members or the veteran-caregiver dyad, being familiar with the multiple resources and supports available to

military caregivers, and advancing policy initiatives that addresses the unique needs of this group.

## Compliance with Ethical Standards

**Conflict of interest** Jessica D. Strong declares that she has no conflict of interest.

**Ethical Approval** This article does not contain any studies with human participants or animals performed by the author.

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