

Further support for the families of Australia's war veterans requires a broad research strategy

Hedley G Peach

Shortly before the 2004 federal election, the former Minister for Veterans' Affairs announced a second health survey of the children of Vietnam veterans.¹ The Minister acknowledged her department already funded counselling and other support for veterans' dependents. However, it needed to know how children of Vietnam veterans could be further supported. The current Minister has made a commitment to honour that announcement.

Now might be an appropriate time to reflect on the value of further research into the health of veterans' dependents, particularly if it were confined to children of Vietnam veterans.

Why more research?

A survey of children of Vietnam veterans and of a comparison group of non-deployed veterans has been proposed. Although the Australian Government has recently completed a health study of the dependents of Vietnam veterans,² this relied on veterans' reports about medical conditions affecting their partners and children, and lacked a control group. Nevertheless, more than 40 000 veterans responded. The results are summarised in Box 1. Reports of selected conditions were verified against documentation from doctors, national databases, or the children. A higher prevalence of accidental deaths and suicide among the children than the Australian norm was confirmed. Many problems were not verified, so we do need to collect reliable diagnostic information from the children themselves — and from veterans' partners.

The proposed study has the support of veterans¹ and affords the opportunity to follow the children, at least, through middle age. However, given that most of these children are now adults, the opportunity to find out how the findings in Box 1 came about and how they might have been avoided has been lost. Earlier studies of the children of Vietnam veterans in Australia have been small or lacked rigour (Box 1).

Families of veterans from other conflicts and a life course perspective

A high prevalence of problems among partners and children more than 30 years after the Vietnam War suggests that researchers need to take a life-course perspective on the health of veterans' families. Such a perspective has illuminated the aetiology of children's health problems in the general population and generated a theoretical basis for new interventions.⁷ Box 2 covers conflicts after World

ABSTRACT

- Vietnam veterans reported a high prevalence of health problems among their partners and children in a 1998 survey.
- Data about the effect of our veterans' war service on the health of their families are quite limited. These data are mainly from the Vietnam and Gulf Wars; cover veterans, partners and children independently; and largely focus on the individuals' medical conditions and risk factors.
- Australia should develop a broad research strategy that uses a wider definition of health, looks at veterans' families as a whole, and does so from a range of perspectives, including sociological, life-course and trans-generation perspectives.
- Preventive research should be emphasised, especially into enhancing resilience of veterans' families.
- The use and usefulness of current services should be evaluated, including whether they need to be more family-inclusive.

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War II, in which only a minority of fathers participated and it is possible to compare their children with those of men not involved. The similarity of the findings from different conflicts means that we might glean an idea of how a veteran's war service affects his or her children and partner at different stages in their lives if we studied the families of veterans from more recent conflicts, such as Iraq, East Timor and the Gulf War, in addition to Vietnam.

Trans-generation perspective

We also need to know how the health of veterans' children and grandchildren relates to that of the veterans and their parents. Such trans-generational research in Australia has focused on congenital malformations and other reproductive problems and whether they could have been caused by exposure to chemicals (Box 1). However, research on the possibility of a veteran's behaviour being transmitted to his or her children, and from children to grandchildren, through shared time in the early years of life has been neglected in Australia, despite the obvious possibilities for prevention.

Family focus

Studies of children in the general population with similar problems to the children of war veterans have often included their siblings and parents. Such research has led to theoretical support for family-based interventions, many of proven effectiveness.⁷ However, none of the studies in Box 1 included veterans, partners and children. Such research should recognise the diversity of veterans' families in composition, stage in life course and religion; look beyond separate households to a network of relatives; and recognise the unique features of military families.⁸ It should also

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1 Main findings from studies into the health of the families of Australia's war veterans

Study	Subjects and design	Main findings
Australian Gulf War Veterans' health study (2003) ²	<ul style="list-style-type: none"> • 1424 veterans and 1548 ADF controls reported on their reproductive histories and children's health between 1991 and 2002 • Partners and children not interviewed 	<ul style="list-style-type: none"> • Veterans more likely to report fertility problems • No difference in pregnancy outcomes or children's reported health
Vietnam veterans' health study (partners and children) (1998) ²	<ul style="list-style-type: none"> • 40030 Vietnam veterans reported on their partners' and children's health • Partners and children not interviewed 	<ul style="list-style-type: none"> • Proportion reporting their partner: <ul style="list-style-type: none"> • was affected by veteran's experience, 36%; • suffered stress, 40%; anxiety, 34%; or depression, 30%; • had problems conceiving a child, 21%; or had a miscarriage, 22%. • Proportion reporting they had a child with: <ul style="list-style-type: none"> • major illness, 27% • psychiatric problem, 11% • anxiety disorder, 16% • congenital abnormality, 16% • cancer, 2% • fatal accident, 2% • suicide 1%
Adjustment of children of Vietnam veterans study (2001) ³	<ul style="list-style-type: none"> • 50 older children of veterans and 33 controls completed PTSD, self-esteem and family functioning inventories • Veterans, spouses and young children excluded 	<ul style="list-style-type: none"> • Children of veterans reported more family dysfunction (FAD=13.9), no difference in PTSD and self-esteem, compared with controls (FAD=12.9)
Partners and children of Vietnam veterans study (1999) ⁴	<ul style="list-style-type: none"> • 32 female partners and 22 older children of veterans attending a PTSD clinic and volunteer controls (15 adults, 14 children) completed self-esteem, health, lifestyle and family environment inventories • Veterans and young children excluded 	<ul style="list-style-type: none"> • Partners reported less self-esteem (CI = 50), more somatic symptoms, anxiety, depression and insomnia, more social dysfunction (GHQ = 10), more family conflict (FES = 4.3), compared with control group (CI = 80, GHQ = 1.5, FES = 1.2) • Children of veterans reported more family conflict, similar self-esteem, symptoms and social functioning, compared with those of control group
Chronic PTSD and family functioning of Vietnam veterans and their partners study (2003) ⁵	<ul style="list-style-type: none"> • 270 veterans attending a PTSD unit and their partners completed PTSD, anger, depression, alcohol use and family function inventories • Children excluded 	<ul style="list-style-type: none"> • Veterans' avoidance ($r = 0.19$), anger ($r = 0.20$), or depression ($r = 0.16$) (but not alcohol use) and partners' anger only ($r = 0.14$) were associated with family dysfunction
Risk of congenital anomalies among Vietnam veterans study (1984) ⁶	<ul style="list-style-type: none"> • Comparison of proportion of Vietnam veterans among fathers of 8517 infants with congenital anomalies and healthy controls 	<ul style="list-style-type: none"> • Risk of a Vietnam veteran fathering a child with an anomaly similar to that of other fathers

ADF = Australian Defence Force. CI = Coopersmith Inventory. FAD = Family Assessment Device. FES = Family Environment Scale (mean scores). GHQ = General Health Questionnaire. PTSD = post-traumatic stress disorder.



look at veterans' families over time. For example, a supportive partner may become less so as a veteran's depression becomes chronic, with interpersonal, economic and social consequences.⁹

Research should also look at the relationship between a veteran's family and the community. A positive partnership between families, their networks of relatives and friends, employers and health, welfare or religious organisations enhances family wellbeing.⁸ The converse is also true. For example, lack of community awareness about depression, unwillingness of other family and friends to help, adverse experiences with health care providers and the exclusion of family members from decision-making may impair a family's ability to cope with a veteran suffering from depression.⁹ This sequel might be avoided by community education and provision of more family-inclusive services.

How might research change current policy or practice?

If the proposed study confirmed a high prevalence of physical problems among children of Vietnam veterans, then the eligibility

criteria for support may need reviewing. Service providers might also need to be more proactive in protecting the future health of the children. For example, a high prevalence of depression may put them at higher risk of coronary heart disease and suicide in later life. Opportunistic screening of the children by GPs, with attention to other risk factors for heart disease and suicide, might theoretically reduce the incidence of these diseases. However, further research would be more likely to lead to policy changes and service innovation if it was neither confined to the children of Vietnam veterans nor focused on individuals' medical conditions and risk factors, but took account of other research needs.

The same limitations of previous research on Vietnam veterans' children and partners apply to families of veterans from other conflicts, requiring broader health, sociological, life-course, and trans-generation perspectives. Health is generally considered a state of complete physical, mental, social and spiritual wellbeing, not just the absence of disease. Sociology sees veterans' children and partners as members of groups, such as families, self-help associations and the wider community. Sociological methods can

2 Main findings from studies of the health of war veterans recently undertaken or commissioned by the Australian Government

Study	Subjects	Design	Main findings
Korean war veterans' mortality study (2003) ²	More than 17 000 male military veterans	Comparison of cumulative mortality between 1950 and 2000 with that of general population	Higher mortality from suicide (up by 31%), alcoholic liver disease (up by 36%) and other selected causes
Korean war veterans' cancer incidence study (2003) ²	More than 15 000 male military veterans alive in 1982	Comparison of cumulative cancer incidence between 1982 and 1999 with that of general population	Higher cancer incidence overall (up by 13%) and for selected sites
Second Vietnam veterans' mortality study (1997) ²	More than 57 000 male military veterans	Comparison of cumulative mortality between 1980 and 1995 with that of Australian male population	Higher mortality from suicide and from all cancers combined
Vietnam veterans' health study (male veterans) (1998) ²	More than 40 000 male military veterans	Survey of health as reported by veterans in 1996	Proportion reporting only fair or poor health, 50%; depression, 45%; anxiety disorders, 41%; PTSD, 31%; panic attacks, 30%; and being diagnosed with cancer, 25%
Mental Health Project (1998) ²	More than 87 000 mental health clients of the Department of Veterans' Affairs, 75% of whom were veterans	Survey of disorders experienced by clients	Most common disorders were anxiety (42%), PTSD (30%), depression (9%), and alcohol dependence (7%)
Australian Gulf War Veterans' health study (2003) ²	More than 1400 male and female veterans	Comparison of health between 1991 and 2002 with that of non-deployed ADF personnel	More psychological disorders (PTSD, anxiety, depression, substance use disorders, problem drinking); some aspects of physical health also poorer

ADF = Australian Defence Force. PTSD = post-traumatic stress disorder.

show how their health, attitudes and behaviours are shaped by the family, on one level, and social influences, such as society's attitudes to war and veterans and society's policies and systems, on another.

The expectation is that further research covering more recent conflicts from a range of perspectives would underpin innovation or enhancement in policies and services to better help families cope.

Focus on resilience

The term "resilience" denotes a combination of abilities and characteristics that allow individuals to bounce back, cope successfully and function above the norm in spite of significant stress or adversity.¹⁰ Epidemiological studies have demonstrated the importance of resilience for health, for example, of children.¹¹ There has been no research in Australia into why some veterans' families are more resilient than others and how this resilience might be enhanced. Programs focusing on resilience were well received by participants in the Vietnam Veterans' Sons and Daughters Project.¹² The project was part of the Australian Government's response to a higher rate of suicide among sons and daughters of veterans than the Australian norm.² It aimed to reduce suicide risk by increasing personal strengths, coping skills, resilience and access to care.

Evaluation of services

Although participants in the Sons and Daughters Project do benefit, only 2% of children use the service.¹² That being so, research into why the children do not use services provided for them, and whether their needs are being met elsewhere, would seem worthwhile.

Involvement of spouses in a lifestyle management course for Australian war veterans improved the mental health of both.¹³ Given this, research is needed into whether the services available to veterans and their dependents involve other family members as often as they could. If service providers are shown not to have been trained to deliver family-inclusive programs, resources could be developed to assist them, as has recently been the case with drug and alcohol workers.

The way forward

Australia should develop a broad strategy for research into the effect of war service on veterans' families. This could be achieved in a similar way to the United Kingdom research strategy for its Gulf War veterans: through a National Health and Medical Research Council and/or Australian Academy of Social Sciences workshop for researchers to identify priority areas, followed by a call for projects. As in the UK, research into the health of veterans and their dependents is undertaken by a small network comprising government departments and universities. The network is largely focused on individuals' medical conditions and risk factors. Membership may need to be enhanced if the network is to undertake a broad program of research into the families of veterans.

The strategy should focus on families as a whole and take a range of perspectives, including sociological, life-course and trans-generational perspectives. Preventive research should be emphasised, especially into enhancing resilience of veterans' families. The use and usefulness of current services should be evaluated, including whether they need to be more family-inclusive.

Competing interests

None identified.

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Bernard John Amos

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BERNARD AMOS, former Director General of Health in New South Wales and founding General Superintendent of Westmead Hospital, died on 9 May 2005.

Bernie was born in Townsville on 5 April 1935. He attended secondary school at "Shore" (Sydney Church of England Grammar School) in North Sydney. He became a formidable athlete, representing his school at the top level in cricket (his first love), rugby and athletics. He entered medicine at the University of Sydney in 1953, and began a long relationship with Royal North Shore Hospital (RNSH) as a student in 1956. Initially, he wanted to become a surgeon, but an accident with a blood-transfusion needle damaged a nerve in one hand, and, with characteristic insouciance and competence, he changed direction and completed training as a physician. He moved progressively through the ranks at RNSH, completing his residencies and registrar training and obtaining his Fellowship of the Royal Australasian College of Physicians in 1971.

He became Clinical Superintendent at RNSH, and Director of Medical Services in 1964, while continuing to practise as a physician. Although his subsequent career was strongly identified with health administration, he remained a clinician at heart, with a keen understanding of the difficulties and frustrations of the clinical life.

A critical moment of his professional life came in 1972, when he joined the Project Committee for the proposed Westmead Hospital. Bernie clearly saw the proposed hospital's role in providing medical services in Greater Sydney and in New South Wales. Westmead had unobtrusively become the demographic centre of Sydney's population, and there was a need for high-level teaching hospital services for the Western metropolitan population.

His subsequent career took him further into the public domain. He became Chief Executive Officer of the Cumberland Area Health Service in 1986, and then of the Western Sydney Area Health



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Service in 1988. His public career reached its zenith with his appointment as Director General of the NSW Department of Health in 1989, an appointment he held until 1993. In recognition of his public service, he was made a Member of the Order of Australia in 1988 and an Officer of the Order of Australia in 1994.

After his retirement in 1993, he continued to consult on health services and became Professorial Fellow in the Department of Public Health and Nutrition at the University of Wollongong. He was Chair of the Johnson & Johnson Medical Education Foundation and of the Institute of Psychiatry, and Deputy Chair of the Centenary Institute at Royal Prince Alfred Hospital. He had been President of the Medical Board of New South Wales from 1984 to 1989, and returned as a member of the Medical Board from 1993 to 1998.

Bernie married Helen Harbison in 1960. Bernie's public success was balanced by a profound devotion to Helen and their four children. He took great pride in his children's achievements and loved spending time with his grandchildren.

Bernie died of complex malignancy just a few weeks after his 70th birthday. In his largeness, his wisdom, his generosity, his restrained vigour, he seemed unfit for death. We offer his family our deepest sympathy, and our gratitude for sharing him with us and with the Australian community.

Miles Little

(with much help from the Amos family, Peter Castaldi and other friends)