

Trauma-Focused Cognitive Behavioral Therapy for Military Families: An Implementation Manual

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Introduction

Almost 2 million American children have at least one parent who is a member of the U.S. military with 1.2 million children in Active Duty families and more than 700,000 children in families of the Selected Reserves (National Guard and Reserve). Many other children have siblings or other close relatives serving in the military whose service experiences can profoundly impact these children. The term “military children” refers to all children who have immediate or extended family members in the U.S. military. In 2010 the U.S. combat operations in Iraq and Afghanistan became the longest war in American history. The psychological impact on service members and their families continues to be significant. Military children are experiencing greater anxiety and posttraumatic stress disorder (PTSD) symptoms as the war continues. As service members leave active duty and they and their families move to civilian settings, these negative impacts often continue. Military and civilian child mental health providers must be available to serve these children’s needs, including providing trauma-focused treatment when appropriate.

In 2009 the Substance Abuse and Mental Health Services Administration (SAMHSA) designated military families as a priority population to receive culturally appropriate trauma-focused treatment and services through the National Child Traumatic Stress Network (NCTSN, www.nctsn.org). As the developers of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, Cohen, Mannarino & Deblinger, 2006), we proposed through this funding mechanism (Grant No SM54319-9) to evaluate how TF-CBT could be applied most effectively and culturally competently for trauma-affected military children and families. We worked with our friend and colleague, retired Army Colonel and child psychiatrist Stephen Cozza, M.D., of the Uniformed Services University of the Health Sciences and the Center for the Study of Traumatic Stress to understand different aspects of military culture, values and military life, and how these might

impact TF-CBT implementation. His contributions have been central to the project and we are honored that Steve is a co-author of this manual.

In order to meet the goals of the project, we provided TF-CBT to military children and consulted with other programs that provided TF-CBT to military children, particularly the NCTSN-funded Trauma Informed and Disaster Evidence Based Services (TIDES) Program directed by Shelley Foreman, L.P.C. We also worked closely with several military experts and military-affiliated programs, especially the Tragedy Assistance Program for Survivors (www.taps.org) whose bereaved military family members generously welcomed us to their family camps during which they and their children shared personal experiences and allowed us to understand part of their traumatic grief journeys. We were honored to work closely with Sesame Workshop during the development of its Talk, Listen, Connect products which have helped hundreds of thousands of young military children. The Military Child Education Coalition, the National Military Family Association and Zero to Three have provided ongoing collaboration in developing our greater understanding of how best to provide TF-CBT for military children of different ages; how uniquely military circumstances (e.g., a Permanent Change of Station) may impact TF-CBT provision in ways that require adjustment; and considering how to provide TF-CBT for military children with special needs. Their extensive military cultural knowledge pervades this manual and our understanding of how to effectively engage, understand and work with military children and families. This manual represents the collective knowledge gained from the project.

Throughout the manual we include clinical examples. In order to protect the privacy of military families who have participated in this project, all clinical examples in this manual are *composite case descriptions*.

We are exceedingly grateful to all of the members of the U.S. military and their families, who serve every day. Above all, we thank the many military children and families who have participated in TF-CBT treatment, without whom we could not have developed this manual. These families have taught us that freedom is not free, but is paid for by their sacrifices, courage and valor.

Review of TF-CBT Core Components

In order to implement TF-CBT with military children, therapists must have basic TF-CBT knowledge and skills. These are provided in detail elsewhere (Cohen, Mannarino & Deblinger, 2006; Cohen, Berliner & Mannarino, 2010; Cohen, Mannarino & Murray, 2011; Cohen, Mannarino, Kliethermes, & Murray, in press; Cohen, Mannarino & Deblinger, 2012; www.musc.edu/tfcbt; www.musc.edu/tfcbtconsult). We briefly summarize the core TF-CBT components here. We describe family engagement and assessment later in this manual (pp 23-33) as they are critical to successfully beginning TF-CBT.

Trauma reminders are people, places, situations, thoughts, internal sensations or other cues that remind the child of the original trauma(s). Trauma reminders may be easy to connect to the child's initial trauma. For example, military children's trauma reminders may include seeing media war coverage or seeing a parent's war-related amputation. However trauma reminders are often idiosyncratic and hard to connect to the child's trauma.

Clinical example: Sarah was 12 years old when her father returned from Afghanistan after sustaining serious head injuries. Sarah's mother had just answered the phone when father grabbed the phone out of mother's hand and screamed at her to "get the hell off the phone" then started punching her. Sarah became irritable and angry as the domestic violence escalated after this episode. Sarah started having angry outbursts at school, particularly when the bell rang for class change at which time she would jump up yelling, "Shut that damn thing up!" Loud noises, and particularly the school bell, served as trauma reminders for Sarah of the domestic violence.

Gradual exposure (GE) is a core feature of all TF-CBT components. During the GE process the therapist carefully calibrates the amount and intensity of exposure to trauma material such as trauma reminders that the child can tolerate during treatment sessions without being overwhelmed, and slowly increases this during successive sessions and TF-CBT components in order to help the child be able to tolerate and eventually, master exposure to trauma thoughts, memories, discussions and reminders. The therapist encourages the child to use newly acquired TF-CBT coping skills during this process and helps the parent to assist the child in implementing these skills when trauma reminders occur outside of treatment sessions. If the therapist is implementing GE consistently and correctly, this process is analogous to climbing a gently sloping hill (if the therapist does not implement GE but suddenly introduces the idea of talking about the child's trauma during the Trauma Narrative component, this sudden exposure will feel more like scaling an imposingly steep cliff, and is not consistent with the TF-CBT model). This is diagrammed in Figure 1. Through GE the child steadily gains the ability tolerate feared reminders and memories. The core TF-CBT components are summarized by the acronym "PRACTICE" (Figure 2). Therapists should review these components using our free web-based training course, TF-CBT*Web* (www.musc.edu/tfcbt) and our free TF-CBT consultation product, TF-CBT *Consult* (www.musc.edu/tfcbtconsult).

More than 5000 service members have died in combat operations as well as from suicide, accidents and other causes since 2001. As a result, many military families must cope with grief and/or childhood traumatic grief (CTG). Concepts of typical and traumatic grief are evolving . Consensus is growing that some individuals have grief experiences that merit clinical intervention. Clinical interventions for CTG, which includes PTSD symptoms that impinge on and interfere with typical tasks of grieving, are part of the TF-CBT treatment model and are

available in the TF-CBT treatment manual (Cohen et al, 2006) as well as in our free training course, CTG *Web* (www.musc.edu/ctg). Additional information and resources about CTG are available on the NCTSN website at www.nctsn.org/trauma-types/traumatic-grief and on the NCTSN Learning Center at www.learn.nctsn.org

FIGURE 1: GRADUAL EXPOSURE DIAGRAM

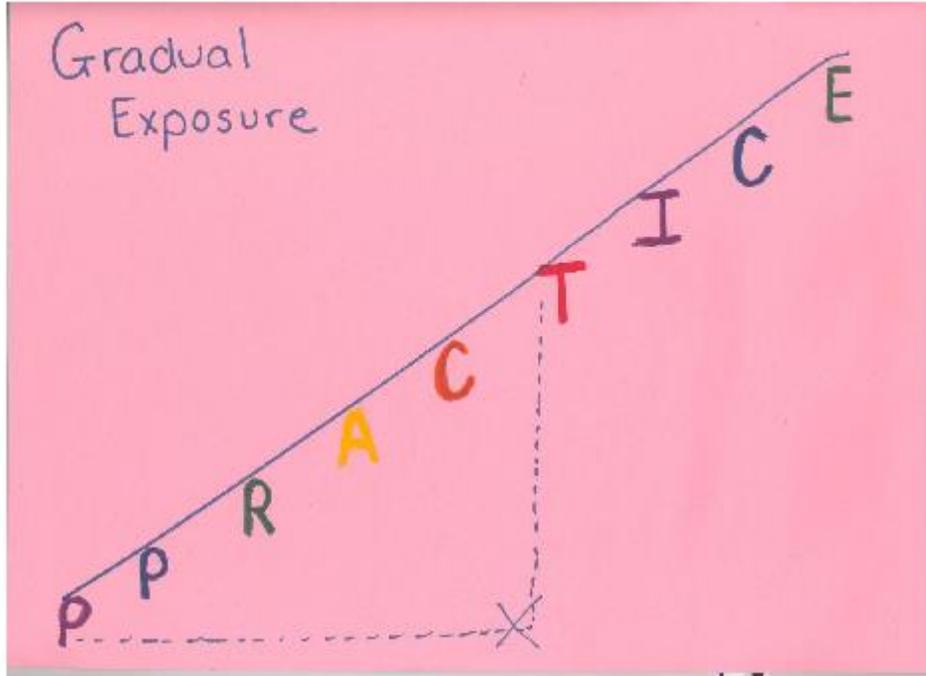


FIGURE 2: SUMMARY OF TF-CBT PRACTICE COMPONENTS

P: Psychoeducation	Educate child and parent about trauma impact, reminders and provide hope for recovery
P: Parenting Component	Include parent in all components; connect child’s behavior problems to trauma experiences; provide effective parenting skills
R: Relaxation Skills	Develop effective relaxation skills to address physical trauma impact; implement with trauma reminders
A: Affective Modulation Skills	Develop effective affective identification and management skills; implement with trauma reminders
C: Cognitive Coping Skills	Recognize connections among thoughts-feelings-behaviors; develop ability to change maladaptive thoughts to improve feelings and behaviors
T: Trauma Narrative & Processing	Develop narrative of child’s personal trauma experiences and cognitively process
I: In vivo Mastery	Develop mastery of overly generalized trauma reminders
C: Conjoint Child-Parent Sessions	Joint sessions with child and parent(s) to share narrative, improve family communication and enhance family support and functioning
E: Enhancing Safety	Develop effective safety skills and other relevant resiliency skills to optimize future developmental trajectory

Military Families, Trauma, and TF-CBT

Military families are expected to successfully manage with the stresses of hazardous duty and deployment related separations. Children are typically resilient during these periodic changes, perhaps because of the military cultural expectations and because other military families model and mentor effective family deployment strategies. In addition to separations, deployments also contribute to greater levels of family distress and challenges of family reunification.

There is a small but growing literature that examines elevated levels of distress and psychosocial difficulties in military children associated with parental combat deployment (Flake et al, 2009; Chandra et al, 2010; Lester et al, 2010). Two of these studies also found a negative cumulative effect of parental deployment on children's emotional outcomes (Chandra et al, 2010; Lester et al, 2010). Recently, Mansfield et al. reported the result of a large retrospective (from 2003 to 2006 – peak periods of military family deployment) cohort study using the medical outpatient treatment data of more than 300,000 children who had a parent or parents in the U.S. Army. The authors examined the relationship between pediatric mental health-related outpatient visits and parental combat deployments, comparing those groups of children whose parents were deployed for 1 to 11 months, for more than 11 months, or not at all. An association between parental combat deployment and risk of children's mental disorder visits was found for both boys and girls, with the greatest increase in the number of excess mental health cases in children whose parents were deployed for more than 11 months. The largest deployment-related effects were noted in acute stress disorder, adjustment disorders, pediatric behavioral disorders, and depression (Mansfield et al, 2011).

Clinical example: Jason was 7 years old when his father deployed for the first time. At first he adjusted well, spending time with many other children whose family members from the same installation were also deployed. However, after three service members from the base were killed in one day, Jason became increasingly anxious about his father's safety. His school work worsened, he had difficulty sleeping and wanted to Skype with his father nightly. He was extremely anxious about any war-related news, and this was compounded by his mother's increased worry about her husband. When father suffered a significant injury, Jason believed that he should have warned father about the dangers Jason had been worrying about, and if he had done so, father might have escaped harm.

Other reports have linked negative effects of deployment on other military family outcomes. Several authors have described increasing rates of deployment-related military child maltreatment since the start of combat operations in 2001, especially child neglect (Rentz et al, 2007; Gibbs et al, 2007; McCarroll et al, 2008). The U.S. Department of Defense has reported that divorce rates in both enlisted members and officers have increased during the past decade, with higher rates in 2009 than in 2000 for both officers (1.8% vs. 1.4%) and enlisted members (4.0% vs. 2.9%) in all military service branches (Department of Defense, 2009). Milliken et al. reported changes in self-identified concerns in 88,000 U.S. Army soldiers between initial post-deployment screening and a screening that occurred 3 to 6 months later, with a fourfold increase in the number of soldiers endorsing "serious conflict with your spouse, family members or close friends" at the second screening (Milliken et al, 2007). These and other reports suggest a broader

effect of deployment on the military family, a critical finding since the health of military children is likely connected to the health of their parents and other family members.

Clinical example: During two combat deployments to Afghanistan, John became annoyed when his wife Wendy constantly asked him to help her manage issues with their sons Derek and Michael, ages 6 and 7 years. John had his own stress related to the deaths of several close comrades and he felt worse, not better after talking to Wendy. She was always complaining about the kids fighting or not listening to her, while he was dealing with life or death issues. Upon returning home John was excited to see his family but soon his annoyance resurfaced. When Wendy told him he needed to do his share of the work at home, they got into a loud fight culminating in John threatening divorce. Michael and Derek started crying and begged their father not to leave. Mother became angry and accused the children of “taking your father’s side.”

Service members sometimes return with conditions that complicate family reunification and post-deployment life such as posttraumatic stress disorder, depression, or substance use disorders or with combat-related injuries, to include traumatic brain injury (TBI). Therapists should be aware of the changing nature of military wounds during the recent combat operations. Improvised explosive devices (IED) have produced severe injuries that in the past would have been fatal; newer surgical procedures have allowed many service members injured by IED to survive but often with severe wounds that require months of rehabilitation and termination of military service. Disfiguring amputations, TBI or other severe orthopedic injuries, and/or mental wounds such as PTSD, depression, or suicidal ideation are all occurring at higher rates during OIF/OEF than in previous conflicts. When serious injuries occur, they can lead to a cascade of

effects including family separations, stressful hospital visits, extended medical care, changes in schools, residents and communities, as well as elevated family and child distress (Cozza & Guimond, 2011).

Therapists may not consider the family circumstances or traumas associated with parental PTSD, depression, substance abuse and/or TBI when evaluating military children. However these conditions can contribute substantially to children's trauma symptoms, for example, when children witness or co-experience the parent's self-injurious, threatening or dangerous behaviors as described below.

Clinical example: Eight year old Tonya was very excited when her father, a member of the Army Reserve, returned from his fourth and final deployment in Iraq. Soon after his return it was clear that he had changed—he was jumpy and irritable all the time, and he took a weapon to run routine errands. One evening Tonya and her father drove down a country road to the grocery store, the occupants of a passing car threw a beer can out the window in their direction and yelled something at father. Father suddenly swerved the car off the road, narrowly missing a tree. He pulled Tonya out of the car, diving on top of her, and started screaming while aiming his weapon in circles. Tonya was crying, “Daddy, are you okay?” and asking her father to get off of her. This lasted for several minutes until father “came to” and realized where he was. Tonya was shaking and afraid to get back into the car with her father. She has been afraid of riding in the car with him since this episode.

If a service member dies in combat theater it is usually sudden and the cause is potentially traumatic (e.g., from a training accident, in combat or from a combat-related injury,

or from suicide). No published reports have described the unique experiences of military children who have been parentally bereaved during a time of war. Preliminary study of parental death has found no significant differences between military and civilian children (Cozza et al. ISTSS poster 2011). However, given the violent nature of combat related deaths, military children may be at heightened risk for developing childhood traumatic grief (Cohen & Mannarino, 2004).

Clinical example: Nancy was 14 and a star runner when her older brother joined the service. Living in a civilian family and setting until this time, Nancy and her parents quickly learned about military stressors during his deployment. When the casualty assistance officer arrived to inform the family of her brother's death from an IED, Nancy demanded that he provide details about the death and why the body was not returned. Finally she was told that "sometimes there is nothing to return." Nancy began to have intrusive images of her brother's damaged body whenever she would start to run. She said, "I keep thinking about his legs blown to bits and I feel too sick to run."

In addition to these military-related traumas, military children also experience the same types of traumas that civilian children experience, such as bullying, accidents and medical traumas. Non-deployment-related child abuse and domestic violence occur at equivalent rates in military and civilian children, affecting up to a quarter of all military children (McCarroll et al, 2004; 2008). For all of these reasons, mental health professionals who evaluate and treat military children should be aware that trauma is a relevant issue for these children. For military children

with significant trauma issues, TF-CBT can be a culturally appropriate and highly effective treatment choice as described in the following section.

Military Culture and TF-CBT

Military life has many common elements that all military service children and families share. Service members do not serve alone. Rather, the entire military family, including the military service member, parents, siblings, spouses or partners, and children—all serve together. Military families share common experiences that distinguish their families from civilian families. These experiences including recurring prolonged absences during military duty, living with the possibility of injuries or deaths resulting from combat deployment, as well as post-combat stress-related mental health problems (Cozza et al, 2005). Most military families manage these challenges with a high degree of resilience, in large measure because they are committed to and value their service.

When working with military families, clinicians need to understand the important differences between service branches and components. These are briefly reviewed here but more information about these differences is available at several webinars about military culture on the Center for the Study of Traumatic Stress website, www.centerforthestudyoftraumaticstress.org.

Active duty differs from Reserve and National Guard duty in a variety of ways. Active duty members serve in the military as their full time jobs and typically live on or near military installations primarily with other military families. Most military-related resources and services tend to be concentrated near military installations, so active duty families often have more access to services such as military child mental health specialists, resiliency-based services for military families, and military educational resources. Active Duty families experience regular Permanent Changes of Station (PCS's) that require children to change schools and make new friends every few years, but these families also benefit from living among other military families who understand and support their experiences.

In contrast, Reserve and National Guard service members are usually only activated for extended periods of military service during war or emergencies. These families do not experience PCS moves and typically live civilian lives until their military service family members are activated. At that point their families become “suddenly military”. Reserve and National Guard children may feel that their civilian friends have no comprehension of military life or responsibilities. More often than active duty children, these children report that they are not understood by their friends, teachers or other important people (Chandra et al, 2010). Perhaps related to these differences, Reserve and National Guard children and their non-deployed parents may be at increased risk for developing higher levels of distress or mental health problems during parental deployment (Lester et al, 2010) that TF-CBT can successfully address.

The military also includes distinct service-specific (e.g. Army, Navy, Marines, Air Force, Coast Guard) sub-cultures. When working with military families, it is important to recognize their service branch affiliations in order to build and maintain effective therapeutic relationships and to provide effective treatment (Bates et al, in press). Military life is centered on core values that guide military service members and families, values that often are not shared by their civilian counterparts. Military cultural values are critical to service members performing well in their jobs, serving to bond service members and their families together, and allowing them to successfully survive the rigors of military life, including combat (Bates, et al, in press). These values include commitment to duty (doing what is necessary regardless of personal cost); strength and resilience (continually striving to attain one’s physical, emotional and spiritual best); and loyalty to team and family members, including individual sacrifice for the common good. Understanding and respecting military life and values is critical to both effectively

engaging military families in TF-CBT and to optimally implementing TF-CBT for distressed or traumatized military children.

The first step in the development of a military competent health care practice is for a clinician to be aware of his/her biases, beliefs and attitudes about the military and military community (Bates, et al, in press). These assumptions may be based upon their own personal and family values, as well as prior experiences. For example, therapists who had personal or family experience in WWII are likely to have very different perceptions about military service and military communities than those with experience from the Vietnam War. Past positive experiences are more likely to lead to positive perceptions of the military, where negative experiences tend to result in critical perceptions. In order to be effective with military families, therapists must be aware of these perceptions and biases and not allow any personal negativity to impact therapeutic goals.

Therapists who have not been part of the military may never completely understand the experiences of living a military life but the following resources can significantly enhance their insight into military culture.

The Center for the Study of Traumatic Stress collaborated with the NCTSN to develop a series of webinars on topics including the impact of deployment on children; programs and services for military children and families; how to become a Tricare provider; Military OneSource products for military children, and building community capacity to serve military children. These webinars are available at the NCTSN Learning Center for free CE credits, at <http://learn.nctsn.org/course/category.php?id=10> (select podcasts/"Essentials for Those who Care for Military Children and Families"). Additional resources for therapists who wish to gain military cultural competence include the following:

National Military Family Association: includes “10 things that military teens want you to know” and other important information from military families: <http://www.militaryfamily.org>

General education about military culture, military branches of service, rank structure, and common military stressors, : http://www.ptsd.va.gov/professional/ptsd101/flash-files/Military_Culture/player.html

Information about military acronyms: <http://dtic.mil/dtic/customer/acronyms.html>

Barriers to TF-CBT Access for Military Families

The military cultural value of strength and resilience may result in negative attitudes towards mental illness and/or seeking mental health treatment. Some military members may believe that having a mental illness or needing therapy is a sign of weakness, and that the appropriate response to pain is either to ignore it or get over it by relying on toughness and inner resources. Such attitudes are likely to conflict with talking about difficult experiences and feelings and by extension, with seeking mental health treatment. Consistent with negative attitudes about expressing vulnerability and pain, stigma about mental illness and seeking mental health services is significant among military members and their families (Greene-Sortrig et al, 2007). The U.S. Armed Forces are engaging in multiple efforts to decrease such stigma and to encourage trauma-affected service members or family members to seek needed mental health services. Some evidence suggests that stigma is decreasing (Warner, et al, 2008) but therapists should be aware that military families may need to overcome significant stigma both within and beyond their own family in order to seek mental health services.

In addition to emotional barriers, military members and their families may be concerned about real or imagined consequences to military careers if they seek mental health treatment. In some cases this concern may determine whether a traumatized military child is encouraged or discouraged from seeking needed care. All military services take allegations of child maltreatment and domestic violence very seriously. If substantiated, a family related maltreatment or domestic violence incident could have financial impact on the family, significant disciplinary consequences to a service member or potentially be career ending. In addition to the consequences to a service member perpetrator, families may also be at risk for losing financial support or housing should that service member be financially penalized, lose subsidized housing

or lose his/her military career. Parents may be hesitant to seek needed pediatric or mental health care for their child if they are concerned that the clinical evaluation will lead to the discovery of a maltreatment or domestic violence event. When a perpetrator is outside of the family, the child or parents may be concerned how the child's disclosure may impact the service member parent's career or the family's image in a tightly knit community. Any or all of these concerns can diminish the comfort of parents and children to self-identify or seek services that could be of help, out of fear of discovery or negative outcomes.

Finally, insurance or access barriers to accessing TF-CBT may exist due to lack of TF-CBT training among Tricare providers; Tricare providers no longer accepting new military service members on their caseloads; and civilian child mental health providers not belonging to Tricare provider panels. These barriers are significant even for Active Duty military children since only recently have there been military efforts to provide training in evidence-based trauma treatments for children who have experienced maltreatment, domestic violence or other significant traumas. Reserve component children who only have Tricare insurance often face even more daunting odds since there are fewer child mental health providers available to address these children's needs and few have specialized training in trauma EBT. Fortunately the DOD and Tricare are working actively to address these problems and recent NCTSN funding initiatives have focused on increasing availability of EBT treatments for military children. Hopefully these efforts will increase access of these services for military children and families.

TF-CBT Assessment and Engagement Strategies for Military Families

When assessing military children who have experienced stressful events and are evidencing traumatic response, clinicians must not only inquire about exposure to the typical types of traumas included in child assessments (i.e., those included in the UCLA PTSD Reaction Index, Steinberg et al, 2004), but also thoroughly ask about exposure to and impact of stressors and traumas that are unique to military life. As always the interview with the child is critical to determining the impact of potentially stressful or traumatic events.

Identification of military children: First, clinicians should not assume that they automatically know whether or not a child is a member of a service family. Rather clinicians should routinely screen all new adult and child clients for exposure to military related stressors. Simple questions such as “Have you or someone in your family served in the military or been deployed?” can quickly determine military family experiences. The clinician should then follow these questions by inquiries about the relationship to the military family service member and the nature of military-related exposures.

History of Deployments and Family Relocations: When the clinician identifies exposure to military-related stressors, further assessment should include questions about the number of parental, sibling or other family member deployments, the duration of these deployments and whether or not these deployments were into combat theater. Ask about the child’s adjustment before and during each deployment, whether the family relocated during deployment, and how the non-deployed and deployed parent or sibling and other family members adjusted. If both parents were deployed, ask who cared for the child during the parents’ joint deployments and whether the child had to relocate to live with this new caretaker, how well the child knew the caretaker, and how well the child adjusted to these changes. History of other family relocations

is also important to consider. Relocations can result in disruptions in education, relationships, activities, friendships or required care for preexisting medical, developmental or educational conditions. These stressors can be magnified for children who have pre-existing problems since accessing needed services at new military or civilian locations may be challenging and may not occur for several months.

Deployment related injury including traumatic brain injury (TBI): The assessment should also include information about whether the deployed parent or sibling experienced significant injury during deployment, and if so, the nature of the injury, where the injured service member received treatment, length of time the service member was separated from the child and whether the non-deployed parent joined the injured parent or sibling and was also separated from the child after the service member's injury. Inquire about the child's response to injury, whether the child visited the wounded parent, sibling or other family member at the hospital or tertiary care center, saw disfiguring wounds, and/or feared that their loved one would die. Also ascertain the non-injured parent's and other family members' responses to the injury, and how these may have contributed to the child's positive or negative adjustment. It can also be helpful to simply ask "What have you told your child about the injury?" A parent's response to this question informs the clinician about the nature of the information that was shared and the parent's comfort or discomfort in addressing painful subjects with the child. In situations where injuries have been serious, it is important to ask whether the injury included TBI or resulted in changes in family relationships. Finally, it can also be helpful to assess whether or not family members have developed new and successful ways of engaging based upon post-injury realities (Cozza & Guimond, 2011).

Post-deployment mental health problems: Inquire about whether the deployed parent, sibling or other family member developed mental health problems, particularly PTSD, depression or substance use problems, and to what extent the child has been exposed to these problems, the child's response to these problems, and other family members' responses to these mental health problems and their impact on family relationships. Since combat stress related disorders can result in reactivity and anger, also assess for elevated levels of family distress or discord, domestic violence and child maltreatment.

Military-related death of parent: If a service member parent, sibling or other family member dies, inquire about the cause of death (combat; accident; suicide; other), the child's response to the death, including asking about childhood traumatic grief symptoms (Cohen & Mannarino, 2004) and about non-deployed family members' responses to the death, both at the time of notification and subsequently.

Focus on family functioning and resilience: It is especially important to ascertain how the non-deployed parent has functioned during the parent's or sibling's deployment and how all family members have related and functioned since return from deployment (Lester et al, 2010). It is equally critical to ask in what ways the child and family are doing *well*; i.e. to take a strengths-based approach and focus on resilience. Inquire about support systems that are available to the family, keeping in mind that the military provides many natural supports to military families.

Attention to risk factors: An understanding of factors associated with poorer clinical outcome in military children and families can help clinicians recognize potential at-risk cases that are more likely to develop more serious problems. Early military deployment literature suggests that younger children and boys may be at greater risk of developing symptoms during deployments (Jensen PS, Martin D, & Watanabe, 1996). More recently, girls and older teens

have been identified as being at greater risk of deployment-related problems (Chandra et al., 2010). These age and gender discrepancies likely reflect differences in study samples and methods of assessment. Children are likely to variably experience, respond to, and report their reactions depending on gender, age, and developmental needs.

Military children of non-deployed parents who exhibit higher levels of distress and poorer functioning during deployment also appear to do more poorly than children of non-deployed parents without those problems (Jensen PS, Grogan D, Xenakis SN, & Bain MW, 1989; Chandra et al., 2010; Lester et al., 2010). The trauma literature identifies those children who are more highly exposed to a traumatic event or have poorer access to a social support network as being at higher risk of the development of posttraumatic psychiatric sequelae (Pine & Cohen, 2002).

Additional risk factors for child traumatic response include the lack of social connectedness (Pine & Cohen, 2002) that may occur when military families are unable to gain access to services, are geographically isolated, live in communities that do not understand or recognize military culture, or when language poses a barrier to connectedness. Preexisting developmental, learning or emotional problems have also been associated with posttraumatic outcomes in children (Pine & Cohen, 2002). Given the negative impact of child maltreatment on child development and the relationship between deployment and elevated rates of military child neglect, risk factors for child maltreatment are likely to put military children and families at risk as well. Demographic risk factors (e.g. low income, low maternal education, maternal youth, or single parenthood), familial and parenting risk factors (e.g., maternal anger, dissatisfaction, low self-esteem, or illness; low father involvement or warmth), and child risk factors (e.g. difficult

temperament, developmental or learning problems) have all been associated with risk of child maltreatment (Brown et al., 1998) and may be relevant in determining military family risk.

In situations where clinicians are engaging military children whose parents are suffering from post-deployment combat stress conditions, they must be aware of the potential negative consequences of those conditions on children. Children and parent-child relationships have been noted to be negatively affected in multiple studies of Vietnam veterans with PTSD (Jordan et al, 1992; Rosenheck R & Fontana A, 1998; Ruscio et al, 2002). Ruscio et al. (2002) described “the disinterest, detachment, and emotional unavailability that characterize emotional numbing may diminish a [parent’s] ability and willingness to seek out, engage in, and enjoy interactions with [his or her] children, leading to poorer relationship quality” (p. 355).

Incomplete information about the child: More than 50,000 military children experience the simultaneous deployment of both parents and are living with a non-parent caregiver. If a military child requires mental health services in this situation, the caregiver may not have important background information (it is now feasible for evaluators to reach a deployed parent via Skype and this should be considered in such situations.) After severe injury wounded service members typically receive care in regional trauma centers and the non-service member parent may travel to these locations, leaving the children with relatives or friends for days or weeks. If a service member has been killed or when the primary caregiver parent is absent for significant periods during the child’s life, children may live with other adults (e.g., step-parent, grandparent, etc) who may not have complete or accurate information about their development. In such situations, child clinicians should obtain as much information as possible from the available caregiver, the child, and other potential sources (e.g., school, pediatrician) and formulate a working diagnosis and treatment plan based on the available information.

Determining whether TF-CBT is appropriate for the child: Military children experience a variety of stressors associated with military life including long separations from parents, frequent moves and associated disruptions in peer relationships and school settings; however for most children these do not lead to significant mental health symptoms. Deployment is a normative experience for military families although many military families do not experience repeated combat deployments such as those of the current wars. While the Iraq and Afghanistan wars are associated with higher levels of child and family mental health difficulties than previous conflicts, most military children adapt well during parental deployment and do not require mental health intervention. Clinicians should not assume that military children, even when exposed to significant levels of distress, parental injury, illness or death necessarily have traumatic responses. Careful evaluation to determine the source, severity and quality of symptoms, to include post-traumatic symptoms, is critical to determining the appropriate clinical course.

The serious injury, illness or death of a military parent will be sad and difficult for many children but after a period of adjustment most will likely adjust fairly well. However, some smaller number will experience these events as highly stressful or traumatic, developing significant depressive, PTSD, anxiety, behavioral and/or functional impairment that requires active clinical attention and trauma-informed strategies. Similarly, some children may experience child abuse or domestic violence and adjust without significant disruptions in adaptive functioning or mental health problems, while many others suffer traumatic consequences. It is critical that clinicians evaluate children to determine the severity of their reactions and not assume either traumatic or resilient responses based upon the nature of the exposure.

The appropriateness of using TF-CBT in the care of a military child with any of these experiences depends on whether the child has had a significantly traumatic reaction that interferes with adaptive functioning and/or cause significant mental health problems. If the child evidences traumatic response to one or more of these events (deployment, parental injury, parental death, or more typical traumas such as child abuse or domestic violence), TF-CBT is a well-studied, evidence based clinical intervention that is likely to provide relief.

Generally TF-CBT is applied in a similar manner for military and civilian families, with some specific applications that are unique for military families. These applications are described throughout the manual but are briefly described here.

Include different military parents during treatment as appropriate: TF-CBT is best conducted with the presence of a consistent parent or parents throughout the treatment process. Military families would find this approach engaging, but due to the frequent changes in the structure of military families secondary to deployments, moves, parental injury and/or death, parents' availability to participate in TF-CBT may vary from session to session. TF-CBT therapists must recognize the changing circumstances of military family life and flexibly include different caregivers to the greatest degree that is clinically appropriate.

Plan for upcoming changes in living arrangements: Changes in living arrangements resulting from parental deployment and/or transfers through PCS are commonplace for military families. Therapists must be aware of these possible disruptions at the start of TF-CBT in order to appropriately map the length and pace of TF-CBT, and to plan for treatment termination or if necessary, arrange transfer to another TF-CBT therapist in the family's new location.

Understand unique needs of Reserve and National Guard families: Unlike active duty families, Reserve and National Guard families typically live in largely civilian settings, often

isolated from other military families. These children may not know or attend school with any other military children and their non-deployed parents may lack military friends to provide support throughout the deployment cycle, potentially putting National Guard and Reserve families at risk for increased distress or mental health problems during deployment.

Understand the nature of modern military injuries and issues related to traumatic grief:

Accurately understanding the changing nature of wounds in the current conflicts both as these apply to more severe injuries than survived previously and mental illnesses and traumatic brain injuries, is critical in order to effectively engage military families in treatment. Recognizing childhood traumatic grief and explaining this to family members is also important for effective engagement. These are described in detail below.

Engagement strategies for military families starting TF-CBT: Once the assessment has determined that the child is appropriate for trauma-focused treatment, the therapist must successfully engage the child and family in this treatment. Therapists hoping to successfully engage military families in TF-CBT treatment must respect the military values described above. Military families are most likely to engage in TF-CBT treatment if it is presented in terms of a family-focused resilience-building model rather than as treatment for a trauma related condition or mental health disorder. Since family-based treatment and resilience-building skills are core TF-CBT values (Cohen et al, 2006, pages 32-33), this is an accurate and engaging way to present TF-CBT to military families. At the same time an important engagement strategy is to recognize why families are seeking treatment and to effectively and promptly make progress towards addressing these problems, particularly when distress or traumatic exposure is present.

Clinical example: A military family presented for assessment for 13 year old Anthony's school behavior problems. The school constantly called mother because Anthony was rude to teachers, cutting class, and fighting with peers. The clinician noted that these problems had worsened since the father's return from deployment in Iraq and corresponded with an increase in fighting and tension between the parents. Upon further exploration mother reported that father was having unpredictable explosive outbursts that Anthony had witnessed. Father had experienced a possible concussion after a roadside bombing, losing consciousness for several minutes, followed by severe headaches and irritability but had refused to see a health care provider, insisting there was nothing wrong with him. During the interview with Anthony, the therapist specifically asked him about his father's angry outbursts. Anthony acknowledged that he was very worried about his father and scared that "something bad is going to happen." When rating the UCLA PTSD RI with regard to his father's outbursts Anthony scored 30, in the moderate range of severity.

The therapist presented TF-CBT as a model through which parents could assist Anthony "to build on your strengths to work together and help address Anthony's stress-related behavior issues." Specifically, the therapist explained to the parents that she believed Anthony's behaviors were related to worry about his father, and supported this by sharing with them his completed UCLA PTSD RI in which he noted his worst trauma as "The parents agreed to participate because instead of focusing on Anthony's "bad" behaviors, the therapist emphasized the child's and family's strengths, which was consistent with the family's pre-deployment identity, their military cultural identity, sense of resilience and their prior experience of helping each other solve problems. The therapist provided information that related Anthony's behaviors to possible biological stress-related changes. As the therapist implemented the skills components and the

parents began to see improvements in Anthony's behavior and their own relationship, their engagement with the therapist became more committed. The parents were receptive to the explanation of stress-related brain changes leading to behavioral problems, which over time enabled Anthony's father to be more accepting of his own possible stress-related brain changes. As he saw the improvements in Anthony's behavior he decided to seek an evaluation for himself. He was diagnosed with severe traumatic brain injury and the entire family experienced significant relief when this diagnosis was made and treatment was initiated. As his father sought treatment, Anthony reported in his trauma narrative that his father was his hero because "he was a brave soldier and even braver to get help."

TF-CBT for Deployment-Related Trauma

Most military children adapt well during parental deployment. After an initial adjustment period many military children obtain enhanced self-competency in being able to help the non-deployed parent and contributing to the family's functioning in the absence of the deployed parent. Successful adaptation during deployment is supported by other military families who are also experiencing deployment and coping with the same stressors. Families living on or near military installations (typically Active Duty military families) are more likely to have large numbers of other military families nearby who also have deployed families members and this likely accounts for some findings suggesting that children of Active Duty deployed military personnel are less likely to have mental health difficulties than those of Reserve or National Guard military personnel. However, for any military child, successful adaptation during deployment can be prevented or disrupted by a variety of factors, including child or parent health or mental health issues; interpersonal issues in the family; or bad news about combat operations.

The reality of parental deployment is that children and parents must adapt to real and ongoing danger to their military family members. This danger is significantly heightened during combat deployment but service members are trained to minimize danger and the odds of serious injury or death are small. Military children and non-deployed parents can enhance their adaptation through enhancing resiliency coping skills. In such circumstances when family members are under stress but not exhibiting clinically significant symptoms, universal, indicated or selective prevention strategies can serve to support military family health and function.

One such program, Project FOCUS (Families Overcoming under Stress, <http://www.focusproject.org>) is an evidence-informed resiliency training program for military

families to prevent deployment-related stress. FOCUS is being implemented in many military installations across the U.S. FOCUS is highly recommended as a first line preventive intervention program for military families who can access it. FOCUS has also been modified and is used as a prevention strategy in injured populations, as well (Operation Mend and FOCUS-CI). For those children who have significant mental health symptoms, TF-CBT is often appropriate and can be offered as a clinical adjunct to such prevention approaches, or when programs such as FOCUS are unavailable, can bridge clinical and prevention strategies. For example, TF-CBT includes psychoeducation, resiliency coping skills and other supportive approaches that have been successfully applied with children exposed to ongoing trauma (Cohen, Mannarino & Murray, 2011).

The following case illustrates some of the special needs of Reserve or National Guard families. Connecting these families to online resources or to other military families is especially important for families who do not have other sources of support. In this example, the therapist also effectively helps the parents to understand the meaning of the child's symptoms (e.g., by making appropriate connections between behavioral problems and parental deployment) as well as helps the family to develop effective plans for addressing the child's difficulties.

Clinical example: Ron was 10 years old when his father's Reserve unit was deployed to Iraq. His family lived in a suburban area where he didn't know other military children. Although he admired his father's military service and he was accustomed to brief absences during his father's Reserve training, Ron was upset when told that his father would be gone for a much more extended period. He was especially angry that his father would miss coaching his little

league baseball team, saying “Why do you always have to leave? Why can’t one of the other dads do it this time?” Ron’s older sister tried to help out at home but she was busy with her friends and annoyed at Ron’s negative attitude and as time went on she increasingly stayed out with friends and avoided being at home. As his father’s duty was extended to a second and then a third deployment, Ron’s mother became increasingly depressed over her husband’s absence and grew ever more anxious about his safety. In response to his mother’s difficulties Ron’s behavior became more problematic, especially at school where he was not paying attention and he was fighting with peers. Ron was also worried about his father’s safety, compounded by the fact that his father was communicating less and less, and seemed to be withdrawing from the family. Mother finally brought Ron for an evaluation at the pediatrician’s suggestion. During the evaluation Ron told the therapist that he was mad because “no one at school knows what it’s like. They talk about their dads all the time, they get to go hunting and fishing and play ball with their dads, and I don’t even get to talk to my dad anymore. I hate everyone.” Upon further assessment Ron endorsed significant worries and PTSD symptoms (intrusive thoughts about war-related media coverage; avoidance of thoughts about what might have happened when his father failed to call; and hyperarousal symptoms) related to father’s deployment.

Ron and his family had used some local community support programs and were aware of widely available psychoeducational materials, but did not live in a state where Project FOCUS was offered. In addition, Ron’s symptoms included high levels of traumatic response and behavioral problems that required clinical intervention. Ron and mother participated in TF-CBT to address these identified problems. Ron and mother both benefitted from affective modulation and cognitive processing interventions. Both Ron and mother expressed feelings of anxiety, worry as well as anger at father. Both expressed beliefs that father “would rather be with his

Army friends than with us” and that father “cares more about the Army than us”. During individual parent and child sessions the therapist explored alternative cognitions that could explain father’s military service (e.g., “he is doing what he believes is right”; “he is earning more money to support our family”; “he is setting a good example for me”). The therapist used online military family resources (e.g., www.militaryfamily.org) to reinforce these positive cognitions since the family did not have contact with other military families from whom to obtain such support. The therapist also actively engaged Ron’s father through Skype and e-mail exchanges to help him understand the importance of increasing communication with his family during deployment to reduce their anxiety. As TF-CBT progressed, father participated in some sessions via Skype; this reduced Ron’s and mother’s maladaptive cognitions that father was “enjoying” being away from them and had a positive impact on Ron’s and mother’s negative emotions and on Ron’s behavior problems. Even when Ron’s father could only participate for a few minutes it had a very positive impact, and contributed to Ron and mother feeling more united, supported and supportive of father’s military service. These joint sessions also provided opportunities for Ron to show his father newly acquired skills and for Ron’s mother to discuss parenting strategies. The therapist linked Ron and his mother to resources (www.militaryfamily.org) through which Ron could connect with other Reserve and National Guard children via camps and online programs, thereby decreasing his sense of isolation. Mother became more available to help Ron implement TF-CBT strategies at home as her depressive symptoms lifted.

Ron created a narrative in which he described having heard news reports of service members’ deaths. In the narrative he said that even before father’s deployment he had nightmares and intrusive thoughts about father dying and never returning home. His fears were exacerbated by father’s failure to call or Skype when expected and by mother’s withdrawal.

Through the narrative Ron's parents were able to further understand the meaning of Ron's symptoms as well as how their own actions impacted on these. Father apologized for not understanding that Ron was worried. He explained all of the measures in place to assure his safety and reassured Ron that the odds were highly in his favor. The family also agreed to a plan whereby Ron would not listen to media coverage of the war, and if he heard something that scared him from another source, he would talk to his parents about it instead of keeping it to himself. His father explained that his duties prevented him from communicating on regular schedule but he committed to more regular communications with his family. As the family instituted these plans Ron's symptoms significantly improved.

As with all TF-CBT treatment, therapists implementing TF-CBT for deployment-related trauma must take into account the child's developmental level and the specific circumstances of the trauma. The following case description underlines some of these factors with regard to a younger child's PTSD symptoms related to other stressors that occurred during parental deployment.

Case example: Maria was 5 years old when her mother was deployed to Afghanistan. Maria lived on a military installation with her stepfather Sam (also an Active Duty service member) and her 2 year old half brother. Maria was best friends with Alice, whose father was in mother's unit and who was deployed at the same time as mother. The two families were friendly and spent time together before and after the parents' deployment. Maria initially adjusted well to mother's deployment, in large part because she continued to spend time with Alice and Alice's mother.

Six months after mother's deployment, mother's unit suffered several casualties. Three members were killed and two were severely injured. Mother was unhurt but Alice's father was severely injured. Alice's mother left to be with her husband and Alice went to live with her grandparents nearby. Maria became extremely fearful for mother's safety, asking about her constantly, wanting to talk to her every night, becoming very clingy toward Sam and asking to stay home from school for minor somatic complaints. Sam took Maria to the pediatrician who referred her for mental health evaluation. At that time Maria acknowledged that she had heard older children talking in school about Alice's father and the other injured service members' "arms and legs being blown off" and that she was having scary images of body parts blowing up during the day and at night. Maria was diagnosed with PTSD and referred to TF-CBT treatment.

The therapist initially met with Sam to provide psychoeducation about Maria's PTSD symptoms and some suggestions about how to respond to these in an age-appropriate and reassuring manner. Sam seemed to have good insight in this regard and was eager to participate in treatment. He said that until his wife's deployment he had been less involved in parenting tasks and that Maria did not talk to him about her feelings like she did to his wife. He hoped that participating in Maria's treatment might change this. During this initial session Sam also provided additional clarification about the nature of Alice's father's wounds (TBI and a leg amputation).

The therapist initially met with Maria to introduce relaxation strategies. Maria quickly engaged in simple visualization activities such as drawing butterflies; imagining the ocean; and muscle relaxation techniques including blowing bubbles to practice focused breathing and progressive relaxation strategies for young children described elsewhere (Drewes & Cavett,

2012). She showed these to Sam and they practiced these together at home when Maria became anxious.

During the following sessions the therapist continued to develop affective modulation resiliency skills, incorporating gradual exposure by asking Maria about military life generally (e.g., “So you live in Fort X! Wow, what’s that like? Do you go to school on base?”), encouraging Maria to describe her life as a military child including her mother’s deployment. This led naturally to asking about Alice and to the therapist introducing a question and answer game through which the therapist was able to provide developmentally appropriate psychoeducation about combat injury. During this process the therapist and Maria asked general questions about combat injuries and took turns giving answers to these questions. As the game evolved Maria disclosed misinformation about such injuries based on things she had heard at school (e.g., “people’s legs and arms blow into the trees and no one can find them”; “their body parts might fall on you when it rains.”). When the therapist said that this is usually not what happens, Maria looked doubtful. The therapist suggested that they invite Sam in to answer the questions. Maria agreed that Sam would know the answers to these questions. Sam joined the game and based on the information and an analogy that the therapist had previously provided to him, he was able to provide the following age-appropriate reassuring information to Maria: “The kids in school just talk. I’ve seen it happen and it’s like this: the person still has their arm or leg but it got hurt in a way that they can’t use it anymore so they decide that they want a new one that will work better. Remember when your old bicycle got run over by the car and it didn’t work anymore? It’s like that—you still had the old bike but we got you a better one. Wouldn’t you rather have the new bike than the old one that didn’t work anymore?” Through this process Maria was able to

understand combat injuries in an age appropriate manner that was less frightening and more helpful.

The therapist introduced cognitive coping skills to Maria by using examples from her school interactions. Maria told the therapist that other children did not like her. The therapist knew from Sam that Maria was socially withdrawn since Alice's departure and had refused most invitations to play from other children. The therapist asked Maria how she knew that other children did not like her. Maria said that they did not play with her. The therapist designed a role play in which the therapist played Maria and Maria played another child who asked Maria (the therapist) to play but Maria (the therapist) said no. Through this process, the therapist helped Maria to understand that perhaps other children might have hurt feelings from having been refused and think that Maria did not like them, and this might lead them to longer ask her to play. Maria then was able to see that she could make new friends by changing her own thoughts ("maybe they just think that I don't like them"), feelings (from sad to hopeful) and behaviors (asking other children to play and not refusing invitations when she received them).

Maria then developed a trauma narrative related to hearing about Alice's father's injury and to Alice and her mother moving away. She described that when the news of the injuries came to the installation the school had an assembly to honor the soldiers who died and those who were hurt but Maria did not understand what had happened to them. Some of the older kids at school talked about how the IED had blown their body parts into trees and they couldn't find their arms or legs. Maria kept thinking that if this happened to her mother, she would "not be able to get away from the bad people who were trying to hurt her and maybe mommy would never be able to come home." This made Maria very scared. Hearing this talk made her very afraid of what Alice's father looked like but she was afraid to ask anyone about this. She kept

having intrusive images of a horribly disfigured, mangled person screaming in pain which was terrifying. Her confusion and fear were exacerbated by the departure of Alice and her mother since in her mother's absence these were the two people in whom she was most likely to confide and now she had no one with whom to talk. She described being afraid to go to school where she might be reminded of these images or to go to sleep where she sometimes dreamed of them. As Maria dictated this narrative to the therapist she was able to clarify that she no longer had these fears or intrusive thoughts since coming to therapy and talking with the therapist and Sam had helped her to understand that what the kids in school said was not true. She also said that she now knew how to "relax myself" when she was scared by using the coping skills and asking Sam for help. Sharing the narrative with the therapist and with Sam was very helpful to Maria. Sam praised her and told her that she could always talk to him or her teacher about being scared, and they shared the narrative with Maria's mother in a letter. Together they developed a safety plan for helping Maria feel safe. One of her requests was to talk to Alice on the phone and to ask her about her father. Alice sent Maria a picture of her family in which her father was wearing his new prosthesis. Maria was much relieved to see "his new leg" and this provided her with additional reassurance. By the end of TF-CBT Maria's PTSD symptoms had resolved and the family was eagerly looking forward to mother's return from Afghanistan the following month.

TF-CBT for Parental Injury and Death

Parental Injury: The types and severity of military injury are changing. The use of Improvised Explosive Devices (IED) is leading to novel blast injuries including TBI. Due to improved medical technology service members are surviving extremely serious wounds that previously would have been fatal. This has decreased mortality while increasing morbidity associated with these wounds such as serious complications, disability and/or mental illness. The military is attempting to optimize communication to families after injury occurs (for example whenever possible the wounded Service member him or herself is the one to contact the family) but therapists must be aware that the trauma of the service member's injury may be further complicated by any of the following: 1) children may receive inaccurate or age-inappropriate information about what happened to wounded parents, siblings or other family members or they may witness frightening emotional reactions of adult family members; 2) the service member may require extended care at a trauma center far from the family's home leading to extended separations from children; 3) the non-deployed parent may join the wounded parent or family member, possibly leading to children's separation from both caregivers; and 4) children may travel to visit wounded parents, siblings or other family members, resulting in frightening exposures to disfiguring wounds, medical procedures, or equipment, without age appropriate explanation or preparation. Any of the above experiences may contribute to children's distress or traumatic symptoms (Cozza & Guimond 2011).

The following clinical example emphasizes the importance of engagement strategies, understanding of military culture and the centrality of a family-focused approach in treating military families. The therapist explained her view that initial individual sessions were important,

but was also flexible in including the whole family in later sessions when this seemed appropriate.

Clinical example: The wife of an Army officer sought family treatment after her oldest son, Matthew who had joined the Army the previous year, was severely injured in Afghanistan and returned home with a disfiguring injury. Jessie, 7 years old, was demonstrating significant traumatic responses, including having nightmares about her brother's injury. Parents agreed that Jessie would be best served if mother and all of the siblings including the injured 19 year old Matthew, 12 year old Michael and 14 year old Julie attended therapy to help Jessie "get it off her chest". The therapist asked how the siblings were helping Jessie at home. Mother said, "Not well, they make fun of her when she has nightmares and call her a big baby". The therapist reflected that it sounded like it might be hard for Jessie to share her fears with her older siblings, since she was the youngest and the older kids might make her feel like she was a baby if she talked about being afraid. Jessie's mother understood and said she could talk to her older children so they would stop teasing Jessie. The therapist said, "I wonder if it's not hard for all of your kids to see how Matthew has changed. Maybe they tease Jessie so they don't have to admit that they're scared too." Mother became tearful and said that she felt that way herself. The therapist said "Families are a wonderful source of support but sometimes it can be really hard for everyone to feel like they have to be strong for everyone else. Therapy could give Jessie a chance to express her own feelings without having to worry about that. Matthew has changed in some ways, but I'm betting that he is the same in many more ways than he has changed. By giving your kids a chance to talk about what they are afraid of—the ways he has changed—it will open the door to talking about ways that he hasn't changed." Mother seemed relieved by this and

agreed that she and Jessie would participate in TF-CBT. She then asked whether her older children might also benefit from TF-CBT. The therapist agreed to include Michael and Julie in individual TF-CBT with mother as well, so they would each have the opportunity to talk about their own reactions to Matthew's injuries. By helping Jessie's mother understand the impact of trauma on her children ("your children are all worried that their brother has changed; they are just showing it in different ways") and also emphasizing resilience ("Matthew has changed in some ways but he is still the same in many ways and your children will soon be able to talk about that"), mother was able to understand the logic of providing the initial parts of TF-CBT in a family focused manner, but with individual sessions.

The therapist focused on resilience not only through developing skills with each child, but also by using TF-CBT skills to help all family members recognize ways that Matthew had not changed. For example, Jessie used visualization to remember when Matthew first taught her to play "Go Fish." Then she practiced asking the therapist to play "Go Fish," pretending the therapist was Matthew. Finally Jessie went home and asked Matthew to play "Go Fish" with her. After weeks of Jessie avoiding being anywhere near him, Matthew was delighted that his little sister invited him to play. He told his mother, "All of a sudden I felt like she didn't notice anything was wrong with me." After Jessie and her siblings participated in individual TF-CBT and shared their confusing and upsetting feelings with the therapist and their parents, the three siblings agreed that they would like to have several family sessions. During these sessions the children shared their narratives with each other, Matthew and their parents, and this was a very emotional and healing experience for the family. The parents and children agreed that the earlier individual TF-CBT sessions were critical to the success of the conjoint family sessions.

In this example the therapist begins treatment with a child whose parent was injured during a training accident (it is important to recognize that military personnel are injured in accidents and intentional acts, e.g., suicide, assault, etc) as well as in combat). The therapist here showed critical clinical judgment and flexibility after learning that the family was to experience a Permanent Change of Station in the next several weeks, and with appropriate knowledge of the TF-CBT treatment components and available resources in the family's new community, planned TF-CBT treatment accordingly.

Clinical example: Tyrell, a 5 year old boy was living with his single service mother when she was involved in a serious fire during a training accident. She was hospitalized due to severe burns. Tyrell went to live with his maternal grandmother in a different state for 3 months while his mother recovered. Tyrell developed PTSD in response to his mother's injuries and was terrified at seeing any reminders of the fire, including returning to the military installation or seeing his mother's scars. Shortly after mother's discharge from the hospital she and Tyrell started TF-CBT at the recommendation of their therapist. However, the family was going to experience a PCS to another state two months after the initial assessment. The therapist decided it was best to only provide initial TF-CBT skills training as she realized that there would not be time to complete the entire treatment and that it would be unwise to start the trauma narrative during the disruption of the family's move. The therapist located a TF-CBT therapist close to the family's new installation and facilitated the mother and Tyrell "meeting" the new therapist via Skype (which Tyrell liked because he loved computers) in order to facilitate the treatment transfer. The therapist also encouraged the mother to begin treatment for her own accident-related PTSD symptoms, to which mother agreed after her positive experience with this

therapist. With these resources and their newly acquired TF-CBT skills, mother and Tyrell made a smooth transition to the new therapist and completed TF-CBT treatment.

The following example demonstrates the importance of integrating understanding of the child's developmental level into TF-CBT treatment for military children and sharing this in a sensitive manner with military parents who often are struggling with their own personal trauma issues following injury.

Clinical example: Mother brought 3 year old Carlos for treatment shortly after his father returned to the family's home following a near fatal combat injury in Afghanistan. Father required a double amputation, losing both legs and retaining only partial use of his dominant arm. He was hospitalized for several months far from the family's home while Carlos stayed with his maternal grandmother for several weeks so his mother could be with his father. During the hospitalization, Carlos visited his father just after he had received prosthetic legs. Mother tried to prepare Carlos telling him that "Daddy lost his legs but now he has new ones." However Carlos started crying when he saw the metal prostheses, and screamed, "No monster legs!" For weeks after this visit Carlos had nightmares about monsters chasing him, began wetting the bed, and became very clingy. At the initial assessment Carlos' father told the therapist, "What's the point of therapy? I know my son's real feelings. I'll never be a real man to him again." Father became somewhat depressed and angry at this point and for a time was less interested in participating in physical rehabilitation.

The therapist began TF-CBT by educating the parents about the impact of unexpected visual images on young children. Specifically she told the parents that any confusing or

frightening vivid image could be scary to a 3 year old. She gave the example of her own 3 year old son who had developed a phobia of ghosts one night when he mistook a bathrobe hanging in his closet for a ghost, thereafter refusing to go to bed until his mother (the therapist) checked the closet and under the bed to be sure there were no ghosts. Carlos' parents laughed in recognition and recalled a time when they had had to do a similar thing the previous year when Carlos had become afraid of monsters. In fact, the parents recalled that father had had to reassure Carlos over the phone from Afghanistan that there were no monsters in the house. This helped the father understand that Carlos' fears of monsters was a normal 3 year old fear, and not specifically related to his prosthetic legs. Father said that this made him feel better about the episode in the hospital. The therapist continued to provide TF-CBT to Carlos and his parents, emphasizing the importance of Carlos and his father spending quality time together doing things they both enjoyed. The family also benefitted from the Sesame Workshop resources Talk, Listen, Connect at <http://www.sesameworkshop.org>. Over time Carlos accommodated to his father's physical condition. In addition, his father became increasingly comfortable lifting Carlos, playing games and doing light household chores, even with the limited use of his dominant arm. Through his drawings and his transcribed words, Carlo's narrative described how he felt both scared and sad when "Daddy got hurt" and "Mommy went to the hospital without me," and later how he became "happy when Daddy came back." His wish for the future was for "Daddy to go to school and show my friends his new legs." When the therapist shared this with his parents, Carlos' father became emotional, saying that his son's narrative helped him realize that Carlos still looked up to him as a role model. During the conjoint session, the therapist read Carlos' story as Carlos sat on his father's lap. Father told Carlos that he would come to school with him and let the other kids

see how his prosthetic legs worked. Carlos' symptoms were resolved when therapy ended. Father's personal mental health adaptation was also substantially improved.

Mental illness is one of the most if not the most common wound suffered by military members who have served in the current conflict. Depression, PTSD, and/or substance abuse affect more than 20% of returning warriors (Tanielian & Jaycox, 2008). The parent with a mental health disorder typically would benefit from individual mental health treatment but in many instances is only willing to seek treatment for the child. The following case example describes TF-CBT implementation for a child whose parent has severe PTSD.

Clinical example: Tara was 9 years old when her mother, a member of the National Guard, was deployed to Iraq for the first time. Mother was deployed twice more over the subsequent four years and experienced heavy combat each time. Tara remained at home with her father. They family adjusted well, with expected concern and worry about mother. After the first two deployments the family had wonderful reunions; mother was her usual physically affectionate self. However upon return from her final deployment, mother was markedly different. She wanted to avoid all physical contact and barely kissed Tara or her husband hello. She thereafter shied away from any physical contact, eventually insisting on not being touched at all. She needed to sleep on the couch to "feel safe". Once when Tara came downstairs at night, mother confronted her with a loaded weapon, threatening to kill her. This episode terrified Tara and led to father insisting that mother relinquish the weapon. Mother often screamed at Tara or father for no apparent reason, and when they became upset, mother would break down sobbing

inconsolably. Father asked mother to seek help but she refused. Mother was increasingly restrictive of Tara, insisting that she tell mother where she was at all times, and monitoring Tara's activities with peers. Tara was afraid and angry about these changes in mother. Tara became oppositional at home and began cutting school, leading to a school mental health evaluation. Tara told the evaluator that her whole life was falling apart since mother's return and that she was afraid her mother was "brain damaged" in Iraq. She had PTSD symptoms related to mother threatening her with a gun and was referred to TF-CBT.

During the initial treatment session the therapist provided psychoeducation about child PTSD and also about combat related PTSD. Mother acknowledged that she had been exposed to combat and might have some after-effects. The therapist provided mother with written information about combat PTSD and suggested that it would be helpful for mother and therapist to help Tara understand this condition. During this discussion the therapist was struck by how guarded mother appeared. This prompted the therapist to inquire whether mother had experienced any other trauma that could contribute to PTSD symptoms. Mother became agitated and objected that this therapy was for Tara, not her. The therapist gently said, "This therapy is for Tara. She is very worried and afraid for you. Tara and your husband see changes in you since you returned from this deployment. Tara doesn't know but she instinctively senses that something bad has happened to you. She and your husband love you and they want to be here for you. It would help Tara to worry less if she understood what was going on with you." Mother agreed to think about this and to provide the written information to Tara. The therapist met with Tara (and later spoke with father on the phone) to provide psychoeducation about PTSD. Tara was relieved to recognize virtually all of mother's symptoms in the written information the therapist provided but she still felt hurt about mother's behaviors.

The therapist provided feeling identification and modulation, relaxation and cognitive coping strategies, working with Tara and her mother in individual sessions to implement these skills. Tara and mother practiced these skills at home and Tara also shared what she learned in therapy with father. Tara gained insight and empathy into her mother's condition, and her relationship with her mother improved but due to her mother's ongoing and unpredictable PTSD symptoms these gains were somewhat limited.

During an individual cognitive coping session with mother, the therapist again asked mother whether she had experienced other traumas. This time mother disclosed that she had been raped by a fellow service member during her final deployment. Because of threats the perpetrator made she had been too afraid to report it. Mother described that her combat-related PTSD symptoms had improved during Tara's treatment but she continued to have symptoms related to the rape. The therapist supported mother in talking about the rape and processed some of mother's maladaptive cognitions, e.g., "I was asking for it by joining the Army as a woman"; "It's my own fault the perpetrator wasn't punished" and "I deserve for my family to hate me.". With the therapist's support mother made the decision to invite father to the next session in order to tell him about the rape, and to plan how to tell Tara about it.

In the subsequent session father was very supportive and relieved that mother was willing to talk to someone about her problems. (Privately to the therapist he expressed extreme anger and resentment towards the Army and perpetrator and asked about possible legal recourse.) The parents agreed that they wanted to tell Tara together with the therapist about the rape. The therapist provided several psychoeducational materials about acquaintance rape for the parents to read, in order to further prepare the parents for the discussion. They met together with Tara to explain what mother had experienced. The therapist introduced the discussion using the

cognitive coping paradigm that Tara and mother had recently been using, saying, “Something happened to your mother during her last deployment. Since it happened she has been struggling with inaccurate and unhelpful thoughts, like blaming herself and thinking that no one would love her if they knew. These thoughts have affected her feelings and behavior and her relationship with you and your father. Now she understands that these thoughts were not true and she wants to talk to you about what happened.” Mother then told Tara that she had been raped by another soldier, who had threatened to hurt her physically if she reported it. Parents had been concerned that mother’s disclosure would frighten Tara but like father, Tara was very sad and outraged that this could have happened to mother, and also relieved to understand the source of mother’s symptoms. Tara spontaneously hugged her mother and started to cry; when mother held Tara and said everything would be okay, Tara said, “This is the first time you’ve hugged me since you came home.” Following this session mother agreed to begin individual treatment.

Tara created a trauma narrative which described the above events. Tara also cognitively processed her relationship with her mother in light of her evolving understanding of what her mother had experienced. For example, initially Tara’s narrative described anger at mother for intruding in her peer relationships; in retrospect Tara was able to say that “I can see now that mom was afraid that someone would hurt me like she had been hurt; she just wanted to protect me and didn’t know how to talk to me about it.” Tara shared the narrative with both parents and this introduced the TF-CBT safety component. Mother, father and Tara together developed rules that allowed Tara reasonable age-appropriate privileges while incorporating important safety awareness. When TF-CBT treatment ended Tara was doing well; mother continued to be involved in her own treatment.

TF-CBT for traumatic grief: Service members may die in combat, in accidents (training accidents or other types), or through suicide or homicide. Suicide is increasingly a concern for the military. Veteran suicides have recently reached an unprecedented rate of 19 per day with Active Duty suicides also on the rise. Once a service member dies, the Active Duty military family experiences not only the loss of the military member, but also (unless the other parent is also a member of the military) the loss of the extended military “family” that is experienced from living among and attending school with other Active Duty military families. Suddenly the family is different from all of their military peers: they must move out of military housing (within one year), receive a different identification card, and in some cases, lose income, health and other benefits of Active Duty military family members. Often the family moves away from the installation to live close to civilian relatives; in this case the children often have no other military peers who understand their previous experiences as a military child or their military bereavement. When a Reserve or National Guard service member dies, the extended family and friends may not understand or in some cases may not even support the military mission for which the deceased service member sacrificed his life. This can lead to increased isolation at a time when bereaved children and families are in most need of support and understanding.

To date, no scientific studies have definitely examined the unique impact of military-related death on children. While preliminary evidence suggest that there may be no differences between military and civilian child grief (Cozza, Ortiz, Fullerton et al., 2011), the violent nature of many military deaths may lead to additional risk to military children of developing child traumatic grief. Therapists working with bereaved military families must be skilled in diagnosing

this condition. Therapists should also become familiar with military rituals related to service members' deaths and how these rituals can contribute to trauma and loss reminders. Children and families may have difficulty recalling these details long after the death, making it difficult for therapists to connect such rituals to trauma cues.

Clinical example: Laura was 15 when her father, a National Guardsman, died during his second deployment to Iraq. Laura was called home from band practice when the death notification occurred. She didn't tell her friends what happened because she was "in shock", but she ran all the way home. When she got home her mother was crying hysterically with two uniformed officers trying to comfort her. Laura told them to leave. Immediately following notification, local news reported started calling and Laura stopped answering the phone. Mother agreed to her deceased husband's parents' request for a military funeral (paternal grandfather was a retired service member). Although her paternal grandparents and younger brothers seemed to appreciate the military rituals at the funeral, Laura was angered by the presence of so many uniformed military members who reminded her of the death notification officers and worried that these uniforms would upset her mother, who was still crying much of the time. Indeed, Laura's mother did cry when she was handed the folded flag and when Taps was played. Laura wanted to leave but her paternal grandparents insisted that the family stay and speak to all of the guests. When they were leaving Laura saw protesters with signs reading "The only good soldier is a dead soldier." Mother started sobbing when she saw these protesters and Laura was so furious that she refused to ever return to the cemetery. Later, Laura became irritable and left the room whenever anyone mentioned her father and she refused to talk about his death to her friends. Laura's maternal grandmother insisted that her daughter bring Laura for an evaluation.

During the evaluation the therapist confirmed that Laura met criteria for military child traumatic grief. TF-CBT for Laura required skills for coping with military-specific trauma and loss reminders. For example, media coverage of combat activities that included political opinions against the war, which previously would have been only of minor interest to Laura, aroused extreme anger since it triggered trauma and loss reminders. During the affective modulation component Laura acknowledged that it was hard not being able to talk to her friends about how she felt, because they didn't get what it was like to be partly military, partly civilian. Her therapist suggested that Laura attend a regional TAPS Camp (www.taps.org) and Laura and her mother did so. This was a turning point for Laura, who met other bereaved National Guard and Reserve teens who felt similarly to her. Laura's mother also met several women at the TAPS Camp to whom she related well. Laura and her mother worked through the trauma narrative and bereavement-focused components of TF-CBT with positive results.

TF-CBT for Family Violence

Generally, TF-CBT is provided to military children in a similar manner as to civilian children; however therapists who work with military children must understand the potential impact of military life and culture on the meaning and practical impact of child or family maltreatment. When child maltreatment or domestic violence is reported on military installations it is investigated by the installation's Family Advocacy Program (FAP), the military equivalent of a civilian Child Advocacy Center (CAC). The military takes child abuse and family violence charges very seriously and as described above, the alleged perpetrator may lose military rank, income and housing as well as receiving a prison term. Abused military children or partners also face potential risks in making such allegations. Due to the close and supportive nature of most military communities, an investigation of this nature is more likely to become general knowledge than in a civilian setting. The resulting loss of privacy, questioning at school by peers, taking of sides, etc may lead families to request transfer. The hierarchical nature of the military may also impact some children's beliefs about the abuse (or willingness to disclose), for example if the perpetrator had a superior rank to the child's military family member, the child may be concerned about damaging his family member's military career. The child's developmental ability to differentiate the perpetrator's manipulative statements from fact may also influence the child's beliefs in this regard. TF-CBT therapists must inquire about and address these military-related issues in TF-CBT treatment for military children.

Clinical Example: Six year old TJ and her best friend Ally attended the same school and often slept over at each other's houses. TJ's father was a Reservist under Ally's stepfather. TJ's

father was deployed to Afghanistan but due to an injury Ally's father did not go. During a sleepover at Ally's house, Ally's stepfather came into Ally's room and began to sexually abuse her. During a phone call TJ asked her father if he always had to do what Ally's father said. Her father said, "That's the Army, you have to follow orders." TJ took this to mean that she had to do what Ally's father told her to do or he would get in trouble. The sexual abuse continued for several months. Upon her father's return TJ asked if he could leave the Army. TJ then said, "I don't like to follow John's orders" and upon further questioning, disclosed the sexual abuse. She had been afraid that not obeying would get her father in trouble when he was in Afghanistan.

Another clinical issue that often arises in military families is the need to include multiple different parents or caregivers, as described above. Due to deployment, changes in custody due to allegations of abuse, parental injury or death, the therapist may need to be more flexible when treating military families with regard to which caregiver to include during TF-CBT treatment. This may involve having additional parental sessions in order to get the new parent "caught up" with TF-CBT components that have already been provided to the child and a previous participating parent. Such flexibility will go a long way in engaging military families in this treatment and in serving the military child's best interests.

Clinical Example: Eight year old Kelly lived near an Army base with her mother and mother's live-in boyfriend, Dwayne, both active duty service members. Kelly also had ongoing contact with her biological father, a service member who was deployed to Iraq. A teacher reported Kelly to the local Family Advocacy Program after seeing suspicious bruises on her arm. During the FAP interview Kelly acknowledged that she had gotten bruised by trying to stop

Dwayne from hitting her mother. This led to Kelly disclosing domestic violence perpetrated by Dwayne toward her mother. Kelly's mother minimized these allegations at first and Dwayne was not charged but the couple separated and Dwayne was transferred to another base. Mother participated in TF-CBT with Kelly and received her own treatment. During the skills-based sessions the family heard that Dwayne had been deployed to Afghanistan. Kelly was already worried about her own father's safety and this news triggered Kelly's feelings of guilt about disclosing the domestic violence because she believed she was responsible for Dwayne being deployed. The therapist addressed this maladaptive cognition through cognitive coping (e.g., if Dwayne hadn't perpetrated the domestic violence, Kelly could not have disclosed it, so it was Dwayne who was responsible for what happened, not Kelly). Kelly asked whether her father could participate in some sessions via Skype. Mother was apprehensive at first, since she was afraid that father would blame her for what had happened to Kelly. The therapist addressed this with the mother (i.e., mother and Kelly were both victims) and the therapist spoke with father about participating in treatment. Although he was upset, Kelly's father was very invested in supporting his daughter in treatment. Father participated intermittently via Skype and e-mailed supportive messages and praise to his daughter and over time these expressions of support also included his ex-wife. Father asked for special permission to be sure he was able to participate in the conjoint session at which time Kelly shared her trauma narrative with both parents. During this session father told Kelly that she was a hero in his eyes for having revealed the domestic violence.

The following example illustrates many of the issues related to implementing TF-CBT in cases of military child abuse.

Clinical example: Ann was 9 years old when her father, an Army officer, returned from combat deployment to his home Army installation. Ann had experienced minor anxiety problems during her father's absence but was excitedly looking forward to his return. Family reintegration went smoothly, with the family quickly accommodating to new routines with the father's return, getting together with other close friends and families that had also experienced reunions, and comforting the families of a few families who had experienced losses, including one close friend of Ann's whose father had died. Initially all seemed to be going well, but a few months after the family reunion Ann developed sleep problems, nightmares and school refusal, insisting that she was sick on school mornings, often returning home from school with a terrible stomach ache. She was also throwing tantrums and refusing to follow rules at home, playing one parent against the other, and fighting with her younger sister. With the family's agreement, the school decided not to send Ann home when she complained of stomach aches, but to allow her to go to the nurse's office. One day the school nurse noticed that while Ann was lying on a cot with a stomach ache, she was shaking under the blanket. The nurse asked Ann to sit up so that she could check her temperature. Ann started sobbing. The nurse asked her what was wrong and Ann showed the nurse her underpants, which were blood stained. The nurse asked Ann whether someone had hurt her and Ann nodded her head yes. The nurse called Ann's mother and reported this incident to the FAP on post. Ann was examined by a military pediatrician and at the FAP later that day.

At the FAP Ann reported that her father's friend "Uncle Joe", a very well-liked member of her father's unit, had been sexually abusing her since shortly after the family's arrival at the current installation 2 years prior. The abuse had stopped when father and Uncle Joe were

deployed to Iraq, but had restarted when the men had returned from Iraq and about a month ago Uncle Joe had begun forcibly raping Ann. Uncle Joe told Ann that if she told anyone about this he would not be able to help soldiers like her daddy win the war, and it would all be her fault. Ann was scared that her disclosure would make her country lose the war, or that Uncle Joe would no longer help her father or be their family friend. She tearfully said, “I’m sorry but I had to tell.” Physical findings confirmed Ann’s report and charges against Joe were prepared.

Ann’s parents were devastated and furious when they heard about what Ann had reported. Ann and her parents were referred for TF-CBT treatment and parents were eager to participate. Parents were preoccupied about how to proceed in terms of the criminal charges, and at the initial evaluation were very focused on asking the therapist questions such as, “will it be helpful or harmful for Ann to testify against Joe”; and “should we try to get transferred so she doesn’t run into people who know about this?” Ann endorsed significant symptoms of PTSD and anxiety about what her disclosure would do to her father and her family, as well as how her friends and other parents in the community would respond to her allegation. Her UCLA PTSD RI score was 57, in the severe range.

Ann’s parents were very supportive and determined to do whatever was in Ann’s best interests. The therapist began TF-CBT by providing useful information to the family, for example, she emphasized how important the parents’ support was to Ann’s positive recovery (Cohen & Mannarino, 2000; 1998). The therapist also normalized Ann’s experience by informing parents that rates of sexual abuse in military girls appears similar to rates in civilian communities; one out of four girls experience sexual abuse. Although shocked, parents were also relieved that their daughter was not alone in this regard. The therapist also emphasized that Ann disclosed the abuse soon after it occurred, and that this was a credit to Ann’s trust in her parents

despite the huge guilt that the perpetrator had attempted to instill in her. Parents asked, “If this was the case, why didn’t she tell us instead of the nurse?” The therapist helped the parents understand common responses and concerns of children who have experienced sexual abuse, including the desire to protect the people they love most, i.e., their parents. In Ann’s case, feelings of loyalty, concerns about military mission and Joe’s popularity in his unit and the community likely made these feelings even stronger. Parents understood and seemed comforted by this explanation.

The therapist then provided TF-CBT skills components to Ann and her parents. For relaxation, the therapist started by asking Ann what activities she really liked. Ann said she liked to sing, dance, collect butterfly stickers and play with her friends. Based on this information, the therapist and Ann designed several relaxation strategies for different settings: for falling asleep, Ann would imagine a butterfly gently fluttering its wings until it slowly, slowly landed in a bed of grass. Ann practiced this with the therapist and then with her mother and later reported that this visual image helped her fall asleep. In order to improve school attendance, Ann imagined herself dancing across a beach, while relaxing each part of her body. For times when she had intrusive and scary thoughts about the sexual abuse, Ann agreed to sing her favorite song in her head or out loud (depending on the situation) in order to calm herself down. Parents practiced this with her in the session and agreed to reinforce this with her at home. They also spoke with the school nurse and Ann’s home room teacher about how to reinforce these skills in school.

The therapist also taught Ann’s mother and father important skills to optimize their parenting. For example, both parents were tempted to overindulge Ann following the sexual abuse disclosure, because they felt guilty about not knowing that this was occurring and father in particular felt personally responsible for exposing Ann to the perpetrator. The therapist helped

the parents understand that Ann needed to know that her parents did not see her as “damaged” and that all children need reasonable limits and rules in order to develop appropriate behavioral regulation. This was reassuring to parents and consistent with their military respect for predictable structure and rules. They were further reassured when Ann’s behavior problems improved. Parents worked with the school to institute an in vivo plan to get Ann back to school (described below).

Ann could express a range of feelings (e.g., mad, sad, happy, frustrated, annoyed, excited, etc) but she believed it was her job to help her mother when her father was deployed, and had mistakenly assumed that she should not talk about or need help with negative feelings. The therapist asked her, “What are you supposed to do with bad feelings?” Ann replied, “Just make it go away.” The therapist clarified that sometimes this doesn’t work, making feelings too big to handle on our own and that it might be better to ask our parents for help. Ann said, “But then Mommy will have too much to handle.” The therapist said, “When Mommy and Daddy say they want you to help out, they mean like helping with the dishes or helping your sister get dressed in the morning. They don’t mean by ignoring big problems or worries. Mommies’ and daddies’ jobs are to help kids with their problems. If you don’t believe me, let’s go and ask them, okay?” Ann was reticent to ask her parents, but the therapist insisted. Ann’s parents very clearly told Ann that they did not want her to keep worries or problems to herself. They explained that they were her parents, and while they appreciated all of her help, they wanted her to be a child, not another grown up. Ann hugged her mother and said, “Okay Mommy”. Together the parents, Ann and the therapist then designed several affective modulation strategies for Ann, including seeking support from parents, spending time with peers, distraction through enjoyable activities such as dance and music, and self-soothing activities such as crafts and physical activities.

Mother particularly reinforced these when Ann had intrusive reminders about the sexual abuse, such as when she was in places or situations where Joe abused her.

Cognitive coping was a very important component for this family since many people on the base learned about the allegations. Joe was a well known and well-liked member of the community and the family encountered gossip about Ann's abuse allegations. People "took sides" and many people did not believe Ann's disclosure. The parents felt ostracized by many of their former friends, leading Ann to feel like she "caused a lot of trouble for my family". At one point Ann told her mother that "I don't know if it really happened. Maybe I just dreamed it." Mother called the therapist crying, saying, "How could she say that, after all we're going through?" The therapist said, "That may be exactly why she said it. Your daughter loves you so much she would try to do anything to keep you from pain." Ann's parents decided that her father should request a transfer. Father even considered leaving the military service since he felt disillusioned that some of his colleagues disbelieved what had happened to his family. The therapist helped the parents reexamine this by asking "Before, when you were so close to Joe, if another child had accused him of sexual abuse and you didn't know all of the information you know from Ann's perspective, would you have automatically believed it?" Parents were able to see that other people had heard a lot of inaccurate gossip (some of it distorted information provided by Joe and his friends). Ann's family had been instructed not to talk about her situation since she might have to testify in the future, so they had not been able to defend themselves with their version of the events. Ann's parents were able to change their thoughts from "some of our military friends have deserted us" to "they don't know the facts", and this helped them to feel even more supported by the friends who had stuck by them even without knowing all of the details of the situation.

In Ann's trauma narrative she included the additional information that Uncle Joe had threatened to sexually abuse her 3 year old sister Emma if she ever disclosed the abuse. Ann said, "After he did that (the rape) the first time, I tried not to go to school so he couldn't hurt Emma (Emma did not yet attend school). When the nurse wouldn't let me go home I knew I had to tell. He might go to my house when I was at school and do it to her." When the therapist shared this part of Ann's narrative with the parents during their parallel individual sessions they both became tearful as they realized that Ann's school refusal and her disclosure had been attempts to protect her younger sister.

The therapist had been instituting in vivo mastery to help Ann return to school. However, this had only been moderately successful, due to Ann's unexpressed worries about Joe abusing Emma. Once Joe was arrested (a process that took several weeks) Ann was more confident about returning to school and her school refusal diminished.

During the conjoint child-parent sessions Ann shared her narrative. Her father was extremely helpful by reinforcing Ann's new cognitions. For example, father told Ann during this session, "Joe's job was to take care of his soldiers. Instead of doing that he abused one of our children. He hurt our soldiers. By telling the truth about him you helped every soldier in the Army. You made our Army stronger." The family worked together to develop a safety plan and Ann asked if Emma could also be included. Parents, Ann and Emma used the "What do you Know?" game (UMDNJ, 2000) and age-appropriate healthy sexuality education. At the end of treatment Ann's RI score was 12 (in the normal range).

Summary

Military children and families face many challenges resulting from the duties of their military service member parents, siblings and other family members. Since the start of combat operations in 2001, military families have been faced with multiple combat deployments that have resulted increased levels of distress in children and adults. In circumstances of complicated deployment, combat exposure may lead to the development of combat related stress disorders (PTSD, depression, anxiety and substance use disorders), combat injuries (including TBI), and in the most severe circumstances military family member death. Military children and families are typically healthy and they face these deployment-related challenges with strength and resilience. However, effort to mitigate distress is an important goal of community, family and individual prevention and intervention strategies. TF-CBT provides useful skills and strategies that can assist military families manage successfully. When stresses are of a traumatic level, TF-CBT should be a critical component of the care of military children and families, given the evidence of its success in treating traumatic disorders. Clinicians who are unfamiliar with military communities can benefit from further understanding about military children and families, their unique strengths and the unique challenges that they face, in order to more successfully implement treatments.

Resources for Military Families

Understanding post-deployment stress symptoms: available at http://www.cstsonline.org/wp-content/resources/CSTS_understanding_postdeployment_stress_symptoms.pdf

Information about children of wounded warriors:

<http://blogs.extension.org/militaryfamilies/2011/11/14/children-of-wounded-warriors-guidance-for-caregivers/>

Information about military child abuse: <http://www.militaryhomefront.dod.mil/tf/childabuse>

Information sheet about Military childhood traumatic grief for families:

http://www.nctsn.org/nctsn_assets/pdfs/Military_Grief_Families_final3.pdf

Sesame Street online, print and video resources

Talk Listen Connect: Helping Families during Military Deployments (TLC 1)

Talk Listen Connect: Deployments, Homecomings and Changes (TLC 2)

Talk Listen Connect: When Children Grieve (TLC 3)

Available at <http://www.sesamestreet.org/parents/topicsandactivities/toolkits/tlc>

Resources for Mental Health Professionals

Traumatic grief information sheet for professionals:

http://www.nctsn.org/nctsn_assets/pdfs/reports/childhood_traumatic_grief.pdf

Child sexual abuse fact sheet for parents:

http://www.nctsn.org/nctsn_assets/pdfs/caring/ChildSexualAbuseFactSheet.pdf

TF-CBT Web: Free training website offers 10 free CE credits: available at www.musc.edu/tfcbt

CTG Web: Free training website to implement TF-CBT for childhood traumatic grief offers 6 free CE credits: available at www.musc.edu/ctg

TF-CBT Consult: Free consultation product for mental health professionals regarding TF-CBT implementation: available at www.musc.edu/tfcbtconsult

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