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Implementing Trauma-Focused CBT for Children of Veterans in the VA: Providing Comprehensive Services to Veterans and Their Families

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Abstract

Military families experience unique stressful circumstances such as frequent moves, service-related physical and mental health difficulties, and separation from support. Although many families exhibit high resilience in response to these stressors, military children are at an increased risk for emotional and behavioral difficulties, exposure to intimate partner violence, and child maltreatment. These potential problems not only affect child functioning, but often also negatively impact family and veteran outcomes. Although the Department of Defense has enhanced efforts to address child and family trauma among military families, many veterans' families are still not receiving timely, evidence-based treatment. With many veterans receiving care through Veterans Affairs (VA) medical centers, incorporating family treatment into VA services is important for promoting optimal veteran outcomes. Trauma-focused cognitive-behavioral therapy (TF-CBT) has been used successfully for civilian and military children exposed to trauma including child maltreatment, intimate partner violence, and traumatic grief. This article reviews research regarding veterans' mental health, child and family functioning, and parenting, and highlights the value of implementing TF-CBT in the VA given its family and-resilience-focused structure, strong empirical support, and flexible delivery model. Strengths of delivering TF-CBT in the VA (e.g., provision of trauma services for families where veterans are already receiving care, family education about trauma), as well as implementation barriers (e.g., VA policy regarding veteran-focused treatment, reduced facility resources) are discussed. Finally, future research directions are proposed, including mixed-methods research with veterans' families to investigate the effectiveness and feasibility of TF-CBT dissemination within VA facilities.

Keywords

veterans; trauma-focused CBT; parenting; family services

Over two million U.S. veterans and their families have been impacted by recent military conflicts, Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). Deployments continue to place service members and families in uniquely stressful circumstances such as frequent moves, separation from support, traumatic brain injuries (TBI), other physical injuries, and mental health difficulties, such as posttraumatic stress disorder (PTSD) and depression (Hoge, Auchterlonie, & Milliken, 2006; Tanielian & Jaycox, 2008; The National Child Traumatic Stress Network, 2016). The effects of these difficulties also significantly impact their families, as 83% of service members have children under the age of 20 (Shiffer, & Maury, 2015).

With so many children in military families, it is important to consider how these service-related difficulties influence their functioning. These children are exposed to a number of unique challenges including separation from a caregiver who may be exposed to dangerous situations, frequent role and relationship changes, and health problems among at-home or military-connected caregivers. In addition to potential increases in child anxiety and mood problems, social adjustment difficulties, and disruptions in attachment relationships (Lester et al., 2016), service-related challenges place military children at heightened risk for traumatic experiences including witnessing intimate partner violence (IPV) among caregivers (Ruscio, Weathers, King, & King, 2002; Taft, Watkins, Stafford, Street, & Monson, 2011), child maltreatment (Rentz et al., 2007), and other dangers that may occur during reduced supervision. Thus, it is important that these children and families have adequate access to evidence-based services to identify and address trauma symptoms. The purpose of this article is to (a) provide a more detailed review of the impacts of stressors unique to military families, (b) discuss evidence-based treatment services for military and veteran families, and (c) introduce trauma-focused cognitive-behavioral therapy (TF-CBT) as a useful protocol for veteran families to be implemented in VA family clinics.

Family Difficulties Among Military Service Members

Family difficulties among military family members are complex and lead from dysfunctional emotional functioning of the military parent, to emotional functioning of the partner, which can lead into IPV, general family functioning, than parenting difficulties, child maltreatment, and child emotional and behavioral problems. It is difficult to piece apart these constructs, given that they are overlapping and impact one another cross-sectionally and longitudinally.

Service-Related Effects on Child and Veteran Functioning

Although many families exhibit high rates of resilience, military children are more likely to experience emotional and behavioral difficulties (Lester et al., 2016), exposure to IPV (Ruscio et al., 2002), and child maltreatment (Rentz et al., 2007). Children with a deployed parent have more child mental health outpatient visits (Gorman, Eide, & Hisle-Gorman, 2010), higher internalizing and externalizing symptoms (Chartrand, Frank, White, & Shope,

2008), and more psychosocial difficulties (Flake, Davis, Johnson, & Middleton, 2009) compared to military children without a deployed parent. These difficulties in functioning often persist once deployment has ended (Lester et al., 2010). The link between parenting difficulties and parental mental health problems is well established in the literature (e.g., Ammerman, Putnam, Chard, Stevens, & Van Ginkel, 2012; Dix & Meunier, 2009; Field et al., 2007; Pelaez, Field, Pickens, & Hart, 2008). There is a significant bidirectional relationship between child behavior problems and parenting stress (Neece, Green, & Baker, 2012), which is particularly important given the negative impact of parenting stress on adult outcomes including depression, separation anxiety, personality disorders, substance use, and marital discord (Deater-Deckard, 2008). This association is also documented among veterans, with mental health problems (e.g., PTSD) being associated with poorer parenting skills and lower parenting satisfaction (Berz, Taft, Watkins, & Monson, 2008; Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010).

Further, poorer family functioning often negatively influences PTSD treatment outcomes in veterans (Evans, Cowlshaw, Forbes, Parslow, & Lewis, 2010). Longitudinal data suggest that lower family functioning ratings at baseline significantly predict higher levels of PTSD symptoms following treatment (Evans et al., 2010). One likely explanation for this association is the impact of service-related difficulties on parenting among veterans and their spouses (Gewirtz et al., 2010). Caregiver mental health problems, child emotional and behavioral difficulties, and parenting abilities demonstrate a reciprocal relation, suggesting the need for interventions aimed at improving parenting abilities among affected veterans.

Service-Related Effects on Parenting

Mental health problems commonly manifest in veterans by disengagement from parenting problems with affect and behavior regulation (Field et al., 2007) and emotional numbing and avoidance (Ruscio et al., 2002). Veterans with PTSD and/or depression also often experience negative cognitions and mood, causing them to feel isolated from their families, numb when interacting with or holding their child (Sherman, Gress Smith, Straits-Troster, Larsen, & Gewirtz, 2016). Consequences of these symptoms may include lack of child supervision, IPV in the presence of children, and harsh discipline strategies (Gibbs, Martin, Kupper, & Johnson, 2007; McCarroll et al., 2000; Rentz et al., 2007).

Family Violence Among Veteran Families

Child maltreatment.

The number of military members has increased in the last two decades, with over two million service members serving in OEF, OIF, and OND. Rates of child abuse and neglect have also increased among military families, with significant heightened rates during periods of heavy conflict (OEF, OIF, Operation Desert Storm; McCarroll, Ursano, Fan, & Newby, 2008). Upsurges in rates and severity of child maltreatment are particularly salient during deployments, with rates more than three times higher (Gibbs et al., 2007; Rentz et al., 2007). Neglect is the most common form of maltreatment among military families, followed by physical abuse. Severity of child abuse and neglect also increases during deployment, as moderate to severe maltreatment is found to be 60% greater during deployment compared to

when not deployed (Gibbs et al., 2007). With partners of service members experiencing increased anxiety and sleep problems among other stressors, their ability to provide adequate supervision and care for their children may be compromised. It is plausible that these stressors contribute to the finding that child maltreatment occurs more frequently in military than nonmilitary families, particularly during or immediately following deployment (Gibbs et al., 2007; Rentz et al., 2007).

IPV.

In addition to child maltreatment, IPV rates are higher in military compared to civilian families (Taft et al., 2011). Children exposed to IPV are more likely to demonstrate adjustment difficulties including internalizing and externalizing symptoms and posttraumatic stress symptoms compared to children not exposed to IPV (Blair, McFarlane, Nava, Gilroy, & Maddoux, 2015; Ehrensaft, Knous-Westfall, & Cohen, 2017). PTSD symptoms specifically are linked to initiation of IPV (Taft et al., 2009), a noteworthy finding given that most U.S. service members have children who may then be exposed to IPV (Shiffer & Maury, 2015). In addition, approximately 30–60% of military families reporting IPV also reporting child maltreatment (The National Child Traumatic Stress Network, 2016). Higher rates of family violence among military families place them at greater risk of mental and physical health problems over time, highlighting the importance of early assessment and treatment of trauma-related issues for the entire family system. Given the additional indirect impact that stressors to the family have on the service member, treating the family system could arguably be as important as treating the individual.

Evidence-Based Treatment for Military Families

Family Treatment in the VA

Enhanced access to child and family services for veterans' families is warranted to help mitigate the reciprocal negative impacts of child and parenting problems on veteran outcomes. These services can be provided at the VA to meet the needs of veterans and their families. Although the VA is progressing in terms of incorporating couples and family therapy into mental health care, (e.g., Doss et al., 2012; Rowe, Doss, Hsueh, Libet, & Mitchell, 2011), much of the focus is on couples therapy specifically. This is likely due to lack of knowledge of services, lack of evidence-based child/family treatment, and few family clinics in VA facilities across the country.

Call for more family services.—Since 2008, VA medical centers are in fact required to offer family education/psychoeducation and consultation, as well as couples and family therapy (U.S. Department of Veterans Affairs, Veterans Health Administration, 2008). However, veterans continue to express a desire to incorporate greater family involvement in VA care, and also that family members would prefer more involvement in treatment (Batten et al., 2009; Fischer et al., 2015; Khaylis, Polusny, Erbes, Gewirtz, & Rath, 2011; Meis et al., 2013).

Extant data suggests that both veterans and partners would like to improve communication with family members (87.2%), to better understand the issues (80.9%), and to improve

relationships with their children (63.8%; Fischer et al., 2015). Among veterans and their family members, 14.5% requested parenting-related skills, 20.5% wanted increased support for family members, and 26.5% hoped for enhancement of family perspective on veterans' experience (Fischer et al., 2015). Despite the practice guidelines' increased emphasis on family involvement (Foa, Keane, & Friedman, 2009; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2010) and strengthened efforts to implement this (Glynn, 2013), many veterans' family functioning issues remain unaddressed and family programs remain underused (Institute of Medicine, 2014; Meis et al., 2013).

Military family treatment protocols.—Wood and colleagues (2017) found that among children of U.S. Army members from 2004 to 2007, only 20% of families with a child maltreatment diagnosis also had a substantiated report to the agency responsible for identifying and reporting IPV and child maltreatment among military families, the Family Advocacy Program (FAP). Although it is possible that only 20% of these cases were substantiated by the FAP, the average substantiation rate for overall child maltreatment reports to the FAP is more than double this number, suggesting that a large number of cases involving child abuse and neglect are not being adequately reported. More consistent and adequate reporting of maltreatment could strengthen family connections to appropriate services, however, the low rates of reporting and referring families out of the VA system for care results in failure to activate this resource.

Enhancing implementation of family services within the VA would allow for more timely assessment and intervention of child and family trauma-related issues. In fact, Pemberton, Kramer, Borrego, and Owen (2013) call specifically for implementation of evidence-based parenting interventions, such as parent-child interaction therapy (PCIT), for veterans and their children within VA facilities. Using such interventions within the VA provides a number of benefits for the veteran, including improved mental health, enhanced parenting skills, decreased stress, and strengthened relationship and family functioning. Other evidence-based treatments are also used with military and veteran families, such as Behavioral Family Therapy for Serious Mental Illness and the Support and Family Education Program (SAFE). See Table 1 for a list of additional evidence-based protocols. However, although we fully support integration of these interventions to veteran's care, they do not directly address children's trauma-related symptoms which impact veteran's individual and family functioning. To address this need, we propose that implementation of evidence-based child trauma protocols, such as trauma-focused cognitive behavioral therapy (TF-CBT), in family clinics within the VA is an important next step to provide comprehensive veteran and family care. Potential positive impacts, challenges, and future research directions are discussed.

Trauma-Focused Treatment for Military Families

Trauma-Focused Cognitive Behavioral Therapy

Although children are often resilient in the face of trauma, some develop related symptoms, including reexperiencing the event (e.g., nightmares, flashbacks, trauma-specific reenactment during play), avoiding reminders of the trauma, changes in thoughts or mood

following the trauma (e.g., negative thoughts/feelings leading to self or other blame, diminished interest in school or extracurricular activities), and hyperarousal (e.g., irritability, aggression, sleep disturbance). TF-CBT is an evidence-based treatment aimed at addressing these symptoms, among others, for children and adolescents ages 3 to 17 exposed to a range of traumatic events including abuse or neglect, witnessing IPV, traumatic grief, and natural disasters (Cohen, Mannarino, & Deblinger, 2010).

Approximately 15 randomized controlled trials and numerous research studies provide the strongest empirical support for TF-CBT compared to other trauma-focused treatments for children and families (e.g., Cohen & Mannarino, 2017; Pollio, McLean, Behl, & Deblinger, 2014). Specifically, TF-CBT is significantly associated with reductions in child behavior problems, decreased child symptoms of PTSD and depression, and diminished feelings of shame. Regarding improvements in parents, TF-CBT is linked to reduced parental depression and PTSD symptoms, attenuated emotional distress, and strengthened ability to support their children (Cohen, Deblinger, Mannarino, & Steer, 2004). Thus, TF-CBT would likely be useful particularly among veterans' families given their risk for heightened mental health problems, stress, child maltreatment, and IPV. In addition to research supporting use of TF-CBT for civilian children exposed to trauma, it has been argued that TF-CBT is also particularly useful for bereaved military children experiencing traumatic grief (Cohen & Mannarino, 2011). This provides support for the use of TF-CBT with children and families of veterans, and the need to tailor the intervention's components to reflect the unique circumstances of the military family.

Trauma-Informed Care in the VA System

Significant attention over the past two decades has focused on increasing efforts to address traumatic stress among children and families, with multiple federal agencies dedicating specific initiatives and funding to examining the impact of trauma (The National Child Traumatic Stress Network, 2007; Substance Abuse and Mental Health Services Administration, 2011). Specifically, agencies have adopted practices such as “trauma-informed care” (TIC) highlighting the prevalence and effects of trauma exposure (Hanson & Lang, 2016). This concept endorses best methods for supporting children and families exposed to trauma, in an attempt to address child trauma earlier and more effectively, resulting in improved outcomes, more efficient services, and reduced cost. Overall, an organization's commitment to TIC is critical to addressing the impact of trauma on children and families. Importantly, the VA's commitment to TIC, via encouragement of TF-CBT and other trauma-focused efforts, is integral to improving outcomes for children and families.

Tailoring TF-CBT to Veterans' Families

Psychoeducation.—The first component of TF-CBT provides an overview of TF-CBT (i.e., frequency, duration) and the critical role of the caregiver throughout trauma, as well as psychoeducation to the child and caregivers. This piece is important for helping parents understand their children's behavior and emotional responses in the context of trauma and serves as an appropriate first step toward more effectively supporting their child and addressing child behavior. Psychoeducation may be particularly beneficial for veterans with trauma histories because research suggests that many people with PTSD lack sufficient

education about trauma, its symptoms, and effective treatment for the disorder (Harik, Matteo, Hermann, & Hamblen, 2017).

Parenting skills.—Once caregivers have received education related to their child’s trauma and associated symptoms, they learn how to effectively address them while simultaneously enhancing parental support and the parent–child relationship. During the “parenting skills” phase of treatment, behavioral management strategies are taught to address common trauma-related behavioral problems, and to enhance the caregiver’s general parenting knowledge and skills. They are also reminded that children’s behavior problems often co-occur with trauma symptoms and are maintained by environmental rewards and may be inadvertently reinforced through parental inconsistency and lack of expectations.

This treatment component is particularly important when implementing TF-CBT in the VA, given the link between mental health problems, decreased parenting skills, and decreased parenting satisfaction (Berz et al., 2008; Gewirtz et al., 2010; Solomon, Debby-Aharon, Zerach, & Horesh, 2011). Specifically, avoidance and emotional numbing symptoms impede the ability to establish and maintain positive emotional connections and interactions with their children (Paris, DeVoe, Ross, & Acker, 2010; Ruscio et al., 2002). In addition, veterans reporting hypervigilance may exhibit lower tolerance for children playing loudly and/or arguments between siblings, which may be exacerbated during public outings or crowded areas. The effects of combat-related PTSD and traumatic brain injury may also manifest as unpredictable parental behaviors such as irritability and angering easily, causing increased child distress, particularly for those with trauma histories. These patterns would be thoroughly assessed and addressed in the early phases of TF-CBT, with in-house referrals to individual treatment as needed.

The parenting skills component is also beneficial for veterans without physical/mental health difficulties, as the negative impact of deployment alone on child and family outcomes has been well documented (Gorman et al., 2010; Lester et al., 2016). These findings suggest that education regarding the potential impacts of deployment on child and family functioning is warranted, as well as discussions concerning methods to enhance the parent–child relationship and appropriately address behavioral issues.

Veterans may also benefit from enhancing parenting skills due to the possible influence of military training on child rearing. Although strict and sometimes punitive contingency plans are adaptive in military culture and can lead to successful, safe outcomes, these tactics may not be developmentally appropriate or realistic for children, particularly those with trauma histories. A combination of education about developmentally appropriate norms with strengthened emotional communication skills and behavior management strategies is respectfully provided to veterans to enhance safety and parent–child interactions.

Relaxation.—During the relaxation component, skills such as controlled breathing, progressive muscle relaxation, and mindfulness and meditation are taught to assist children in managing the physiological manifestations of fear and anxiety (e.g., increased heart rate, hyperarousal, and sleep disturbances). Children are encouraged to teach their caregivers relaxation skills during the joint sessions, so that strategies can be practiced throughout the

week. Although relaxation techniques are often useful for all individuals faced with stress, they may be particularly advantageous for veterans and their families given the unique and increased stressors they frequently encounter.

Affective and cognitive coping skills.—After psychoeducation, parenting skills, and relaxation are provided, two components addressing coping skills, including affective identification and modulation and cognitive coping techniques, are introduced and practiced with the child. These skills allow the child to recognize physiological, emotional, cognitive, and behavioral reactions to stress and subsequently apply skills learned in the relaxation component to decrease the body's alarm reaction. These treatment components are beneficial not only for the child's individual functioning, but also for parental and family functioning as well.

Veterans with PTSD and/or depression often exhibit significant difficulty with expressive flexibility of emotions (Rodin et al., 2017), with individuals with PTSD and/or depression reporting difficulty enduring and regulating negative emotions and tendencies toward rumination and catastrophizing (Ehring, Fischer, Schnulle, Bösterling, & Tuschen-Caffier, 2008; Ehring, Tuschen-Caffier, Schnulle, Fischer, & Gross, 2010). When implementing TF-CBT in the VA, practicing affective modulation and cognitive coping skills with children and caregivers may be particularly useful for veterans dealing with PTSD, especially when used in conjunction with veterans' individual treatment. In addition, emotional expression is not reinforced in the military, or may even be discouraged in order to successfully execute missions. Although this practice is adaptive on deployment, it can contribute to family difficulties upon transition to civilian life. Cognitive restructuring techniques allow the family to acknowledge the connections between thoughts, feelings, and behaviors and strengthen cognitive flexibility to view events in more accurate and helpful ways. Collectively, TF-CBT coping skills help the child deal more effectively with trauma, provide opportunities for skills rehearsal for veterans and partners faced with stress, strengthen parenting abilities through improved affective/cognitive coping, and improve parent-child relationship through skills practice, particularly when the relationship was affected by deployments.

Trauma narrative.—The trauma narrative (TN) and processing component involves gradual exposure, in which the child is encouraged to create a detailed account of the traumatic event(s) that includes thoughts and feelings, as well as any trauma-related sensations, such as smells, tastes, touches, and sounds, that may trigger a fear response. The child is asked to share as many details as possible and to include what occurred before, during, and after the event(s). These tasks are typically accomplished through writing a book, drawings, creating a timeline, or writing songs or poetry. Once the child has completed a number of sessions targeting the narrative, he or she is encouraged to share his narrative in conjoint parent-child sessions if appropriate. Individual sessions with caregivers are completed prior to conjoint sessions to assess caregivers' knowledge and comfortability with the child's trauma and to prepare them for child's narrative. Assessing caregiver readiness and appropriateness for the narrative-sharing session is always important; however,

some specific issues are particularly salient when implementing TF-CBT with veteran families in the VA.

It is necessary to gather information regarding veteran mental health history prior to these sessions. For instance, veterans with PTSD may have difficulty specifically listening to the details of their child's TN and its impact on the child, as it could serve as a potential trigger or reminder of their own trauma symptoms. This is particularly true for veterans with high physiological reactivity to trauma using avoidance coping techniques, as this combination is associated with more severe PTSD symptoms (Pineles et al., 2011) and may impact affective control and effective parenting methods following the trauma narrative. Further, for children impacted by sexual trauma, the joint narrative session may be particularly difficult for veterans impacted by military sexual trauma (MST), as approximately 41% of women and 4% of men who served during OEF/OIF reported experiencing MST (Barth et al., 2016). These issues may arise in later TF-CBT sessions as well, when sex education, personal safety skills, and abuse prevention are discussed in the enhancing Future Safety and Development component.

It is important to note that veterans' increased risk for mental health problems and military-related stress does not make them unable to cope with family trauma or provide support to their children. Caregivers are often a powerful source to provide support and challenge distorted cognitions, and most veterans are equipped to adequately address their child's trauma-related symptoms. In fact, many veterans demonstrate valuable coping skills in the face of stressors and approximately 80% of veterans who experienced trauma do not develop mental health conditions (Tanielian & Jaycox, 2008). However, these potential difficulties are simply important to consider when working within the VA with such a unique population as veterans and their families.

In vivo mastery of trauma reminders.—After addressing the trauma through imaginal exposure, it is important to examine whether the child experiences trauma triggers in his or her 'real world' environment that negatively impact functioning. Although not all children experience these, it is important to address any existing trauma-related fears. For example, a child who was sexually abused in their bedroom may be fearful of sleeping alone, leading to disrupted sleep and impaired functioning. During in vivo mastery of trauma reminders, the therapist engages the child in gradual, incremental steps to help the child directly face his or her fears in real world settings by working through activities on the child's fear hierarchy. Given that in vivo exposures take place outside of the therapy setting, involving the caregiver is very critical. Because of this, it is imperative to assess the veteran's mental health history, trauma history, and specific trauma triggers, to ensure that assisting the child with in vivo exposures does not serve as a trigger to the veteran.

Enhancing safety.—The final component of TF-CBT treatment involves presenting strategies to reduce the risk for revictimization, which is extremely important to increase the child's sense of safety by planning for the future. During the enhancing safety sessions, the child discusses what has been learned in therapy, plans for the future by contextualizing the traumatic event and attaining closure, and reviews signs that the child or caregiver may need a booster therapy session.

Although the enhancing safety component is important for all children, it may be additionally important for children of veterans due to potential elevated risk for engaging in high risk behaviors. Although many children of veterans exhibit high rates of resilience and healthy coping skills, some may be at higher risk for substance use and experiences of violence and harassment compared to their peers (Gilreath, Astor, Cederbaum, Atuel, & Benbenishty, 2014; Gilreath et al., 2013; Lipari et al., 2017; Sullivan et al., 2015). This underscores the utility of delivering TF-CBT in VA facilities and involving the veteran throughout treatment.

Treatment adaptations.—When considering evidence-based treatments for families, it is important to attempt to reduce barriers and enhance access to care for families impacted by trauma. A number of adaptations of TF-CBT are available to reduce mental health care disparities and can be applied in VA settings with adequate resources. TF-CBT effectiveness has been demonstrated across numerous studies supporting its use with ethnically diverse populations, children exposed to various types of trauma, and in diverse clinical settings (e.g., Murray et al., 2013; Weiner, Schneider, & Lyons, 2009), in group formats, and via telehealth. Just as individual VA providers aim to provide culturally competent care to address veteran needs, diverse families presenting with a range of trauma-related needs should receive appropriate, effective treatments, and evidence-based adaptations of TF-CBT within the VA could address this need.

TF-CBT is also delivered in group formats across various settings, with trauma narratives discussed and shared individually outside of group sessions (Deblinger, Pollio, & Dorsey, 2016). Effectiveness of Group TF-CBT has been demonstrated in randomized controlled trials providing support among groups of culturally diverse families where children were affected by various traumas including sexual abuse, war, and traumatic grief (McMullen, O’Callaghan, Shannon, Black, & Eakin, 2013). In addition to symptom improvement, group TF-CBT allows for greater reach, decreased waiting lists, cost-effectiveness with fewer therapists needed to treat more families, destigmatization, reduced shame and guilt, and strengthened social support for children and their caregivers. Group therapy and peer-based programs are recommended for veterans experiencing self-stigmatization and stereotyped attitudes toward PTSD to facilitate treatment initiation and engagement (Greden et al., 2010; Mittal et al., 2013). Thus, Group TF-CBT may be attractive for this population specifically where trauma-related stigma is amplified.

Just as group treatments can enhance cost-effectiveness by reducing the number of therapists needed to reach more families, other treatment modalities, such as video telehealth, increase cost-effectiveness by reaching families in areas with fewer resources. Use of telehealth services is associated with many advantages including improving access to mental health services, decreasing costs for patients and providers, and better reach for rural and/or low-income populations (Dunn, Choi, Almagro, Recla, & Davis, 2000; Grady & Melcer, 2005; Gros et al., 2013). Compared to in-person treatments, telehealth services for evidence-based protocols are associated with equivalent treatment outcomes including symptom reduction, satisfaction levels, and service attrition (Gros et al., 2013).

According to the Veterans Health Administration Office of Rural Mental Health, 5.3 million veterans live in rural communities, with over half of them enrolled in the VA system. For veterans' families impacted by trauma, delivery of TF-CBT via telehealth in the VA would enhance access to services for these families and be beneficial in areas where access to specially trained providers may be limited (The National Advisory Committee on Rural Health & Human Services, 2009). Community Outreach Program-Esperanza, a community-based program that provides TF-CBT, was developed to reduce treatment barriers for underserved populations including economically disadvantaged families and families living in rural areas (de Arellano et al., 2005). The developers of this program encourage its use via telehealth, and provide suggestions for its implementation via telemental health videoconferencing technology (Jones et al., 2014). The "push" for delivering TF-CBT through telehealth, coupled with the increase in telehealth utilization for evidence-based treatments for veterans in the VA, provides support for the use of TF-CBT in the VA to address trauma in children and families of veterans.

Challenges and Future Research Directions

Challenges

Implementing TF-CBT with veterans' families in the VA is associated with many potential positive outcomes, however, barriers do exist for employing this protocol. One of the more difficult challenges to providing this service is the lack of family clinics within VA facilities across the nation. Although there has been an increase in family involvement in veteran care across VA medical centers (U.S. Department of Veterans Affairs, Veterans Health Administration, 2008), much of this effort to enhance family involvement includes only spouses and partners with fewer medical centers offering child-inclusive services. The lack of family specialty clinics can make it more difficult to implement TF-CBT in the VA.

Similarly, most VA facilities are not "child friendly" such that most do not provide childcare, playrooms, or toys to be used in waiting rooms or in treatment, particularly for young children. Children also may become noisy, potentially disrupting treatment for other veterans, particularly those receiving individual trauma treatment. In these instances, TF-CBT could be delivered via home-based telemental health services and may even enhance comfortability and reduce barriers (e.g., transportation, childcare issues) for many families. Current research supports the use of TF-CBT via telemental health services (Jones et al., 2014), as well evidence-based treatments to veterans via the same method (e.g., Gros et al., 2013), though additional research is warranted to determine feasibility and effectiveness of TF-CBT administration through telemental health by VA providers to veterans' families.

Another concern is that most VA mental health staff are not adequately trained to provide services to children and families. While TF-CBT training manuals and online training resources are available free of charge (Cohen & Mannarino, 2011; <http://tfcbt.musc.edu>), many mental health personnel may not feel comfortable providing child and family services. In addition, when using trained TF-CBT providers, it is important to consider potential challenges such as cost, availability of approved TF-CBT trainers, and the high level of fidelity required by TF-CBT developers. However, with more focus on involving family members in veterans' care, this could be a helpful consideration for VA staff training and

hiring to help ensure that veterans receive comprehensive care to include parenting and education, both of which are addressed in TF-CBT.

Future Directions

Although some challenges exist to implementing TF-CBT in the VA, there are several available options for overcoming these barriers to provide more comprehensive care for veterans and their families. Research is needed to identify barriers to delivering TF-CBT in the VA in addition to the ones listed above to adopt strategies to decrease treatment delivery challenges. For instance, qualitative interviews with veterans who have children and are receiving treatment in the VA would elicit information regarding specific family needs, barriers to care, parenting issues that impede treatment progress, and other important information to increase access to care. If veterans report that parenting difficulties (e.g., lack of childcare, parenting stress, scheduled child activities, etc.) impede their ability to attend regular VA appointments, for example, then this information would be useful in adapting evidence-based treatments for veterans with children, and for including children in family treatment when warranted.

Although TF-CBT has been adapted for use among diverse populations to address a wide range of traumatic experiences, it has not yet been examined for veteran families within the VA. Future research should investigate the effectiveness and feasibility of TF-CBT dissemination within VA facilities with the aim of providing well-rounded care to veterans and their families who often experience unique traumas and stressors. These studies should incorporate measures of constructs more frequently observed in veterans' families such as caregiver PTSD and depression symptoms, substance abuse, postdeployment health and adjustment, and parent-child relationship functioning (Hoggatt, Lehavot, Krenek, Schweizer, & Simpson, 2017; Sherman et al., 2016; Tanielian & Jaycox, 2008). Robust results of these effectiveness studies, coupled with veterans' desire for family involvement in treatment (Fischer et al., 2015) would strengthen the argument to increase the number of couples and family specialty clinics in VA facilities throughout the country.

To increase the number of trained mental health family providers in the VA system, learning collaboratives could be an effective way to reach a large number of providers in a relatively short period of time. A significant push for increasing dissemination and implementation of TF-CBT throughout community-based settings has occurred over the last decade, and many efforts have focused on the most efficient ways to disseminate the model including (a) improving distance or web-based learning, (b) increased trainings and ongoing consultation models, and (c) implementation of learning collaborative models (Cohen & Mannarino, 2008). Learning collaboratives can also enhance sustainability of TF-CBT in settings where trained therapists are no longer providing services due to relocation or changing positions. In addition, an emphasis on hiring social workers and/or psychologists from child, family, or generalist training backgrounds may help to improve dissemination and implementation of TF-CBT.

Summary and Conclusions

Although there is an improved emphasis on family involvement in veterans' care (Foa et al., 2009; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2010), family programs remain underused in the VA (Institute of Medicine, 2014; Meis et al., 2013). Additional outcomes research on evidence-based family treatments, such as TF-CBT, within VA medical centers could strengthen development and utilization of family specialty clinics within the VA and serve as an initial step toward broader TF-CBT dissemination through group-based formats and telehealth services to reach rural families. Other postdeployment family protocols, such as ADAPT (Gewirtz, Pinna, Hanson, & Brockberg, 2014), have demonstrated effectiveness via group-based formats for military parents experiencing significant stressors. Similarly, widespread dissemination of TF-CBT in unique formats has potential to positively impact military and Veteran children exposed to traumatic events. The ultimate goal of increasing reach and providing comprehensive care to veterans and their families impacted by trauma begins with evidence-based assessment and treatment for veterans, their spouses, and their children, and frequently can be addressed within VA facilities across the country.

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Table 1

List of Evidence-Based Protocols for Military and Veteran Families

Protocol name	Brief description	Intervention timing	Authors
After Deployment: Adaptive Military Tools (ADAPT)	Emotional skills-focused parent training program aimed at improving effective parenting practices and parenting locus of control and reducing child risk for emotional/behavioral problems	Postdeployment	Gewirtz, Pinna, Hanson, & Brockberg, 2014
Behavioral Family Therapy for Serious Mental Illness (BFT for SMI)	9- to 12-month behavioral treatment aimed at family intervention in which one family member has a SMI, providing psychoeducation, communication skills training, and problem-solving training	As needed	Mueser & Glynn, 1999
Families Overcoming Under Stress (FOCUS)	8-session treatment addressing stress reactions, family communication, family strengths, child development, and problem solving	Any point in deployment cycle	Lester et al., 2012
Reaching out to Educate and Assist Caring, Healthy Families (REACH)	9-month, 3-phase, psychoeducational multifamily group model providing education, strengthening problem-solving skills, and maintaining support for veterans with PTSD and their families	As needed	Sherman, Fischer, Sorocco, & McFarlane, 2011
Strong Families Strong Forces	8-module treatment aimed at reducing parenting stress and parental mental health concerns, and strengthening parental reflective capacity	Postdeployment (reintegration period)	De Voe, Paris, Emmert-Aronson, Ross, & Acker, 2017
Support and Family Education Program: Mental Health Facts for Families (SAFE)	18-session family education program providing education to family members and friends of veterans with various mental health problems (e.g., PTSD, depression, schizophrenia)	As needed; typically implemented in VA settings	Sherman, 2003

Note. PTSD = posttraumatic stress disorder.