

When a Parent Goes to War: Effects of Parental Deployment on Very Young Children and Implications for Intervention

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Young children (birth through 5 years of age) are disproportionately represented in U.S. military families with a deployed parent. Because of their developmental capacity to deal with prolonged separation, young children can be especially vulnerable to stressors of parental deployment. Despite the resiliency of many military families, this type of separation can constitute a developmental crisis for a young child. Thus, the experience may compromise optimal child growth and development. This article reviews what is known about the effects of the military deployment cycle on young children, including attachment patterns, intense emotions, and behavioral changes and suggests an ecological approach for supporting military families with infants, toddlers, and preschoolers. Specifically, home-based family focused interventions seem to warrant the most serious consideration.

Since the September 11, 2001, attacks, U.S. military operations related to Afghanistan and Iraq have involved frequent and lengthy deployments and heavy reliance on Reservists and National Guard units. In war zones, troops have faced near-constant threats from urban and terrorist combat strategies, such as the use of improvised explosive devices and roadside bombs, and have endured extremely harsh environmental conditions. The cumulative effects of combat and deployment-related experiences, including multiple deployments, on service members have been well documented and continue to be an area of intense inquiry (American Psychological Association Presidential Task Force on Military Deployment Services for Youth Families and Service Members, 2007; Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004; Mental Health Advisory Team [MHAT-V], 2008). By contrast, the strains of deployment and reintegration for family members of those serving in Afghanistan (Operation Enduring Freedom [OEF]) or Iraq (Operation Iraqi Freedom [OIF]) are only beginning to be identified (Chandra et al., 2010; Faber, Willerton, Clymer, MacDermid, & Weiss, 2008; Hoge et al., 2004; Hoge et al., 2006; Milliken, Auchterlonie, & Hoge, 2007). While many service

members and families have shown remarkable resilience in coping with the demands of these ongoing conflicts (Elder & Clipp, 2006), very young children (ages 5 and younger) in military families may be particularly vulnerable. Developmentally, babies, toddlers, and preschoolers do not yet possess the requisite skills to understand lengthy separations from their deployed parent (Rosenblum, Dayton, & Muzik, 2009); even under the most favorable circumstances, the child's relationship with the service-member parent must be reestablished postdeployment. Of significant concern, however, are the added challenges to the parent-child relationship when a service-member parent returns home with a physical injury, permanent disability, or war-related mental health symptoms (Goff, Crow, Reisbig, & Hamilton, 2007).

The deployment cycle varies dramatically for members of the different military branches. How often one is deployed, the length of deployment, and the nature of combat exposure differ among the U.S. Army, Navy, Marines, and Air Force, and their active and Reserve components. The specifics of these differences are beyond the scope of this article, but they are noteworthy as they have important implications for family life and for parent-child relationships (Cozza, Chun, & Polo, 2005). Young children in families where service members experience longer and more frequent deployments, as well as greater combat exposure, may be most vulnerable to the challenges of separations and combat stress (Cozza & Lieberman, 2007).

Young children are disproportionately represented among families with at least one parent who has deployed in these wars. In 2008, the U.S. Department of Defense (DOD) reported that approximately 1,200,000 children, of whom 41% were under the age of 5 (compared to 24% of all U.S. children that are under 5; U.S. Census Bureau, 2000), had at least one parent on active

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duty (Office of the Deputy Under Secretary of Defense, 2008). Some of those deployed are mothers (15% of service members in Iraq and Afghanistan are women). Given the number of young families directly affected by ongoing war operations in Iraq and Afghanistan, it is critical to understand the unique impact of deployment-related experiences and stressors upon very young children and their relationships with their mothers and fathers. The DOD has begun to recognize the needs of family members throughout the deployment cycle; however, the developmental realities of young children require specific attention and support within the current military context. To date, most of the available literature and programming have focused on older children or adolescents. For example, Operation Military Kids, National Guard family activities, Military One Source, and Families Overcoming Under Stress (FOCUS) primarily target children from elementary through high school (Huebner, Mancini, Wilcox, Grass, & Grass, 2007).

In developing interventions for very young children, it is critical to consider children's health and development in the context of their multiple ecologies. An ecological perspective serves as a comprehensive and integrating framework for conceptualizing the full range of influences on young children's adaptation and on the child's relationship with each parent throughout deployment and reintegration (Bronfenbrenner, 1979). Accordingly, the impact of deployment separation on very young children and on the parent-child relationship may be considered along four interacting levels of risk: (a) the ontogenetic level refers to the personal factors that are unique to a child's developmental history; (b) the microlevel refers to the immediate social and familial context of deployment-related stress experienced by the child and family (Steinberg & Avenevoli, 2000); (c) the exolevel refers to all variables that may act as external stressors or buffers with respect to the developing child, including quality of parenting, the parent-child relationship, and psychological functioning of both parents; and (d) the macrocultural level, which is defined in ecological theory as the broad cultural values and belief systems that influence all other analytic levels. Attachment and family systems theories also deepen our understanding of how the same lived experience (e.g., deployment) may result in different presentations and responses in each family member. For young children, responses will be related to the nature of the child's understanding of the deployment and return, individual child characteristics including temperament and emotion regulation, the developmental process, and the specific familial context in which the child is functioning, including parenting practices and the quality of the early parent-child relationship at each point in the deployment cycle (Garmezy, 1983; Rutter, 1990). Children whose parents are better able to sensitively respond to their emotional needs, have a strong relationship as a couple, and have siblings who assist in emotional support during predeployment, deployment, and reintegration will likely have healthier capacities for emotion regulation and overall psychosocial development. In summary, an integrated ecological-attachment framework incorporates the unique combination of variables at play for each OEF or OIF family through all phases of deployment. Consequently, family interventions focused on mitigating the negative impact of deployment or combat stress should be aimed at one or more ecological levels as well as the quality of attachment in the parent-child relationship.

This article has two overarching goals. One is to review the existing literature regarding the impact of parental combat stress and deployment on young children, parenting, and the parent-child relationship. The second is to examine existing evidence-informed family based programs for infants, toddlers, and preschoolers with the aim of identifying intervention principles that would readily translate to a program for military parents and children during reintegration from deployment. The programs we chose to review have family systems orientations that include individual treatment for any family member, as well as working with the child(ren) and parent(s) together. They recognize the importance of an integrated ecological-attachment approach to human development (Bronfenbrenner, 1979) that includes targeting the multiple factors influencing child development and parenting practices within families (Belsky, 1984). Several treatments that we review have been developed specifically to address direct trauma to the child, and others focus more directly on parent-child interactions and parenting in support of the young child who may be at risk of developing social-emotional difficulties. Because trauma to the young child is not typically the central issue facing military families postdeployment, reintegration programs should target parent-child and/or family relationships as the main focus of treatment.

Combat Stress and Mental Health Concerns in Returning Service Members

Trends in the mental health status of returning soldiers have been documented most systematically in the MHAT reports conducted by the U.S. Army (MHAT-V, 2008). Unlike previous surveys, MHAT-V includes separate reports for OIF and OEF, with 2,295 soldiers from OIF and 699 OEF soldiers. Rates of mental health problems were similar across samples at approximately 17.9% for acute stress, depression, or anxiety (MHAT-V, 2008). Research indicates that service members returning from Iraq were more likely to meet screening criteria for post-traumatic stress disorder (PTSD), major depression, and generalized anxiety disorder than those who served in Afghanistan (Hoge et al., 2004). Results revealed a strong association between combat-related experiences and endorsement of PTSD symptoms. Hoge et al. (2006) also report that OIF service members were significantly more likely to be seen in a mental health clinic within 1 year postdeployment than those returning from OEF (Hoge et al., 2006). More recent data on OEF/OIF veterans estimate that 40% of those seeking services do so because of mental health concerns (Veterans Health Administration Office of Public Health and Environmental Hazards, 2008). However, the MHAT-V data indicate that while soldiers report more willingness to seek help, it has become more difficult to find help particularly in theater (MHAT-V, 2008). Additional barriers to help-seeking for military families include structural barriers within the service delivery system (e.g., lack of coverage of family and couple treatment, short-term and acute intervention), stigma, concerns about confidentiality, lack of availability of mental health professionals trained to work with military personnel and their families, and lack of accessible services particularly for families who do not live near a military installation (American Psychological Association Presidential Task Force on Military Deployment Services for Youth Families and

Service Members, 2007; U.S. Government Accountability Office, 2006).

Impact of Parental Combat Stress and Mental Health on Parenting and the Parent–Child Relationship

The relationship between parental functioning and child adaptation in the context of trauma and separation is well established (e.g., Appleyard & Osofsky, 2003). Investigations of the impact of PTSD in Vietnam War veterans on family functioning, marital adjustment, and child outcomes suggest evidence of higher frequencies of negative effects in veteran populations, such as increased intimate partner violence (Jordan et al., 1992), reduced family cohesion, less effective coping in spouses (Galovski & Lyons, 2004; Rosenheck & Nathan, 1985), difficulty parenting (Jordan et al., 1992), and more perceived child behavior problems (Caselli & Motta, 1995). Research from earlier conflicts also reveals trauma-related interference in parenting practices of Vietnam War veterans such as: controlling and overprotective parenting behavior, parenting styles of disengagement, or enmeshed relationships with the child (Rosenheck & Nathan, 1985).

Researchers have examined the relationship between specific PTSD symptom clusters (e.g., intrusion, avoidance, numbing, and hyperarousal) and Vietnam War veterans' perceptions of their relationships with their older children. Findings from one study revealed that certain symptom clusters associated with PTSD were most predictive of poor parent–child relationships; specifically, avoidance-numbing symptoms interfered most significantly with parenting practices, suggesting that the avoidance response functions as an impediment to the parent's ability to sustain and/or initiate actions that foster a connected and continuous relationship with the child (Ruscio, Weathers, King, & King, 2002). These findings are consistent with earlier research that established emotional numbing in the constellation of PTSD as the primary factor linked to relationship difficulties after war trauma (MacDonald, Chamberlain, Long, & Flett, 1999; Rosenheck & Thomson, 1986). Although these studies did not examine the association between veteran parents' PTSD symptoms and their relationships with young children, their findings suggest that avoidance and numbing responses would be likely to interfere with parenting of young children. In addition, a parent's hyperarousal and hypervigilance might result in reactive parenting responses to the young child that are inconsistent with the intensity or content of the child's behavior (Lieberman, 2004).

Parental reflective functioning (RF), the attachment-based concept referring to the capacity to understand behavior in light of underlying mental states and intentions (Fonagy et al., 1995), enables a parent to keep his or her child's emotions in mind in the context of behavioral interactions (Slade, 1999). When this ability is disrupted, as with parental depression, drug abuse, or trauma symptoms, children may exhibit dysregulated behavior or disrupted development (Lieberman, 2004; Slade et al., 2005; Suchman, McMahan, & Luthar, 2004; Truman, Levy, & Mayes, 2002). Increasing parental RF in service members postdeployment has important implications for improving child adjustment and strengthening the parent–child relationship in newly reintegrated military families.

The Experience of Deployment, Parental Stress and Combat Trauma for Young Children

Until recently, most research has focused on the mental health needs and service utilization of soldiers who have been deployed in current wars and has not addressed the needs of families. MacDermid et al. (2005) recently conducted family focused research with deployed fathers. Their findings demonstrated that multiple deployments severely limited a service member's involvement with his children and caused significant stress for the deployed parent and the entire family. Young children of service members face multiple challenges, including the impact of deployment separation, the increased stress on the parent left behind, and the impact of the service-member parent's psychological responses to war zone related trauma on his or her ability to reestablish the parent-child relationship and parenting role after deployment.

Deployment Separation

Repeated or lengthy deployments may result in increased risk to the child of attachment disturbances, depression and anxiety responses (Chandra et al., 2010; Cozza & Lieberman, 2007). The uncertainty and ambiguity of the parent's arrivals and departures are particularly challenging for young children given their developmental capabilities (MacDermid et al., 2005). For children under the age of 5, separation from primary caregivers can constitute a developmental crisis. Young children develop healthy attachment relationships in the context of available, reliable, and nurturing parenting practices and consistent caregivers. Children who are not able to develop secure relationships—either because of the prolonged absence of a parent or the compromised emotional status of the parent (or both)—may experience life-long consequences to future healthy functioning (Sameroff & Fiese, 2000; Siefer & Dickstein, 2000). For example, because early attachment patterns are ontogenetic adaptations and become incorporated into behavioral patterns throughout life, insecurely attached young children who may be clingy or dependent can grow into young adults with interpersonal difficulties (Thompson, 1999).

For the youngest children in military families, deployment interferes with the opportunity to develop and maintain relationships with service-member parents during critical developmental periods. Young children with special needs, such as persistent development disorder and autism spectrum disorders, among others, experience additional challenges given the periodic deployment of a service-member parent (Fitzsimmons & Krause-Parello, 2009). Babies and toddlers have not yet developed the cognitive capacity to process either the separation from or sudden reappearance of a deployed parent (Gorman & Fitzgerald, 2007). The experience of loss and separation is likely to be mediated through the available parent (i.e., the nondeployed partner or caregiver), as has been found in earlier research on children exposed to natural disasters (Green et al., 1991) and war (Laor et al., 1996; Levy-Shiff, Hoffman, & Rosenthal, 1993). More specifically, when the remaining parent is able to provide consistent, nurturing care to a young child, the young child's resilience and security are supported in the face of trauma or loss. In the context of deployment, when the

at home parent is not able to manage his or her own distress or mental health difficulties in the face of separation, the young child may not receive optimal caregiving (Gorman & Fitzgerald, 2007). Furthermore, for some service-member fathers, their children are born during deployment. New parents who are deployed may grieve the loss of the first months or years of their child's life (MacDermid, 2006; MacDermid, Olson, & Weiss, 2002). These circumstances can be painful for the returning parent who may encounter avoidance, hesitance, and even fear from the child. The deployed parent may feel or be perceived as being unable to meet the child's needs and may not understand the developmental meaning of the child's responses. The simultaneous demands of managing the transition to parenthood and/or adapting to a new developmental period in the child's life combined with reintegration can be overwhelming, especially for first-time parents (Barker & Berry, 2009).

Preschoolers are more likely to be aware of deployment and to have the psychological capacity to grieve the loss of the deployed parent. Preschoolers are also often developmentally sophisticated enough to have a beginning understanding of potential danger to the deployed parent. They are capable of reading and feeling emotional tones of sadness, anger, and anxiety from the adults in their lives and, thus, experience the predeployment anticipatory stress within their families (Chartrand, Frank, White, & Shope, 2008). Thus, separations from parents during this stage of development may have a stronger impact if the reason for the separation involves danger (Rutter, 1990). Research has also established the salience of the young child's appraisals of caregivers' safety and their behavioral status. In one study of children age 4 and younger, the strongest predictor of traumatic stress symptoms in children was the perception of threat to their caregiver (Scheeringa, Zeanah, Drell, & Larrieu, 1995). In the current context of OEF/OIF deployment, preschoolers may be uniquely vulnerable because they are old enough to have partial awareness of risk to a parent, but too young to accurately assess or understand the specifics of the threat.

We are aware of only one published study that has examined the effects of parental deployment related to Afghanistan or Iraq on young children (Chartrand et al., 2008). Chartrand et al. (2008) conducted a cross-sectional study of 169 children ages 1.5–5 years in child-care settings at a large U.S. Marine base. Findings indicate that children aged 3 or older who had a deployed parent, had significantly higher externalizing and total scores on the Child Behavior Checklist (Achenbach & Rescorla, 2000) when compared to peers whose parents were not currently deployed.

Increased Stressors for Parent Left Behind

Numerous studies have documented the centrality of parental ability to manage stress as a key predictor of the child's ability to cope with adversity (Burlingham & Freud, 1942; Shonkoff, 1985). As such, the ability of young children to manage a parent's deployment effectively is somewhat contingent upon the available parent's ability to cope with the additional stressors, role negotiation, and responsibilities necessitated by the deployment (Chartrand et al., 2008; Cozza et al., 2005). For deployed families who have extended family or military community to rely upon, the added strains of parenting during a partner's

deployment may be manageable (Williams & Rose, 2007). However, it is possible that isolation from other military families who understand the strains of deployment may intensify the demands of parenting young children especially for National Guard or Reserve families who typically do not live on or near a military installation. Partners with deployed spouses also may experience increased fatigue and burden that negatively affect both parenting behaviors and the quality of the parent-child relationship (Williams & Rose, 2007). Additionally, partners who are parenting a child with special needs face even more challenges (Fitzsimmons & Krause-Parello, 2009). Results from studies investigating the occurrence of child maltreatment in Army families reveal that children were at increased risk of maltreatment, primarily neglect, during a parent's combat-related deployment, with nearly 50% of incidents involving children under age 5 (Gibbs, Martin, Kupper, & Johnson, 2007; Rentz et al., 2007).

Impact of Service Member Combat Stress on Children and Parenting

Research and clinical reports on children of Vietnam War veterans indicate incidence of a range of behavioral and emotional difficulties, including attention deficit disorder, anorexia, severe academic and behavioral problems (Davidson, Smith, & Kudler, 1989; Galovski & Lyons, 2004), and play characterized by combat-related themes (Rosenheck & Nathan, 1985). A more recent report examined the impact of PTSD on Vietnam veterans' family functioning by comparing children of Vietnam veterans with PTSD, children in families of Vietnam veterans without PTSD, and children in matched families of non-Veteran status (Davidson & Mellor, 2001). Results revealed a positive association between the veteran's PTSD and greater problems with communication, family dysfunction, and problem-solving skills than either of the comparison groups (Davidson & Mellor, 2001).

Developmentally Targeted Interventions to U.S. Military Families With Young Children

The capacity of the current U.S. mental health delivery system has been overwhelmed by the level of need among returning service members (American Psychological Association Presidential Task Force on Military Deployment Services for Youth Families and Service Members, 2007). Thus, even when service members are able to overcome concerns about stigma (e.g., Hoge et al., 2004), appropriate mental health care may not be available. For service-members' children, services are even more limited, if they exist at all. For example, Military One Source, the primary clearing house for mental health services for families of the military, does not generally offer individual therapy for children under age 12, but may sometimes see them in the context of family work (American Psychological Association Presidential Task Force on Military Deployment Services for Youth Families and Service Members, 2007), and the Veteran's Administration (VA) typically does not offer family-based services. Often child treatment models depend upon the child's capacity to understand and be able to talk about separation and parent functioning; these abilities typically do not

begin until a child is approximately 4 or 5 years old. Furthermore, many evidence-based treatments, including cognitive behavioral models (Cohen & Mannarino, 1996; Scheeringa et al., 2007), were developed to address PTSD in children who have been directly traumatized. Finally, although effective with older preschoolers and school-age children, these models have not been adapted to the developmental realities of infants and toddlers (Galovski & Lyons, 2004).

The emerging but robust body of research documenting the mental health needs of returning service members, the impact of those conditions on the family, and the unique developmental vulnerabilities of very young children in this context build a strong case for making appropriate services available to families with young children. In addition to facilitating family reintegration by strengthening the parent-child relationship, support during the postdeployment period may serve to mitigate the legacy of combat stress in service-member parents and provide a powerful foundation for regaining a healthy developmental trajectory for young children. Such services could address family needs at all four ecological levels: personal, micro, exo, and macro as well as the interpersonal attachments so vital for growth and development.

Creating Evidence-Informed Interventions for Military Families With Young Children

In 2008, the National Child Traumatic Stress Network (NCTSN), in collaboration with the National Crime Victims Research and Treatment Center at the Medical University of South Carolina (MUSC), published a report (de Arellano, Ko, Danielson, & Sprague, 2008) identifying trauma-focused interventions that have been developed and used with trauma-affected youth populations from various cultural backgrounds. Of the interventions developed for use with infants, toddlers, and preschoolers, we identified three interventions with goals, principles, and approaches that could easily be applied to home-based work with military families postdeployment. These interventions, Child-Parent Psychotherapy (Lieberman & Van Horn, 2005), Trauma-Focused Cognitive Behavioral Therapy for preschool children (Cohen, Mannarino, Berminger, & Deblinger, 2000), and Parent-Child Interaction Therapy (Eyberg & Mata-razzo, 1980) will be discussed later in this section.

Most interventions identified in the report were designed for use with school-aged children (Jaycox, 2004; Kolko & Swenson, 2002) and for circumstances in which the child was directly exposed to trauma (Lieberman & Van Horn, 2005) or has symptoms of PTSD (Cohen et al., 2000; Saxe, Ellis, & Kaplow, 2006). For children dealing with parental deployment, separation is often the primary distressing experience, as opposed to direct trauma exposure. However, it is important to note that for a very young child, separation from the service-member parent is a potentially traumatic event in the absence of a supportive and responsive caregiver. In addition, the added component of parental trauma symptoms may exacerbate existing difficulties in the parent-child relationship, especially during reintegration. Relationship-based interventions are indicated for military families with young children who have experienced disrupted attachments, parental trauma symptoms, or both during reintegration. There are several empirically tested parent-child models

that do not use trauma to the child as their organizing principle. These models are relevant when designing interventions targeting military families with very young children because of their centrality in the infant and toddler mental health field; the models also offer techniques to improve parenting practices and the quality of relationships between parents and children, and they work to prevent child maltreatment (McDonough, 2004; Slade et al., 2005).

Babies and Toddlers

The first parent-child model, *Interaction Guidance*, is a manualized treatment focused on observable interactions between an infant and caregiver (McDonough, 2004). This approach was originally developed for families challenged by poverty, poor education, mental illness, substance abuse, lack of a parenting partner, or inadequate social support. Sessions with the parent and infant are videotaped and later viewed as part of the intervention. Within the therapeutic alliance, the clinician works to improve the quality of the parent-infant relationship by using techniques such as education, support, practical advice, and reinforcement of good parenting practices.

The second model, *Minding the Baby* (Slade et al., 2005), utilizes an organizational framework rooted in the concept of RF (Fonagy, 1998). Parental RF, or the ability to understand and process internal states within oneself and in others, is hypothesized to be important to healthy emotional development of the child and the development of a secure parent-infant relationship. In this home-based program, the clinician enhances RF through modeling and encouraging parental insight into the impact of his or her own symptoms and history upon the baby. Parents are encouraged to engage with their babies in face-to-face vocal interactions and to connect through simple caregiving actions (e.g., holding, cuddling). Evaluations have found both models to be effective in improving the infant-parent relationship (Cooper & Murray, 1997; Slade et al., 2005).

These two models, which are not necessarily trauma focused, offer relevant approaches to working with military families that have endured long separations where a parent has been in harm's way. For example, the approach to building the parent-child relationship through observing video interactions could be adapted for military families with the aim of sensitizing parents to children's communication styles and/or helping parents understand children's reactions to separation and reunion.

In contrast to *Minding the Baby* and *Interaction Guidance* models, *Child-Parent Psychotherapy*, one of the models identified by the NCTSN, specifically targets young children and mothers who have experienced domestic violence (Lieberman & Van Horn, 2005). The premise of this intervention is that young children's social-emotional development unfolds in the context of primary attachment relationships. Trauma, for either the parent or the child, undermines attachment security. *Child-Parent Psychotherapy* is a dyadic intervention model, using play and relationship-focused activities to improve the parent-child relationship as a means of reducing child symptoms. Results of randomized clinical trials reveal that the intervention is effective in reducing child symptoms and improving parental trauma symptoms (Cicchetti, Rogosch, & Toth, 2000; Lieberman, Van Horn, & Ippen, 2005). Although the primary outcome goals of

the above three models are improved child functioning and parent-child interactions, these interventions also address parental emotional distress and parental attitudes toward their children. Similarly, an intervention for military families with young children would focus on improving child adjustment and parent-child interactions, as well as addressing parental affect and behavior associated with deployment and combat stress.

Preschool children

Two cognitive behavioral interventions have been implemented with preschool children who have experienced trauma. *Trauma-Focused Cognitive Behavior Therapy* adapted for preschool children (CBT-SAP; Cohen & Mannarino, 1993), the second model identified by the NCTSN, was developed to treat preschoolers who had been sexually abused. In sessions with both the child and nonoffending parent, clinicians use CBT techniques to directly address the experience of sexual abuse and the behavioral, affective, and relational sequelae (e.g., aggressiveness, sexually inappropriate behaviors with others, fear, and anxiety). This approach was found to be superior to a nondirective supportive therapy for improvement in most child symptomology (Cohen & Mannarino, 1996). Scheeringa et al. (2007) assessed the feasibility of a similar CBT approach with young children who had experienced trauma other than sexual abuse. Their case report of two children between the ages of 3.5 and 4.5 years suggests that preschoolers with PTSD can benefit from using a CBT approach, including exposure exercises and relaxation techniques, with the assistance of their parents (Scheeringa et al., 2007). Importantly, the authors note that parent involvement is essential to successful child outcomes, but improvement in parental anxiety is not. As long as the parent can assist the child in his or her treatment, even if it means enduring his or her own anxiety, the child can improve. Although preschool children in military families may not be directly traumatized, CBT strategies such as cognitive processing, reframing, and relaxation can be employed in relationship-based interventions where the child experiences anxiety or distress secondary to separations and the parent's experience of trauma. In this type of treatment, the deployed parent, who may be struggling with war-related mental health difficulties, can still be a significant source of support to his or her child.

Parent-Child Interaction Therapy (PCIT; Eyberg & Matarazzo, 1980), the third model identified by NCTSN, was not developed initially to treat trauma exposed children but has been adapted for that population. The therapy seeks to improve the quality of the parent-child relationship by improving adaptive prosocial behaviors and increasing consistency and predictability of existing parent-child interaction patterns and behavior management routines. PCIT facilitates parental expression of behavioral and emotional responsiveness and displays of warmth and affection between both the parent and the child to strengthen the parent-child relationship while teaching parents to facilitate consistent application of behavior management techniques and patterns through two discrete interactions. PCIT has been used to treat conduct-disordered young children (Eyberg, Nelson, & Boggs, 2008) as well as disruptive young children carrying a diagnosis of mental retardation (Bagner & Eyberg, 2007).

Home-Based Services for Families With Young Children

Two of the approaches described above, *Minding the Baby and Interaction Guidance*, utilize home-based interventions. Additionally, *Child-Parent Psychotherapy* can be implemented at home. For families with very young children, providing services in the home warrants serious consideration for a number of reasons. First, because home visitation is conceptualized as a service strategy rather than a specific intervention, most treatment approaches can be adapted for implementation in the family's home. For example, one national model developed to prevent child maltreatment and optimize parent-child relationships, *Healthy Families America*, has been adapted to particular populations and is now implemented in 430 sites across the country (Diaz, Oshana, & Harding, 2004). While the relationship between the parent and the home visitor is a critical component of program success (Jacobs, Easterbrooks, Brady, & Mistry, 2005; Paris, 2008), home-based interventions are also effective because they bring the service to the family and allow workers to observe the environment in which the family and children reside (Gomby, Culross, & Behrman, 1999; Olds et al., 2004). Second, home-based interventions have been utilized successfully in military populations since 1984 (e.g., Family Advocacy Program, New Parent Support Program) and have been credited with reducing rates of reported child abuse in military populations in some states (Inouye, Cerny, Hollandsworth, & Ettipio, 2001). In addition to home visits, the New Parent Support Program also includes support groups for new mothers, parent guidance classes and a food voucher program (Raiha & Soma, 1997). Results of a recent evaluation of a Navy-based New Parent Support Program indicate that parents participating in parenting classes and home-based visits reported high levels of satisfaction with the program and improvement in both quality of life and self-reported parenting and coping skills (Kelley, Schwerin, Farrar, & Lane, 2006). Third, the issue of stigma, which serves as a barrier to service members seeking assistance on a military base, a VA hospital, or a known community mental health clinic, may be minimized when services are provided in the home because of greater privacy. All of the above intervention models have the potential to address the ecological environment of families. A home-based intervention for military families with young children would need to adopt the best of these evidence-based approaches and incorporate strategies to address attachment relationships, deployment separations, parental combat stress, as well as military culture and community support.

Implications for Service Delivery to U.S. Military Families With Very Young Children

We recognize the ethical complexities of war, and of current U.S. war operations related to Afghanistan and Iraq. However, regardless of one's personal and political views on these wars, the fact remains that an enormous number of young children in military families are dealing with the effects of deployment and postdeployment adjustment. In response, major resources should be directed at services that bolster the well-being of children and parents in military families. The extraordinary demands of fighting two long and unconventional wars have

strained the capacities of existing systems of care and of many military families. Programs that support the military families throughout the cycle(s) of deployment are greatly needed. Furthermore, program elements that address service-member parents' ability to reintegrate upon returning from deployment may be especially helpful to children of all ages and young children in particular. These needs are even more urgent when a parent returns from war with mental health concerns, such as combat stress, substance abuse, and injury or disability that may complicate his or her efforts to cope with the simultaneous demands of recovery, reintegration, and parenting.

Certainly, adequate funding for research on the mental health status of returning service members will continue to be critical. The multiple and overlapping systems of care for veterans, current service members, and military family members remain as significant structural barriers to service utilization. Thus, there is a need for development and adaptation of programs that are ecologically valid, relevant to the military culture, and community informed. Such approaches may reduce longstanding issues regarding stigma, fragmentation of services, and impediments to outreach that target military families. Given the potential generational impact of current and ongoing U.S. war operations, it is imperative that the mental health professions support research and training initiatives that address the need for evidence-informed approaches to working with military families.

Keywords: young children; military families; United States; parental deployment; war; trauma; separation; development; combat stress; intervention; ecological approach; evidence-based approach; family-based services; parent-child interaction

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