F·O·C·U·S

Strengthening the Home Base
The Need

Millions of service members and their loved ones are facing the challenges that come with military service: reintegration, frequent transitions and deployments, and illness and injury. These stressors mean many families go through a series of emotional ups and downs that affect service members, spouses, parents, kids and extended family members. FOCUS doesn’t just help military families cope with these challenges; it trains them to use skills that will strengthen them today and in the future.

FOCUS, or Families OverComing Under Stress, is a brief, trauma-informed and strength-based program that is grounded in more than two decades of research and experience serving families dealing with stress and changes. It is specially adapted for the needs of military couples, children and families and provides training in core resilience skills. These skills increase closeness, support, communication and adaptability. Couples and families learn to work together to manage difficult emotions, set goals and problem solve, communicate clearly and effectively, and develop customized strategies to deal with ongoing stress and change.

To date, FOCUS has delivered services to more than 743,000 active-duty military community members, including service members and their families. It has been successful with families, couples, single parents, toddlers, school-aged children and teenagers.

FOCUS is strengthening military families, one family at a time.

“I was shocked at the amount of information and resources I got out of the FOCUS Program … it made us better parents.” - FOCUS Mom

“It really opened my eyes on where my son was… and I wasn’t getting that communication from him. He feels he’s gotten a huge benefit from it. He communicates so much better and interacts with his younger brother. It is a complete 180.” - FOCUS Mom
Enhancing Resilience: Measures of Success

Project FOCUS provides a wide range of effective prevention services customized to the needs of military service members and their loved ones. Since the project’s inception in 2008, FOCUS has established that a family-centered prevention program is both feasible and effective for military families. This success is demonstrated through:

• Growing impact, with more than 743,000 service members, family members, and providers reached through our programs and outreach

• Significant increases in parent and child psychological health over time, suggesting benefits for military family wellness and preparedness

• High satisfaction ratings, making it clear that a strength-based approach to building child and family resilience is well received by service members and their loved ones

• Elevated referral rates, highlighting a dedication to comprehensive care and community engagement

Expanding Reach
Since 2008, Project FOCUS has enrolled more than 20,586 children and adults in Family Resilience Training, and has had 42,105 parents, teens, and children attend Family Resilience Skill Building Groups.

Improved Psychological Health
After completing the FOCUS program, both service members and civilian parents showed significant improvements in psychological health.

Children also showed significant improvements in pro-social behaviors such as cooperating, helping and sharing, improved coping skills, and less behavioral and emotional distress.

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High Satisfaction
Service members and their family members are asked to provide feedback on program impact, and overall satisfaction with the program is very high.

Bridging Systems of Care
FOCUS actively receives and makes referrals to other providers in the continuum of care, with the goal of providing seamless support services to military families.

“It was good for me to be able to voice some concerns in a safe, unbiased environment and have my feelings and situations validated. I also appreciated the guidance I received for dealing with everyday situations with my children. Many were things I tried to employ anyway, but having the trainer verbalize them helped remind me how important it is to be sensitive to my children’s emotional needs.” - FOCUS Dad
FOCUS in Action

FOCUS provides resilience training to service members and their families.

What is resilience?
Resilience is the ability of couples and families to “bounce back” and grow stronger following stressful or traumatic experiences. Resilient couples and families cope with and overcome challenges through their ability to:

• Communicate openly and effectively
• Express a shared understanding of experiences
• Manage emotions
• Develop shared goals
• Engage in collaborative problem solving
• Mobilize support and resources
• Understand combat stress reactions and deployment reminders

Using visual tools: the Narrative Timeline and Feeling Thermometer
The Feeling Thermometer is a visual tool that children and adults can use to express and manage their emotions. This tool helps families build healthy conversations about their experiences and feelings.

After practicing using the Feeling Thermometer, each family member is asked to build a timeline of his or her individual experiences and feelings during milestones, transitions and challenges. Select portions of these individual timelines are presented in the later family meetings to support a shared understanding of the entire family’s journey through difficult times. This process highlights family strengths and provides an opportunity to work through misunderstandings. It also increases family empathy and closeness.

“A FAMILY NARRATIVE

“The Feeling Thermometer has definitely been a big one in our house … it is on our refrigerator. We always talk about how we want to avoid going to the red. It’s simple and our kids can point to where they are.” – FOCUS Mom
Professional Trainers

FOCUS trainers are master’s or doctoral-level service providers who are trained and experienced in working with military couples, children and families. Many are themselves veterans or military spouses. They are located on military installations and community settings for maximum access and convenience for the military families they serve. FOCUS trainers have flexible office hours to accommodate busy schedules.

Partnering with each couple or family to realize their unique goals, the FOCUS trainer brings the best research-supported practices and combines them with compassion and a personal commitment to serving military families. Studies have shown that participation in FOCUS leads to sustained improvements and functioning for all family members.

In sum, FOCUS builds healthier, happier and stronger families, one family at a time.

“The FOCUS program has helped our relationship by leaps and bounds in every way that we asked it to.” - FOCUS Couple
A Wide Range of FOCUS Services for Families

No matter your family’s dynamic, FOCUS has customized training to meet your family’s needs.

Family Resilience Training
Family Resilience Training is a multi-session program for military and veteran families with children ages 5 and above. Sessions are organized around the development of a family timeline, which is used to teach families how to manage feelings, improve communication, and learn problem-solving and goal-setting skills. Family Resilience Training is generally 6 to 8 sessions but can be modified, depending on the family’s needs.

Couples
Resilience Training is also available for couples without children. Sessions help couples to recognize and express feelings more clearly, enhance problem-solving skills, and improve communication about relational stress and traumatic events.

Early Childhood
Families with children younger than age 5 can also participate in Resilience Training. Sessions focus on increasing parents’ knowledge about developmental needs of young children, promoting more positive parent-child relationships, and allowing for improved communication and understanding.

Online
For families unable to attend FOCUS sessions in person, FOCUS World and FOCUSproject.org bring Family Resilience Training activities and resources online. Parents and children can log into the FOCUS World website to play skill building games and share stories and pictures with family members through private chats. Parents can also watch educational videos about ways to deal with common family challenges and download resources with suggestions for family activities to do at home.

Visit focusproject.org and focusworld.org for more information.

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Skill Building Groups
Skill Building Groups provide an introduction to the key FOCUS resilience skills. They are generally 90 minutes in length. The groups can be for parents, families, or children in specific age ranges (for example, school-aged children or teenagers).

Consultations
Consultations are available for families or service providers.

Family consultations provide guidance and professional expertise on a specific topic, such as a child’s adjustment to reintegration. Consultations are also provided around specific trauma, grief, or loss issues. Following the consultation, families can choose to participate in Family Resilience Training or be linked to other appropriate services.

Provider consultations offer education to community providers (for example, teachers or counselors) on family and child-centered topics, such as the effects of deployment on child development. The lengths of consultations are generally 30 to 60 mintues but are flexible depending on audience and venue.

Educational Workshops
Workshops cover specific topics, such as developmental reactions to deployment or reintegration. They can be tailored to address topics for any stage of deployment and are approximately 60 minutes long.

Outreach and Engagement
Outreach presentations include an overview of FOCUS services as well as education about child development, the unique needs of military and veteran families, and the types of resilience training strategies for families that can be helpful. Presentations range in length from 15 to 90 minutes depending on the request. Engagement services facilitate a dialogue with providers about how they can partner with FOCUS to deliver Family Resilience Services to military families.

“My husband was very skeptical about the FOCUS program, but now he comes home in the evening and sees how peaceful our dinners are and everyone is getting along. And now he’s a believer.” - FOCUS Spouse
Evaluation of a Family-Centered Preventive Intervention for Military Families: Parent and Child Longitudinal Outcomes

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Objective: This study evaluates the longitudinal outcomes of Families OverComing Under Stress (FOCUS), a family-centered preventive intervention implemented to enhance resilience and to reduce psychological health risk in military families and children who have high levels of stress related to parental wartime military service.

Method: We performed a secondary analysis of evaluation data from a large-scale service implementation of the FOCUS intervention collected between July 2008 and December 2013 at 15 military installations in the United States and Japan. We present data for 2,615 unique families (3,499 parents and 3,810 children) with completed intake and at least 1 postintervention assessment. Longitudinal regression models with family-level random effects were used to assess the patterns of change in child and parent (civilian and military) psychological health outcomes over time.

Results: Improvement in psychological health outcomes occurred in both service member and civilian parents. Relative to intake, parental anxiety and depression symptoms were significantly reduced postintervention, and these reductions were maintained at 2 subsequent follow-up assessments. In addition, we identified an improvement over time in emotional and behavioral symptoms and in prosocial behaviors for both boys and girls. We observed reductions in the prevalence of unhealthy family functioning and child anxiety symptoms, as well as parental depression, anxiety, and posttraumatic stress symptoms from intake to follow-up.

Conclusion: Longitudinal program evaluation data show sustained trajectories of reduced psychological health risk symptoms and improved indices of resilience in children, civilian, and active duty military parents participating in a strength-based, family-centered preventive intervention.

Key words: military-connected children, wartime deployment, family-centered prevention, family resilience, parental mental health


The wars in Iraq and Afghanistan have resulted in the deployment of more than 2.5 million US service members since 2001. Approximately 45% had dependent children, and more than three-fourths had experienced 1 or more deployments. Military children and their parents have negotiated the unprecedented challenges of recurrent separations, frequent moves, and the high operational tempo associated with a country engaged in a long war overseas. Many children have also experienced the hardships of parental injury, illness, and even loss within their families, influencing both child and parental well-being over time, as well as the reverberating impact of these events within their communities (for review, see Holmes et al.). A rapidly expanding body of research has consistently documented increased social, emotional, behavioral, and academic risk associated with parental wartime military service for children across developmental periods, as well as the direct and indirect reverberations of heightened stress across the family system (for review, see Lester and Flake). In this context, there has been a growing public health awareness of the impact of these stressors on the well-being of military children and their families, with increased recognition of the importance of developing and evaluating preventive interventions to reduce psychological health risk and to promote resilience and positive coping in at-risk military families and children.

Family-centered preventive interventions have consistently demonstrated effectiveness in promoting positive outcomes in children at risk for poor developmental and psychological health outcomes across multiple contexts. Family prevention science has documented the important role of parenting and family processes for child well-being and has identified specific family-level interactions as mediators of children’s ability to adapt and thrive in the context of adversity. Interventions that include specific developmental guidance and psychoeducation, as well as the opportunity to build and practice skills that support positive
parenting practices, parent–child relationships, and individual and family coping have been shown to enhance behavioral and emotional regulation in children.\textsuperscript{11} Prior research also indicates that family-centered approaches are likely to be more engaging and culturally acceptable than individual interventions.\textsuperscript{11,12}

With the rapidly evolving conditions of a country at war, the Families OverComing Under Stress (FOCUS) preventive intervention was designed to build upon the findings of foundational intervention research, which demonstrated that family-centered preventive interventions targeting child outcomes in at-risk families could also improve parental psychological and family adjustment over time.\textsuperscript{13} FOCUS was adapted from 2 evidence-based, family-centered preventive interventions shown to enhance child and family adjustment in the context of parental medical and mental health problems,\textsuperscript{14,15} as well as a third intervention for children and parents affected by wartime exposure.\textsuperscript{16} This framework builds upon developmental and intervention research that identifies the mutual influences among individuals and relationships within families, and between families and broader social contexts.\textsuperscript{17} FOCUS was designed to improve individual adjustment of parents and children as well as their functioning within family relationships (e.g., parent–parent, parent–child), with the expectation that improvements in each domain will reverberate throughout the entire family.\textsuperscript{13,18}

The FOCUS intervention development team conducted a rigorous review of each of the foundational interventions’ protocols and research, and identified 4 core elements that were then adapted for military families and culture through a previously reported assessment of risk and protective processes\textsuperscript{8} and a partnered adaptation process with military providers and families.\textsuperscript{13,19,20} The core intervention elements include the following: 1) Family Resilience Check-in: a Web-based standardized psychological health and family assessment and provider decision-making tool that provides immediate analytics and guided feedback to provider and family; 2) family psychoeducation and developmental guidance with an emphasis on strengthening parenting, and information on the impact of military-related stressors on children, parents, and family (such as deployment cycle/separation stressors, posttraumatic stress, traumatic brain injury, and physical injuries); 3) narrative timelines: structured, graphic narratives of the experiences of individual family members surrounding key family transitions to enhance perspective taking, reflection, communication, and understanding, and to promote the construction of a shared family narrative; and 4) resilience skill building: learning and practicing key skills, including communication, problem solving, goal setting, emotional regulation, and the management of reminders of separation, trauma, and loss. The FOCUS intervention has been implemented for active-duty military families at 15 US and international installations through the leadership of the US Navy’s Bureau of Medicine and Surgery. Consistent with the Institute of Medicine framework\textsuperscript{11} for a public mental health approach to the prevention of mental health disorders, the intervention was implemented as a selective and indicated prevention program in nonclinical community settings using a psychoeducational, skills-based approach to reduce psychological health symptoms and to strengthen individual and family processes identified as protective for youth well-being.

In this observational evaluation study, we examine the impact of the intervention on parents, children, and family outcomes using data collected to guide service delivery and continuous quality improvement. In previous studies of a demonstration pilot, the intervention was found to be feasible, acceptable, and to demonstrate preliminary effectiveness. Initial pre-post examination of the intervention indicated that it reduced parent and child psychological health risk symptoms, as well as improved family adjustment, and met the expectations of program participants.\textsuperscript{19} A second evaluation study showed that child outcomes at follow-up were predicted by changes in family adjustment targeted by the intervention, including improved family-level communication and problem solving.\textsuperscript{21}

The goal of the present study is to build upon these findings to examine whether the trajectory of improvements following the intervention is consistent over time for all family members. We use a longitudinal regression model to examine patterns of psychological health adjustment outcomes for children as well as parents in this large, observational evaluation study.\textsuperscript{22,23} We hypothesized that both parents (civilian and military) and children participating in the intervention would have an improved pattern of psychological health adjustment outcomes over time following the intervention. We also hypothesized that the prevalence of clinically meaningful levels of parent and child psychological health symptoms would be lower, and that family adjustment and child coping would be improved post-intervention compared to intake.

METHOD

Intervention

FOCUS was designed as a structured, manualized, psychoeducational, and skill-building intervention, but with the flexibility to be customized to fit each family’s unique goals and challenges.\textsuperscript{20} The intervention was delivered via in-person, provider-led sessions for individual families. Intervention modules included 8 sessions, with parent-only sessions (sessions 1 and 2), child-only (sessions 3 and 4), parent-only (session 5), and family sessions (sessions 6–8). In sessions 1 and 2, parents complete the Family Resilience Check-In, a narrative timeline activity, and psychoeducation and learning/practicing resilience skills. In sessions 3 and 4, children also complete the Family Resilience Check-In (age 6 years and older), a graphic narrative activity, and learn and practice skills outlined above. Session 5 supports parenting skills and planning for family sessions, and sessions 6 to 8 include narrative sharing and additional family-level skill building. Sessions attended only by parents were scheduled for 90 minutes, and children-only sessions were 30 to 60 minutes, depending on the child’s development level.

Sessions were delivered by doctoral or master’s level mental health providers with a background in child and family intervention delivery. Providers were employed, trained, and managed by a University of California, Los Angeles (UCLA)-based administrative and intervention development team. Provider training included an online and in-person curriculum, as well as ongoing advanced
training through a virtual learning community platform. Model supervisors provided weekly supervision, reviewed intervention fidelity measures and delivery notes, and conducted quarterly site visits with observed sessions. Adult participants used the Family Resilience Check-In to complete standardized assessments at intake, program exit, and follow-up at 1 month (follow-up 1) and 6 months (follow-up 2) postcompletion. Child participants aged 6 years and older also completed the Family Resilience Check-In at intake and program exit. Demographic and deployment history information was obtained from parents at intake. Following intake, assessments were scored and interpreted in real time. When clinical risk, such as suicidal ideation, was identified, further screening and appropriate treatment referrals, including emergency management, were implemented. Upon completion, parents were asked to provide contact information, and a plan for continued contact was developed. Providers were automatically reminded to contact the parents for ongoing support and follow-up. At the time of voluntary enrollment in the intervention, families completed and signed a service agreement outlining the goals of the intervention and evaluation, as well as confidentiality standards and mandatory reporting requirements. The UCLA institutional review board approved this study on the existing service delivery evaluation data.

Recruitment
Participants were active-duty military families living at designated active-duty installations that enrolled in the FOCUS intervention between July 2008 and December 2013. Eligibility criteria for voluntary participation in this free, confidential military service program included active duty families with at least 1 child 3 to 17 years of age with a military parent serving at 1 of the designated military installations. Families with active cases of domestic violence/child abuse were not eligible for participation and were referred for appropriate services according to installation protocols. Outreach was done through a variety of strategies, including media outlets (e.g., military radio), word of mouth, community events, and referrals by other providers (teachers, chaplains, primary care doctors, and mental health providers).

Study Sample
Between July 2008 and December 2013, a total of 3,431 active-duty military families consisting of 5,136 adults (service member and civilian parents) and 6,339 children enrolled in the intervention. Our final sample was obtained by excluding the following: families still actively participating in the intervention (146 families), families who did not complete an intake and at least 1 postintervention assessment (850 families), and families who had invalid postintervention assessment dates (20 families). The resulting final sample consisted of 2,486 families (1,426 service member parents, 2,073 civilian parents, and 3,810 children). Among parents who did not complete any postintervention assessments, there were more males and service members relative to those parents included in the postintervention assessments, there were more males and service of 2,615 families (1,426 service member parents, 2,073 civilian parents) and 6,339 children enrolled in the intervention. Our military families consisting of 5,136 adults (service member and civilian parents) and 6,339 children enrolled in the intervention. Our sample was obtained by excluding the following: families still actively participating in the intervention (146 families), families who did not complete an intake and at least 1 postintervention assessment (850 families), and families who had invalid postintervention assessment dates (20 families). The resulting final sample consisted of 2,486 families (1,426 service member parents, 2,073 civilian parents, and 3,810 children). Among parents who did not complete any postintervention assessments, there were more males and service members relative to those parents included in the final sample. Children who did not complete any of the follow-up assessments were significantly older than children who were included in the final sample.

We categorized the families in our final sample into “completers” and “partial completers.” Completers were defined as those families for whom parent(s) and youth had at a minimum completed the core elements of the intervention (check-up, narrative timeline, psychoeducation, and skill building) through sessions 1 to 4. Families considered partial completers were those who completed at least 1 intervention session but who did not complete all of the core elements (<4). We designated 2,486 families as completers (n = 3,362 adults and 3,577 children). Remaining families were categorized as partial completers (n = 129 families; 137 adults and 233 children). The 2 most common reasons for families not completing the intervention included relocation or deployment (49.3%) and being “too busy” (27.9%). Another reason was the family reporting that they no longer needed services (9.9%). Among adults belonging to partial completer families, there were more females, civilian parents, younger adults, and lower levels of healthy family functioning at intake relative to those belonging to completer families. Children from partial completer families were not significantly different compared with children from completer families.

Primary Outcome Measures
Parental psychological health outcomes were assessed using 2 subscales of the self-report Brief Symptom Inventory-18 (BSI-18), those indexing depression and anxiety symptoms administered at intake, exit, and 2 follow-ups. Service member and civilian parents indicated the extent to which they had been bothered or distressed by symptoms during the past week on a Likert scale. Anxiety and depression symptom scores were calculated by averaging across the 6 items pertaining to each primary symptom dimension (Cronbach α = 0.83 and 0.84, respectively). A higher score indicated a higher level of depression or anxiety symptoms. Clinical cut-offs were used to identify clinically meaningful levels of anxiety (0.68 for men, 0.99 for women) and depression symptoms (0.66 for men, 1.11 for women).

Child psychological health symptoms and prosocial outcomes were assessed using the Strengths and Difficulties Questionnaire (SDQ). Parent Report. Age-appropriate versions of the SDQ were completed by both parents at intake and follow-ups with regard to each of their children aged 3 to 17 years. When multiple parents completed an SDQ for a single child, 1 parent was selected as the primary reporter, and his or her assessments were used across all time points. The primary reporter was the parent with the most postintervention assessments completed, which increased our ability to compare across multiple time points. If multiple parents completed the same number of postintervention assessments, the primary reporter was determined based on endorsement of the self-reported primary caregiver question. A total difficulties score was calculated by summing the scores received on 2 Likert scale items related to conduct problems, emotional symptoms, hyperactivity, and peer problems (Cronbach α = 0.83). A higher score indicated a child had more difficulties. A prosocial behavior score was calculated by summing the scores received on the 5 items that assessed a child’s consideration of other people’s feelings, willingness to share with other children, helpfulness toward other hurt or upset children, kindness to younger children, and voluntary helpfulness toward others (Cronbach α = 0.90). Higher scores indicated greater prosocial behaviors. A cut-off score of ≥16 was used to indicate high total difficulties, and a cut-off score of <6 was used to indicate high difficulties with prosocial behavior.

Secondary Outcome Measures
Family functioning was measured by the 12-item General Functioning subscale of the self-report McMaster Family Assessment Device (FAD) that was administered to both parents when available at intake and exit. The General Functioning subscale is designed to be a shorter version of the FAD and provides an overall measure of family adjustment including communication, problem solving, and emotional relatedness. Scores on some items were reversed so that high scores always reflected unhealthy family functioning. The score was calculated by taking the average across all 12 items (Cronbach α = 0.91). A cut-off score of ≥2 was used to identify unhealthy family functioning.
Parent posttraumatic stress was assessed using the PTSD (post-traumatic stress disorder) Checklist (PCL), a brief inventory of 17 self-report items designed to determine the severity of PTSD symptoms within the past month. At intake and exit, parents selected how much they had been bothered by symptoms related to a stressful event. Military and civilian versions of the PCL were available and administered to service member and civilian parents, respectively. A PCL total score was calculated by summing the scores from all 17 items (Cronbach $\alpha = 0.94$). A cut-off score of 30 or greater indicated a high probability of the presence of PTSD.

Self-reported symptoms of anxiety among children aged 8 to 17 years were assessed at intake and exit using the Total Anxiety scale from the 39-item Multidimensional Anxiety Scale for Children (MASC). The MASC asked children to provide a response to items related to physical symptoms, harm avoidance, social anxiety, and separation/panic using a Likert scale. The Total Anxiety score was calculated by summing all items, with higher scores corresponding to increased emotional problems (Cronbach $\alpha = 0.90$). t Scores were calculated based on child age and gender. A t score cut-off of >65 was used to indicate clinically meaningful elevated anxiety.

Child coping was assessed by the KidCope, a brief child self-report measure. At intake and exit, children ages 6 years and older provided responses to 15 items assessing their positive and negative coping strategies. Cognitive restructuring, emotional regulation, and social support scores were set equal to the numeric score of the single items associated with each subscale. The problem-solving subscale was calculated by averaging 2 different item scores.

### Statistical Analysis

Descriptive statistics and frequencies for parents’ (service member and civilian) and children’s characteristics, and descriptive statistics of primary and secondary outcome measures for parents and children were calculated. The results are displayed in Table 1 below.

### Table 1: Demographic and Intake Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Service Member</th>
<th>Civilian</th>
<th>All</th>
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<tbody>
<tr>
<td><strong>Parents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male, n (%)</td>
<td>952 (66.8)</td>
<td>19 (0.9)</td>
<td>971 (27.8)</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>474 (33.2)</td>
<td>2,054 (99.1)</td>
<td>2,528 (72.3)</td>
</tr>
<tr>
<td>Age at intake, y, mean (SD)</td>
<td>33.8 (5.99)</td>
<td>33.1 (6.27)</td>
<td>33.4 (6.17)</td>
</tr>
<tr>
<td>BSI measures at intake</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety, mean (SD)</td>
<td>0.58 (0.71)</td>
<td>0.63 (0.68)</td>
<td>0.61 (0.69)</td>
</tr>
<tr>
<td>Clinically meaningful, n (%)</td>
<td>341 (23.9)</td>
<td>485 (23.4)</td>
<td>826 (23.6)</td>
</tr>
<tr>
<td>Depression, mean (SD)</td>
<td>0.56 (0.72)</td>
<td>0.63 (0.68)</td>
<td>0.60 (0.70)</td>
</tr>
<tr>
<td>Clinically meaningful, n (%)</td>
<td>387 (27.1)</td>
<td>409 (19.7)</td>
<td>796 (22.8)</td>
</tr>
<tr>
<td>FAD unhealthy family functioning, mean (SD)</td>
<td>1.97 (0.52)</td>
<td>1.87 (0.51)</td>
<td>1.91 (0.51)</td>
</tr>
<tr>
<td>Unhealthy functioning, n (%)</td>
<td>702 (49.3)</td>
<td>882 (42.6)</td>
<td>1,584 (45.3)</td>
</tr>
<tr>
<td>PCL total score, mean (SD)</td>
<td>27.1 (13.2)</td>
<td>27.8 (10.9)</td>
<td>27.5 (11.9)</td>
</tr>
<tr>
<td>Clinically meaningful, n (%)</td>
<td>370 (26.1)</td>
<td>643 (31.1)</td>
<td>1,013 (29.1)</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at intake, y, mean (SD)</td>
<td>7.14 (3.46)</td>
<td>7.40 (3.59)</td>
<td>7.26 (3.52)</td>
</tr>
<tr>
<td>SDQ measures at intake</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Prosocial behavior, mean (SD)</td>
<td>7.47 (2.03)</td>
<td>8.16 (1.89)</td>
<td>7.79 (2.00)</td>
</tr>
<tr>
<td>High difficulties, n (%)</td>
<td>382 (18.6)</td>
<td>205 (11.6)</td>
<td>587 (15.4)</td>
</tr>
<tr>
<td>Total difficulties, mean (SD)</td>
<td>13.2 (6.69)</td>
<td>11.4 (6.25)</td>
<td>12.4 (6.55)</td>
</tr>
<tr>
<td>High difficulties, n (%)</td>
<td>723 (35.3)</td>
<td>435 (24.7)</td>
<td>1,158 (30.4)</td>
</tr>
<tr>
<td>KidCope measures at intake</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive restructuring</td>
<td>1.55 (1.01)</td>
<td>1.56 (1.01)</td>
<td>1.56 (1.01)</td>
</tr>
<tr>
<td>Emotional regulation</td>
<td>1.49 (0.99)</td>
<td>1.56 (0.93)</td>
<td>1.52 (0.96)</td>
</tr>
<tr>
<td>Social support</td>
<td>1.70 (0.99)</td>
<td>1.82 (0.98)</td>
<td>1.76 (0.99)</td>
</tr>
<tr>
<td>Problem solving</td>
<td>1.21 (0.84)</td>
<td>1.26 (0.78)</td>
<td>1.24 (0.81)</td>
</tr>
<tr>
<td>MASC measures at intake</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total anxiety, mean (SD)</td>
<td>46.03 (17.58)</td>
<td>51.39 (17.99)</td>
<td>48.64 (17.98)</td>
</tr>
<tr>
<td>Clinically meaningful, n (%)</td>
<td>119 (14.3)</td>
<td>116 (14.7)</td>
<td>111 (6.8)</td>
</tr>
</tbody>
</table>

Note: BSI = Brief Symptom Inventory; FAD = McMaster Family Assessment Device; MASC = Multidimensional Anxiety Scale for Children; PCL = PTSD (Posttraumatic Stress Disorder) Checklist; SDQ = Strengths and Difficulties Questionnaire.
children at intake, were summarized. For the primary outcome measures for parents, linear mixed-effects longitudinal regression models with family-level random effects were used to assess the change in anxiety and depression symptoms reported by parents over time. The fixed effects included participants’ age and gender, and a time variable (intake, exit, and 2 follow-up assessments). Time effects were estimated by calculating the difference between intake and each postintervention assessment through model contrasts. The models included family-level random intercepts to account for dependence within families and a first-order autoregressive (AR1) covariance structure to account for repeated observations per participant. These adjusted analyses were done for all parents (main models), and separately for service member and civilian parents. We used the same modeling approach to assess the time effects on children’s prosocial behaviors and total difficulties reported by parents on the SDQ. Additional regression models were conducted by adding a gender-by-time interaction term to evaluate whether there were gender differences in changes of these SDQ outcomes. To examine time effects on the prevalence of clinically meaningful levels of parental anxiety and depression symptoms, and child total difficulties, logistic mixed-effects longitudinal regression models were analogously constructed using the same sets of fixed effects, family-level random effects, and AR1 covariance structures.

For the secondary outcome measures (collected at intake and exit), we simplified the above models by including family-level and participant-level random intercepts that accounted for dependence within families and repeated observations per participant, respectively. Fixed effects included were gender and a time variable (intake and exit). Similarly, time effects were assessed by estimating the difference from intake to exit using a model contrast.

Finally, we conducted exploratory analyses to investigate whether the time effects on parent anxiety and depression symptoms (BSI) for participants from the families who completed FOCUS differed from those who were partial completers. We included 2 additional fixed-effects, study status (completers versus partial completers), and time-by-study status interaction term, to the main models, and examined the differences in time effects on these measures between completed and partially completed families through model contrasts. All statistical analyses were done using SAS 9.4; PROC MIXED and GLIMMIX were used to fit all linear and logistic mixed effects models, respectively. All of the graphs were generated using R.

**RESULTS**

Demographic and Intake Characteristics

Table 1 presents the demographic characteristics and primary and secondary outcome measures at intake for service member and civilian parents and their children. Of the parents, 41% were service members. Approximately 67% of the service member parents were male, and 99% of the civilian parents were female. The average age for all of the parents was 33 years (range 18–66 years), and the average ages for service member and civilian parents were similar. In all, 54% of the children were boys, and the average age of

**FIGURE 1** Estimated trajectories of Brief Symptom Inventory (BSI) outcomes overall (a, b) and by parent type (c, d). Note: Estimated means with 95% CIs (mean bars) for anxiety symptoms (a, c) and depression symptoms (b, d) are plotted at the following assessments: intake (pre), exit, and 2 follow-ups. Solid line with circle represents the mean bar for service member parents (SM); dashed line with triangle represents the mean bar for civilian parents (CP).
children was 7.3 years. A highly deployed population, families in this sample reported an average of 2.12 combat deployments and 2.41 noncombat deployments, or 4.53 total deployments before enrollment.

At intake, service member parents reported lower levels of anxiety (mean 0.58 versus 0.63, respectively; \( p = .042 \)) and depression symptoms (mean 0.56 versus 0.63; \( p = .002 \)) than their civilian parent counterparts. At intake, approximately 23% of service members and civilian parents reported clinically meaningful levels of anxiety symptoms, based on gender-specific cut-offs. In all, 27% of service members and 20% of civilian parents reported clinically meaningful levels of depression at intake based on gender-specific cut-offs. Notably, 31% of civilian and 26% of service member parents were identified as having FCL scores above the cut-off of 30, indicating clinically meaningful levels of posttraumatic stress symptoms. Civilian parents reported significantly lower levels of unhealthy family functioning relative to service member parents (1.87 versus 1.97; \( p < .0001 \)). Almost 50% of service member and 43% of civilian parents indicated unhealthy family functioning at baseline.

Of children entering the intervention, 35% of boys and 25% of girls had high total difficulties assessed by the SDQ parent report. In all, 19% of boys and 12% of girls had high difficulties with prosocial behaviors at intake. The mean level of total difficulties for all children was 12.4 (± 6.55). Boys had significantly higher levels of total difficulties at intake compared to girls (13.2 versus 11.4, respectively; \( p < .0001 \)). Compared to girls, boys also had significantly lower levels of positive prosocial behavior (7.47 versus 8.16; \( p < .0001 \)).

Among the 1,624 children who completed the MASC, girls reported significantly greater levels of anxiety symptoms than boys (51.4 versus 46.0; \( p < .0001 \)). At intake, 14.3% of boys and 14.7% of girls between the ages of 8 and 17 years reported clinically elevated levels of anxiety symptoms. Among the 2,755 children who completed self-reported coping on the KidCope at intake, mean scores on cognitive restructuring and problem-solving measures were similar for boys and girls. Girls reported significantly higher scores than boys on the emotional regulation (1.56 versus 1.49; \( p = .047 \)) and social support measures (1.82 versus 1.70; \( p = .002 \)).

### Parents: Improvement in Psychological Health Symptoms Over Time

The estimated mean levels (with 95% CIs) of anxiety and depression at intake, exit, and the 2 follow-up assessments for all parents and by parent type (service member or civilian) are plotted in Figure 1. The estimated changes in anxiety and depression symptoms from intake to each of the post-FOCUS assessments are summarized in Table 2.

Parental psychological health symptoms improved over time. In Figure 1a, the estimated mean level of anxiety symptoms decreased at the exit assessment (estimated change: 0.191 ± 0.010, \( p < .0001 \); Table 2) and continued to decrease at the 2 follow-up assessments (0.223 and 0.233, respectively). A significant reduction in depression symptoms at exit was observed (0.224 ± 0.010, \( p < .0001 \)). However, the estimated mean level of depression symptoms went up slightly at follow-up 1, then went down again at follow-up 2 (Figure 1b). Figures 1c and 1d present the mean levels of depression and anxiety symptoms for service member (solid line with circle) and civilian (dashed line with triangle) parents estimated from the stratified longitudinal analyses, suggesting that improvement in psychological health symptoms occurred in both service member and civilian parents. Relative to intake, significantly lower odds of clinically meaningful levels of anxiety and depression

### TABLE 2 Improvement in Parent Psychological Health Symptoms and Reductions in the Prevalence of Clinically Meaningful Symptoms Over Time

<table>
<thead>
<tr>
<th>Change From Intake</th>
<th>Anxiety Symptoms</th>
<th>Depression Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate (SE)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>All Parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exit</td>
<td>0.191 (0.010)</td>
<td>0.33 (0.30–0.37)</td>
</tr>
<tr>
<td>Follow-up 1</td>
<td>0.223 (0.013)</td>
<td>0.33 (0.29–0.37)</td>
</tr>
<tr>
<td>Follow-up 2</td>
<td>0.233 (0.015)</td>
<td>0.32 (0.28–0.37)</td>
</tr>
<tr>
<td>Service Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exit</td>
<td>0.147 (0.015)</td>
<td>0.33 (0.27–0.38)</td>
</tr>
<tr>
<td>Follow-up 1</td>
<td>0.180 (0.021)</td>
<td>0.34 (0.28–0.43)</td>
</tr>
<tr>
<td>Follow-up 2</td>
<td>0.195 (0.025)</td>
<td>0.30 (0.24–0.38)</td>
</tr>
<tr>
<td>Civilians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exit</td>
<td>0.222 (0.013)</td>
<td>0.19 (0.17–0.22)</td>
</tr>
<tr>
<td>Follow-up 1</td>
<td>0.253 (0.015)</td>
<td>0.19 (0.16–0.22)</td>
</tr>
<tr>
<td>Follow-up 2</td>
<td>0.260 (0.016)</td>
<td>0.21 (0.18–0.26)</td>
</tr>
</tbody>
</table>

Note: All comparisons were statistically significant (\( p < .0001 \)). OR = adjusted odds ratio; SE = standard error.

aAdjusted for participant age and gender.
bModels for civilians were adjusted for participant age because 99% of the civilians were female.
Symptoms were observed at all postintervention assessments for both service members (range of adjusted odds ratios [ORs] for both symptoms: 0.24–0.34) and civilian parents (range of adjusted ORs: 0.16–0.31; Table 2). Among all parents, percentages of clinically meaningful anxiety and depression symptoms decreased from approximately 23% at intake to around 11% at exit and remained similarly low at both follow-ups (range of adjusted ORs: 0.29–0.36).

Both civilian and service member parents reported a decrease in PTSD symptoms (3.08/C6 0.16, p < .0001) from intake to postintervention. Significantly lower odds of clinically meaningful posttraumatic stress were observed at the postintervention (adjusted OR = 0.47, 95% CI = 0.42–0.53). Overall, parents also reported a decrease in unhealthy family functioning (0.19 ± 0.01, p < .0001), and a lower odds of meeting the cut-off for unhealthy functioning (adjusted OR = 0.50, 95% CI = 0.43–0.58).

Children: Improvement in Psychological Health Symptoms and Prosocial Behaviors Over Time

The estimated levels (with 95% CIs) of prosocial behaviors and total difficulties at intake and the 2 follow-up assessments by child gender are plotted in Figure 2. The changes in prosocial behaviors and total difficulties from intake to each of the follow-up assessments are summarized in Table 3.

Significant reductions in children’s total difficulties were found at both follow-up assessments (3.45 ± 0.09 and 3.79 ± 0.11, respectively; both p < .0001). Furthermore, improvement in children’s prosocial behaviors was significant at follow-up 1 (0.61 ± 0.03, p < .0001), and the scores continued to increase at follow-up 2 (0.68 ± 0.04, p < .0001). Relative to intake, we observed significantly lower odds of high total difficulties and high difficulties with prosocial behavior for boys and girls at both follow-up assessments (range of adjusted OR: 0.16–0.44; Table 3). Among all children, the prevalence of high total difficulties (30% to < 14%) and high difficulties with pro-social behavior (15% to < 9%) dropped from intake to both follow-up visits.

Results from the interaction regression model indicated that total difficulties and prosocial behaviors improved more among boys than among girls. These time trends can be seen in Figures 2a and 2b for prosocial behaviors and total difficulties, respectively.

We also observed significant improvement in children’s self-reported anxiety symptoms (MASC total score: 2.57 ± 0.37, p < .0001). Among children 8 years and older, the prevalence of clinically elevated anxiety decreased from 14.5% at intake to 11.8% postintervention. We found significantly lower odds of clinically meaningful anxiety from intake to postintervention (adjusted OR = 0.78, 95% CI = 0.63–0.96). A significant improvement was observed in the following child-reported positive coping skills: cognitive restructuring (0.06 ± 0.02, p = .008), emotional regulation (0.09 ± 0.02, p < .0001), and problem solving (0.04 ± 0.02, p = .016).

Exploratory Analysis: Completed Versus Partially Completed Families

The mean levels of depression and anxiety symptoms (± standard error) over time for parents from families that completed versus partially completed the intervention were...

**FIGURE 2** Estimated trajectories of child Strengths and Difficulties Questionnaire (SDQ) outcomes for boys and girls. Note: Estimated means with 95% CIs for child SDQ prosocial behaviors (a) and total difficulties (b) are plotted at the following assessments: intake (pre) and 2 follow-ups. Solid line with circle represents the mean bar for boys; dashed line with triangle represents the mean bar for girls.
estimated. Because there were very few parents who partially completed and reported their depression and anxiety at exit \((n = 7)\), the variability for depression and anxiety symptoms among this group was too high to make reasonable inferences. Thus, we removed depression and anxiety symptoms at exit from these analyses. Instead, we focused on the data at intake and the last 2 follow-ups. The 2 groups had comparable levels of depressive and anxiety symptoms at intake. Estimated time effects on parental depressive and anxiety symptoms from the completer families were consistent with those for the entire sample. For example, the levels of anxiety symptoms between the 2 groups were similar at intake (0.019 ± 0.054). However, the difference in anxiety symptoms became larger, but not significant, at the last follow-up (0.049 ± 0.078), suggesting that the families who completed FOCUS may improve more over time.

**DISCUSSION**

US military families have experienced the impact of a sustained war overseas for more than a decade, presenting unprecedented tests of the resilience of service members, their families and children, as well as the systems that support them.\(^3^8,3^9\) The FOCUS preventive intervention was implemented at highly deploying military installations as a response to a growing public health awareness of the impact of parents’ military service on their children and families during a historical period of high operational tempo, including 2 military surges overseas.\(^3^9\) In this context, the families participating in FOCUS had experienced an ongoing, cumulative exposure to stress. The mean number of deployments reported by families before entering the intervention was >4 since the birth of their first child. This observational evaluation study of the FOCUS intervention provides detailed information on trajectories of longitudinal psychological health and resilience outcomes in active-duty military parents, civilian partner parents, and children. To our knowledge, this is the largest longitudinal study of post–9/11 active-duty military children and parents that includes individual parent-, child-, and family-level assessments.

About one-third of children participating in the FOCUS intervention were at increased risk for clinically significant difficulties at baseline, with boys (35%) at greater risk than girls (25%) for emotional and behavioral symptoms and poor peer relationships at the time of enrollment. Military and civilian parents participating in this community-based prevention program also reported increased risk for clinically significant symptoms of anxiety, depression, and PTSD at intake. Both service member (27%) and civilian parents (20%) experienced clinically significant depressive symptoms, whereas civilian parents reported higher risk levels for clinically significant PTSD symptoms (31%) than did service member parents (26%) at baseline. The prevalence of clinically meaningful PTSD symptoms in civilian parents warrants further investigation to better understand these symptoms in the context of lifetime or recent exposures to traumatic events and to examine their impact on family functioning and child well-being. These data underscore the importance of integrating trauma-informed, behavioral health screening practices in systems serving military-connected families as an opportunity to identify and address early behavioral health risk.

As hypothesized, both military and civilian parents completing the FOCUS intervention demonstrated patterns of improvement in depression and anxiety symptoms over time. For both types of parents, a similar pattern of change indicated a reduction in symptoms after completion of the intervention that was sustained and continued to improve over 6 months of repeated follow-up. Notably, we also found significant reductions (from 23% to 11%) of those parents screening at risk for anxiety and depressive symptoms that were sustained at longitudinal follow-up.

**TABLE 3 Improvement in Child Psychological Health Symptoms and Prosocial Behaviors and Reduction in the Prevalence of High Difficulties Over Time**

<table>
<thead>
<tr>
<th>Change From Intake</th>
<th>SDQ Measures</th>
<th>Prosocial Behavior</th>
<th>Total Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate (SE) OR (95% CI)</td>
<td>Estimate (SE) OR (95% CI)</td>
<td></td>
</tr>
<tr>
<td>All^a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up 1</td>
<td>0.613 (0.029) 0.47 (0.42–0.53)</td>
<td>–3.454 (0.088) 0.21 (0.18–0.24)</td>
<td></td>
</tr>
<tr>
<td>Follow-up 2</td>
<td>0.677 (0.037) 0.46 (0.41–0.52)</td>
<td>–3.787 (0.114) 0.22 (0.19–0.25)</td>
<td></td>
</tr>
<tr>
<td>Boys^b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up 1</td>
<td>0.704 (0.040) 0.42 (0.36–0.49)</td>
<td>–3.755 (0.121) 0.16 (0.13–0.19)</td>
<td></td>
</tr>
<tr>
<td>Follow-up 2</td>
<td>0.797 (0.051) 0.44 (0.38–0.51)</td>
<td>–4.104 (0.156) 0.16 (0.13–0.19)</td>
<td></td>
</tr>
<tr>
<td>Girls^b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up 1</td>
<td>0.502 (0.043) 0.44 (0.37–0.52)</td>
<td>–3.092 (0.131) 0.17 (0.14–0.21)</td>
<td></td>
</tr>
<tr>
<td>Follow-up 2</td>
<td>0.533 (0.056) 0.37 (0.31–0.45)</td>
<td>–3.427 (0.170) 0.22 (0.18–0.26)</td>
<td></td>
</tr>
</tbody>
</table>

Note: All changes from intake \((= FU-Intake)\) were statistically significant \(p < .0001\). OR = adjusted odds ratio; SE = standard error.

^aAdjusted for participant’s age at intake and gender.

^bInteraction model (gender-by-follow-up) adjusted for children’s age at intake, used to generate improvement estimates, and model adjusted for age was used for adjusted odds ratios.
Similarly, both male and female children participating in the intervention also demonstrated significant and clinically meaningful improvements over time, with similar patterns of change in emotional and behavioral symptoms and prosocial behaviors. The identification of similar outcome trajectories for all types of family members provides support for the expectation that improvements in both individual and family adjustment will reverberate across the family system.

Changes in service member and civilian parental PTSD symptoms also reflected significant and clinically meaningful improvements. This finding was particularly notable because the FOCUS intervention was not a clinical treatment program but did provide trauma-informed psychoeducation and skills training in the management of traumatic reactions and reminders that are typically not included in family preventive interventions. We anticipated that these skills would improve parenting and family relationships in the presence of the often corrosive impact of posttraumatic stress symptoms on interpersonal relationships. Child self-reported anxiety symptoms also improved following completion of this intervention, as did reports of improved positive coping skills, such as emotional regulation and problem solving, both of which are key skills taught and practiced during the intervention.

Taken as a whole, this evaluation study suggests that participation in the intervention provided durable improvements in parent and child psychological health outcomes. Given that parental psychological adjustment has been identified in previous research as a consistent and robust mediator of child adjustment, the reduction of parental symptoms is particularly important at both an individual and a family level. Both civilian and military parents also reported significant improvements in family adjustment following the intervention, reflecting positive changes in domains associated with family-level resilience and positive child outcomes including communication, problem solving, and emotional relatedness consistent with the intervention’s theoretical framework.

Participating parents consistently indicated that they sought out the FOCUS intervention to help them manage their child’s distress and/or to be better prepared for future stressors, but then found that the information and skills that they learned helped “everyone in the family.” The finding that 49% of participating parents in this voluntary program were active-duty service members suggests that family-centered prevention services can successfully engage and retain military personnel through approaches that are designed to proactively strengthen the family as a whole, providing guidance to future intervention research and program implementation design.

The current study is limited by the open trial design of the program. We conducted this evaluation study on an existing data set for a large-scale implementation of a family-centered preventive intervention for the US military. The optimal design to evaluate effectiveness of this adapted intervention might have been a randomized controlled trial (RCT) or other implementation design such as a stepped wedge design, but this was not feasible in the context of a rapidly evolving public health need that emerged during wartime operations. The findings are also limited by the availability of information about parental characteristics in this data set. Aside from parent age and gender, other parental characteristics that could potentially have influenced child outcomes were not collected among this sample, such as type of parent (biological/nonbiological) or marital status of parents. Similarly, characterization of the intervention participation in relation to the deployment cycle was not possible, given the heterogeneous nature of the timing and type of deployments across participating service branches. We also note that 1 of the primary child outcomes uses a parent-report assessment (i.e., the SDQ), which could reflect response bias from parent characteristics. However, additional child self-report measures (e.g., MASC and Kidscope) provide confirmatory findings for the parent-report assessment. Improvements in child adjustment over time may have been attributable in part to maturational change, although it is unlikely that the nonintervention changes would account for differences over a relatively brief developmental period.

Despite these limitations, the current study design has several strengths. First, the implementation design included a continuous quality improvement monitoring data infrastructure that provided the opportunity to provide ongoing follow-up assessments over time with 67% of the enrolled families. Second, we selected a mixed effects longitudinal analytical model for this study to provide novel information about the pattern of improvement over time among this large, unique sample of active-duty families and children. Furthermore, we used data from multiple reporters: including, for both parents, self-report, parent report on child, and parent report on family assessments, and for children, child self-report assessments.

The implementation of this theoretically grounded preventive intervention through a partnered collaboration with military medicine, families, and communities represents a paradigm for adapting existing evidence-based interventions in response to urgent public health challenges. Consistent with recommendations of a comprehensive continuum of care as outlined by the Institute of Medicine for at-risk and distressed populations, FOCUS was integrated as a selective and indicated preventive intervention, with the goal of bridging gaps in the existing continuum of behavioral health care for military families. Distinct from many family-centered and parenting intervention models that focus on child outcomes as the primary targets of prevention, the underlying ecological framework of this intervention included attention to the reverberating impact of adversity as potentially disruptive to any combination of individuals and relationships within the family system, addressing stress at the level of the family unit. Findings that similar patterns of improvements were seen in the trajectory of outcomes for parents and children alike provide further support for this framework. The longest war in US history has led to a rapid expansion of research on the impact of parental military service on children, as well as on their prevention and treatment needs. These findings contribute unique information about the psychological adjustment in...
parents and children in active duty populations navigating wartime service, underscore the relevance and potential of family-centered preventive intervention to enhance the well-being of military children and families, and provide guidance for further intervention research design.

Clinical Guidance

- The longest war in US history has led to a rapid expansion of research on the impact of parental military service on the well-being of children and families, as well as on their mental health prevention and treatment needs.
- As a trauma-informed, family-centered intervention, FOCUS is grounded in an ecological model designed to enhance resilience and mitigate mental health risk at both the individual and family level through psychoeducation, narrative construction, and cognitive-behavioral skill building.
- Using a public mental health framework, FOCUS was implemented as a selective and indicated preventive intervention to bridge gaps in the continuum of behavioral health care for military families.
- The positive evaluation of this intervention for children, parents, and families encourages further research into family-centered prevention for families facing adversity.

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5. Dr. Nash is with the United States Marine Corps Headquarters, Arlington, VA. Dr. Beardslee is with Children’s Hospital Boston, Harvard Medical School, Boston.
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Dissemination of Family-Centered Prevention for Military and Veteran Families: Adaptations and Adoption within Community and Military Systems of Care

William R. Beardslee · Lee E. Klosinski · William Saltzman · Catherine Mogil · Susan Pangelinan · Carl P. McKnight · Patricia Lester

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Abstract In response to the needs of military families confronting the challenges of prolonged war, we developed Families OverComing Under Stress (FOCUS), a multi-session intervention for families facing multiple deployments and combat stress injuries adapted from existing evidence-based family prevention interventions (Lester et al. in Mil Med 176(1): 19–25, 2011). In an implementation of this intervention contracted by the US Navy Bureau of Medicine and Surgery (BUMED), FOCUS teams were deployed to military bases in the United States and the Pacific Rim to deliver a suite of family-centered preventive services based on the FOCUS model (Beardslee et al. in Prev Sci 12(4): 339–348, 2011). Given the number of families affected by wartime service and the changing circumstances they faced in active duty and veteran settings, it rapidly became evident that adaptations of this approach for families in other contexts were needed. We identified the core elements of FOCUS that are essential across all adaptations: (1) Family Psychological Health Check-in; (2) family-specific psychoeducation; (3) family narrative timeline; and (4) family-level resilience skills (e.g., problem solving). In this report, we describe the iterative process of adapting the intervention for different groups of families: wounded, ill, and injured warriors, families with young children, couples, and parents. We also describe the process of adopting this intervention for use in different ecological contexts to serve National Guard, Reserve and veterans, and utilization of technology-enhanced platforms to reach geographically dispersed families. We highlight the lessons learned when faced with the need to rapidly deploy interventions, adapt them to the changing, growing needs of families under real-world circumstances, and conduct rigorous evaluation procedures when long-term, randomized trial designs are not feasible to meet an emergent public health need.

Keywords Core elements · Adaptation · Dissemination · Military families · Systems of care

Introduction

There is growing evidence of the psychological health impact of over a decade of war on service members, veterans, and their families (Institute of Medicine [IOM], 2013; Paley et al. 2013; Tanielian and Jaycox 2008). The cumulative effect of repeated family separation in the context of danger, the recurrent exposure to traumatic combat experiences, and the reverberating pain of injury and loss represent significant challenges for military and veteran families. In response to this need, several efforts at large-scale implementation of preventive psychological health services have been initiated, with varying and often limited information about the effectiveness of these
programs, and with varying levels of evaluation to guide the process of implementation (IOM 2013).

In response to the growing recognition that wartime service affects the entire family, preventive interventions that involve the whole family deserve much greater consideration. Family-centered approaches have the potential not only to help the service member, but also to increase his/her engagement with the family, strengthen the family, and prevent difficulties in the spouse and children (MacDermid-Wadsworth et al. 2013). Moreover, decades of prevention research have demonstrated the effectiveness of manual-based interventions for families at high risk in a variety of domains (National Research Council [NRC], 2009a, b) including parental depression (Beardslee et al. 2007), parental bereavement (Sandler et al. 2003), parental medical illness (Rotheram-Borus et al. 2001, 2004), and parental divorce (Wolchik et al. 2002). There is equally strong evidence that interventions that enhance parenting have value to parents in general, not just those at risk (NRC 2009a, b; Spoth et al. 2006). Equally important, there is growing interest in how to implement and disseminate effective evidence-based strategies widely in order to have a population-level impact (Biglan et al. 2012; NRC 2009a). The timely relevance of attention on implementation and dissemination processes is highlighted by the 2010 Patient Protection and Affordable Care Act (ACA) with its strong emphasis on preventive services and on using evidence-based practices (Fiese et al. 2013; Howell et al. 2013).

One example of a family-centered, strength-based preventive intervention program adapted from existing evidence-based interventions and operationalized through careful attention to the implementation and dissemination processes is FOCUS (Families OverComing Under Stress). We have previously described its foundational research, adaptation, and implementation for active duty military families undergoing multiple deployments, and parental psychological and physical injuries, as a suite of family-centered prevention services along the continuum from universal to indicated prevention (Beardslee et al. 2011). Further, a multi-informant evaluation protocol has demonstrated sustained positive psychological health and family adjustment outcomes for families, parents, and children from pre-assessment through several follow-ups (Lester et al. 2012, 2013).

In this report, we describe our adaptation of the original FOCUS model to several different distinct groups of families and its adoption in a community context to meet the needs of civilian dwelling military families including National Guard, Reserve, and veterans. Each adaptation occurred because we identified a large group of families in need of FOCUS type prevention services for whom the intervention could be specifically adapted.

Two broader key aspects of public health intervention implementation and dissemination are highlighted: (1) the challenges and opportunities in developing and disseminating interventions in response to real-world families’ needs without time to test interventions in long-term randomized trials and (2) the adaptation of intervention models to respond to emerging population needs and their adoption for use in different settings.

While we strongly support randomized trial testing of interventions when possible (currently three randomized control trials of the FOCUS intervention have been initiated: Cozza/Combat Injured, Lester/FOCUS for Veteran Families in Los Angeles County, and Lester/FOCUS for Early Childhood for Civilian Dwelling Military Families), we present the current service dissemination model as a rigorous implementation and adaptation framework to respond to a rapidly changing set of challenges facing military families.

Description of a Family-Centered Prevention Model: FOCUS

Consistent with a family systems and social ecological model framework, the FOCUS intervention model builds upon developmental and intervention research that identify the mutual influences among individuals and relationships within families, and between families and broader social contexts (Bronfenbrenner 1977, 1986). FOCUS was designed to enhance both the individual functioning of parents and children and functioning within and across relationship dyads, with the expectation that improvements in one area will reverberate throughout the entire family (Lester et al. 2010; Saltzman et al. 2011).

The FOCUS intervention development team adapted existing evidence-based interventions that had been evaluated through randomized control designs in other contexts (Beardslee et al. 2007; Layne et al. 2008; Rotheram-Borus et al. 2006) and piloted the intervention at US Marine Corps Base Camp Pendleton in 2006 for use with military families. Standardized for broader implementation (Saltzman et al. unpublished manual), the US Navy Bureau of Medicine and Surgery (BUMED) then contracted with the UCLA Semel Institute in 2008 to implement FOCUS for Navy and Marine families, initially at seven installations in the United States and Japan. Support from the US Department of Defense (DOD) Office of Community and Family Policy enabled the expansion of FOCUS services to US Army and Air Force families at selected sites to include delivery at 21 active duty installations (Fig. 1).

FOCUS was developed using a public health model (NRC 2009a, b) as a suite of services from universal to selective and indicated prevention, including group level briefs, skill building and psychoeducation groups, consultations, an eight-session model including parent sessions,
sessions for children ages five and older, and family sessions designed to enable families to develop a narrative regarding their deployment and reintegration experience (Beardslee et al. 2011). Experience with this suite of services was vitally important in defining the need for adaptations as these emerged, as well as providing a framework for the adoption process within community and veteran systems of care.

Framework to Support Program Adaptation and Adoption

The Centers for Disease Control and Prevention’s (CDC) effort to identify and disseminate evidence-based HIV prevention interventions (Collins et al. 2006) provides a conceptual framework that can be used to map the development of the FOCUS prevention model and its adaptations for diverse target populations. Core elements are an intervention’s components that cannot be changed, are rooted in its foundational behavioral theory, and are assumed to be responsible for its effectiveness (Collins et al. 2006; Kegeles et al. 2000; Kelly et al. 2000). Key characteristics are its activities and methods of delivery that can be adapted for a particular population or service setting (Collins et al. 2006; Kelly et al. 2000). Adaptation is the process of modifying key characteristics to address a target population’s unique risk behaviors or other influencing factors. Adoption is the process of implementing an intervention as it was originally developed; its core elements and key characteristics remain intact.

While a number of methods have been described to guide the identification of core elements (Bell et al. 2007; Center for Substance Abuse Prevention 2002; Fixsen et al. 2005; Galbraith et al. 2011; Kelly et al. 2008; McKleroy et al. 2006), we followed Kelly et al.’s (2000) useful approach of using program practice analysis to identify the core elements of FOCUS. We assembled an expert panel consisting of the intervention’s original developers and end users to conduct a qualitative assessment of its components, activities, and delivery methods. This approach provided a detailed description of the core elements by answering questions like: “What components are central to FOCUS and cannot be changed?” “What components of the intervention are responsible for its effectiveness?” “How are these components related to its theoretical model?”

Our interest in identifying the core elements of FOCUS is threefold. As the intervention was first introduced for military families at active duty installations, identification of its core elements helped to define the program’s uniqueness over and against extant services for military families. Describing it through the frame of its core elements helped to shape understanding of its distinctiveness within the continuum of care. Secondly, identification of its core elements promoted its dissemination with fidelity. Finally, consensus about the identification of core elements and key characteristics facilitated rapid adaptation of the intervention to different target populations and stakeholders, consistent with other fields of prevention work like substance abuse and violence prevention, in order to promote adaptation and fidelity (Galbraith et al. 2011).

Description of FOCUS Core Elements

Family Psychological Health Check-In

Described previously, innovative web-based, real-time assessment uses standardized psychological health and family functioning measures that are completed by all family members at initiation, completion, and at 1, 6, and 12 months (Lester et al. 2011; 2012). This process helps parents have a clear picture of both individual and family strengths and risks, so they can better identify targeted areas of attention and consider the need for evaluation or referral. It supports change by helping parents to better address challenges and also reinforces the strengths of the family and individuals within the family—a skill that the parents can apply to other family transitions. In addition, significant psychological health symptoms, including suicidal ideation, are flagged and addressed by the assessment in order to support appropriate referrals and emergency interventions. The Check-in provides information to the intervention provider (referred to in FOCUS as a Resiliency Trainer) about how to tailor the intervention’s psychoeducation and skill building components to the family’s unique situation. Conducting follow-up Check-ins enables families to
identify ongoing strengths and challenges, the need for referrals, or the opportunity to utilize booster sessions or other services in the community.

**Family-Specific Psychoeducation**

Information gathered from the Family Psychological Health Check-in assists the Resiliency Trainer in delivering psychoeducation that is family specific. This assists parents in making better and more coordinated decisions as the leaders of their family. Education may cover many topics including developmental guidance, understanding symptoms and behaviors associated with diagnoses, evidence-based interventions, navigation of systems of care, and advocating for family needs. It provides new information that can also normalize family reactions and help parents to better understand each other and how to help their children.

**Family Narrative Timeline**

The development of a family narrative that particularly covers the period of time surrounding key family transitions (e.g., deployments, reintegration, moves, injuries) proved central to our work. The family narrative is developed first in a “parents only” session by gathering the parents’ (or single parent’s) individual narrative timeline. In a separate “kids only” session, the children develop their own narrative timelines or time maps. The Resiliency Trainer also prepares the parents as family unit leaders to hear and respond to their children’s narratives. During a family sharing session, the Resiliency Trainer assists the family as a whole in constructing a family narrative. Inherent to this timeline activity is the perspective taking that occurs through sharing individual perceptions of past and present experiences that are represented in the narratives. Subsequently and essentially, therefore, part of the goal of the family sharing of parent and children timelines is to combine the parents’ and children’s narratives into a unified family narrative, which in turn supports the family’s ability to develop shared understanding and to make meaning out of challenging experiences. Making meaning and sharing perspectives help families to come together during hard times, to support one another more effectively, and to value what was gained even when much was lost or shifted because of stressful events (Beardslee 2013; Saltzman et al. 2013).

**Family-Level Skills**

The FOCUS intervention teaches five primary family-level skills designed to enhance individual and family resilience processes (Saltzman et al. 2011).

**Emotional Regulation** This skill is taught with the help of a range of tools designed to enhance emotional regulation including a feeling thermometer that each member of the family learns to employ in order to communicate about emotions. Designed to be developmentally relevant, these tools include a variety of activities that promote appropriate identification and expression of emotions, and assist in the development of strategies to support and maintain parent self and child emotional regulation.

**Problem Solving** The family is able to address challenges in an organized, step-by-step manner. When parents use an organized approach to problem solving, they also model that problems are not insurmountable and can be overcome. For both adults and children, effective problem solving supports both individuals and families in their ability to act in the world and be successful (as opposed to the world acting on them and feeling powerless). This skill is particularly relevant to families planning for future challenges together, such as injury recovery and rehabilitation.

**Communication** This skill helps family members to express their own experience and preferences while also listening and understanding those of another person. Being able to clearly express one’s own needs and experiences and also truly understand another’s experiences and preferences helps parents and/or couples to better understand and support one another. It also supports parenting techniques including setting stable care routines and discipline. Subsets of communication may include injury communication, co-parenting, and play for younger children.

**Managing Deployment, Trauma, or Loss Reminders** This assists family members to recognize when a reminder might be triggered and result in emotional or behavioral activation. It also allows for a plan to address this activation. Recognizing and responding to deployment, trauma, or loss reminders normalize stress reactions. The reminders may not be taken away, but family members develop a specific plan that enhances coping with the associated thoughts, feelings, and behaviors when reminders happen.

**Establishing Readiness and Goal Setting** Setting achievable goals helps parents to guide their family through initially smaller steps, celebrate small successes, and problem-solve and/or try again when success is not yet achieved (Table 1).
The evolving impact of these circumstances has presented medical and mental health providers with what may be best described as “a moving target” for prevention and treatment. In order to provide relevant and effective services, systems of care and service providers have had to rapidly evolve and adapt their approaches. Each of the adaptations to the original FOCUS intervention was made because we identified a target population in need of services whose needs would be better met by an intervention adapted to fit its risk behaviors and influencing factors. These adaptations were designed, as in the original FOCUS intervention, to be widely used in multiple contexts (e.g., with veterans).

An important component of each adaptation described below has been the inclusion of standardized, multi-informant, psychological health and family functioning assessments collected at baseline, completion, 1-month,
6-month and 12-month follow-up. While it is beyond the scope of this report to present evaluation data, we note that preliminary findings on specific adaptations have been previously presented and indicate enhanced family functioning, and reduced psychological distress similar to the primary intervention findings (Mogil et al. 2012; Niv and Saltzman 2012; Saltzman 2009). For each of the adaptations, a core intervention development team standardized the intervention and tested it with pilot families. A revised assessment, an implementation manual, and online and in-person training and quality assurance protocols for that specific adaptation were developed to support implementation.

FOCUS for Wounded, Ill, and Injured Families

Need for Adaptation

Challenges associated with reintegration following each deployment may be further complicated by the large number of service members returning with either a psychological or physical injury (IOM 2013). During the wars in Afghanistan and Iraq, improved surgical and medical technologies have resulted in high survival rates among those sustaining serious injury relative to prior wars (Manring et al. 2009). The majority of these physical injuries were the direct result of exposure to an explosive device in a combat zone, with an unprecedented number of traumatic brain injuries (TBI) (IOM 2013; Tanielian and Jaycox 2008). As a result, there have been a large number of service men and women returning home with serious injuries, disability, and requiring long-term care, with broad implications for caregiving family members (Tanielian et al. 2013). The number of those who sustained serious physical injury in Afghanistan and Iraq is over 50,000; the number with either post-traumatic stress disorder (PTSD), TBI, or depression is 33 % of that total, and the numbers who meet criteria for all three is about 5 % (Cozza et al. 2013, Tanielian and Jaycox 2008).

The FOCUS intervention development team adapted the core intervention’s activities and methods of delivery to more fully address the specific ways in which physical and psychological injuries, including TBI and PTSD, impact parenting, family relationships, and child functioning, and to address the specific care and recovery contexts for the combat injured population. Many of these changes were developed in coordination with the Uniformed Services University of the Health Science team, which lead the development of the FOCUS-Combat Injury intervention, which currently is being studied through a randomized controlled trial at multiple US Army medical facilities (Cozza et al. 2013).

Context

The work with the wounded involved much greater coordination with those providing medical services and increased knowledge about the implications of medical and psychiatric treatment, recovery, and rehabilitation. The presence of so many wounded warriors meant we needed to work in a variety of settings to engage people in the recovery process, including acute medical/surgical care units and community health settings.

Family Psychological Health Check-In

Additional information is gathered regarding the severity and impact of the service member’s injuries, stage of recovery and rehabilitation, and prior and ongoing medical and psychological treatment. This information helps to locate the family along an illness and recovery trajectory and to customize the program to their current needs. It also assists the Resiliency Trainer in gauging accurate expectations of the service member’s functioning and ability to participate in the intervention, plan for anticipated medical procedures, and coordinate efforts with other care providers. Additional time may also be taken during the initial sessions to build trust and to ensure that program goals address immediate concerns of the parents both about immediate life circumstances and about the injury and its sequelae.

Family-Specific Psychoeducation

This component is expanded to include information about when and what children are told about the parental injury. Significant risk for misunderstandings and gaps in knowledge can result in extreme child distress and needless worry or self-blame. A primary goal is effective injury communication that involves the timely, developmentally appropriate, and accurate sharing of information across the family from the moment of notification of injury through treatment and rehabilitation (Cozza and Guimond 2011).

Family Narrative Timeline

This activity has also been adapted for use with couples who may have cognitive or attention difficulties or extreme emotional reactivity secondary to TBI, other physical impairments, or severe post-traumatic stress. For example, the process of eliciting husband and wife narratives with a spouse with TBI may require more time, be broken into smaller tasks over more sessions, or involve a husband and wife taking turns sharing their experiences about individual events rather than one waiting for the other to complete his/her entire narrative. To safeguard the experience of
narrating traumatic events related to the injury, specific guidance is provided on what parts of the experience are appropriate to share, and the Resiliency Trainer makes sure to provide education on possible reactions and puts in place necessary supports and follow-up.

**Family-Level Skills**

Training families with a wounded, ill, or injured parent on family-level resilience skills involves a number of adaptations to address the severity of the service member’s and family’s experience, the potential volatility and emotional reactivity across the family, and the extremity of impairments in individual and family functioning. For example, the injured service member may require individual coaching or a referral for individual treatment with regard to emotional regulation and anger management issues, and skills training may need to proceed slowly with multiple assignments and incremental generalization.

Overall, the pacing, length of sessions, and the sequencing of the content areas must remain flexible to accommodate the family needs, capacities, and levels of availability. These families generally are over-extended with regard to juggling medical appointments and family obligations, and are continually buffeted by difficult transitions, changing circumstances, and shifting priorities. The program is made more modular with the expectations that interruptions in attendance are likely, and that urgent needs may trump programmatic requirements at any time.

Of note, this adaptation has been adopted for use in health care settings in order to integrate family-centered care and prevention services in treatment and rehabilitation settings that are providing medical and surgical services for returning warriors. The UCLA Health Services Operation Mend-FOCUS prevention program (http://operationmend.ucla.edu) is an example of such an adoption. Operation Mend provides returning military personnel with severe facial and other medical injuries access to a team of reconstructive surgeons as well as comprehensive medical and mental health support for the service members and their families. The Operation Mend-FOCUS Family-Centered Care and Resilience services incorporate core elements and have modified sequencing and key activities designed to enhance surgical preparation, coping, and recovery across the family (MacDermid-Wadsworth et al. 2013). Each patient and any accompanying family members who visit the Ronald Reagan UCLA Medical Center for surgical assessment participate in a protocol designed to help the patient and family members identify and assess the current strengths and challenges associated with the critical injury. Key activities focus on the marital relationship (e.g., intimacy, communication, support), parenting, the impact of combat injuries, surgical interventions and care recovery, and development of family-level understanding and communication regarding the veteran’s injuries. The model also includes a continuity family plan that maps out strategies to enhance recovery and increase individual and family adjustment. This program includes a FOCUS “tele-prevention” delivery platform (described later in this paper) to provide distance delivery and continuity of services for families when they return home.

**FOCUS for Early Childhood**

**Need for Adaptation**

This adaptation was developed out of a clear need for more high-quality services aimed at families with children ages 3–5 years. Approximately 40% of military children are under the age of 5 years. As of 2011, there were approximately 375,064 children ages 3–5 in military families (US Department of Defense 2011). For many of these families, parenting a young child through deployment and reintegration poses unique challenges (APA Presidential Task Force 2007; Paris et al. 2010). Developmental tasks, such as managing autonomy and navigating pre-school settings, can be difficult transition points for any family, but these can be complicated by parental deployment separations and reunions (Murray 2002). Often pre-school-aged children of military parents exhibit higher levels of both internalizing and externalizing behavior compared to their similarly aged civilian counterparts (Chartrand et al. 2008). Additionally, their response to their caregiver’s distress or separation from a primary caregiver is typically not verbalized directly but manifests in behavioral regressions, irritability, and difficulty with self-regulation (e.g., sleeping) (Carroll 2009).

**Context**

When families with young children request FOCUS family resiliency training, they are offered the option of receiving the FOCUS for Early Childhood adaptation. This adaptation was developed at UCLA and on military bases. It has been used with active duty and civilian dwelling military families.

**Family Psychological Health Check-In**

This core element is largely unchanged but includes standardized assessment of behavioral and emotional adjustment in very young children.
**Family-Specific Psychoeducation**

This core element is typically more focused on early childhood developmental guidance as compared to the primary intervention with older children. Early childhood is a time of rapid growth and development, physically, cognitively, emotionally, and socially, prompting a range of expected transitions for parents and children. Considerable time is spent helping the parent understand the internal world of the young child, particularly as the challenges of parental separation and concerns about safety and danger emerge for the child. Enhancing parental understanding of the young child’s social-emotional and cognitive capacities helps parents to better understand their child’s perspective, respond to their concerns, and appreciate what their child is capable of at a specific developmental level. This also allows parents to see that their child is not experiencing the world and events in the same way that the parent perceives them. Time is spent helping the parent to observe their child’s cues and finding new ways to sensitively respond to them.

**Family Narrative Timeline**

In FOCUS for Early Childhood, initial sessions help parents to reflect on their experiences of family events in the construction of a narrative timeline. Because the young child may not be able to produce a timeline, parents are encouraged to reflect on their child’s experience of family events (deployment separations, major life events, etc.) and to include these on the timeline. In this case, the narrative becomes a perspective-taking activity, which strengthens the parents’ ability to see the world through the eyes of their child and better understand his or her experiences. Important parenting and co-parenting issues are identified and discussed and become a focus of subsequent sessions aimed at building family-level skills.

**Family-Level Skills**

Particular attention is given to addressing parenting and co-parenting skills specific to early childhood. The goals of enhancing perspective taking and making meaning of shared family experiences begin with the parent narrative timeline, but are continued throughout the remainder of sessions. Continued support for these skills is best achieved through parent–child play interactions. In family sessions, parents and children are guided through strategies to enrich play and enhance the parent–child relationship. Parents learn strategies to talk to their child about his or her concerns or misconceptions in a developmentally appropriate manner, using clear language and considering the child’s need for reassurance and information management.

Additional shifts are made in the number and length of intervention sessions, which are reduced to better accommodate the attention span of children ages 3–5 years old. The environment in which the core elements are delivered is shifted somewhat, also. Child-parent interactions and play may happen on the floor instead of at a table or on a couch. The number and type of toys and materials used to engage the young child can also be quite different from those used with older children. Finally, the knowledge base and skill set of the Resiliency Trainer must be expanded to include information on young child development as there is more variability in this age range with physical mobility (e.g., walking, hopping), language acquisition, cognition, self-care (e.g., toilet training), tantrums, sleep, and feeding routines.

**FOCUS for Couples**

**Need for Adaptation**

During the initial implementation of FOCUS at active duty military installations, there was a recurring request for similar programming for couples. Anecdotal reports of high levels of marital stress associated with multiple deployments were aligned with research that indicated many couples experienced difficulties during post-deployment reintegration (Chapin 2011) and that couples in which a service member experienced combat or returned with a significant mental health disorder were at heightened risk for relationship problems and marital dissolution (Karney et al. 2012; Riviere et al. 2012). The UCLA development team joined with the Military Family Research Institute at Purdue to adapt the intervention for use with couples with or without children desiring to enhance their relationship.

The adaptation for couples required significant adjustments in all of the key characteristics. Part of the reason for this, beyond the obvious differences between couples and family work, was that couples seeking services were often more distressed and volatile than families seeking services. As is often the case, couples only seek out professional services after a long period in which relations have deteriorated markedly and as a final effort prior to separation or divorce (Long and Young 2007).

**Context**

The adaptation was piloted over 18 months at an active duty installation and a US Department of Veterans Affairs (VA) Medical Center as a six-session model delivered by designated trained providers who collected data about the implementation processes to refine and standardize the intervention protocol. Since then, it has been delivered at
all FOCUS active duty military sites and in several centers where civilian dwelling military families access services.

**Family Psychological Health Check-In**

Additional measures are included to assess the quality of the relationship and dyadic coping skills. Equally important was the assessment of safety and the capacity to engage productively in conjoint sessions and complete home assignments. Depending on the volatility and skill level of the partners, as well as the presence of such explosive issues as infidelity, the sequence of the program components could be diverted as needed to shore up containment and de-escalation practices.

**Family-Specific Psychoeducation**

A major focus of education is discussion of specific ways that deployment and psychological or physical injuries impact the relationship. Whenever possible, factual information is linked to interpersonal difficulties and conflicts with the intent of normalizing current difficulties and developing a collaborative frame for shared solutions. Available content is also extended to general concepts on effective couple’s communication and support, as well as more trauma-specific considerations regarding the role of trauma and loss reminders, and specific ways in which post-traumatic stress symptoms, particularly avoidance and numbing, may undermine closeness and connection in a relationship.

**Family Narrative Timeline**

Couples are encouraged to include experiences across the span of their relationship in their timelines, including when they met and earlier, less problematic periods in order to gather possible examples of times in which they did well together. Early traumatic and loss experiences are also included in the timelines because of their formative influence on current interpersonal relationships and trust issues. In addition to tracking their personal levels of distress across different events on their timelines, couples are also asked to track the quality of their relationship over time and at key junctures in the relationship.

**Family-Level Skills**

Additional time is dedicated to specific communication skills. We have also developed a graphic means of mapping conflict cycles, identifying “hot spots” as well as specific types of support preferred by each partner. Overall, initial and ongoing assessment on couple needs informs the selection of specific skills for training. For example, some couples require much time spent on emotional regulation and anger management skills, while others may most profitably spend their time practicing problem solving or scheduling mutually enjoyable activities.

The experience of many Resiliency Trainers conducting FOCUS for Couples has been that much more effort is required to circumscribe the preventive focus of the work as compared to conducting FOCUS with families. This is attributed to the greater pull toward individual problems with couples and the lack of children who, in the family work, provided a common base of mutual concern. Participants have ranged from very young and recently active duty couples to middle-aged veteran couples with more entrenched difficulties. It has also been used with couples in which the service member spouse has sustained moderate to severe TBI, often with co-morbid post-traumatic stress and depression. The latter more severe presentations were seen in the VA pilot study. Pre-post results from the 18-month pilot showed that participation resulted in increased dyadic satisfaction, consensus and affectional expression, along with improved individual and relational coping (Niv and Saltzman 2012).

**FOCUS for Parents**

**Need for Adaptation**

This adaptation grew out of requests from parents who wanted to attend resiliency training, but whose children had difficulty participating for various reasons: their children were infants, the parents wanted to focus on getting on the same page before involving their children, or the location of the service did not allow for children (e.g., a VA setting). Further, many parents attending the FOCUS for Couples program shifted their primary attention to issues of family communication or parenting strategies in addition to the more direct couple communication, suggesting the need for a unique parenting adaptation.

FOCUS for Parents allows for the parent or parents to learn the identified FOCUS skills, customize key activities for their family, and then practice and use family activities at home with their children. Essentially, the parents receive from the Resiliency Trainer the education and training that empowers the parents to become the leaders of the intervention with the family at home.

**Context**

This adaptation has been used with active duty and civilian dwelling military families. A demonstration project underway with the Veterans Health Administration to disseminate FOCUS Parents has been initiated.
Family Psychological Health Check-In

This is altered to include measures related to parenting and co-parenting.

Family-Specific Psychoeducation

The content is similar to the original intervention and includes information for the parents about child development, reactions to transitions and parental separations, and family communication.

Family Narrative Timeline

Parents are engaged in perspective taking and asked to reflect upon what family events and transition points might have been like for each of their children. This reflective process tests the parents’ reflective mental capacity (Saltzman et al. 2013), their ability to see the world through the eyes of their child, and engage in activities to enhance this ability. The family narrative presents an opportunity to strengthen this capacity in the parents regarding their own experiences. Additionally, the timeline provides the opportunity to clarify key parenting and co-parenting processes and identifies specific skills and education linked to the family’s unique experiences.

Family-Level Skills

The same skill set that is used in the original intervention is used in the FOCUS for Parents adaptation. Utilizing these skills with the entire family, including the children, is achieved through the parent home activities; in session, parents learn the skills themselves and then practice how they will bring them home. The Resiliency Trainer helps the parents to customize the activity for the family and then provides strategies and coaching to help the parents best accomplish the activity and incorporate the skill use into the everyday lives of the children.

FOCUS Use with Communities: Adoptions and Innovative Technologies

Need for Services in National Guard, Reserve, and Veteran Communities

The long-term conflicts in Afghanistan and Iraq have also placed an unprecedented level of reliance on the National Guard and Reserve (NG/R) components. Prior to September 11, 2001, NG/R personnel were rarely deployed to war, and deployments were limited to 6 months for each 5 years of regular drill. Since that time, deployment periods have increased fourfold to 24 months in a six-year enlistment period, and NG/R are routinely sent to combat hot spots alongside regular military (DOD 2011; Gewirtz et al. 2010). This kind of deployment appears to be especially stressful for NG/R “citizen soldiers” who report levels of mental health problems (depression, post-traumatic stress, and relationship problems) at more than double the rate of active duty service members (Milliken et al. 2007). This is thought to be due to lower levels of training and preparation for separation than active duty personnel (Browne et al. 2007; Gewirtz et al. 2010). The broader impact on the service member and family may also be related to the fact that NG/R service members tend to be older, more likely to be married with dependent children, and live in civilian communities without the support, routine, or structure of a military base. They often find themselves isolated in communities, jobs, and systems of care that do not understand them and are poorly equipped to address their needs. Furthermore, NG/R are often geographically dispersed and at a distance from military mental health services, and have variable levels of insurance coverage from combined military and civilian sources.

Returning women veterans experience additional unique challenges reintegrating and accessing appropriate mental health services. Women NG/R veterans tend to suppress their personal needs in their attempts to quickly resume caregiving for their “abandoned” families (Military Department: Targeting Member’s Needs 2013; Resnick et al. 2012). Admitting they need help is also a challenge because of the perceived need to prove themselves as equals in a military environment. Furthermore, many women veterans feel uncomfortable seeking services or speaking openly of their experiences in the predominantly male-focused VA clinical setting (Military Department: Targeting Member’s Needs 2013; Resnick et al. 2012).

For other military veterans and their families, accessing appropriate mental health services can also be problematic. Very often, veterans do not know the full range of benefits available to them or, in many cases, have limited or no access to coverage. Families may find it especially daunting to navigate the complex VA system. VA medical centers are charged primarily with serving the service member and, quite often, family members will not qualify for services. Additionally, they usually are not community based nor do they accept sliding-scale fees for their services. Moreover, many centers and clinics are understaffed and have a priority system for access to care with recently discharged combat veterans having a higher priority than other veterans. Means testing also can be a part of the registration process for VA care. An additional threat to addressing the mental health needs of civilian dwelling military families is the impact that political decisions about
the size of the federal budget and related austerity measures will have on the availability of services.

**FOCUS Innovative Technology Platforms**

In response to the need to make services available to military and veteran families who may not have direct access to mental health or family support facilities and to provide an additional resource to those receiving live FOCUS training, the intervention development team has used an iterative process to develop and implement a range of web-based, distance delivery platforms. The reach of web- and smart phone-based applications is an important factor for several reasons. For example, NG/R service members and their families have access to fewer social supports and behavioral health services than active duty service members, as they typically live in civilian communities and have limited contact with other military families or behavioral health providers trained to address their needs (Milliken et al. 2007). Many veterans live in rural areas, far from VA health facilities, and likewise have difficulties accessing family-centered services. Even among rural veterans with some access to VA mental health services, their health-related quality of life is lower than urban veterans with mental health problems, suggesting poor access to high-quality care (Wallace et al. 2006).

These technology platforms are not identified as adaptations within the CDC framework because they do not re-create the intervention’s core elements in a new medium. However, they support universal and selective prevention by providing psychoeducational and skill building content to all families regardless of their unique needs. These platforms provide an additional element to the FOCUS suite of services and are designed to reinforce core intervention elements. They also provide flexibility in geographic reach and timing of delivery, enabling families to proceed with education and skills practice at their own pace and in convenient locations.

**Self-Administered Family Check-In**

Both a web-based Family Psychological Health Check-in (http://nfrc.ucla.edu/sa) and a mobile application platform, FOCUS On the Go! (UCLA NFRC 2013), offer standardized psychological health and family resilience screening measures to any family. They provide end users with real-time feedback based on standardized scoring and interpretation of assessment including an interpreted flagging system to decode standardized psychological health and coping assessment outcomes. This feedback can assist users, or can be shared with mental health providers to guide referral and intervention.

**FOCUS World**

This is a web-based virtual environment (www.focusworld.org) that provides educational content for parents and children, and uses animated avatars to create a fun, inviting experience for children with the sophisticated interactivity and graphic design that is now available on many child-oriented games. It enables families to build an online family narrative, engage in real-time chat, and learn and practice resiliency enhancing skills. In addition, a parent library includes modeling videos to help families learn new ways to talk about challenging situations with children of all ages, and provides a collection of family-friendly activities and information that support family wellness and coping.

**Focus Mobile Application**

A FOCUS mobile application resilience gaming and resource platform (FOCUS On the GO!) has been launched to engage children in learning and practicing key resilience skills; it also provides educational resources and communication modeling videos to parents (UCLA NFRC 2013). As noted above, the mobile application platform enables parents to access the Family Psychological Health Check-in and receive immediate educational feedback and guidance regarding their own and their children’s psychological health needs.

**Remote Delivery of FOCUS Adaptations**

To enable remote, in-home delivery of the complete multi-session FOCUS family resilience training adaptations to civilian dwelling military families, we have tailored and conducted pilot delivery of FOCUS through an integrated “tele-prevention” video-teleconferencing (VTC) platform using secure software. This pilot work has demonstrated the feasibility of remote delivery of the FOCUS intervention. All intervention activities and delivery methods have been tailored for the remote delivery platform, and intervention training, delivery, and technical support manuals have been developed. This intervention platform responds to an identified and urgent gap in care for civilian dwelling military families; if successful in demonstrating efficacy, this intervention will serve as a national model for delivering in-home preventive services to this high-risk group.

**Los Angeles County Department of Mental Health Adoption**

Given the needs of NG/R families as well as the large number of veterans and their families who have difficulty in accessing mental health services, it was strategic to provide
family-centered preventive services to returning warriors and their families through a community mental health infrastructure. Los Angeles County Department of Mental Health (LAC DMH), the largest public mental health system in the country with high concentrations of military families within its catchment area, identified the FOCUS intervention as a relevant program for their system of care. LAC DMH collaborated with the UCLA intervention development team and planned and implemented a two-step program to test the feasibility of implementing the FOCUS model. First, the team conducted a small implementation pilot offering FOCUS family resilience training intervention in the community setting; then, LAC DMH expanded implementation to include three levels of training and program dissemination that mapped to the FOCUS suite of services. The first level involved identifying and training “Peer Navigators,” individuals embedded in local communities and knowledgeable about service systems, military and veteran culture, family resilience, and best practices for conducting outreach and engagement directly with veterans and their family members. The second level involved training mental health providers in the public schools to conduct the group version of the FOCUS program with children. The third level included training child and family clinicians within directly operated and contracted DMH clinical sites to conduct the FOCUS family resilience training program. To insure fidelity and skilled delivery of the services, intensive training and ongoing model supervision have been provided. To date, this approach has given the LAC DMH a greater reach into the non-served and underserved population of veterans and their families in the nation’s largest county.

The FOCUS intervention has been used in other ecological contexts, as well. The University of Southern California Military Social Work Program has integrated the school-based skill building groups from the FOCUS suite of services for delivery to high-density military-connected children in San Diego County through the “Building Capacity in Military-Connected Schools” program (www.building.capacity.usc.edu). The National Military Family Association (NMFA) (www.militaryfamily.org) adopted components of the FOCUS suite of services for use in their Operation Purple Family Retreats and Operation Purple Healing Adventures national camp programs for military children (Chandra et al. 2011). Both initiatives include evaluations currently underway.

Discussion

The long wars in Afghanistan and Iraq characterized by an all-volunteer, professional military with prolonged, multiple deployments, and significant changes in wartime duties, demographics, communication technologies, and combat injuries (Tanielian and Jaycox 2008) have created unprecedented tests for the resiliency of military families and the systems that support them. These challenges have highlighted a political, cultural, and scientific convergence around the significant potential of family-centered preventive interventions for promoting psychological health for military and veteran families. Both the DOD and VA have highlighted the key role of families to military operations, as well as establishing the needs of military and veteran families as a national public health priority (MacDermid-Wadsworth et al. 2013). In this context, the fields of family prevention and intervention science have provided relevant guidance to responding to these issues, as family-centered approaches to prevention and treatment in the context of adversity have consistently demonstrated effectiveness in promoting psychological health and mitigating stress in children and adults (NRC 2009a, b). Evidence suggests that approaches to psychological health prevention and treatment that engage families early, before pathology has emerged, are more likely to be appealing and culturally acceptable to military families, as is embedding evidence-based care in settings where family members are already served (Kumpfer et al. 2002; NRC 2009a, b).

This report provides a framework for addressing these prevention challenges within military and veteran families utilizing existing prevention science research and implementation strategies, and reports on the application of this framework through the example of a family-centered prevention program adapted for multiple field conditions, implemented at scale within military installations, and adopted through community and veteran settings. This theoretically driven method to rapid dissemination of evidence-based practice is consistent with recent demands for the need for a systematic approach to disruptive public health innovations—one that enables a broad knowledge base developed within prevention science to respond to a rapidly moving target. Embedded within the implementation of FOCUS are a number of factors previously theorized as central to successful disruptive innovations in behavioral health initiatives (Rotheram-Borus et al. 2012).

Identification of core intervention elements through a process of literature review, foundational intervention research, program piloting, and expert consensus were fundamental for the adaptation of evidence-based interventions for military families in the initial piloted program standardization, as well as for the subsequent programmatic adaptations and adoptions described in this report. Notably, core elements are meant to reflect the theoretical underpinnings, internal coherence, and causal pathway of the intervention (Eke et al. 2006). Each adaptation both affirmed the robustness of the core principles and taught us about the process of intervention while also highlighting
new elements as has been true in the adaptation of interventions devised in one setting to others (Podorefsky et al. 2001). Over the last decade, there has been increasing recognition across a variety of intervention strategies in cognitive behavior therapy, child mental health, and preventive interventions suggesting that interventions derived from common principles are likely to be applicable to many situations (Chorpita et al. 2005a, b; Weisz et al. 2006; Weisz and Kazdin 2010). Notably, several of the core components identified for FOCUS are consistent with this literature: the usefulness of context-specific psychoeducation, importance of specific skill building, and the role of developing a coherent family narrative (Saltzman et al. 2013).

We note that within the FOCUS implementation, evaluation with families and community members consistently indicated the preference for interventions that were relevant to their family context and accessible in their existing care systems (health care, school, day care, community support). This feedback was integrated into the selection and development of specific adaptations, as well as within the key activities.

From the point of view of intervention development, we also emphasize that a key element was having the same team to develop these adaptations. The FOCUS development team has worked together for more than 10 years, with experience in the dissemination of the original model to multiple military bases (Beardslee et al. 2011). Many of the original team members participated in the adaptation process. We also encouraged a participatory approach with our field provider staff, who were involved in the development of the adaptations and encouraged to have shared ownership. Enjoying strong partnerships with local and national military/veteran and research leadership, community members, and organization has been critical to work on the adaptations as well as their implementation across multiple settings.

As identified, adaptations of the FOCUS intervention are now being tested in three randomized trials. While clearly randomized designs are appropriate to test the interventions that will be used with a large group of people, the wars in Afghanistan and Iraq have underscored the need for expanded research to examine the implementation and dissemination of behavioral health prevention programs. Moreover, the urgent need that military families facing the demands of war have for evidence-informed interventions that require rapid adaptation and implementation for different populations is similar to the challenge confronting non-military populations as they encounter other critically urgent situations including natural disasters and terrorist attacks.

Rapid intervention development, implementation, and adaptation of interventions are not to be undertaken lightly: they require core support for the activities, a dedicated staff, an explicit measurement strategy, the capacity to work efficiently and to produce interventions on schedule, and then to use appropriate quality control training and support to ensure that adapted interventions are delivered with fidelity. Greater attention to what enables these processes to be most effectively instituted is needed. Increased attention needs to be directed to both funding mechanisms and institutional supports to address these issues for military and veteran family needs specifically, as well as family-centered prevention approaches broadly. Finding the appropriate structures under the ACA for implementing and sustaining family-centered prevention in general remains a pressing issue.

Acknowledgments The authors acknowledge their profound appreciation to US service members and their families who teach us each day what it means to serve our national community and to the partnership of the Navy Bureau of Medicine and Surgery for their vision and commitment to public mental health prevention. Project FOCUS (Families OverComing Under Stress) for military families provides services to military families through a contract to the University of California—Los Angeles from the Navy Bureau of Medicine and Surgery. Dr. Lester receives research grant support from the Department of Defense, McCormick Foundation and Major League Baseball, and the Eunice Kennedy Shriver National Institute of Child Health and Human Development, R01 HD073234-01A1.

References


Evaluation of a Family-Centered Prevention Intervention for Military Children and Families Facing Wartime Deployments

More than 1.7 million children in the United States have a parent serving in the military. Since September 1, 2001, approximately 900,000 children have had a parent who deployed multiple times as part of Operation Iraqi Freedom or Operation Enduring Freedom. For a decade, children and their parents have negotiated repeated separations and subsequent family reunions in the context of wartime risk. Recent studies have begun to document the psychological health impact of wartime deployments on service members, spouses, and children, suggesting that greater attention should be paid to the implementation and evaluation of selective prevention strategies that target at-risk families and promote resilience across the military community.1-4

Deployed service members are often exposed to a landscape of chronic stressors, potential traumatic events, and harsh environmental risk factors during combat duty. Among those service members returning from deployment to Iraq, 16% to 17% meet criteria for depression, posttraumatic stress disorder (PTSD), or generalized anxiety.5 Repeated deployments or exposure to adverse conditions have been associated with higher rates of combat-related psychological health problems, traumatic brain injury, substance abuse, and marital conflict.6-15

Extended separations in the context of combat deployment may also affect psychological health for the at-home spouse and children. Recent evidence suggests that distress levels of at-home family members increase as the number of deployment months increases.16 Military children may also be vulnerable to emotional and behavior disruptions, including heightened anxiety and academic difficulties.17-21 Consistent with the larger literature on child distress,22 psychological symptoms in military parents predict child adjustment problems.16,23,24 Additionally, the cumulative length of parental deployments correlates with increased risk for depression and behavioral disruptions in school-aged children16 and with increased distress in adolescents.24

Interventions that target families facing adversity and build on family strengths to reduce psychological distress have been shown to have a positive effect on parent and child adjustment and to provide sustained benefits.25 In randomized controlled trials involving families in challenging circumstances (i.e., parental medical illness, parental depression), targeted family interventions that strengthen parent–child relationships, promote effective parenting practices, and increase family understanding have consistently demonstrated positive outcomes in child development and psychological health over time.25-28 Effective coping skills, particularly those that address traumatic stress reactions, are associated with enhanced stress management,29-31 and effective caregiver–child relationships support the development of child adaptive skills such as emotional and behavioral regulation.32,33

The FOCUS (Families OverComing Under Stress) project for military families emerged from foundational research on a previously described family-centered preventive intervention model and then was adapted and manualized by a University of California, Los Angeles (UCLA)–Harvard intervention development team at Marine Corps Base, Camp Pendleton.34,35 The program was subsequently implemented as a large-scale demonstration program for the US Marine Corps and US Navy, funded by the US Navy’s Bureau of Medicine and Surgery. Importantly, potential barriers to accessing mental health services have been addressed by a FOCUS implementation emphasis on being strength and skills based, practical, and easily accessible and applicable.

Objectives. We evaluated the Families OverComing Under Stress program, which provides resiliency training designed to enhance family psychological health in US military families affected by combat- and deployment-related stress.

Methods. We performed a secondary analysis of Families OverComing Under Stress program evaluation data that was collected between July 2008 and February 2010 at 11 military installations in the United States and Japan. We present data at baseline for 488 unique families (742 parents and 873 children) and pre–post outcomes for 331 families.

Results. Family members reported high levels of satisfaction with the program and positive impact on parent–child indicators. Psychological distress levels were elevated for service members, civilian parents, and children at program entry compared with community norms. Change scores showed significant improvements across all measures for service member and civilian parents and their children (P<.001).

for military families. Implementation also includes strong military leadership involvement and community partnership to ensure active outreach and family engagement.

FOCUS provides education and skills training for military parents and children. Training is designed to enhance coping with deployment-related experiences, including possible combat-related psychological or physical injury in the service member. Through a structured narrative approach, family members share their unique perspectives of deployment-related experiences, thereby enhancing understanding, bridging communication, and increasing family cohesion and support. This process mobilizes theoretically and empirically supported family resiliency processes.36,37

FOCUS also integrates the US Navy and US Marine Corps stress continuum model,38 which categorizes deployment stress into 4 color zones—green, yellow, orange, and red—reflecting an increasing level of risk for psychological distress, injury, and disorder and providing a framework to guide risk identification and referral. Details regarding the FOCUS program foundation, model, and implementation are described elsewhere.34,39

We hypothesized that parents completing the program would report improved understanding of deployment and combat stress, improved family skills (emotional regulation, communication, family goal setting, management of stress reminders and triggers) and intrafamilial support, satisfaction with the program, and a likelihood of recommending the program to others. We also hypothesized that families who completed the program would experience improved individual psychological health outcomes and improved family functioning. To our knowledge, this is the first systematic program evaluation examining the effectiveness of a trauma-informed, selective prevention program for military families experiencing wartime deployments.

METHODS

We conducted the evaluation as part of the FOCUS service delivery project funded by the US Navy’s Bureau of Medicine and Surgery. We performed a secondary analysis of de-identified data originally collected (July 2008–February 2010) to customize delivery and improve program quality. The program-level data we have presented is from 11 US Marine Corps and US Navy installations located in California (4 sites); North Carolina; Hawaii; Okinawa, Japan; Virginia (2 sites); Mississippi; and Washington State.

FOCUS family resiliency training is delivered to individual families in 8 sessions scheduled according to the family’s convenience. Parent and family sessions last 90 minutes and child sessions last 30–60 minutes, depending on the child’s developmental level. Although standardized and manualized to ensure that each family learns core FOCUS skills, the intervention allows flexibility and customization to address specific family goals and needs. FOCUS providers (called resiliency trainers) are master- or doctoral-level specialists in child and family mental health. They complete extensive web-based and in-person initial training from UCLA-based supervisors and then participate in weekly reviews of the intervention delivery with their team and with supervisors. UCLA staff also provide ongoing training, intervention materials, emergency support, and technical assistance. Centralized management of the program ensures adherence to program fidelity, coordinated military partnerships, and ongoing quality improvement processes.

An innovative Internet-based “cloud-computing” management system (described in Lester et al.34) is used for quality control and to track implementation. The web-based, real-time assessment provides immediate feedback, enabling families to receive appropriate psychoeducational materials, a customized intervention protocol, and timely service referrals if needed. The assessment protocol includes standardized psychological health and coping measures that children, parents, and FOCUS providers complete. We obtained community norms for comparison and cutoffs for clinically significant symptoms from instrument-specific published sources (e.g., a scoring manual, meta-analyses, or similar peer-reviewed data). For measures with psychometrically established properties, we have reported Cronbach α for this sample. Cronbach α is a measure of the internal consistency (reliability) of responses on a questionnaire. Values that fall between 0.70 and 1.0 are acceptable.

Demographics and Descriptive Assessments

Parents answer general demographic and deployment history questions at intake. Active duty parents then complete the PTSD Checklist-Military,40 a 17-item self-report measure to assess the severity of PTSD symptoms in the past month. Non–active duty parents complete the PTSD Checklist-Civilian.40 Both the PTSD Checklist-Military and the PTSD Checklist-Civilian are administered at entry to guide program delivery (e.g., to identify need for referral or skills to target in intervention); we include them here to provide a description of population risk. A score of ≥30 is considered clinically significant for screening purposes in primary care settings.34,42

Parent and Family Outcome and Process Assessments

Parent emotional distress was used to assess psychological distress symptoms. Brief Symptom Inventory (BSI)1843 is an abbreviated version of the widely used BSI,44 a self-report inventory with extensively published psychometric data and community norms by gender. Parents complete the BSI at program entry and at 1 and 4 to 6 months postintervention. Cronbach α for this sample was excellent (0.91). We have reported details for global severity and prevalence of clinically significant symptoms of anxiety and depression. BSI norms are gender specific, and both genders were represented in non–active duty and active duty groups. Thus, all pre–post analyses of the BSI included gender as a covariate. To determine family adjustment, parents complete the McMaster Family Assessment Device (FAD),45 used to assess problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning. The FAD is administered at program entry and exit. For this sample, Cronbach α was excellent (0.92). An FAD general functioning score ≥2 is considered unhealthy functioning.45

The FOCUS resiliency trainer completes a Global Assessment of Functioning (GAF) rating for each family member at entry, midpoint, and exit. GAF is a numeric scale (0–100)
of overall current functioning that can be used with adults and children. Scores are characterized as follows: moderate to severe impairment (0–50); variable or single area difficulty (51–70); and slight or no impairment across all areas of home, school, and peers (71–100).

Upon completing FOCUS, parents are asked to rate their perception of change. Adapted from a previous prevention trial, this 29-item scale assesses the parents’ perception of improvement regarding 6 core intervention domains, including communication, problem solving, emotional regulation, managing trauma reminders, goal setting, and overall family support. Ratings anchors are 1=less than before, 4=same as before, and 7=much more than before. Cronbach \( \alpha \) was acceptable (0.73).

At the time of program completion, parents are asked to rate their overall satisfaction with their family’s participation in the program on the basis of how harmful or helpful the program was (1=very harmful to 7=very helpful), the parent’s satisfaction with the program (1=very dissatisfied to 7=very satisfied), and whether the parent would recommend this program to another family (1=definitely not recommend to 7=definitely recommend).

**Child Outcome Assessments**

Child psychological adjustment at baseline and follow-up was assessed using the Strengths and Difficulties Questionnaire—Parent Report (SDQ), a widely used instrument with subscales for conduct problems, emotional symptoms, and prosocial behaviors as well as a summary score of total difficulties. Normative data are available for both genders and for individuals aged 4 to 18 years. For simplicity, we have reported details for the total score and prevalence of clinically significant conduct problems and prosocial behaviors for the age groups specified in the SDQ manual.

Child coping was assessed using the Kidcope measure, a self-report checklist to assess the use of various types of coping strategies in youths. Children aged 7 to 18 years complete the coping measure at baseline and program exit. Cronbach \( \alpha \) was acceptable (0.73).

We analyzed continuous intake data (e.g., comparing those with and those without post data on severity of distress) using analysis of variance. We analyzed categorical intake data (e.g., prevalence of clinically significant distress) with the \( \chi^2 \) test. We analyzed pre–post change score continuous data using the single-sample \( t \) test, comparing data to the null hypothesis (no change) or to community norms when available, using the paired sample \( t \) test, or using the mixed model linear models when comparing groups. We analyzed pre–post categorical data with the \( \chi^2 \) and the McNemar tests. We addressed violations of normality or homogeneity of variance assumptions with nonparametric tests (e.g., the Mann–Whitney \( U \) test) that confirm results by providing a more conservative analysis without such assumptions.

**RESULTS**

There were 488 families (742 parents) enrolled in FOCUS family resiliency training from July 2008 through February 2010. Participants were self-referred (51.2%) or referred by providers (42.6%), including military medical, mental health, social services, chaplain, or school staff, with 6.2% indicating another referral source such as a military volunteer or a friend. The mean number of active duty parent deployments since the birth of the family’s first child was 4.51 (SD=4.78). Of 488 families, 331 (67.8%) completed the intervention; 89 (18.2%) were unable to complete it because of relocation or deployment, 42 (8.6%) reported the family was too busy to complete the program, 13 (2.7%) reported they no longer needed services, and 13 (2.7%) had not completed the program for unspecified “other” reasons.

Non–active duty and active duty parents enrolled in the program did not differ from each other on self-reported family functioning (FAD) or BSI distress levels, and both groups were significantly more distressed than were community norms. Non–active duty (mean=1.93; SD=0.54) and active duty (mean=2.02; SD=0.51) parents reported less healthy family functioning compared with community norms (mean=1.84; SD=0.43; \( t_{411}=6.32; P<.001 \)). On the global severity index of the BSI, both non–active duty (mean=10.82; SD=10.60) and active duty (mean=7.89; SD=9.20) parents had elevated distress relative to gender-specific community norms (males: mean=8; \( t_{357}=5.67; P<.001 \); females: mean=5; \( t_{357}=4.87; P<.001 \)). Notably, 33.7% (n=150) of non–active duty parents were above the cutoff of 30 for elevated posttraumatic stress symptoms at intake compared with 23.3% (n=69) of active duty parents.

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**TABLE 1—Changes in Parental Distress, Family Functioning, and Global Functioning at Intake and Postintervention: Families OverComing Under Stress, United States and Japan, July 2008–February 2010**

<table>
<thead>
<tr>
<th></th>
<th>Non-Active Duty, Mean (SD)</th>
<th>Active Duty, Mean (SD)</th>
<th>Normative Data, Mean (SD)</th>
<th>Time Effect (95% CI)</th>
<th>Group Effect (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intake</td>
<td>Post</td>
<td>Intake</td>
<td>Post</td>
<td>Intake</td>
</tr>
<tr>
<td>BSI global severity index</td>
<td>0.56 (0.56)</td>
<td>0.29 (0.33)</td>
<td>0.35 (0.37)</td>
<td>0.25 (0.24)</td>
<td>0.47 (0.53)</td>
</tr>
<tr>
<td>BSI anxiety</td>
<td>0.65 (0.67)</td>
<td>0.37 (0.43)</td>
<td>0.44 (0.54)</td>
<td>0.26 (0.31)</td>
<td>0.52 (0.59)</td>
</tr>
<tr>
<td>BSI depression</td>
<td>0.69 (0.73)</td>
<td>0.32 (0.47)</td>
<td>0.36 (0.56)</td>
<td>0.21 (0.33)</td>
<td>0.60 (0.68)</td>
</tr>
<tr>
<td>Family Assessment Device, general functioning</td>
<td>1.89 (0.54)</td>
<td>1.73 (0.43)</td>
<td>1.84 (0.43)</td>
<td>1.84 (0.43)</td>
<td>2.00 (0.49)</td>
</tr>
<tr>
<td>Global Assessment of Functioning</td>
<td>72.54 (10.78)</td>
<td>78.13 (9.53)</td>
<td>. . .</td>
<td>. . .</td>
<td>74.46 (11.54)</td>
</tr>
</tbody>
</table>

Note. BSI = brief symptom inventory; CI = confidence interval. Family and global functioning increase and distress declines over time. BSI was analyzed with gender as covariate.

*Not significant.

A Family Assessment Device score \( \geq 2 \) refers to unhealthy functioning.

\( *P<.05; **P<.01; ***P<.001 \).
SDQ scores for boys enrolled in the program (mean = 13.54; SD = 6.9) were significantly higher than were those of normative data (mean = 7.63; SD = 5.9; t (486) = 18.86; \( P < .001 \)), as were scores for girls enrolled in the program (mean = 11.11; SD = 6.3 vs norms mean = 6.56; SD = 5.2; t (378) = 4.55; \( P < .001 \)). There were no substantive differences in parent or child outcomes as a function of military branch, thus results are from combined data.

**Characteristics of Participating Families**

We have reported pre- and postintervention data from 331 families representing 466 parents (300 non-active duty and 166 active duty), with pre- and postassessment for at least 1 parent and 493 children from those families. The BSI was not part of the original follow-up assessment (it was added after the program’s initial implementation for service delivery needs), and thus matched data for the BSI are available for only 287 parents (221 non-active duty and 66 active duty).

Non-active duty primary caretakers were predominantly female (97.2%). Of the 166 active duty caretakers, 27 (16.3%) were female. Most parents (95.6%) were married. The mean age of parents was 34.39 (SD = 6.04), with no difference between non-active duty and active duty parents. Posttraumatic stress symptoms were assessed once, soon after intake, showing elevations (PTSD Checklist ≥ 30) among 94 (31.3%) of non-active duty and 35 (21.2%) of active duty parents and no difference between families who completed intervention versus those who did not.

Reflecting the age demographics of the child population within the military at large, there were more children aged 3 to 7 years (61.1%) than aged 8 to 10 years (19.0%) or aged 11 years and older (19.9%). There were more boys (55.1%) than girls (44.9%).

Families and parents who completed the intervention were more likely to be self-referred, less distressed on the BSI and FAD, and older than noncompleters. Children who completed the intervention did not differ from those who did not at intake on the SDQ.

**Implementation Process Outcomes**

Perception of change and parent satisfaction ratings (from 0 to 7) were completed by 363 parents. Mean values ranged from 5.52 (SD = 0.79) for improvements in emotional regulation to 6.05 (SD = 0.95) for improvements in understanding combat stress and parent–child stress reactions, indicating a high degree of perceived change. Parent satisfaction mean ratings were also high, with 6.51 (SD = 0.69) for overall helpfulness to their family; a satisfaction with the program rating of 6.58 (SD = 0.62); and a willingness to recommend the program to another family rating of 6.70 (SD = 0.60). Ratings were similar for active duty and non-active duty parents.

**Intervention Effects**

Parental distress, family functioning, and global functioning levels at intake and postintervention are shown in Table 1. There were no significant time \( \times \) group effects on any outcome. Change scores showed significant improvements across all measures for non-active duty parents and active duty parents (\( P < .001 \)). BSI-assessed parental distress and FAD-assessed unhealthy family functioning were significantly reduced, and post scores were at or better than normative data. The provider GAF rating for global functioning was significantly improved after intervention, despite mean intake scores indicating minimal impairment at the outset. Figure 1 illustrates the percentage of parents with clinically meaningful improvements in family functioning and anxiety and depression symptoms at intake and postintervention. Both non-active duty families and active duty families demonstrated significant decreases in prevalence of impairment and distress symptoms from pre- to postintervention (all \( P \) values < .001).

The SDQ total difficulties score and the prosocial behaviors subscale, by age and gender, are in Table 2. At intake, girls and boys in every age group were rated as

### TABLE 2—Changes in Child Adjustment on the Strengths and Difficulties Questionnaire at Intake and Postintervention: Families OverComing Under Stress, United States and Japan, July 2008–February 2010

<table>
<thead>
<tr>
<th>Age, y</th>
<th>Girls (n = 216)</th>
<th>Boys (n = 277)</th>
<th>Time Effect (95% CI)</th>
<th>Gender Effect (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intake, Mean (SD)</td>
<td>Post, Mean (SD)</td>
<td>Norms, Mean (SD)</td>
<td>Intake, Mean (SD)</td>
</tr>
<tr>
<td></td>
<td>Total difficulties</td>
<td>Prosocial behavior</td>
<td>Total difficulties</td>
<td>Prosocial behavior</td>
</tr>
<tr>
<td>3-7</td>
<td>11.59 (5.65)</td>
<td>8.25 (5.20)</td>
<td>6.8 (5.1)</td>
<td>13.54 (6.93)</td>
</tr>
<tr>
<td>8-10</td>
<td>11.00 (7.23)</td>
<td>7.41 (5.52)</td>
<td>6.4 (5.1)</td>
<td>13.47 (6.78)</td>
</tr>
<tr>
<td>≥11</td>
<td>11.63 (6.97)</td>
<td>7.59 (5.72)</td>
<td>6.5 (5.5)</td>
<td>14.55 (6.59)</td>
</tr>
</tbody>
</table>

Note. CI = confidence interval; NS = not significant. Time \( \times \) gender effects were not significant and are not shown. Total difficulties decline and prosocial behaviors increases.

Sample size is n = 295: 131 girls and 164 boys.

Sample size is n = 101: 44 girls and 57 boys.

Sample size is n = 97: 41 girls and 56 boys.

Not significant.

\( *P < .05; **P < .01; ***P < .001. \)
significantly less adjusted than were comparative gender- and age-specific norms ($P < .001$). Change scores indicate significant reductions in the total difficulties score for boys and girls across all age groups ($P < .001$) and significant improvements in prosocial behaviors ($P < .05$ to $P < .001$). Figure 2 shows the prevalence of clinically significant conduct problems, emotional symptoms, and total difficulties at intake and postintervention. Reductions in the prevalence of children with clinically significant symptoms over time were all significant ($P < .001$).

Children aged 7 years and older who completed a self-report of coping at intervention intake and exit (Kidcope; $n = 298$) evidenced significant increases in the use of positive coping strategies. McNemar tests indicated improvements in emotional regulation, problem solving, cognitive restructuring, and increased use of social support (all $P$ values significant at $P < .001$).

**DISCUSSION**

Increased attention has been paid to identifying the psychological health needs of service members and their families and to identifying and responding to gaps in the continuum of preventive care for military families. This has led to the proliferation of expanded and new programs and resources to address the needs of military families. Despite the expansion of family services provided by the public and private sectors, there has been limited systematic evaluation of these programs to guide national screening and prevention efforts. Our evaluation provides both implementation process and effectiveness findings that demonstrate the acceptability, feasibility, and effectiveness of strength-based, family-centered skills training designed to promote resilience and mitigate wartime deployment distress in military families.

The implementation and process outcomes provide preliminary evidence that recipients of FOCUS perceive that the program addresses relevant issues facing them during deployment and reintegration transitions. Consistent with the implementation of FOCUS as a selective prevention program, families entering the program may be proactively seeking to enhance coping in the face of increased challenges or may already be experiencing deployment distress. About one third of individuals entering the program were also referred to other social support and mental health providers, indicating the potential for selective prevention as a gateway to other services when needed.

Consistent with recent studies of military families who experienced wartime deployments, parents and children entering FOCUS were more likely to report symptoms of psychological distress than were nonmilitary gender-matched peers. Notably, non-active duty spouses were as vulnerable to distress, including posttraumatic stress symptoms as...
were their active duty partners. Military family experts have noted that the stress demands of civilian spouses may equal or even surpass their active duty partners because they lack the support of being embedded in a cohesive unit, they frequently lack clear information on the risk status of their loved one, and they are unable to act instrumentally on his or her behalf. Child distress was common at program entry, underscoring the relevance of providing selective preventive services that may provide early mitigation of child psychological distress. As anticipated, both parents and children participating in FOCUS demonstrated significant improvement in emotional and behavioral adjustment. Further, children’s prosocial behaviors and positive coping skills increased from initiation of training to postintervention. The reductions in psychological distress for both service members and spouse parents are noteworthy given the brevity of the intervention and the importance of parental psychological health and effective parenting to family and child resilience and adaptation.

FOCUS enhances family resilience processes and targets individual parent and child distress. The model provides individual and family level training in resiliency skills and builds on existing family strengths and increases family cohesion, communication, and support and the maintenance of consistent care routines in the home—all core characteristics of resilient families. On standardized assessment, we found that family adjustment improved significantly. We hypothesized that reduced parental distress and improved family adjustment would support positive child adaptation. Significant postintervention reductions in emotional and behavioral problems for boys and girls in all age groups support this hypothesis.

This evaluation also provides initial information regarding the challenges of implementing family prevention services for a mobile military population. Of the approximately 30% of families who initiated services but did not complete the intervention, more than half (18.2%) did not complete because of work-related relocations or deployments. Despite this “artificially inflated” attrition rate, almost 70% of families enrolled completed the FOCUS intervention, representing service completion rates much higher than those of community child mental health services (25%–60%); for review, see Greeno et al. . The evaluation also indicates that more distressed parents may have had greater difficulty completing the program, suggesting that higher risk families may require greater outreach and engagement, processes to bridge services during relocations, or improved identification and support for referral. We conducted this program evaluation on an existing data set, and it is limited by the lack of a control group. We have addressed the absence of a control group in several ways. We conducted analysis of change scores, verifying that reductions in symptoms occurred among those parents and children who were above and below clinical cutoffs at baseline. Reductions in the prevalence of clinically significant distress after intervention also suggest meaningful improvement. Both parents and children gave satisfaction ratings, and parents also rated the degree of perceived change around the core family domains, which were the intended targets for intervention change. Children also self-reported on specific ways of coping with a self-selected problem, indicating the process by which mental health symptoms may have improved. Also, clinician ratings of change augmented participant self-report measures. Although child developmental processes could have contributed to the positive outcomes, the brief nature of the intervention makes it unlikely that nonintervention changes could account for such rapid improvement across all age groups. An “attention-control” group in future evaluation studies may help to verify the active ingredients of positive intervention change.

Despite its limitations, this evaluation provides preliminary evidence that FOCUS for military families is feasible, is well tolerated, and can lead to significant benefits for parents, children, and families. Future examination of implementation challenges and program evaluation of FOCUS services in other service branches and for geographically dispersed populations, such as the National Guard and Reservists, will be important to provide information about program generalizability for other military branches.

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P. Lester, W. R. Saltzman, R. Pynoos, and W. Beardslee codeveloped the family preventive intervention program. P. Lester and W. Saltzman codeveloped the implementation design and program evaluation methodology. K. Woodward contributed to the program evaluation and implementation for the Navy and Marine Corps. D. Glover, G. A. Leskin, and B. Bursch contributed to the program evaluation methodology design. D. Glover was the primary analyst on this study. G. A. Leskin and B. Bursch contributed to data analysis. R. Pynoos and W. Beardslee contributed to the program design and implementation and data interpretation. All authors contributed to the writing of the article.

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Human Participant Protection
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