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Promoting Parenting to Support Reintegrating Military Families: After Deployment, Adaptive Parenting Tools

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Abstract

The high operational tempo of the current conflicts and the unprecedented reliance on National Guard and Reserve forces highlights the need for services to promote reintegration efforts for those transitioning back to civilian family life. Despite evidence that parenting has significant influence on children's functioning, and that parenting may be impaired during stressful family transitions, there is a dearth of empirically-supported psychological interventions tailored for military families reintegrating after deployment. This paper reports on the modification of an empirically-supported parenting intervention for families in which a parent has deployed to war. A theoretical rationale for addressing parenting during reintegration after deployment is discussed. We describe the intervention, After Deployment, Adaptive Parenting Tools (ADAPT), and report early feasibility and acceptability data from a randomized controlled effectiveness trial of ADAPT, a 14-week group-based, web-enhanced parenting training program. Among the first 42 families assigned to the intervention group, participation rates were high, and equal among mothers and fathers. Satisfaction was high across all fourteen sessions. Implications for psychological services to military families dealing with the deployment process are discussed.

Keywords

military deployment; National Guard/Reserves; children; parenting; prevention

Introduction

It is estimated that more than three million family members have been affected by the deployment of more than two million troops to the wars in Iraq and Afghanistan. Fifty percent of military personnel are married, and forty percent have children; 63% of military families live off military bases in more than 4000 communities across the USA (Department of Defense, 2011). The wars in Iraq and Afghanistan also have resulted in deployments of unprecedented numbers of 'civilian soldiers' – those in the National Guard and Reserves (NG/R). On average NG/R personnel are older, and more likely to be partnered and

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parenting, than ‘regular’ active duty military personnel. The high operational tempo of the conflicts in Iraq and Afghanistan also has resulted in longer and more deployments of these personnel. For example, average deployment of Army National Guard personnel since 2001 has been 2.2 times, each of an average length of 12 months. Other services (e.g. Air National Guard) see shorter but far more frequent deployments.

Military families are resilient, but an increasing body of literature has documented the psychosocial toll of a parent’s deployment. Children with parents deployed show increased anxiety, conduct and depression symptoms (Chandra et al., 2010; Flake et al., 2009). Maltreatment data indicate increases in abuse perpetrated by spouses left at home during the stressful period of deployment (Rentz et al., 2006). Spouses of military members have reported that deployments result in loss of emotional support, loneliness, role overload, role shifts, and concerns about the safety and well-being of the deployed military members (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008).

Following reintegration, arguably the most stressful period in the deployment cycle, the service member must resume the role of partner and parent, while dealing with the aftermath of battle. Physical injuries, traumatic brain injuries, and/or PTSD and other psychiatric illnesses can further complicate the period of reintegration. For example, Gewirtz et al. (2010) found that increases in PTSD symptoms during the year following the return home were significantly associated with parenting impairments among male National Guard soldiers deployed to Iraq.

Fortunately, initiatives to support service members are increasingly broadening their focus from individual service members to military *families*, partly as a result of findings indicating the stress of deployment and reintegration on service members’ families (e.g., Faber et al., 2008), and partly as a result of the large body of literature indicating the inextricable link between individual health and family health (e.g. Dekel & Solomon, 2005; Palmer, 2008). What appears to be lacking, however, is a focus on empirically supported programs to strengthen parenting in military families as a means to support children and their parents. Several decades of developmental research have demonstrated the importance of parenting for children’s healthy development in general – and in particular, its key role in promoting children’s resilience in highly stressful situations (e.g. Masten, 2001).

In this paper, we focus on parenting as a crucial mechanism for child and family functioning following deployment. We conceptualize deployment as a family stressor for two reasons: the separation inherent in a parent’s deployment, and stress associated with the residual impact of exposure to combat on parental functioning during reintegration. Drawing from family stress research, and a social interaction learning framework, we provide a theoretical/conceptual rationale for the After Deployment, Adaptive Parenting Tools/ADAPT program, a web-enhanced, group-based parent training intervention currently being evaluated in an NIH-funded randomized controlled trial. We provide preliminary data on the feasibility, and acceptability of the program, as well as data on dosage (physical and online participation/engagement) for the first cohort of families participating in the ADAPT program.

Deployment, parenting, and child adjustment: Models of stressful family contexts.

Over the past decades, family stress models (e.g., Conger, Ge, Elder, Lorenz, & Simons, 1994) have shown how stressful family situations such as socioeconomic stress, family transitions such as divorce and re-partnering, parental illness, and incarceration, affect child adjustment largely by impairing parents' parenting. Patterson and colleagues (e.g., Patterson, Reid, & Dishion, 1992) demonstrated that coercive family interactions are the mechanisms through which stressful events might result in increased child behavior and conduct problems. Studies examining observed family interactions indicated that the frequency and intensity of coercive parent-child interactions (i.e. negative, escalating conflict bouts initiated by parent or child) predict subsequent behavior problems, delinquency, police arrests and other adverse child outcomes.

Applying this social interaction learning model to intervention, Forgatch & DeGarmo (1999), Dishion & Andrews (1995), Chamberlain et al (2008), and others developed parent training interventions to buffer parenting in stressful situations with the goal of improving child outcomes. For example, Forgatch's 14-week long Parenting Through Change (PTC) program based upon the Parent Management Training-Oregon model, was aimed at buffering mother's parenting during the stressful period immediately following a divorce or separation. Her randomized controlled trial of PTC with a divorced/separating mother sample, demonstrated improvements to parenting, child outcomes (reduced conduct problems, depression symptoms, arrests, drug use, and improved school performance) and parent outcomes (depression symptoms, drug use) lasting 9 years following baseline, with effect sizes actually growing over time in key variables (Forgatch, Patterson, DeGarmo, & Beldavs, 2009). In addition, families in the intervention group also benefited through lasting improvements in the intervention families' education, occupation and income relative to the control group (Patterson et al, 2010). A study examining the impact of a parent training program for stepfamilies indicated benefits to couple functioning (both self-reported adjustment and observed couple interaction) in addition to parenting and child outcomes (Bullard et al., 2010).

Parent management training interventions have strong evidence for their efficacy and effectiveness (Kazdin, 1997). They have been tested in multiple contexts with diverse populations. However, they have not been adapted and tested within military populations affected by deployment. The current study, based upon Parent Management Training—Oregon (PMTO) model, documents the adaptation, and early evaluation of a PMTO intervention modified for military families. To our knowledge, this is the first empirically-supported parent training program targeting school age children that is modified specifically for National Guard and Reserve military families.

After Deployment, Adaptive Parenting Tools/ADAPT

ADAPT is an adaptation of a 14-week group-based PMTO prevention intervention (Parenting Through Change; Forgatch & DeGarmo, 1999). A summary of the ADAPT's key content is provided in Table 1; more information about the program can be found on the ADAPT project website: <http://www.cehd.umn.edu/fsos/projects/adapt/default.asp>. Consistent with PMTO principles, ADAPT targets five positive parenting practices: skill encouragement, positive involvement, family problem-solving, monitoring, and effective

discipline (Forgatch & Patterson, 2010). These parenting practices are taught in weekly 2-hour groups using active teaching methods such as role play, practice, and discussion. Three specific adaptations were made for the ADAPT curriculum on the basis of empirical data about military families, and findings from focus group and key informant interviews in the first phase of this project. These adaptations addressed (i) military culture and context, and needs specific to the nature of reintegration (e.g. parenting together after separation); (ii) how combat stress reactions might influence parenting and the family context, and (iii) barriers to participation in weekly groups.

Feedback from NG/R parents suggested that one of the most challenging aspects of reintegration was developing a 'united parenting front' following one parent's separation. While not all parents participating in ADAPT are in 2-parent families, the majority are, and strong attention is paid to supporting parents to be 'on the same page' with regard to family rules, roles, and routines (Gewirtz, Erbes, Polusny, Forgatch, & DeGarmo, 2011). ADAPT strategies to support parents to develop a united parenting front include helping parents to develop joint goals for their children, practice discipline strategies, and problem solve co-parenting challenges. This may also be useful for divorced or separated military families where co-parents do not participate in groups.

The second major category of modifications includes addressing the challenges associated with parenting in the aftermath of combat. To be successful in a combat zone requires an individual to be always vigilant, expect danger, and be primed to react immediately. Indeed, those behaviors may be critical for survival in war zones. However, reintegration requires a recalibration of emotional responding; immediate reactivity and hyper-vigilance can increase the volatility of family interactions and raise the likelihood of coercion. PTSD symptoms, particularly those of experiential avoidance, are associated with family and parenting challenges (Samper, Taft, King, and King (2004); see Galovski & Lyons, 2004, for a review). We hypothesize that parents' capacities to implement effective parenting tools are predicated on their ability to regulate emotions, yet this capacity may be impeded by PTSD or other anxiety symptoms associated with combat exposure. In addition, we hypothesize that parents' capacities to socialize their children in healthy emotional responding (i.e. emotion socialization) is key to addressing children's deployment-related anxiety and other adjustment difficulties (Gewirtz & Davis, in press). Thus, we added material to the existing PMTO curriculum that specifically targets improved parents' emotion regulation and socialization. Each ADAPT session includes mindfulness exercises aimed at increasing present moment awareness, or the capacity to be present and pay attention to family members, and particularly children. Parents are taught to pay attention and respond to their children's emotions using emotion coaching techniques (Gottman, Katz, & Hooven, 1996).

Barriers to participation in group sessions were anticipated for this population of families simultaneously juggling home, work, and military obligations. Anticipating this, we developed a set of web tools for ADAPT that can be accessed from home at any time. The ADAPT online enhancement includes skill and practice videos showing military families learning and practicing key positive parenting skills with their children. Mindfulness exercises taught in the group are downloadable to cellphone and MP3 players for daily

practice. Home practice assignments and summary sheets may be completed online and printed or downloaded.

In this paper we report early data from the first two cohorts of 42 parents who were randomly assigned to the ADAPT treatment condition. We address three primary questions: (i) Is the ADAPT intervention feasible for this NG/R population? (i.e. to what extent do families assigned to the intervention group actually participate in groups, use the online modules and complete home practice?); (ii) Is the ADAPT intervention acceptable to families? (i.e. how satisfied are parents with their experiences with the ADAPT program), and (iii), What baseline demographic factors appear to be associated with attendance in group, use of the online tools, home practice completion, and satisfaction with the ADAPT program?

Methods

Design

The ADAPT parenting program is being tested in a randomized effectiveness trial funded by the National Institutes of Health (R01-DA030114). Families are randomly assigned to participate in the experimental group/ADAPT program (60% of total sample, final $N = 240$) or to services-as-usual (i.e. print, online, and email parenting resources; 40% of total sample, final $N = 160$). Families participate in the study in four assessment interviews conducted over a two-year period to investigate the effectiveness of the parenting program on parenting, child, and parent outcomes. In this paper we report information gathered at baseline, and during groups, for the first 42 families assigned to the intervention condition/ADAPT group program.

Participants

For inclusion in the ADAPT study, families were required to have at least one child living with them between the ages of four and twelve, and at least one parent who had deployed to the current conflicts (i.e. Iraq or Afghanistan). Most participants were married (81%) for the first time (84%), and mean length of current marriage was 9.65 years ($SD = 3.86$). The median number of children was two; 44% of families reported 3 or more children. The racial composition of the parents was 89% European American, 3% African American, 1% Asian American, 1% Native American, 1% multiracial, and 5% unreported. Parents reported their ethnic background as 92% non-Hispanic, 3% Hispanic and 5% unknown. This racial/ethnic distribution is similar to statewide data for Minnesota (87% European American). Household income ranged from \$20,000 to \$155,000 per year; median was \$80,000. More than half of the parents (56%) reported completing at least a Bachelor's degree.

Table 2 provides demographic information. All families comprised of at least one parent who had been deployed to OEF/OIF since 2001. Number of overseas deployments ranged from 1 to 11 for men (mean was 2.52 (2.37)), and 1 to 6 for women (mean was 1.70 (1.34)). Fifty-six percent of the sample had deployed at least once, an additional 5% were NG/R members who had not deployed, and 39% were civilian. Among the deployed parents, 24% were mothers and 76% were fathers.

Procedures

Potential participants were reached in several ways: (1) presentations at mandatory pre-deployment and reintegration events for all NG/R personnel, (2) mailings from the Minneapolis Veterans Affairs Medical Center to all OIF/OEF veterans, (3) flyers posted throughout the Minneapolis/St. Paul area, (4) media (e.g. newspaper and radio reports), and social media coverage (e.g. Facebook and Twitter), and (5) word of mouth by fellow military parents and stakeholder groups. Families could go directly online to consent to participate in the study; typically, however, recruitment staff would call families who provided contact information at the above events, and direct them to the hyperlink for the screener and online consent form. Participants who submitted their informed consent were automatically directed to a HIPAA-compliant site to complete an online assessment; each participating parent completed a separate assessment. Following this, project staff scheduled an in-home assessment with the family. During in-home assessments, assessment technicians gathered self-report, observational, and physiological data from parent(s) and target child; only self-report data on demographic variables are reported here. Parents were each paid \$25 for the online assessment and each family received \$50 for completing the in-home assessment.

Families were randomized following the in-home assessment via a phone call from project staff. Those randomized to services-as-usual were sent print (i.e. tip sheets) and online parenting resources. Those randomized to intervention were invited to the next ADAPT group to start in their geographic area. Because the groups are closed and run for 14 weeks, intervention participants assessed after the closing of one group are invited to participate in the next cohort of groups. Data reported below are from the first two cohorts recruited into the study, a total of six groups.

Participant Flow

Figure 1 provides a consort diagram of participant flow. The current sample consists of 42 families assigned to intervention (27 additional families were assigned to services-as-usual). Services-as-usual families are included here only for purposes of comparison on baseline demographic variables. Families randomized to intervention did not differ from controls in marital status (married vs. not married), income, or number of children in the home (p s $> .13$). Parents assigned to intervention vs. control conditions did not differ in education, employment, race, or ethnicity (p s $> .18$).

Intervention

Families randomized to the intervention condition were offered a parenting group in a community location (i.e. church, library, or community college) within reasonable driving distance (30 to 40 minutes) in the greater Minneapolis/St. Paul metropolitan area. Groups met weekly, except holidays, for two hours in the evening for 14 weeks. Each group consisted of five or six families (8 to 12 individuals) and each family was provided with heavy snacks or dinner, and childcare during the session, along with a stipend of \$15 to offset travel costs.

Prior the first session, group facilitators called families by phone to provide an introduction to the group and the ADAPT program, and to problem-solve any barriers to attendance. This call set the precedent for the midweek call, a weekly check-in with families and an opportunity to troubleshoot home practice assignments between group sessions. At the first ADAPT session parents each received a binder with handouts of key material covered in the session, home practice assignments, and instructions for accessing the ADAPT website. Home practice assignments reinforced skills learned in the group, and were reviewed in the subsequent meeting. After each group, parents received an email prompt directing them to the relevant online content for that week. Parents were encouraged to view online material between sessions, and could share web resources with other family members. ADAPT online is available to parents for one year.

Two or three military and non-military male and female trained facilitators lead each group. Facilitators are typically NG/R members, employees, or spouses, and community human service providers; most have a Master's degree in a human service field. Facilitators are provided an in-depth training in both the PMTO model and the ADAPT modifications. They utilize manuals with agendas, objectives, exercises and role-plays for each session and all sessions are videotaped to assess fidelity to the model. Facilitators are supported by biweekly coaching sessions.

Group sessions provide parents with active teaching of parenting skills, practice through role-play, and support through group discussion. Issues associated with deployment and related stressors are addressed in each session, and emotion regulation skills are taught throughout. The content for each group session is summarized in Table 1.

Measures

Feasibility (recruitment and retention into the group)—*Recruitment* was assessed by examining the proportion of invited participant families who attended at least one session of the group. *Retention* was assessed by (1) weekly attendance by parents and families, (2) number of families completing home practice assignments, and (3) usage of online tools.

Acceptability—Acceptability of the ADAPT group was assessed using a 20-item participant feedback survey developed for PMTO interventions (Forgatch, 1994) and modified for ADAPT use. Surveys for each of the 14 weeks were placed in each participant binder prior to the first session of the group, and pre-labeled only with the session and participant numbers. Facilitators asked each parent to complete the questionnaire at the end of each weekly group session and place them in an envelope. Items on the questionnaire use 5-point Likert scale ratings (0=not at all to 4=very much). Examination of the item reliabilities and factor analysis of the scale yielded three empirically and rationally-derived subscales: *Participant satisfaction* (agreed with ideas, info today was helpful, enjoyed group; alphas ranged from .84 to .95); *Positive Group Experience* (leader encouraged participation, leader understands me, liked group leader, felt accepted by group, something humorous happened during group, felt open to new information, paid careful attention, actively participated; alphas ranged from .84 to .95 across sessions), and *Home Practice Satisfaction* (home practice was helpful, I was successful with home practice, my children

responded well, assignment fits well with my family life; alphas ranging from .80 to .98 across sessions). Factor analysis revealed four items (felt angry/irritable, felt criticized, felt sad/depressed, home practice was hard) that did not consistently load onto a factor and so were dropped. One additional item, which assessed whether parents completed home practice, considered as a separate outcome, was also dropped.

Control Variables—Demographic variables: marital status, income, education, employment, minority status, ethnicity, and number of children in the household were assessed using parent self-report measures gathered at baseline.

Results

Forty-two families were invited to attend cohort 1 and cohort 2 groups. Of these, 33 attended at least one session. Of the 9 remaining families, 2 did not respond to invitations, 2 requested to wait for a group at a better time and location, 1 decided not to attend groups due to an in-progress divorce, and 4 agreed to attend, but did not show up. Figure 1, a consort diagram, shows the flow of families and individuals to groups. Families who attended did not differ from those who did not attend in marital status (married vs. not married) or income $ps = .49$. However, families who attended had fewer children living in the home than those who did not attend $t(37) = -2.20, p = .03$. Median number of children for families not attending was 3, compared to the median of 2 children in families who attended. Parents who attended did not differ from those who did not attend in education, employment, minority status, or ethnicity ($ps = .17$). The nine families who did not attend any parenting group sessions were excluded from the following analyses of program dosage.

Of the 33 families who participated in the group intervention, the majority of parents were married, contributing to the approximately equal representation by mothers and fathers. As expected, approximately half of parents were recently deployed; non-deployed parents represented a mix of never-deployed service members and civilian spouses/partners. Most parents were European-American, non-Hispanic, and had some college education. Household income ranged from \$22,500 to \$155,000 per year, with a median income of \$80,000.

Attendance

Attendance by at least one parent in a given family ranged from 1 to all 14 sessions; $M = 10.33, SD = 3.76$. Over three quarters of families (79%) attended at least 50% of the sessions, and a large majority of parents (92%) attended at least one session. Average family attendance did not differ significantly by cohort or group *Cohort 1* $M = 9.82 (SD = 4.05)$; *Cohort 2* $M = 10.88 (SD = 3.48)$, and was not correlated with household income $ps = .06$. At the parent level, average attendance did not differ by gender *Cohort 1: Mothers* $M = 7.94 (SD = 4.68)$, *Fathers* $M = 8.71 (SD = 4.97)$; *Cohort 2: Mothers* $M = 10.13 (SD = 3.14)$, *Fathers* $M = 8.64 (SD = 5.42)$, or deployment status, and was not correlated with education or household income $ps = .54$.

Home practice assignments

Completion of home practice assignments (HPA) by at least one parent in a given family ranged from 0 to 12 (of 13 total assignments); $M = 6.82$, $SD = 4.07$. Cohort and group differences were not significant *Cohort 1* $M = 7.00$ ($SD = 4.37$); *Cohort 2* $M = 6.23$ ($SD = 3.84$); $p = .53$. At the parent/family level, HPA completion did not differ by gender or deployment status, and was not correlated with education or income ($ps = .29$).

Online tools

Family use of online tools averaged 14.97 of 56, and varied greatly (*Range 0–54*, $SD = 19.16$). About half (55%) of families accessed the online tools at least once. In terms of percent of the total number of families using specific online tools, families used summaries (33%), knowledge checks (32%), and videos (30%) the most, followed by handouts (25%), and mindfulness exercises (19%). Cohorts and groups did not differ significantly in family use of online tools (number of components completed, proportion of online tool types; $ps = .21$), with one exception. The percent of families using online tools at least once differed significantly across groups $F(5,27) = 3.64$, $p = .01$. Family online use was not related to household income ($ps = .17$). At the parent level, use of online tools did not differ by gender or deployment status, and was not correlated with education or household income ($ps = .06$), with one exception. Proportion of videos used by parents was correlated with education $r = .31$, $p = .02$, with higher educated families accessing videos more frequently.

Associations of attendance, HPA completion, and online tool usage

Families who attended more sessions, also completed more HPAs ($r = .85$, $p < .01$). Family attendance and completion of HPAs were significantly correlated with total use of online tools ($r = .35$, $p = .05$ and $r = .43$, $p = .01$, respectively). Family attendance and HPA completion were also correlated with use of all types of online tools except mindfulness exercises (attendance and HPA) and knowledge checks (attendance, only). At the parent level, parent attendance and HPA completion were correlated at $r = .90$, $p < .01$. Both were correlated with total number of online components completed ($r = .36$, $p = .01$ and $r = .41$, $p < .01$, respectively). Parent attendance and HPA completion related to use of online types of components in similar ways to the family level.

Participant Feedback/Acceptability

Mean *parent satisfaction* was high at all sessions (mean = 3.39; $SD = .48$) ranging from 3.25 ($SD = .57$) at session four, to 3.49 ($SD = .52$) at session fourteen. Mean *positive group experiences* was also high at all sessions, ranging from 3.25 ($SD = .49$) at session three to 3.50 ($SD = .50$) at session 12. Finally, mean *homework satisfaction* ranged from 1.72 ($SD = .98$) at session two to 2.29 ($SD = .74$) at session 11.

Parent satisfaction, positive group experiences, and homework satisfaction did not differ significantly between cohorts, groups, genders, or deployment status, and were not significantly correlated with education or income $ps = .06$.

Associations among parent feedback scales

Associations among participant feedback form scales indicate that parent satisfaction was closely related to report of both positive group experiences and home practice satisfaction $r = .93, p < .01$ and $r = .38, p < .01$, respectively. Similarly, positive group experiences were also closely associated with home practice satisfaction $r = .38, p < .01$.

Associations of parent feedback with engagement

Accounting for gender, deployment status, and income, separate regressions predicting engagement (attendance, HPA completion, and measures of online use) from parent feedback form scales (all scales entered in step 2) were significant only for HPA completion $R^2 = .39, R^2 = .36, p < .01$. Only home practice satisfaction was a significant predictor of home practice completion $\beta = .68, p < .01$, while general satisfaction and positive group experience were not $ps = .33$.

Discussion

Data from the first two cohorts of ADAPT intervention participants suggests that the program is both feasible and acceptable. Seventy eight percent of families invited to participate in the intervention came to at least one session. Once a family attended at least one session, average participation was extremely high for a parenting group (79% attended at least seven out of fourteen, weekly, 2-hour sessions). Data on participation rates have been documented to be as low as 30% for parenting prevention programs (e.g., Spoth & Redmond, 2000; Heinrichs, Bertram, Kuschel, & Hahlweg, 2005). Although only outcomes data will demonstrate whether the program makes a difference to parenting practices and child adjustment, it appears that the vast majority of families received an adequate dosage of the program. Forgatch & DeGarmo (1999), for example, reported in their efficacy study of Parenting Through Change, that a minimally adequate dosage of the program was attendance at four sessions, and they found evidence for a dosage effect favoring those who attended more than four sessions, compared with those attending fewer than four sessions.

Participation in different aspects of the program was associated – that is, families who attended more in-person group sessions also used the web tools more frequently. The exception was access to the mindfulness exercises. We speculate that motivation to access the online mindfulness exercises may more likely be associated with an individual's (or family's) readiness to practice strategies that are qualitatively quite different from parenting strategies. It is possible that baseline mindfulness or other related variables (e.g. positive attitudes towards mindfulness and meditation) may be most associated with an individual's use of these exercises, rather than general motivation to address parenting. In fact, anecdotally, some parent participants expressed questions about how mindfulness was relevant to parenting – it is not so clearly obvious why a 10-minute mindfulness practice would improve parenting compared with practice at giving effective directions!

Our rationale for developing the web tools was to provide additional parenting tools that did not require face-to-face participation; we were thus surprised to see web participation significantly associated with group participation. In fact, we had expected to see lower

attendance from this population overall compared with civilian prevention programs (and particularly from fathers) given the barriers to care and low mental health service utilization documented in prior studies of military families (Hoge et al., 2004). Therefore, we wanted families to be able to use the web when they were unable, or if they were unwilling to attend groups.

We speculate that there may be two reasons for the relatively high participation rates. First, it may be that families saw ADAPT as a community-based parent education program, and a source of peer social support (rather than, for example, a mental health resource). In our focus groups, families (and particularly civilian spouses) spoke of the lack of opportunities to meet and mix with other NG/R families, and the need for programming that would provide peer support. It also may be however, that accessing more aspects of the program (or immersion in the program across delivery media) is simply reflective of a family's commitment to participate in the program overall. Cunningham (in press) has used data from preference trials to suggest that there is a segment of 'highly committed' parents who tend to indicate interest in whatever resources are available (the more, the merrier!) He suggests that these families would participate regardless of the intervention modality or what is required of them. It may be that the families participating in the first cohort of ADAPT, and particularly those who attended more frequently, represent, on average, this segment of families.

SES data from the families in this study whole suggests a middle class, relatively highly educated (more than half have a Bachelor's degree) group of participants. Our data on military rank in this sample indicate that 31% of participants were officers (and 69% enlisted) compared with national averages of 15% officers in the NG/R (Department of Defense, 2012). However, it should be noted that officers are one-and-a-half times more likely to have dependents than enlisted personnel (DoD, 2012), which would account for some of the skew towards older, more established, higher income, and higher rank participants. Once the full study sample has been recruited, we will know more about whether the demographic reported above represents those first to sign up for the study, or is indicative of a lasting tendency towards increased study participation by those in higher ranks and higher SES. Our study recruitment efforts did not favor this demographic – recruitment was conducted at mandatory family preparation and reintegration academies in Minnesota that all deploying NG/R personnel must attend. However, ADAPT's early champions included NG/R leaders and officers, and it is possible that their endorsement had the most influence on those with status closest to their own. We were pleasantly surprised that group attendance did not differ by gender, or by deployment status. In the larger parent training literature, far more data are available for women than men, and women attend parenting programs in far larger numbers (e.g. Reyno & McGrath, 2006). Anecdotally, we hear that women (typically civilian spouses) are often those who first contact our project to participate, and later recruit their husbands. (Parents may participate in the study even if their spouse/partner does not consent to participate). These data, as well as the data indicating no gender differences on home practice completion, online access, and satisfaction, suggest that ADAPT may be equally acceptable and relevant to both genders. This is critical given the population of deployed fathers we were aiming to reach, and we hope that our data will answer important questions regarding military father outcomes

following participation in this parenting program. We also were pleased that participation of deployed mothers was high relative to their proportion in the deployed population (24% of deployed individuals in this study were mothers, compared to 18% women nationally). There is almost no published research addressing the specific reintegration challenges that face mothers who deploy.

On average, participants gave high satisfaction ratings for every group session (on average 3.3, on a 0–4 scale, or ‘quite satisfied’), and ratings did not differ by gender (or other demographic variables). As noted above, we are particularly gratified that both fathers and mothers, deployed and civilian parents appeared to find the material relevant and useful.

There are several limitations to this study. First, the small sample of Midwestern, primarily National Guard families limits generalizability of the findings. Moreover, the wide variability in attendance and home practice completion suggests variations in the use of the program that were not captured by our analyses of primarily socio-demographic variables. As noted, that there are subsamples of this population who may be more challenging to reach and engage in a prevention program (e.g. enlisted families). Although we provided families with several ways of engaging in the program (i.e. both web and group), we are not able to dismantle dosage and outcomes for each component because the research only involves a two-group (i.e. intervention vs. treatment-as-usual) design, requiring a further study to understand which intervention components might be ‘core’ in predicting engagement and outcomes.

Subsequent analysis of the entire sample will give us more clues about how and when participants use the various intervention components, and whether these first two cohorts are representative of the sample as a whole. The relatively slow pace of most research studies means that data often are not available when they are most needed. Military families need services now, and cannot wait the several years for a research study to be complete. Given the urgency of learning about military families’ engagement in family-based services, and their significant needs for such services, we believe that these interim data can inform both ours, and others’ intervention development and implementation.

For example, the finding that fathers participate in ADAPT as much as mothers (even though mothers are the first to contact the program) suggests that male soldiers – often seen as harder to reach than their typically civilian female partners - are willing to engage in services to strengthen their family relationships. Clinicians working with military families may therefore find that although mothers are more amenable to initial outreach efforts, providing tools for fathers can pay off in increased involvement by men. The high rates of attendance should also be heartening to clinicians, suggesting that although military families may be harder to engage initially, once they commit to services, they follow-through with relatively high rates of attendance and home practice completion. Anecdotally, several families have suggested to us that they particularly enjoy ADAPT because the tools provided in the program are very consistent with what they value in military life (i.e. structure, clarity, routines, protocols, etc). At the same time as providing clearly structured skills (e.g. a script for the time out procedure), ADAPT also stresses the value of regulated emotional interactions, and flexible responding to children’s reactions. For example, active

listening skills build on units teaching parents to identify and respond to their children's negative emotions, particularly anxiety, so that parents can acknowledge and emotionally coach their children through anxiety-provoking situations (e.g. deployment) by responding to, rather than dismissing or rejecting children's worries.

The fact that ADAPT is a prevention program, rather than mental health treatment, also appears to help with engagement. Anecdotally, families have shared with us that they see ADAPT similarly to a form of parent education that is well used and universally available in Minnesota – Early Childhood Family Education/ECFE. If parent training can be framed in a prevention or health promotion context by clinicians, and, ideally, delivered in a community location (community center, church, etc) families may be more willing to participate. Finally, the VA has recently changed its service policies, with an explicit move towards encouraging service provision of families, rather than just adults. This potentially opens the door to providing the kinds of parenting services that can support the resilience of both the current and the future generation of US military service members.

Combined with the participation data, the ADAPT preliminary satisfaction data suggest that this intervention is both feasible, and acceptable. Participants appear to like, and want to participate in ADAPT, which is all the more remarkable given the extent of the commitment required to participate (14 weekly sessions of 2 hours, plus home practice assignments, as well as online components). Our experience suggests that military families may be a special population in a prevention context; time and again families told us 'when we commit to something, we follow through' and this indeed appears to be the case. Alternatively, or maybe in addition, we may be seeing a less representative group of families with greater resources than those who may be at the highest risk for poor parenting during reintegration from deployment. This is the classic dilemma of recruitment in every prevention study; ours is no exception.

Obviously, we are hopeful that the combination of high satisfaction and high participation will prime participants for positive behavior change – i.e. that ultimately the program will result in improved parenting and child outcomes for military families. However, ADAPT seems to have passed the first hurdle of successfully engaging an underserved and typically hard-to-reach population – NG/R families – including both deployed and non-deployed mothers and fathers. Although only further research with an Active Duty military population will confirm whether this program will generalize, research indicates common reintegration concerns across both Reserve and Active Duty components (Hoge, Auchterlonie, & Milliken, 2006), and thus there is reason to believe that ADAPT's program content is likely relevant to all military families, regardless of the nature of their service. Research on psychological services for deployed military families is desperately needed, given the extensive reliance of our country on so many US service members and their families over more than a decade of wars.

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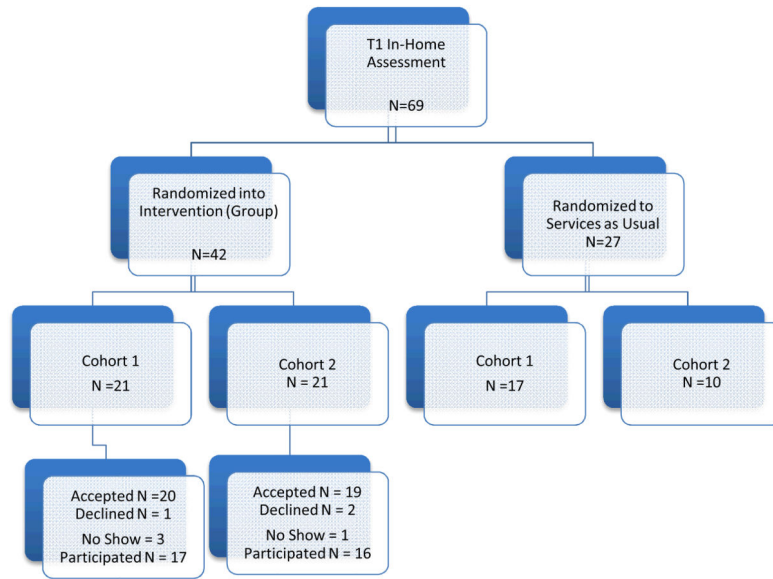


Figure 1.
Consort diagram indicating flow of families to groups.

Table 1

ADAPT Curriculum

Session	Title	Main Content
1	Building Blocks of Resilience	Introduction with emphasis on coping skills to promote healthy families in context of reintegration following deployment; identifying strengths in military families and deployment-related stressors.
2	Encouraging Cooperation	Promoting children's cooperation through use of effective parental directions.
3	Teaching New Behavior	Parents as children's most important teachers: effective teaching strategies using contingent positive encouragement.
4	Recognizing Emotions	Observing & labeling emotions; mindfulness
5	Responding to Emotions	Recognizing and responding to difficult emotions, renegotiation of family roles after deployment.
6	Setting Limits	Effective discipline with children.
7	Follow Through	Establishing family rules and strategies for negative sanctions.
8	Communicating with Children	Active listening skills, family meetings, introduction to emotion coaching.
9	Problem Solving	Strategies to anticipate and address stressors, problematic family situations, and plan positive family activities.
10	Managing Conflict	Builds upon sessions 4, 5, 8, and 9 to manage family conflicts, addressing children's deployment-related anxieties.
11	Monitoring Children	Keeping children safe; tracking children's whereabouts, peers.
12	Promoting School Success	Positive involvement in academic development at home and at school; home-school communication regarding deployment.
13	Linking Home and School	Emotional regulation, positive parenting practices, and problem-solving home-school communication.
14	Balancing Work and Play	Planning for work and play as parents and a couple. Negotiating future deployments.

Table 2

Sample Demographics

	N	Percent (Sub-group %)	N	Percent
Families (N = 42)				
* Marital Status				
Married	34	81%		
Divorced	1	2%		
Separated	4	10%		
Never Married	3	7%		
Parents (N = 75)				
Gender				
			Ethnicity	
			Non-Hispanic	69 92%
Mothers	39	52%	Hispanic	2 3%
Fathers	36	48%	Unknown	4 5%
Deployment Status			Education	
Deployed	42	56%	GED	1 1%
Mothers (% of Deployed)	(10)	(24%)	HS Diploma	2 3%
Fathers (% of Deployed)	(32)	(76%)	Some College	22 29%
Non-Deployed Guard/Reserve	4	5%	Associate's Degree	4 5%
Mothers (% of Non-Deployed)	(3)	(75%)	Bachelor's Degree	32 43%
Fathers (% of Non-Deployed)	(1)	(25%)	Master's Degree	9 12%
Civilian	29	39%	Doc/Prof Degree	1 1%
Mothers (% of Civilian)	(26)	(90%)	Unknown	4 5%
Fathers (% of Civilian)	(3)	(10%)	Employment	
Race			Full Time	41 55%
European-American	67	89%	Part Time	12 16%
African-American	2	3%	Retired	1 1%
Asian-American	1	1%	Homemaker	7 9%
Native American	1	1%	Student + add. employment	1 2%
Multi-racial	1	1%	Unemployed	5 7%

	N	Percent (Sub-group %)	Not Reported	N	Percent
Unknown	3	4%		4	5%

* Note: Marital Status did not differ by gender $p = .43$