Published in final edited form as:

Contemp Fam Ther. 2015 September 1; 37(3): 199–208. doi:10.1007/s10591-015-9327-9.

FOCUS for Early Childhood: A Virtual Home Visiting Program for Military Families with Young Children

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Introduction

Over 2.6 million military service members have served in Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) (Tanielian, et al. 2014b). These missions have required multiple deployments from service members, resulting in the risk accumulation of increasingly severe negative psychological consequences over time. The risk for mental health problems among multiply deployed service members is well established (Bliese et al. 2007; Hoge et al. 2004; Hoge et al. 2014; Milliken et al. 2007; Vanderploeg et al. 2014; and see Kok et al. 2012, for a meta-analysis). Importantly, risk is elevated among high-risk subgroups, including, National Guard (up to 25.6%; Martin 2007; Milliken et al. 2007; Thomas et al. 2010), and those accessing Veteran's Health Administration services (24.7%; Dursa et al. 2014).

Reserve component (i.e., Reserves and National Guard) and veteran families face particular challenges as they are geographically dispersed in civilian communities and often have fewer nearby military social support networks and military-informed health and community services than active duty service members (Milliken et al. 2007). Research has consistently shown that reserve component families experience greater challenges than their active duty counterparts, including a higher prevalence and increased severity of maladjustment for both service members (Martin 2007; Milliken et al. 2007; Thomas et al. 2010) and non-deployed partners (Lara-Cinisomo et al. 2012; Mansfield et al. 2010). In addition, over one million veterans have transitioned to civilian life since September 11, 2001 (Seal et al. 2008) and this population will continue to grow with the reduction in total force size. Thus, reserve component and veteran families have a pressing need for services, particularly those that are flexible and can reach them within the dispersed civilian communities in which they live (Glynn 2013).

Ecological systems theory (Bronfenbrenner 1979) posits that individual development and well-being is influenced by and interacts with multiple systems in the environment (e.g., family, community). From an ecological systems perspective, the well-being of individual family members is intertwined. Thus, combat stress, operational strain, and mental health

problems experienced by service members may have significant implications for the well-being of military and veteran spouses (Gewirtz et al. 2011; Lara-Cinisomo et al. 2012; Lester et al. 2011; Mansfield et al. 2010) and children (Lester 2012a; Paley et al. 2013). Among military families, parent psychological distress is associated with child maladjustment (Lester et al. 2010), and in the general population, there is evidence that risk is at least partially transferred through maladaptive parenting behaviors and parent-child interaction (Goodman 2007; Lovejoy et al. 2011; Lovejoy et al. 2000). Previous research has suggested a direct impact of military status on parenting behaviors, suggesting that veterans are at risk for engaging in less effective discipline, emotional involvement, problem solving, and communication with their children (Davidson and Mellor 2001; Gewirtz et al. 2010), negative parenting cognitions (e.g., decreased satisfaction; Samper et al. 2004; Gold et al. 2007), and higher rates of maltreatment (Gibbs et al. 2007; Rentz et al. 2007; Sheppard et al. 2010). Further, the very nature of deployment means that the parent-child relationship develops in the context of prolonged and repeated separations. The nature of military child separations are differentiated from others (e.g., divorced families, incarcerated parents) in that military family separations occur in the context of grave danger to the deployed parent (Lipari et al. 2011). The evidence supports the utility of an ecological systems perspective when considering the impact of military deployments not only on the individual service member, but also on family members and the relationships among them.

The Impact on the Young Child

Young children (ages 0-5 years-old) have been disproportionately affected by parental deployments as they make up the largest percentage (37.5%) of military youth (Office of the Deputy Assistant Secretary of Defense 2012). These children are especially dependent on primary caregivers for both instrumental (e.g., feeding, hygiene) and emotional support (e.g., soothing). Repeated parent-child separations caused by deployments may be particularly disruptive for infants, toddlers, and preschoolers because the socio-emotional milestones of this period (i.e., development of primary attachment relationships and increasing ability to self-regulate emotions and behavior) hinge on consistent and healthy parent-child interaction (Lieberman and Van Horn 2013; Paley et al. 2013). Early childhood represents a sensitive developmental period for emotional and behavioral regulation capacities, as children's ability to manage emotions requires significant external intervention and parental support from birth through the preschool years, when children are increasingly aware of their emotions and have greater ability to cope with strong feelings on their own (Eisenberg et al. 1998). The attachment relationship serves as the context in which children make this progress (Cassidy 1994). By being attentive and responsive to young children's needs, parents serve as external sources of emotion regulation, which (1) communicates that the child's needs will be met and (2) models emotional awareness and coping strategies. As previously noted, relationships with both parents are profoundly affected by deployments. For the service member parent, the physical separation caused by a deployment precludes ongoing development or maintenance of a healthy attachment relationship, and distress associated with post-traumatic stress and re-integration may complicate re-building of the relationship once deployment ends. For example, a service member who experiences a trauma reminder during play may suddenly become irritable, inattentive, or withdrawn, undermining warm and sensitive responding to the child. Attachment and bonding with the

non-deployed parent may also be hindered, as mental health symptoms, which are common in the at-home parent, reduce responsivity to the child (Carter et al. 2001; Goodman 2007; Lovejoy et al. 2000).

Given these challenges, it is not surprising that toddler and preschool-aged children of deployed military parents exhibit higher levels of internalizing and externalizing behavior than their peers whose parents have not deployed (Chartrand et al. 2008), and may experience difficulties with previously established physiological patterns (e.g., sleeping, eating), regression to previous behaviors, and withdrawal (Carroll 2009). The mechanism of action may be multifaceted as the impact of repeated deployments affects children not only through the parent-child relationship, attachment, and emotion socialization, but also directly through disruptions in daily routines and exposure to marital strain. Research showing that the preschool years are characterized by rapid neurobehavioral growth and gains, but also linked to the onset of psychopathology in children (Keenan et al. 1998), suggests that it is a sensitive period in which children may be particularly vulnerable. Thus, it is a critical time to intervene with military and veteran parents and children (Paris et al. 2010).

The Need for Military-Informed Family Services

While there is clear evidence that military families are at greater risk for a variety of relational and developmental challenges and that young children may be particularly vulnerable (Paris et al. 2010), there exists a gap of preventive and treatment services for these families (Tanielian et al. 2014a). The Veteran's Health Administration (VHA) offers few services for children and families (Makin-Byrd et al. 2011), yet military veterans have reported preferences for family-based services over individual treatment (Khaylis et al. 2011). As a result, service providers and researchers have called for the development of accessible, military-informed, family interventions to address the needs of these children (Paris et al. 2010; Tanielian et al. 2014a). While there is increasing evidence for feasibility and effectiveness of programs for school-aged children (e.g., ADAPT, Gewirtz et al. 2014; FOCUS; Lester et al. 2011), there are very few programs for military families with young children (Paris et al. 2011). This paper will describe the development of an early childhood adaptation of Families OverComing Under Stress (FOCUS), an established trauma-informed preventive intervention for military families with school-aged children.

Families OverComing Under Stress

Grounded in foundational research on individual and family resilience (Beardslee et al. 2011; Saltzman et al., 2011), FOCUS utilizes a trauma-informed narrative approach to help families reflect upon their experiences, improve communication, develop a shared sense of family meaning related to their deployment and reintegration experiences, and enhance skills in emotional regulation, communication, goal-setting, problem-solving and managing deployment and trauma reminders. FOCUS has shown program effectiveness for active duty families with school-aged children across multiple measures and reporters, including significant improvements in positive coping, prosocial behaviors and family functioning, as well as improved parent and child psychological health outcomes (anxiety, depression; Beardslee et al. 2013; Lester et al., 2010; 2012b).

The FOCUS for Early Childhood (FOCUS-EC) model was adapted for families with a child between the ages of 3 and 5-years-old (Mogil et al. 2010) and is comprised of the same FOCUS core elements delivered through six modules. As shown in Figure 1, the core elements include: 1) completion of a real-time psychological health assessment, 2) provision of psychoeducation and developmental guidance, 3) creation of a family narrative timeline, and 4) implementation of family resilience skills (Beardslee et al. 2013). The real-time assessment (or family check-in) is used to assess the domains of parent psychological health, child behavioral symptoms, and general family functioning (see Figure 2). Similar to the broader FOCUS model, FOCUS-EC is framed within a skill-building and relationship-strengthening psychoeducational framework that integrates research on family resilience, traumatic stress, child development, and the military-developed stress continuum model for prevention (Nash 2011). FOCUS-EC provides developmental guidance, parent education, and teaches key resilience skills (Beardslee et al., 2010) that promote positive individual and family coping, including emotional regulation, problem solving, goal setting, communication, and management of deployment and combat stress reminders, which foster parent-child and family cohesion.

One notable difference in the FOCUS-EC model is the method of developing the family narrative timeline. Young children are often not able to create a visual chronology of their experiences; thus, parents are encouraged to draw upon their perceptions of their child's understanding of the key events and plot those reflections onto their timeline. In addition, FOCUS-EC incorporates parent-child sessions to build the young child's emotional awareness skills including talking about and managing feelings (Beardslee 2013).

Preliminary results from the early childhood adaptation with active duty families included 637 families with children aged 3 to 5 years old yielded positive findings, including: a reduction in child psychopathology symptoms ($p < .001$) and concurrent increases in prosocial behaviors ($p < .001$). Further, family adjustment benefited as both service member and civilian parents reported improvements in their family's functioning, including more effective problem solving, communication, affective responsiveness, and behavior control ($p < .001$). Lastly, the intervention was associated with improvements in self-reported parental mental health symptoms with both service members and spouses reporting significant declines depression ($p < .001$) and anxiety ($p < .001$; Mogil and Garcia 2012) from baseline to post-treatment. These promising findings led to the pursuit of a rigorous study of the FOCUS-EC. Funded by the National Institute of Child Health and Human Development, a randomized control trial of FOCUS-EC is currently underway to evaluate the effectiveness of the model for use with veteran, Reserves, and National Guard families.

Leveraging Technology

There are limited military-informed service providers in civilian communities, which presents an obstacle for efficient and targeted in-person service delivery (Tanielian et al. 2014a). This gap in providers applies to veterans living in rural communities (Link and Palinkas 2013), as well as those in urban areas where a significant portion of reservists and veterans reside. Population density and urban sprawl can further compound access to care.

Thus, telehealth platforms for service delivery offer the unique opportunity to improve access to high quality services for widely dispersed populations.

The VHA has successfully used a telehealth platform in the treatment of veterans (adults) with posttraumatic stress disorder (PTSD; Fortney et al. 2014), however, little research has tested the applicability and effectiveness of in-home telehealth service delivery models with children and families. While the increased accessibility associated with internet-based service delivery is appealing, the developmental capacities of young children present unique challenges that require service delivery and treatment content adjustment in order to maintain adequate impact and maximize receptivity by families and children. Prior research has provided some guidance on the adaptations necessary for virtual home visiting with families. In particular, Fiechtl and colleagues (Fiechtl et al., 2010) demonstrated that a parent coaching intervention delivered through video teleconferencing technology was not only feasible, but that parents who participated in the telehealth condition were more engaged with their children during sessions than those participating in in-person home visits. Incorporating techniques from a parent coaching framework to support delivery of dyadic (and triadic) sessions with young children, FOCUS-EC was further adapted to include parent play skills, interaction guidance, and emotion coaching. The parent-only sessions utilize a web-based platform that allow for conjoint construction of the family narrative timeline and session handouts/activities through screen sharing between the parents and provider. During the parent-child sessions, the young child interacts with his parent who is interacting with the service provider. A small pilot examining the feasibility of FOCUS-EC Virtual Home Visiting model indicated that the technology platform was acceptable to parents, suitable for facilitation of parent-child sessions, and provided expedient access for families. A description of the FOCUS-EC Virtual Home Visiting model along with a case example is included below.

FOCUS-EC Virtual Home Delivery

The intervention is delivered in six virtual home visiting sessions leveraging a secure web-based platform that allows the family and FOCUS-EC facilitator to meet online. Sessions vary in length from 30 to 90 minutes depending on the phase of treatment and developmental needs of the child. Each session is structured with a check-in about progress toward the family goal, review of the previous week's "home activity," primary activity and discussion, and selection of a new "home activity". The family learns and practices the skills during the sessions, commits to practicing the skills during the week, and reports on their experiences during the following session to reinforce the skills. FOCUS-EC promotes parenting skills and more cohesive family relationships in two key phases: 1) understanding the family context and creation of a family narrative timeline and 2) enhancing parent-child interactions.

Case Illustration

To facilitate presentation of the FOCUS-EC model, we will describe the session content and provide illustrative examples with a case study. While the session content described closely reflects the treatment sessions, names and other identifiable information have been changed to protect participant identities and confidentiality.

The first phase of treatment (Sessions 1 and 2), focuses on understanding the family context through the assessment of family strengths and challenges, the development of family goals, and the construction of a family narrative. In the first session, parents complete a family check-in that allows them to reflect upon their family and individual functioning across the domains of: parent behavioral health, child adjustment and family functioning. The results of this check-in are presented to the parents and contextualized within the family's story and intervention targets. Familial strengths and challenges are identified and translated into positively stated realistic, objective and achievable goals (i.e., the identification of desirable and undesirable behaviors). These goals are deconstructed into operationally defined steps to facilitate goal attainment. Additionally, parents are provided with developmental guidance and psychoeducation in domains relevant to military families with young children. Thus, session content includes material related to traumatic stress and transitions, typical child development, and techniques for improving the parent-child relationship.

At the start of FOCUS-EC, Michael and Marjorie's daughter, Emma, was 3 years old. Michael had been in the Army reserve, but was activated in 2009 and again in 2012, deploying to Iraq both times. Emma was born a year before the second deployment, and was just learning to walk when Michael left. Marjorie initially shared that she didn't really think the deployment affected Emma although she acknowledged increased stress from parenting alone during that time. Upon further reflection and following education about common reactions in young children, Marjorie shared that Emma experienced some regressions, such as a return to co-sleeping during the deployment. Results of the family check-in indicated that Michael was experiencing symptoms of posttraumatic stress related to his combat deployments. While Marjorie did not endorse any symptoms of psychological distress, both Michael and she expressed concerns about their family communication. During the first session, Michael and Marjorie expressed concern and frustration about Emma's increasingly defiant behaviors, including refusing to eat most foods and to go to the bathroom on the potty. Michael expressed frustration with the fact that Emma was typically more noncompliant with him than with Marjorie, and admitted that he often ended up yelling in response, which escalated into a temper tantrum and Marjorie intervening to de-escalate the situation. Marjorie was increasingly on edge because she felt she needed to always be on the lookout to make sure things stayed calm at home. The provider reflected on the consistency between Michael and Marjorie's reports in-session and on the assessment questionnaires, including elevated behavioral health symptoms for both Michael and Marjorie, and externalizing problems for Emma. For their family goal, they initially stated that they would like Emma to comply on the first request; however, they were responsive to developmental guidance provided by the trainer and ultimately the goal stated that Emma would comply on the first or second request most of the time. The parents were introduced to the FOCUS Goal Tracking form that was completed at each session to rate their progress over the course of the program, and rated themselves as currently at a 3 out of 10. Michael and Marjorie asked many questions about the techniques for enhancing parent-child interactions and they were hopeful that Michael's engagement in regular one-on-one playtime with Emma would improve their relationship and subsequently her

compliance towards him, but also expressed concerns about the time demands of this technique. After discussing ways to address the anticipated difficulties, they agreed to try out regular playtime in the coming week.

This first phase of treatment also supports development of a family deployment/reintegration narrative, which fosters perspective taking, communication, mutual support, and positive co-parenting across the parenting dyad (Session 2). Parents recount a narrative timeline for their deployment/separation and reintegration history. Through perspective taking and active listening, parents bridge estrangements and enhance their understanding of their child's reactions to deployments and separations, co-parenting, and family leadership.

Michael initially appeared apprehensive to revisit past events during the narrative session, particularly regarding his deployment and the first few months after his return home, but was encouraged by the interventionist's emphasizing that a major goal of the session was to identify strengths that helped the family get through challenges and that could be leveraged to address ongoing difficulties. Seeing a visual representation of events helped the parents see how the start of Emma's behavioral difficulties overlapped with Michael's return from deployment, and worsened with increased marital conflict that occurred in the months after Michael returned home. Michael expressed guilt when he considered his deployment and reintegration as causing Emma distress to such an extent that it manifested in behavior problems, but Marjorie was able to support and reassure him in the moment. Furthermore, the session provided an opportunity for Michael and Marjorie to repair misunderstandings that had led to increased conflict and dissatisfaction during his reintegration. Specifically, Marjorie came to understand that Michael's seeming distance from her family was not an indication of his dislike of them, but rather his own discomfort in large group situations which were activating and anxiety producing for him. Michael's reflections on his own deployment reminders, facilitated his communication with Marjorie, allowing her to understand and better support his needs. Finally, the couple became aware of the impact that the health of their relationship had on Emma's well-being, and noted that perhaps they should start to schedule regular "date-nights," as they had prior to Emma's birth.

In the second phase, parents work on enhancing parent-child interactions in a series of parent-only education and parent-child practice sessions (Sessions 3-6). In these alternating sessions, parents learn and practice important parenting strategies. Session 3 uses in vivo coaching to introduce and scaffold parental play, attunement, and relationship-enhancement strategies. The session uses a dyadic, parent-child format and the session length is generally reduced to a developmentally appropriate length for the child's age (i.e., around 30-45 minutes). The session specifically teaches parents how to follow their child's lead in play, including how to observe what their child is interested in and how to positively reinforce the child's curiosity through narration.

During Session 3, Michael and Marjorie brought the toys discussed with the interventionist at the end of Session 2: blocks, crayons and paper, and dolls. With guidance, they allowed Emma to choose which activity to start with and to use

praise and narration as they had been practicing during parent-child playtime. Marjorie was vocal in using praise and narration, however Michael presented as more reserved. The interventionist provided Michael with prompts of what to say (e.g., “Michael, now say, ‘Emma, I see that you started to brush the doll's hair.’”), modeled positive reinforcement when he followed through, and highlighted Emma's positive reaction to his engagement. The provider also praised Marjorie when she set up an opportunity for Michael and Emma to engage more closely with one another, and commented on how her facilitation of their interaction was relevant to their family's goal to improve the father-daughter relationship. Lastly, the provider noticed Emma's verbal abilities facilitated the inclusion of reflecting, and incorporated the introduction of reflecting back Emma's language as an additional skill to facilitate engagement.

Session 4 is a parent-only meeting that allows for the development of a parenting plan, with multiple strategies for behavior management. Desirable behaviors are introduced as “green” behaviors and targeted through the use of positive reinforcement. Conversely, less desirable behaviors are introduced as “yellow” behaviors and are defined as children's behaviors that may be annoyances but are not dangerous or harmful, such as whining. To reduce the frequency of less desirable behaviors parents are taught to respond with differential attention, active ignoring, redirection, and provision of alternatives (i.e., two choices). Lastly, undesirable and unsafe behaviors are labeled as “red” behaviors, and are defined as potentially harmful or dangerous behaviors, to which the parent may use consequences (e.g., time-out) or the loss of a privilege. Additionally, attention is given to increasing the parents' awareness of trauma, loss, and separation reminders that can impact effective parenting.

Although Michael and Marjorie reported improvements in Emma's compliance, they were eager to discuss specific strategies to use when she still showed problematic behaviors. The interventionist first helped the parents identify the positive counterparts of Emma's problematic behaviors, which they could praise and reinforce. They noted that they could praise her during instances when she ate the meal they served, for the times that she attempted to go to the bathroom on the potty, for using a big girl voice, and for being gentle with her toys. Michael and Marjorie noted that they regularly used timeouts for undesirable behaviors, such as refusing to eat dinner or to use the potty. By the end of the session, the parents understood that time-outs should be reserved for Emma's “red” behavior of throwing toys in defiance of requests to share with others. Michael and Marjorie elected to use “two-choices” for food refusal and active ignoring for whining about the potty (i.e., Emma's “yellow” behaviors). Although Michael understood why these behaviors fell in the yellow zone, he shared that sometimes these situations did feel dangerous to him because the sound of Emma's crying put him “on alert” in a similar way as during his last deployment. This led into a larger discussion of how deployment reminders can come up during parenting, and they were able to come up with a plan for Michael to ask for support and calm himself down when these situations arose.

In Session 5, the parents and child are present for another virtual coaching session during which they are taught strategies to help the young child with emotional identification and

communication. This is done through play and the same play principles learned in Session 3 are reinforced (i.e., narrating and praising), but additionally they begin to attend to children's emotional expressions and are introduced to emotion coaching skills.

At the start of session, Michael and Marjorie were reminded of the discussion of emotional labeling from Session 4, and asked to practice that in addition to the other play techniques they had learned. Both parents equally engaged with Emma during this session, and Michael was given extra praise for his increased comfort in interacting with Emma and using the various skills. Less time was spent providing the exact words for Michael to say to Emma, and greater emphasis was given to the rationale for the strategies Michael was using and how they were beneficial to the relationship (i.e., "Reflecting her language shows her that you think what she just said is important, and that helps with her self-esteem."). During the session, both parents were able to increase their use of emotional coaching, as they began to label their emotional expressions and project emotions onto the toys (e.g., dolls, stuffed animals). Finally, given the parents' report during Session 4 of Emma's difficulty sharing and throwing toys, the parents were coached to praise Emma for being gentle and giving her parents turns, and noted that the skills discussed in Session 4's Parenting Plan can be used during play as well as other day-to-day interactions.

The final meeting (Session 6, parent only) is spent reviewing the family's progress toward their goals, making any necessary modifications to the parenting plan and brushing up on any skills about which the parents remain unsure. The session also includes planning for the future and discussing how the skills learned during FOCUS-EC might be used to address future transitions (e.g., starting kindergarten, addition of another child) or family challenges such as unemployment, career transitions, or medical procedures.

At the final session, both parents reported marked improvements in Emma's behavior, which was reflected in their final rating of their family goal for Emma to be compliant on the first or second request most of the time. Specifically, Michael and Marjorie rated Emma's compliance as 8/10 at the end of treatment, representing a dramatic improvement from their initial rating of 3/10 at the start of treatment. The interventionist reviewed this improvement over the course of the treatment sessions, noting that her compliance was rated as steadily increasing over the course of 6-weeks, with a slight dip in the middle during the week that Marjorie had been ill. Despite this set-back the continued improvement was highlighted as an example of the family's ability to bounce back from a challenge, and normalized the degree to which improvement can be nonlinear. Michael and Marjorie attributed the improvement in Emma's compliance to much more positive interactions with Michael in general, and to their consistency with each another on discipline strategies. In particular, the parents reported that providing Emma with two choices of what to eat was helpful in increasing her compliance at mealtime, eliminating the need to use time-out in recent weeks. They also talked about an instance in which Michael had become triggered by Emma's crying, but instead of escalating he sought out Marjorie for support and everyone calmed down quickly. Marjorie noted that having a plan in place for supporting Michael as a co-parent increased her sense of control and reduced her sensitivity and stress level. When

planning for the future, the parents expressed some worry about Emma's transition to a full-day preschool in the fall. The trainer helped the parents think about how the skills they learned during the program could be used to address issues around the transition, and helped them generate a concrete action plan in preparation. The session ended with praising the parents for their hard work and progress, and emphasizing that the skills they learned throughout the program can be applied to other challenges that their family may face in the future.

Conclusion

Evidence-based programs aimed at enhancing positive development for military families and children, particularly young children, are limited (Paris et al. 2010). The preschool period is a time of rapid growth and a sensitive period for achieving self-regulatory capacities, emotion regulation, and forming the foundation for future interactions with primary caregivers in a way that shapes children's ongoing development and relationships. The increased psychological distress among military-connected service members and their partners, as well as the growing population of young children in these families underscores the urgent need for services that improve parent-child attachment, build effective parenting strategies, and mitigate the impact of parent psychological health challenges on adaptive family communication and cohesion. FOCUS for Early Childhood seeks to bridge the gap by integrating both military- and trauma-informed practice and family resilience-enhancing strategies within a prevention framework.

Home visiting models have been used successfully for both high-risk families with young children (Heinicke et al. 2000; Moss et al. 2011; Van Doesum et al. 2008; and see Howard and Brookes-Gunn 2009, for a review) and for military families (Kaufman Kantor et al. 1999; Paris et al. 2011). FOCUS- EC's use of a web-based telehealth platform allowed us to leverage the well-established effectiveness of home visiting in order to be maximally accessible to veteran, Reserves, and National Guard families. Such families are at increased for problems with mental health and family functioning (Lara-Cinisomo et al. 2012; Mansfield et al. 2010; Martin 2007; Milliken et al. 2007; Thomas et al. 2010), and are often underserved due to a lack a military-informed providers in civilian communities. Thus, it is imperative that a new wave of military-informed family interventions are developed to be flexible in their delivery to better reach geographically dispersed families. Virtual home visiting makes high-quality, military-informed programs available to families who might otherwise be unable to travel to providers due to living in remote rural areas, traffic congested urban areas, and/or poverty. It allows clinicians to serve more families by cutting down on the cost and time spent on travel in traditional home-visiting models. Additionally, stigma associated with acquiring mental health treatment is longstanding in the military (Burnam et al. 2009), so service members may feel more comfortable receiving services in the privacy of their home, without a mental health provider visiting in-person. Furthermore, recent research suggests that in addition to breaking down barriers to care, telehealth models may be uniquely useful in parenting interventions because without a clinician present, parents are more likely to engage with their children directly rather than relying on clinicians to do so (Feichtl et al. 2010). Thus, in-session activities are more focused on

parents practicing the skills themselves, with clinician coaching and support, as opposed to greater time spent on clinician modeling.

Results of a small pilot study and ongoing data collection for a larger randomized control trial for FOCUS-EC suggests that virtual home visiting is feasible with military connected families living in civilian communities. Participants were generally able to utilize and navigate technology successfully with brief written instructions and phone support from the clinician as needed. Furthermore, families have been engaged in both parent-only and parent-child sessions. The use of video conferencing makes it possible for the clinician to facilitate communication between mothers, fathers, and young children, while the use of a “shared screen” allows both clinicians and family members to view the parent-constructed narrative timeline as well as worksheets used to facilitate psychoeducation and training in resiliency skills (e.g., emotional regulation, parenting strategies). In sum, telehealth models appear to be a promising format to reach families with young children, and the military community will benefit from ongoing research and development of flexible delivery of prevention and intervention programs for children and families.

Acknowledgments

The authors acknowledge support from the National Institute of Child Health and Human Development for a randomized control trial of FOCUS-EC (R01-HD072324-01A1). They also acknowledge the strength, honor, commitment, and sacrifices made by military families on behalf of our country.

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Phase I			Phase II			
Family Check-In	1	2	3	4	5	6
	Parents		Child & Parents	Parents	Child & Parents	Parents

Core Elements:

1. Innovative web-based family psychological health check-in (real time assessment)
2. Trauma-informed education, parenting strategies and developmental guidance
3. Enhanced communication through development of parental narrative timeline
4. Development of key family resilience and parenting skills (e.g., problem solving, emotional regulation)

Figure 1. FOCUS-EC Module Overview

Domain	Parent Psychological Health	Child Behavioral Targets	Family Functioning
Measures	Brief Symptom Inventory – 18 (Derogatis, 1993)	Strengths and Difficulties Questionnaire (Goodman et al. 2000)	McMaster Family Assessment Device (Ryan et al. 2005)

Figure 2. Real time assessment