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ORIGINAL PAPER

Fathers' Perspectives on Strengthening Military Families: A Mixed Method Evaluation of a 10-Week Resiliency Building Program

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Abstract A recent Institute of Medicine report on "The Assessment or Readjustment Needs of Veterans, Service Members, and Their Families" http://nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx, (2013) underscored the need for effective support for military families with young children, and that effective engagement into existing services remains a challenge. This mixed-method study involved 14 fathers (previously deployed military) who engaged in the Strong Military Families Program, a resiliency-building group for families with young children. The purpose of this paper was twofold: first, to identify the efficacy of this brief intervention for reducing mental health symptomatology among previously deployed military fathers who completed the group, and second to better understand the perceptions and reflections of fathers who completed an effective symptom management program in order to fill the literature gap around this issue and guide future efforts at increasing engagement of this population. Pre- and post-group assessments were administered including depression and posttraumatic stress symptom ratings. Assessments also included interviews designed to elicit fathers' expectations before the program and to capture their reflections after completion. Quantitative analyses examined changes in symptoms pre- to post-group, and qualitative analyses aimed to better understand fathers' experiences and help guide future efforts to increase engagement of this population. A grounded theory approach was employed to analyze interview content, and two themes were identified reflecting a desire for (1) connection and (2) learning. The prominence of these themes both before and after group underscored the value of connection to others who shared experience and opportunity for learning effective parenting strategies. Corresponding quantitative analyses indicated a significant decrease in self-reported posttraumatic stress ($p < .05$) and trend level reduction in depression ($p < .10$), suggesting participation may contribute to more effective symptom management. Subgroup analyses contrasting the pre-group interviews of fathers who endorsed higher ($n = 9$) versus lower ($n = 5$) levels of symptoms revealed that those with greater symptomatology expressed more themes related to fear of committing to the program. Discussion will focus on effective outreach and engagement, and the need to align programs to the interests of previously deployed fathers of young children.

Keywords Family program · Fathers · Military · Reintegration · Young children · Expectations · Reflections

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Introduction

In the United States, the number of military personnel totals over 3.5 million (Department of Defense, 2014). Data indicate that military personnel who have deployed in recent conflicts experience a number of challenges with

reintegration, including elevated rates of mental health symptomatology, such as Post Traumatic Stress Disorder (PTSD) and/or depression, and family relationship stresses (Hoge et al. 2006, 2004; Lapierre et al. 2007; Sayer et al. 2010; Smith et al. 2008). However, it is not only the service members that are affected by the deployment process, but their families as well. For example, wives with a deployed spouse have been found to report significantly higher depression and anxiety, feelings of isolation and loneliness, and to meet criteria for acute stress reaction and adjustment diagnoses more often than those without a deployed spouse (Beks 2016; Mansfield et al. 2010). Additionally, research indicates that the deployment process, as well as other periodic military separations, can be significantly challenging and distressing for military families and are associated with increased incidence of behavioral problems amongst the children of a deployed parent (Burrell et al. 2006; Chartrand et al. 2008; Esposito-Smythers et al. 2011; Lester and Flake 2013). It is not only active duty branches that undergo these stresses, National Guard and Reserve service members also go through the stresses of a deployment without the community of an active duty base (Gerwitz et al. 2010). Even after leaving the armed service and receiving veteran status, families and couples still cope with reintegration issues after deployment, including such challenges as coping with PTSD and/or depression symptoms (Hinojosa et al. 2012; Sayers 2011).

Research that has looked at the needs of mothers who are service members indicates that women are more stressed before rather than following deployment, and that single mothers report more separation anxiety than those in a two parent household (Kelley et al. 1994). More current research has looked at deployment differences between male and female veterans and showed that while women are less exposed to combat than their male counterparts, they are just as resilient (Street et al. 2009; Vogt et al. 2011).

Previous literature that examines the parenting needs of service member fathers underscores the importance of maintaining involvement with the child and family, and of continuing to feel a sense of responsibility for providing for the family (Schachman 2010; Willerton et al. 2011). For example, Schachman (2010) found that among first time deployed fathers online communication allowed them to still feel a sense of connection to their families and a sense of being able to provide and protect even from afar. Other studies that have examined the reintegration period have described the return process as a period of "work[ing] your way back into the family," and that it required time (Walsh et al. 2014; Willerton et al. 2011).

In an effort to understand and mitigate these symptoms and stressors, resiliency building programs for military families have been implemented and evaluated in recent years (Lester et al. 2012). A prominent goal in most of these programs is to prevent the challenges faced by military families from becoming normative by strengthening protective factors such as familial and military social supports, parental wellbeing, and access to care (Chapin 2011; Flake et al. 2009; Maholmes 2012; Rosenblum et al. 2015). Evaluation of many of these programs have indicated high levels of satisfaction, as well as significant improvements across many measures of psychological distress levels for the service members, their partners, and their children (Lester et al. 2012). Additionally, it is estimated that 96% of Iraq and Afghanistan combat veterans who used VA medical care reported interest in services for community reintegration problems (Sayer et al. 2010). One community resiliency program, Strong Military Families, focuses on resilience and positive parenting among military and veteran families with young children (Rosenblum and Muzik 2014; Rosenblum et al. 2015). This program offers both a community group option, or at home mail option. This paper only focuses on the perspectives from the community group option.

While there is literature about the effects of deployment on males and females, and on parenting and familial stresses surrounding the deployment cycle, there is a lack of research on the specific perspectives of previously deployed fathers on family based interventions, and in particular, a focus on the perspectives of fathers who are experiencing mental health symptoms. The purpose of this paper was twofold: first, to identify the efficacy of this brief intervention for reducing mental health symptomatology among fathers who completed the in-person Strong Military Families group, and second, to better understand the perceptions and reflections of fathers who completed an effective symptom management program in order to guide future efforts at increasing engagement of this population.

Strong Military Families Program

Strong Military Families Program (SMF) is a 10-week program tailored to service members with young children and their partners and developed by researchers as part of the Military Support Programs and Networks (M-SPAN) at the University of Michigan's Department of Psychiatry and Comprehensive Depression Center (Rosenblum et al. 2015). The primary goals of the program are to (1) promote parent resilience and (2) to address parenting skills during the post-deployment reunification phase. The program specifically seeks to address five core components (or "pillars"): (1) attachment-based parenting psychoeducation for parents of young children, (2) self-care, (3) supporting positive parent–child interaction, (4) enhancing social supports, and (5) connecting to community resources. The first pillar, attachment-based psychoeducation, centers on educating parents on common emotional reactions of young children to deployment and reintegration, and providing the parenting

skills necessary to address children's needs. The self-care pillar focuses on stress-management for parents and providing stress-coping skills intended to enhance resiliency and empowerment. The parent–child interaction pillar shifts the focus on the relationship between the parent and child by using games and activities to address topics like separation and reunion in a supportive environment. Additionally, the multi-family program focuses on enhancing social supports by connecting service members with other military families through a shared group experience. Finally, the SMF program strives to use an individualized approach to connect families to relevant and culturally informed community resources such as early childhood education programs in the community and available mental health resources. SMF involves the whole family in the healing process. It views the family as a dynamic system, recognizing that the strength of each individual within the family system, as well as the relationships among family members, contributes to the adaptability and resilience of the whole. The goal of the current study was to (1) establish efficacy of this program specifically for fathers who had experienced a deployment (2) to utilize the previously uncoded narrative data to conduct a qualitative analysis oriented towards understanding the perspectives of the fathers that participated in order to inform future interventions and to increase engagement of this specific population.

Methods

This paper presents data collected from participants in a larger "parent" study examining the impact of a military tailored resiliency building intervention, SMF, on overall parenting outcomes. The parent study was targeted towards military members with young families who had experienced a military related separation and were seeking community and parenting skills. A description of the parent study along with findings related to associated changes in parenting has been previously reported (Julian et al. in press). The parent study operated across the southeast region of the state of Michigan and utilized a quasi-experimental design with two conditions: (1) a multi-family SMF group as the treatment condition, and (2) a waitlist comparison "home-based" group. Each family was enrolled after initial recruitment into either the multifamily intervention group or the "home based" condition based on availability of the multifamily group in the families location; multifamily groups were offered on an intermittent basis at several different locations. Home-based families were provided with written materials conveying the psychoeducational content of SMF without the 'in person' attendance at a multifamily group. Quantitative and qualitative data were collected from parents before and after completion of the multifamily group program.

Participants

Data used for the present manuscript were from a subset (n = 14) of participants enrolled in the larger parent study (N = 107), and were selected to only include fathers (previously deployed military) who completed both the pre- and post-semi-structured qualitative interviews for the multifamily group-based SM F Program. Eligibility criteria for the parent study included that at least one parent (mother, father, or both) had experienced at least a 6-week long deployment, and that the family had at least one child between the ages of 1–6 years old. Of the 107 participants in the parent study several parents withdrew prior to intervention (n = 13), while others dropped out of the study after intervention but before completing the post-assessments (n = 10). However, selection of participants for the current study required that the fathers had completed both a pre- and post-assessment for analysis. Participants were all male, with the majority between the ages of 31–40 years old (78.6%), Caucasian (85.7%), and lived in a suburban neighborhood (71.4%). The majority of participants were married (n = 12); the rest were divorced (n = 1) or single (n = 1). Fourteen percent of the fathers were in dual career families, where both parents served in the military (n = 2). Consistent with the local region, the majority of participants were either National Guard (n = 5) or Reserve (n = 5); the remainder identified as active duty (n = 1) or veterans (n = 3). With regard to service branch, the majority were Army (n = 10); the remainder served in the Air Force (n = 2), Navy (n = 1) and Marine Corps (n = 1) The average number of children in the household was 2.29. The modal number of sessions attended was 9 (35.7%), with an average of 6.43. Modal annual income was between 50,000 and 75,000 (35.7%) and many had completed a bachelor's degree (35.7%).

Procedures

This study was approved by the University of Michigan Institutional Review Board. Participants were recruited through flyers, military/veteran events across the state, referrals from Veterans Affairs Medical Centers or other previously deployed military serving clinicians/professionals, and word of mouth. Participants were notified there would be home visit interviews when they were initially recruited to participate in the SMF Program. Clinically trained Masters level research staff conducted the interviews at participants' homes. The pre-interviews were conducted after informed consent was obtained, and the post interviews were conducted 4–6 weeks after the last session of the 10-week group. Informed consent was obtained from all individual adult participants included in the study. When families had more than one young child within the 1–6 age range, the interviews were conducted with a specific child in mind

to ensure continuity of responses. Additional paper questionnaire packets were mailed to the participants before the group and after the group for either pick-up by study staff or mailing in. The group program was conducted at different times out of four locations between January 2013 and April 2015 across southeastern Michigan. Multifamily group size ranged from 3 to 6 parents with an average group size of 4.5.

Measures

Demographic Questionnaire

Participants answered questions about their education level, household composition, income levels, martial status, ages and genders of children, deployment history, current and/or past service branch, health insurance, and rank.

Post-Traumatic Disorder Checklist-Military (PCL-M)

The *Post-Traumatic Disorder Checklist-Military* (PCL-M) is a self-report measure of the 17 DSM-IV symptoms of PTSD, adapted for the military population. Using a Likert-like scale, symptoms are rated from 1 (not at all bothersome) to 5 (extremely bothersome) and summed for a total score ranging between 17 and 85. Prior research has demonstrated that this scale has strong psychometric properties, with an alpha = 0.94 for the total scale (Ruggiero et al. 2003). Scores ≥ 30 indicate a likely PTSD diagnosis. The PCL-M cut-off of 30 is consistent with other research that suggests lowering the threshold of the checklist to increase the sensitivity of identifying the disorder (Keen et al. 2008; Andrykowski et al. 1998).

Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9) is a self-report instrument that assesses 9 DSM-IV symptoms of depression over a 2-week period, with total scores ranging from 0 to 27 (Kroenke et al. 2001). The PHQ-9 has acceptable reliability, validity, sensitivity, and specificity. Specifically, PHQ-9 scores ≥ 10 have a sensitivity of 88% and a specificity of 88% for major depression, and scores are sensitive to change.

Parent Interview

The semi-structured interview guides were based on a Working Model of the Child Interview (WMCI) (Rosenblum et al. 2002). The WMCI lasts about 45–60 min and is designed to assess parents' mental representations of parenting and of their young children. The interviews also incorporated questions about program expectations (pre-interview) and reflections (post interview) to assess the program. This paper focused on the portions of the interview that assess parental expectations and reflections about the program.

Analysis

Pre- and post-program semi-structured interviews were tape-recorded and later transcribed. Only questions about expectations for the program in the pre-interview and reflections on the program in the post interview were coded and discussed. A grounded theory approach was used to extract themes from the transcripts (Corbin and Strauss 2008). Two analysts, included on this manuscript, independently read through each interview to identify common themes. The two then came together to establish an agreed upon codebook. This codebook was then sent to a service member father, who did not participate in the program, for consultation and to ensure that conclusions regarding themes identified were considered appropriate. Edits were made to incorporate his feedback and a final codebook was generated from which both analysts independently coded each pre- and post-interview questions. Interviews were coded using NVivo (Version 10) data analysis software (QSR International Pty Ltd., 2012).

Paired samples *t* tests were run to assess the potential changes in mental wellness. Therefore, we compared the differences in pre- and post-posttraumatic stress and depression. Tests were run using IBM SPSS statistical software for windows, version 23.

Based on the results from the quantitative analysis, coded interviews were compared to identify prevalence of themes among symptomatic versus non-symptomatic parents. Symptomatic was defined as having a PHQ score greater than or equal to 5 or a PCL-M score greater to or equal to 30. The PHQ-9 cut-off of 5 indicates that a participant is experiencing at least 2 symptoms of depression and is considered a mild form of depression (Kroenke et al. 2001). We were primarily interested in assessing PTSD symptomatology instead of diagnosis, therefore we used a lower cut off score of 30, consistent with other research that suggests lowering the threshold of the checklist to increase the sensitivity of identifying the disorder (Keen et al. 2008). Only one participant fit the criteria of symptomatic after, but not before, the program; he was not included in the analysis comparing symptomatic versus non-symptomatic parents due to concerns for maintaining participant confidentiality.

Results

Results revealed high levels of inter-rater reliability for the qualitative interview coding of themes, with 99% average agreement across all codes for the pre-interviews. The two most common pre-group themes were: (1) a desire to learn,

gain wisdom or guidance from participation in the program (referenced 34 times) and (2) a hope for connection within their own family or others in the group through participation (referenced 32 times). To learn, gain wisdom or guidance was defined as references to the educational experience provided both from the program itself as well as from the other participants. To hope for connection was defined as references to a hope for coming together through a sense of community or family unity (see Table 1 for illustrative quotes for each theme). These themes were present in the interviews of both fathers who were classified as "symptomatic" as well as those designated "non-symptomatic." Indeed, the only significant theme that emerged from the symptomatic group that was not present for the non-symptomatic group was fear of commitment, which is described in more detail later in this section. We therefore include all participants (symptomatic and non-symptomatic) in describing and illustrating all other themes regarding the program.

Learning

In the pre-interviews fathers expressed a desire to learn and know more about parenting, military families, and communication. For example, one father stated, "I'm hoping it gives me the tools and understanding not just personally but great tips later on in life to build a stronger family that, cause right now I feel so divided from here to [child]…" There was a similar desire reflected in the post-interviews, participants felt that they gained a better understanding of the parent–child relationship as a whole and tools to communicate and interact with the family to facilitate a healthy relationship. For example, in talking about how the program helped

Table 1 Most frequent themes in pre- and post-interviews of strong military families

Connection	Learning
Hope for connection	*To learn, gain wisdom or understanding from*
Pre-program	
"And I hope that maybe there is just setting up a support network or other people who are in the same boat, so she can get together and hangout, or whatever. Ya know, like 'Hey, let's trade kids. I need a night because I am just losing my mind.'"	"If there's something we don't know, hopefully you guys can give us some advice."
"I guess, people, ya know, that go down in like a, a small group kinda thing and talk about, ya know, good things they got going on right now or, ya know, maybe talk about some of their problems that they're having. Um, and I think that's a good thing, ya know. And I think a lot of people need that to, to get it out, ya know. Get out some problems and talk to other people about it, ya know"	"I'm hoping it gives me the tools and understanding not just personally but great tips later on in life to build a stronger family that, cause right now I feel so divided from here to [child] because we buried all these feelings about love, joy you know what I mean, happiness, why we don't smile in a photograph to not have that. So anything I can do or any insight to do, to get a piece of that."
"I hope it will be a benefit to our family and that we'll, we'll gain not just from what the program has to give us, but that we'll be able to gain from the other participants. Need all our family members there and actually create that, that community which is, people feel isolated and today's national guard, they are, they don't feel like they in any way understand what they're going through and the joy of having that group setting is it helps normalize things..."	"Educational…yeah. I'd like to know more about…mainly…I'd—I'd like to know a little bit more about child behavior."
Shared experience	*Understanding of parenting*
Post-program	
"A better understanding of what's it like to be involved in a group setting like that with ya know not just military guys I've dealt with that all my life but actually the families…and listening to other folks open up ya know and just knowing it's okay to do that and it was good to see that…"	"For people who have parenting… problems or children problems, they give them different ways to cope and learn and relate and get, you know, tools to interact and deal with their kids."
"That we're not alone, when it comes to kids problems, I guess, um a way we have, yeah, we have the same, um, we're not the only ones having hard time with over military lifestyle and at the same time spouse understanding not understanding, kids away, all that stuff. Plus good suggestions, ya know, learn so much."	"A better way to understand my children personally instead of like a dictatorship to understand that they're humans too so, they got feelings and stuff like. They almost took care of that instead of how I was raised just its dad's way and that's it."
"I think it was hopeful. You know, it was kind of, it made me feel like I was less of a person being all by themselves trying to accomplish this monumental task of bringing a kid up but. It showed me commonalities that I shared with the other parents and stuff like that…"	"This was cool because it touched on, on a lot of similar ideas and it also helped us—it made [mom] and I think about a lot of stuff and because it was spread out over a long period of time and it gave us a good sample of, you know, 'hey what are we doing?' and, you know, 'hey, how could I have handled that differently?' Uh I really got pissed off at the kids, they did this. I lost my cool, 'what could-what should I have done different?'"

address problems commonly encountered in parenting, one participant stated "… they give [participants] different ways to cope and learn and relate and get, you know, tools to interact and deal with their kids." Both these sub-themes were coded under a larger theme of "learning" (see Table 1).

Connection

The second theme of connection was shown in the pre-interviews as a hope to relate to others who had been through similar experiences in the past and/or were currently experiencing certain issues. For example, one father stated "… Need all our family members there and actually create that, that community which is, people feel isolated and today's National Guard, they are, they don't feel like they in any way understand what they're going through and the joy of having that group setting is it helps normalize things..." In the post interviews fathers commented on the community they felt from the group, "That we're not alone, when it comes to kids problems, I guess, um, a way we have, yeah, we have the same, um, we're not the only ones having hard time with over military lifestyle and at the same time spouse understanding not understanding, kids away, all that stuff." Both of these sub-themes were coded under a larger theme of "connection" (see Table 1).

In the post-group interviews there was a 98% average agreement among all codes as noted previously, the two themes that were identified as common across both pre- and post-group were connection and learning. The two most common post-group themes were: shared experience (referenced 19 times) and understanding of parenting (referenced 19 times). Shared experience was defined as learning from and connecting with the families in the program. Understanding of parenting was defined as being able to see the parent–child relationship from a different point of view. These themes are each described briefly in more detail as follows.

Shared Experience

In the post interview a common theme was the importance of sharing the lessons the participants themselves had learned with others, as well as learning from the experiences of others. For example, one father described one of the aspects he liked about going to the group as, "I mean you go there and talk about your problems and take suggestions to others and you learn from other parents [at] the same time." Another father described one of things he liked most about the group as, "The shared experience, I mean, more the validation that yeah, we're all going through some weird things." Fathers reported feeling less alone because they could bond over the similar experiences they were going through.

Understanding of Parenting

Another common theme that was referenced in the post interview was a new way to look at or understand parenting. For example, when one father was explaining what he got out of the program he described, "A better way to understand my children personally instead of like a dictatorship [is] to understand that they're humans too; so they got feelings and stuff like [that]." When a different father was asked the same question he responded similarly with, "I think that it, it, for people who have parenting…problems or children problems, they give them different ways to cope and learn and relate and get, you know, tools to interact and deal with their kids." The fathers referenced having different tools in their "parenting toolbox."

Quantitative Analysis

Paired samples *t* tests and descriptive statistics showed a significant decrease in self-reported posttraumatic stress ($p < .05$) and an overall trend level reduction in depression ($p < .10$) (see Table 2).

Fear of Commitment

Based on the PHQ-9 and PTSD-C cutoff scores at the pre-assessment, there were $n = 9$ symptomatic and $n = 5$ non-symptomatic fathers. The third most common theme after connection and learning (described previously) among the symptomatic fathers before starting the program was a fear of commitment (referenced 13 times). This was defined as a concern of not completing or committing the time to the program due to other appointments—i.e. scheduling conflicts, busy schedules, etc. For example, one father stated, "That was my first thought was, ugh, it's going to be kind of a commitment." This was indicative of a mindset that could have potentially prohibited participants from attending (see Fig. 1 for additional quotes). In contrast, among the non-symptomatic fathers, the 3rd most common theme was 'provide support for family,' which was defined as a mention

Table 2 Pre and post *t* tests and descriptive statistics for strong military families program

Results of *t* test and descriptive statistics (N = 14)					
Questionnaire	Before program		After program		Pre-post test results
	M	SD	M	SD	t(df)
PCL-M	33.79	18.74	26.79	13.51	t(13) = 2.942**
PHQ	4.29	4.55	3.5	4.35	t(13) = 1.39*

*p < .10

**p < .05

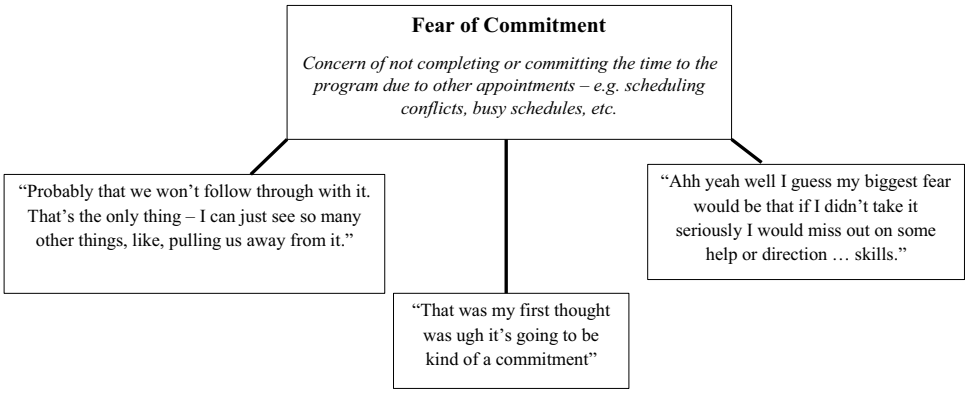

Fig. 1 Most frequent theme in post interviews among symptomatic participants of strong military families program

of the group serving as a support system for the kids as well as both partners.

Discussion

Previously deployed military fathers of young children face significant challenges around deployment experiences. Results of the current mixed-method analysis provide some evidence for program efficacy and highlight common themes raised by fathers regarding motivation to engage and the value of intervention. Pre-post quantitative analyses revealed a significant decrease in PTSD symptoms and trend level reduction in depression symptoms for previously deployed military fathers who completed the 10-week program. This reduction is consistent with evaluation of other programs that aim to promote military/veteran family resiliency building programs and is consistent with a call for more strength-based military family programs (Lester et al. 2010; Ross and DeVoe 2014; Saltzman et al. 2011).

The two main themes that emerged from the pre- and post-interviews were (1) a hope for connection with their family or with other families and (2) a desire to learn and gain insight into their own family dynamic or families in general.

The first theme, reflecting a desire for connection, builds on previous resiliency literature that emphasizes the importance of building protective factors such as social support and specifically strong military communities (Chapin 2011; Flake et al. 2009; Lester and Flake 2013; Maholmes 2012; Rosenblum et al. 2015). One of the main challenges faced by today's veteran, National Guard, and/or Reserve community is that these service members are immersed within the civilian community, making it difficult for these families to find culturally informed social support around military duties. Findings from our study confirm that from the perspective of military fathers connection is a prominent perceived benefit of participation in a family program. This could suggest that when advertising such group programs for the military population elements of connection should be prominent. This could be especially true when advertising to veteran, National Guard, or Reserve communities who do not have frequent interactions with other service members. This hope for connection in our small sample of multifamily group members compliments our main "parent study" findings that indicated improvements in domains of parenting among participants that attending the multifamily group versus the home-based group (Julian et al. in press). Specifically, parents who participated in the multifamily group demonstrated enhanced connection with their children as evidenced by increases in parenting reflectivity, that is, parents' capacity to empathize with and understand their own and their children's emotional experiences. This is notable given the prominent theme of hope for connection, both within and outside the family, expressed by fathers in the current subset analysis, suggesting the possibility that the intention set by male participants prior to the multifamily group came to fruition through an increased capacity to "connect" and "empathize" with their children. These findings suggest the possibility that, consistent with motivational interviewing approaches more generally, supporting fathers in setting intentions for personal, family and parenting outcomes prior to initiating a parenting intervention may help enhance positive outcomes.

The second theme, expressing a desire to learn and gain insight into the fathers' own families, is in line with similar qualitative analyses focused on understanding the fathers' perspectives on familial relationships surrounding the deployment cycle (Walsh et al. 2014; Lee et al. 2013; Willerton et al. 2011). Other analysis has shown that men noticed shifts, suggesting some dilution in their relationship with their family and/or in their role as father figure (Lee et al. 2013; Willerton et al. 2011). These findings indicate awareness around changed familial relationships following deployment, and suggests that this knowledge may be a door that clinicians can use to open awareness to other potential issues and common challenges surrounding the deployment cycle.

Analyses contrasting "symptomatic" versus "nonsymptomatic" fathers at baseline indicate that among the symptomatic group there was a prevalent theme of fear of committing to a group because of other stressors or obligations going on in their lives. This is consistent with other research that looks at barriers to completing treatment among military families, in particular for National Guard and Reserve members (Ross and DeVoe 2014). This suggests a need for programs to meet military families where they are at, geographically and mentally, by addressing other stressors and practical barriers. For example, a unique element of the SMF program was the emphasis on accessibility through its community-based approach. SMF was offered in multiple counties across Michigan in order to enhance reach and create local spaces for previously deployed military/veteran families to come together and share their experiences in a place where they felt safe to do so. Another prominent strength and skills based military family intervention, FOCUS, demonstrated the efficacy and sustained impact overtime of a program that also prioritized accessibility by implementing the program on a variety of Naval and Marine bases (Lester et al. 2011, 2012, 2016). Both FOCUS and SMF have prioritized the location of program delivery in order to maximize the feasibility of intended participants being able to attend such a program (e.g., active duty service members with access to an installation versus Reserve Component troops and/or veterans who are geographically dispersed in civilian communities). Indeed, access to family based parenting interventions is important not only for the benefit of the service member, but also for his or her potential civilian spouse. To illustrate, in the "parent" SMF study analyses comparing the service member outcomes with civilian parent outcomes revealed no differences, suggesting that both civilian and military parents benefit from this type of interventions (Julian et al. in press).

Limitations

While present findings may help inform planning and engagement strategies for programs for military and veteran fathers, several factors limit conclusions. First, although not inconsistent with qualitative research, the current sample size was quite small with only 14 military/veteran fathers that completed both pre- and post-interviews, thus constraining generalizability. Yet nonetheless our findings are consistent with other strength-based military programs in demonstrating a positive impact on symptoms from pre to post, as well as in identifying psychological barriers such as a fear of commitment (e.g., Lester et al. 2012; Saltzman et al. 2011). Other limitations include that our program had an emphasis on families with young children under 6 years old, again constraining generalizability, yet also contributing to the literature and interventions specifically targeted towards young previously deployed military families.

Our findings support the need for continued development and dissemination of group military family programs given the clear expressed desire from all participants for learning and connection, and the value they perceived in these same domains on program completion. Multifamily groups can provide both the space for relationship building and discussion around specific issues. However, our findings also highlight the need to reduce barriers for fathers who are experiencing more distress as they are more likely to be deterred by perceived practical barriers. Practical barriers that were mentioned in the interviews were current work schedule, children extracurricular activities, and travel time to meeting location. This suggests the need for additional innovative strategies for engagement of military fathers. Our group is currently evaluating an innovative "weekend retreat" adaptation of the SMF program to provide an immersion experience that may also decrease both practical and psychological barriers.

Conclusion and Implications for Practice

This paper examined program efficacy for PTSD and depression symptom reduction as well as demonstrating key insights into the military father population: a desire for connection and learning, as well as a fear of commitment from those who experience high levels of mental health symptoms. These findings help to identify areas of parental concern that might lead to more effective engagement of this population into symptom management interventions.

Our findings suggest that two keys ways to engage this population may be to (1) emphasize the opportunity for connection to other military families, including other fathers, that arises from participation in these types of groups, and (2) to capitalize on fathers' own awareness that familial roles may have changed post deployment, thus creating an interest in learning new tools for parenting in the post-deployment phase. Utilizing motivational interviewing strategies including support for goal-setting may help increase positive outcomes, and addressing barriers through innovative delivery strategies including reducing geographic barriers to access, may help to decrease the fear of commitment we found was commonly expressed by symptomatic fathers, and increase participation of this important population. These efforts are important not only for the participating father, but also because, as our parent study found, participation in these types of parenting programs can improve outcomes for other families members as well (Julian et al. in press).

Previous research indicates that program tailoring and use of continuous engagement strategies have shown higher retention and completion rates among families with children.

A recent pilot study of a military family strength-based program that was specifically targeted towards National Guard and Reserve members and offered in-home, 1:1 intervention (versus multifamily group) and this approach also yielded high levels of program retention and completion (Ross and DeVoe 2014). This suggests that a variety of modes of delivery (in home versus multifamily group) may allow families to find approaches and programs that best meet their needs and experiences.

Other research on effective engagement and retention strategies with families in parent and child mental health programs has shown that strategies that are employed continuously or integrated into the treatment process have significant increases in retention and program completion rates compared to interventions that do not use these methods. Examples include brief early treatment engagement discussions, family systems approaches, enhancing family support and coping, and motivational interviewing with an emphasis on engagement (Carroll et al. 2006; Ingoldsby 2010; Miller et al. 1992; Nock and Kazdin 2005). This suggests that when working with a symptomatic population with children part of the program should continuously address the potential difficulties for attending a therapy group or treatment. Addressing the families' hardship and exploring their motivation for seeking treatment can act as validation for their current difficulties and perhaps increase readiness for change (Ingoldsby 2010).

There is a clear need to continue to explore how programs can best meet needs, and how to tailor program content and delivery to be responsive to these needs. Ongoing evaluation of outreach strategies and examination of "what works best for whom" can help to inform program development and engagement approaches to increase the involvement of previously deployed military fathers and families who may be most in need.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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