

# Moving Forward: A Problem-Solving Training Program to Foster Veteran Resilience

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It is vital for mental health professionals serving veterans to be able to address the full range of needs presented by returning veterans, including those that affect a veterans' daily life (e.g., relationships, employment, and community functioning) but may not rise to the level of requiring specialty mental health care. This article describes the development and evaluation of an innovative Veterans Affairs program, Moving Forward, which focuses on building resilience and reducing emotional distress. Moving Forward is based on the principles of problem-solving therapy that have been adapted for use in a four-session, classroom-based training program for veterans. The program evaluation results indicate that Moving Forward is feasible, well-received by veterans, and yields improvements in social problem solving, resilience, and overall distress levels. Although there is a strong evidence base for problem-solving therapy in a range of clinical settings and with a variety of patient populations (Nezu et al., 2013), this represents the first effort to apply these principles in a program focusing on the readjustment and resilience of our nation's veterans. We include several recommendations for building on these results, including the use of Internet-based training, inclusion of family members in training, and recommendations for research in this important area.

*Keywords:* veterans, problem solving, resilience, social problem solving, readjustment

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THIS PROJECT WAS SUPPORTED BY Mental Health Services, U. S. Department of Veterans Affairs Central Office. Partial results were presented at the annual meeting of the Association for Behavioral and Cognitive Therapies (November 2011), Toronto, Ontario, and (November 2012), National Harbor, Maryland. The authors thank Dr. Ira Katz and Dr. Antonette Zeiss for their generous support of this project. The authors thank Dr. Bruce Levine, Dr. Ruth Ann Tsukuda, and Laurie Arnold for their special contributions to training staff and Dr. Sherry Beaudreau for overseeing the data collection and management.

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According to data on health care utilization from the Department of Veterans Affairs, Epidemiology Program, Post-Deployment Health Group, Office of Public Health, *Veterans Health Administration* (2013), over 2.5 million United States troops have served or are serving in Iraq or Afghanistan as part of the “global war on terrorism” effort (as of March, 2013). Since October 2001, ~1.6 million of those service members have left active duty and become eligible for Veterans Affairs (VA) health care, and 899,752 (56%) have received care in VA. The most common mental health problems among veterans returning from Iraq and Afghanistan are posttraumatic stress disorder (PTSD), affective disorders such as depression, and substance use disorders. Research (e.g., Pietrzak et al., 2009; Sayer et al., 2010) has found that in addition to these mental health problems that are experienced by some veterans, subdiagnostic symptoms and challenges in a variety of domains of functioning and community involvement that may not reach the threshold for a mental health diagnosis are quite common. Sayer et al. (2010) found that 40% of Iraq or Afghanistan combat veterans in their sample reported at least some difficulty in readjusting to civilian life within the past 30 days. Difficulties in social and family relationships and in job and daily functioning were the most common types of problems cited. Notably, the vast majority of those experiencing readjustment challenges also reported an interest in assistance for community reintegration problems, including 75% who were interested in “educational material to help self,” 64% interested in “techniques or exercises to help self,” and 62% interested in “educational classes,” for reintegration problems (Sayer et al., 2010). A recent Institute of Medicine (*Institute of Medicine*, 2013) report concluded that the readjustment needs of veterans, service members, and families who have experienced deployment, “encompass a complex set of health, economic, and social issues” (*Institute of Medicine*, 2013, p. 2). In this report, the Institute of Medicine noted that, although there are many programs intended to support the needs of returning veterans, there is little evidence regarding the effectiveness of these programs.

Although VA offers a full continuum of mental health services and has focused heavily over the past several years on providing evidence-based psychotherapies for a variety of mental and behavioral health conditions (e.g., Karlin et al., 2012; Karlin, Trockel, Taylor, Gimeno, & Manber, 2013), very few efforts to date have focused on building resilience and improving functioning among veterans dealing with the full range of readjustment experiences and challenges. For example, as part of the Department of Defense (DoD)/VA Integrated Mental Health Strategy, VA conducted a survey of 153 facilities to identify best practices and promising programs that had a focus on promoting psychological resilience and prevention (*Department of Defense and Department of Veterans Affairs*, 2012). Only 22 facilities had programs that met the specified criteria. Notably, the report identified problem-solving training as one of the most promising approaches for promoting resilience and preventing mental health problems.

### **Problem-Solving Therapy as a Model for Intervention**

Problem-solving therapy (PST; Nezu, Nezu, & D’Zurilla, 2013) is a psychosocial intervention, generally considered to be under a cognitive-behavioral umbrella, that focuses on enhancing one’s

recovery from, and resilience to, the negative effects of stressful events (Nezu & Nezu, 2014). Specifically, PST aims to foster one’s ability to effectively cope with a wide variety of stressful events. Major treatment objectives include helping individuals to (a) adopt an adaptive worldview or orientation to problems in living (e.g., optimism, positive self-efficacy, acceptance that problems in living are common occurrences and not catastrophes; and (b) effectively implement adaptive problem-solving behaviors when attempting to cope with stressful circumstances (Nezu et al., 2013).

The conceptual justification for this approach emanates from three lines of empirical endeavor (see D’Zurilla & Nezu, 2007, and Nezu et al., 2013, for detailed summaries of these bodies of research). These include (a) scores of studies that have consistently found a significant association between ineffective social problem solving (SPS) and a vast array of health and mental health problems (e.g., depression, pain, generalized anxiety/worry, suicidal ideation and behaviors, hypertension, PTSD symptoms, anger proneness, and substance abuse), (b) evidence that effective SPS buffers and attenuates the negative effects of stressful events (both major life events and daily problems), and (c) multiple demonstrations of PST as an evidenced-based psychotherapy that is effective in helping a wide variety of clinical populations. Several recent meta-analyses of the PST literature provide summary evidence for its efficacy across various health and mental health problems (e.g., Malouff, Thorsteinsson, & Schutte, 2007), particularly clinical depression (Bell & D’Zurilla, 2009; Cuijpers, van Straten, & Warmerdam, 2007). The effectiveness of PST in treating psychological conditions has also been recognized by VA and DoD, and its use for treatment of mild to moderate major depression, particularly in primary care settings, is included in the VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder (*Department of Veterans Affairs and Department of Defense*, 2009).

### **Relevance for Training Veterans in Problem Solving**

The above bodies of research provide a conceptual foundation for the relevance of a PST-based intervention for prevention of mental and physical problems and fostering wellness in veterans. In essence, we suggest that various premorbid factors, plus the experience of moderate to severe stressful events experienced during active duty, can collectively serve to increase a veteran’s vulnerability to experience intense, immediate, negative distress symptoms (e.g., arousal, anger, sadness, and anxiety) when confronted with daily stress upon returning to civilian life. Premorbid vulnerability factors include both biological/physiological (e.g., genetic background, physiologic arousal, and emotional reactivity) and behavioral/psychological (e.g., prior exposure trauma, emotional dysregulation, and low self-efficacy) factors. Military service, especially if it includes multiple deployments, can represent a series of major life events (e.g., exposure to combat, significant time away from family) that can influence future emotional and health outcomes. In addition, postdeployment adjustment and the demands of day-to-day life, civilian employment, significant others, and the veteran’s health, all serve as potential stressors, which can further increase the likelihood of experiencing significant distress. This potentially creates a multitude of challenges and problems on a daily basis that in turn serve as additional sources of

stress, thus further increasing the likelihood of experiencing an actual clinical syndrome, such as major depression, PTSD, or substance abuse.

However, we additionally suggest an important influence that potentially mediates the likelihood that psychological and emotional distress will emerge is the degree to which individuals can effectively adapt to such stressors as a function of their problem-solving abilities and skills (Nezu et al., 2013). How one reacts to the immediate arousal can predict the length and intensity of this reaction. For example, does the individual view the initial arousal as a signal that a problem exists, which can then activate attempts to effectively cope with the stressor, or does he or she allow this negative arousal to go unchallenged, and thus, trigger further negative thoughts, emotions, behavior, and physical arousal? Within this context, we view effective problem-solving ability as helping to minimize the likelihood that a veteran will experience clinical levels of distress and stress-related barriers to successful coping (Nezu & Nezu, 2014; Nezu, Nezu, & Clark, 2008). For veterans who are already experiencing symptoms of emotional distress or beginning to develop styles of avoidance or impulsive behavior, this framework suggests that PST-based interventions may be an important means to decrease such symptoms, enhance their resilience to stress, and potentially have an important impact on their quality of life, and possibly prevent more serious emotional or physical problems from occurring.

The purpose of this article is to describe the development of an innovative resilience-focused psychosocial intervention based on PST principles that has been piloted in the VA health care system from 2010 to 2012. Initial program evaluation results are also presented. Participation in this program, called Moving Forward: A Problem-Solving Approach to Achieving Life's Goals (i.e., Moving Forward), was open to veterans (a) seeking health care at a VA medical center or community-based outpatient clinic who identified distress and/or challenges, (b) who were willing to attend four group training sessions with other veterans, and (c) who agreed to complete the program evaluation materials. Although the initial impetus was to develop a resilience/prevention program that would be available to address the readjustment challenges faced by veterans returning from Iraq and Afghanistan, there was no data or a priori reason to expect that Moving Forward would be applicable only for veterans from the current conflicts. Therefore, participation was open to veterans from all eras of military service.

## Method

### Program Development

The Moving Forward program consists of a four-session group curriculum, conducted in a "classroom" environment. It is described to potential participants as a "life-skills program that provides tools to help one cope more effectively with daily problems and to achieve important life goals." The Moving Forward Instructor's Manual (Nezu & Nezu, 2013a) is provided to VA providers when they attend a Moving Forward training workshop and Participant Guidebooks (Nezu & Nezu, 2013b) are provided to each veteran who participates in a Moving Forward group. These materials contain detailed descriptions of

specific tools based on contemporary PST (Nezu et al., 2013). The toolkits presented are: (a) problem-solving multitasking, (b) the "Stop, Slow Down, Think, and Act" (SSTA) method of emotional regulation, and (c) planful problem solving.

**Problem-solving multitasking.** This set of tools is geared to help an individual overcome the ubiquitous human experience of cognitive overload when attempting to cope with stressful situations in real life (Rogers & Monsell, 1995). Because of basic human limitations, people in general are unable to manipulate large amounts of information in their working memory, while simultaneously attempting to solve complex problems or make effective decisions, especially when under stress. Moving Forward teaches individuals to use three "multitasking enhancement" skills to better manage this experience of overload: externalization, visualization, and simplification.

Externalization involves displaying information "externally" as often as possible. Veterans are taught to write ideas down, draw diagrams or charts, make lists, and audio record ideas. In this manner, one's working memory is not overly taxed and can allow one to concentrate more on other activities, such as creatively thinking of various solutions. The visualization tool is presented as using one's "mind's eye" or visual imagery to help clarify the nature of problems, practice carrying out a solution, and/or reduce high levels of negative arousal. Using simplification, participants are taught to break complex problems down into smaller, more manageable components, and to translate complex, vague, and abstract concepts into more simple, specific, and concrete language.

Another use of visualization in Moving Forward is to enhance veterans' motivation and feelings of hope. Participants are specifically taught to not focus on how the problem got solved; rather, to focus on the feelings associated with having already successfully solved it. The central goal of this strategy is to have individuals create their own positive consequences (in the form of affect, thoughts, physical sensations, and behavior) associated with solving a difficult problem as a major step toward overcoming low motivation and establishing a sense of hope.

**"Stop, Slow Down, Think, and Act."** In situations where an important goal is to decrease significant emotional distress, training in this second toolkit becomes especially important. Veterans are taught a series of steps to enhance their ability to modulate negative emotional arousal. This is a core strategy for emotional regulation and will enable the veteran to more effectively apply the planful problem-solving skills presented in the third toolkit. According to the SSTA method, veterans are initially taught to become "emotionally mindful" by being more aware of when and how they experience negative emotional arousal. Specifically, they are taught to notice changes in physical (e.g., headache, fatigue), mood (e.g., sadness, anger), cognitive (e.g., worry, negative thoughts), and/or behavioral (e.g., urge to run away, yelling) indicators. Next, they are taught to "STOP"; that is, to engage in behaviors that help them to "put on the brakes." This step allows the veteran to (a) become more aware of their actual emotional experiences, (b) understand the important role that emotions play in daily life, and (c) prevent the initial arousal from evoking more intense emotion and concomitant negative thinking, state-dependent negative memories, negative affect, and maladaptive behaviors.

Next, to meaningfully be able to “STOP,” participants are further taught to “Slow Down”; that is, to decrease the rate at which one’s negative emotionality occurs. Specific techniques are taught and practiced to offer veterans several potentially effective tools for “slowing down.” These include counting down from 10 to 1, diaphragmatic breathing, guided imagery, fake “yawning” (in keeping with recent neuroscience research demonstrating the efficacy of directed yawning as both a stress management strategy and a means to enhance cognitive awareness; see Walusinski, 2006), exercise, and prayer, if relevant. Participants are also encouraged to use other strategies that have been helpful to them in the past.

**Planful problem solving.** The third toolkit provides training in four planful problem-solving tasks that represent the “Thinking” and “Acting” steps in SSTA: (a) defining the problem and setting realistic goals, (b) generating alternative solutions, (c) decision making, and (d) solution implementation and verification represents the “Thinking” and “Acting” steps in SSTA training in these tasks is facilitated by a Problem-Solving Worksheet that guides veterans through the planful problem-solving process.

Problem definition involves having individuals separate facts from assumptions when describing a problem, delineate a realistic and attainable set of problem-solving goals and objectives, and identify obstacles that prevent one from reaching such goals. Note that this approach advocates delineating both problem-focused goals, which include changing the nature of the situation so that it no longer represents a problem, as well as emotion-focused goals, which include moderating one’s cognitive-emotional reactions to those types of situations that cannot be changed. Strategies that might be effective in reaching emotion-focused goals can include stress management, forgiveness of others, and acceptance that the situation cannot be changed. The second task, generating alternatives, involves creatively brainstorming a range of possible solution strategies geared to overcome the obstacles to their goals. Decision making, the third planful problem-solving task, involves predicting the likely consequences of the various alternatives previously generated, conducting a cost-benefit analysis, and developing a solution plan geared to achieve the identified goal. The last activity, solution implementation and verification, entails having the person carry out the solution plan, monitor and evaluate the consequences, and determine whether his or her problem-solving efforts have been successful or need to continue.

Moving Forward places a heavy emphasis on providing feedback and tailoring training to veterans as they continue to apply the three toolkits to current problems that they are experiencing. In addition, the program teaches participants to anticipate future stressful situations, whether positive (e.g., getting a promotion and moving to a new city) or negative (e.g., the break-up of a relationship) and how these tools can be applied in the future to minimize potential negative consequences.

### VA Moving Forward Training Program

From 2010 to 2012, five training workshops were held that led to 90 different instructors conducting Moving Forward with veterans at 75 VA sites across the continental United States. VA staff who have been trained as Moving Forward instructors represent a wide range of professional disciplines including psychologists, psychiatrists, social workers, nurses, and counselors. Most did not

have any prior professional experience with PST though many had experience conducting psychotherapy and delivering care in group-based settings. The training program entails a 2.5 day face-to-face workshop followed by participation in weekly telephone consultation calls with PST experts and other program trainees. The workshops have been led by PST experts (AN and CN) and are a combination of didactic presentations on the principles of PST, intensive training and clinical demonstrations on the four-session Moving Forward curriculum, and experiential training within a small group setting. This intensive skills-based approach allows the novice instructors to engage in extensive role-plays and receive immediate feedback from training faculty before returning to their VA facility and implementing Moving Forward. After completion of the workshop, weekly telephone consultation is provided by members of the training faculty. The consultation calls provide logistical support, facilitate adherence to the curriculum, and allow instructors to receive feedback on their implementation of the protocol.

### Program Evaluation

In an attempt to determine whether the Moving Forward program has been effective thus far in improving psychological well-being and resilience among veterans, we analyzed program evaluation data from the first 3 years of the program (2010–2012).

### Veteran Participants

During this 3-year period, 621 veterans enrolled in the program and participated in 155 different groups, yielding an average of approximately four participants per group (range of 1 to 11). Of these 621 individuals, 479 completed all four sessions and the postintervention assessment, yielding a completion rate of ~77%. There were 349 veteran participants who served in Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)—the conflicts in Iraq and Afghanistan—270 of whom completed the overall program, resulting in a similar completion rate of ~77%.

Of the overall sample, the mean age was 42.44 years ( $SD = 13.10$ ), whereas the mean age for the OEF/OIF/OND cohort was 34.14 years ( $SD = 9.00$ ). With regard to sex, ~83% were men in terms of the overall sample, with close to 86% being men within the OEF/OIF/OND subgroup. Ethnicity breakdown was as follows for the entire sample: 58% White, 26% Black, 7% Latino/a, 2% American Indian/Native Alaskan, 0.6% Asian, 0.6% Native Hawaiian, 4% multiracial, 0.8% “other,” and 1.4% not providing this information. This distribution was very similar among the OEF/OIF/OND veterans.

### Measures and Analysis

**Depressive symptoms.** The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a 10-item self-report inventory that measures depression symptom severity, as well as “problem difficulty” (i.e., item 10: “If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?”). Each of the 10 items is rated on a scale from 0 to 3 to reflect the frequency/severity of each symptom, with the first 9

items summed to generate a total score ranging from 0 to 27. Higher scores represent higher levels of reported symptoms. A reduction of >5 points on the PHQ-9 is considered to represent a clinically significant change (e.g., Löwe, Kroenke, Herzog, & Grafe, 2004; Löwe, Unutzer, Callahan, Perkins, & Kroenke, 2004)

**General symptoms and functioning.** The Outcomes Questionnaire-30 (OQ-30; Lambert et al., 2004) is a 30-item self-report inventory that assesses symptoms of distress, problems with interpersonal functioning, and problems with social role performance. It was developed specifically to help monitor changes that occur in psychotherapy. The 30 items are scored on a 0–4 scale to reflecting the presence or absence of symptoms, with a range of 0–120. Higher scores represent higher levels of reported distress. A reduction of 10 points or more on the OQ-30 is considered to represent a clinically significant change.

**Resilience.** The Brief Resilience Scale (BRS; Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008) is a six-item self-report inventory that measures “the ability to bounce back or recover from stress.” Each item is rated from 1 to 5, based on the extent to which one generally reacts to stressful events, and an item average score is generated that ranges from 1 to 5. Higher scores represent higher levels of resilience.

**Social problem solving.** The Social Problem Solving Inventory-Revised: Short Form (SPSI-R, D’Zurilla, Nezu, & Maydeu-Olivares, 2002) is a 25-item questionnaire that assesses SPS attitudes and behaviors and yields five scale scores in addition to a total score: *positive problem orientation* (the constructive problem-solving set of attitudes and beliefs characteristic of optimism and strong self-efficacy), *negative problem orientation* (the maladaptive problem-solving orientation representing pessimism, poor emotional regulation ability, and low frustration tolerance when problems arise), *rational problem solving* (the constructive problem-solving style characteristic of planful and thoughtful approaches to solving real-life problems), *impulsive/careless style* (a maladaptive style characterized by the tendency to be incomplete, hurried, and careless when attempting to solve a problem), and *avoidant style* (another maladaptive style represented by procrastination, passivity, and avoidance of stressful problems). Higher total scores indicate more effective problem solving.

**Program satisfaction.** In addition to the above measures, veterans were asked to complete a program satisfaction questionnaire at the end of the four sessions. This included items about (a) how much the program has helped them, (b) how helpful various components of the program were, (c) the length of the program, and (d) what they might identify as helpful additional components.

**Statistical analysis.** To assess the presence of significant differences, the following analyses were conducted: (a) a repeated measures one-way multivariate analysis of variance (MANOVA) that included the PHQ-9 total score and the “difficulty” score, (b) a second repeated measures MANOVA that included all five SPSI-R scales scores, as well as the total score, (c) a correlated *t* test for the OQ-30 total score, and (d) a correlated *t* test regarding the total BRS score. If the MANOVAs yielded significant findings, individual contrasts regarding within-subject analyses were further conducted. A Bonferroni procedure was used to correct for multiple comparisons. All analyses were conducted using SPSS version 21.

## Results

Baseline and postintervention means and *SD* for all measures by sample (i.e., entire cohort and OEF/OIF/OND veterans) and by assessment point are presented in Table 1. Results of the MANOVA regarding the PHQ-9 were significant,  $F(1, 401) = 167.41, p < .0001$ , as was the MANOVA on the SPSI-R scores,  $F(1, 454) = 26.06, p < .0001$ . Table 1 provides the *t*-values and their associated effect sizes (Cohen’s *d* values) for specific prepost comparisons. Collectively, these results revealed that all contrasts were statistically significant (all *ps* < .001). Analyses of data only from the OEF/OIF/OND participants show the same patterns of distress and problem solving at baseline, as well as with regard to overall improvement as a function of participating in Moving Forward. Among veterans for whom both pre- and postintervention scores were available, 186 of 416 (44.7%) exhibited  $\geq 10$

Table 1  
Moving Forward Program Evaluation Measures

Measure	Baseline	Posttreatment	<i>t</i> ( <i>df</i> ) <sup>a</sup>	<i>d</i>
PHQ-9 total <sup>b</sup>				
Full sample	13.47 (6.61)	10.50 (6.20)	13.79 (463)	0.48
OEF/OIF/OND	14.03 (6.37)	11.06 (6.04)	10.39 (266)	0.48
PHQ-9 “difficulty”				
Full sample	1.63 (0.97)	1.25 (0.83)	8.26 (403)	0.42
OEF/OIF/OND	1.74 (0.90)	1.36 (0.85)	7.05 (234)	0.43
SPSI-R total <sup>c</sup>				
Full sample	10.47 (3.43)	11.55 (3.38)	−9.25 (454)	0.32
OEF/OIF/OND	10.40 (3.54)	11.34 (3.47)	−6.27 (254)	0.27
SPSI-R: PPO				
Full sample	10.67 (4.10)	11.28 (3.97)	−3.61 (455)	0.15
OEF/OIF/OND	10.90 (4.19)	11.36 (4.01)	−2.23 (255)	0.11
SPSI-R: NPO <sup>d</sup>				
Full sample	10.32 (4.80)	8.63 (4.50)	9.57 (457)	0.36
OEF/OIF/OND	10.47 (4.94)	9.03 (4.48)	6.16 (256)	0.31
SPSI-R: RPS				
Full sample	9.70 (4.19)	10.60 (4.15)	−4.92 (455)	0.22
OEF/OIF/OND	9.64 (4.15)	10.52 (3.90)	−4.12 (255)	0.22
SPSI-R: ICS				
Full sample	8.72 (7.67)	7.67 (4.36)	6.10 (456)	0.23
OEF/OIF/OND	8.93 (4.64)	8.13 (4.46)	3.57 (254)	0.23
SPSI-R: AS <sup>d</sup>				
Full sample	8.95 (5.06)	7.77 (4.70)	6.04 (456)	0.24
OEF/OIF/OND	9.11 (5.08)	7.97 (4.80)	4.46 (255)	0.23
BRS				
Full sample	2.64 (0.85)	2.94 (0.83)	−9.61 (460)	0.35
OEF/OIF/OND	2.65 (0.86)	2.93 (0.84)	−6.93 (263)	0.33
OQ-30 total <sup>e</sup>				
Full sample	59.86 (20.70)	50.83 (21.14)	13.16 (415)	0.43
OEF/OIF/OND	62.26 (20.93)	52.69 (21.75)	10.30 (226)	0.45

*Note.* PHQ-9 = Patient Health Questionnaire-9; OEF = Operation Enduring Freedom; OIF = Operation Iraqi Freedom; OND = Operation New Dawn; SPSI-R = Social Problem Solving Inventory-Revised; PPO = positive problem orientation; NPO = negative problem orientation; RPS = rational problem solving; ICS = impulsive/careless style; AS = avoidant style; BRS = Brief Resilience Scale; OQ-30 = Outcomes Questionnaire-30.

<sup>a</sup> Values for the degrees of freedom (*df*) associated with the individual contrasts are variable because of missing data. <sup>b</sup> PHQ-9 scores of 10–14 are considered to be in the minor depression to mild major depression category. <sup>c</sup> Age-corrected total mean SPSI-R score is 1 *SD* below the age-corrected mean. <sup>d</sup> Scores on the NPO and AS scales are >1 *SD* below age-corrected mean. <sup>e</sup> OQ-30 scores above 44 are considered to be in the “clinical range.”

point reduction on the OQ-30 and 162 of 464 (34.9%) exhibited a change of  $\geq 5$  points on the PHQ-9.

Exploratory correlational analyses showed that, in keeping with the basic justification for focusing on PST principles as the foundation for Moving Forward, baseline total SPSSI-R scores were significantly correlated in the expected direction, at the .01 level, with baseline PHQ-9 scores ( $r = -.47$ ), baseline OQ-30 scores ( $r = -.61$ ), and baseline BRS scores ( $r = .62$ ). Additional correlational analyses showed that prepost changes in total SPSSI-R scores were significantly correlated with improvements in PHQ-9 scores ( $r = -.37, p < .01$ ), OQ-30 scores ( $r = -.47, p < .01$ ), and BRS scores ( $r = .29, p < .01$ ).

### Program Satisfaction and Attrition

Veterans were asked to respond to five statements about their reactions to Moving Forward (1 = *completely disagree* and 5 = *completely agree*). The overall mean ratings on these items ranged from 3.56 ( $SD = 0.85$ ) for, "I am better able to reach my life goals as a result of this program," to 4.34 ( $SD = 0.75$ ) for, "I would recommend this program to other veterans." The other questions were, Program helped me cope better with stressful situations, ( $M = 3.79, SD = 0.77$ ); My training has been effective in helping me deal better with my problems ( $M = 4.18, SD = 0.75$ ) and Because of this program I feel more optimistic about the future ( $M = 3.73, SD = 0.89$ ). Other questions included in the postintervention evaluation involved rating a list of six program-specific treatment components (e.g., inclusion of a participant guidebook, practice assignments) and three setting-specific components (e.g., timing of sessions, location of program), where 1 = *very unhelpful* and 5 = *extremely helpful*. Overall results indicated a range of 3.77 to 4.01 ratings of helpfulness across these nine variables, suggesting a strong sense of satisfaction. In response to two questions regarding the length of the program, veterans responded with a mean rating of 3.78 (where 1 = *much too long* and 5 = *much too short*) regarding overall length of the program (i.e., four sessions) and a mean rating of 3.41 regarding the length of each session (i.e., 1 hr).

Last, six possible additional treatment components were listed whereby veterans were asked to rate the degree to which each might be helpful (where 1 = *very unhelpful* and 5 = *extremely helpful*). These included (a) additional sessions at the present time ( $M = 3.53$ ), (b) booster sessions at a later time ( $M = 3.62$ ), (c) individual training ( $M = 3.70$ ), (d) telephone check-ins ( $M = 2.99$ ), (e) email or Web check-ins ( $M = 2.88$ ), and (f) Web-based information ( $M = 3.13$ ).

In an attempt to better understand the reasons why a veteran did not fully complete the program, Moving Forward instructors were asked to contact individuals who left before finishing all four sessions. Of the original 142 veterans who dropped out, instructors were able to contact and obtain information from 92 individuals. The top three reasons for not finishing the program were transportation problems (27.8% of cohort), motivational issues (26.9%), and scheduling difficulties (25%).

### Discussion

The primary goal of this article was to describe the adaptation of PST principles for use with veterans—Moving Forward. We pre-

sented preliminary program evaluation data from efforts to train instructors and disseminate this brief PST-based training intervention. Although there is a strong evidence base for PST in a range of clinical settings and with a variety of patient populations (Nezu et al., 2013), this is the first effort to apply these principles in a program focusing on the readjustment and resilience of our nation's veterans. The results strongly suggest that this program is feasible, well-received by veterans and staff, and yields improvements in SPS, and overall distress levels. Veterans who participated in the Moving Forward program were able to learn new SPS skills in the four-session classroom-based training format, including improvement on all subscales as well as the total score on the SPSSI-R. The statistically significant changes across the SPSSI-R scales placed the veterans' mean scores within the "average" range for their age cohort. Participants also showed overall decreases in distress levels on both the PHQ-9 and the OQ-30. Baseline PHQ-9 and OQ-30 scores (see Table 1) suggest that many of the veteran participants were experiencing significant distress at the beginning of the program. Although postintervention mean PHQ-9 scores continue to place this group of veterans in the minor depression/mild major depression category, it is only barely so. With regard to improvement as measured by changes in OQ-30 scores, the overall cohort continued to report significant distress. It is notable that after only four sessions, it appears that meaningful change occurred for a sizable portion of the veteran participants, as indicated by the percentages of veterans who exhibited reductions of  $\geq 5$  points on the PHQ-9 or  $\geq 10$  points on the OQ-30. Although we were unable to identify normative data for the BRS, prepost improvement in self-reported resilience was also found to be statistically significant. Collectively, whereas the overall level of distress for both the entire sample and the OEF/OIF/OND subgroup continue to be elevated, statistical and clinical change appears to have been significant, suggesting the efficacy of this brief program. Furthermore, although the results from exploratory correlational analyses do not constitute proof that improvements in SPS mediated clinically significant improvements in distress, this finding is certainly in keeping with and supportive of the conceptual basis for this program.

Feedback from veterans about the program was very positive, with particularly strong ratings for the training being effective in helping them deal better with their problems and for recommending the training to other veterans. Veterans appeared to be very receptive to the idea of receiving "training" via the Moving Forward program. We believe this approach (a) served to normalize the problems they may be having, and (b) is consistent with their military experience in which training occurs as a matter of course whenever one is faced with a new task. It is also noteworthy that there was a relatively low drop-out rate of veterans in the program. The finding that approximately 77% of veterans completed the program compares favorably to attrition rates reported in the psychotherapy (e.g., Wierzbicki & Pekarik, 1993) and behavioral medicine (e.g., Davis & Addis, 1999) literatures, which are the most closely aligned comparisons available. Veterans who did not complete the program cited logistical and motivational factors as the most common reasons for dropping out.

There are several specific strengths of the Moving Forward program, both at the patient level and at a programmatic level that are worthy of highlighting. First, on an individual level, this program has provided veterans an opportunity to address life's

challenges in a nonstigmatizing, nonpathologizing setting. The focus is on building upon their existing strengths and includes a very pragmatic focus on helping veterans improve their quality of life and functioning by focusing on the problems that they self-identify as most important. There is a great deal of flexibility to tailor the training to each veteran's needs and the specific problems that they see as interfering the most in their lives. In addition, the brevity of the intervention was seen as a positive by many veterans, and the data presented above suggest that the length was sufficient to teach the core PST skills that were contained in the curriculum. From the first session, there is a focus on teaching veterans how they can continue to develop and utilize the skills they learn in Moving Forward, even though the actual number of classroom sessions is low. We believe that the group format also allows veterans to learn from each other in a mutually reinforcing manner. Lastly, Moving Forward can potentially serve as an entry point into further mental health care for those who need it by (a) helping them identify that the problems they have may warrant further professional attention, (b) reducing the stigma associated with help-seeking behavior, and (c) instilling hope that psychological interventions can be effective. Based on our clinical judgment, experience with Moving Forward and the preliminary data presented here, we would suggest that Moving Forward is an appropriate intervention to offer individuals who are experiencing mild to moderate symptoms or distress, but who are not severely impaired as a result of mental health concerns.

On a programmatic level, the program's firm basis in well-researched PST principles is very consistent with the field's increasing focus on providing evidence-based mental health care. VA, for example, has a strong commitment to training providers and disseminating evidence-based practices and has, to date trained more than 6,500 mental health staff in one or more evidence-based psychotherapies for a wide range of mental and behavioral health conditions (Karlin & Agarwal, 2013).

It is notable that most of the staff trained to conduct Moving Forward groups did not have prior experience with PST and were from a variety of professional backgrounds. This is consistent with research indicating that professionals of varying backgrounds are effective in conducting PST-based interventions (e.g., D'Zurilla & Nezu, 2007). This suggests that in the context of a rigorous training program, a wide range of staff in different settings, both clinical and nonclinical (e.g., university and college counseling centers, chaplains, peer counselors) could be trained in interventions such as this. The ability to address a wide range of problems and tailor the intervention specifically to each veteran participant is also seen as a strength that is consistent with contemporary models of patient-centered care. Additionally, going beyond a focus on specific mental health diagnoses to focus on quality of life and functioning, building on each veteran's existing strengths, is also consistent with an increasing focus in VA, and in the health care system in general, on holistic, recovery-oriented approaches to care.

Although the findings presented here are very promising, they should be considered a preliminary demonstration of the feasibility, acceptability, and effectiveness of a brief PST-based intervention for reducing distress among a broad sample of veterans. There are several important limitations that warrant consideration. First, because the results are from a clinical demonstration program rather than a randomized clinical trial, there was no control or

comparison group that would be necessary to validly test its efficacy (Nezu & Nezu, 2008). Second, although the training faculty had ongoing contact with the Moving Forward instructors via weekly consultation phone calls, it was not feasible to conduct a rigorous evaluation of provider adherence and competence in this context. The telephone consultation sessions did not incorporate review, rating, and feedback, of actual session recordings as would be ideal when staff are being trained to provide a new intervention. Third, although the emphasis of the Moving Forward program is on resilience and prevention and instructors were encouraged to identify individuals who were not already in specialty mental health treatment, veterans were not excluded if their clinician felt they would benefit from the program even if they had already received mental health treatment. The baseline PHQ-9 and OQ-30 data suggest that many of the veterans who participated in Moving Forward may in fact have already met criteria for a mental health diagnosis. Anecdotal reports from clinicians also indicated that it was difficult at many sites to identify and engage veterans before their receiving any mental health treatment. Thus, although this was not the intended audience, these results suggest that such a program may be an effective adjunct to disorder-specific mental health treatments. Instructors' descriptions of the types of problems veterans chose to address in Moving Forward suggest that in this context it may be particularly helpful to address the functional and relational impacts of mental health disorders.

In summary, the findings reported here indicate that a very brief, Group PST-based intervention can result in enhanced SPS skills, reduced distress, improved functioning, and increased resilience. The findings support the utility and effectiveness of such a program for addressing interpersonal and emotional problems, as well as stressful circumstances they may face upon separation from the military. Based on the findings reported here and the extant literatures on PST and veteran readjustment needs, we provide several recommendations for future work in this arena. First, we recommend further development and clinical implementation to make this type of intervention more widely accessible. For example, Sayer et al. (2010) noted the openness of veterans to receiving information and educational materials via the Internet. VA and DoD have worked together to develop a Web-based self-help version of the Moving Forward program ([www.startmovingforward.org](http://www.startmovingforward.org)) that is now available online and is undergoing preliminary evaluation. A companion Moving Forward mobile phone application is currently under development. There is also a small pilot effort underway to explore the inclusion of family members as problem-solving "coaches" for veterans who participate in Moving Forward, entitled, "The Power of Two." There is considerable potential for family members to reinforce newly acquired problem-solving skills as veterans are applying them to real-life challenges. Another promising avenue is implementation of Moving Forward in VA and military primary care settings, especially in light of previous evidence in depressed and anxious non-veteran populations that brief PST is effective in primary care settings (e.g., Hassink-Franke et al., 2011; Unützer et al., 2002). Primary care provides an ideal setting to determine if early identification of difficulties and engagement in a training-focused PST intervention can indeed avert the need for more intensive specialized mental health care. Participating in training in a primary care setting does not carry the stigma that is unfortunately still associated with seeking mental health care. Thus, Moving Forward may allow

patients who would not otherwise seek care to benefit from an effective, evidence-based intervention. Finally, although the results presented here are very positive, there is a need to conduct rigorous clinical trials that include longitudinal follow-up, clear inclusion and exclusion criteria including diagnostic assessment, and an evaluation of the comparative effectiveness for different subpopulations of veterans. Such research should include efforts to determine whether the severity of difficulties or the presence/absence of a mental health diagnosis predict who is most likely to benefit from an intervention such as Moving Forward. Longitudinal research will also demonstrate whether gains shown after a brief intervention period continue to accrue as veterans use their newly learned skills or whether they show a decrement in the absence of additional intervention. It will be especially important for this research to evaluate whether early identification and training can prevent conversion of readjustment challenges to more severe psychopathology requiring more intensive treatment. It is our hope that these findings will lead to further development of training and dissemination initiatives as well as research to further delineate the potential impact of brief resilience-oriented, evidence-based psychosocial interventions such as Moving Forward, in helping service members, veterans, and their families.

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Received May 15, 2013

Revision received March 18, 2014

Accepted March 20, 2014 ■

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