

# Families Overcoming Under Stress: Implementing Family-Centered Prevention for Military Families Facing Wartime Deployments and Combat Operational Stress

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**ABSTRACT** The toll of multiple and prolonged deployments on families has become clearer in recent years as military families have seen an increase in childhood anxiety, parental psychological distress, and marital discord. Families overcoming under stress (FOCUS), a family-centered evidence-informed resiliency training program developed at University of California, Los Angeles and Harvard Medical School, is being implemented at military installations through an initiative from Navy Bureau of Medicine and Surgery. The research foundation for FOCUS includes evidence-based preventive interventions that were adapted to meet the specific needs of military families facing combat operational stress associated with wartime deployments. Using a family narrative approach, FOCUS includes a customized approach utilizing core intervention components, including psychoeducation, emotional regulation skills, goal setting and problem solving skills, traumatic stress reminder management techniques, and family communication skills. The purpose of this study is to describe the development and implementation of FOCUS for military families. A case example is also presented.

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## BACKGROUND

Since the beginning of Operation Iraqi Freedom and Operation Enduring Freedom, the majority of over 2 million children with an active military duty parent have experienced one or more parental combat-related deployments. Although many military children and families adapt well to routine deployments, the stress of multiple and prolonged wartime deployments may take their toll.<sup>1-5</sup>

Military service members exposed to high operational stress experience higher rates of post-traumatic stress disorder, traumatic brain injury, substance use, and major depression.<sup>6-12</sup> Increased marital conflict and domestic violence have been identified in families with a deployed parent,<sup>13</sup> and combat-related deployment increases risk of parental maltreatment or neglect of children.<sup>14,15</sup> Combat stress may lead to “secondary traumatization” of spouses and children and interfere with effective parenting.<sup>16,17</sup> Returning service members may demonstrate difficulties in reconnecting with family members or become highly concerned about family safety. Children of any age might experience emotional or behavioral difficulties during parental deployments<sup>1,4,18-22</sup> and emotional distress during reintegration following deployment.<sup>5</sup> Risk factors for child distress related to parental deployments include ongoing parental psychological distress<sup>18,21</sup> and cumulative months of combat deployment in a child’s lifetime.<sup>5,20</sup>

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Recognizing that maintaining a fully capable military force requires support for the psychological health, resilience, and recovery of service members and their families, the Department of Defense Task Force on Mental Health issued a report to address the psychological health of military families.<sup>23</sup> Four interconnected visionary goals were presented, including development of a culture of support for psychological health, a full continuum of excellent care, sufficient and appropriate resources, and active involvement of visible and empowered leaders. Recommendations included (1) integrating and normalizing the concept of psychological health into everyday life at every level, including military policies, visible leadership support, allocation of resources, and education and (2) providing universally accessible excellent care related to prevention, early intervention, and treatment of mental health disruptions. FOCUS was implemented in line with these recommendations and integrated with the Combat and Operational Stress Continuum Model to further support military culture and doctrine (described further). The purpose of this study is to describe the development and implementation of FOCUS Resiliency Training for military families.

## FAMILIES OVERCOMING UNDER STRESS

### History

Developed at the University of California, Los Angeles (UCLA) and Harvard Medical School, FOCUS is a family-centered resiliency training program based on interventions previously found to improve psychological health and resiliency (defined as engagement in adaptive behaviors and achieving developmental milestones in the face of stressful or traumatic life events) among highly stressed children and families. Consistent with the Institute of Medicine Framework

for the Prevention of Mental Health Disorders, FOCUS was developed as a selective preventive intervention for an at-risk population.<sup>24,25</sup> In 2006, with feedback from military providers and family members, this intervention was first adapted for the United States Marine Corps (USMC) at Camp Pendleton and standardized for broader implementation as FOCUS. In March of 2008, Navy Bureau Medicine and Surgery (BUMED) contracted with UCLA Semel Institute to implement Project FOCUS for United States Navy (USN) and USMC families as a large-scale demonstration project. An “out-of-the box” application of psychological health care, from a public health perspective, was deemed important to effectively assist service members and families in psychological distress from combat and operational stress exposure and multiple combat deployments. In 2009, FOCUS services were expanded within the USN and USMC and made available to Army and Air Force families at selected installations through support from the Department of Defense’s Office of Family Policy/Children and Youth to the BUMED implementation.

### **Implementation**

The BUMED implementation of FOCUS, currently serving 18 military installations, provides an example of selective evidence-informed prevention for families by military medicine implemented in close partnership with military installation communities. Although maintaining common core components from evidence-based interventions, FOCUS strives to be responsive to the requests and needs of families and personnel on individual bases and, consequently, has been adapted for the specific military communities served and is embedded within a continuum of family care. FOCUS is linked to local partners including chaplains, medical and mental health providers, family service programs, and school staff. FOCUS staff participate with local partners in joint educational outreach events and encourage families to utilize their services when appropriate. FOCUS is housed in family friendly, accessible locations such as within family service centers, chapels, and base shopping centers. Services are available during the workweek, after school, evenings, and weekends. FOCUS resiliency skills training is also offered in a range of group formats for family, provider, and community level education using core FOCUS principles. Brief, trauma-informed consultations are also available for interested families.

### **General Program Description**

FOCUS is available to all interested active duty families at designated installations. It does not provide services within a mental health diagnosis and treatment model. Referrals to mental health or other social support services are provided for family members with an untreated significant mental health problem that is identified during the initial “check in” assessment or during a training session or follow-up assessment. Families experiencing ongoing domestic violence or active substance abuse problems are referred to address those problems before enrolling in FOCUS. FOCUS works closely

with both military and community mental health resources to provide service and family members with referral options, if requested by the family member. For individual families, FOCUS is delivered in eight modules (Table I). Parent and family sessions last for 90 minutes. Child sessions last for 30–60 minutes depending upon the children’s developmental levels. Families may participate at any point in the deployment cycle, ideally with both parents. Although standardized and manualized to ensure that each family learns core FOCUS skills, the intervention allows flexibility and customization for each family to address their specific goals and needs.

FOCUS utilizes web-based, real-time assessment to provide a check-in to the family with immediate feedback, enabling them to receive appropriate psychoeducational materials, a customized intervention protocol, and appropriate referrals. Primary measurement tools include standardized assessments of child’s social, behavioral, and emotional adjustment and coping; parent’s psychological adjustment; family functioning; parent’s program satisfaction and perception of change measures; and trainer’s (provider) ratings of global adjustment. As a resilience training program, the program does not measure domestic violence and child maltreatment.

FOCUS trainers hold master’s or doctoral level degrees in a mental health field, with child and family clinical experience. They complete extensive web-based and in-person training from UCLA and are provided with an array of supportive educational and intervention materials. FOCUS trainers participate in weekly reviews of their work with their team and with model supervisors. UCLA conducts quality control checks across all sites and tracks implementation activities using an innovative web-based management system. There is a continuous quality improvement process in place, allowing headquarters to monitor program fidelity and quickly respond to identified needs of individual families and local community requirements. As part of the contractual requirements for BUMED, FOCUS developed an ongoing evaluation process to measure program effectiveness.

### **Research Foundation of FOCUS**

Interventions using strength-based approaches have previously been developed and demonstrated as effective for family members facing challenging and stressful situations, such as parental divorce, parental depression, and parental bereavement.<sup>25</sup> Grounded in this family-centered prevention framework, the foundational research for FOCUS demonstrated that family-centered approaches reduce developmental and psychological risk and maximize positive outcomes.<sup>26–36</sup>

FOCUS was designed using the UCLA–Harvard developers’ 3 evidence-based interventions and adapted for military families.<sup>27–29,31,32,34,35</sup> Earlier research revealed that parents’ coping skills impact their ability to effectively understand their emotional and physical problems and to plan for stressful events.<sup>27,37</sup> Education and effective coping skills improve adjustment, stress management, and problem solving.<sup>35,38,39</sup> Drawing on these well-established interventions, FOCUS

**TABLE I.** FOCUS Family Session Core Activities

Session	Core Activities
1. Parents: Parent Introduction to the Program	Provide psychoeducation about expected reactions to deployments and ways parental distress impacts children and families Highlight parental and family strengths and adaptive coping responses Obtain family deployment history Review results of parent, child, and family assessments Identify and prioritize family goals Select home activity
2. Parents: Mapping Parental Timeline Narratives	Elicit individual parental narrative timelines Discuss differences between parents' experience and interpretation of stressor events Discuss differences in communication and parenting Address impact of missed developmental milestones or major child/family events during the deployment period Provide education regarding stress and resiliency in children and age-appropriate expectations for children during and after deployment Select home activity
3. Child(ren): Child Introduction and Exploring Emotions	Provide information regarding the impact of deployments on parents, children, and families Teach emotional identification, awareness, and regulation tools Introduce the concept of deployment reminders; practice identifying personal reminders Identify short and long-term goals Select home activity
4. Child(ren): Constructing Child Narrative Map	Explain and construct the narrative map with the child Prepare the child for the family sessions Identify concerns and questions the child wants to discuss during the family sessions Select home activity
5. Parents: Preparing for the Family Sessions	Explain upcoming family sessions Review child narrative maps Clarify which parts of parental narrative should be shared with children Coach parents on good listening and support skills Provide developmental guidance and prepare parents to appropriately respond to children's questions and concerns Select home activity
6. Family: Developing a Family Narrative	Review the rationale and goals for the family meeting Support child and parents in sharing appropriate portions of their narratives Facilitate discussion about differences in experience, reactions, and interpretations between family members Address misattributions or distortions, especially those regarding blame, guilt, and shame Help the family develop a shared understanding of the deployment experience and greater awareness of how they may support each other Select a home activity
7 and 8. Family: Final Family Sessions	Process the divergent aspects of the individual narratives and arrive at a family consensual understanding of the experience Address the primary distortions, problematic attributions, and interpretations identified in the narrative discussions Identify and prioritize the major challenges facing the family Develop individual and family coping strategies for dealing with reminders and other stressful events Apply a problem solving model to interpersonal and practical problems Identify family goals and activities for the weeks and months after the program

is based on developing a shared family narrative to support family communication and understanding and to form the basis for learning and practicing skills (e.g., emotional regulation, management of trauma and loss reminders, communication, goal setting, problem solving) that support family resiliency, enhance family cohesion, and increase social support.

As part of the implementation adaptation, family-level assessments and psychoeducation are designed to be consistent with the Combat and Operational Stress Continuum Model,

the heuristic on which other stress control and resiliency programs in the USN and USMC are based.<sup>40,41</sup> This evidence-informed model categorizes stress states into four color-coded zones—green, yellow, orange, and red—each representing a different level of risk for role impairment and mental disorder based on stressor exposures and stress responses.<sup>40,41</sup> Education is used to encourage communication and understanding among family members regarding the most toxic operational experiences to which everyone in the family is

exposed and to reduce stigma by characterizing persistent distress or dysfunction resulting from exposure to operational stressors as literal injuries to the brain and mind rather than personal weakness.

### Core Components of FOCUS

Woven throughout each session, the core evidence-informed components of FOCUS include psychoeducation, emotional regulation skills, goal setting and problem solving skills, traumatic stress reminder management techniques, and family communication skills. A family deployment timeline and narrative framework is used to increase family understanding, communication, support, and cohesion. Intervention adaptations for the military context include examples and psychoeducation, which directly address deployment-related stress and operational stressors, and frame the family narrative timeline around the deployment cycle.

It can be extremely useful for parents to receive information about typical child development, expected emotional and behavioral reactions of children to stressful situations, and ways to mitigate the effects of deployments on children. Specific targets include the following: (1) education about stress reactions: assisting the family in identifying reminders that trigger unhelpful emotional and behavioral responses (stress reactions) and linking specific stress reactions to breakdowns in family cohesion, communication, routines, and parenting activities; (2) education about family perceptions and communication, such as similarities and differences among family members' understanding of and reactions to deployment and reunion experiences; (3) education about how to use family strengths in new situations; and (4) education and guidance about child development.

Goal setting techniques help family members identify how they would like things to be different, develop realistic goals, and monitor progress towards their goals. Family goals are selected during their first sessions, and progress towards goals is rated in subsequent sessions. Goals may be related to daily family functioning, plans for upcoming deployments, or reintegration of a returning parent to the family. Problem-solving techniques can be practiced to make progress towards family goals. For example, "SNAP" is the simple four-step FOCUS problem-solving model that can be utilized with a problem the family has identified (State the problem; Name the goal; All possible solutions; Pick the best one and try it out). Once trained, families practice their skills at home and, in subsequent sessions, review their experiences to refine their skills.

The monitoring and regulation of emotional states and related behaviors is used to identify stress reactions. A feeling thermometer helps families monitor their emotional states and the effectiveness of the strategies they employ to lower their emotional distress (Fig. 1). Stress reaction coping strategies typically include identifying cues in their daily lives that trigger memories of stressful or painful experiences, monitoring their reactions to these cues, communicating to other family members when they are experiencing a stress reminder,

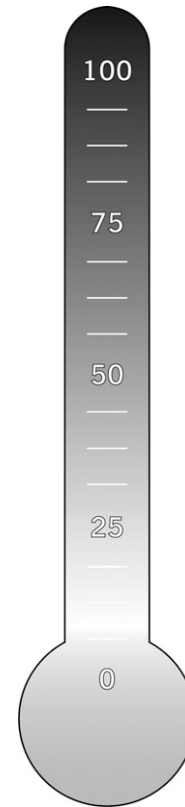


FIGURE 1. The feeling thermometer.

developing a plan for how family members can respond supportively, and practicing ways, such as relaxation techniques, to alter their arousal and reactions when triggered or when in situations that may trigger them.

The centerpiece of FOCUS is enhancing communication among family members. Combat deployments (anticipated, current, and/or completed) or high operational tempo can contribute to disruptions in communication and a tendency for family members to become emotionally isolated from each other. Children frequently keep problems to themselves to avoid worrying other family members, particularly a stressed caretaker. Although sometimes adaptive, this may result in family members keeping silent about personal fears, worries, and needs that could be effectively addressed if successfully shared. FOCUS addresses communication obstacles by bridging the individual experiences of family members through their narratives, or stories, about deployments and other times of heightened family concern and challenge.<sup>42,43</sup> Deployment narratives are generated by individuals, or by natural family subsystems, and placed on a timeline (or time map for children; Figs. 2 and 3). The individual storylines and concerns are then shared in planned and structured family sessions. With an enhanced level of understanding and connection, the family can jointly problem solve breakdowns in communication and adopt parenting practices and enhanced interaction styles that facilitate family openness, cohesion, and support, even during physical separations.<sup>44</sup>

## Sample Parent-Child Narrative Timeline

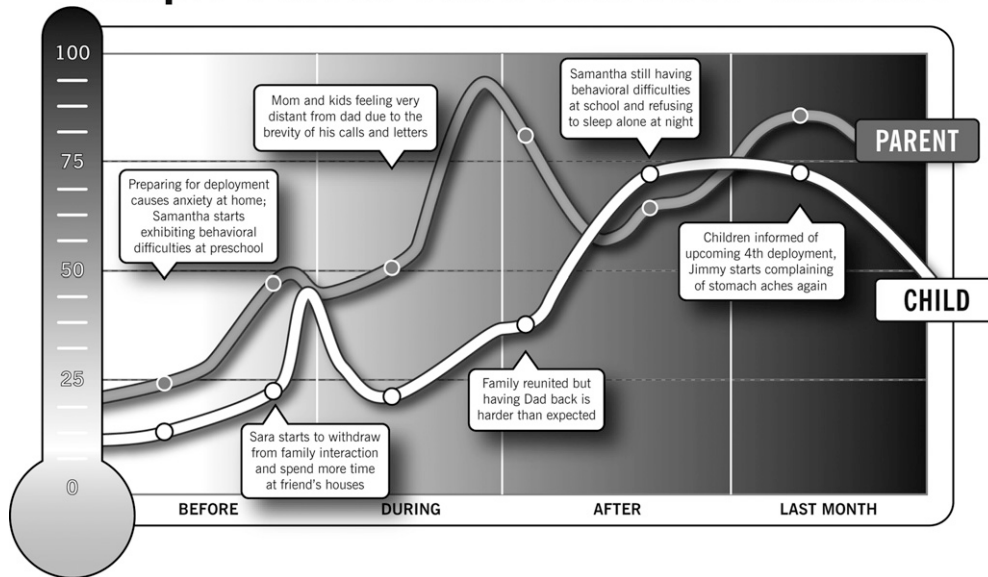


FIGURE 2. Sample parent-child narrative timeline.

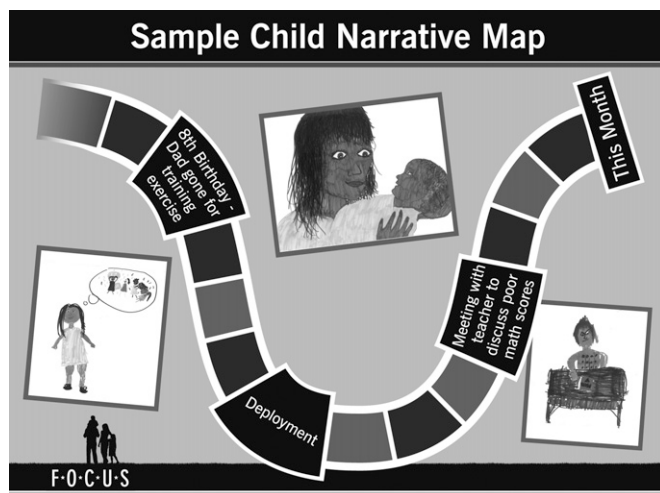


FIGURE 3. Sample child narrative map.

### FOCUS: AN EXAMPLE OF A FAMILY OVERCOMING UNDER STRESS

Paul and Serena Murray (a composite family case example is presented to protect confidentiality) started FOCUS Resiliency Training because of concerns their family was having trouble “getting on the same page” after their most recent deployment. Their children, Sara (aged 13), Jimmy (aged 8), and Samantha (aged 4), were each experiencing challenges. Their parents worried that Paul’s upcoming fourth deployment would increase their difficulties and potentially cause them long-term damage.

During the first two sessions, held with the parents, Serena and Paul reported that Sara had withdrawn from the family

and was frequently upset about peer interactions; Jimmy was having school difficulties—his grades had fallen and he frequently had stomachaches; and, during the last deployment, Samantha insisted on sleeping with Serena and cried when dropped off at preschool.

While summarizing their concerns, the FOCUS trainer delivered education about normal, usually temporary, child reactions to stress and parental absence. This allayed some of the parents’ immediate fears. The trainer then helped the parents individually describe their experiences of deployments using a timeline, reflecting on the commonalities and differences. Through this process, the parents were able to better appreciate the unique challenges they each faced and to bridge some longstanding misunderstandings. For example, Serena had felt that when Paul was “down range,” his calls were so short and business-like that neither she nor the children felt Paul missed them. Using the timeline, Paul described how his worry about the family peaked while away, yet his way of coping was to “go on emotional lockdown.” This discussion deepened Serena’s understanding and feelings of closeness to Paul. With the trainer’s guidance, they identified family goals, including learning to support each other and improve communication during deployments and to explore ways to engage the schools to be more responsive to their children’s needs.

In the next session, the older children were taught to use the feeling thermometer, identifying situations that prompted “yellow,” “orange,” or “red” levels of stress, and to use the time map to describe their experiences during deployments (Fig. 3). Educational approaches were used to normalize many of their thoughts and feelings. They were assisted with making sense of their own experiences and encouraged to think about what to share with their parents.

In the next parent session, the trainer helped the parents develop a plan for supporting Samantha's return to sleeping alone and with daily separations. Much of the session was spent preparing them for the family session. The trainer described the format of the next session, explored which parts of their narratives should be shared, reviewed good listening and support skills, and facilitated practicing appropriate responses to their children's questions and concerns. Psychoeducation about normal adolescent development prepared Paul to better understand Sara's desire to spend time with her friends. Education about combat operational stress and the continuum model helped Paul feel better about acknowledging his stress reactions. With the trainer's assistance, Paul and Serena developed a plan to support Paul during times when he might be exposed to stress reminders.

The trainer started the family session by describing ground rules for sharing and supportive listening. As planned, the children shared their narratives and drawings about their experiences, especially during the past month. The parents listened respectfully and shared aspects of their experiences that helped the children better understand them or to address points of confusion. After all family members shared their narratives, the trainer facilitated a family discussion to develop a shared narrative reflecting the family's overall experiences, acknowledging their family's strengths and sources of resilience.

The final two family sessions were spent clarifying family misunderstandings identified while sharing the narratives, practicing constructive communication and support, and practicing problem-solving skills. The family decided to use the feeling thermometer for daily check-ins with each other; collectively identify reminders that trigger sad, anxious, or angry feelings; draft a family plan for coping and supporting each other during high stress; develop a calendar to help them anticipate and plan for family fun days and difficult days; and hold family meetings to plan for Paul's upcoming deployment.

During the final session, Sara reported success using the breathing and imagery techniques and satisfaction with her parents' decision to allow her to host a sleepover. Jimmy's teacher agreed to break his assignments into smaller pieces, and they made a plan for Paul to spend special one-on-one time with him before deployment. To improve their communication during deployment, they decided Paul would make DVDs of himself reading and saying goodnight to the children. He would have separate calls with Serena and the children while deployed, and the children would send him artwork and letters. They also created a developmentally appropriate calendar for 4-year-old Samantha so that she could track her father's return. Overall, the family showed progress in working as a team, with an improved ability to collectively set goals, use problem-solving tools, and adapt to challenges.

## CONCLUSION

Sustained military engagement puts unparalleled demands on service members and their families, evidenced by height-

ened child and family psychological distress and by increased mental health problems in highly deployed families. As a selective prevention program, the FOCUS demonstration project provides an example of an evidence-informed preventive intervention adapted specifically for military families based on current research and according to a rigorous and innovative implementation and evaluation model. Done in close partnership with military medicine, line programs, and command structure, the FOCUS model provides a public health strategy for addressing the needs of families and children with increased risk due to wartime deployment.

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