INTRODUCTION

Over the past several decades, the Army has grown to appreciate the important contributions Families make in maintaining the psychological health of Soldiers. The Army Family Covenant is a testament to the Army's commitment to creating a strong supportive environment that promotes resiliency in Army Families. These measures have become essential as large numbers of Soldiers deploy in support of continuing overseas contingency operations. This point was illustrated by the Presidential Task Force on Military Deployment Services for Youth, Families, and Service Members as it acknowledged that the demands of a robust deployment tempo place service members and their families at-risk for the development of significant emotional problems. One disturbing manifestation of the distress experienced by Soldiers returning from a military deployment can be seen in the well publicized accounts of Soldiers physically assaulting, and in some cases killing, their spouses after returning home from combat duty. The Army Family Advocacy Program (FAP), which has responsibility for preventing abuse, protecting abuse victims, and treating all individuals impacted by family violence, currently does not routinely extend to combat zones. Consequently, the present pace of deployments has created a gap in services that limits the program's effectiveness in reaching those individuals who may be at greatest risk for family violence. Although the US Army Medical Command encourages family advocacy personnel to collaborate with forward deployed behavioral health assets, a standardized process has yet to be implemented. After 9 years of war, it is time to transform the program to more effectively meet the evolving needs of the most vulnerable Army Families. This article proposes expanding the FAP across all phases of the deployment cycle by the better use of behavioral health assets currently assigned to maneuver units.

DOMESTIC VIOLENCE AND MILITARY DEPLOYMENTS

A growing body of evidence indicates that military deployments can disrupt family functioning by altering family roles, stressing adaptive coping strategies and increasing the likelihood of child maltreatment. Frequent deployments are thought to be linked to the dramatic rise in divorce rates in Army marriages with infidelity, domestic violence, and substance abuse believed to be contributing to the increasing numbers. According to a study of the psychological effects of deployments on military families, feelings of loneliness, and problems communicating with deployed spouses stand out as prominent stressors reported by spouses left at home. Deployments also have been shown to place families at a heightened risk for domestic violence. McCarroll et al discovered that Soldiers who had deployed within the past year were more likely to report committing severe aggression towards their spouses and that the longer the deployment, the more likely violence would occur. Similarly, deployment-induced family separation has been suggested as a contributing factor in the increased rates of spouse abuse among enlisted personnel. Particularly relevant to contemporary military operations is a study of families affected by Operation Desert Storm that found coping with residual aggression to be more problematic for war-time veterans and their families than for those who endured a routine deployment. This may be due, at least in part, to the


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introduction of psychological symptomatology, including posttraumatic stress disorder (PTSD), into the family dynamic. This possibility is supported by a 6-year study of veterans who received couples therapy at a Veteran’s Affairs Medical Center which found that veterans diagnosed with PTSD were 26 times more likely to commit severe acts of violence towards their partners.15 Also, PTSD has been correlated with a greater likelihood of female Vietnam veterans becoming psychologically abusive in relationships with significant others.16 Interestingly, depression and PTSD symptoms have been found to be more closely linked to postdeployment aggression than the degree of actual combat exposure experienced by veterans.17 A connection between postdeployment psychological symptoms and an increased potential for violence may be especially disconcerting, given the estimated 17% of Soldiers that are at-risk for developing mental health problems, including PTSD, depression, and alcohol misuse, after returning home from combat duty in Afghanistan or Iraq.18

ARMY FORCE GENERATION MODEL AND FAMILY ADVOCACY

Today’s Army finds itself confronted by persistent conflicts and protracted operations against an enemy that uses asymmetrical tactics such as those used in Afghanistan and Iraq. To counter these threats, the Army developed the ARFORGEN model to meet the demands of current operations and to prepare for future contingencies. A Department of the Army White Paper describes the ARFORGEN as:

…a rotational readiness model that is designed to effectively and efficiently generate trained and ready forces for combatant commanders at sustainable rotational levels.19

The model categorizes the operational force into 3 functional pools based upon recent deployment utilization: Train-Ready, Available, Reset. As units move through the ARFORGEN cycle, mission-essential tasks must be completed to successfully transition from predeployment preparation to mission execution in a theater of operations, then return for postdeployment reconstitution. During the Train-Ready phase, a unit trains to restore readiness levels to prepare for future contingency operations. Throughout this period, a unit prepares for deployment through individual and collective training that typically culminates in a mission readiness exercise conducted at either the Joint Readiness Training Center or National Training Center. At the pinnacle of the ARFORGEN cycle, a unit deploys to tactically implement national security strategy during the Available phase of the process. Afterwards, during the Reset phase, efforts are made to restore Soldiers and Families to predeployment levels of functioning. Reintegration programs, such as Battlemind postdeployment training, Strong Bonds, and Yellow Ribbon, help ease the transition from a war zone. Additionally, the postdeployment health assessment and postdeployment health reassessment, conducted during the first 180 days following a deployment, are used to gauge a Soldier’s biopsychosocial adjustment after returning home. Referrals for medical and psychological assistance are made as needed.

The ARFORGEN model provides a logical framework for the design and implementation of family advocacy measures to support deploying units. Each stage presents distinct opportunities to target interventions to those Soldiers and Families that may be at-risk for domestic violence. Evidence-based prevention and treatment initiatives can be tailored to address the unique family stressors characteristic of each step in the deployment process. The establishment of a partnership between the military treatment facility’s family advocacy treatment team and the deploying unit’s behavioral health officer is essential to achieving this objective. More importantly, the benefits of working together become most evident during the deployment.

THE 4TH INFANTRY DIVISION EXPERIENCE

The 4th Infantry Division’s deployment to OIF 05-07 provides insight into constructive actions to take, and obstacles to avoid, in the creation of an operational family advocacy program. Author Arincorayan, who was assigned to the 4th Sustainment Brigade at Fort Hood, Texas, about one month prior to deployment, proactively worked to structure a comprehensive behavioral health support plan that included family advocacy outreach and follow-up. Conceptually, activities were planned based on the unit’s immediate requirements and on the anticipated future needs of Soldiers. Special consideration was placed on the identification of high-risk populations that could emerge at each stage of the deployment.

Train-Ready Phase (Predeployment)

To secure support for behavioral health initiatives, relationships were established with the division’s
senior leadership and the local family advocacy supervisor. Each endorsed the incorporation of family advocacy interventions into the behavioral health plan. In an effort to provide continuity of care during the 12-month deployment, a list of 56 Soldiers who were actively receiving family advocacy services was obtained from the FAP supervisor. Shortly thereafter, the division surgeon was briefed on the status of high-risk Soldiers enrolled in FAP and brigade behavioral health officers were alerted so they could plan the provision of care to those assigned to their area of operations. Recognizing the importance of maintaining an efficient flow of communication between the theater of operations and the home station, one FAP staff member was designated the primary point of contact for the unit during the deployment. As an aside, although telephone and e-mail capabilities were readily available in Iraq, time zone differences and communication blackouts created challenges that mirrored the same frustrations Soldiers experienced trying to communicate with spouses back home.

Much more could have been accomplished, had time permitted. Integrating into the unit as a provider from the Professional Filler System (PROFIS*) late in the Train-Ready phase hampered deployment preparation. Foremost, not training with the unit during the mission readiness exercise was a missed opportunity. The exercise, which usually lasts 30 to 45 days and simulates the deployment, provides an indication of how well Soldiers and spouses might cope during the year-long deployment and can be used to test the link between the behavioral health team and the supporting FAP staff. Additionally, time constraints made it difficult to establish credibility and develop trusting relationships with company commanders and first sergeants. Having limited access to company-grade leadership made it difficult to identify, and provide early intervention, to Soldiers at-risk for domestic violence based on a history of previous incidents of family violence, marital discord, alcohol abuse, or financial problems. In some instances, the behavioral health provider, in concert with the FAP staff, may need to recommend the delay of a Soldier’s deployment or suggest that he/she be assigned to the rear detachment to grant additional time to stabilize the family environment. Nevertheless, these recommendations should be used judiciously and only if sufficient evidence suggests that additional time at home will eventually produce a deployable Soldier.

Available Phase (Deployment)

While operating in a war zone, behavioral health providers primarily focus on the prevention and treatment of combat and operational stress reactions. However, the provision of FAP support is an important, if often overlooked, component of a comprehensive behavioral health program. This is particularly true since the Army broadly defines domestic violence as the use, or threat to use, force or violence against a current or former spouse, a person with whom one has a child, or a current or former intimate partner with whom a domicile has been shared. With the composition of today’s military, many units have dual military couples who may share living quarters while deployed, and unmarried, cohabitating couples who deploy together with the same unit. Therefore, it is reasonable to expect that domestic violence incidents could occur in theater. It is prudent that the behavioral health officer prepare a protocol to respond to abuse allegations.

Operationally, a forward-deployed family advocacy program would essentially involve the same activities as those found in garrison, namely, continued care for existing active cases; assessing reports of domestic violence that occur in theater; providing treatment to new cases and conducting secondary prevention for Soldiers who become at-risk due to marital conflict caused, or exacerbated, by deployment-related family separation. That being said, it is worth reiterating that the primary purpose of all deployed Soldiers, to include behavioral health providers, is to conduct potentially stressful military operations. Family advocacy intervention is a secondary objective. Nevertheless, an exception should apply to individuals who become victims while in theater. For them, implementation of a safety plan and the provision of emotional support become a priority.

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*PROFIS predesignates qualified Active Duty health professionals serving in Table of Distribution and Allowance† units to fill Active Duty and early deploying and forward deployed units of Forces Command, Western Command, and the medical commands outside of the continental United States upon mobilization or upon the execution of a contingency operation.

†Prescribes the organizational structure, personnel and equipment authorizations, and requirements of a military unit to perform a specific mission for which there is no appropriate table of organization and equipment (the document which defines the structure and equipment for a military organization or unit).
Behavioral health operations at Camp Taji during OIF 05-07 reflect many of the challenges inherent in managing FAP cases during a combat deployment. Most notably, only 12 of the 56 Soldiers (21%) identified as enrolled in family advocacy treatment prior to deployment received follow-up in Iraq. Most could not access care because of assignment to outlying patrol bases throughout the Multi-National Division–Baghdad area of operations. Others could not make appointments because of mission requirements such as combat logistics patrols, command post duty, and other combat support activities. At about the 7-month point of the deployment, 3 allegations of domestic violence were reported on Taji. In response to each incident, command was notified and safety plans were implemented, including temporary weapons restrictions for all involved Soldiers. Also, to remain compliant with the family advocacy regulation, law enforcement and the FAP reporting point of contact (RPOC) were notified. These steps in the FAP protocol were complicated by the fact that the RPOC was located at Fort Hood, and there was no clear guidance with regard to which law enforcement agency has jurisdiction over in-theater family advocacy reports. Frustratingly, neither the provost marshal at Camp Taji nor the military police at Fort Hood accepted responsibility for the report.

Soldiers going home for environmental management leave, commonly known as R&R, presented an interesting and somewhat unexpected set of challenges. After returning to Taji from R&R, one female Soldier reported being physically assaulted by her civilian husband while on leave. Implementation of the FAP protocol with this allegation was made more difficult due to the Soldier’s assignment to a unit deployed from Fort Riley, Kansas. Unfortunately, no predeployment coordination had been arranged with the supporting FAP office. Initially, the RPOC at Fort Riley refused to accept the spouse abuse report, but relented only after consulting with the US Army Medical Command’s FAP program manager. While the Soldier entered treatment at Taji and continued services until redeploying 5 months later, the eventual outcome of the case is unknown. Also, in conjunction with R&R, 4 Soldiers with acute marital conflict were believed to be at-risk for committing family violence while on leave. Prior to each of them leaving Camp Taji, coordination was made with the rear detachment commander and FAP supervisor to have them evaluated by FAP personnel at Fort Hood before having contact with their spouses. These precautionary steps may have helped to prevent any incidents, as no abuse reports were received.

The majority of the FAP work focused on providing secondary prevention to Soldiers experiencing marital problems with spouses back home. Twenty-five Soldiers, 21 male and 4 female, received supportive counseling for partner relational problems associated with infidelity or being told that their spouse wanted a divorce. Most presented to the clinic experiencing anger, depression, inability to concentrate on missions, sleep difficulties, and appetite disturbances. Some expressed suicidal ideations while others wanted desperately to go home so they could “fix” their marriages. Usually, once the initial crisis was stabilized, Soldiers received supportive intervention using individual and group modalities that emphasized stress management strategies, methods to cope with family separation, improving communication in a marriage, and restoring trust in a relationship. No one had to be redeployed early because of FAP related issues.

Reset Phase (Postdeployment)
At this point in the deployment cycle, the primary responsibility for the unit’s family advocacy support reverts to the home station FAP. After the 4th Infantry Division redeployed from Iraq, the 3 abuse cases that occurred in-theater, including all documentation, were formally transferred to Fort Hood’s FAP supervisor. Of the cases that were active prior to deployment, written updates were provided on the 12 Soldiers who received follow-up in Iraq. Eleven of the Soldiers who received treatment for partner relational problems were recommended for continued follow-up by FAP clinicians due to lingering symptoms that placed them at-risk for family violence. Additionally, 8 Soldiers were referred to the outpatient Resilience and Restoration Center for further assessment and treatment of combat-related psychological symptomatology in hopes that any related family difficulties could be averted. As a PROFIS provider, the behavioral health officer did not accompany the unit to Fort Hood and thus was unable to personally ensure that Soldiers received recommended follow-up. This lack of continuity reinforces the importance of direct assignment of organic behavioral health providers to the brigades they support. Finally, redeployment is the time to review lessons-learned so that behavioral health ser-
VICES can be improved for future operations. The re-
view should include the FAP protocol to determine if
adjustments should be made to develop more effective
family advocacy support for the next deployment.

**POLICY IMPLICATIONS**

Although there are limited empirical data to help
define the extent of family advocacy problems in the
current theaters of operation, we believe that the
anecdotal evidence inherent in the 4th Infantry
Division’s experience during OIF 05-07 reflects the
challenges confronted by most operational units.
Presently, since no standardized approach to
operational family advocacy exists, deploying units
must rely on the professional experience and personal
interests of its behavioral health officer for the design
and implementation of a FAP support plan.
Institutionalizing a systemic response, rather than
relying on individual initiative, requires the
modification of existing policy. We recommend
consideration of the following policy initiatives:

- Issue command guidance on which provisions of
  *Army Regulation 608-18* apply to deployed units
  operating in a combat zone.

- Assign the Chairperson, FAP Case Review
  Committee (CRC) as the responsible agent for
  ensuring that follow-up of all active cases is
  properly coordinated between the installation’s
  FAP and the deploying unit.

- Modify the composition of the FAP CRC to
  include the brigade behavioral health officer for
  cases involving Soldiers assigned to his or her
  brigade.

- Clearly designate one organization, either the
  deployed unit or home station, to take
  responsibility for the management of family
  advocacy cases that occur in theater, to include
  CRC review and records management.

- Clarify whether the in-theater provost marshal or
  the law enforcement agency at the home
  installation has responsibility for spouse abuse
  reports from the deployment area.

- Create a reporting mechanism to specifically track
  the number of spouse abuse incidents occurring in
  a theater of operations.

- Extend the victim advocate program to support
  victims of domestic violence in theater.

- Update the programs of instruction for the Family
  Advocacy Staff Training and Combat Operational
  Stress Control Courses, conducted at the Army
  Medical Department Center and School, to include
  family advocacy support for overseas contingency
  operations.

- Reduce the reliance on PROFIS providers for
  filling behavioral health officer authorizations in
  the brigade combat teams.

Other policy actions may be warranted as we learn
more about the impact multiple deployments have on
marriage and family relationships. To help target
prevention efforts at critical junctures, domestic
violence rates should be carefully monitored for
increases associated with each phase of the
deployment cycle.

**CONCLUSIONS**

As the Army continues its transformation into an
expeditionary force, new approaches to the delivery of
behavioral healthcare to Soldiers and Families will be
needed. The Army Campaign Plan for Health
Promotion, Risk Reduction, and Suicide Prevention
aims to improve existing programs and to ensure they
are well coordinated to maximize effectiveness. For
some, blending family advocacy functions into brigade
behavioral health operations will not be a popular
proposal, and it is arguable that active spouse abuse
cases could be suspended during a deployment since
the threat of physical harm is minimal. However,
ensuring continuity of care for family advocacy cases
sends a strong message that meeting the psychosocial
needs of our Soldiers and the execution of operational
missions can coexist. The provision of family
advocacy support to forward operating areas, with its
bureaucratic complexities and clinical challenges,
requires innovative thinking that integrates
contributions from behavioral health providers, family
advocacy personnel, and unit commanders.
Deployment area family advocacy procedures, at least
those measures to protect and support victims in
theater, will further solidify the Army’s commitment
to provide for the psychological health and well-being
of its Warriors and Families.
REFERENCES


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