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Helping military families through the deployment process: Strategies to support parenting

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Abstract

Recent studies have highlighted the impact of deployment on military families and children and the corresponding need for interventions to support them. Historically, however, little emphasis has been placed on family-based interventions in general, and parenting interventions in particular, with returning service members. This paper provides an overview of research on the associations between combat deployment, parental adjustment of service members and spouses, parenting impairments, and children's adjustment problems, and provides a social interaction learning framework for research and practice to support parenting among military families affected by a parent's deployment. We then describe the Parent Management Training-Oregon model (PMTO™), a family of interventions that improves parenting practices and child adjustment in highly stressed families, and briefly present work on an adaptation of PMTO for use in military families (After Deployment: Adaptive Parenting Tools, or ADAPT). The article concludes with PMTO-based recommendations for clinicians providing parenting support to military families.

Keywords

Military families; children; parenting; deployment

The potential challenges and mental health consequences of war-time deployments to service members and veterans are considerable, and increasing evidence suggests that families face diverse stressors at different periods in the deployment cycle (Pincus, House, Christenson, & Adler, 2005). Family members of deployed personnel are often the "unsung heroes" of a combat deployment, supporting service members before, during, and after a deployment. Consequently, the psychological consequences of deployment also apply to families. Partners of service members who are deployed, for example, face the challenge of worrying about and supporting a loved one for an extended period without knowing if or

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when they will return (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008). Children face a variety of challenges at all stages of deployment, as they prepare for the absence of one of their parents, adapt to the changes in the home that are inevitable parts of that absence, and then re-adjust to the return of their parents months or even a year or more later. Service members themselves may face a range of challenges in reintegrating to civilian life following return from a combat deployment, including posttraumatic stress disorder (PTSD), depression, substance abuse, or simply transitioning back to work and family life. In this article, deployment related stressors and their impact on parents' wellbeing are conceptualized as interrelated factors influencing parenting and children's adjustment. We review the literature on relationships among deployment and related stressors, family relationships, and child adjustment with an explicit focus on parenting because research and practice show parenting is a key mechanism through which relationships operate to protect children, or place them at risk for maladjustment. We then discuss the Parent Management Training-Oregon model (PMTO™) and our efforts at adapting PMTO for work with military families. Finally, we discuss strategies and recommendations for clinicians providing parenting support to military families.

Effects of Combat Deployment on Families

Impact of Combat Deployment on Service Members

Department of Defense data indicated that among soldiers returning from combat operations in Iraq (Operation Iraqi Freedom; OIF), 27.7% of active duty and 35.5% of National Guard and Reserve component service members screened positive for clinically significant mental health concerns (PTSD, depression, suicidal ideation, interpersonal conflict, or aggressive ideation) three to six months after returning from deployment (Milliken, Auchterlonie, & Hoge, 2007). Service members returning from combat deployment also are at increased risk for substance use problems (Jacobson et al., 2008). Although the majority of combat exposed service members will not develop long-term mental health problems (Hoge et al., 2004), short-term readjustment reactions are common and can include difficulty sleeping, irritability, and difficulty concentrating (Shea, Vujanovic, Masfield, Sevin, & Liu, 2010). Evidence also indicates that reintegrating service members experience family challenges as much as three years post-deployment: Sayer et al (2010) reported high rates of divorce and anger control problems in a sample of 754 treatment-seeking OEF/OIF combat veterans.

Impact of Combat Deployment on Spouses and Partners

Considerably less attention has focused on spouses/partners of deployed soldiers; however, a growing body of research shows increased risk for psychological distress in this population. In a recent review of the medical records of over 250,000 Army wives, Mansfield and colleagues (2010) found that soldier deployment to OEF/OIF was associated with elevated rates of treatment for, and diagnoses of, depression, sleep problems, anxiety disorders, acute stress reactions, and adjustment disorders. Such findings are not surprising given the stressors that military spouses face in the context of a combat deployment. These include ambiguous loss (prolonged absence of the service member combined with worry that s/he will be injured or killed), disrupted communication with the deployed partner, parenting stress in non-deployed caregivers, and financial or occupational strains (Faber et al., 2008; Flake, Davis, Johnson, & Middleton, 2009; Warner, Appenzeller, Warner, & Grieger, 2009).

Impact of Combat Deployment on Children

Deployment of a parent to the combat zone has been described as a "catastrophic" stressor for military families (Peebles-Kleiger & Kleiger, 1994). This may be particularly true in the current conflicts, as the sustained high operational tempo means that families face more frequent, longer, combat deployments with shorter breaks between them (Hosek, Kavanagh,

& Miller, 2006). Child distress, depression, and anxiety are associated with parent combat deployment (Jensen, Martin, & Watanabe, 1996) with greater distress associated with longer deployment, and deployment related to more transitions in children's lives (Pierce, Vinokur, & Buck, 1998). Transitions are particularly problematic for school aged children, who are developing social networks through school and neighborhood (Sameroff & Haith, 1996).

Four recent OEF/OIF studies mirror these earlier findings. Chandra and colleagues (2010) conducted telephone interviews with 1507 families with a deployed parent and an 11–17 year old child, finding the incidence of emotional problems to be higher than national averages. Length of deployment and poorer at-home caregiver mental health were associated with child maladjustment both during deployment and following reintegration. Flake and colleagues (2009), in a study of 101 families living on a military base, reported that 32% of 5–12 year old children with a deployed parent had Pediatric Symptom Checklist scores in the "high risk" range for psychosocial problems, approximately 2.5 times the national norm. In a study examining child and parent distress among 272 6–12 year old children of active duty soldiers deployed to OEF/OIF, both length of deployment and parental distress were associated with children's depression and externalizing symptoms (Lester et al., 2010). Similarly, Chartrand, Frank, White, and Shope's (2008) study of 169 families living on Marine bases revealed significantly poorer parent-reported adjustment among 3 to 5 year olds with a deployed parent, compared to peers without a deployed parent, controlling for caregiver's stress and depressive symptoms.

Associations Between Parent Distress and Child Adjustment

There is a well-established literature demonstrating that many of the mental health challenges faced by deployed service members and their spouses affect child wellbeing. Studies across a range of populations have demonstrated that parental depression, substance abuse, and subsequent parenting impairments predict increases in children's behavioral and emotional problems (e.g., Beardslee, Bemporad, Keller, & Klerman, 1983; Patterson, Reid, & Dishion, 1998). Glenn et al. (2002) reported that veterans' combat exposure, PTSD symptoms, and aggressive behavior were related to hostility and aggression in children.

Deployment has been shown to adversely impact parent-child interactions for those who go to war as well as for caregivers remaining at home (Gibbs, Martin, Kupper, & Johnson, 2007). Studies of male Vietnam veterans have found PTSD to be associated with decreased parenting satisfaction (Samper, Taft, King, & King, 2004) and parenting skills (Glenn et al., 2002; Jordan et al., 1992). Other studies have described the association of PTSD with impairments in a range of parent-child and family relationship variables: problem-solving, interpersonal expressiveness, family cohesion, and conflict (Repetti, Taylor, & Seeman, 2002).

While smaller, the literature on OEF/OIF families is consistent with these broader findings of parent, child, and parent-child interaction impairments related to the stressors of combat deployments. In a longitudinal study of 468 National Guard soldiers deployed to Iraq, increases in PTSD symptoms (from in-theater to one year following return home) were significantly associated with veterans' self-reports of poorer parenting practices (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010). Flake et al. (2009) found that parental stress was the most significant predictor of child functioning during deployment. Rentz et al. (2006) came to a similar conclusion in their study comparing Texas Child Maltreatment records among military and non-military populations from 2000 to 2003 (coinciding with OEF/OIF increases in deployment). The rate of child maltreatment rose by approximately 30% for every increase of 1% in operation-related deployment and reunion following deployment. Utilizing the Army Central Registry Database, Gibbs and colleagues (2007) reported 3 times greater risk of child neglect and 4 times greater risk of moderate to severe

child maltreatment during deployment. During deployment, the large majority of offenders were civilian mothers; when fathers were at home, they were more likely to be perpetrators of child maltreatment (Gibbs et al., 2007). These studies suggest that strengthening and supporting parenting in military families for the home-based parent and the deployed soldier can support children's adjustment during and following deployment.

Deployment-related injuries, illness, or death provide additional parenting challenges (Cozza et al., 2010). Reunion with an injured parent, for example, may be complicated by additional separation from the non-deployed parent who may spend substantial time in the hospital with the injured service member, resulting in reduced monitoring of and communication with children. The degree and nature of a parent's injuries (e.g. the extent of disfigurement, dismemberment, and incapacity) also may complicate parenting practices, including family communication around injuries, family problem-solving of daily challenges, positive involvement with, and monitoring of children (Cozza et al., 2010; Gewirtz et al., 2010). While data on these issues remain limited, there is a clear implication that families facing these more significant stressors may require focused clinical attention.

Effective Parenting Mediates Associations Between Deployment-Related Stressors and Child Adjustment

Studies of children's resilience have revealed the critical role of effective parenting in healthy youth adaptation among families living in stressful circumstances (Masten, 2001). This is not surprising given parents' roles as the adults primarily responsible for the socialization of their children. Effective parenting practices can provide a protective buffer for children and youth, particularly during times of adversity (Gewirtz, Forgatch, & Wieling, 2008).

Given the associations of deployment and reintegration with an array of family stressors – separation and transitions, relationship challenges, mental health difficulties and substance abuse - it is not surprising that evidence suggests that the detrimental impact of combat deployment on children may be mediated through its effects on *parenting practices* (Palmer, 2008). The mediating role of parenting practices in the relationship between family stressors (transitions, parental distress, socioeconomic stress) and child behavioral/emotional problems has been well documented in a range of populations (Beardslee et al., 1983; Patterson, 1982). The next question for the field to address is whether this relationship holds with military families facing deployment stressors. Clinical observation and anecdotal reports, which will require systematic data collection to verify, do suggest that military deployment can alter parenting practices, fostering, for example, more aversive interactions.

Patterson's (1982; 2005) *Social Interaction Learning* model describes the mechanisms by which stressful life circumstances impair parenting practices and child outcomes in a dynamic process. Family stressors are associated with family interactions characterized by low levels of positive communication (e.g. effective problem solving, encouragement, involvement) and high levels of coercive interactions (i.e. aversive behaviors, negative reinforcement and reciprocity, and escalation). Coercive interchanges with parents, siblings, and peers lead to rejection by peers, and a drift into a deviant peer group, increasing behavior problems, depression, school failure, and delinquency (Patterson, 2005). Experimental tests of the Social Interaction Learning model have demonstrated that coercive parenting practices associated with child behavior problems are malleable and that child adjustment (both internalizing and externalizing) can be improved with interventions that improve positive parenting practices (e.g., Forgatch & DeGarmo, 1999).

Parent Management Training – Oregon Model (PMTO)

Theoretically informed by the Social Interaction Learning model, Parent Management Training – Oregon Model (PMTO; Patterson, 2005) is a group of empirically-supported parenting interventions that may be quite applicable to military families. Moreover, preliminary data suggest that military families desire family-based services. Results of a needs assessment of 100 National Guard soldiers who had recently returned from OEF/OIF deployment indicated a greater preference for family-based interventions over individual therapy (Khaylis, Polusny, Erbes, Gewirtz, & Rath, in press). All PMTO programs adhere to the same core principles, providing information, teaching, practice and support regarding five effective parenting practices designed to reduce coercive tactics and promote positive parenting (Patterson, 2005; Reid, Patterson, & Snyder, 2002). These are: 1) contingent skill encouragement, 2) limit-setting, 3) positive involvement, 4) monitoring children's activities, and 5) effective family problem-solving.

Over the past forty years, PMTO interventions have been well-validated in improving parenting, child adjustment and family functioning among a range of populations including universal (i.e. general) populations, children raised by single or divorcing parents, low-income parents, abused and neglected children, and children with early onset conduct problems (Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Reid et al., 2002). PMTO represents the single largest group of evidence-based parenting programs listed on national clearinghouses such as SAMHSA's National Registry of Evidence-based Programs and Practices (Oregon Social Learning Center, 2010; Reid et al., 2002).

Longitudinal findings from PMTO studies have demonstrated cascading benefits not simply to parenting and child adjustment, but also to other aspects of family functioning. For example, PMTO has been shown to lead to reduced maternal depression, reduced maternal substance use, and reduced child substance use, increased income, reduced financial stress, and lower rates of police arrests for youngsters and mothers, all extending over a *nine-year* period following a PMTO group intervention for single mothers (Forgatch et al., 2009; Patterson, DeGarmo, & Forgatch, 2004). Data from a study of PMTO with stepfamilies indicated significant intervention effects on parenting, which mediated significant effects on marital relationship processes, and subsequently (24 months post baseline) self-reported marital satisfaction (Bullard et al., 2010). The prior two prevention studies were timed to intervene shortly after a critical transition; both demonstrated that strengthening parenting practices promoted long-term positive adjustment for children and their parents. These studies demonstrate the potential utility of PMTO in intervening with military families around the time of stressful military transitions such as preparing for or readjusting after a combat deployment. The empirical data for the effectiveness of PMTO in these and other, large-scale studies provide a strong foundation for its modification and evaluation with military populations.

PMTO may also be particularly relevant to military families because of its data regarding *fathers*, who constitute the majority of deployed parents. Brott (2009) has drawn parallels between father separation during deployment and marital separations; data from programs for divorced and separating fathers might thus inform interventions for military fathers. A PMTO intervention for recently married stepfather families demonstrated positive program effects on fathering with medium effect sizes for improved positive and reduced coercive parenting in stepfathers at six and twelve month follow-up (DeGarmo & Forgatch, 2007). Of note, improvements in stepfather parenting practices were associated with reductions in children's internalizing and externalizing behaviors *independent* of mothers' parenting. The intervention also produced significant improvements in mother-father co-parenting

behaviors, which were associated with reductions in parent- and teacher-reported problem behaviors at the two-year follow up (Forgatch, Patterson, & DeGarmo, 2005).

The After Deployment Adaptive Parenting Tools Program/ADAPT: Extending PMTO for Military Families

Given its extensive empirical base, the demonstrated generalizability of the program through several adaptations, and its relevance for U.S. military populations dealing with combat deployment, we have been funded by the National Institutes of Health (National Institute on Drug Abuse) to modify and evaluate PMTO in a web-enhanced, group-based format for military families (Gewirtz, Polusny, Forgatch, DeGarmo, & Marquez, 2009). The After Deployment Adaptive Parenting Tools/ADAPT program is based on a PMTO group intervention (Parenting Through Change; Forgatch & DeGarmo, 1999; Forgatch et al., 2009) that has already been shown to be feasible, acceptable, and engaging for a range of civilian populations with a history of exposure to stressful transitions and traumatic events (e.g., Gewirtz & Taylor, 2009). The ADAPT curriculum and materials (e.g., role play exercises, audio-visual material) are developed to be relevant and unique to military families and culture. Further, the program targets common post-deployment adjustment reactions (e.g., irritability, hypervigilance, and avoidance) that can disrupt family relationships by incorporating psycho-education and a focus on emotion regulation within a parenting context. Specifically developed web content ensures that the ADAPT program is accessible to family members beyond group sessions. ADAPT will be empirically evaluated as part of this development effort. Although outcome data are not yet available, key strategies from PMTO, which have been shown to be effective for other stressed populations and are incorporated into ADAPT, may be useful in working with this population. Next, we offer a review of some of these strategies.

Recommendations for Providers: Supporting Parenting in Military Families

The strategies for supporting parenting in military families outlined below emerge from PMTO principles, and may be delivered in the context of a variety of psychological services (i.e. individual or family therapy, or prevention services). Broadly, these strategies include: (1) building on the resilience of military families, (2) addressing family stress within the context of the deployment cycle, and (3) offering strategies to enhance emotion regulation as a key to effective parenting.

It is important to note that these parenting strategies do not constitute treatment for severe individual distress faced by some returning veterans, and therefore, are not a substitute for individual therapy for issues such as PTSD, depression, or substance abuse and dependence. Similarly, families with injured or ill service members, or those who have lost a parent in combat, face more significant challenges that may require more intensive, individual or family treatment (e.g., trauma focused cognitive-behavioral therapy for child traumatic grief; Cohen & Mannarino, in press). However, even in situations where families and military service personnel are confronted by more complex stressors, these strategies may be important adjuncts to other treatment approaches. They can also be helpful in working with less severely distressed families facing the more universal stressors of military deployments. Helping parents or caregivers work together as a team to apply effective child-rearing strategies reduces stress at home and provides a supportive context for the transition between the battlefront and the home front. Success on the home front promotes parents' self-esteem and mastery as well as children's resilience.

Building on the Resilience of Military Families

We recommend that clinicians emphasize a strengths-based, resilience-building approach, rather than a treatment of psychopathology approach, in their work with military families. This is especially important in the context of concerns that a record of mental health services will affect a service-member's military career (Hoge et al., 2004), and for military families for whom self-sufficiency is particularly highly valued. The approach may be as simple as beginning an intervention by eliciting from parents their own parenting strengths and values, their children's strengths, and connecting those parenting values and strengths to their parenting goals. Discussing ways the family has successfully confronted and grown from other significant military and more general stressors can be useful in identifying and emphasizing existing, effective practices, within the family. A focus on goals (rather than problems) also sets up parents to be future-oriented, positive, and realistic as they move towards changing their child-rearing behaviors.

Addressing Family Stress within the Context of the Deployment Cycle

While heuristic models have been proposed to summarize several stages of a deployment cycle (Pincus et al., 2005), we find it helpful to consider three broad periods of deployment and associated family stress: 1) Pre-deployment, 2) Deployment, and 3) Post-deployment or reintegration. Throughout the deployment cycle, military families may experience a range of stressors and challenges. For example, during the pre-deployment period, family stressors associated with preparation for deployment may involve anticipatory worry and tension associated with impending separation. During the deployment, families face the stress of prolonged separation and single parenting while the deployed parent is absent. The post-deployment period, or period of reintegration after deployment, can bring additional challenges for two-parent families in re-establishing a parenting 'equilibrium' upon the service member's return. Below, we provide some practical recommendations aimed at addressing family stressors within the context of the deployment cycle.

Help parents maintain rules, routines, and rituals during the deployment cycle—Parents may provide inconsistent limits, or may relax limits, when the non-deployed parent is single-parenting during deployment or following reintegration when the deployed parent is reentering the family. This may occur simply because parents are exhausted from the stress of single parenting or as a way of assuaging guilt about parental absence. However, rules and clear limits on children's behavior protect both children and parents (Howard, 1996). Providing parents with tools for effective limit-setting (e.g., by teaching and practicing time out) can help increase children's sense of security and predictability, while also supporting parents to be in control and follow through with a limit-setting routine, rather than feeling powerless to stop children's acting-out behavior or acting out angrily in response to that behavior.

During times of uncertainty, children and parents alike benefit from 'The Three Rs'- predictable routines, clear rules or limits, and family rituals that carry family members through unpredictable transition times. Knowing that the family is engaging in familiar activities may also reassure the deployed parent that s/he knows what is happening at home even though s/he is not there to experience family life. The three Rs also provide a shared family narrative – a constant and expectable series of events in family life – that can help in reestablishing family equilibrium upon reintegration. Maintenance of these rules, routines, and rituals may represent a means of maintaining family stability in the face of the stresses experienced before, during, and after deployment (Sheppard, Malatras, & Israel, 2010).

Help parents to support children's coping—We also recommend clinicians use family problem solving as a tool to support children's coping. Supporting parents to teach

their children problem-solving skills increases effective communication, and provides a method for solving everyday conflicts in a cooperative manner. The problem-solving process provides a way to reduce children's daily anxieties by increasing predictability and communication. Family meetings are one vehicle for family problem-solving that create the additional advantage of a shared history, particularly during times of transition, when family members may be feeling isolated and unheard. In addition, at specific transition points during the deployment cycle, family goal planning can help parents and child(ren) alike to clarify their values and goals as well as to identify sources of support.

Help parents understand and respond to child anxiety—Family worries during deployment are realistic and are not helped by the uncertainty of combat and the irregular communication between the deployed service member and his/her family. Clinicians can help parents to understand children's cognitive capacities and how much information children can absorb at particular developmental stages. Role-playing situations in which difficult topics emerge for parent-child discussion can support parents to strengthen children's coping with anxiety at stressful times (e.g., when return from deployment is delayed, or when a notice of deployment has just been received). In addition, media and other resources directed at children facing the deployment cycle can be very helpful, particularly when read or viewed as a family. Examples include Sesame Street's "Talk, Listen, Connect" program for young children, family resources from the Defense Centers of Excellence in Psychological Health's www.afterdeployment.org website, and books written in the voices of children and youth (e.g., Sherman & Sherman, 2009).

Help parents minimize child transitions—Helping parents to understand that transitions are anxiety-provoking for adults and children alike will increase parents' awareness about the importance of minimizing additional child transitions during the deployment cycle. For example, a parent may desire to move children into new schools or daycare situations that are more convenient for life with a single parent, but those transitions in and of themselves might be more stressful for the children.

Help parents maintain a united parenting front—Keeping parenting practices consistent across partners may be challenging during deployment and particularly reintegration, after a parent has become used to managing children alone. In two-parent families, explicitly focusing on a united parenting front will facilitate both partners to remind themselves of common parenting goals during reintegration. In preparation for key transitions during the deployment cycle, a discussion of the goals, values, and expectations of each parent's role and responsibilities in the family can facilitate the changes in co-parenting that take place.

Offering Strategies to Enhance Emotion Regulation as a Key to Effective Parenting

Supporting parents to manage stress—Supporting parents – the at-home parent during deployment and both parents following deployment – means supporting the efforts of the individual parents and the couple to reduce stress and care for themselves. Often, this is most critical precisely at the times when parents feel as if they have the least time to engage in self-care (e.g., while training and preparing for a deployment or single-parenting during deployment). However, helping parents to identify small stress reduction techniques acknowledges parents' needs to take care of both their children and themselves in healthy ways. Indirectly, a focus on healthy stress reduction also addresses the challenges of alcohol and other substance abuse as a way to dissipate stress or relieve tension.

Providing strategies for regulating emotions in parenting – e.g., effective directions—Repeatedly practicing positive and neutral ways to interact with children – for

example, in giving effective directions – can help parents regulate emotions by giving them a 'script' or simple tools that support parents' remaining in control and reining in aggressive reactions even in an affectively-arousing situation. Parents might learn, for example, that an effective direction is short, clear, specific, and given in a neutral manner with clear follow-through. Chances to practice giving clear directions, through role play with a partner and/or a provider, enables parents to internalize this effective tool.

These strategies can be particularly helpful in the context of post-traumatic symptoms that some veterans experience when returning from combat deployments (Hoge et al., 2004). As noted above, posttraumatic stress symptoms, depression, and substance abuse have all been linked with impaired parenting practices (e.g., Gewirtz et al., 2010). The anger, avoidance, and ineffective coping (e.g., drinking) that commonly occur in this context highlight the need and potential utility of these strategies in reducing impaired parenting.

Helping to balance encouragement and discipline – the power of the 5:1 ratio —Stress magnifies the occurrence and maintenance of ineffective and coercive parenting practices. A tense parent concerned for her deployed spouse from whom she recently has heard no word, can easily transfer her stress to her child, when presented with an opportunity via non-compliance. Similarly, a reintegrating parent (frustrated with the lack of discipline among his/her children, and sensitive to loud noises or other trauma reminders) and an acting-out teen (or one who enjoys playing loud music) is a volatile family combination!

Providing parents with tools to teach children using encouragement (i.e. token systems, incentive charts, use of praise and tangible rewards) is important as a counterbalance to the downward spiral of coercive cycles between parents and children. The "5:1 ratio" simply reminds parents to provide five supportive, encouraging or rewarding behaviors or statements for every time a correction or consequence is delivered to a child. The ratio of 5:1 establishes a positive climate in the household and prevents the entrenchment of coercion. In such a context, also, limits can be set and followed through upon - more effectively.

Conclusions

A substantial body of evidence highlights the need to pay increased attention to military families affected by combat deployment to the current conflicts. Transitions – such as those engendered by the deployment cycle – offer prime opportunities to strengthen already present skills and introduce new strategies. We have discussed PMTO, which provides a framework for understanding and supporting military families affected by deployment, and ADAPT, a new implementation of PMTO being developed specifically for military families that empowers parents to be their children's best teachers. We have provided recommendations for practitioners that are based upon PMTO principles and that emerge from the extant empirical literature. In conjunction with other existing and developing military supports for families, these strategies show good promise for enhancing the wellbeing of military children and families.

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