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A Comparison of Building Strong and Ready Families (BSRF) and Strong Bonds

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Introduction

As community health nursing students, we are often sent into situations with little preparation and we frequently do not see or comprehend the “big picture.” This is what happened to our community health clinical group when we were invited to facilitate small group teaching sessions at a program called Strong Bonds at Fort Lewis, WA. We could tell that all the Army Public Health Nurses (APHN) loved the program, but we did not know why. On September 28, 2006, we spent the morning facilitating and teaching at skills stations that covered reproductive health, healthy eating, physical fitness, stress reduction, and tobacco cessation. We also had the opportunity to fill out a Family Health and Behaviors Genogram and a Readiness to Change questionnaire. Upon completion of the health fair, and after talking with some of the leaders and participants, we were impressed and intrigued by the program and questioned why the seminar was not full, with a long waiting list.

Assessment

Objective.

A community assessment of Fort Lewis revealed that Fort Lewis is a closed system that includes active army soldiers and their families, retired soldiers and civilians who are employed on the post. Active army personnel are assigned to Fort Lewis and stay for approximately two to three years, before moving on, either out of the Army or to another post. During this time, the soldier is frequently deployed for a year or more, leaving his or her family behind. This lifestyle makes it difficult for people to feel settled, and to grow roots and develop a sense of belonging within the community. Added to this sense of “just passing through” is the fact that most of the soldiers are young and in young marriages with young families. For many of them this is the first

time they have been away from home, and the first time they have been without family support nearby. It can be a very challenging time.

However, we also found through the community assessment, that Fort Lewis has sufficient community resources available to their members that cover a wide range of needs, usually without cost. “Military life places extreme hardship on relationships, especially in wartime, so the Army, backed by Congress, has committed unprecedented resources to help Soldiers” (U.S. Army, 2006). What appears to be missing is resource knowledge and utilization by the community. The members do not seem to know what is available and therefore do not seek out the help that would decrease their strain and strengthen their bonds with each other, with their community and with the Army. These bonds are vital to maintaining a strong and ready Army. Our community assessment led to the diagnosis of family strain related to frequent deployment, change of duty stations, lack of knowledge of supportive services, as evidence by reported stress of family members and key informants.

The Strong Bonds program, originally called Building Strong and Ready Families (BSRF) was designed in 1997 as a “community-based, health promotion intervention aimed at reduction of multiple unhealthy behaviors in Army soldiers and their spouses” (Niederhauser, Maddock, Ledoux & Arnolds, 2005, p. 227). It was a collaboration between Army chaplains and APHN that used a proactive approach to relationship enhancement (the chaplain’s focus) and healthy lifestyle promotion and risk behavior elimination (the APHN focus) (Niederhauser et al., 2005).

The name was changed to Strong Bonds in 2005 and additional programs were added to help single Soldiers and families. To date more than 1300 training events have been held and over 30,000 Army couples have participated in Strong Bonds (U.S. Army, 2006). At Fort Lewis,

from January through September 2006, 29 Strong Bonds for Couples, 33 Strong Bonds for Singles, and six Strong Bonds for Families programs were conducted. Fort Lewis chaplains received \$193,000 in funding to implement these programs (P. Schmitt personal interview, November 2, 2006).

Subjective.

After the health fair, we talked with the Army chaplains who are in charge of Strong Bonds and the Army Public Health Nurses (APHN). It was revealed that this particular Strong Bonds program was not fully enrolled, and therefore was not as effective as it could be in promoting health, wellness, and readiness of the soldiers and their families. Chaplain Assistant SGT Michael Verdonk (personal interview, September 28, 2006) stated, “We have capabilities for taking 25 couples.” Only 16 couples had signed up for the session and not all of them had attended the health fair. Our group was impressed with the focus and strength of Strong Bonds and felt this was a worthy program that, if properly utilized, would reduce family strain in the community.

Madigan’s Chief APHN, COL Hollandsworth, was one of the nurses involved in the development of the BSRF program at Tripler Army Medical Center in Honolulu, Hawaii. We met with COL Hollandsworth to obtain background information about the program that would facilitate our assessment. She expressed concerns about how the program has changed over the years. What began as a solid, evidence-based program built on theory and research has changed so much that the original studies no longer validate the current program (J. Hollandsworth, personal interview, October 26, 2006). She shared with us her desire to conduct a research study at Fort Lewis in the near future that would again establish the reliability and validity of the program, and ensure congressional funding for the future.

It was at this point our group decided rather than focusing on promotion of the program, what was needed was a comparison of the original BSRF and Strong Bonds as it exists today. This analysis would be useful to the colonel as a first step in her research. She suggested that a focus group be conducted a month after completion of the program to measure the long-term effectiveness in the lives of the participants. In order to compare the two programs, we would also need to speak with the chaplains to establish what the program is as it stands today.

Analysis

Building Strong and Ready Families.

Building Strong and Ready Families (BSRF) is a holistic, proactive, preventative approach to health promotion, soldier and family readiness and well-being. BSRF is a Commander's training program led by the Chaplain Ministry Team in partnership with Health Promotion Community Nursing (CHN) [APHN]. The goal of the BSRF is to help participants build a strong family physically, mentally, relationally and spiritually--to support "Readiness" (Niederhauser & Hollandsworth, 2002, p. 38).

According to Niederhauser and Hollandsworth (2002) the program was available to single soldiers as well as married couples, and couples with children. It consisted of three distinct levels, which provided the participants with a variety of topics to focus on throughout the program. The first level was awareness, the second was skills for promotion of health and well-being, and the third focused on integration of the skills taught during levels I and II. The chaplains were involved with the program throughout all three levels while the APHN was involved with the first two levels of the program.

Level I was the awareness level of the program. The APHN portion at this level was to raise awareness of the effects of risk behaviors such as smoking, stress, and poor diet, and educate individuals of the potentially negative outcomes these behaviors may have on their

health. A one-hour session lead by an APHN helped individuals identify potential health risks. Participants filled out a wellness assessment, a readiness to change survey, and a genogram. The chaplains' portion at this level addressed improving communication strategies. This session totaled seven hours and consisted of several components including discussion of the book *Men are from Mars; Women are from Venus* by Dr. John Gray and a Meyers Briggs Personality Assessment.

In level II the APHN's portion focused on health promotion and disease prevention skill building. This three-hour session consisted of small, interactive seminars which included topics such as breast and testicular self exams, stress management, nutritional planning, tobacco cessation, nutrition, weight management, fitness, alcohol and safety information. Participants completed a wellness matrix in which their height, weight, blood pressure, and body fat were analyzed and then met with an APHN to examine any risk factors that had been identified. Using the data collected in level I they discussed their willingness to change their risk behaviors. From this interview the APHN nurse further facilitated health promotion by making appropriate referrals for those participants who were considered high risk. The chaplains conducted a four-hour seminar during level II, using Prevention and Relationship Enhancement Program (PREP) materials.

Level III was run by the chaplains and included a two-day overnight stay at a hotel with food and lodging at no cost to the participants. This retreat was one of the perks used to generate interest and buy in with the participants. The content of this part focused on strengthening and facilitating communication and relationship building.

Collaboration between the APHN and the chaplains was a vital component to the success of this program. Evaluation of the program was also a crucial part of its success. "[The] key to

such initiatives is outcome measures that enable monitoring the intervention's effectiveness on an ongoing basis" (Niederhauser & Hollandsworth, 2002, p. 39). Many methods and tools were used to analyze the effectiveness of this program including: collected demographic information; program evaluations for levels I, II, and III from the participants; data on lifestyles, health risks and stages of behavioral change; focus groups and group participant feedback. Using these tools, at least two studies have been conducted to measure various impacts of the program (Niederhauser & Hollandsworth).

BSRF based on research.

BSRF was based on sound, theoretical curriculum (Niederhauser & Hollandsworth, 2002). The first evidence-based program used by BSRF was The Prevention and Relationship Enhancement Program (PREP), a program that helps relationships succeed. The second was the Adverse Childhood Experiences (ACE) study (Felitti, et al., 1998). This study looked at adverse events during childhood to see how these experiences affected behavior as an adult. The conceptual framework on which BSRF was based was the Transtheoretical Model of stages of change. This curriculum formed the foundation on which BSRF was built.

According to their website, PREP is the "most rigorously tested program for the prevention of marital distress ever developed" (PREP Inc., 2006). It is a program based on research that extended through many different countries including the U.S., Germany, Australia and the Netherlands. Researchers analyzed hours of conversations and garnered risk factors that affected marriage viability. From this data, a marriage enrichment program was developed. Couples were taught healthy marriage skills and then compared to couples that were not taught these skills. The studies consistently found that couples who went through PREP had lower rates of separation before and after marriage, reported lower levels of physical abuse, lower levels of

negative communication and a higher rate of maintaining satisfying relationships for years after the program (PREP Inc). BSRF used PREP materials to teach their couples, building on the high success rates reported by the PREP research. These positive outcomes have been seen to last for four to five years after the completion of the program (PREP Inc).

While marriage skills are highly important, the ACE study (Felitti et al., 1998) showed that adverse childhood experiences need to be identified as well. In the study, 9,508 people responded to questionnaires that asked about psychological, physical, or sexual abuse, violence against their mother, or living with household members who were substance abusers, mentally ill, suicidal or ever incarcerated. More than half the participants reported experiencing at least one adverse childhood experience. One in four reported experiencing two or more adverse childhood experiences (Felitti et al). This study showed that it is vital to look at familial patterns so couples can try to correct their negative cycles, which include behaviors such as alcoholism, drug abuse, depression, and suicide attempts. Because of these alarming findings BSRF incorporated interventions into their program that would help identify and break these cycles.

It is important to note that while PREP skills can be taught and adverse behaviors can be identified, if a person is unwilling to change his/her behavior then relationship problems will still occur. The Transtheoretical Model of stages of change was used in BSRF to assess an individual's readiness to change, an important consideration in reducing unhealthy behaviors (Niederhauser, Maddock, Ledoux & Arnold, 2005). The Transtheoretical Model identifies the stages of change as: precontemplation, contemplation, preparation, action, maintenance and termination (Prochaska & Velicer, 1997). These stages identify where people are in terms of their readiness to change. A person in the precontemplation stage is still weighing the pros and cons of change while someone in the preparation stage has made a commitment to change.

Identifying these stages is important to help individuals change their behavior concerning marital skills or adverse behaviors. BSRF used a condensed version of the Transtheoretical Model to determine an individual's readiness to change, and based on their responses the APHN provided information and support that would move them along the change continuum.

A program with strong theoretical curriculum and clear objectives makes evaluation straightforward. BSRF has solid data that supports its goal of “community-based, health promotion intervention aimed at reduction of multiple unhealthy behaviors in Army soldiers and their spouses” (Niederhauser, Maddock, Ledoux, & Arnolds, 2005, p. 227).

Strong Bonds.

Strong Bonds is fully-funded and Chaplain-led with the support of the Commanding Officer. Soldiers and their families attend with others in the unit who share the same deployment cycle. During the retreat, Soldiers and families participate in small group activities that reveal common bonds and nurture friendships. This shores up spousal support at home, which can be vitally important while the Soldier is away. In addition, Soldiers and families gain awareness of community resources that can assist with concerns about health and wellness, even crisis intervention. (U.S. Army, 2006, The history of Strong Bonds).

The mission of Strong Bonds is to “build Soldier readiness by providing skills the Soldier can use to strengthen his or her marriage and other relationships” (U.S. Army, 2006). Currently, there are four programs within Strong Bonds used to accomplish this mission—single soldiers, couples, families, and pre- and re-deployment.

Strong Bonds for Singles is conducted by the Army Chaplains. The program consists of two distinct parts. The first section consists of ten hours of programmed time. Five hours of this

section must be focused on Pick-a-Partner (No Jerks). This is an empirically tested program that focuses on spouse selection. Each soldier is required to purchase a Pick-a-Partner workbook prior to attending the seminar. The second half of the singles consists of an “experiential excursion (which may be overnight)”(Hicks, 2006, p. 4).

The Strong Bonds for Couples implementation guide is divided into required activities and activities that are strongly recommended. The required activities include twelve hours of marriage education and communication skill building. Six of the twelve hours must utilize PREP. The chaplains conduct this portion. Each participant is also required to fill out pre- and post-training surveys. The purpose of these surveys is to document the effectiveness of the program. The activities that are no longer required but are strongly recommended are the health promotion and disease prevention section and Army Family Team Building (AFTB) Level One. It is recommended that this program be conducted in several phases, which are to be completed within six weeks.

The third Strong Bonds program is Strong Bonds for Families. The focus of this program is not only on the couple’s marriage but it also incorporates information concerning parenting and child rearing skills. Additionally, children eight years old and older can participate in most of the program. Like Strong Bonds for Couples, this program has required sections and strongly recommended sections. The chaplains primarily do the training for this program. It must consist of ten hours of parenting and family education, six of which must be spent using the Family Wellness curriculum. The program must include at a one-night retreat somewhere off post. All participants of this program are also required to fill out a pre- and post-training survey. The optional parts of the program are the health promotion and disease prevention section lead by the

APHN, AFTB Level One, and phase training prior to the retreat or follow-up training after the retreat.

The newest element of the program, launched in October of 2006 is Strong Bonds for Pre- and Re-deploying soldiers and their families. This program focuses on the challenge of keeping families strong and connected throughout deployments (U.S. Army, 2006).

The effectiveness of Strong Bonds is measured using participant feedback. Couples who have completed the program report increased marriage satisfaction and survival. They also feel more committed to the Army community. More than 90% of all participants report that the program was helpful and appreciated (U.S. Army, 2006).

Comparison of BSRF to Strong Bonds.

Although BSRF and Strong Bonds are similar in some aspects, they differ in many as well. One key difference is the division of Strong Bonds into Strong Bonds for singles, Strong Bonds for couples, Strong Bonds for families and Strong Bonds for pre-and re-deployment. Each of these subdivisions has different material that is covered and different requirements of implementation. Some sections that were an integral part of BSRF are no longer required to be part of Strong Bonds; they are only strongly recommended or left out completely. Secondly, the strong collaboration between the APHN and Army chaplains has been removed. It is no longer a requirement in any of the programs and is completely missing in Strong Bonds for singles. Finally, it is important to note that while statistical data and research studies could be found to demonstrate the effectiveness and validity of BSRF, our group has been unable to find any such evidence for Strong Bonds.

Nursing Diagnosis

After a thorough analysis of both programs, our group developed the following nursing diagnosis: Risk for ineffective Strong Bonds program related to the changes in the program since inception, frequent personnel changes due to military structure, a lack of continuity, and minimal APHN involvement.

Planning

The Public Health Core Functions of this project is Assessment. Strong Bonds is an existing program that claims to have evidence-based research as its foundation. We want to verify that claim in order to justify the cost of the program to the American taxpayers.

The goal for this project is to establish the reliability and validity of Strong Bonds by December 6, 2006. Our first objective is to gather information about both programs and conduct key informant interviews in order to compare BSRF and Strong Bonds by November 11, 2006. Our second objective is to conduct a focus group of participants from the September 28, 2006, Strong Bonds health fair one month after the completion of the program to evaluate the effectiveness of that program. Before conducting the focus group we will research focus groups and develop a list of questions to be used in order to elicit the information that we need from the participants. Our third objective is to present the collected information to COL Hollandsworth on December 6, 2006. She will use the information to begin her research on the effectiveness of the current Strong Bonds program.

Implementation

To compare the original program, Building Strong and Ready Families, with the current program, Strong Bonds, we will gather information and research concerning the two programs. Contact will be made with key informants to gather additional information. We will talk with the following key informants: Chief APHN, COL Hollandsworth, Brigade Chaplain at Fort Lewis, CHP Schmitt, and LTC Frederich, an Army Chaplain with the Family Ministries Office

in Washington, D.C. Sydney will research how to conduct a focus group and develop the questionnaire. Mary will contact the Chaplain's assistant to schedule the focus group. Darren and Lucretia will conduct the focus group. We will produce a written document with our findings and recommendations for COL Hollandsworth.

Evaluation

Our goal of establishing the reliability and validity of Strong Bonds was not met. Our group found that data is being collected by the chaplains and the APHN but we were unable to locate a centralized database where the information is deposited and organized. We did not find any evidence that the outcomes of Strong Bonds are being monitored on an ongoing basis. We met our objective to compare BSRF with Strong Bonds. We met our objective to learn about focus groups and developed the questionnaire (see Appendix A). However, we were unable to conduct the meeting due to the training schedule of the participants. We met our objective of providing COL Hollandsworth with information for her research project.

Recommendations

In the current healthcare crisis that is facing our nation today, it is imperative that funding shifts from tertiary prevention to primary prevention or secondary prevention. The Strong Bonds program must return to its original foundation with a strong research-based prevention program. Strong Bonds in its original form as BSRF ties in well with several of the Healthy People 2010 Leading Health Indicators. These indicators reflect the major health concerns in the United States at the beginning of the 21st century and will be used to measure the health of the United States over the next 10 years. They were selected on the basis of their ability to “motivate action, the availability of data to measure progress, and their importance as public health issues” (U.S. Department of Health and Human Services, 2006). Of the ten indicators, the goals and objectives of BSRF can be directly linked to seven of them: physical activity, overweight and

obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, and injury and violence. The BSRF program is exactly what Healthy People 2010 is calling for—community-based health promotion and prevention with measurable results. Strong Bonds needs to be able to do the same.

We strongly recommend that Strong Bonds define measurable program outcomes, develop consistent data collection and analysis protocol in order to track program outcomes, and return to the original collaboration level between Army chaplains and APHN. The APHN should take on the responsibility of data collection and organization because of their scientific education. Additionally, we recommend that they establish ongoing research studies that will measure the benefits and effectiveness of Strong Bonds and provide feedback for continued quality improvement of the program. Finally we recommend that follow-up surveys of randomly selected participants at one month and six month intervals (and even longer) should be developed to help determine the long-term effects of the program.

Appendix A

Focus Group Questions

1. What was the most enjoyable part of Strong Bonds Program and why?
2. What did you learn during the Strong Bonds Program?
3. Which skills that you learned at the Strong Bonds Seminar have you continued to use since you arrived home?
4. Do you feel that your relationship with your spouse has improved since you attended Strong Bonds?
5. Is there any part Strong Bonds that you felt that you felt was not beneficial?
6. What was your least favorite part of Strong Bond?

7. Is there any part of the weekend that you or your spouse would have liked to spend more time on?

8. Do you feel that you communicate more effectively with your spouse since you attended Strong Bonds?

9. Do you feel that attending Strong Bonds will have an affect on your relationship in the future?

10. How has attending Strong Bonds affected your mental health?

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