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Prevention of Child Maltreatment in U.S. Air Force Families

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ABSTRACT

The Department of Defense created the Family Advocacy Program (FAP) to provide primary and secondary intervention and prevention services to military families to decrease the risks of family maltreatment. This review synthesized literature to reveal how deployment, domestic abuse, mental health, and substance abuse relate to adult and child maltreatment in the armed forces. Systematic review procedures are used to evaluate nine studies meeting inclusion criteria to correlate factors significant in the increased risk of child maltreatment. Based on results, this paper discusses how FAP can effectively provide primary and secondary services by transitioning from a traditional medical model to a public health model using a social-ecological framework. Additionally, this paper suggests a development of a logic model for FAP by reviewing the already suggested logic model that is more risk focused by including intrapersonal vulnerabilities and assets as well as contextual risks and assets. This paper presents strategies to decrease child maltreatment by identifying the risks, intervening efficiently, and providing adequate primary and secondary services as soon as risks are present compared to once abuse is completed.

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I dedicate this thesis to my husband, Brandon, and my children, Ty'Janae and Xavier.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

A family consists of a blend of individuals with different personalities, roles, and responsibilities. In this blend, stressors are developed, as these individuals try to live their daily lives in harmony. The stressors in every family can be very similar in the context of marriage problems, work issues and child behavior. When a family is a part of the military system, there are more specific stressors on the family. When these stressors are elevated, the risk for child or partner abuse increases. During this time, prevention, intervention, and social support are important.

Child and partner abuse can be defined as family violence for civilian families or family maltreatment for military families. The Texas Family Code, Section 71.004 (2017) defines family violence as an act by a member of a family or household against another member that is intended to result in physical harm, bodily injury, assault, or a threat that reasonably places the member in fear of imminent physical harm. "Family maltreatment is generally conceptualized as the perpetration of non-accidental physical, sexual, or emotional trauma, abuse, or neglect of a partner or child" (Bowen, Jensen, & Williams, 2016, p. 1). The terms family violence and family maltreatment in this report include partner maltreatment and child maltreatment.

When maltreatment occurs in civilian families, the local authorities such as the police department and district courts have the responsibility to ensure allegations are investigated and prosecuted. Additionally, civilian families receive prevention services

and intervention services from the community. The Uniform Code of Military Justice (UCMJ) is federal law, enacted by Congress. The UCMJ defines the military justice system and lists criminal offenses under military law (Uniform Code of Military Justice, 2011). The local military installation command determines when and if a military member has met qualifications under the UCMJ for a general court-martial, for serious offenses, or a nonjudicial punishment, known as an Article 15. Depending on the severity of a UCMJ offense of partner and/or child maltreatment, a military member may receive a military discharge. Military members receive prevention and intervention services through the Family Advocacy Program located on military installations.

> In 1981, the Department of Defense (DoD) issued a policy directive to establish a Family Advocacy Program (FAP), which mandated each service branch to create a program to address the prevention, evaluation, and treatment of family maltreatment in the context of its own requirements and resources. (Bowen et al., 2016, p. 2)

The Family Advocacy Program (FAP) has the responsibility for preventing abuse, providing intervention, and implementing research, program evaluation, and treatment for all individuals impacted by family violence (Arincorayan, Applewhite, & Robichaux, 2010; McCarthy, Rabenhorst, Milner, Travis, & Collins, 2014). According to an article by Jones (2012), she reported 12,043 allegations of family maltreatment, from 708,228 couples in the military, with nearly two percent being substantiated. That's a decrease from fiscal year 2005, where there was just under 16,000 cases of spouse abuse reported to FAP (Savitsky, Illingworth, & DuLaney, 2009). The USAF requires any information of suspicion of family maltreatment be reported to the FAP, and these referrals are

generated from a variety of military and civilian sources (Jones, 2012; McCarthy et al., 2014). The military procedures to address and prevent family maltreatment are complex in nature. When maltreatment occurs, the question of who is responsible and who has authority over the perpetrator, whether it be the military member or their civilian spouse, differs in interventions and consequences. The purpose of this research is to create a best practice model for military practices for family maltreatment, specifically child abuse.

Air Force Instruction (AFI) 40-301 defines and outlines the FAP program. FAP personnel are tasked to provide training and consultation services to active duty members and their families, base leadership, helping agencies and other eligible beneficiaries. FAP seeks a proactive approach to reduce domestic abuse and child maltreatment through multiple educational and awareness programs. Additionally, FAP will also take a reactive role to ensure the safety of victims by providing therapeutic interventions to overcome trauma and training to end the cycle of family violence. There are three components of the FAP program: prevention (prevention/outreach program, New Support Parent Program (NPSP) and Family Advocacy Strength-base Therapy (FAST); maltreatment intervention; and research and program evaluation (Force, 2015). Prevention is the cornerstone of the FAP program, providing primary services on issues of maltreatment as well as secondary prevention services when there are early indications of risk associated with partner violence and child maltreatment. FAP aims to also provide public awareness on maltreatment and support to the community.

Reports of family maltreatment by a military member can derive from both military and civilian sources. After a military member is reported to FAP for a maltreatment allegation, Treatment Managers conduct assessments with the military

member and their family and documents all of the provided information. This documentation is sent to the CRB. Each incident is reviewed by the Central Registry Board (CRB) and the allegations are evaluated to determine whether or not the circumstances met criteria or, in cases of insufficient evidence or where maltreatment has not occurred, the allegations are classified as not met criteria for maltreatment (McCarthy et al., 2014). CRB members include the CRB chair, Judge Advocate, Command Chief Master Sergeant, Security Forces, Office of Special Investigations, Family Advocacy Officer, and the respective Squadron Commanders (Force, 2015). Cases can also be deferred if additional information is needed before it is sent to the CRB. Cases that meet criteria for maltreatment are referred to intervention/treatment services. Cases that do not meet criteria are referred to prevention programs to help ensure maltreatment does not occur in the future or to address stressors that caused the case to come to the attention of FAP to begin with.

CHAPTER II

REVIEW OF THE LITERATURE

The following discussion integrates the findings of articles discussed in this review of the literature on partner and child maltreatment.

Adult

Military families contend with four major sources of stress: frequent relocations, family separation, adapting to danger, and acclimation to the military way of life (Padden & Agazio, 2013). The stressors a military member experiences on the job are distinctly different than a civilian's occupational stress because of uncertainty of military deployment and the potential for personal harm these deployments subject a military member to (Williston, Taft, & VanHaasteren, 2015). The military member's exposure to war and violence creates a new psychological state where aggression becomes a norm and once the member returns home from their deployment, this exposure to war violence is superimposed at the family level (Paley, Lester, & Mogil, 2013; Nandi, et al., 2017; Williston et al., 2015). FAP specifies partner maltreatment can be both physical and emotional.

Partner emotional abuse is defined as the non-accidental act(s) or threat(s) adversely affecting the psychological well-being of the partner and is used to control, degrade, humiliate and punish a spouse through verbal abuse such as yelling, name-calling, blaming, shaming, isolation, intimidation, controlling behavior, and threats of physical violence (Jones, 2012; Rabenhorst et al., 2012). Physical abuse is defined as a

non-accidental use of physical force against a partner that results in any physical injury or the reasonable potential of injury. For the military to label the abuse as severe, the injury either requires inpatient medical treatment, or causes either temporarily or permanently, a disability or disfigurement (Rabenhorst et al., 2012; Stamm, 2009). Although physical abuse is more easily identifiable and often presents an immediate physiological concern, studies show the impact of emotional abuse is more concerning and serves as a precursor to future episodes of physical abuse (Foran, Heyman, & Smith Slep, 2014; Padden & Agazio, 2013).

Deployment

The life of a military member is both physiologically and psychologically challenging, and military members receive extensive and ongoing training in these areas to maintain combat readiness (Williston et al., 2015). Military members can be involved in areas of direct combat and are exposed to the most life-threatening stressors imaginable. This can result in numerous adverse psychological and behavioral issues, such as posttraumatic stress disorder (PTSD), depression, alcoholism, anxiety, intense fear, antisocial behavior, aggression and an increase in chemical dependency (Hogan, Hegarty, Ward, & Dodd, 2012; Padden & Agazio, 2013; Rabenhorst et al., 2012; Savitsky et al., 2009). Even after providing military members with extensive training, the emotional strain of deploying, especially into combat areas, it is exceedingly demanding and often military members find themselves incapable of dealing with the experience of sustaining personal injuries, the act of taking another person's life, or witnessing the injury or death of a comrade. With 44% of military personnel married with children, they

must also deal with the trials and tribulations of a military lifestyle (Padden & Agazio, 2013).

The United States has always had a military, but for nearly 28 years America has been in a persistent and constant state of military conflict in the Middle East. In 2011, the White House reported that in post-deployment, 9% of military members reported symptoms of PTSD, more than 19% reported symptoms of traumatic brain injury (TBI), and more than 27% suffered from depression (Frey, Collins, Pastoor, & Linde, 2014). The physiological and psychological needs of our military members and their families are steadily increasing largely due to an increase of deployments; where military members once remained at home station for 18 - 24 months, they now find themselves redeploying in half that time (Frey et al., 2014; Paley et al., 2013; Rabenhorst et al., 2013) The increased frequency of military deployments disrupts the family structure by challenging each member's adaptive coping strategies and increasing the likelihood of maltreatment. Additionally, deployments also are a contributing factor to an increase in divorce, infidelity and substance abuse (Arincorayan et al., 2010). Deployments are broken down into three phases, with each phase presenting challenges: pre-deployment, deployment, and post-deployment.

The pre-deployment phase begins by military command notifying the military member they will deploy, contingent on the confidentiality of the mission, command may or may not inform the military member where and for how long they will deploy. During this period military members make preparations to ensure their families are legally prepared for their deployment, such as establishing Power of Attorney. Ensuring families are mentally prepared is much more difficult, as the family will not only contend with the

emotional aspects of this loss, but will also contend with the military member's absence in the daily routines: finances, chores, home repairs, childcare, etc. Studies have shown that the pre-deployment stage results in high rates of depression, anxiety and other mental health symptoms for the remaining spouse who can easily become overwhelmed by anticipation (Erbes, Meis, Polusny, & Arbisi, 2012).

The first week of the deployment stage might possibly be the most difficult, as it can take several days or even weeks before the military member can communicate with their spouse and family. Although developing communication is important, it can also be problematic for some families as frequent communication can increase the family's awareness of each other's stressors resulting in feelings of guilt, frustration and further increased anxiety (Paley et al., 2013). The military member's mission limits communication with their family, and as their families depend on the media for insight about deployments, there can be fluctuation in their emotions between hope, despair and even fear for their spouse's death (Link & Palinkas, 2013; Padden & Agazio, 2013). Even the best orchestrated deployment and establishment of routine communications can leave the homestead spouse feeling disoriented. The realization to the spouse they are alone can result in a plethora of conflicting and ricocheting emotions: emptiness, loneliness, abandonment, fear, pride, gratitude, excitement and even anger over unresolved conflicts with the deployed spouse (Cafferky & Shi, 2015; Padden & Agazio, 2013).

The post-deployment phase is when the military member returns to home station and their families. This return can alleviate some of the challenges previously discussed; however, it can bring an assortment of new and potentially more challenging obstacles for the family to contend with. One of the first challenges a family may experience is the

reintegration of the military member back into family life. For six months or longer, the spouse has basically become the 'head of household' assuming all the financial, parental and domestic responsibilities. Although this role is often a great source of stress, many spouses report they acquire a heightened sense of independence, self-reliance, and power. Upon the return of the military member the spouse may, consciously or subconsciously, not want to relinquish these newly established routines, such as being the primary parent, household chores or paying bills, and this can manifest itself into resentment and conflict between spouses (Williamson, 2012). Life as the family knew it before may not be possible. Not only are the roles and responsibilities altered, the spouse and family now may have to contend with the realization that the effects of armed conflict may have potentially, and perhaps irreversibly, altered the military member.

The ravages of war and armed conflict and its impact on the military member can have potentially prolonged physical and mental damage. A military member exposed to combat participates in wartime violence, they can sustain or witnesses combat injury or death, and may develop combat-related PTSD, TBI, depression and/or anxiety. All of these can have a profound impact on the family and increase the likelihood of domestic violence, physical and mental health problems, and divorce (Link & Palinkas, 2013). The family may have to contend with a military member who experiences hypervigilance and may channel combat aggression into their family and community (Nandi, et al., 2017).

Domestic Abuse

To understand the impact of domestic abuse in the U.S. military, one must understand the military member. Military members are often told they are the property of the U.S. military and, although they may be released from their military duties at a

specific time of day, they are considered to meet military standards twenty-four hours a day, seven days a week. Civilians have careers, but for most people who wear a military uniform their enlistment in the U.S. military becomes an identity (Stamm, 2009). This identity creates distinct challenges in any therapeutic intervention. A military member may guard this identity like an average person guards an injured appendage, consequently, a substantiation of domestic abuse could result in a service member becoming dishonorably discharged. A discharge results in a military member being stripped of their career and their identity (Stamm, 2009). As a result, this fear often impedes the effectiveness of treatment, as a military member may be apprehensive and untrusting about utilizing offered prevention and intervention services. Additionally, the thought of a possible military discharge may actually increase the abuser's propensity to use violence because they feel there is nothing more to lose (Jones, 2012).

Male Maltreatment

The vast majority of research focus on females as the only victims of domestic violence; however, that is not always the case. There are few studies that exclusively focus on males as the victims in cases of domestic violence. In fact, there are studies that assert males are not victims of domestic violence, that it is exclusively a woman's issue, and when a woman does aggress towards their male partner, that it is only in an act of self-defense (Dragiewicz & DeKeseredy, 2012). The University Hospital in Lausanne and the University Center of Legal Medicine in Switzerland, established The Violence Medical Unit in 2006 and found that 10% of their physical violence consultations were males that experienced physical abuse at the hands of a female partner (De Puy, Abt, & Romain-Glassey, 2017). The first U.S. domestic abuse helpline for men established in

2000 revealed a male's experience was similar to a female's; however, unlike females, males also felt victimized by a system designed exclusively for females (Hogan et al., 2012). Male military members share this similar stigma as they have challenges in recognizing men can be a victim of domestic violence. This stigma results in reluctances to report maltreatment or seek assistance as it challenges their masculinity or invokes fear of being shamed by their comrades.

Substance Abuse

U.S. military history shows that the consumption of alcohol and participating in alcohol related events were customary and expected. For instance, meeting at the Non-Commissioned Officer (NCO) or Officers' Club after work for drinks was a usual practice, and at times those military members who did not participate in this ritual were viewed as not being team players. This was not only limited to casual, social gatherings but actual formal events and occasions for recognition.

Air Force dining-ins are social gatherings that actually predate the establishment of the USAF and are designed to instill a sense of camaraderie. One highly anticipated event at these functions is the tradition of drinking from the grog bowl, which is an amalgamation of a wide variety of alcohols commonly poured into a massive bowl utilizing military helmets or combat boots. Military members who do not strictly adhere to the grog bowl protocols have to consume more of the grog. With the growing awareness of the negative effects of alcoholism, these functions now have a non-alcoholic version of the grog, which is typically a concoction of foods and drinks that most people simply do not find palatable.

Another military tradition that encourages the consumption of alcohol in the U.S. military is the observance of the challenge coin. The challenge coin is a commemorative token typically presented by a military member of some importance, like a commander, chief or first sergeant to a lower ranking military member in recognition of some type of superior service or action. A military member slamming their challenge coin down upon a table or surface is initiating the coin challenge. All other military members must quickly slam their coins down upon the table or surface in response to the challenge. The last one to do so, or the military member who does not have their coin in their possession, must then buy a round of drinks for everyone. To not participate in either tradition like the grog or the challenge coin would ostracize one's self from their comrades and potentially subject the military member to other, far less desirable, military traditions.

In addition to the lingering influences of consumption of alcohol as a military tradition, some military members utilize alcohol as a means to self-medicate against existing symptoms of PTSD and depression, which can result from family separation (Skipper, Forsten, Kim, Wilk, & Hoge, 2014). Military members suffering from depression typically experience low levels of depression in the early stages of deployment that escalate throughout the deployment cycle. Those members utilizing alcohol as a means to combat their depression typically experience a similar increase in the amount of alcohol they consume (Erbes, Kramer, Arbisi, DeGarmo, & Polysny, 2017). Although alcohol consumption is limited if not prohibited entirely in most deployment locations, members tend to feel a need to "play catch up" upon their return to celebrate. Unfortunately, the end of a deployment, returning to home station, and the unification of a military member with their family does not necessarily alleviate the

problems. In as early as 90 days upon returning home from a deployment, studies have shown that up to 15% of active duty and National Guard/Reserve military members exhibited alcohol-related problems (Skipper et al., 2014). The misuse of alcohol has direct correlations to a military member's inability to utilize good judgement and impairs impulse control; subsequently, instances of domestic abuse are significantly more severe when the consumption of alcohol is a contributing factor (Rabenhorst et al., 2013; Skipper et al., 2014).

Child

Child maltreatment is a significant issue in the U.S. military, with approximately 6,500 incidents confirmed annually (Gibbs, Martin, Clinton-Sherrod, Hardison Walters, & Johnson, 2011). The definition of child maltreatment is defined by the state in which the abuse occurs. The Texas Family Code, Section 261.001 (2017) defines child abuse as:

> (1) "Abuse" includes the following acts or omissions by a person: (A) mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning; (B) causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning; (C) physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm; (D) failure to make a reasonable

> effort to prevent an action by another person that results in physical injury that results in substantial harm to the child.

Further, Military OneSource (2017) explains:

> child abuse and neglect in the military are defined as injury, maltreatment, or neglect to a child that harms or threatens the child's welfare (para. 3).
>
> The FAP will get involved when one of the parties is a military member or, in some cases, a DoD civilian serving at an overseas installation. For the FAP to be involved in reports of child abuse, alleged victims must be under age eighteen or incapable of self-support due to physical or mental incapacity, and in the legal care of a military member or military family member. The FAP will also intervene when a dependent military child is alleged to be the victim of abuse and neglect while in the care of a DoD-sanctioned family child care provider or installation facility such as a Child Development Center, school, or youth program (para 4).

Military children adopt stressors that other civilian children may not have to face. Some of the specific family stressors for military members include isolation from extended families and involuntary relocations. Military members also experience long work hours and lengthy absences from home for temporary assignments and deployments (Gibbs et al., 2011). Additionally, as mentioned above, a military child must learn to adjust from living in a dual-parent household, to then living with only one parent when a parent deploys. Alongside this adjustment, the military spouse and children can develop increased stress and depressive symptoms, which can affect the household dynamic.

Deployment

Deployments cause unwanted negative outcomes for the military member that can transfer to their children which can result in child maltreatment. Taylor et al. (2016) examined soldiers who had one or two total deployments and which of those deployments time periods resulted in child maltreatment. The observed children years of age ranged from birth to 24 months and were assessed according to their soldier parents' or caregivers' deployment time period. The study considered child maltreatment reports from Family Advocacy Program and a medical diagnoses of child maltreatment. Results showed nearly 50% of children had a substantiated maltreatment episode and a medical diagnosis of maltreatment among soldiers who only deployed once. For soldiers who had deployed twice, results showed 50% had a substantiated maltreatment episode, and 40% had a medical diagnosis of maltreatment. The study points out an elevated risk at six months directly after deployments. Among substantiated FAP reports filed during soldier deployment, the perpetrator was listed as the non-soldier caregiver in nearly 90% of all cases. In all other periods of non-deployment, the perpetrator was listed as the soldier about 60% of the time. The study suggests these rates are due to high stress of integration, young age of children, behavioral change in the children, and prevention programs lacking sufficient support and preparation for military families (Taylor et al., 2016).

Mental Health

The household dynamic changes significantly when one parent is absent, especially for long periods of time, which can result in behavior changes in the other parent or children. A child must change schools and friends. A child may miss deadlines

to extra-curricular activities or must completely change choice of activity if the new school does not offer activities. Parenting styles can differ between two parents; however, a child can adapt to both parenting styles. When one parenting style is absent, both the child and parent must adjust. Spouses have reported stress and depression hamper their ability to care for children during deployments and children have been found to have increased rates of depression, anxiety, and behavioral problems (Gibbs et al., 2011). A Gibbs, Martin, Kupper, and Johnson (2007) study shows that there is an increase in child abuse and neglect by four times caused by civilian female caregivers when male military members are deployed compared to non-deployment periods.

A military spouse can become isolated and withdrawn in new environments while the military member is deployed, which will transfer into the household. The military family can feel unsupported and even unwanted in these times, which may cause the military spouse and children to develop depressive symptoms. A Kees, Nerenberg, Bachrach and Sommer (2015) study showed themes of helplessness and feeling unsupported during deployment were significantly correlated with higher rates of depressive symptoms in the pre-group assessment. A Wang, Nyutu, Tran, and Spears (2016) study finds a military spouse's psychological well-being increases when they are capable to master their living environments with the support of their military community. It is imperative the military family receives support and services if needed while the military member is away. Alternatively, if support and services are provided when the military member is not deployed, there will be a stronger foundation of support for the military family to decrease stressors and potential child maltreatment.

Substance Abuse and Domestic Abuse

Unfortunately, a common factor in any type of child maltreatment involves substance abuse for both military members and civilians. Substance abusing parents are two to three times more likely than other parents to maltreat their children (Gibbs et al., 2011). Military members are held to a higher standard of regulations concerning alcohol and drug use compared to civilians. Bray et al. (2003) compared rates of substance abuse among military personnel to those in the civilian population, standardizing national data to the characteristics of the military. They found that military personnel are more likely to report heavy alcohol use during the previous 30 days than civilians but much less likely to have used illicit drugs. The numbers may be lower than civilians due to military members are screened prior to enlistment and during training. Additionally, military members are regularly screened throughout their military term for drug use and are administratively separated due to zero tolerance rule. Gibbs et al. (2008) found during a five-year period that nearly 4,000 child maltreatment offenders were noted to have been abusing alcohol or illicit drugs at the time of their first child maltreatment incident. Nearly 90% of offenders who committed substance abuse largely used alcohol, compared to 6% of offenders using illicit drugs. For the remaining 5% of offenders, both alcohol and illicit drug abuse were noted.

When violence is in the home, there are usually multiple forms of abuse. A child may indirectly or directly receive maltreatment from exposure to their parents experiencing domestic abuse. Children may be directly harmed during a domestic violence incident, or they may be maltreated by a domestic violence victim whose parenting capacity has been diminished as a result of abuse (Gibbs et al., 2011).

Offenders who also committed spouse abuse on the same day as the child maltreatment incident were more likely to have abused substances than those who committed only child maltreatment (Gibbs et al., 2008).

CHAPTER III

METHODOLOGY

Design

This research systematically reviewed and correlated literature to identify child maltreatment in military families and examined the prevention and intervention services offered through the Family Advocacy Program and, in turn, aimed to use that information to create a best practice model that exemplifies best practice interventions for military members and their families. Although there is no mandated best practice model for the United States Air Force's Family Advocacy Program, local Family Advocacy Programs have to ability to evaluate its individual mission. Dyess Air Force Base in Abilene, Texas assesses and evaluates their quality of FAP best practice interventions for military families by ensuring the use of evidence-based practices for prevention and intervention for partner and child maltreatment. It was determined difficult to create a best practice model based on literature, so it is suggested FAP transition to a public health model and develop a logic model to effectively deliver services. Dyess Air Force Base was evaluated by overviewing printed agency literature including Air Force Instruction, policies, procedures, and services, through examining the agency website and through interviews of Air Force Medical Operations Agency, Outreach Program Director and other military support staff.

Procedures

It is of particular interest that although child maltreatment rates in military families continue to be present, the literature showing intervention and prevention services decrease these maltreatment rates is limited. There is an abundance of literature explaining the cause and effect of military family maltreatment but minimal on effective intervention and prevention strategies. Given this unbalanced relationship, the research presented in this thesis has the ability to positively impact military families by suggesting the current medical model transition to a public health model and developing a logic model for the Family Advocacy Program.

Based upon the research collected in the literature review, this researcher has identified broad, but very significant areas of concentration, in regard to identifying risk factors for family maltreatment: deployment, domestic abuse, mental health, male maltreatment, and substance abuse. These broad areas were used to identify the most recent research from the last 18 years pertaining to family maltreatment in the armed forces. Articles and studies were identified using a worldwide library search of EBSCOHost search engine. The databases that were used were Academic Search Complete. Keywords included military, intimate partner maltreatment, child maltreatment, family advocacy program, United States Air Force, family violence, prevention and maltreatment.

There is minimal current literature identifying best practice models for family maltreatment in the United States Air Force. Additionally, there are limited systematic reviews of research on prevention and intervention of family maltreatment in the U.S. Air Force. A Richmond-Crum, Joyner, Fogerty, Ellis, and Saul (2013) article was assessed

and utilized to help provide guidance in how to apply a public health model approach to prevent and decrease child maltreatment. A systematic review by Bowen et al. (2016) was assessed and utilized for this research. The article explains its systematic review procedures "were used to evaluate the 'implicit' logic model that guides the Air Force Family Advocacy Program's secondary prevention efforts of family maltreatment; the results, identified critical success variables that function as family protective factors to decrease the likelihood of family maltreatment" (Bowen et al., 2016, p. 1). Furthermore, an increase is necessary in literature reviewing the measurements issues in monitoring and evaluating FAP prevention programs to prevent inefficiency.

The selected research in this thesis on family maltreatment and review of FAP procedures was reviewed to create suggestions for a best practice model for prevention and intervention of military child maltreatment. This researcher hopes these results will be compared to the current Family Advocacy Program policies, practices, procedures and services. This proposal was exempt in requiring Abilene Christian University Institutional Review Board approval, as no human subjects were used in data collection.

CHAPTER IV

RESULTS

Systematic Review

After researching relevant material, nine articles were included in systematic review. Table 1 identifies describes the nine reviewed articles by author, article title and year, purpose of the study, method, and findings.

Identifying Literature

The identified literature was searched by the following one electronic database: EBSCOhost. The searched journals included the following: Child Maltreatment, Journal of American Medical Association, Contemporary Family Therapy, American Journal of Epidemiology, Child Abuse & Neglect, American Journal of Public Health, and Journal of Mental Health Counseling.

Studies researched met inclusion criteria: (1) empirical, peer-reviewed journal article (quantitative, qualitative, or mixed methods); (2) samples consisting of U.S active-duty military families and (3) analysis focused on predicting some form of child maltreatment or (4) analyzed the military spouse's well-being. Studies chosen ranged from the year 2000 to 2016. This year range was important in order to examine how effects of deployment after the attacks in the United States on September 11, 2001, related to child maltreatment. All military branches were included in the review since all service branches function under a common DoD Family Advocacy Program policy directive for the prevention and treatment of family maltreatment. Additionally, all

military branches share the same stressors for military life and have the availability of similar resources.

Table 1 shows the nine studies included in this systematic review that met inclusion criteria. The number of participants range from 1,858, to 164,239. Six articles used research quantitative, longitudinal data; one article used quantitative, time-series data; one article used quantitative market research, and one article used mixed methods. Two of these articles were pilot studies. Two studies examined all military branches, four examined the Army, and one study examined the Air Force.

Data collection for studies ranged across many military registries, and Department of Defense reports. A single article just used Department of Defense data. Family Advocacy Programs document data into military databases, however, the name of the database differs across military branches. Out of the nine studies, four studies collected data from Army FAP's database, named Army Central Database. One study collected data from the Air Force FAP database, named Family Advocacy System of Records (FASOR). Four studies collected Army deployment data from the Defense Manpower Data Center. One study collected Air Force deployment data from the Clinical Informatics Branch. One study obtained data from the Drug and Alcohol Management Information System. One study collected data from the Army Human Resources Data. One study obtained data from the National Child Abuse and Neglect Data System (NCANDS). One study collected data from the patient administration systems and biostatistics activity.

Out of the nine studies, two focused on examining the rates of child maltreatment during combat-related deployments. Two studies focused on comparing results to

families out in the community. Two studies evaluated just female military spouses' psychological well-being.

Seven articles included male and female as study participants. Out of these five studies, three found male parents to be the main perpetrator of child maltreatment, two articles specified this was during non-deployment. One study specifically examined and found female parents to be the main perpetrator of child maltreatment during deployments. There were similar themes that showed nonmilitary caregivers were the perpetrators during deployments, however, gender was not always specified. Three studies focused on race as a correlate with high child maltreatment rates, these found that both male and female parents were White, non-Hispanic. There was a common theme that White, non-Hispanic resulted in higher percentages of occurrence because the vast majority of the armed forces were of this race. Age was not always specified or examined as a factor in child maltreatment since the age range for all military services start at the age of 18. One study reported on all pay grades/ranks of the active force. Two articles focused on the enlisted rank in the Army. Two studies examined both the enlisted and officer rank, however, only one study found the child maltreatment rates for enlisted parents were higher than parents who were commissioned officers. One study stated child abuse did not vary by pay grade or age. However, there were common themes with enlisted parents and high child maltreatment rates due to young age and a lower education status. Three articles examined marital status as a correlate to child maltreatment rates. One study found married couples had higher rates of child maltreatment than single, conflictingly, one study showed single parents had higher rates

of child maltreatment, and the third study found child maltreatment rates were higher if spouse abuse was identified.

Bray et al. (2002) updated the Department of Defense survey of health behaviors among military personnel, finding that in all military services, military members are more likely to report heavy alcohol use than civilians but less likely to have used illicit drugs. Gibbs et al. (2008) completed the first study to describe substance abuse among Army military child maltreatment offenders, study found that 13% soldiers were abusing alcohol or illicit drugs at the time of the child maltreatment incident. Gibbs et al. (2007) examined Army soldiers' association between combat-related deployment and rates of child maltreatment, results showed the overall rate of child maltreatment by the remaining spouses was higher during deployment times. Kees et al. (2015) conducted a pilot study on the implementation of HomeFront Strong, a group intervention for military spouses, results showed the intervention increased positive cognitions towards deployments. Rabenhorst et al. (2015) examined rates of child maltreatment, as well as severity among Air Force parents who participated in combat deployments, results showed maltreatment rates and the number of incidents were higher post combat deployment with mostly mild incidents. Rentz et al. (2007) examined changes in the occurrence of child maltreatment in military and nonmilitary families and the impact of recent deployment increases, results showed child maltreatment rates increased before and after deployment, especially after September 11 attacks. Rumm et al. (2000) estimated risk of child abuse in relation to a report of spouse abuse, study found Army families were twice as likely to have a substantiated report of physical or sexual child abuse along with an incident case of spouse abuse. Taylor et al. (2016) described the risk

for maltreatment among toddlers of Army soldiers, study found there was an elevated risk after single deployments but not for two deployments. Wang et al. (2016) studied military spouses' psychological well-being, results showed that a perceived sense of military community helps military spouses gain a sense of mastery and control of their environment.

Table 1

Articles Reviewed

Author(s)	Article or Study Title	Purpose of the Study	Method	Findings
Bray et al.	2002 Department of defense survey of health-related behaviors among military personnel (2002).	The survey is the eighth in a series of DoD surveys conducted since 1980 and has three broad aims: (a) to continue the survey of substance use among active-duty military personnel, (b) to assess progress toward selected *Healthy People 2000* objectives for active-duty military personnel, and (c) to provide baseline data regarding progress toward selected *Healthy People 2010* objectives for active-duty military personnel.	Quantitative, Longitudinal Data: Population included all active-duty military personnel except recruits, students, absentees, and who had a duty change in progress. The final sample consisted of 12,756 military personnel who completed self-administered questionnaires anonymously. All pay grades were represented. Data was collected in group sessions at military installations; they were obtained by mail for those not attending the sessions. The overall response rate was 56%.	Updated data from the prior surveys and provides trend analysis. Estimates of health behaviors pertaining to fitness, cardiovascular disease risk reduction, injuries and injury prevention, and sexually transmitted disease risk reduction. Provides assessment of the mental health of military personnel, including stress and depression, and examines oral health and dental check-ups, gambling behaviors, and special gender-specific health issues pertaining to women's and men's health. Found that military personnel are more likely to report heavy alcohol use during the previous 30 days than civilians but less likely to have used illicit drugs.

Gibbs et al.	Child maltreatment and substance abuse among U.S. Army soldiers (2008).	First study to describe substance abuse among child maltreatment offenders in the military and reported the extent of offender substance abuse in substantiated child maltreatment incidents committed by U.S. Army soldiers.	Pilot, Quantitative, Longitudinal Data: Analyzed U.S. Army data on all substantiated incidents of parental child maltreatment committed between 2000 and 2004 by 3,959 active duty soldiers. Compared the characteristics, patterns of maltreatment, prevalence of co-occurring spouse abuse, and service responses for offenders whose child maltreatment incidents involved substance abuse and those without substance abuse involvement.	Study found 13% of offenders were noted to have been abusing alcohol or illicit drugs at the time of their child maltreatment incident. The odds of substance abuse were increased for offenders who committed child neglect or emotional abuse but were reduced for child physical abuse. The odds of offender substance abuse nearly tripled in child maltreatment incidents that also involved co-occurring spouse abuse. Findings include a lack of association between offender substance abuse and child maltreatment recurrence, possibly because of the increased likelihood of removal of offenders from the home when either substance abuse or spouse abuse were documented.
Gibbs et al.	Child maltreatment in enlisted soldiers' families during combat-related deployments (2007).	Examined the association between combat-related deployment and rates of child maltreatment in families of enlisted soldiers in the U.S.	Quantitative, Longitudinal Data: Descriptive case series of substantiated incidents of parental child maltreatment from 1,858 parents in	A total of 1,858 parents in 1,771 different families maltreated their children. The overall rate of child maltreatment was higher during the times when the soldier-parents were deployed compared with the times when they were not deployed

Army who had 1 or more substantiated reports of child maltreatment.	1,771 different families of enlisted U.S. Army soldiers who experienced at least 1 combat deployment between September 2001 and December 2004.	(942 incidents and 713,626 days at risk during deployments vs 2,392 incidents and 2.6 million days at risk during nondeployment). During deployment, the rates of moderate or severe maltreatment also were elevated (638 incidents and 447,647 days at risk during deployments vs 1,421 incidents and 1.6 million days at risk during nondeployment). The rates of child neglect were nearly twice as great during deployment (761 incidents and 470,657 days at risk during deployments vs 1,407 incidents and 1.6 million days at risk during nondeployment); however, the rate of physical abuse was less during deployments (97 incidents and 80,033 days at risk during deployments vs 451 incidents and 318,326 days at risk during nondeployment). Among female civilian spouses, the rate of maltreatment during deployment was more than 3 times greater (783 incidents and 382,480 days at risk during deployments vs 832 incidents and 1.2 million days at risk during nondeployment), the rate of child neglect was almost 4

				times greater (666 incidents and 303,555 days at risk during deployments vs 605 incidents and 967,362 days at risk during nondeployment), and the rate of physical abuse was nearly twice as great (73 incidents and 18,316 days at risk during deployments vs 141 incidents and 61,105 days at risk during nondeployment).
Kees et al.	Changing the personal narrative: A pilot study of a resiliency intervention for military spouses (2015).	Presented early findings from the development and implementation of HomeFront Strong (HFS), an 8-week group-based resiliency intervention designed to support military spouses through deployment transitions.	Pilot, Mixed Methods, Longitudinal Data: In three group cohorts, 20 women participated in the HomeFront Strong intervention group. The group provided evaluation data at the pre-group and three-month follow up assessments, including a semi-structured interview designed to elicit a personal narrative about deployment experiences.	Thematic analyses of the personal narratives demonstrated that negative cognitions (e.g., helplessness; feeling unsupported) about deployment were associated with higher rates of depression prior to group participation. At the three-month follow-up, personal narratives included more positive cognitions and fewer negative cognitions, suggesting that HomeFront Strong changed the way spouses thought about their deployment experiences. Moreover, participants reported fewer symptoms of depression, higher levels of social support, and greater life satisfaction at three-month follow-up.

Rabenhorst et al.	Child maltreatment among U.S. Air Force parents deployed in support of Operation Iraqi Freedom/Operation Enduring Freedom (2015).	Rates of child maltreatment, as well as type and severity of maltreatment, were compared predeployment and postdeployment among Active Duty U.S. Air Force parents who participated in combat deployments.	Quantitative, Longitudinal Data: This study examined child maltreatment perpetration among 99,697 active-duty U.S. Air Force parents who completed a combat deployment. Using the deploying parent as the unit of analysis, it analyzed whether child maltreatment rates increased postdeployment relative to predeployment. These analyses extend previous research that used aggregate data and extend previous work. Data was included for only active duty Air Force personnel who had deployed for at least 31 days during OIF/OEF and who had at least one child under the age of 18 years;	Among the 99,697 active duty USAF parents who had a combat-related deployment in support of OEF/OIF during the study period, there were 183,672,477 total days at risk for child maltreatment, of which 38% were predeployment and 62% were postdeployment. Approximately 2% of deployed parents perpetrated 2,653 substantiated incidents involving 2,943 child maltreatment types. During the predeployment period, 12.4% of the offenders had more than one incident of child maltreatment. During the postdeployment period, 17.3% of the offenders had more than one incident of child maltreatment. Only 2.2% of the offenders had at least one incident during the predeployment period and during the postdeployment periods. Among the 2,943 substantiated maltreatment types, the most frequent type was neglect, followed by emotional abuse, physical abuse, and sexual abuse. More than two thirds of the incidents were mild and 29% were moderate/ severe. Offenders used

			maltreatment incidents included only substantiated incidents of child maltreatment (e.g., neglect, physical abuse, sexual abuse). Child maltreatment rates were calculated as the ratio of maltreatment incidents to the number of days maltreatment could have occurred, and rates were compared between deployment stages, demographic characteristics, and deployment characteristics.	substances (98% alcohol use) in just under 12% of all incidents. Nearly one fifth of all incidents resulted in a child injury. Rates of maltreatment incidents that included offender alcohol use or child injury, particularly moderate or severe injury, were significantly higher post-deployment than pre-deployment. Regardless of deployment stage, maltreatment rates were higher among fathers than mothers, never married or divorced parents than married parents, and enlisted parents than parents who were officers.
Rentz et al.	Effect of deployment on the occurrence of child maltreatment in military and nonmilitary families (2007).	Examined changes in the occurrence of child maltreatment in military and nonmilitary families over time and the impact of recent deployment increases.	Quantitative, Time-series Data: Analyzed Texas child maltreatment data from 2000 to 2003. Study used monthly individual-level child maltreatment data and state-level population estimates to calculate rates of substantiated	Substantiated maltreatment in military families was twice as high in the period after October 2002 (the 1-year anniversary of the September 11th attacks) compared with the period prior to that date. Among military personnel with at least one dependent, the rate of child maltreatment in military families increased by approximately 30% for each 1%

			child maltreatment in military and nonmilitary families. State-level military data on departures to and returns from operational deployments were used to examine the relation between deployment and the occurrence of child maltreatment for each month of the study period.	increase in the percentage of active duty personnel departing to or returning from operation-related deployment. These findings indicate that both departures to and returns from operational deployment impose stresses on military families and likely increase the rate of child maltreatment.
Rumm et al.	Identified spouse abuse as a risk factor for child abuse (2000).	Estimated the subsequent relative risk of child abuse in families with a report of spouse abuse compared with other families.	Quantitative, Longitudinal Data: First cohort study to examine The U.S. Army Family Advocacy Program's Central Database to identify child and spouse abuse in married couples with at least one spouse on active duty in the U.S Army during 1989-1995. The exposure was an episode of identified spouse abuse	A total of 21,643 Army families with children had identified episodes of spouse abuse during the study period and were at risk for subsequent child abuse during an estimated 53,959 family-years. Families with an incident case of spouse abuse identified during the study period were twice as likely to have a substantiated report of child abuse compared with other military families. Young parental age had the highest rate ratio, in the subgroup analysis controlling for rank. Identified spouse abuse was associated with physical abuse

			and the main outcome was a substantiated episode of subsequent child abuse.	of a child, and with sexual abuse of a child. Identified spouse abuse was not associated with child neglect or maltreatment.
Taylor et. al.	Differential child maltreatment risk across deployment periods of U.S. Army soldiers (2016).	Described the risk for maltreatment among toddlers of U.S. Army soldiers over different deployment cycles to develop a systematic response within the U.S. Army to provide families appropriate supports.	Quantitative, Longitudinal Data: Conducted a person-time analysis of substantiated maltreatment reports and medical diagnosis among children younger than 2 years, of 112,325 deployed U.S. Army soldiers between 2001 and 2007. Studied across stages of soldier deployment tempo, characterized by increased frequency and length of deployment in the last decade.	Study found that risk of maltreatment was elevated after deployment for children of soldiers deployed once but not for children of soldiers deployed twice. During the 6 months after deployment, children of soldiers deployed once had 4.43 substantiated maltreatment reports and 4.96 medical diagnoses per 10,000 child-months. The highest maltreatment rate among children of soldiers deployed twice occurred during the second deployment for substantiated maltreatment and before the first deployment for medical diagnoses of maltreatment.
Wang et al.	Finding resilience: The mediation effect of sense of community on the psychological well-	Identified positive factors that increase the psychological well-being of military spouses in the areas of	Quantitative Market Data: Participants were 207 female spouses of active-duty military members. Data was	Results indicated that social support from friends and positive affect did predict a sense of community, which in turn was associated with increased feelings

being of military spouses (2016).	environmental mastery. Proposed that positive affect and social support from family and friends would have indirect effects on psychological well-being through their association with a greater sense of community with the military culture.	collected by a voluntarily online survey. Survey obtained participant's demographics, perspective on their marital relationship, the military spouse's deployment status, and feelings about the level of support received from the military.	of psychological well-being. The findings suggested a perceived sense of military community helps military spouses gain a sense of mastery and control in a constantly changing environment.

Literature Correlation

Table 2 lists the studies in which correlates factors significant in the increase risk of child maltreatment. The table correlates factors under the categories contextual; intrapersonal and safe; stable, and nurturing families. The study findings are listed as either significant or non-significant if the respective correlations are factors that show increase child maltreatment.

Notably, under the category of contextual, five studies linked deployment as contributing factor to child maltreatment (Gibbs et al., 2007; Kees et al., 2015; Rabenhorst et al., 2015; Rentz et al., 2007; Taylor et al., 2016). Under the category intrapersonal, four studies indicated substance abuse as a significant factor in child maltreatment (Bray et al., 2002; Gibbs et al., 2008; Rabenhorst et al., 2015; Taylor et al., 2016). Stress (work or daily) is listed in one study as a contributing factor to child maltreatment (Gibbs et al., 2007). One study showed mental health as a contributing factor (Taylor et al., 2016). Several studies showed when there is a lack in safe, stable and nurturing families it becomes a factor in child maltreatment: marital problems (Taylor et al., 2016), family coping (child behavioral) (Gibbs et al., 2007; Kees et al., 2015; Taylor et al., 2016; Wang et al., 2015), parental stress (Gibbs et al., 2007; Wang et al., 2015), social support (sense of community) (Wang et al., 2015), domestic violence (Gibbs et al., 2008; Rumm et al., 2000; Taylor et al., 2016) and parental affect (Kees et al., 2015; Wang et al., 2015).

Table 2

Correlation of Child Maltreatment Factors

	Child Maltreatment	
Correlate	**Significant**	**Not Significant**
Contextual		
Deployment	Gibbs, 2007 Kees, 2015 Rentz, 2007 Rabenhorst, 2015 Taylor, 2016	
Intrapersonal		
Substance abuse	Bray, 2002 Gibbs, 2008 Rabenhorst, 2015 Taylor, 2016	
Stress (work or daily)	Gibbs, 2007	
Mental Health	Taylor, 2016	
Safe, stable, and nurturing families		
Marital problems	Taylor, 2016	
Family coping (child behaviors)	Gibbs, 2007 Kees, 2015 Taylor, 2016 Wang, 2015	
Parental stress	Gibbs, 2007 Wang, 2015	
Social support (sense of community)	Kees, 2015 Wang, 2015	
Domestic violence	Gibbs, 2008 Rumm, 2000 Taylor, 2016	
Parental affect	Kees, 2015 Wang, 2015	

CHAPTER V

DISCUSSION

The purpose of this thesis was to assess current literature and review the current best practices for prevention and intervention for military child maltreatment in the Family Advocacy Program. The Air Force Instruction (AFI) 40-301 implements Department of Defense Instruction (DODI) 6400.1 by describing the responsibilities of Air Force personnel to implement the Family Advocacy Program. The AFI states:

> The FAP Prevention is the focal point for the FAP outreach and prevention services. The Prevention and Outreach Program is an assets-based support program that provides primary prevention and public awareness on maltreatment and support to the community, and secondary prevention services to clients with indicators of risk associated with partner violence or child maltreatment.

Each Air Force installation FAP provides primary prevention and secondary prevention services, these services are determined by each individual FAP. AFI 40-301 requirements for intervention are as follows:

> All prevention program interventions including consultation and coaching, training, and skill development, will be provided using evidence-informed programs and approaches for supporting protective factors as determined by AF FAP. Family Advocacy Outreach Manager (FAOM) provides a secondary prevention assessment and activity plan for programs and services targeting individual, couple, or group psychosocial skill development. Training,

consultation, coaching, including couple relationship and family management, parenting of age 3 and above, stress and anger management and other proactive problem-solving and strength-based services are also offered.

In summary, "in concert with installation and community agencies, the AF FAP personnel provide a continuum of services designed to build community health and resilience by reducing domestic abuse and child maltreatment and promote family, community, and mission readiness" (Force, 2015, p. 22).

FAP is the office of primary responsibility (OPR) for family violence education and prevention training. FAP is required to provide annual trainings, briefings, education and awareness activities to all levels of military command, frontline supervisors, support agencies, child development center (installation child care), family child care providers, youth center and all incoming new airmen.

As mentioned above, prevention; maltreatment intervention; and research and program evaluation are the three principal components of FAP. It is important to distinguish primary prevention services are mandated for maltreatment cases and secondary prevention services are offered when there are indicators of risk of family violence. However, families with open maltreatment cases will be mandated to participate in treatment and when cases are closed, the families may voluntarily continually utilize secondary prevention services. Also, some of these preventative services require a pre and post test to determine the effectiveness of the evidence-informed programs.

Maltreatment intervention is provided when there is an alleged incident of domestic abuse or child maltreatment by offering comprehensive family assessments, safety and intervention planning and case management. FAP will collaborate and

coordinate with the respective military members command, law enforcement agencies, victim advocates, local child protective services, medical and mental health professionals, community service providers, and other helping agencies to deter recurrence of domestic abuse or child maltreatment. For an alleged child maltreatment case, child protective services (CPS), security forces (SFS) and the office of special investigation (OSI) will always be contacted and a report will be made. However, the FAP does not accept maltreatment referrals on alleged maltreatment of a fetus. When a military member has an open maltreatment class they are mandated to attend FASES class, and any applicable secondary preventative services. FAP does not determine if an allegation becomes a substantiated abuse case nor is it involved in the consequences that follow. Allegations are ultimately determined as substantiated partner or child abuse by the CRB, known as the Incident Determination Committee (IDC) and consists of a multidisciplinary team.

Prevention includes the outreach program, New Parent Support Program (NPSP) and Family Advocacy Strength-based Therapy (FAST). NPSP is a secondary prevention program for families with children from birth to three years of age, including the prenatal period. FAST provides short-term therapy and psychosocial assessments to families at risk for child maltreatment or domestic abuse when the family does not qualify for NPSP and there is not an open maltreatment case. When a military member and/or their dependents request preventative services, their command is not notified. Unless, if during FAST treatment an allegation of abuse is made, the case becomes a maltreatment case and command is notified.

Table 3 shows the primary and secondary prevention and intervention classes offered at FAP. Recently FAP at Dyess AFB changed the classes to occur at different times of the year and frequency of times it is offered. This change had to occur because

of the amount of low attendance that was occurring. Over eighty hours of personnel time was being allocated for these classes to be offered for only about one to three people in attendance. Because these classes are attended on a voluntary basis the frequency had to be shortened. The majority of classes were offered every week out of every month, but now most have changed to a quarterly basis. FAP intends to offer the curriculum of these class one on one in individual or couple counseling with treatment managers if needed. As mentioned before if a case meets the criteria for maltreatment these classes are then mandated for the military member and/or spouse to complete in a timely manner. Therefore, they can still receive the service while meeting with their treatment manager to complete their treatment plans. Offering voluntary classes in the community has shown over the past few years to be of little benefit due to lack of participation. Leadership intervention is key to helping troops and family members better themselves and/or decrease potential for risk of maltreatment. Offering classes in the unity may be a better way of encouraging participation in these early prevention services.

Table 3

FAP Primary and Secondary Services

Name of Service	Original Frequency	Frequency Change
FASES: Enables one to evaluate couple interaction, differentiate healthy from unhealthy relationships, analyze factors influencing behavior, learn anger management, improve communication, and maintain safe and secure families. Replaced with: **SsTAR:** Same definition as FASES however class will utilize motivational interviewing, positive psychology and four step model building on client's strengths.	One four-hour session, monthly	One four-hour session, monthly
Communication Training: Prevention and Relationship Enhancement Program (PREP 8.0) aimed at helping couples reduce risk and raise protective factors; with focus on helping couples develop and maintain safety in terms of emotional and supportive connections.	Four 60-minute sessions, monthly	Four 90-minute sessions, quarterly
Anger Management: Help recognize anger and choose a better way to respond, overcome history or negative behaviors and replacing them with positive-ones.	Four 60-minute sessions, monthly	Four 90-minute sessions, quarterly
Parent Supportive Training: Help moms and dads learn how to be a better parent to teenagers and tweens	Four 60-minute sessions, monthly	Four 90-minute sessions, yearly
Love and Logic: Positive parenting and teaching techniques to build healthy relationships with kids. For school-age children up to 12 years old.	Four 60-minute sessions, monthly	Eight 90-minute sessions, yearly
Magic 1,2,3: Program aims to teach parents how to deal with their children's difficulty behaviors by using an easy-to-learn and signaling system.	Four 60-minute sessions, monthly	Four 90-minute sessions, yearly
Stress Management and Relaxation Skills for changing how you think about situations that cause stress. Relations techniques to help reduce stress on the body and feel more in control.	Four 60-minute sessions, monthly	One two-hour session, monthly
Change Step Group: Interactive program for men to learn skills for safe and healthy relationships. *By referral only	Once a week; 2 hours and 15 minutes	Once a week; 2 hours and 15 minutes

Medical Model vs. Public Health Model

The military offers many medical services, trainings, and briefings based on the risk of deploying. Military members will receive vaccines and medical trainings starting in basic training, though technical training and throughout their whole military career, even if member never deploys. A military member will practice by suiting up in full combat gear to protect from gas attacks at least once a year. Additionally, the military installation will practice lock downs just in case the installation becomes under attack. Many of these exercises are mandated due to being in constant military deployment operation tempo. The United States has been under national threat and in deployment status for many years and has increased after the September 11 attacks. The military has to always stay physically ready to deploy to protect the nation. Military members are held under strict physical standards and will actually be discharged from the military if they do not uphold these standards. The military does a wonderful job by ensuring military members are physically fit and mission ready just on the risk of deploying.

During a military member's career, their mental health is assessed upon first entering the military, annually at medical appointments which can include an in-depth mental health assessment, and before and after deployments. The opportunities for military members' mental health to be evaluated increase the chances of early intervention. However, intervention cannot be provided until a diagnosis is assumed. This process is based on the traditional medical model. The Mosby's Medical Dictionary (2009) defines the medical model:

> as a set of assumptions that view behavioral abnormalities in the same framework as physical disease or abnormalities and it is the traditional approach to the diagnosis and treatment of illness as practiced by physicians in the Western

world. The physician focuses on the defect, or dysfunction, within the patient, using a problem-solving approach. The medical model is thus focused on the physical and biological aspects of specific diseases and conditions.

Contrasted to a public model which aims to provide intervention and prevention once risks are visible by looking at the client in a holistic view. The first step of the public health model is surveillance, which is *defining and monitoring the problem,* which helps in understanding of prevalence and risk, supports effecting planning, implementations, and evaluation of public health programs. The second step is to focus on characteristics that increase or decrease the likelihood someone will be a victim or perpetrator of child maltreatment by *identifying risk and protective factors.* When these factors are identified, they are combined with surveillance data to plan prevention strategies. The third step builds upon the first steps by *developing and testing prevention strategies* by creating programs that promote protective factors and reduce risk factors in individuals and communities. During this step the prevention programs and practices are continually being evaluated to ensure they are meeting the standards of an evidence-based program and effective at achieving positive outcomes. In the last step, the purpose is to distribute and implement the evidence-based programs and practices by *assuring widespread adoption.* In the fourth step, *support for individuals and organizations*, it is critical to ensure they have the proper capacity to implement the model successfully (Richmond-Crum, Joyner, Fogerty, Ellis, & Saul, 2013).

Richmond-Crum et al. (2013) explains that the public health model uses a social-ecological framework to answer the questions, “What, and who, should be the focus of our prevention efforts?” The public health model aims to view the range of conditions that place children at risk for abuse and/or neglect at the community and societal levels,

not just at the individual and family levels. The public model recognizes that there must be a holistic approach by looking at all of the environmental factors that affect human behavior. Figure 1 shows a the social-ecological framework Richmond-Crum et al., (2013) used to show the strategies related to child maltreatment protective factors at each level.

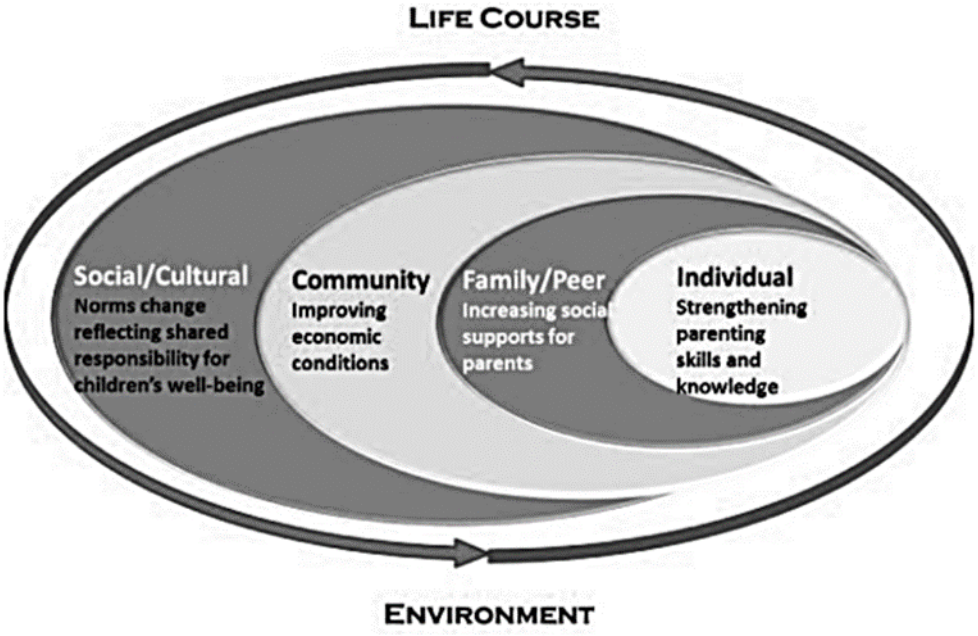

Figure 1. A Social-Ecological Framework (Richmond-Crum et al, 2013).

The Australian Government (2016) explains:

> A public health approach aims to prevent or reduce a particular illness or social problem in a population by identifying risk indicators. It is an approach that aims to prevent problems occurring in the first place, quickly respond to problems if they do occur, and minimize any long-term effects – and prevent reoccurrence. (para.1)

Currently in Australia, the public health model is comprised of three platforms: primary, secondary, and tertiary services to ensure the safety and wellbeing of children. Primary

services aim to change societal and cultural norms, such as common parenting beliefs or practices, legal reforms and policy, and alleviating social inequalities. These services are delivered to the whole community through the delivery platforms families already have access to through schools, early childhood education and health services. The secondary services are offered when risk indicators are already present and there is a higher risk of child maltreatment. These risk factors are similar to the ones listed in Table 2. This is where step 2 of the public model is implemented to ensure evidence-based programs are utilized for prevention and intervention. Finally, the tertiary services are offered where child abuse or neglect has occurred or believe to have occurred. These services will meet the safety needs of the children who have been removed from their home, by reducing the long-term implications of maltreatment and to prevent maltreatment reoccurring. Many of these services will be delivered by child protection services by focusing on prevention. The public health approach is centralized on focusing on prevention, which is detailed by prioritizing services, information and supports through primary prevention (universal) platforms, connected to a comprehensive suite of secondary services to assist families (progressive universalism) (Australia, 2016).

Based on presented articles it is determined to be difficult to present a best practice model for child maltreatment and to aid in the transition from a traditional medical model to a public health model, it is this researcher's recommendation a logic model should be developed for the Family Advocacy Program to better deliver their primary and secondary services.

Logic Model

There is extensive amount of studies that have examined family maltreatment in military branch of services. More specifically, this thesis aimed to find research for best

practice regarding child maltreatment by reviewing the current Air Force logic model. The hope is when military parents receive adequate psychoeducational parenting skills; adequate support from their installation and the military community; and prevention services, child maltreatment will decrease.

AFMOA currently reports that there is no current logic model for USAF FAP. Bowen et al. (2016) created an implicit logic model for the Air Force FAP program by using the current AFI policy and systematically reviewed literature. The purpose of the logic model was to aid in identifying and prioritizing evidence-informed secondary prevention services, more specifically the services target the most vulnerable to family maltreatment.

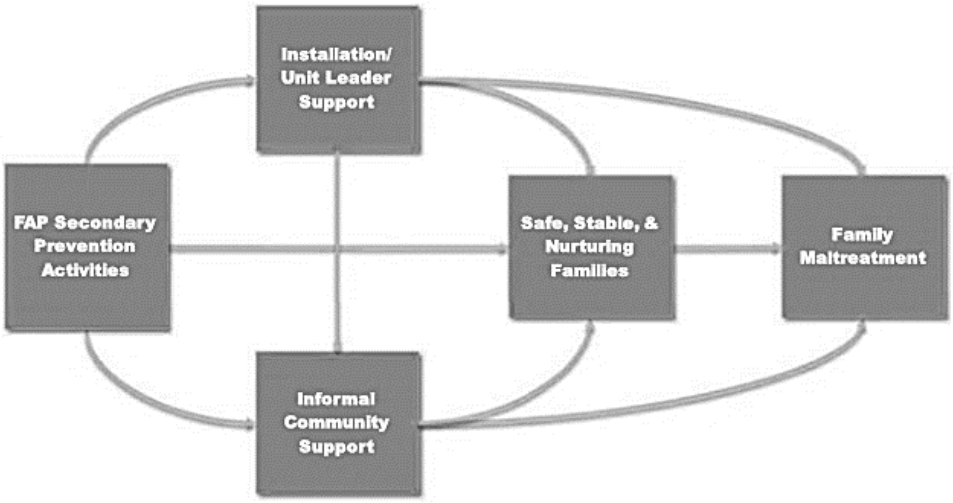

Figure 2. Current Family Advocacy Program logic model for secondary prevention of family maltreatment (Bowen et al., 2016).

Bowen et al. (2016) states this logic model

> proposed two primary targets for prevention activities that decrease the likelihood of family maltreatment in the context of family risk and family vulnerability: (1) family protective factors in the form of safe, stable, and nurturing family processes and (2) ecosystem supports from installation leaders (the installation

> commander and other senior leaders) and unit leaders (commanders, first sergeants, and front-line supervisors at the squadron and flight level) as a component of the formal community, and supports from fellow service members and families as a component of the informal community. (p. 6)

The model represents that FAP secondary prevention services are more asset focused than risk focused. Bowen et al. (2016) argues that this current logic model focuses more on interpersonal variables rather than intrapersonal vulnerabilities.

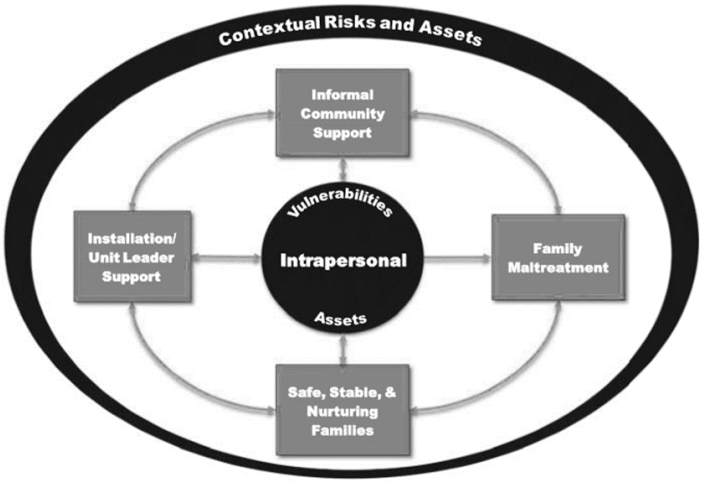

Figure 3. Revised Family Advocacy Program logic model for secondary prevention of family maltreatment (Bowen et al., 2016).

Bowen et al. (2016) states:

> Intrapersonal factors can be conceptualized either (1) as mediators that stand partially or fully between microsystem-level factors (i.e., informal and formal community, family) and the probability of perpetrating family maltreatment, or (2) as moderators that strengthen or attenuate the influence of microsystem-level factors on the probability of perpetrating family maltreatment.

Intrapersonal factors include some of the categories included in Table 2: work or daily life stressors (Gibbs et al., 2007), mental health (Taylor et al., 2016) and substance abuse

(Bray et al., 2002; Gibbs et al., 2008; Rabenhorst et al., 2015; Taylor et al., 2016). Additionally, some factors under the category of safe, stable and nurturing families include intrapersonal variables, such as, family coping (child behaviors) (Gibbs et al., 2007; Kees et al., 2015; Taylor et al., 2016; Wang et al., 2015) and parental affect and wellbeing (Kees et al., 2015; Wang et al., 2015). This revised model also added contextual risks and assets, such as, deployments (Gibbs et al., 2007; Kees et al., 2015; Rentz et al., 2007; Rabenhorst et al., 2015; Taylor et al., 2016). If all the risks and assets are examined in these intrapersonal and contextual variables, applicable secondary prevention services may be developed and offered to prevent child maltreatment.

As mentioned above the military is a tight knit culture and held to different standards than families in the community. Military command is held to higher standard of supervising their troops, than compared to the community, these troops lives literally lie in their commands hands. Military leadership is fundamentally responsible for the military families' health and stability by circulating the appropriate information of prevention efforts the USAF has to offer. Front line supervisors are in the role to recognize indicators of family maltreatment. When strong mentorship relationships are formed between troops and their supervisors, these risks may be recognized quicker and intervention can be applied in a faster manner.

A logic model is based on facts of the program it is evaluating, therefore, it can allow clinicians to provide treatment based on what level the client is currently on within the logic model. With the public health model combined with a working logic model, risks correlating to child maltreatment will be identified earlier and intervention and prevention services can be offered sooner before the risk of child maltreatment increases.

CHAPTER VI

LIMITATIONS

Many studies have provided possible reasons as to why military family violence persists. However, research appears to be outdated as there is not much current literature on military family violence and intervention and prevention suggestions. Among the studies found, it was noted that one factor that could prevent the recurrence of maltreatment is the applied criteria for determination of substantiated partner and child maltreatment is fair and concise in the FAP (Snarr, Malik, Heyman, Smith Slep, & Program, 2011). Additionally, the measurement tools used for assessment in FAP need to be appropriate and efficient to help determine the best practice for prevention and intervention when family maltreatment is present. Devoe and Kantor (2002) evaluate screening tools, assessments and outcome tools used in FAP. The article also provides guidelines for selecting measurement tools and suggests measures of individual and family constructs. Chamberlain, Stander, & Merrill (2003) argue that data collection can be affecting rates of child abuse. The data collected could also be skewed or inaccurate due to deployments, military status (active duty, reservists) and overall each military branch has differences in definitions of terms, data collection and regulations. Additionally, Rabenhorst et al. (2015) state the databases don't always have the information needed to answer many important questions for studies investigating child maltreatment rates. Finally, since policy states the primary and secondary preventative

programs are evidence-informed programs, pre and post tests for every service would prove the reliability and validity of the offered programs.

The public model does contain limitations. There amount of evidence to support the efficacy of the approach is limited. Governments commonly focus time and resources on secondary services instead of the primary services reaching families universally. Additionally, the public health model argues that some primary, secondary, and tertiary services need to be combined for certain complex issues in child maltreatment, but this requires an increase in intensity of meeting those family's needs. Which translates into: resources, training of staff and support needs to increase dramatically for these services to be effective and reliable (Australia, 2016).

CHAPTER VII

CONCLUSION

Despite some limitations, this research can provide beneficial awareness to all Family Advocacy Programs serving military families. The DoD directed the armed services to implement the FAP program to identify and attempt to prevent and intervene for family maltreatment by facilitating evidence-informed programs. The systematic review completed in this research shows that family maltreatment has been recognized and there are common correlating factors that increase child maltreatment. FAP transitioning to a public health model can reduce child maltreatment by identifying and treating the risks on a holistic community approach as they are recognized. Additionally, developing a logic model, specifically focusing on intrapersonal variables, will allow the military community to intervene when the risks are present and provide treatment more effectively. These changes will help the Family Advocacy Program's primary and secondary services keep military families mission ready by decreasing family maltreatment.

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