

CLEARINGHOUSE FOR MILITARY FAMILY READINESS

Family Violence Prevention and Military Families: Rapid Literature Review

Clearinghouse Technical Assistance Team

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Table of Contents

Executive Summary	3
Introduction	3
Scope of the Problem	4
Child Maltreatment Outcomes	5
Intimate Partner Violence Outcomes	5
Family Violence in the Military	5
Risk and Protective Factors for Family Violence	7
CM Risk Factors	7
CM Protective Factors	7
IPV Risk Factors	7
IPV Protective Factors	8
Table 1: CM & IPV Risk Factors	8
Table 2: CM & IPV Protective Factors	9
Evidence-Based, Family Violence Prevention Programs	9
What works in CM prevention?	9
What works in IPV prevention?	9
Child-Level Efforts	10
Parent/Family Level Efforts.....	11
Relationship Education.....	12
Life Skills Education	13
Community-Level Efforts	13
Recommendations	14
Prevention Programming Improvement Recommendations	14
Program Evaluation Recommendations	14
Online Resources	15
Child Maltreatment.....	15
<i>Center for Disease Control (CDC)'s Child Abuse and Neglect Prevention</i>	15
<i>Child Welfare Information Gateway</i>	15
Intimate Partner Violence	15
<i>National Resource Center on Domestic Violence (NRC DV)</i>	15
<i>Center for Disease Control (CDC)'s Intimate Partner Violence</i>	15
<i>Domestic Violence Research Network (DVRN)</i>	15
Conclusion	16
References	17

Executive Summary

This report, conducted in response to a request from the Family Advocacy Program (FAP) of the USMC, addresses research related to family violence prevention, including risk and protective factors. The focus of this research is on family violence in the context of military families. However, because of a lack of strong research data and evidence collected on family violence in military families, the report also includes research informed by family violence prevention efforts in civilian populations.

Currently, family violence remains a complex issue for both civilian and military families and effectively addressing it requires a continuum of evidence-based strategies and services. Family violence is a significant public health problem that can result in immediate consequences including injury and death, long-term individual physical and psychological health problems, and lasting community-level economic repercussions. The construct of family violence is generally categorized into two sub-types: child maltreatment (CM) and intimate partner violence (IPV). CM is a broad term encompassing physical abuse, psychological abuse, sexual abuse, and neglect of children. IPV classifications include physical, psychological, and sexual abuse between spouses or partners.

This report addresses:

- the scope of the problem,
- definitions of IPV and CM,
- risk and protective factors,
- strategies to guide evidence informed prevention efforts,
- recommendations, and
- online resources.

Please note that this rapid review provides a preliminary examination of the research on family violence prevention; however, it is not intended to serve as a comprehensive review of the literature.

Introduction

The Technical Assistance team at the Clearinghouse for Military Readiness at Penn State (Clearinghouse) conducted a brief, rapid review of the literature on the topic of family violence prevention including risk and protective factors. Research examining family violence and military families were identified by searching peer reviewed journal articles limited to publications between 2000 and 2019. Search terms included: *family violence*, *service members*, *risk and protective factors*, *family violence prevention*, and varying combinations of the terms *military families*, *service members*, and *veterans*.

This review has been adapted from a 2018 report addressing family violence prevention created by Clearinghouse research scientists on behalf of Army FAP (Jones, Davenport, White, Crowley, & Perkins, 2018). A complete copy of the ARMY FAP Economic Assessment Report can be accessed here:

https://militaryfamilies.psu.edu/wp-content/uploads/Public_Resources/ACS_pdf/Econ%20Assess%20of%20FAP%20Report_7Jan2019.pdf

For the purposes of this review, *child maltreatment* is defined as “the physical or sexual abuse, emotional abuse, or neglect of a child by a parent, guardian, foster parent, or by a caregiver, whether the caregiver is intrafamilial or extrafamilial, under circumstances indicating the child’s welfare is harmed or threatened” (DoDI 6400.06, 2017, p. E2-33). *Domestic abuse*, also referred to as *intimate partner violence (IPV)*, encompasses:

Domestic violence or a pattern of behavior resulting in emotional/psychological abuse, economic control, and/or interference with personal liberty that is directed toward a person who is:

- A current or former spouse.
- A person with whom the abuser shares a child in common; or
- A current or former intimate partner with whom the abuser shares or has shared a common domicile. (DoDI 6400.06, 2017, p. E2-35)

Scope of the Problem

Services to address family violence are essential wherever there are families. Violence in families may lead to ruined relationships and physical and/or mental health disorders that can affect all family members in substantial ways. The implications from unaddressed cases of CM and IPV can have significant long-term negative impacts for many lives (Fang, Brown, Florence, & Mercy, 2012; Schafer, Caetano, & Clark, 1998). This negative impact on personal and family well-being can translate into lower productivity at school or work (Currie & Widom, 2010). Children exposed to violence and neglect can have developmental problems that last a lifetime, with an increased likelihood for emotional and behavioral disorders, as well as family relationship problems that extend morbidity across generations (Dube et al., 2003; Turner, Finkelhor, & Ormrod, 2006). Therefore, addressing CM and IPV is critical to preventing further violence and reversing long-term negative impacts.

However, effectively addressing family violence is complicated. Often individual cases of CM or IPV are undetected, unseen, and underreported. Few effective interventions exist and those that are effective may be less effective if not delivered in a timely and sustained manner (MacMillian et al., 2009). For higher-risk cases, short-term interventions may have little impact, if any. Nonetheless, given the dire outcomes from

unaddressed issues, family violence must be a prioritized concern for both governments and communities.

Child Maltreatment Outcomes

Children who have experienced maltreatment are more likely to have poorer physical health, poorer emotional and mental health, and social and cognitive deficits (e.g., insecure attachments and low problem-solving skills) (Romano, Babchishin, Marquis, & Fréchette, 2015). The effects of CM can result in adverse effects throughout the lifespan. CM can transcend into adulthood resulting in lower rates of educational attainment, increased problem behaviors (e.g., delinquency, criminality, violent behavior, substance abuse), and overall lower quality of life (Butchart, Kahane, Phinney-Harvey, Mian, & Fürniss, 2006; Gilbert, et al., 2009). In addition, adults who have experienced CM may be more likely to abuse or neglect a child (Crouch, Milner, & Thomsen, 2001; Merrill et al., 2005; Milner et al., 2010).

In the United States, 3.3 million cases of CM are reported to child protective services (CPS) each year (Fang et al., 2012). Of course, the number reported does not include all cases of CM. Research has indicated that the rate of children who have experienced maltreatment is approximately 10% (Finkelhor, Turner, Ormrod, & Hamby, 2009).

Intimate Partner Violence Outcomes

IPV impacts both men and women, and some evidence suggests that men and women perpetrate at comparable rates (Archer, 2000; Capaldi, Knoble, Shortt, & Kim, 2012; Tjaden & Thoennes, 2000). However, women are more likely to experience more severe physical and psychological consequences. Women who have experienced IPV are more likely to have problems related to physical and mental health including, depression, substance use, and suicidality (National Center for Injury Prevention and Control, 2003). IPV is also associated with relationship discord and relationship dissolution (Smith Slep, Foran, Heyman, & Snarr, 2011). Children can also be victims and experience negative outcomes if they are exposed to IPV (Holt, Buckley, & Whelan, 2008; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Unlike child abuse and neglect, there is no federal mechanism to track rates of civilian spouse abuse for comparison to the military population. This, in part, is because each state has different laws and definitions of domestic abuse, which makes any aggregation of these incidents challenging.

Family Violence in the Military

Research on family violence in military families is limited, with CM receiving greater attention in military research than IPV. IPV research in military populations is limited and most studies have not been methodologically rigorous. CM rates in the military appear to be lower than the rates in the general population (McCarroll, Ursano, Fan, &

Newby, 2004; Milner, 2015; Minnesota REACH, 2016; Rentz et al., 2008). However, the rates of confirmed cases in military families appear to be increasing at a slightly quicker pace (Minnesota REACH, 2016). The current research suggests that rates of IPV are higher in the military and cases are more severe than in civilian populations (Rentz et al., 2006; Stamm, 2009; Trevillion et al., 2015). The most common form of IPV is physical abuse. Less common among military families is emotional and sexual abuse (Rentz et al., 2006).

However, comparing rates of CM and IPV between civilian and military families is difficult for several reasons and so the data should be approached with caution. For example, agencies and states have varying definitions of CM and IPV. IPV, in particular, has suffered from a noted lack of consensus over its definition and to whom it applies. Some researchers and organizations define abuse more broadly while others define IPV more strictly (i.e., only acts that may cause physical harm): some definitions of IPV have traditionally excluded unmarried, former partners, and same sex partners.

In addition, both civilian and military agencies have distinct processes for determining substantiation and procedures for reporting. The increase of confirmed cases of CM is likely due to reporting changes in the military and the implementation of standardized protocols for assessing suspected CM rather than true differences in rates. Finally, data on IPV is further complicated by a historic lack of national data collection mechanisms; and research with military populations have been overrepresented by samples with psychopathology (e.g. substance abuse and PTSD) (Jones, 2012; Marshall, Panuzio, & Taft, 2005).

In general, rates of family violence are difficult to determine due to the sensitive nature of the topic, and this results in underreporting of family violence. In particular, the IPV literature has noted a reluctance to report victimization in order to protect the perpetrator (i.e., “a culture of secrecy”). Furthermore, reporting for IPV may not be as robust as CM due to mandated reporting (Smith Slep & Heyman, 2008). The military allows for IPV reporting to be either restricted (i.e., confidential and does not result in investigation or Command notification) or unrestricted, which will lead to an investigation, to balance the need for victims to seek appropriate care in situations where they may be reluctant due to potential consequences (e.g., dismissal from the military, loss of earnings).

In a sample of 205 servicewomen who experienced sexual assault (not necessarily within the context of IPV), only 25% reported the assault and unrestricted reporting was used most often (Mengeling, Booth, Torner, Sadler, 2014). Further, military families may report to civilian providers, but these cases may not be relayed back through military channels (Wood et al., 2017). Moreover, belonging to the military is both a job and an identity. Therefore, reporting could mean the loss of employment and thus, loss of status as a military family which may further impact the accuracy of reported incidences of CM and IPV in the military (Jones, 2012; Stamm, 2009).

Risk and Protective Factors for Family Violence

Risk factors increase the likelihood that favorable outcomes will not be achieved and increase the likelihood of negative outcomes. Protective factors help to minimize the risk of reaching negative outcomes, decrease the likelihood of problem behavior, and increase the likelihood of attaining positive outcomes. Military families share the same general risk and protective factors as civilian families, and they also face unique, military-specific challenges. However, the military provides buffers to alleviate challenges unique to the military lifestyle, meaning that additional protective factors also exist.

CM Risk Factors

Characteristics of individuals and families are linked to CM. For example, poor parenting knowledge, efficacy, parental stress, and unrealistic expectations for child development all contribute to the potential for CM (Lee, 2013; Slack et al., 2011). In addition, parental characteristics (e.g., young maternal age, low socioeconomic status, and mental health) may also be linked to negative outcomes (Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016; Lanier, Maguire-Jack, Walsh, Drake, & Hubel, 2014). In addition, military families may face additional stressors (e.g., relocation, extended separations, and deployment) which when coupled with maladaptive coping behaviors is a risk factor for CM (Porter, 2013; Taylor et al., 2016). Moreover, low social support is a risk factor for CM. Military families may perceive lower levels of social support as they are typically isolated from their families of origin and their traditional support networks (e.g., immediate and extended family) (Davis, Hanson, Zamir, Gewirtz, & DeGarmo, 2015; Hisle-Gorman et al., 2015; Saltzman et al., 2011).

CM Protective Factors

Building parental knowledge, efficacy, and realistic expectations of child development can be protective factors. In addition, improving social support and helping individuals access and use resources (e.g., mental health services) may reduce CM (Douglas & Mohn, 2014; Li, Godinet, & Arnsberger, 2011; Maguire-Jack & Negash, 2016). Military families have built-in economic supports (e.g., at least one employed parent, housing allowance, medical care) and military programs and policies designed to support families [e.g., FAP, child care] (Chamberlain, Standler, & Merrill, 2003; Gibbs et al., 2008; McCarroll, et al., 2004; Milner, 2015; Rentz et al., 2006).

IPV Risk Factors

Individual characteristics (e.g., young age, low socioeconomic status, mental health issues) are risk factors that may contribute to the likelihood of IPV (Capaldi et al., 2012; O'Donnell, Smith, & Madison, 2002; Trevillion et al., 2015). In addition, a number of relationship characteristics can contribute to a risk for IPV including, marital status (i.e., newly married, divorced or separated) and relationship dissatisfaction and discord (Schmaling, Fonseca, Stoeber, & Gutierrez, 2006; Stamm, 2009).

Being a female Service member married to a civilian spouse, a dual military couple, and a lower rank Service member are also risk factors for IPV (Aronson, Perkins, & Olson, 2014; Foran, Smith Slep, & Heyman, 2011). Also, Service members who experienced abuse prior to their time in the service were also more likely to have an IPV incident (Aronson et al., 2014; Taft, Schumm, Marshel, Panuzio, & Holtzworth-Munroe, 2008). Military culture, itself, may be a risk factor as it promotes the use of violence to resolve a conflict (Adelman 2003; Jones, 2012; Trevillion et al., 2015). Assignment to combat and combat-related PTSD and traumatic brain injuries (TBI) may also contribute to IPV (Cesur & Sabia, 2016; Gerlock, 2004; Orcutt, King & King, 2003; McCarroll et al., 2004; Sayers, Farrow, Ross, & Oslin, 2009; Taft, Vogt, Marshall, Panuzio & Niles, 2007; Tinney & Gerlock, 2014).

IPV Protective Factors

Protective factors include social support (Huang, Wang, & Warrener, 2010; Smith et al., 2010), marital status (i.e., married or never married) (Slashinski, Coker, & Davis, 2003; Sorenson & Telles, 1991), and sex-role egalitarianism (Forgey & Badger, 2010). While protective factors related to IPV have not been adequately studied in the context of the military, they are likely similar to CM protective factors which include economic supports (e.g., at least one employed parent, housing allowance, and medical care) and military programs and policies designed to support families (e.g., FAP, relationship education) (Chamberlain et al., 2003; Gibbs et al., 2008; McCarroll, et al., 2004; Milner, 2015; Rentz et al., 2006).

The two tables below list the risk and protective factors associated with CM and IPV. Factors common to both CM and IPV are highlighted in gray. Neither table is intended to serve as a comprehensive list of risk or protective factors.

Table 1
CM & IPV Risk Factors

Risk Factors	CM	IPV
Poor parenting knowledge	X	
Poor parental efficacy	X	
Unrealistic expectations of child development	X	
Young parental age	X	X
Low socioeconomic status	X	X
Mental health issues	X	X
Stressors associated with Military life (e.g., relocation, deployment)	X	X
Low social support (e.g., isolation from traditional support networks)	X	X
Marital status (e.g., newly married, divorced, separated)	X	X
Relationship dissatisfaction		X
Female gender		X
Dual military couple		X
Lower ranking Service member		X
Military culture influence (e.g., use of violence to resolve conflict)		X
Lower leadership support for Service member and spouse		X
Post-Traumatic Stress Disorder		X
Traumatic Brain Injury		X

Table 2
CM & IPV Protective Factors

Protective Factors	CM	IPV
Parental knowledge	X	
Parental efficacy	X	
Realistic expectations of child development	X	
Access to and use of resources (e.g., mental health resources)	X	
Military related economic support (e.g., one parent employed, housing allowance, medical care)	X	X
Military policies and programs designed to support families (e.g., FAP)	X	X
Sex role egalitarianism		X
Marital status (e.g., married or never married)		X
Social support	X	X

Evidence-Based, Family Violence Prevention Programs

What works in CM prevention?

The prevention of CM is linked to addressing risk factors (e.g., poor parenting knowledge and efficacy) and enhancing protective factors (e.g., realistic expectations about child development, access to and use of resources, social support) simultaneously across multiple levels (i.e., individual, family, and community). Primary and secondary prevention efforts to prevent CM in the civilian literature involve efforts at the child-level, parent/couple-level, and the community-level (Butchart et al., 2006).

Efforts typically are targeted toward two different avenues: prevention of becoming a victim and prevention of offending. The following section describes child, parent/couple, and community-level efforts. Child-level efforts include child education, primarily to prevent sexual abuse. Parent/couple-level efforts include home visitation programs, parent education programs, infant head trauma prevention programs, and couple/relationship education programs. There are also a number of promising prevention efforts at the community-level including mass media/social norms campaigns and education for community members, specifically those working with children.

What works in IPV prevention?

Although there are number of promising interventions to address aspects that contribute to IPV (e.g., couple relationship satisfaction, communication), there are no known effective interventions that directly target IPV as an outcome (MacMillan et al., 2009). However, there are strategies that have not yet been evaluated, or have been evaluated, but not yet disseminated.

Much of the prevention of IPV has focused on strengthening couple functioning and satisfaction through relationship education with mixed success. A secondary focus has been on dating education as the seeds of IPV show up in dating relationships as early as middle school (Foshee et al., 1996; Smith Slep & Heyman, 2008). Like CM, primary prevention efforts have the most promise in preventing IPV rather than trying to prevent its reoccurrence. IPV interventions should also focus on developing and delivering low-cost interventions that can be disseminated widely to reach those that need them most (Braithwaite & Fincham, 2014).

The section below represents general family violence prevention strategies that have been used in civilian prevention at the child-level, parent and family-level, and community-level. Please note that FAP's diverse components, installation-specific programs and services, and varying implementation strategies make direct comparisons to civilian programming implausible. A program evaluation or program component analysis would be necessary to understand how FAP programs and services mirror evidence-based civilian programs. Rather, civilian programs that have some evidence of effectiveness as prevention efforts are discussed. Although the mentioned efforts have varying levels of success as strategies, the program summaries offered here are to demonstrate that increased positive outcomes can be reached with effective family violence prevention efforts.

Child-Level Efforts

CM prevention efforts have mainly focused on educating children to prevent victimization, particularly with regards to sexual abuse. These prevention efforts are typically delivered in school-based settings and focus on teaching children definitions of abuse, how to recognize abuse, strategies to avoid abuse, and how to report abuse (Cale, Burton, & LeClerc, 2017). Promising CM prevention programs targeted to children have several key ingredients including activities that allow children to actively engage with the content (e.g., role play, skill practice); use of a variety of teaching methods (e.g., knowledge relay, videos, discussion); wide coverage of important concepts, especially positive skill development (e.g., communication, problem-solving); and content that is incorporated as part of the regular school day (Brassard & Fiorvanti, 2015). Longer programs (i.e., programs with four or more sessions) with trained facilitators (regardless of type - e.g., teacher, mental health professional) also had better outcomes (Davis & Gidycz, 2000; MacIntyre & Carr, 2000).

Parent engagement was also an important component of promising programs to prevent abuse. Parental involvement increased the likelihood of achieving positive program outcomes as it served to reinforce program content and increased parent-child communication regarding abuse (Kenny, Capri, Ryan, & Runyon, 2008). Furthermore, while the evidence is mixed, child age does not necessarily relate to program benefit. Studies demonstrate that content can be delivered at a young age so long as the material is age-appropriate (Brassard & Fiorvanti, 2015; Kenny et al., 2008).

However, the research is not clear to what extent child-focused education programs

prevent child abuse (Brassard & Fiorvanti, 2015; Rheingold et al., 2015). Children participating in school-based prevention programs are more likely to have a substantiated case of child abuse, yet this is most likely because these children are more likely to recognize and report abuse (MacIntyre & Carr, 1999). Child abuse prevention efforts may also be associated with some potentially negative consequences (e.g., increased anxiety and fear, false reports of abuse, harm to the child if they resist) (Cale et al., 2017; Wurtele, 2009). To avoid these potential negatives, child education efforts should focus on empowering children by building protective factors, such as self-confidence and self-esteem rather than try to prevent victimization (Cale et al., 2017).

One example of a promising strategy is the school-based, Safe Child Program. The Safe Child Program is for students in preschool through 3rd grade and is designed to teach children life skills to prevent abuse by people that they know and by strangers. The program is delivered over ten weekly sessions each 20 minutes in length for preschoolers and kindergartens and in five longer sessions for first through third graders. The program aligns with the key ingredients of promising prevention programs. Safe Child focuses on how children can protect themselves through various methods including, role play, scenarios, and skill building both during the school program and at home. The program is easy to implement as the manual is scripted and the facilitator training is included with the materials. Safe Child also has components tailored to various program audiences (e.g., children, parents, teachers) (Brassard & Fiorvanti, 2015).

While the authors did not test outcomes related to abuse from known individuals, results from a randomized controlled trial demonstrated that those who participated in the Safe Child Program were more likely to resist a request from a stranger to leave the school building. In addition, higher pre-test self-esteem scores and higher post-test awareness of risk scores were predictive of students' decreased risk to comply with the stranger's request. These effects were maintained during a six-month follow up and findings were replicated with the control group who later received the program (Fryer et al., 1987a, 1987b). For more information on the Safe Child Program, please see https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_883.

Parent/Family Level Efforts

The core focus of preventing perpetration of CM is through the promotion of positive parenting practices. Parent education programs have been the primary method for improving parent's self-efficacy and competence, thus reducing risk factors for CM. Parent education programs vary widely in their structure and setting (e.g., universal group-based, selective/indicated home visitation). Universal programming may afford the greatest reduction potential and widest reach to prevent family violence as these efforts are community-based and decrease the stigma associated with prevention efforts offered to at-risk families (Altafim & Linhares, 2016; Byrne, Rodrigo, & Maiquez, 2014; Heinrichs, Kliem, & Halhweg, 2014). Parenting programs focus on promoting safe and healthy child-caregiver relationships, teaching effective parenting practices, increasing knowledge of child development, and encouraging positive discipline strategies (Mikton & Butchart, 2009). Although parent education programs reduce risk

factors for CM, these programs may not directly reduce CM (MacMillan et al., 2009). This finding could be an artifact of measurement as parenting programs tend to focus on assessing increases in parental skills and relationships rather than the direct measurement of CM as an outcome (Altafin & Linhares, 2016).

One example of a parenting program with promising outcomes is the Positive Parenting Program, also known as Triple P. Triple P is a comprehensive community-based population-level parenting program aimed at reducing family risk factors for CM and risk factors for child behavioral and emotional problems. Triple P is designed to be delivered across a variety of community settings including schools, child care, family support services, and other community organizations. Triple P has five levels that increase in intensity (i.e., universal, selected, primary care, standard and group, and enhanced) and narrow the segment of the population participating in the intervention.

Triple P has demonstrated reductions in poor parenting behaviors and has sustained its outcomes up to 4-years post-intervention (Heinrichs, et al., 2014). A population-based study in the U.S., by Prinz, Sanders, Shapiro, Whitaker, and Lutzker (2009) found positive outcomes in counties that implemented Triple P on rates of substantiated CM, rates of out-of-home child placements, and rates of hospitalizations and emergency room visits related to CM. Furthermore, they determined that in a community with 100,000 children under eight years old, these outcomes would result in 688 fewer cases of CM, 240 fewer out-of-home placements, and 60 fewer children requiring hospitalization or emergency room visits (Prinz et al., 2009). For more information on Triple P, please see:

https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_1556.

Other means of preventing CM through primary prevention programming have included infant head trauma education for parents. Interventions that target new parents and provide education on shaken baby syndrome and help parents cope with crying have demonstrated success in reducing the incidence of infant head trauma (Barr, Trent, & Cross, 2006; Dias et al., 2005).

Relationship Education

The prevention of IPV has focused on strengthening couple functioning and satisfaction through relationship education. Couple relationship education (CRE) programs have the potential to prevent relationship distress and enhance already positively functioning relationships. Often CRE programs rely on general skill-based methods in communication and conflict management, education around relationship expectations and standards, and relationship awareness. CRE programs have the most robust outcomes for at-risk individuals (Halford et al., 2015; Markman & Ritchie, 2015; Stanley et al., 2014). However, as is often the case with these types of programs, it is often low-risk couples that are more likely to participate in CRE programs.

One example of a relationship education program is the Marriage Check-Up. The goal of Marriage Check-up is to increase relationship satisfaction and improve the couple

relationship. Marriage Check-up is a brief intervention designed for all couples (i.e., non-distressed and at-risk or distressed couples). Marriage Checkup has three components - an IPV questionnaire, an in-person session, and a feedback session conducted by a trained psychologist or doctoral student. The Marriage Check-up program has produced comparable outcomes to traditional therapies in improving couple relationship functioning (Cordova et al., 2014; Doss et al., 2016). These modalities may make therapy more palatable and accessible and act as a referral mechanism to more traditional therapy for distressed couples (Fleming & Cordova, 2012). More information on Marriage Check-up can be accessed at https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_2002.

Life Skills Education

Although not explicitly studied, individual prevention programming efforts to address stress, anger, and other life skills (e.g., communication) may be promising to prevent CM and IPV as they address direct risk and protective factors associated with family maltreatment (Sanders et al., 2004). Typically, individual life skills are often components included in effective preventative programming to support parenting and relationships (MacLeod & Nelson, 2000).

Community-Level Efforts

Only a small number of prevention programs at the community-level have been evaluated. The most prevalent effort in the prevention of CM is child abuse prevention classes for teachers, child care providers, and other professionals. These types of programs allow for increased awareness among adults who work with children in a professional capacity (Rheingold, Zajac, & Patton, 2012; Rodriguez & Richardson, 2007). These individuals may be in a unique position to reduce CM through developing organizational policies that prevent internal possibilities of maltreatment (e.g., employee screening), identification, and intervention in potential cases of CM (Rheingold et al., 2012).

Mass media or social norms campaigns in conjunction with availability of services have demonstrated promise to produce positive changes in negative health outcomes or behaviors (e.g., smoking, drinking) although it has not been studied specifically in the context of family maltreatment (Wakefield, Loken, & Hornik, 2010). This approach can be used to change community attitudes about violence and help scaffold individual's resources to confront or intervene in situations where violence may be present (Berkowitz, 2010). Community-level interventions have the potential to touch more people and reduce individual risk (Smith Slep & Heyman, 2008).

This mirrors findings on community-level efforts on availability of social services, specifically with regards to availability of prevention programming. One study noted that the risk for CM decreased as county spending on prevention programs for CM increased (Maguire-Jack, 2014; Maguire-Jack & Negash 2016). Furthermore, there is evidence that the availability of social services (e.g., health care, housing, adoption, preschools, substance abuse) decreases rates of maltreatment referral rates

(Freisthler, 2013; Klein, 2011; Maguire-Jack, 2014; Maguire-Jack & Negash, 2016; Morton, 2013).

Recommendations

Prevention Programming Improvement Recommendations

- Ensure existing psychoeducation programs and classes in use have demonstrated evidence of effectiveness; replace those without evidence with evidence-based or evidence-informed programs.
 - Focus programs on high-risk families.
 - Target multiple risk factors through prevention strategies rather than focusing on one singular risk factor (Lamela & Figueiredo, 2018)
 - Focus programs to address high-risk times for military families (e.g., relocation, deployment, and family reunification).
 - Expand child care services to encourage families to attend events that provide FAP related education.
- Implement evidence-based, universal parenting programs, such as Triple P. The Clearinghouse has also reviewed additional parenting programs on our Continuum of Evidence found here:
<https://www.continuum.militaryfamilies.psu.edu/>
 - For example, the online version of the Take Root! parenting program is available free of charge on our website.
 - For more information, on Take Root!, please see <https://thrive.psu.edu/#take>
- Implement evidence-based universal programs focusing on relationship well-being (e.g., Marriage Check-Up, Couple Coping Enhancement Training).
- Offer online/web-based or hybrid programming to reach a greater number of families and serve as a gateway for more intensive services.
- Implement additional marketing recruitment efforts.
- Utilize social media for recruitment and ongoing connection.
- Employ a marketing campaign targeting social norms.

Program Evaluation Recommendations

- Conduct a rigorous process and outcome evaluation of FAP and its sub-programs.
 - FAP and each sub-program needs to be assessed for consistency in implementation.
 - If the outcome evaluation of FAP and its sub-programs indicates positive impacts, assess data for a cost-benefit analysis.
 - If the outcome evaluation of FAP or its sub-programs indicates no impacts

or negative impact, refine or decommission programs.

- Conduct a comprehensive review of administrative data of service utilization to identify patterns and resource requirements for different FAP services.
- Review the current client tracking system (i.e., program usage data)
 - Determine the system's comprehensiveness and utility in tracking process and outcome data related to FAP and its sub-programs.
 - Implement enhancements to allow for better cost tracking and capture linkage among FAP and its sub-programs.

Online Resources

Child Maltreatment

Center for Disease Control (CDC)'s Child Abuse and Neglect Prevention

- Offers risk and protective factors, prevention strategies, statistics on child abuse, and a report on evidence informed recommendations for prevention programming strategies
- <https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html>

Child Welfare Information Gateway

- Provides resources on child abuse prevention, protecting children from risk of abuse, and strengthening families. Includes information on supporting families, protective factors, public awareness, community activities, positive parenting, prevention programs, and more.
- <https://www.childwelfare.gov/topics/preventing/evidence/>

Intimate Partner Violence

National Resource Center on Domestic Violence (NRC DV)

- Provides a wide range of free, comprehensive, and individualized technical assistance, training, and specialized resource materials and key initiatives designed to enhance current domestic violence intervention and prevention strategies.
- <https://nrcdv.org/>

Center for Disease Control (CDC)'s Intimate Partner Violence

- Offers a variety of resources and strategies aimed at preventing IPV across the lifespan. Risk and protective factors as well as evidence informed recommendations are provided.
- <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html>

Domestic Violence Research Network (DVRN)

- Funded by the U.S. Department of Health and Human Services, provides links to two national resource centers, four special issue resource centers, three culturally-specific resource centers, the National Domestic Violence Hotline, and the National LGBTQ DV Capacity Building Learning Center.
- <https://www.acf.hhs.gov/fysb/programs/family-violence-prevention-services/programs/centers>

Conclusion

Family violence prevention remains a complex problem for both civilian and Military families. While new research studies have continued to increase knowledge of best practices to combat family violence, further study and research is needed in this area, particularly in addressing the unique needs and stressors faced by Military families. Utilizing promising programs and strategies informed by evidence as well as considering how to conduct evaluations of current programming already in place is recommended as an initial step towards moving towards a more effective family violence prevention effort.

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