Letter from the Chair

In the midst of our busy lives, it is often easy to lose sight of the many freedoms and liberties that we as Americans enjoy every day. While we don’t live in a perfect society, in comparison to many other countries throughout the world, we have privileges that include freedom of speech and religion, and overall independence. Current events remind us that we enjoy these freedoms because many of our men and women make a choice to serve our country abroad. These soldiers leave their families, children, and personal lives to ensure that these freedoms endure. But at what personal cost do these brave men and women fight? As the number of returning veterans continues to increase, we become aware of the many mental health as well as medical- and family-related challenges they face. Returning to family life, learning to readjust to civilian life, living with a medical condition or disability caused by war, or post-traumatic stress experiences are just a few of the challenges veterans and their families encounter.

Family systems theory asserts that when there is a change in one part of the family system, it affects all members of that system. This is the case for military families who have to cope with not only the problems the individual veteran faces but also with the effects of a military lifestyle on other family members. For example, the deployment of a veteran parent will affect the children and the spouse or partner left at home. A parent left behind may experience the additional stressors of financially contributing to the family system while also acting as the primary parent, often without much support from extended family members. Younger and older children who are separated from the parent may exhibit a wide range of reactions to this absence. The military parent, the remaining spouse or partner, and the children must make adjustments as everyone learns how to live with a fluctuating family landscape resulting from multiple deployments. Or in other cases, the family needs to reintegrate to the previous family configuration, which includes the returning veteran parent. That landscape often includes the emotional and health-related effects of war on the veteran and requires that the family system find a new equilibrium, but until the family can do that, they may be at risk for additional problems, such as child maltreatment.

In this issue we draw attention and give recognition to the many challenges faced by military families with children. Though our primary focus is on the veteran population, Emily Putnam-Hornstein in her article “Child Fatalities: An Overview of Recent Epidemiological Data from California” presents a valuable overview of child abuse and child fatalities. More important, she points out how the absence of an epidemiological perspective limits decision making in child protection, and such decisions could prevent not only future child maltreatment but also child fatalities. She goes on to explain how linking data collected at birth to child protection records and death records provides valuable information to the California child protection system, which can then engage in early identification of at-risk children. In his article “Children of Returning Warrior Parents: Child Abuse and Neglect Challenges of the Military and Veteran Family Systems,” Michael Bermes describes how wars influence the children of military families. He notes the
When a child dies following an allegation of maltreatment to Child Protective Services (CPS), public outcries are quick and severe: the system tasked with responding to child abuse and neglect was informed a child was at risk and yet failed to intervene in a manner that kept him or her safe. In an effort to learn from these and other tragic cases, Child Death Review Teams (CDRTs) across the United States compile data to identify child death patterns and clusters, examine possibly flawed decisions made by CPS and other systems, and summarize the characteristics of fatally injured children in order to take actionable steps toward improving child safety and reducing child deaths (Douglas & Cunningham, 2008).

Currently, 49 states and the District of Columbia report teams in place to review child maltreatment fatalities; several states have now moved to investigate all causes of child death (National Center for Child Death Review, 2011). Yet—absent a broader context—such scrutiny of individual decisions made in isolated fatality cases offers limited practice and policy insights. In the case of deaths following CPS contact, looking only at those children who have already died fails to inform our understanding of how the experiences and characteristics of deceased children fit within the broader population of those who were similarly reported to CPS—but did not die. Nor does it allow for these deceased children to be understood within the population of demographically similar children who died despite having never been reported to CPS. The absence of an epidemiological perspective profoundly limits our ability to make informed modifications to CPS practices or policies. The newly linked data sources from the state of California advance our knowledge of risk factors for both non-fatal and fatal child maltreatment.
To date, the birth records of more than 4.3 million children born in California have been linked to hundreds of thousands of CPS records and death records. This unique data source—supported through funding from the California Department of Social Services, the Stuart Foundation, and Casey Family Programs—provides an understanding of maltreated children within the full population of children born in California, and several key findings have already emerged.

**EARLY IDENTIFICATION**

First, these linked records demonstrate that data universally collected at birth can be used to identify those children at greatest risk of maltreatment. We have long known that children reported for maltreatment had a distinctive profile, but by considering children reported to CPS within the context of all children born in California, it becomes clear we do not have to wait for reports of maltreatment to intervene. It is possible to identify more than 50 percent of children who will be reported to CPS before the age of five from a relatively small subset of all births (15 percent) based on the presence of multiple risk factors associated with child abuse and neglect. While tertiary services provided through the current CPS system are critical—and will always be a necessary component of our effort to address child maltreatment—these reactive services have proven wholly inadequate in isolation. Data suggest that there is no reason we cannot move strategically upstream in our prevention efforts, creating services and supports that are tailored and targeted to those families at greatest risk of child maltreatment. And we can provide these services during the peak period of a child’s developmental and physical vulnerability, when child maltreatment fatalities are highest.

**IT’S MORE THAN JUST POVERTY**

Second, these population-based data indicate that a child’s report to CPS for maltreatment is not random, nor is it simply a result of poverty. After adjusting for other risk factors, children reported for maltreatment sustained inflicted fatal injuries at 5.9 times the rate of children who had not been reported. A prior allegation of maltreatment was the single strongest predictor of an intentional injury death—much stronger than poverty, maternal age, child health, or other risk factors. The National Incidence Studies (Sedlak et al., 2010) and other sources of surveillance data (Theodore et al., 2005) suggest that the CPS system misses a large share of maltreated children. Yet, the heightened rates of intentional injury deaths leave little doubt that those children who are known to CPS do, in fact, face threats that run far deeper than poverty or sociodemographic factors alone would indicate. In public health research, death is frequently employed as a marker of population-level differences in health and well-being. These data demonstrate that a report of maltreatment to CPS is more than just a marker of poverty: it is an important signal of child risk.

**RISK OF “ACCIDENTAL DEATHS”**

Third, these data indicate that a narrow focus on intentional or maltreatment-related deaths fails to consider the fact that children reported for maltreatment also face and the available services. Their article concludes with a list of valuable recommendations for practitioners working with the veteran population.

Our issue concludes with the article “Child Maltreatment in Military-connected Families: Risk and Protective Factors” by Eugenia Weiss and Tara DeBraber. Using existing literature, they present an overview of the risk and protective factors of military families. The authors highlight the importance of support services for military families, including those families in the Reserve or National Guard. The article provides valuable information on how social work practitioners can help to strengthen military family systems. It concludes with a list of military resources that practitioners can access to learn more about the challenges military families face and the available services.

There is no question that children and their military families will require a wide array of support services. These services, often provided by social work practitioners, are essential in helping families cope with the many challenges identified in this newsletter. Prevention and intervention services are necessary to help families address the stressors of military life that may place children at risk for maltreatment. It is our responsibility to acknowledge the strengths and challenges inherent in military families and to find ways to help eliminate the stressors that may lead to such problems as child maltreatment. We must all begin this process by appreciating these challenges, acknowledging the sacrifices that military parents and families make, and increasing our own awareness on how to best serve this population. Join me in thanking our military families for their sacrifices, and let’s remind them that, as social workers, we are now here to serve them.

Please consider submitting an article to our newsletter, and do not hesitate to contact us for any information about or assistance with submissions. As always, I look forward to hearing from you.

Ana M. Leon, PhD, LCSW, ACSW Chair, Child Welfare Specialty Practice Section
die from unintentional injuries at twice the rate of their sociodemographically similar peers who have not been reported to CPS. The purpose of identifying high-risk subsets of children vulnerable to negative outcomes (such as death) is that it enables our ability to provide targeted services in order to decrease the incidence of the outcome’s occurrence. Linked data from California indicate that children known to CPS are at much greater risk of not only intentional/maltreatment-related injury death, but also unintentional injury death, suggesting that child protection campaigns should focus on the prevention and surveillance of both unintentional and maltreatment deaths and that partnerships with public health agencies may prove fruitful.

CONCLUDING THOUGHTS

It is important to note that among the more than half a million children reported for maltreatment and examined in the data that have been linked to date, less than one percent sustained a fatal injury. While children reported for maltreatment face a much greater preventable fatality risk than children who have not been reported, death is, thankfully, still a relatively rare event. Given the infrequency of fatal injuries, it is unlikely we will ever be able to predict, with any reasonable degree of accuracy, which children among those reported to CPS will later die. There is a degree of randomness to nonfatal versus fatal injuries. A neglected infant may drown in the bathtub on the first unsupervised exposure, or not until the fifth. A physically abused toddler may receive the fatal blow the third time they are struck, or not until the tenth or twentieth time. But being reported to CPS is not random, and CPS contact is tied to fatality risk. This means that targeted efforts that successfully reduce the incidence and prevalence of child maltreatment may also have the positive benefit of reducing deaths. As it stands, an unknown number of child fatalities are prevented through service interventions offered by child welfare workers every year. But the system can be even more deliberate in its efforts, relying on epidemiological data to ensure those children who are most at risk are protected from harm.

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It has been more than a decade—military operations in Iraq have finally ceased, and there appears to be an end in sight in terms of operational forces in Afghanistan. More than two million military members have been deployed to these conflicts. There is in excess of two million children with one or both parents employed by the military (Lester et al., 2011). Nearly one million of these children have had a parent deployed to a warzone, and more than 250,000 have had both parents simultaneously serving in these hostile areas (Park, 2011). Deployment of a parent or parents to a warzone—commonly called a “catastrophic” stressor for military families—greatly enhances the risks for a range of psychosocial problems for military children; a parent’s post-traumatic stress disorder (PTSD) symptoms could manifest as child abuse and neglect.

PTSD
PTSD remains one of the most common disorders found among our returning veterans (Tanielian & Jaycox, 2008). Several problems can occur in military children when their reintegrating parent or parents have PTSD. These parents may (a) discuss frightening traumatic experiences in the presence of the child; (b) avoid other people, places, and events, resulting in isolating and ignoring the child; or (c) become distant, irritable, or extremely overprotective. One of the major responses of the children to these PTSD symptoms is a confused feeling that the parent no longer loves them or is interested in their welfare. As a result, the child’s behaviors may drastically change to adapt to the dysfunctional behaviors of the parent in order to cope with the alarming changes within the family system. Some of those behaviors can be (a) behaving like the parent in an effort to gain their attention and love; (b) assuming the role of the absent parent in an effort to fill the void within the family; and (c) developing relational problems in school that may transcend these worries and fears into later life (Price, 2009). While PTSD is the predominant problem, other comorbid challenges of returning parents include depression, substance abuse, and aggressive behaviors, all of which predict maladaptive changes in the family and ultimately influence child welfare-related matters (Gewirtz et al., 2011).

CHILD ABUSE AND NEGLECT
There is little research that focuses on the long-term effects of deployments on child maltreatment, especially in the context of the Iraq and Afghanistan conflicts. The bulk of the literature focuses on child neglect and abuse during the critical stressor periods in which the military member is absent because of combat duties. For example, one American Medical Association (AMA) study suggested that during these critical periods, child neglect was two to four times greater and abuse was three times greater among non-deployed military mothers (Gibbs, Martin, Kupper, & Johnson, 2007).

Although military child abuse rates are similar to civilian rates, fatal child maltreatment has been found in greater numbers within the former population. With high military and veteran rates of alcohol abuse, child maltreatment rates are generally two to three times higher than non-substance-abusing parents. However, military families in general are at risk of higher rates of child neglect and abuse simply based on the predictors generated by military life, especially during periods of deployment. Child maltreatment increases by 42 percent during these times (Gibbs et al., 2007).

While there is a lack of substantial information regarding military child abuse, it seems relevant to discuss that the literature does indicate that adult perpetrators of child...
abuse within the military have much greater rates of personal childhood trauma in addition to PTSD. These abusers have prevalence rates seven times higher than those with PTSD within the general population. While this does not reflect direct causality, it certainly is a consideration in viewing the family system within a treatment environment (Jenness, 2010).

Although military children are generally considered more resilient, resourceful, flexible, and responsible—and they can adapt to greater levels of family crisis and challenges than can their civilian counterparts—current wartime involvement has not come without cost to many of these military children. Since 2003, both inpatient and outpatient mental health services have doubled for America’s military children (Park, 2011). Research is beginning to document the long-term child welfare and trauma effects of multiple and lengthy deployments. Such effects manifest themselves as significant health problems, reduced academic performance, increased behavioral issues, greater rates of depression and anxiety disorders, and other increased stress-related problems. Military children exhibit significantly increased biological and developmental difficulties and 2.5 times greater psychosocial challenges at the various stages of mental, social, and emotional growth as compared to their civilian counterparts (Park, 2011). These issues occur because of neurobiological changes in the form of disorders to the nervous, musculoskeletal, circulatory, and digestive systems. In addition, eating and sleeping problems, onset of type-1 diabetes mellitus, and a myriad of behavioral problems can present themselves to parents, teachers, and others within the family’s ecosystem (Mowery, 2011).

The non-deployed parent risk for psychosocial problems is seven times greater than that of the general population in the form of depression, anxiety, and detachment. These are a consequence of the extended duration and number of deployments occurring within the contemporary military system. Although military children are adept at shorter family separations, these current types of longer and more frequent deployments have greatly stressed the military family system (Flake, Davis, Johnson, & Middleton, 2009). These stresses upon the military family are of immense concern as they relate to the treatment and care of military children (Lincoln & Sweeten, 2011). These challenges are multiplied by the community’s lack of training and education to provide culturally competent services and treatment to this unique population (Flake et al., 2009).

**WAR’S EFFECT ON PARENTING**

These multiple and demanding deployments come with increased risks of parental PTSD, intergenerational trauma, traumatic brain injuries (TBI), poly-traumatic injuries involving various biological systems, substance use disorders (SUD), marital problems, and increased rates of domestic violence. Quantitative studies have shown that child behavioral and attachment problems increase as the number and duration of deployments increase (Barker & Berry, 2009). These complex problems are not just happening upon the return of the deployed veteran; current literature suggests that rates of child maltreatment and neglect have increased on the part of the non-deployed parent as well (McFarlane, 2009). Deployments and related problems are complex and should be viewed as a cyclical process. Five phases comprise the continuum that military families typically navigate from pre-through post-deployment (Brelsford & Friedman, 2011). Each segment poses a unique and distinct set of problems for both the individual military member and the children. Consequently, problems are not static or predictable, and must be viewed individually within each family. This places additional burdens on not only the family system but also the health care providers to ensure clarity and appropriateness for each intervention applied to these families (Lincoln & Sweeten, 2011).

**PRACTICE IMPLICATIONS AND RECOMMENDATIONS**

Although there are similarities in clinically intervening with military and civilian families who have children, the differences outweigh them. Considering that approximately 50 percent of military children receive their health and behavioral care within the civilian communities, it is essential to understand the uniqueness of the military culture, family subculture, and the biopsychosocial functioning and adaptation skills of this population (Davis, Blaschke, & Stafford, 2012). Social work as a profession emphasizes cultural differences and diversity within its course work. But even though sensitivity to military families is increasing, much of the existing academic work does not cover the broad spectrum of diversities to include these families. Many civilian clinicians and providers are diligently attempting to meet the large volume of need created by these decade-long wars, but they are doing so without clarity and focus on the vast cultural differences within the military community. The following list of practice recommendations is not exhaustive, but it does provide the basics necessary to practice more effectively with military families in the clinical community setting (Gewirtz et al., 2011).

- Implement a military trauma-related genogram as a solutions-focused assessment tool. Use this tool to build a therapeutic relationship while providing the military family a pictorial roadmap to identify their familial patterns and attributes, and to bring clarity to both individual and family developmental and growth patterns within the unique military family context (Weiss et al., 2010).
- Consider the Parent Management Training-Oregon Model (PMTO) for improving parenting skills, child adjustment, and family functioning (Gewirtz et al., 2011).
- Integrate the After Deployment Adaptive Parenting Tools Program (ADAPT) that can provide an array of psycho-educational and emotional regulation techniques (Gewirtz et al., 2011).
- Build upon family resilience from a strengths perspective rather than what is perceived as broken within the family. This can be addressed through using the military family’s strong self-sufficiency values that focus on goals, rather than problems, and that can be linked to desired parenting outcomes, which ultimately foster positive
CONCLUSION

To help our reintegrating military families during these tumultuous times, it is essential that community service providers understand the unique culture of military families and how PTSD affects this vulnerable system. Clinicians must develop skills and knowledge to assist with the unique needs of military families. Understanding the unique needs of these families will provide appropriate and effective interventions by reducing barriers to treatment for these military children and families (Gamst, Der-Karabetian, & Dana, 2008). Local counselors, agencies, child welfare workers, schools of social work, local veteran’s affairs chapters, veteran groups, and government military family advocacy programs must unite to find common ground and the most efficacious interventions specific to this military family system. Social workers must be proactive and lead in this endeavor to bring success in these critical collaborations and partnerships by linking military families to evidenced-based practices within our communities.

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REFERENCES


CHILD MALTREATMENT in Military-connected Families: Risk and Protective Factors

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There are approximately 1.2 million children of military service members (Budzik, 2008). Although military families have such protective factors as at least one salaried person, free medical care, and community networks to reduce the risk of child maltreatment, the stress and challenges of the military lifestyle can also increase the risk (Palmer, 2008). For example, the active duty service member may experience stress as a result of combat exposure. A new parent may be isolated (if his/her spouse or partner is deployed) and battle symptoms of postpartum depression, which can create an environment of poor coping (Budzik, 2008). Research shows that the risk of child maltreatment increases during deployments (i.e., during separations and reunions) by 42 percent and can result in child “negative health behaviors, depression, and chronic health conditions, with negative sequelae extending into adulthood” (Gibbs et al., 2007, p. 528).

There are several identified risks for military families, including multiple and lengthy deployments, limited communication, isolation, geographic distance from family or other support systems, fear for the safety of the deployed service member, and other strains and cumulative stressors unique to the military lifestyle (Thieman, 2011). An Army study found that certain demographics—such as young parents and individuals on the lower socioeconomic strata—can also increase the risks for child maltreatment (Campbell et al., 2011). Compromised parenting, as seen in the use of “inconsistent discipline, lack of adequate supervision, and excessive corporal punishment” (Campbell et al., 2011, p. 132).

The military offers programs and resources to help families learn positive coping skills, such as stress management, and cognitive techniques to manage behaviors and reactions. Parents are also taught the importance of rewarding positive behaviors in their children and using logical consequences for misbehavior instead of corporal punishment (Campbell et al., 2011).

Each branch of the military affords family support services that assist service members and their families in preparing for the cycles of deployment (Rentz et al., 2007). One specific family program, the Family Advocacy Program (FAP), provides information and education to prevent, identify, and intervene in cases of family violence. In many instances, county-operated social service agencies/child welfare agencies will have a memorandum of understanding (MOU) with FAP on military installations to facilitate communication and coordination of child welfare services for those military families that are identified or served by child protective agencies. If these county–military agreements are not in place, then social workers should advocate for MOUs to be created in their regions. FAP also boasts an array of services (depending on branch of service), including educational classes, individual counseling, case management, and chaplain services (Campbell et al., 2011). As a whole, the military community is making a concerted effort to make families aware of the services that are available to them and to reduce the stigma in accessing these services.

Military families that are part of the Reserve or National Guard may be especially vulnerable, as they are not always living near a military base and therefore do not have ready access to military support services. Often these families obtain services from community agencies and civilian mental health professionals with little or no experience with military culture. It is important for civilian providers to inquire about the family’s support system, and they should be familiar with the resources that are available for these families (Budzik, 2008). Civilian practitioners can also seek out continuing education in military culture or topics relating to military families in order to competently serve this population.
Social workers who serve military families can build upon the family’s inherent protective factors that are often associated with military lifestyle, such as enhanced self-esteem, pride and mastery, and a sense of duty and honor. With some support, these families will be better equipped to handle the challenges that arise in military life in terms of shifting roles during phases of deployment, reintegration into the community, facing the demands associated with caregiving, and dealing with grief and loss. Social work practitioners also can assist these families in further developing their informal and formal support networks (Bowen et al., 2003), improving communication, and providing them with knowledge of child development and appropriate expectations for child behaviors (Thiemann, 2011). Social workers who build family resilience, enhance social supports, and strengthen coping among caregivers help to reduce the incidents of family violence and child maltreatment in military connected families. In summary, the family environment may serve as either a protective or a risk factor, and, thus, prevention and intervention services need to be addressed from a systemic and family psychosocial perspective.

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Tara DeBraber, M.Ed., MSW, is a Marine Corps spouse and financial caseworker with the Navy Marine Corps Relief Society. A graduate of the University of Southern California, School of Social Work, she specializes in mental health with a subconcentration in military social work.

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MILITARY RESOURCES
Families OverComing Under Stress (FOCUS)
Navy/Marine Corps program (collaborative with the University of California, Los Angeles) designed to build resiliency in military families and children facing combat deployments. It works to strengthen families through available resources, child developmental screenings and support groups. www.focusproject.org/home

New Parent Support Program (NPSP)
NPSP works with families who have been identified as needing extra support. The families have factors known to increase the risk of child abuse and neglect. NPSP provides home visitation services, playgroups, parenting classes, and education. During home visitations, gaps are identified to provide support to strengthen protective factors and minimize risk factors. www.militaryhomefront.dod.mil/pls/psgprod/?P=MHF:HOME1:0:0:SID:20.40.500.420.0.0.0.0

NASW RESOURCES
Standards for Social Work with Service Members, Veterans, and Their Families

Social Work and Service Members: Joining Forces to Support Veterans and Military Families
www.socialworkers.org/military.asp

National Child Traumatic Stress Network (NCTSN)

Family Advocacy Program (FAP)
Located at every military installation, FAP serves as the social service agency for the Department of Defense. FAP handles cases of child abuse and neglect, and domestic violence. It provides prevention programs, education classes and seminars, playgroups, and support groups. www.militaryhomefront.dod.mil/pls/psgprod/?P=MHF:HOME1:0:0:SID:20.80.500.188.0.0.0.0

MILITARY STANDARDS
Family Advocacy Program (FAP)
FAP handles cases of child abuse and neglect, and domestic violence. It provides prevention programs, education classes and seminars, playgroups, and support groups. www.militaryhomefront.dod.mil/pls/psgprod/?P=MHF:HOME1:0:0:SID:20.40.500.420.0.0.0.0
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