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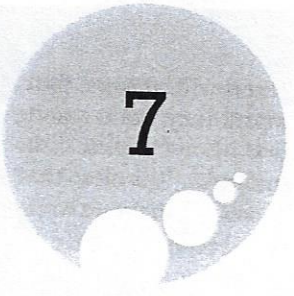



# Family Life at Risk

## *Pressure from Outside and Turmoil Within*

Eleanor W. Lynch

*"The family is one of nature's masterpieces."*

—George Santayana (1905, p. 35)

*"Life in itself is neither a good nor an evil; it is the scene of good and evil."*

—Seneca (as cited in Gardner & Reese, 1975, p. 107)

*"Sometimes we love with nothing more than hope. Sometimes we cry with everything except tears. In the end, that's all there is: love and its duty, sorrow and its truth."*

—Gregory David Roberts (2003, p. 465)

All families have challenges–times of sadness and loss, concerns in the present, and worry about the future. All families also have times of joy, hope, optimism, and contentment. For most families, the positive times outweigh the negative; the family maintains its equilibrium and functions successfully. For other families, negative events, experiences, and feelings exceed the positive. Balance is never achieved, and family life unravels. In some instances, external events or experiences such as extended unemployment, natural disasters, bankruptcy, or exposure to violence alter the family's positive trajectory, resulting in changes in family resources as well as family dynamics. In other instances, the proclivities of one or more of the family members, such as an addiction or abuse, cause the family to lose its purpose and sustainability. Whatever the cause, when families fail to fulfill the functions that are expected of them, the consequences can be profound.

This chapter focuses on the risks involved in addiction, violence, trauma, loss, and disability. The ways in which these life circumstances affect families are described along with promising practices in prevention and intervention. The information presented is often disheartening. For service providers who focus on the positive, many of the situations described may be difficult to imagine or consider. This chapter is included because many service providers encounter these situations daily; it is highly likely that

others will, at some time, be exposed to the consequences of these risks in families with whom they work, among their acquaintances and colleagues, or within their own families. Many of these risks transcend the stereotypes of the popular press; in numerous instances, it is clear that the adage "bad things happen to good people" is often true. If professionals are to provide support to families who face the challenges of addiction, violence, trauma, and loss, service providers need to understand the problems and their solutions.

## ADDICTION AND VIOLENCE

Addiction and violence are topics that fill headlines and prisons, that break up families and break hearts. They are also concerns that touch the entire population–men and women, children and adults, rich and poor, urban and rural. However, like many risks, the negative effects fall disproportionately on groups with limited resources and often on populations of color. Their impact on families is profound in economic, social, and medical terms; their relationship to disability and risks in development is becoming increasingly clear.

Research, statistics, and recommendations related to addiction and violence abound. The indicators and the outcomes are clear, but comprehensive prevention and intervention efforts that can stem the tide of negative effects are often lacking. Addiction and violence put the lives of families and family members at extreme risk. Recall, for example, the family systems framework described in Chapters 3 and 4. Consider the ways in which drug addiction and violence affect the family system. What might these problems do to communication within and outside the family? How would they affect the functions that families are expected to perform? In what ways might the family life cycle be altered by violence or addiction? The following sections discuss addiction, family violence, child abuse, and neglect; their impact on families; as well as promising practices in prevention and intervention practices of promise.

### Addiction

The words *addiction* and *physical dependence* are often used interchangeably, but groups such as the American Pain Society, the American Society of Pain Medicine, the American Society of Addiction Medicine, and the Liaison Committee for Pain and Addiction argue that they are not the same (Heit & Gourlay, 2009). Physical dependence can be defined as an expected neurological adaptation to chronic exposure to a drug or class of drugs. Physical dependence occurs when the body adapts to the drug and requires the drug to function. Drugs of this nature range from illicit drugs such as heroin to common prescription drugs for blood pressure and even laxatives (Berkow, Beers, & Fletcher, 1997). Addiction is a more complex, multidimensional phenomenon that incorporates biological, psychological, and psychosocial elements that result in compulsive use of the drug or involvement in the activity. Using these definitions, substances or activities that do not cause physical dependence may still meet the criteria for addiction: psychological dependence, with the desire to continue to take the drug or engage in the activity because of its pleasurable effects or the reduction in tension and anxiety that occur (Berkow et al.).

In this chapter, addiction and substance abuse are both used to refer to an individual's overwhelming involvement with a drug or other activity–involvement that interferes with daily life, the ability to make sound judgments, and the ability to care

adequately for oneself and others. Alcohol, nicotine, cocaine, marijuana, heroin, and prescription drugs fall into this category, as do gambling, some sexual behaviors, and even Internet use. Addictive behaviors pose serious risks to families because they become all consuming and more important than anything else in the addict's life.

Addictions to and abuse of drugs—both legal and illegal—also pose significant health threats. For example, needle sharing in intravenous drug use is associated with HIV; nicotine addiction is a major cause of emphysema and lung cancer; amphetamine abuse results in increased blood pressure and heart rate, which can lead to heart attacks and strokes; and a woman's alcoholism or long-term use of nicotine, cocaine, marijuana, or methamphetamines may lead to negative health and developmental outcomes for her children (Berkow et al., 1997; Minnes, Lang, & Singer, 2011). The need to obtain drugs or engage in the addictive activity is often associated with or results in criminal behaviors. In 2004, the Bureau of Justice reported that 17% of state prisoners and 18% of federal prisoners had committed their most recent offense to obtain money for drugs (U.S. Department of Justice, 2010). Federal Bureau of Investigation data from 2008 indicate that there were 14 million arrests. Of these arrests, 12.2% were for drug abuse violations—the most common category of arrests for crime (Crime in the United States, 2009). The population of incarcerated individuals reflects the same pattern. According to statistics from the Bureau of Justice, 20% of state prisoners and 53% of federal prisoners are incarcerated because of a drug offense. Multiple studies of drug use, arrests, and convictions indicate that drug users are more likely to commit crimes than are nonusers (Spiess & Fallow, 2000), and some of these crimes are violent. In 2008, approximately 4% of all homicides were drug related (U.S. Department of Justice, 2009).

Finally, when addiction becomes all consuming or substance abuse becomes pervasive, addicts and abusers are unable to put the needs of others above their own. They become unavailable to others physically and psychologically, and parenting or partnering in a relationship become secondary to everything else. The negative outcomes are clearly articulated by the DHHS:

> Alcohol and illicit drug use are associated with child and spousal abuse; sexually transmitted diseases, including HIV infection; teen pregnancy; school failure; motor vehicle crashes; escalation of health care costs; low worker productivity; and homelessness. Alcohol and illicit drug use also can result in substantial disruptions in family, work, and personal life. (2010, p. 33)

Addiction has been defined as "the compulsive activity and overwhelming involvement with a specific activity" (Berkow et al., 1997, p. 440). Orford (2001, p. 18) considers addiction to be a problem of excessive appetite for an activity or substance, stating that in addiction the appetite is "so strong that a person finds it difficult to moderate the activity despite the fact that it is causing harm." Although illegal drugs, alcohol, and nicotine typically come to mind when one thinks of addictions, any substance or activity that is excessive and difficult to moderate in spite of negative consequences is considered addictive. Eating, gambling, sexual behaviors, exercise, and Internet use can be considered as addictions if the individual is compulsively involved in them and finds it difficult to alter his or her behavior in spite of detrimental effects. One study examined the prevalence of addiction to Second Life, a sophisticated three-dimensional virtual world, and found that approximately one third of participants met the criterion for or were at risk for Internet addiction (Gilbert, Murphy, & McNally, 2011). It remains to be determined whether the American Psychiatric Association's forthcoming *Diagnostic and*

*Statistical Manual of Mental Disorders, Fifth Edition,* will include non–drug-related behaviors, such as compulsive gambling and compulsive Internet use, among the list of recognized disorders. Regardless of this decision, many people engage in non–drug-related activities to an extent that is harmful to themselves and their families. Although Orford's broader model of addiction is controversial, it directly addresses the primary concern of this book—families and their resilience in the presence of risk.

**Drugs of Choice in Substance Abuse and Addiction** To understand families' challenges related to addiction, it is important to know more about the most common types of substance abuse and addiction—the drugs that are used and their effects. This section discusses legal and illegal drugs that are commonly abused, are associated with visits to hospital emergency rooms, can profoundly affect family functioning, and are positively correlated with disability in infants and young children.

*Alcohol* When one imagines addiction and its consequences, it is common to think of gangs, guns, and back-alley transactions. This image is in stark contrast to a bright, well-appointed living room with people chatting over a martini or glass of wine after work. The second image, however, is not always as pleasant or benign as it sounds. In the United States, nearly 17.6 million adults have alcoholism or alcohol problems (National Institutes of Health, 2012). These individuals crave alcohol, cannot stop drinking once they start, are physically dependent, and need to drink greater and greater amounts to feel the effects that they seek (National Institute on Alcohol Abuse and Alcoholism, 2012). Alcohol is easily accessible and inexpensive when compared to many other addictive drugs, making it available to teens and even younger children who binge drink (i.e., occasionally drink excessively). More men than women abuse alcohol, but abuse among women has increased in recent years (Enoch & Goldman, 2002).

The causes of alcoholism are unknown, but both biological and social theories related to the addiction continue to be investigated. The biological children of parents with alcoholism are more likely to develop alcoholism than are the adopted children of parents with alcoholism, suggesting some genetic predisposition. There is also evidence that the brains of individuals with alcoholism are less sensitive to the effects of alcohol and less easily intoxicated than individuals without alcoholism (Berkow et al., 1997; National Institute of Alcohol Abuse and Alcoholism, 2012).

Personality traits and environmental factors are also associated with alcoholism. Individuals with alcoholism tend to be more isolated, lonely, shy, depressed, dependent, hostile, self-destructive, impulsive, and sexually immature than individuals without alcoholism (Elkins, King, McGue, & Iacono, 2006; Porter & Kaplan, 2011). In terms of social factors, individuals with alcoholism are more likely to come from homes with one parent absent and have disturbed relationships with their parents. These factors often occur within a larger context of poverty, limited education, psychiatric illness, and inadequate treatment options. However, the puzzle is not easily solved. Do these factors lead to alcoholism or are they its result? Regardless of the answer, alcoholics come from all strata of society, ethnicities, educational levels, and income levels. The consequences of alcohol abuse and alcoholism are profound, including its effects on the developing fetus. It is also the drug that is closest to home in many families—one that does not take sophisticated strategies to intervene, one that we can all have a part in controlling.

*Nicotine* As a legal, easily accessible, and heavily marketed drug, nicotine is one of the most commonly used addictive drugs throughout the world. In the United States,

nicotine addiction occurs most commonly from smoking cigarettes. Although the number of people who smoke cigarettes has dropped in recent years with stop-smoking campaigns, antismoking legislation, and treatment options, the number of smokeless tobacco users has increased (National Institutes of Health, 2011). Like alcohol, nicotine addiction can be found among adults and youth, men and women, and across all ethnicities.

The immediate effects of nicotine are not dissimilar to other addictive drugs—a rush, high, or kick caused by the release of adrenaline and glucose. Heart rate, blood pressure, and respiration also increase along with dopamine levels in the areas of the brain that control pleasure and motivation (DHHS, 2001). The long-term effects of nicotine addiction should no longer be surprising: cancer, emphysema, chronic asthma, heart disease, stroke, aneurysms, and vascular disease. It has now become clear that smokers are not the only ones whose health is affected by their habit. According to the Centers for Disease Control and Prevention, no level of secondhand smoke or environmental tobacco smoke is risk free (Centers for Disease Control and Prevention, 2011). Infants and children are at particularly high risk for serious health problems caused by secondhand smoke. Infants are at greater risk for death from sudden infant death syndrome, and children of smokers get sick more often, have more frequent asthma attacks, more ear infections, and more surgeries to put tubes in their ears for drainage (Centers for Disease Control and Prevention).

Although nicotine is as addictive as alcohol, heroin, and cocaine, it is seldom associated with dramatic, downward economic spirals or loss of home and family. This casual consideration of nicotine addiction does not, however, align with the facts. Both the economic and personal costs are significant. Between 2000 and 2004 in the United States, loss in productivity attributable to cigarette smoking and exposure to secondhand smoke amounted to nearly $97 million dollars (Adhikari, Kahende, Malarcher, Pechacek, & Tong, 2008). Of even deeper concern are the mortality figures. Every year between 2000 and 2004, an estimated 443,595 people (269,655 men and 173,940 women) died as a result of smoking. The three leading causes of death were lung cancer, ischemic heart disease, and chronic obstructive pulmonary disease. Smoking during pregnancy resulted in the death of an estimated 776 infants in each of those years. Exposure to secondhand smoke is estimated to have caused 49,400 deaths annually from lung cancer and heart disease, and 736 deaths each year were the result of residential fires caused by smoking. Losing a mother, father, or child prematurely is always a tragedy, but loss from a preventable disease is even more devastating. Like alcohol addiction, nicotine addiction is common in many homes. It is something many people live—and die—with. It is preventable and treatable, and its reduction would account for significant reductions in many other life-threatening diseases as well as a reduction in premature births among mothers who smoke.

*Illegal Drugs* It is likely that no one begins using drugs with the intent of becoming addicted. However, all too often, casual drug use changes from an occasional, pleasurable high to a physical need and compulsion—an escalating desire that becomes more important and more powerful than everything else in life. Food, health, cleanliness, safety, the smile of one's child, or the love of a caring parent may not compete with the drive for the next high; thus, little by little, life may change completely. The 2010 National Survey on Drug Use and Health, which examined the rate of drug use in the previous month, indicated that 10.1% of 12- to 17-year-old children were using illegal

drugs. Among 18- to 25-year-olds, illegal drug use was 21.5%; among those age 26 and older, 6.6% were drug users. These figures all represent increases in drug use over the previous year. In 2010, 5.8% of 50- to 59-year-olds used illegal drugs (Substance Abuse and Mental Health Services Administration, 2011).

None of the consequences of addiction are positive, so why is addiction so prevalent? Addiction is the result of multiple, complex, and interacting variables. Personality, social, economic, and physiological variables contribute to each individual's reactions to drugs. These variables may predispose individuals to addiction or serve as protective factors that reduce the likelihood of addiction. Although it is not possible to predict the outcomes for an individual, a number of societal variables are associated with risky behaviors that often lead to addiction. For adults, lack of opportunity, unemployment, poverty, limited access to treatment, violence at home and in the neighborhood, and association with substance abusers contribute to drug abuse and addiction.

Marijuana, heroin, cocaine, and methamphetamine are four of the most commonly used illegal drugs along with an ever-changing array of "club drugs." Each drug causes somewhat different effects and each individual's response to a drug is different, but all have significant health risks. All are addictive and can pose serious risks to a mother and her developing fetus during pregnancy (Milligan et al., 2011). For additional information about illegal drugs, their effects, and their health risks, see the resources listed at the end of this chapter.

*Prescription Drugs* Prescription drugs are some of the most important tools in modern medicine. They act to prevent disease, reduce pain, and diminish the effects of illness. Many people avoid illness because of prescription drugs, and many others are made more comfortable when they are ill because of the medicines that have been prescribed. From acne to asthma and hay fever to heart disease, prescription drugs can dramatically improve both the quality and length of life. However, despite the good that they do, an estimated 20% of the U.S. population has abused prescription drugs.

Abuse of prescription drugs takes a number of forms: using drugs prescribed for someone else, altering the prescribed dose, using the medication in a manner that does not correspond with the way it was prescribed, or using the drug simply to experience the feelings that it produces (National Institute on Drug Abuse, n.d.). According to current data, the incidence of prescription drug abuse is increasing (National Institutes of Health, n.d.). Although prescription drugs are misused by individuals of all ages, their misuse is especially common among young people. Narcotic painkillers, sedatives and tranquilizers for anxiety and sleep disorders, and stimulants for ADHD are all commonly abused addictive drugs (Mayo Clinic Staff, 2010).

Prescription drugs can be found in many households. Typically, they are prescribed for someone for a legitimate medical need, but unfinished drugs often remain in the house. Stored in a cabinet or drawer and often forgotten, they are easily accessible and tempting to teens experimenting with drugs or adults with drug habits. Even when prescription drugs are appropriately disposed, online pharmacies and pharmacies outside the United States make it easy to obtain prescription drugs without a prescription (Mayo Clinic Staff, 2010). The consequences of abuse of these drugs have resulted in an increase in emergency room visits, admissions for treatment, and deaths from overdose (National Institute on Drug Abuse, 2011). Like all of the addictive substances discussed, abuse of prescription drugs poses significant health hazards.

***Treating Drug Abuse and Addiction*** The consequences of drug abuse and addiction on families are often devastating: violence, loss of resources, frequent interactions with the police and justice systems, and limited options for treatment and recovery. The loss of one's home as a safe haven and the loss of trust in loved ones are perhaps as undermining to well-being as the loss of material possessions. The consequences of drug addiction and abuse threaten every aspect of family life and make the successful performance of family functions close to impossible. Because of this, considerable effort has been made to develop prevention and treatment programs that work.

Large-scale evaluations of drug prevention and treatment programs have been conducted, and the conclusion is that treatment is effective. However, like so many evaluations of educational and social programs, it is still unclear which programs work for which individuals and under what conditions. Among the models that have been shown to be effective are therapeutic communities, pharmacological treatment, outpatient without drugs or pharmacological management, and inpatient treatment (Office of National Drug Control Policy, 1996). Prevention strategies with young people have included prevention education, opportunities to develop alternative drug-free activities, identifying substance abuse problems early and referring for treatment, building community-based interventions, and working with schools and other institutions to create an environment that reduces risk factors and enhances protective factors (Office of National Drug Control Policy, 2009). Recent efforts in treatment have focused on evidence-based approaches, including pharmacotherapies and behavioral therapies (National Institute on Drug Abuse, 2009). Finally, for any prevention strategy or treatment to work, it has to be available to those who need it when they need it. Making options available, accessible, and culturally competent continue to be challenges to systems and to professionals in those systems that work with and care about families.

Remarkably, many individuals face extremely difficult circumstances and escape addiction. For young people, the risks and protective factors are clear. According to the National Institute on Drug Abuse (2002), the following factors increase the risk of drug abuse among youth:

1. Chaotic home environments, especially those in which parents have mental illness or are substance abusers
2. Lack of parent–child attachment and nurturing
3. Shy or aggressive classroom behavior that is inappropriate
4. School failure
5. Poor social coping skills
6. Friendships and affiliations with peers who display deviant behavior
7. Perception that drug use is acceptable

As might be anticipated, risks that often lead to drug abuse also lead to other forms of antisocial behavior, such as delinquency, youth violence, leaving school, risky sexual behaviors, and teen pregnancy.

Conversely, a number of protective factors help prevent drug abuse and other antisocial behavior. These factors, as identified by the National Institute on Drug Abuse (2002), include the following:

1. Family bonds that are strong and positive
2. Parental monitoring of children's behavior and activities and that of their children's peers
3. Clear, consistently enforced rules of conduct within the family
4. Parental involvement in children's lives
5. School success and strong bonds with community institutions, such as school, church, temple, or synagogue
6. Acceptance of conventional norms about drug use

There are opportunities to prevent or reduce substance abuse and addiction as well as opportunities to help those abusing drugs to change. For this to happen, however, healthy families and supportive communities are requisites.

### Violence

Violence is part of nearly every newscast and is featured prominently in online headlines. Primetime television, movies, computer and video games, comics, and cartoons are rife with acts of random and targeted violence; in many genres, guns figure prominently. It should therefore not be surprising that 10.2 out of every 100,000 people were killed by firearms in 2007 in the United States (Florida, 2011). A state-by-state analysis provides a much more refined view. Hawaii had the lowest rate, with 2.6 deaths per 100,000; the rates for New York and New Jersey were 5.0 and 5.2, respectively. At the other end of the spectrum, the District of Columbia had 21.7 deaths for every 100,000 residents, with rates of 20.2 in Louisiana, 18.5 in Mississippi, 17.8 in Alaska, and 15.1 in Arizona (Florida). Gun deaths, whether from homicide, suicide, accidents, or in self-defense do not just occur among adults. According to the Children's Defense Fund (2001, p. xxii), when children under age 15 in the United States are compared to children the same age in 25 other industrialized countries combined, U.S. children are "9 times more likely to die in a firearms accident, 11 times more likely to commit suicide with a gun, 12 times more likely to die from gunfire, and 16 times more likely to be murdered with a gun." Too often, where there are guns, there is violence; all too often, children are caught in the crosshairs.

Gun violence and other types of violence in schools, neighborhoods, and communities have punctuated lives throughout the nation in recent years. Statistics from the Federal Bureau of Investigation (2010) suggest that a violent crime occurred every 25.3 seconds in 2010—one murder every 35.6 minutes, one rape every 6.2 minutes, a robbery every 1.4 minutes, and an aggravated assault every 40.5 seconds; therefore, it is clear that there is violence in communities. These numbers are clearly worthy of the best efforts of service providers, individually and collectively, to understand and prevent future occurrences; however, the broad topic of community violence is outside the scope of this book. The following sections focus on violence at home—usually violence against women and children. Although domestic violence is frequently nested in society's larger problems, this chapter focuses on what happens to those who are battered, abused, and maltreated and the ways in which that affects families and their ability to function.

***Domestic Violence*** Violence between domestic partners or former partners accounts for much of the abuse in America's homes. In domestic violence, both men and

women are perpetrators, but women are more likely to be victims than men. Between 1998 and 2002, nearly 75% of victims of family violence were women, and approximately 75% of those committing the violence were men (Durose et al., 2005). Although the rate of domestic violence fell between 1993 and 2002, it still accounted for 11% of all reported and unreported violence. A woman is victimized by an intimate partner every 52 seconds and a man is victimized by an intimate partner every 3.5 minutes (U.S. Department of Justice, n.d.). Adding to the toll is the fact that violence is almost always underreported (Watts & Zimmerman, 2002). Victimization includes a number of behaviors: hair pulling, hitting, slapping, kicking, beating, rape, and threatening or hurting with a knife, gun, or other weapon. Violence against women is typically not an isolated incident, but rather an ongoing pattern of behavior over months, years, and decades (Watts & Zimmerman).

Physical and sexual violence are not the only forms of abuse that occur in many of these destructive relationships. Verbal and psychological abuse such as name calling, preventing the partner from having contact with family and friends, jealousy, and possessiveness often co-occur and can change women's perceptions of their own worth, their relationships, and their rights and place in the larger world (Johnson & Ferraro, 2000). These altered perceptions contribute to the inability to leave an abusive relationship. However, contrary to what is sometimes suggested in the popular press and reports of research, many women do leave to protect themselves and their children (Johnson & Ferraro). It may take several attempts, temporary safe housing, legal advocacy, personal counseling, and supports provided by service agencies, but women do leave.

Johnson and Ferraro (2000) detailed four types of partner violence. First, they described common couple violence, which is typical of a more generalized pattern of control. This sort of violence occurs in specific arguments in which one or both partners lash out at the other. It typically does not accelerate over time, is generally confined to a low level of violence, and is likely to be mutual. Intimate terrorism describes a pattern of behavior that is based on the desire to control the partner. It is usually just one strategy of control used in the relationship, but it is often characterized by violence, psychological abuse, escalation over time, and serious injury. Intimate violence is usually practiced by only one partner. The pattern of abusive behavior in which a partner fights back has been labeled as violent resistance. Most often attributed to women and sometimes resulting in death or serious injury, little research has been conducted on it. It is this sort of violence that is often used in a self-defense plea in homicide cases. Some relationships are defined by mutual combat between partners who are both violent and controlling—mutual violent control.

Who batters women? What is known about men who treat their partners with aggression and abuse? Jacobson and Gottman (1998) studied couples involved in violent relationships. Through interviews, observations during conflict, psychometric evaluations, and observations during arguments in the laboratory, at least two types of men seemed to emerge. One type, labeled in the study as "cobras," could be called sociopathic. They seemed to be completely detached physiologically from vicious verbal attacks on their partners. Even in the heat of these vicious verbal attacks, their heart rate and other physiological measures did not change; they also had a history of violent and antisocial behavior. The other type, referred to as "pit bulls," was physiologically attuned to what was occurring during heated, vicious arguments but can be described as dependent and needy. These data suggest that abusive men have personalities and preestablished patterns of behavior that are likely to lead to abusive relationships with

women. Given the longstanding nature of these personality traits and types, in many instances, abuse should be no surprise (Johnson & Ferraro, 2000).

Findings from a landmark survey indicate that rates of assault against women differ by race/ethnicity. The Violence Against Women Survey (Tjaden & Thoennes, 1998) illustrated that American Indian/Alaskan Native women are significantly more likely to report that they were victims of rape or assault than white non-Hispanic, African American, and Asian/Pacific Islander women. Latino women are less likely to report that they have been raped than non-Latino women, but the percent of physical assaults not including rape were similar between the groups. The reasons for these differences cannot be accounted for by the information gathered in the study. The differences may be artifacts of small sample size for American Indian/Alaskan Natives and Asian/Pacific Islanders. They may be the result of different cultural variables, immigration, and comfort in reporting. They may also speak to deeper cultural and sociocultural issues and the nation's ability to address inequities across groups. It does, however, appear that race/ethnicity may be a factor that makes some women more vulnerable to abuse than others. Important next steps are to determine why these differences occur and to find ways to reduce abuse in all relationships.

*Effects on Abused Women* The most obvious outcomes of violence are the negative physical and psychological effects on women: injury, pain, hospitalization, recuperation, embarrassment, fear, and depression. Abuse limits women's options for education, work, and even leaving the house. It also limits women's ability to create alone (or with a partner) a safe haven for their children. It is not uncommon for some abusers to prevent their wives or partners from obtaining or maintaining a job or career. Their controlling tactics are often insidious, including depriving the partner of transportation, beatings before a job interview, turning off the alarm clock, harassment at work, and failing to be available for child care as promised (Johnson & Ferraro, 2000).

In a qualitative study conducted by Levendosky (2000), women in abusive relationships discussed the effects of domestic violence on their parenting. The majority reported that their parenting suffered because of the violence. Women described lack of energy, physical illness and injury, and anger as results of abuse that interfered with parenting. Even in the face of these challenges, a number of women marshaled their resources to protect and provide for their children. They used their circumstances to support positive parenting. For example, some reported being more empathetic toward their children and their needs because of their own experiences. Others put considerable effort into helping their children develop self-esteem so that the children would be less likely to be victims of abuse.

*Effects on Children* Children who witness violence are also affected by it. Depression, anxiety, poor problem solving, psychosomatic complaints, and low self-esteem are common (Szyndrowski, 1999). Among a representative, national sample of teenagers in the United States, respondents who were exposed to violence reported considerably poorer health than those who had not been exposed (Boynton-Jarrett, Ryan, Berkman, & Wright, 2008). At the most basic level, children who witness violence may have difficulty forming secure attachments, making it difficult to establish and maintain relationships later in their lives (Levendosky & Graham-Bermann, 2001). These patterns of behavior often persist, as evidenced by data indicating that women in college who recall violence between their parents are less socially competent, more depressed, and have

lower self-esteem (Henning, Leitenberg, Coffey, Bennett, & Jankowski, 1997). Individually or in combination, these characteristics often interfere with school success.

Of even greater concern are the long-term outcomes for children who witness abuse. Children who witness abuse are at risk for becoming direct victims of the violence and at risk for posttraumatic stress disorder. Children who witness domestic violence learn that violence is a part of intimate relationships, and there is no countervailing force that teaches other ways of communicating and solving problems (Groves, 1996). Victimization places children at risk for delinquency, criminal acts, and violent criminal behavior (National Institute of Mental Health, 2000). Although direct links are difficult to determine because of associated variables, it would not be surprising to find that witnessing violence places children at similar risk. Direct effects of violence on children who are abused are discussed in a later section of this chapter.

The transmission of violence is frequently discussed in the literature. Transmission is believed to have both environmental and genetic components. In other words, children who witness or experience violence and those who live in homes where violence is condoned are in environmental settings in which models of behavior put the child at risk for later violence as a victim or a perpetrator. It is also thought that there may be genetic predispositions to personality and behavioral types that are characteristic of abusers. Children exposed to violence at home and in the community have a higher risk of becoming either a victim or perpetrator of violence as adults (Anderson & Cramer-Benjamin, 1999; Stith et al., 2000). Likewise, men whose childhoods were spent in homes where there was domestic violence have been reported to be more likely to be violent as husbands and partners than those who have not grown up with violence (Johnson & Ferraro, 2000).

*Effects on Society* Homelessness is a serious and thus far intractable problem in the United States. In one study, at least half of homeless women were forced onto the streets and into shelters because of extreme violence against them in their homes (Zorza, 1991). In another interview study of homeless women and women living in low-income housing, one third reported that they had experienced severe physical violence from their current or most recent partner (Browne & Bassuk, 1997). According to the National Coalition for the Homeless (2009), 63% of homeless women are victims of domestic violence. Because battering is a crime, the effects on police departments, courts, jails, and parole officers are also significant. Every dollar spent on the crime of battering subtracts from the resources available for prevention and treatment. At another level, the modeling of violence in the home has a range of incalculable costs. If home is not safe, what is? If those closest to us cannot be trusted, who can be trusted?

***Preventing Domestic Violence*** Domestic violence is not a simple one-dimensional problem. It is a problem that is a result of many interconnected factors and issues. It requires attention and coordinated approaches that involve prevention and intervention at the individual, community, societal, and political levels. As the statistics demonstrate, there is no quick fix. In fact, one of the hallmarks of the progress in this area is getting society to accept the fact that battering is not "the woman's problem." Domestic violence must become unacceptable in homes and communities, and learning that violence in the home is unacceptable should begin early. Families need opportunities to learn child-rearing techniques that do not include physical punishment and to learn communication and problem-solving skills that do not rely on physical force or verbal abuse.

As society's tolerance of abuse decreases, it will be critical to support programs for batterers and ensure that programs are available and accessible. Otherwise, violence will become an even more private and unyielding problem. As with Alcoholics Anonymous, the problem of alcoholism is not condoned, but treatment for it is. This must become equally true for perpetrators of domestic violence. Programs must be delivered to meet the diverse characteristics–cultural, racial, educational, economic, life experience–of those they serve.

In addition to treating batterers, partners and their children must have alternatives that keep them safe and help them regain their sense of control and personal efficacy. Temporary shelters, protection, job training, child care, education, psychological counseling, legal advocacy, and social support are essential to support women leaving violent relationships. Because of the relationship between substance abuse and domestic violence, programs that prevent and treat drug addiction and alcoholism are also keys to reducing domestic violence. Another component in reducing death and serious injury in domestic violence is to tackle an additional public health challenge–the availability and use of guns (Drazen, Morrissey, & Curfman, 2008; Glantz & Annas, 2009). Making guns unavailable has the potential to eliminate or at least reduce access to weapons that are often a part of intimate partner terrorism and violence.

These programs and services are not cheap, nor is it easy to develop them in coordinated and collaborative ways that maximize resources and effectiveness. They are, however, essential if the service providers are serious about the problem, the importance of families, and their ability to function effectively. Interventionists trained to work in family-centered ways have a great deal to contribute to improving their own community's response to family violence. Knowledge of community resources, the ability to work as team members, and advocacy skills are as important to reducing family violence as they are to providing effective intervention with individual families and children.

## CHILD ABUSE AND NEGLECT

There were an estimated 3.3 million referrals of suspected child abuse and neglect in the United States in fiscal year 2010–on average, one every 10 seconds–which involved the health, safety, and welfare of an estimated 6 million children (DHHS, 2011; Childhelp, n.d.). Nearly 2 million of the referrals were screened in and 1,793,724 (90.3%) were responded to with an investigation. More than 400,000 of the reports were substantiated, with nearly another 25,000 reports found to be indicated (DHHS). Three fifths of the reports were made by professionals, such as teachers, social services staff, police officers, and attorneys.

Child abuse is pervasive and occurs across all income levels, ethnic and cultural groups, educational levels, and religions. Anglo-American (44.8%), African American (21.9%), and Hispanic (21.4%) children make up 88% of all abused children (DHHS, 2011). In 2010, states reported 1,537 known fatalities due to abuse or neglect; the DHHS (2011) estimated the total number to be 1,560. Children under 12 months were most likely to be victims of abuse, and nearly 80% of those who died were younger than 4 years of age. The perpetrators of child abuse and neglect do not necessarily conform to stereotypes. More than half (53.6%) of the perpetrators were women; 45.2% were men. Of the perpetrators who were parents, over 80% were the biological parent of the victim (DHHS). More than one third of those who abused or neglected children were 20 to 29 years of age; more than 80% were between 20 and 49 years of age. Although birth

parents are more likely to physically abuse their children than others, the statistics differ in cases of sexual abuse. Half of the children who were sexually abused were molested by someone other than a parent or someone in a parenting role; one fourth were sexually abused by a birth parent, and one fourth were sexually abused by someone other than a parent or parent substitute. An alarming finding was that sexual abuse perpetrated by a birth parent was more likely to result in a serious injury or impairment than abuse by a nonparent (Sedlack & Broadhurst, 1996).

Child maltreatment includes neglect, medical neglect, physical abuse, sexual abuse, and psychological maltreatment. In the National Incidence of Child Abuse and Neglect Studies commissioned by U.S. Congress (Sedlak & Broadhurst, 1996), standardized definitions were used in the determination of child abuse and/or neglect: The harm standard was met when children had already suffered harm from abuse or neglect, and the endangerment standard was met when children had already experienced abuse or neglect that puts them at risk for harm. In the 2010 statistics, 78.3% of abused and neglected children were neglected, 17.6% were physically abused, 9.2% were sexually abused, 8.1% suffered psychological maltreatment, and 2.4% experienced medical neglect. More than 10% experienced other forms of abuse; in less than 1% of cases, the cause was unknown (DHHS, 2011). The percentage of boys and girls who are physically abused is very similar; however, the rate of sexual abuse is greater for girls than boys (Children's Bureau Administration on Children, Youth, and Families, 2002). Conversely, boys are more likely to suffer serious physical injury from abuse and significantly more likely to be emotionally neglected than girls (Sedlak & Broadhurst). In 2010, 16% of abused children were reported to have a disability (DHHS, 2011).

Many children who experience abuse and neglect are living in poverty (Child Welfare League, 1999; Sedlak & Broadhurst, 1996). Risks for children in families earning less than $15,000 per year in 1993 were significantly greater for every type of maltreatment than children from families earning $30,000 or more (Sedlak & Broadhurst). It has been hypothesized that poverty increases stress on family members, which in turn makes abuse more likely. Although there is a relationship between poverty and abuse, however, the vast majority of people who are living in poverty do not abuse or neglect their children. The relationship of poverty to other social factors related to child abuse, such as transient residence, lower levels of education, and higher rates of substance abuse and mental illness, may help to explain the risks for abuse and neglect faced by children living in poverty. The relationship to substance abuse is particularly striking, with almost half of the substantiated cases of child abuse and neglect related to a parent's abuse of alcohol or drugs (Child Welfare League, 1998).

These facts and findings are difficult to comprehend in a country that describes its children as its most precious resource. In 2010, 1,560 children died from abuse or neglect (DHHS, 2011). In contrast, 162 police officers–individuals who put themselves in harm's way on a daily basis–were killed in the line of duty (Flaherty, 2010). These numbers put the scope of the problem of child abuse in somber perspective.

***Child Abuse, Neglect, and Disability*** A national study funded by the National Center on Child Abuse determined that 14.1% of the children who had been maltreated had one or more disabilities (American Academy of Pediatrics, 2001). Children with disabilities are at greater risk for child abuse and neglect than children without disabilities. Children with disabilities were 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused, and 2.2 times more likely to be sexually abused

than children without disabilities (American Academy of Pediatrics). Like estimates of domestic violence, the numbers of children with disabilities who are abused is likely to be underreported. This is especially likely because child protective services workers who are typically on the front line of child maltreatment cases are not trained to recognize disabilities. Numbers may also be higher because of the inability of some children and youth with disabilities to provide any corroborating information of their experiences.

The causes of child maltreatment for children with disabilities do not differ dramatically from the causes for children without disabilities. However, children with disabilities typically place higher physical, emotional, and financial demands on caregivers (America Academy of Pediatrics, 2001). These extra demands and the additional stressors of children with special needs may be overwhelming to some parents whose frustration and inability to cope are turned on the child (Hibbard & Desch, 2007).

Sexual abuse, like the sexual abuse of all children, has other origins. Children with disabilities may have an increased number of caregivers and personal assistants who have intimate contact with them, providing increased opportunities for sexual molestation. On the positive side, when multiple caregivers are involved, it may be more likely that one will discover and report the abuse (American Academy of Pediatrics, 2001). Children and youth with disabilities may not have knowledge of appropriate and inappropriate sexual behavior. It may not be included in their educational curriculum nor taught by parents or other caregivers. This makes it even more difficult for children to know about appropriate boundaries and tell someone when they are being sexually abused. Societal attitudes may also contribute to increased risk of abuse. Beliefs that individuals with disabilities are less important than others, are asexual, or do not feel pain, or that all caregivers are good and saintly people, may interfere with recognition and reporting of abuse (Administration for Children and Families, 2011a).

Family attitudes may also affect the likelihood of abuse or neglect. Those who view the child as unacceptably different, an embarrassment, or a punishment for their own behavior may be more likely to engage in abuse and neglect or ignore abuse perpetrated by others (Burrell, Thompson, & Sexton, 1994; Rycus & Hughes, 1998). As with all other forms of domestic violence and abuse, parents with other serious problems such as alcoholism and drug abuse are more likely to abuse their son or daughter with a disability than parents who do not have such problems

*Effects on Children* Like domestic violence, the immediate outcomes of the physical and sexual abuse of children are physical injury, pain, disability, and death. Negative psychological and cognitive outcomes have been well documented following experiences of victimization and witnessing abuse. They include fear, sadness, bleakness, aggression, learning problems, and depression (Osofsky, 1996, 2000). Children who are abused tend to think less of themselves, to feel guilty, and to feel that they have no control over their own lives–beliefs that can have long-term, negative consequences.

*Effects in Adulthood* Abused children who grow up do not leave their childhoods behind. Abuse suffered as a child follows the child into adulthood. Both retrospective and prospective studies of mental health outcomes attest to the risks inherent in childhood abuse and neglect. The relationship is not one to one. Being abused or neglected as a child does not mean that adult outcomes will be negative; however, it does increase the likelihood of mental health problems in adulthood (MacMillan, Fleming, Streiner, & Lin, 2001). In a 20-year prospective study, adult men who were physically or sexually

abused or severely neglected as children were found to have diagnoses of antisocial personality disorder and more symptoms of the depressive disorder referred to as dysthymia as adults compared with matched controls (Horwitz, Widom, McLaughlin, & White, 2001). Dysthymic disorders are characterized by a depression that begins in early life and alters one's personality. Individuals with this type of depression are usually gloomy, pessimistic, unable to enjoy life, self-deprecating, lethargic, introverted, and hypercritical (Berkow et al., 1997). Adult women who experienced abuse and/or neglect as children are more likely to be dysthymic, have antisocial personality disorders, and report more problems with alcohol abuse and dependence than their matched controls (Horwitz et al.). Women exposed to physical and verbal abuse as victims or as observers of their mother's battering were more likely to engage in risky sexual behaviors such as early intercourse and having 30 or more lifetime sexual partners. As the number of categories of childhood abuse increases (e.g. abuse, neglect, witnessing of violence against their mothers), so may the likelihood that women engage in risky sexual behaviors (Hillis, Anda, Felitti, & Marchbanks, 2001). The relationship between childhood abuse and neglect and adult outcomes is complex, but it is certainly a contributor to greater risk and less-than-optimal outcomes.

*Effects on Society* The economic costs are perhaps the least of the concerns that surround child abuse and neglect, but it would be naive to ignore the financial burden that child abuse and neglect place on communities. Abuse and neglect tax our hospitals, clinics, courts, jails, and community services. Every hour treating a child who has been injured, terrified, or disabled as a result of abuse is an hour that child will not spend playing, learning, and developing a positive sense of self. These costs are immeasurable and have serious long-term consequences that exacerbate the problem, as pointed out previously. At a deeper level, hurting children affects who we are as a society. If the youngest and most vulnerable cannot be protected from interpersonal violence, there is little that can be claimed in terms of compassion and social justice. A society in which the problem is growing rather than abating is one that has considerable work remaining to be done.

***Preventing Child Abuse and Neglect*** Child abuse and neglect results from a multiplicity of personal, social, cultural, political, and societal problems. Prevention cannot be achieved without addressing each individually and each as part of a larger set of issues. Prevention of child abuse and neglect, like other areas of prevention, can be conducted at three levels: primary, secondary, and tertiary. Primary prevention calls attention to the problem by informing the public and decision makers and its scope and the needs that exist. Secondary prevention focuses on children and families that are known to be at risk for child maltreatment, such as children of substance-abusing parents, families reported for domestic violence, extremely low-income families, and families of children with disabilities. Programs directed to these families may include parent education, substance abuse treatment programs, respite care for families of children with disabilities, and information and referral services for low-income families. The focus of tertiary prevention is on families in which neglect and abuse has already occurred and on the children who have been victimized. Mental health workers may provide intensive counseling to family members and children may be removed to safer environments (Administration for Children and Families, 2011b).

In addition to this three-pronged approach to prevention, issues that are deeply embedded in society, such as racial discrimination, gender inequity, economic disparity,

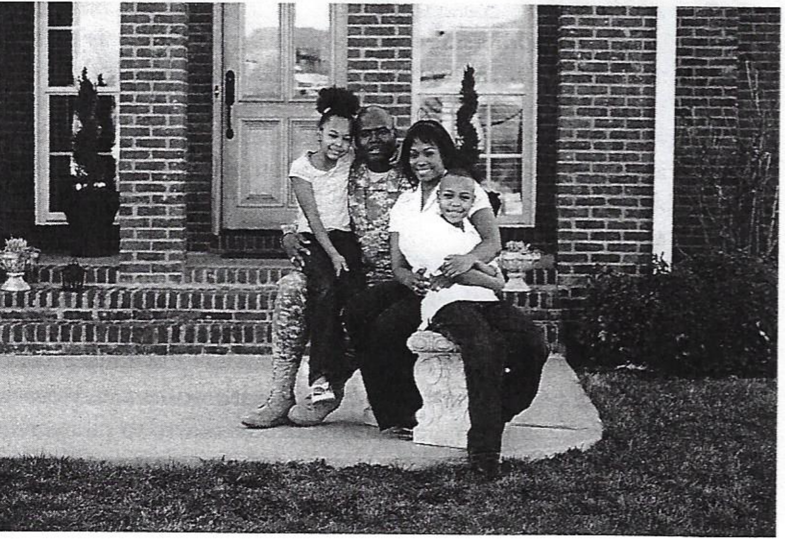
and the condoning (if not glorification) of violence, must be examined. Each contributes to the conditions that allow child abuse to occur. Each individual and each community must reflect upon and make the changes that will improve the chances of protecting children.

## TRAUMA, LOSS, ILLNESS, AND DISABILITY

In the 21st century, there are dramatic ways in which life has improved: individual freedom, advanced health care, increased equality, greater knowledge, and rapid communication. All kinds of devices make lives easier and increase the opportunities to learn and stay connected with one another. Yet even in the richness of this environment, there is trauma and loss. Although trauma is most often thought of as a physical phenomenon and loss is most often thought of in relation to the death of a loved one, both are related to change and have a significant psychological impact. Even changes that are positive, such as getting the job you have always wanted or trying a new sport, can be traumatic. A child's first day of kindergarten or a move to a new city can result in sadness and a sense of loss. Usually, people are able to handle the trauma, loss, and the accompanying feelings; typically the trauma and losses in a person's life do not all occur at once. There is time, space, and help available to deal with one loss before being confronted with another. For some individuals, however, the trauma or losses that they experience are so profound or so close together that finding a path through the fear, anger, and grief seems impossible. When this occurs, it becomes increasingly difficult to fulfill family functions. This section discusses several different life circumstances that often precipitate trauma and loss.

### Families in the Military

Men and women in the U.S. military and reserves are engaged in wars, peacekeeping, nation building, and disaster relief throughout the world. In the 21st century, full-scale combat in Afghanistan and Iraq has lasted for more than a decade. Natural



disasters such as the tsunami in the Indian Ocean, Hurricane Katrina, the earthquake in Haiti, and the tsunami and nuclear disaster in Japan have all used the personnel and expertise of U.S. military forces. All of these missions–including the stress, danger, and distance of soldiers from loved ones–take their toll on the men and women in the military and their families at home. As a result, military families are at risk for trauma and loss.

More than half of active-duty personnel are married. Nearly 40% are married with children, and 5% are single parents. Among families with children, most children are younger than 5 years. Although men still make up the largest portion of active duty personnel (86%), women comprise 14%. In the Selected Reserve and National Guard (those who are prepared for deployment), nearly 50% are married; 34% are married with children, with most children ranging from 12 to 18 years of age, and 9% are single parents (Office of the Deputy Under Secretary of Defense, 2010).

Military families typically adapt very well to frequent relocations, deployments, and demanding responsibilities, and many thrive in the military lifestyle. However, a growing body of evidence shows that multiple wartime deployments, the amount of direct exposure to combat, and psychological and physical wounds result in much higher levels of stress for those involved and family at home (Mogil et al., 2010; Sheppard, Malatras, & Israel, 2010). Increased stress within the family affects the children. Emotional unavailability, depression, posttraumatic stress, and absence due to long hospitalizations for treatment and rehabilitation combine to make it more difficult to meet children's needs. Studies are beginning to find that instances of child maltreatment may increase, children may have more mental health problems, and school performance may decline (Saltzman et al., 2011).

As more research is being done on the family outcomes of combat veterans, the recommended approach to support and treatment is family focused (Arata-Maiers & Stafford, 2010; Gewirtz, Erbes, Polusny, Forgatch, & DeGarmo, 2011; Mogil et al., 2010). Support for families at home during multiple long-term deployments is an important component. Child care, opportunities to talk and socialize with others who understand the stress, and financial assistance all contribute to strengthening families on the home front. When those at home are safe and secure, the men and women who are deployed have less to worry about.

Support for returning veterans and their families is another component of assistance. After any long separation, things change at home. Usually the partner at home has taken on additional roles and responsibilities, children may have developed different patterns of behavior, and everyone has to redefine his or her place in the family. For those who return with injuries, the services, supports, and redefinition may be considerably more challenging. The multiple needs of military personnel who return with posttraumatic stress disorder and/or combat injuries affect every member of the family and require long-term support, care, and community resources.

### Families and Financial Loss

Compared to loss of life and limb, financial loss would seem to be far less traumatic. However, since the banking crisis and beginning of the recession in 2008, financial loss has been a significant contributor to many families' inability to fulfill their expected functions. Losing a job, a home, health care, life savings, and a way of life can be catastrophic. Long-term unemployment and hopelessness about the future for oneself or

one's family often leads to depression and all of the challenges to day-to-day functioning that are a part of being depressed. According to the Brookings Institution, one in nine children had an unemployed parent due to the recession in 2010. These children are more likely to experience homelessness, suffer from child abuse, fail to complete high school or college, and live in poverty as adults than are other children (Isaacs, 2010). Financial losses have increased the number of families who are homeless or close to it because of unemployment or foreclosure. Food insecurity has increased, and the dynamics within families have changed. (For a thorough discussion of poverty and its consequences, please refer to Chapter 6.) For some, the ability to connect and parent effectively has been compromised. For others, financial loss has brought families together, increased their commitment to one another, and increased the number of fathers caring for their children on a regular basis (Berman, 2011).

The new group of individuals and families struggling financially differs from those who have lived in poverty. Middle-class families who had lived comfortable lives and had contributed to charitable causes may have never imagined that unemployment or serious financial difficulty would cause them to need the programs and services to which they once contributed. Families who were already living from paycheck to paycheck were suddenly catapulted over the edge without any backup resources to sustain them. Both groups were faced with daily concerns about food, shelter, and paying the bills.

Providing assistance to these families is complex and especially challenging for several reasons. First, professionals unaccustomed to working with families on issues related to income and financial resources may not be knowledgeable about available community resources. Second, many individuals who are newly and suddenly living in poverty are embarrassed by their situation and reluctant to share their need for help. Third, many families do not meet eligibility requirements for long-established programs and services. In addition, demands on existing programs and services have been overwhelming.

Given these constraints, what can professionals do to assist? The first step is to learn more about the resources available from one's own organization and the community. Certain charities, faith-based groups, and civic organizations have resources that can be used for emergency assistance. They, in turn, have connections to organizations that provide longer-term aid as well as to legislated programs and services. Compiling a list of organizations, summaries of what each one can provide, eligibility information, and a contact name and number is a good starting place. If and when a family member mentions a need or asks about services, information should be immediately available. Once professionals have gained knowledge about resources, they might organize events that include speakers from various organizations that provide assistance. Making this a routine parent night, community event, or coffee hour with child care provided may encourage families to attend and learn in an environment in which they do not have to disclose their own circumstances. Although this approach will attract some families, many will not have the time, emotional resources, or energy to attend a meeting when they are under so much stress. To reach these families, professionals and their organization may elect to send information about available resources to all families. When each child takes information home from school or when it is mailed to all families, no family is singled out or has to share information that they would prefer to keep private. Finally, being available if and when a family asks for help, listening to their concerns and their needs, and following through on providing assistance are critical components when addressing any family's needs.

### Illness and Disability

The economic downturn is not the only cause of financial loss. Illness that requires expensive care, hospitalizations, long-term treatment, and unemployment is also a contributor to financial insecurity in many families. Whether it is cancer, a stroke, or a severe accident, the costs are emotionally and financially enormous. For families that are uninsured or underinsured, the cost of medical care can plunge them into poverty. The birth of a child with a disability may also change the economic outlook for families. If one partner has to quit work to care for the child or if the costs of care are not covered by insurance, the family is suddenly without the necessary resources to sustain themselves. (For a comprehensive discussion of families and the impact of disability, please refer to Chapter 5.) Mental illness may also be the cause of financial loss. Depression and unpredictable behavior can make it difficult to obtain and retain a job; costly, prolonged treatment with uncertain outcomes combine to make an upward career path unattainable for many. (For a more information on mental illness and its effects on families, please refer to Chapter 8.)

Financial loss, whatever its cause, puts additional stress and strain on families at almost all economic levels. As discussed throughout this chapter and others, families in very stressful situations or in crisis find it much more difficult to fulfill the family functions that support healthy growth and development of the family and the children within it.

## SUMMARY

Drug abuse, addiction, family violence, child abuse and neglect, trauma, loss, and disability are a part of life for many families. Their costs and human consequences are devastating, and their prevention continues to be elusive. Substance abuse and violence affect every component of the family system. The family structure often changes as members come and go physically and psychologically. Healthy communication and acceptable boundaries among subsystems are thwarted, and the family's ability to carry out its functions is severely challenged. Even the family life cycle is affected because of changing roles, extended illnesses, incarcerations, deployments, and the transience of caregivers. Trauma and loss of all kinds affect families and their ability to function successfully. The pain, both physical and psychological, of trauma and the sadness that accompanies loss can make family members unavailable to one another, thus interfering with healthy interactions that support growth and development. All of the risks discussed in this chapter are complex, and each is embedded within larger legal, political, and policy issues. No single professional, agency, or organization can resolve all of the challenges that these risks present to families, but concerted efforts at the personal and professional levels can help to build a society that works to reduce risk and support families when they need help.

## *ACTIVITIES TO EXTEND THE DISCUSSION*

1. **Form a small group to discuss the effects of substance abuse on families.** Using the family systems framework, describe the ways in which family functions might be affected by a parent with alcoholism. After you have considered and recorded the possibilities, do the same for a family in which a teen has alcohol problems.
2. **Learn more about your own community's approach to domestic violence.** Find statistics online or from agencies that describe the scope of domestic violence in

your community. What local programs are available to assist victims? Are there any programs designed to help prevent domestic violence?

3. **Search the Internet for information about child abuse and neglect.** How is it defined? What national studies or interventions are being conducted? What are states doing to prevent child abuse and neglect? What local resources are available to help prevent child abuse and neglect?

4. **Invite a veteran to talk with the class about his or her experiences as part of a military family.** Ask the speaker to talk about the supports offered to military families during deployment. Find out what supports he or she wishes had been available. Learn more about what reintegration into civilian life is like.

## *TO LEARN MORE: SUGGESTED WEB SITES*

**American Bar Association**
**Commission on Domestic and Sexual Violence**
http://www.americanbar.org/groups/domestic_violence/resources/statistics.html

**Mayo Clinic: Posttraumatic Stress Disorder**
http://www.mayoclinic.com/health/post-traumatic-stress-disorder/DS00246

**MedlinePlus: Child Abuse**
http://www.nlm.nih.gov/medlineplus/childabuse.html

**The Military Family Research Institute at Purdue University**
http://www.cfs.purdue.edu/mfri/public/about/mission.aspx

**Military Homefront**
http://www.militaryhomefront.dod.mil/

**National Institute on Drug Abuse**
http://www.drugabuse.gov/

**National Institutes of Health**
http://www.nih.gov/

**PubMed Health: Alcoholism and Alcohol Abuse**
http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001940/

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