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Positioning a public health framework at the intersection of child maltreatment and intimate partner violence: Primary prevention requires working outside existing systems☆

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Since about the mid-1990s, researchers have been examining the intersection of child maltreatment (CM; also referred to as child abuse and neglect) and children's exposure to intimate partner violence (IPV; also called domestic violence or DV). Both CM and IPV are major public health concerns that, together, affect a countless number of lives each year in the United States and in other countries around the world. Not only does each form of adversity carry long-term health and psychosocial consequences for those involved, there is increasing evidence of their tendency to cooccur within families. Reviews of research by Todd Herrenkohl and colleagues in 2008 and Daryl Higgins and Marita McCabe in 2001 came to that very conclusion, while underscoring that risk factors like poverty and parental unemployment, parenting stress, social isolation, and drug and alcohol abuse are also present in many cases. For some families with children, community violence and neighborhood social and structural factors add even more stress and trauma into their daily lives.

There is now a sizeable body of research on "adverse childhood experiences," or "ACEs," which include CM and IPV. Studies of ACEs have consistently shown a robust, additive

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Suggested Websites

http://www.cdc.gov/violenceprevention/theacestudy

http://www.cdc.gov/violenceprevention/childmaltreatment/essentials

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effect of these early forms of risk on adult outcomes that include heart and lung disease, diabetes, and certain forms of cancer. Not surprisingly, individuals with more ACEs tend to be the most vulnerable to the early-onset of disease and serious illness. And, studies have shown that adults with this profile can die up to two decades earlier than others with less adversity early on. Twenty-eight states and the District of Columbia now collect data on ACEs using public health surveillance surveys that are part of the Behavioral Risk Factor Surveillance System (BRFSS). Using these data, states are beginning to investigate how ACEs affect life opportunities for their citizens, based on educational attainment, employment, and earnings.

As mentioned in the article by Genevieve Lessard and Pamela Alvarez-Lizotte (this issue), it is now well established that CM and IPV (and other associated risk factors) not only co-occur within families, but also make children susceptible to recurrent forms of victimization over their lifetimes. This pattern is known to researchers as *cumulative victimization* or *polyvictimization*. Additionally, research from multigenerational studies shows that an individual's susceptibility to violence can be passed on to her or his own children, such that violence becomes embedded within families. This raises an important question of how to prevent violence before it becomes an entrenched pattern.

Lessard and Alvarez-Lizotte very appropriately suggest a goal of joining the fields of child welfare and IPV prevention so that information can be freely shared and professionals in both arenas can work to coordinate and target their services on behalf of families, thereby increasing safety and lessening risk for women and children together. At the same time, the authors warn of the possibility of revictimizing women by prematurely removing children from families in which other adults (e.g., father, stepfather, boyfriend) are responsible for the violence that has occurred. It is a valid concern and an important consideration in any effort at system reform. Another concern is about competing values and priorities of service providers working on behalf of individuals within a family. Without sufficient planning and coordination, services may privilege one member over another and thus undermine efforts to attend to families more holistically.

Although supportive of the authors' recommendations, our interest is broader. It focuses on working outside of existing systems to promote large scale, public health-oriented strategies that emphasize primary prevention over reactive intervention. This interest coincides with calls from supporters of prevention to focus attention first and foremost on mitigating risk factors and enhancing child well-being by promoting protective factors through parenting supports and education.

As noted by David Wolfe and colleagues who have written about the prevention of violence through youth empowerment, the disease model of physical health had at one point served as a framework for the prevention of social problems. Noting the limitations of that model and reacting against its deficits orientation, the scholars appropriately recommend a shift toward health promotion and a focus on individual and family strengths. This recommendation is reflected in a well-written edited volume by Kenneth Maton and colleagues, who emphasize the benefits of strengths-based and resiliency-focused programs for children and youth. What Wolfe and Maton and their colleagues propose is a conceptual reframing of a public

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health approach that focuses not only on ameliorating risks, but also leveraging assets and promoting social change by empowering individuals and motivating action around issues of shared public concern.

Accumulating evidence suggests that investing in proactive, primary and even secondary prevention models not only benefits individuals who are directly impacted by violence, but also the average citizen, by reducing costs to health care, child protection, and law enforcement systems. Researchers at the Washington State Institute for Public Policy have helped advance a prevention agenda by investigating the costs and benefits of various prevention models, details of which can be found on their website (http://wsipp.wa.gov/BenefitCost?topicId=3). Their work shows that there are impressive cost savings associated with certain rigorously evaluated programs. For example, in the area of child welfare, a family preservation program like Homebuilders is estimated to save over U.S. $16,000 per individual served. Parent-Child Interaction Therapy (PCIT) is estimated to save a similar amount.

A Public Health Model of Prevention

The focus of a public health approach to prevent family violence is to intervene early and comprehensively to enhance protective factors (leverage strengths and assets) and reduce risk factors, thus minimizing the impact before problems emerge or worsen. Although universal public health prevention approaches are often presented in contrast to indicated or targeted models focused on those at higher risk for perpetrating or becoming victims of violence, interventions really exist along a continuum. Higgins has referred to the “backbone” of public health prevention as a “suite of wide-scale, stepped or escalating interventions that can reach the broadest of audiences, but linked to more specific services for those in need of additional supports.” Also referred to as “progressive universalism,” public health interventions can be delivered at scale in the community and also have a reach into higher risk groups requiring more focused intervention.

A comprehensive prevention strategy seen through a population (or public health) lens locates the problem of concern (family violence) at the intersection between the individual and the environment. A primary prevention strategy for reducing family violence could involve large-scale efforts to help young parents learn strategies for nurturing and caring for their children, or, in certain cases, gaining access to mental health and substance use services to lessen addiction. Increasing public awareness of the causes and consequences of violence is also a critically important component of any universal model.

To end or dramatically reduce the incidence and prevalence of violence within families, there will need to be a major cultural shift in the way that the general public views its responsibility to families. There will also need to be a willingness to allow policy to guide practices that are not at this point routine, such as placing certain demands on parents to acquire skills that are necessary to raise healthy children. We have seen these types of changes before, as with efforts to promote driver safety (leading to laws requiring seatbelt use and mandatory punishments for drunk driving) and lessen teenage smoking (reflected in campaigns to expose the ugly side of tobacco use and taxation of tobacco products).

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Short of the ultimate goal of changing laws and practices in support of families, there are incremental steps that can improve child safety. These are reflected in the *Essentials for Childhood* framework developed by the Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html).

Essentials for Childhood Framework

The framework developed by the CDC emphasizes the promotion of relational and environmental supports that shield children from recurrent and enduring forms of violence. It holds that the presence of safe, stable, nurturing relationships and environments beginning at birth enable children to acquire the skills and competencies they need to thrive in their daily lives—and to mature into productive, engaged, and educated adult citizens. Living in these environments gives children the confidence to venture out into the world with tangible goals and aspirations; to remain grounded and hopeful about the future; and to adapt to changing surroundings and circumstances. The *Essentials for Childhood* framework operates from the premise that positive, safe relationships and environments are critical for all people at all ages, including those at particularly high risk for violence.

There are four goals of the framework:

Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments (SSNREs)

Goal 2: Use data to inform action (i.e., prevention of CM and IPV)

Goal 3: Create the context for healthy children and families through norms change and programs

Goal 4: Create the context for healthy children and families through policies

Each goal aligns a set of priority tasks related to a larger vision—essentially to end violence by cultivating relationships that nurture children, not hurt them. Tasks under Goal 1 include raising awareness by helping the general public understand the negative health and developmental consequences of CM and IPV, as well as the social and economic costs that are experienced when children (and adults) are harmed. Fang and colleagues (2012) have estimated the lifetime cost of nonfatal child maltreatment incidents at over US$210,000 per victim, factoring in health care and medical expenses, among others—a costly sum that can be avoided.

Goal 2 focuses on gathering and using data to understand the scope of the problem and to inform practice and policy change. Data can be gathered from newly implemented tools or from existing data repositories that house information on population demographics, vital statistics, health, criminal justice involvement, education, and child welfare. State and national surveys can also provide valuable information, as has been shown by use of the BRFSS and the National Survey of Children's Exposure to Violence (NatSCEV).

Gathering data from families at a population level to inform practice and policy change is critical. In 2014, the Australian Government published a report by Killian Mullan and Daryl Higgins, which showed that population-level data gathering of this sort is possible and

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fruitful. Using data from children aged 2–11 years who participated in Growing up in Australia—a representative longitudinal study of Australian children—the researchers identified three kinds of family environments that were associated with children's healthy development and wellbeing. The majority of families showed evidence of a positive, cohesive environment in which children developed prosocial behaviors and had positive health outcomes. However, two types of more problematic environments also emerged in which families were either disengaged or enmeshed. Both environments were associated with negative outcomes for children at different ages, such as being underweight, suffering injuries, exhibiting less prosocial behaviors and more problem behaviors, and doing less well academically. Most importantly, by analyzing data longitudinally, Mullan and Higgins found that children whose family environments improved over time (i.e., became more cohesive) had better social and emotional wellbeing and literacy. However, children whose family environments remained the same or worsened over time (i.e., became more disengaged, enmeshed, and less cohesive) had more social and emotional problems.

Professionals from the fields of child protection and IPV prevention (e.g., maternal and child health workers, early childhood educators and caregivers, and other health/allied health professionals) can be instrumental in helping gather data on family dynamics relevant to the prevention cause. Data on family cohesion and parenting practices collected while serving families can, for example, add to data from other sources.

Goal 3 of the framework focuses on developing and promoting norms that support efforts to improve child well-being. This goal involves messaging about positive parenting strategies and healthy relationships, and building capacity within communities for the adoption and implementation of evidence-based parenting programs that nurture children. Public information campaigns to promote information about positive parenting practices and resources are good examples. Making the public aware of available evidence-based parenting programs and supports (such as Nurse-Family Partnership and Triple-P[1]) and providing models for interventions that can serve as back-up supports for families who need them is also critical—as are targeted referrals within child welfare for intensive family support.

Goal 4 addresses the larger policy context. Under this goal are tasks of assessing current policies for consistency with a vision that supports the health and well-being of children and their adult caregivers—and helping legislators understand the importance of evidence-based programming. Community and organizational decision-makers—both in the private and public sectors (e.g., state and local health departments, media, businesses, schools and faith-based organizations)—also play an important role in the development of policies at the local level and thus can help create conditions and resources that support safe, stable, nurturing environments that benefit children and families. Bringing forward examples of policies that can help achieve this vision is an important component of the work under Goal 4 and must not be constrained to those policies that specifically mention child protection in the title. For

[1]Nurse-Family Partnership supports first-time mothers with knowledge and support throughout pregnancy and until their babies reach two years of age (http://www.nursefamilypartnership.org).
Triple P-Positive Parenting Program, provides supports for families and provides an array of strategies to help equip parents with tools to manage challenges and reduce conduct problems among children and adolescents (http://www.triplep.net/glo-en/home/).

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example, Joanne Klevens and colleagues reported that access to subsidized child care and continuity of child health care can lessen rates of child maltreatment.

Conclusions and Areas for Further Investigation

It is important that those who routinely come in contact with families have an awareness of the public health model and evidence about what works in prevention. These frontline workers include professionals in the health sector—particularly general practitioners, and postnatal service providers such as maternal and child health workers—as well as education, child welfare and community mental health workers. Those able to asses it should be cognizant of the presence of violence and unsafe living conditions, as well as underskilled parenting. Making appropriate referrals and accessing resources in the community are critical in cases of concern. Indeed, evidence from available research related to programs and policies for families show that frontline workers are particularly effective if they are attuned to the dynamics that are present in families at-risk or experiencing violence.

There is currently a pressing need to invest more broadly in a set of public health goals that emphasize the primary prevention of CM and IPV and promotion of healthy child development. The motivation for acting on these enduring problems using a framework like that of the CDC's *Essentials for Childhood* is a growing body of evidence that shows these co-occurring types of family violence to have extremely damaging and sometimes life-altering long-term effects for children and their adult caregivers—and they are very costly to society in financial and social terms. To prioritize a primary prevention model requires more research on protective factors and strengths-based programs. Although our understanding of all of the reasons that violence persists in families is still being refined, it is clear that immediate action—by way of public health prevention—is both warranted and cost-effective, and that working with existing siloed models of care and intervention will not suffice. Bridging fields of practice and working at a broad level to increase awareness of the problem are important goals. Primary prevention that uses a public health framework to situate programs and practices within an actionable framework organized around principles of strength and resilience will enhance attempts to move toward large-scale change that we deem necessary to truly make a difference in the lives of families.

Suggestions for Further Reading

Aisenberg E, & Herrenkohl TI (2008). Conceptualizing neighborhood context for child maltreatment and resilience. Journal of Interpersonal Violence, 23, 296–315. [PubMed: 18245570]

Herrenkohl TI, Sousa C, Tajima EA, Herrenkohl RC, & Moylan CA (2008). Intersection of child abuse and children's exposure to domestic violence. Trauma, Violence, and Abuse, 9, 84–89.

Higgins DJ (2015). A public health approach to enhancing safe and supportive family environments for children. Family Matters, 96 (in press). www.aifs.gov.au/institute/pubs/fammats.html

Higgins DJ, & McCabe MP (2001). Multiple forms of child abuse and neglect: Adult retrospective reports. Aggression and Violent Behaviours: A Review Journal, 6, 547–578.

Institute of Medicine. (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities (Report brief for researchers). Washington, DC: National Academy.

Klevens J, Barnett SBL, Florence C, & Moore D (2015). Exploring policies for the reduction of child physical abuse and neglect. Child Abuse & Neglect, 40, 1–11. [PubMed: 25124051]

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Maton KI, Schellenbach C, Leadbeater B, & Solarz A (Eds.). (2004). investing in children, youth, families, and communities: Strengths-based research and policy. Washington, DC: American Psychological Association.

Merrick MT, Fortson BL, & Mercy JA (2014). The epidemiology of child maltreatment In Donnelly PD, & Ward CL (Eds.), The Oxford textbook of violence prevention: Epidemiology, evidence, and policy (pp. 19–26). Oxford, UK: Oxford University Press.

Middlebrooks JS, & Audage NC (2008). The effects of childhood stress on health across the life span. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Mullan K, & Higgins D (2014). A safe and supportive family environment for children: Key components and links to outcomes (Occasional Paper No. 52). Canberra: Commonwealth of Australia.

Wolfe DA, Wekerle C, & Scott K (1997). Alternatives to violence: Empowering youth to develop healthy relationships. Thousand Oaks, CA: Sage.