Journal of Aggression, Maltreatment & Trauma

ISSN: 1092-6771 (Print) 1545-083X (Online) Journal homepage: https://www.tandfonline.com/loi/wamt20

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To cite this article: Sharon G. Portwood (2005) What We Know—and Don't Know—About Preventing Child Maltreatment, Journal of Aggression, Maltreatment & Trauma, 12:3-4, 55-80, DOI: 10.1300/J146v12n03_03

To link to this article: https://doi.org/10.1300/J146v12n03_03

Published online: 11 Oct 2008.

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What We Know– and Don't Know– About Preventing Child Maltreatment

Sharon G. Portwood

SUMMARY. Although child maltreatment is routinely acknowledged as a serious social problem, it remains widespread, raising questions about how prevention efforts can be improved. Following a review of theory and research relevant to prevention programming, the two dominant models of child abuse prevention–child empowerment and parent education–are examined, emphasizing both those factors that appear to contribute to program success (e.g., early intervention, sufficient time commitments, cultural sensitivity) and weaknesses in current efforts (e.g., poor implementation). Although underutilized, broader social and system-level reforms, including social policy and media initiatives, hold promise for prevention. Ways in which to leverage these tools are explored. Additional research is urged to explore assumptions on which programs are based, as well as to conduct more rigorous evaluation of current programs. The article concludes that a sustained commitment to prevention efforts aimed at child abuse and neglect is required. *[Article copies available for a fee from The Haworth Document Delivery Service:*

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[Haworth co-indexing entry note]: "What We Know–and Don't Know–About Preventing Child Maltreatment." Portwood, Sharon G. Co-published simultaneously in *Journal of Aggression, Maltreatment & Trauma* (The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc.) Vol. 12, No. 3/4, 2006; and: *Ending Child Abuse: New Efforts in Prevention, Investigation, and Training* (ed: Victor I. Vieth, Bette L. Bottoms, and Alison R. Perona) The Haworth Maltreatment & Trauma Press, an imprint of The Haworth Press, Inc., 2006. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

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doi:10.1300/J146v12n03_03

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KEYWORDS. Abuse, neglect, prevention, programs, policy

Much has been written on child abuse prevention since the 1960s, when Kempe and colleagues (Kempe, Silverman, Steele, Droegemuller, & Silver, 1962) first identified "the battered child syndrome." However, taken as a whole, this literature might well leave the reader wondering whether to feel optimistic or discouraged about the current state of child abuse prevention efforts. While some commentators have heralded the progress in prevention efforts, others paint a more dismal picture, emphasizing the limitations of current approaches and the fact that there are still many unanswered questions as to whether these approaches achieve their desired effects.

Whatever success is attributable to current efforts, it is clear that the ultimate goal of preventing child maltreatment is far from a reality. According to the U.S. Administration for Children and Families' National Clearinghouse on Child Abuse and Neglect Information (NCAAN), in 2001, approximately 3 million reports involving 5 million children were made to child protection agencies in the United States. Approximately two-thirds of these reports received additional assessment and/or investigation, resulting in the identification of approximately 903,000 children as victims of child maltreatment. Interestingly, although these most recent figures reflect an increase in the total number of cases reported for investigation, the number of substantiated cases of child abuse and neglect has remained virtually unchanged since 1993. Moreover, more than half of confirmed cases were closed on the day of substantiation. However, it should be noted that during roughly the same period, 1992 to 2000, the number of substantiated cases of *sexual* abuse declined. Jones and Finkelhor (2001) reported a remarkable 40% decrease, from an estimated 150,000 cases to 89,500 cases. Based on an examination of the relevant data, they concluded that this trend was due, at least in part, to an actual decline in the number of child sexual abuse cases (Finkelhor & Jones, 2004).

Perhaps in contrast to popular perceptions of child maltreatment, the vast majority of child victims (57%) suffer from neglect, followed by physical abuse (19%), sexual abuse (10%), psychological or emotional

abuse (7%), and medical neglect (2%). Overall, the likelihood of victimization was inversely related to age, with children in the youngest age group (birth to 3) constituting the largest percentage (28%) of identified victims. In 84% of cases, the abuser was a parent or parents (NCCAN, 2003).

Given the continuing severity of the problem of child abuse and neglect, this article aims to review the status of current prevention efforts, using examples of current programs and the relevant research to provide an overview of what we know and do not know about effective prevention. Specific attention will be given to parent education and child empowerment service models, which dominate current programming. The potential of broader solutions, including those that expand their focus beyond a single system within the overall framework of systems (e.g., individual, family, and society) that contribute to the occurrence of child maltreatment, will also be explored.

THE GOAL OF PREVENTION EFFORTS

At the outset, it important to identify exactly what prevention efforts aim to accomplish. Prevention is generally conceptualized according to a three-tiered model. At the broadest level, *primary* (or universal) prevention encompasses interventions that are designed to prevent the target behavior from ever occurring. Such approaches typically focus on reducing risk factors and enhancing protective factors. Examples of primary prevention efforts aimed at child maltreatment include prenatal interventions and universal home visiting programs for all new parents. In contrast, *secondary* (or selected) prevention efforts focus on the early detection and treatment of existing problems, often targeting groups or individuals identified as "at risk." For example, the majority of parent education programs designed to prevent child maltreatment focus on families who meet certain criteria deemed to place them at high risk for abuse and/or neglect. *Tertiary* (or indicated) prevention approaches are designed to reduce the impact of existing problems (i.e., the re-occurrence of abusive behaviors). Thus, tertiary prevention programs focus on families in which abuse has already been identified.

It is important to note that only primary prevention targets the ultimate goal of preventing child abuse and neglect *before* they occur. Nonetheless, the vast majority of current prevention efforts directed at child maltreatment employ secondary or tertiary approaches. For example, some (e.g., Melton, 2002) have criticized current prevention poli-

cies and programs for an over-reliance on solutions based in the legal system, which necessarily focus on only that minority of cases that have been, at a minimum, identified and substantiated. Clearly, if we are to achieve a significant reduction in the occurrence of child maltreatment, a broader approach to prevention is needed.

DEVELOPING A CLEAR CONCEPT OF CHILD MALTREATMENT AND HOW IT CAN BE PREVENTED

Once prevention goals have been clarified, other essential questions remain. Foremost among these are identifying the target behavior and effective strategies for eliminating and/or reducing that behavior.

Definitions

A logical first step in formulating effective response to child maltreatment is to articulate a clear and accurate picture of the problem. Unfortunately, the field continues to be plagued by a lack of clarity of key terms, both between and within the numerous disciplines at work. For example, there has yet to be a definitive answer to such basic questions as "What specific behaviors constitute abuse?" and considerable disagreement persists regarding whether specific acts (e.g., striking a child, kissing a child) can be deemed abusive (Portwood, 1999).

Prevention efforts have been complicated by this difficulty in reaching a consensual definition of key terms, which include not only *child maltreatment*, but also each of its four standard sub-categories: *physical abuse*, *psychological abuse*, *sexual abuse*, and *neglect*. Currently, there is little consensus among the definitions used in law, practice, and/or research. Relevant definitions of child maltreatment are also subject to social, cultural, and historical influences given that child maltreatment is, essentially, a social judgment about appropriate and/or minimal standards of care.

Neglect, in particular, is generally defined as the failure to meet minimal standards of care. Neglect has been subdivided in multiple categories, commonly including physical neglect, educational neglect, emotional neglect, and medical neglect. What each of these typologies has in common is a failure to meet a child's basic needs. Thus, neglect contemplates an act of omission rather than commission. In contrast, *abuse* typically contemplates an intentional act. Many definitions of abuse encompass both a harm standard, requiring some observable in-

jury, and an endangerment standard, under which a child is deemed to be abused if he or she is placed at substantial risk for harm. C*hild sexual abuse* has been defined to include contacts or interactions between a child and an adult (or a person under age 18 who is significantly older than the victim or who is in a position of power or control over the child) when the child is being used for the sexual stimulation of the perpetrator or another person.

Clearly, the experiences of maltreated children are extremely diverse. Likewise, research indicates that the origins and consequences of child maltreatment are complex. No single factor accounts for significant amounts of abuse. To the contrary, the impact of perpetrator characteristics, child characteristics, family characteristics, and the broader social context vary by type of abuse. The task of ascertaining the causes of particular subtypes of abuse, and thus the appropriate targets for prevention, is further complicated by the fact that many children experience multiple forms of maltreatment.

Theoretical Foundations for Prevention Efforts

Current prevention efforts have been based on multiple theoretical foundations.

Macro-Level Theories. The broadest of these theories link child maltreatment to cultural and societal conditions, including poverty, social isolation, racism, sexism, and widespread tolerance of violence and child maltreatment. Within this context of social inequality and injustice, strain theories propose that deviance (e.g., abusive behaviors) is more common among those individuals who experience frustration when they are denied equal access to resources while society emphasizes opportunities for success. The frustration-aggression hypothesis further posits that aggression may be focused on an innocent party (e.g., a child) when the direct source of frustration (e.g., "society") is not available as a target for aggression. According to these theories, maltreatment would decrease if resources and supports for parents were increased and systemic changes were made (e.g., placing high legal and social costs on maltreatment; Daro, 1988). Commentators have also highlighted the role of sexual inequality in contributing to child maltreatment. For example, Straus and Smith (1990) point out that inequality both within and outside the family contributes to the occurrence of family violence.

Family and Individual Theories. Overall, individual- and family-oriented theories underlie most current prevention strategies, including

therapy for parents and/or children, parent education, home-visitation, and support groups (Daro, 1988). According to these theories, changes within particular families or individuals will prevent maltreatment; however, the types of change required vary. Many researchers (e.g., Straus & Smith, 1990) believe that the structure of the family creates a likely setting for violence, noting that family members spend a lot of time together, power differences exist, emotional interactions tend to be frequent, relationships between family members are difficult to break, and families are considered a private institution.

Theories involving psychological and behavioral characteristics of offenders, including caregiver psychopathology, have also been proposed. However, the relationship between specific psychological characteristics and child maltreatment is unclear. While much of the literature has focused on perceived deficits, leading to prevention approaches that emphasize "correction," more recent views have also examined protective factors. For example, the National Research Council (1993) encouraged those developing programs aimed at reducing the risk for child maltreatment to consult research findings from the field of child development regarding those factors that contribute to the development of healthy relationships.

The transactional model of child maltreatment views maltreatment as the result of interactions over time between the parent, the child, and the family context (Wolfe, 1993). For example, research on attachment theory supports the assertion that interactions between caregivers and children that involve maltreatment lead to disorganized patterns of attachment (George, 1996). It follows from this transactional model that parent/child interactions are appropriate targets for prevention efforts.

Many have sought to explain child maltreatment, and in particular, child neglect, through low socioeconomic status. Although abuse and neglect occur in all socioeconomic groups, data have consistently evidenced that child maltreatment, with the exception of sexual abuse (Milner, 1998) occurs at a disproportionately high rate among economically disadvantaged families. However, the relationship between SES and child maltreatment is a complex one. Poverty is characterized by many factors, including unemployment, limited education, single parent households, and social isolation, each of which influences child maltreatment. For example, social distancing often characterizes neglectful families. They tend to move frequently, which can contribute to a deficit in social support networks. Distancing may then extend to the parent-child relationship; neglectful parents have been found to interact less and more negatively with their children (Garbarino & Collin, 1999). The sugges-

tion is that of a cycle of neglect, in which the parent is psychologically neglected by others and then becomes psychologically unavailable to the child. These factors point to the establishment of enduring and productive social relationships as a key factor in preventing child neglect.

Learning and behavioral theories link child maltreatment to a caregiver's lack of knowledge or childcare skills, thus suggesting that prevention should focus on parent education and training (Daro, 1988). One set of factors that distinguishes maltreating parents from their non-abusive counterparts involves the social-cognitive and affective processes tied to parents' perceptions of their children and the parent-child relationship. Offending parents often do not understand the emotional complexity of human relationships, particularly the parent-child relationship. "They have difficulty seeing things from the child's perspective or understanding behavior in terms of the child's developmental level and the context or situation" (Erickson & Egeland, 1996, p. 13). Abusive parents may have high expectations of their children's behavior and/or believe that this behavior is deviant. Lack of understanding regarding the child's developmental level may lead a parent to make negative attributions regarding the child's behavior or motivations. Parents' own developmental level, which is a product of their history of care, autonomy, trust, and level of cognitive functioning, may also impede their ability to provide for children's needs. Social learning theory is frequently applied to understand the perpetuation of maltreatment within families, positing that children who experience or witness violence are more likely to become violent themselves (Widom, 1989).

Recent research suggests that biological factors may also place some individuals at risk for committing child abuse. For example, perpetrators of physical abuse have shown hyperresponsive physiological activity to both negative and positive child stimuli that may influence their physiological responses in stressful situations involving children (Milner & Chilamkurti, 1991). However, there is a clear need for further research in regard to potential biological contributions to child maltreatment.

Scientific Research Relevant to Prevention Efforts

The field of child maltreatment research is relatively young; in fact, almost all relevant research has been conducted since 1970. A significant portion of this research has investigated the causes and consequences of child maltreatment, revealing the complex nature of both constructs. As previously noted, attempts to delineate the causes of child maltreatment have produced evidence that no single factor ac-

counts for significant amounts of abuse. Instead, four categories of causal factors (perpetrator characteristics, child characteristics, family characteristics, and the broader social context) must be considered, with an acknowledgment that the impact of these factors varies by type of abuse, specifically, physical abuse and neglect versus sexual abuse.

Physical Abuse and Neglect. Several parent characteristics have been associated with physical abuse and neglect, including substance abuse and lack of involvement in community activities (Brown, Cohen, Johnson, & Salzinger, 1998). Abusive parents also tend to be single and young, to have lower self-esteem, to have inappropriate expectations of their children, and to be less empathetic with their children (Milner, 1998). In general, five areas have been associated with abusive parenting: cognitive disturbances, deficits in parenting skill, problems with impulse control, difficulties with stress management, and social skill problems (Azar & Twentyman, 1986). Each of these deficits, alone or in combination, can play a role in more systemic difficulties that increase the risk of abuse (e.g., a parent's poor social skills may result in a smaller support network). Child characteristics that have been associated with maltreatment include having a disability, a difficult temperament, psychiatric symptoms, and behavioral problems (Brown et al., 1998). However, when examining the behavior of both parents and children, the question of directionality arises (i.e., does negative parenting behavior produce negative behavior from the child or vice versa?).

Family characteristics are also related to the rate of child maltreatment. Situations that contribute to the level of stress within a family, including illness, death of a family member, and larger than average family size, have been established as risk factors for physical abuse (Miller-Perrin & Perrin, 1999). Other family factors associated with child maltreatment include high levels of conflict, the occurrence of partner violence, social isolation, high levels of stress, and a lack of support (Milner, 1998). Parents who abuse their children tend to communicate less frequently with their children, and they demonstrate fewer positive parenting behaviors. Abusive parents also tend to report more violence in their family of origin. However, it is important to note that while "cycle of violence" theories have garnered a great deal of public attention, the majority of individuals abused as children (about 70%) do not grow up to be abusers (Widom, 1989).

Rates of child physical abuse and neglect are higher in communities with a larger proportion of residents living in poverty (Garbarino, Kostelny, & Grady, 1993). Communities with more female-headed households, a higher unemployment rate, a lower percentage of wealthy

residents, a lower median education level, more overcrowding, and a higher percentage of new residents also tend to have higher rates of maltreatment. However, it is important to note that violence is by no means typical of all families living in poverty, suggesting that other factors, most notably social bonding/social isolation, are at work. Emery and Laumann-Billings (1998) found that even in low income neighborhoods, child maltreatment rates tend to be low when residents know one another, there is a sense of community pride, people are involved in community organizations, and residents feel that they can ask their neighbors for help.

Sexual Abuse. In regard to sexual abuse, the abuser tends to be male, to have interpersonal problems, and to be antisocial (Milner, 1998). Thus, it is perhaps not surprising that research on characteristics of sexual abusers has focused primarily on men and may not be generalizable to female perpetrators. The majority of this research has also been generated from an assumption that the root cause of sexual abuse lies in the individual psychopathology of male abusers. As noted, there is some evidence to suggest that sexual abusers exhibit some antisocial tendencies, including a disregard for others and lack of impulse control, and/or deficits in heterosocial skills. Other theories center on deviant sexual arousal, which prompts offenders to solicit sexual encounters with children. The as yet undetermined origins of this deviant sexual arousal are believed to be primarily biological. However, this explanation does not appear adequate to explain incest. Instead, family dysfunction models posit that either the family or one of its adult members contributes to a context in which the sexual victimization of children is permitted or even encouraged (Miller-Perrin & Perrin, 1999).

Many early researchers focused on child characteristics in seeking explanations for sexual abuse, examining the victim's role in permitting or even encouraging the abuse. However, little evidence has been produced to support such a stance. While many victims of sexual abuse do exhibit sexualized behavior, most experts believe this to be a consequence rather than a cause of the abuse (Miller-Perrin & Perrin, 1999). In regard to family characteristics, poor parent-child relationships and marital conflict are associated with sexual abuse. Additional risk factors, including the presence of a stepfather and not living with one's natural parents for extended periods of time, attest to the heightened risk of being abused by non-biological family members (Brown et al., 1998; Finkelhor, 1984; Finkelhor, Hotaling, Lewis, & Smith, 1990). At the macrolevel, social and community factors, particularly social attitudes

that view women and children as subordinate, no doubt contribute to the prevalence of sexual abuse (Williams, 2003).

PREVENTION PROGRAMMING

Ideally, prevention programs will be based on sound theory and reflect current research knowledge. However, the degree to which particular programs are grounded in theory and empirically-based is highly variable, as an overview of the two most popular program models–child empowerment and parent enhancement–demonstrates.

Prevention of Sexual Abuse: Child Empowerment Models

To date, most "child abuse" prevention efforts have targeted the more restricted category of child sexual abuse, even though this type of abuse accounts for a relatively small proportion of all cases of maltreatment. These programs tend to emphasize "stranger danger," despite clear evidence that the vast majority of abusers are known to the child. One of the most popular models for child sexual abuse prevention, the child empowerment service model, focuses on teaching children to recognize, resist, and report abuse. Among 400 school districts surveyed, Daro (1994) found that 64% had offered a prevention program during the preceding year. Similarly, 67% of children from a nationally representative sample had been exposed to a sexual abuse prevention program; almost all of these programs were school-based and targeted children during the late elementary grades (Finkelhor & Dziuba-Leatherman, 1995). While diverse in format and content, child empowerment program models share the same core assumptions: (a) many children do not know what sexual abuse is; (b) children do not need to tolerate sexual touching; (c) adults want to know about children who experience sexual touching by adults; and (d) disclosure of sexual touching will help to stop it. Clearly, at least some of these assumptions are flawed. For example, when asked how they would respond to a report of abuse from one of their child's playmates, only 14% of parents indicated that they would make an official report (to child protective services or law enforcement) if the alleged abuser was a stranger. This rate increased to a modest 33% for CPS and 25% for police when the perpetrator was a parent (Berrick, 1988).

Key concepts typically incorporated into child empowerment program models include the following: (a) children can control access to their own bodies; (b) there are different types of touches (e.g., good vs.

bad); (c) children can and should tell others about touching; and (d) supportive adults are available for children to tell about problems with touching. It is widely agreed that older children are better able to learn the concepts of sexual abuse prevention than are younger children; however, regardless of age, all children appear to learn best from programs that integrate active behavior skills components (Davis & Gidyez, 2000). Components that allow children to participate physically and behavioral skills training appear to be important program features. However, it remains to be established whether knowledge gains will translate into desired behavioral change when children are confronted with a potential abuser. In fact, research suggests that the self-protection responses that children use most often are not those responses recommended in most prevention programs (Asdigian & Finkelhor, 1995).

Despite support from school administrators, teachers, and parents, most school-based child sexual abuse prevention programs have not been evaluated. In their meta-analysis of 27 studies of such programs, Davis and Gidyez (2000) did find a relatively large effect size for programs, which they interpreted to mean that children's prevention-related knowledge and skills improved as a result of program participation. However, the researchers acknowledged that the largest effect sizes were found in less methodologically sound studies, casting doubt on the validity of study results. Even more troubling was the fact that the large majority of these studies were rated as poor in regard to at least one aspect of their methodology.

Overall, while there is limited evaluation data to suggest that child participants in comprehensive school-based sexual abuse prevention programs demonstrate an increase in knowledge, there is no evidence of a reduction in the actual number of victimizations as a result of participation in these programs (Finkelhor, Asdigian, & Dziuba-Leatherman, 1995). The effectiveness of the child empowerment model as a primary prevention tool is particularly suspect. Although such programs emphasize primary prevention as a goal, in fact, their major emphasis is often on disclosure, which constitutes tertiary prevention (i.e., preventing the re-occurrence of abuse).

Not only is the effectiveness of child empowerment programs subject to debate, but critics (e.g., Reppucci & Haugaard, 1989) have expressed other serious concerns, including (a) the impact of these programs on children's sexual development; (b) confusing curricula (i.e., some concepts may be difficult for children to understand); (c) the danger that such approaches may instill feelings of fear, vulnerability, and anxiety

in children, while at the same time giving adults a false sense of security regarding children's safety; and (d) the threat that these programs send the message to children, teachers, parents, and society that children are responsible for preventing their own abuse. Despite the potential for harm, echoes of public support for so-called "child empowerment" can be seen in recent legal precedent, the effect of which is to place a heavy reporting burden on children. In *Stogner vs. California* (2003), the U.S. Supreme Court rejected a California law affording victims additional time to pursue legal action based on previously unreported abuse. The Court's ruling did not acknowledge scientific evidence put forward by the State and the American Psychological Association (in an amicus curiae brief) to the effect that childhood sexual abuse is rarely reported and that there are numerous reasons why victims do not report their abuse.

Prevention of Physical Abuse and Neglect: Parent Education Models

Parent education models target primarily physical abuse and neglect. Increasing support for parent education programs among practitioners, policymakers, and the general public is linked to a belief that lack of knowledge about child development and inadequate parenting skills are fundamental causes of child maltreatment (Cowen, 2001; Wolfe, 1985). Such programs emphasize teaching parents new skills (outside those learned during their own upbringing) that will enhance their resources, coping skills, and parenting competencies (Reppucci, Britner, & Woolard, 1997).

Despite the prevalence of parent education programs, as with child empowerment programs, relatively few have been evaluated in the scientific literature. Even fewer have been examined for their impact, if any, on child maltreatment specifically. While some evaluations of parent support programs demonstrate success, many fail to provide evidence of program effectiveness (Gomby, Culross & Behrman, 1999). It may well be that some programs are better than others; however, little work has focused on identifying those factors that increase a program's likelihood of success.

We do know that, ideally, parent education and support programs are initiated early in the child's life or before birth. Such interventions (a) seek to influence the parent-child relationship early in the child's life, before abuse can occur and before parents have established themselves in their parenting role; and (b) tend to be voluntary and to provide in-home services as well as case management support. However, there are also a number of characteristics that differentiate prevention programs aimed

specifically at families with young children. Individual programs vary by the setting in which services are delivered (e.g., home, school, community center, clinic); primary target (e.g., child, parent, family); timing of onset (e.g., prenatal, infant); intensity; duration; and training background of the service provider. Programs also vary in terms of the type and number of services that they offer. Home visiting services, the key feature of many parenting programs, have been identified as the "best documented preventive effort," as well as the most promising form of intervention (Daro, 1996, p. 345). Although most programs do involve some form of home visiting, they may also include group meetings or some other form of center-based support, assistance in meeting basic needs, cognitive behavioral skills training, or training in infant cognitive stimulation. While there are programs that focus on primary prevention, many others target specific groups identified as "at risk."

Today, hundreds of parent education and support programs have been developed; however, two have come to dominate the prevention landscape–the Olds model (Olds, Henderson, Chamberlin & Tatelbaum, 1986) and the Healthy Families Model (Breakey & Pratt, 1991). The first of these is also one of the earliest, most comprehensive, best evaluated, and most cited parenting-focused prevention programs. Developed by Olds and colleagues, the Prenatal/Early Infancy Project was initially evaluated through a randomized clinical trial in Elmira, New York. Data demonstrated that intensive nurse home visitation during pregnancy and through the child's first two years had positive effects on parenting attitudes and behavior, as well as on reports of child maltreatment. The Olds' model was subsequently replicated in Memphis, Tennessee, with a population whose demographic characteristics differed substantially from those in the earlier study. Results in Memphis again demonstrated important program effects: children had fewer injuries and ingestions of hazardous substances before age 2 than did a control group of children who did not participate in the program, and their homes were rated as more supportive of healthy development (Kitzman et al., 1997, 2000). However, these results were less pronounced than in the previous study. In part due to its promising results, the Olds' model has now been extended to well over 100 sites (Leventhal, 2001).

An even greater number of programs have been based on the Healthy Families model, which was launched by Prevent Child Abuse America in partnership with Ronald McDonald House Charities in 1992. The Healthy Families model began through the Hawaii Healthy Start program (Duggan et al., 1999), and today exists in over 420 communities

across the United States and Canada (Healthy Families America, 2003). In contrast with the Old's model, the Healthy Families model utilizes a trained paraprofessional home visitor supervised by a social worker and health personnel, rather than a nurse supervised by a social worker. However, as with the competing model, the role of the home visitor is to establish a trusting relationship with parents, to help parents address their needs and connect with resources, and to provide parenting education.

Pilot evaluation data from Hawaii Healthy Start indicated that few reports of child maltreatment were made on participating families during the first three years of the program (Fuddy, 1992). However, the evaluation did not employ a control group, and the follow-up period was short. Initial results have also indicated that the Healthy Families model is rarely implemented as designed. For example, rather than receiving weekly visits for most of the first year as provided in the project design, home visitors averaged 13 contacts per year with parents. Nonetheless, initial results indicate improvements in maternal attitudes and self-reported use of harsh discipline (Duggan et al., 1999).

While both the Olds and the Healthy Families models rely on early and frequent home visits, the provision of care within the context of a therapeutic and supportive relationship, an established curriculum, modeling of effective parenting, and connecting families to appropriate services in the community, Leventhal (2001) noted that there are also several important distinctions between the two models. The primary distinction, as previously noted, relates to the individual providing the intervention. The Olds' model employs nurses, who, as trained health professionals, are practiced at making clinical assessments and offering guidance to clients. In contrast, the Healthy Families model relies on paraprofessionals as the primary change agents. Although less skilled at making assessments and less trained in regard to health and development issues, as community members, these paraprofessionals may nonetheless be better able to establish stronger personal connections with families at risk.

A second distinction between the two models involves the criteria used to identify families for service provision. While both programs target first-time mothers from families perceived as at high risk, the specific criteria, as well as the procedures for determining eligibility, vary. For the Healthy Families program, potential participants are initially selected based on information on various risk factors (e.g., unmarried mother, mother under 19 years of age) obtained through medical records. Qualifying individuals then undergo an interview. Assuming that

at least one parent receives a score indicative of high risk, the family is eligible to receive services from Healthy Families. First-time mothers are eligible for the Olds' model if they demonstrate two of three identified risk factors: less than 12 years of education, unmarried, and/or low socioeconomic status (Leventhal, 2001).

As noted, despite the promise of these parent education models, there are notable limitations to the current research. Clearly, well-designed research is both difficult and expensive to conduct (Leventhal, 2001). In addition, it is at least equally difficult to deliver high quality services. Parent education programs continuously face serious challenges from high attrition and staff turnover (Gomby, 2000).

While preliminary data suggest that parent education models can reduce child abuse and neglect, research also illustrates that home visiting is not a "cure-all." For example, Eckenrode et al. (2000) found that where high levels of domestic violence are present, it is difficult to improve parenting through home visiting. Clearly, change at levels beyond the individual are required to prevent child maltreatment. Even well-designed and well-implemented programs are unlikely to lead to substantial change if they are unsupported by their context.

PREVENTION THROUGH SYSTEMS AND SOCIETAL REFORM

Child maltreatment may also be prevented through social and system level reform; however, the development of programs and policies that aim to prevent maltreatment at this level has begun only recently. Despite substantial evidence that community level factors impact child abuse and neglect, examples of community-based child abuse prevention programs are rare. As noted by Garbarino and Collin (1999), an overarching issue is that of the neglectful society; whereas it is important to intervene on behalf of the individual child, the larger issue looms of how whole segments of society (e.g., the poor) are "neglected." Although, as previously noted, one goal of many parent education and support programs is to enhance social support and to connect families to needed resources, these components tend to be under-emphasized.

While efforts to support parents and to provide them with needed education and/or services recognize, to at least some extent, that certain resources are required to parent effectively, the extent of the multiple difficulties (e.g., poverty, limited education) that many individuals face is sometimes overlooked. Currently, there are not many programs that

seek to prevent maltreatment by helping families to escape poverty. While there are some programs that encourage teen parents to return to school or to obtain further training, this component is often absent from programs targeting older parents, even though they typically face even more serious economic problems. Recently, some programs have been developed to help parents obtain economic self-sufficiency. Initial evaluations of these programs suggest that they may be helpful in improving the economic situation of poor families; however, they require an intensive and long-term approach (Hay & Jones, 1994). Careful evaluation will also be needed to determine their effect, if any, on preventing child maltreatment.

Provision of high quality care for children can also assist in the prevention of child maltreatment, not only directly, but also indirectly, by reducing parent stress. In the United States, statistics evidence both a large number of mothers employed outside the home and an increasing number of female-headed households; when combined with other policies, such as welfare-to-work, the result is a growing number of women who find themselves with no choice but to find some form of childcare. The lack of any national day care system in America results in what Zigler and Styfco (2000) characterized as "a hodgepodge of childcare centers, family day care homes, baby-sitting by neighbors and relatives, for-profits, nonprofits, regulated and underground services," that results in a "nonsystem of care" in the years before children enter kindergarten–a system that is a frequent source of child neglect (p. 16). Only the implementation of uniform standards for early childcare services holds serious promise for reversing this crisis.

As noted, it is difficult to establish uniform standards of parenting behavior given the diverse ethnic and cultural milieu of American society. One controversial area is corporal punishment and the extent to which abolishing it would serve to prevent child maltreatment. Straus and Smith (1990) believe that the elimination of physical punishment is a crucial step in preventing family violence and urge early training in alternative discipline techniques. They emphasize that such training should occur before individuals are parents, possibly through school-based training. Nonetheless, the use of spanking remains widespread, and ending the use of corporal punishment has been widely omitted from discussions of child abuse prevention (Straus, 2000).

The media is one potentially powerful tool for promoting positive parenting and discouraging maltreatment. Although there are some limited data indicating that such campaigns can be effective, the use of public service announcements to prevent child maltreatment has been

limited. For example, in the early 1970s, the doctor who first recognized shaken baby syndrome recommended mass education on the dangers of shaking a baby. Despite support from physicians and researchers, as well as research documenting the lack of public knowledge on shaken baby syndrome, educational campaigns were slow in coming; however, their results have been notable. In an example of public education at the local level, the Mayor's Office for Children and Youth and the Baltimore City Commission for Children and Youth evidenced a reduction in observed incidents of child abuse associated with receiving a bad report card following implementation of a school-related prevention initiative that included televised public service announcements prior to and during the week of report card distribution, along with informational inserts in report cards (Mandell, 2000). On a national level, results from a campaign in the Netherlands aimed at encouraging abused children to disclose their abuse indicated that such societal-level interventions hold considerable promise (Hoefnagels & Baartman, 1997). However, such wide-scaled initiatives require a considerable investment of resources if positive effects are to be maintained over time.

Adult caregivers may also be reached through the health care system. In response to research on attachment and early bonding, many health care facilities have made institutional reforms related to childbirth practices (e.g., preparing parents for childbirth, treating parents as active participants in the process, encouraging parent-child contact directly after delivery, having the baby stay in the mother's room, encouraging visits by family and friends). Although initial evaluation data indicate that the period directly after birth may not be as crucial to the development of a bond between parent and child as was initially believed (National Research Council, 1993), reforming hospital practices to be more family-centered can serve to transform the birth of a child into a social event. Family-centered childbirth may help prevent maltreatment by fostering feelings of social connectedness and social competence in new parents (Garbarino, 1980).

Other opportunities for preventing child maltreatment through health care system reform focus on interactions between hospital staff and parents (Wurtele, 1999). Prenatal visits, perinatal prevention programs, and well-child visits present health care professionals with multiple opportunities to provide education, guidance, and referrals to parents. Potential topics for discussion include child development, handling common problems such as feeding difficulties, how to "child proof" one's home, how to enhance children's development, how to choose child care, how to handle behavior problems, and how to discipline children without using

violence. Clearly, health care professionals are in a unique position in that they have access to almost all families at critical time periods.

Although societal and systems-level prevention efforts are currently underutilized, they do provide a promising direction for the future.

PREVENTION THROUGH PUBLIC POLICY

Given the potential of societal and system-level interventions, it follows that public policy could be a powerful tool in the prevention of child maltreatment. A majority of politicians, at all levels of government, purport to place a high value on children; however, child advocates would vigorously dispute whether this proclaimed concern for children is reflected in current policy. As previously noted, Kempe's seminal paper identifying the "battered child syndrome" was published in 1962. However, it was not until 12 years later, in 1974, that Congress enacted the Child Abuse Prevention and Treatment Act (CAPTA). Today, almost 30 years later, CAPTA remains the sole federal program aimed specifically at child abuse prevention.

In its original form, CAPTA defined child abuse and neglect; established the National Center on Child Abuse and Neglect (NCCAN); established basic state grants for prevention and treatment; provided money for demonstration grants to prevent, to identify, and to treat child abuse and neglect; and founded an advisory board to coordinate the federal response to maltreatment. CAPTA has been reauthorized several times since 1974. These reauthorizations have tended toward expanding the law (e.g., broadening the definition of child maltreatment). Notably, the 1996 reauthorization of CAPTA influenced its prevention component by consolidating several small grant programs previously funded under CAPTA into the Community-Based Family Resource and Support (CBFRS) program. CBFRS is the major prevention component of CAPTA, providing funding for various community-based family support programs designed to prevent child maltreatment, including parenting classes, substance abuse treatment, mental health services, respite care, and domestic violence services. Despite its promise, the impact of CAPTA on child abuse prevention efforts has been seriously undermined by a lack of adequate funding.

To see real evidence of commitment at the national level, it is necessary to examine not only legislation, but also the funding put in place to support that legislation. When legislation is passed, funding is *authorized* for various programs; however, in order for a program actually to

be funded, Congress has to *appropriate* money to the program by including program funds in an appropriations bill. Actual funding appropriated for CAPTA has *always* fallen far short of the amount authorized. For example, in 2003, CAPTA was authorized at $120 million; however, basic grants (to help states improve their child protection systems) and discretionary grants (i.e., research and demonstrations grants that could help to advance knowledge about addressing child maltreatment) received appropriations of only $56 million. Appropriations for Community-Based Family Resource and Support Grants, which support proven prevention programs and strategies designed at the local level to meet individual family and community needs, totaled only $33.4 million of the $80 million authorized. While even these numbers may seem large, it is important to recognize that when considering a federal budget in excess of $2 trillion, the financial investment in protecting children is quite insubstantial.

Other federal policies may impact child maltreatment. For example, health care reform focused on making health care affordable and accessible to all families could prevent infant mortality and medical neglect. The development of welfare policy that seeks to keep children out of poverty and ensures the availability of affordable, quality childcare could also help to reduce maltreatment (Hay & Jones, 1994). However, the lack of specific provisions dedicated to the protection of children makes it clear that the actual federal role in the prevention of child maltreatment is limited. In contrast with other countries, such as Sweden, which have had considerable success with national initiatives that strengthen families and thus serve to protect children, the United States has instead diluted accountability by shifting legislative responsibility back and forth from the national to the state level. At present, there is a trend toward increasing responsibility for child-related programs at the state level, despite the fact that the majority of states are experiencing severe financial problems that have resulted in the reduction of social programs. Arguably, if child abuse and neglect is a "societal" problem, it cannot be addressed effectively unless solutions are implemented at the broader societal level.

CONCLUSIONS AND RECOMMENDATIONS

What We Know

Current research supports several promising approaches to child abuse prevention. Foremost among these are parent education programs that

contain a home visiting component. These programs, which primarily target physical abuse and neglect, are particularly critical to efforts to reduce the incidence of child maltreatment since almost three quarters of identified cases involve these two forms of abuse. We also know a great deal about the factors that make these programs successful, specifically: initiation of services before or as close to the birth of the first child as possible; services that focus on the child's particular developmental level; opportunities for parents to model the behaviors being promoted; sufficient time commitments (i.e., more than 6 months); an emphasis on social supports and the skill needed to access these supports; a balance of home- and group-based alternatives; and recognition of cultural differences in family functioning and the nature of parent-child interactions (Daro, 1996). Conversely, unsuccessful programs tend to be implemented poorly, lack intensity, are of short duration, and/or are insufficiently comprehensive (Guterman, 1997).

Overall, the primary problem in regard to the effectiveness of current child abuse prevention programs appears to be not with the approach, per se, but with its application to a particular subpopulation (Daro, 1988). Although hundreds of parent education and support programs have been developed, few have been focused on specific subpopulations, thus limiting their effectiveness. For example, the literature suggests that existing parent training programs are less effective with disadvantaged parents and low-income single mothers in particular (Webster-Stratton, 1998).

We also know that in order to have maximum impact, child abuse prevention efforts must focus on potential perpetrators who are known to the child. For example, sexual abuse prevention programs, particularly those based on a child empowerment model, typically promote strategies that are more effective with strangers (Ko & Cosden, 2001). Clearly, when the perpetrator is known to the child, there are fewer adults to whom to report, and alternatives may appear more limited. In addition, there has been no evidence that programs that attempt to teach children to protect themselves from abuse lead to a decline in actual victimization. In fact, such programs threaten to promote the message that children are capable of protecting themselves and thus bear some responsibility for their own abuse.

Finally, we know that multiple systems factors (e.g., characteristics of individuals, the family, and society) combine to cause child maltreatment. It follows that multiple levels of intervention are required to address this complex issue, including changes at the broader societal level.

What We Don't Know

Even those who are optimistic about current prevention efforts typically recognize that these approaches are limited. Inadequate research and evaluation is pervasive, and the failure to integrate multiple levels of intervention is a serious weakness. Many studies fail to adhere to appropriate methodology, and there is a critical need to identify appropriate outcome measures. At present, published evaluations of programs tend to provide little information about specific program content and even less information regarding the process by which the program achieved or failed to achieve its desired effects. For example, there is very little data on the effectiveness of specific components of prevention curriculums for children (Reppucci, Land, & Haugaard, 1998). Other potentially promising strategies have yet to be explored. For example, although several good arguments have been put forth encouraging parents' involvement in sexual abuse prevention programming, only a few such programs have actually been implemented (Reppucci, Jones, & Cook, 1994). These parent-focused programs have experienced serious difficulty in recruiting parents to participate (Hebert, Lavoie, & Parent, 2002). Effective responses to this challenge have yet to be explored.

As noted by Melton (2002), child protection policy is based largely on untested assumptions. At the most fundamental level, since most cases of child maltreatment are not identified, it is not at all clear whether those cases that are identified, and upon which current scientific and clinical knowledge is based, are representative of the population of all cases of abuse and neglect. A more integrated and well-supported approach to research, such as that encouraged through recent initiatives by the National Institutes of Health (e.g., increased research on child neglect and a focus on definitional issues around child maltreatment) are required to fill in these critical knowledge gaps.

Directions for the Future

In 1984, the McMartin preschool case, in which the owner of the day care center and six of her employees were accused of sexually abusing 125 children over a 10-year period, brought child sexual abuse to the forefront of the American consciousness. By 1988, the McMartin case, which was still being prosecuted, had cost $7.5 million, prompting Judge Pounders to dub it the most expensive case in American history. Pounders nonetheless believed the expense to be justified since "The

case has benefited society as a whole . . . because people have become aware of a social problem that may not have been spoken about" (quoted in Reppucci & Haugaard, 1989, p. 1266). Public opinion surveys from the 1980s showed that over 90% of the public were aware of the problem, understood that there were different forms of child maltreatment, that the causes of child maltreatment were diverse, and that they would need to act in order to resolve the problem (Daro & Donnelly, 2002). Now, roughly 20 years later, it is clear that increased awareness, without a sustained commitment to action, is insufficient. Given the prevailing political rhetoric, it stands to reason that many, if not a majority, of citizens assume that lawmakers are putting measures in place that protect children. Lawmakers may themselves assume that issues are being addressed at other levels of government. In any event, little pressure is exerted for change, with child advocacy left, in large part, to small, under-funded groups with little political power.

As others (Daro & Donnelly, 2002; Leventhal, 1996; Vieth, this volume) have noted, child abuse and neglect *can* be prevented, if not totally eliminated. There is a great deal that we know about what works in preventing child maltreatment; however, programs are admittedly difficult and expensive to provide. At present, the majority of public funds dedicated to child maltreatment are directed to treatment, despite evidence that prevention efforts for children are cost-effective. For example, Weikart and Schweinhart (1997) demonstrated that for each dollar invested, the High Scope/Perry Preschool Program saved $7.16.

In order to prevent child maltreatment, pervasive and active public support must be amassed. Public opinion favors government funding of prevention programs, particularly home visitation for families with young children (Melton, 2002). However, we have yet to mobilize public opinion to ensure that these services are provided to all families, or even to those most in need. For better or for worse, any issue that impacts society is political (Conte & Savage, 2003). Children are not in a position to advocate for themselves within a complex, politically-charged environment. Accordingly, child abuse prevention is not the responsibility of children; it is the responsibility of all adults.

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