The Importance of Integrating Approaches in Child Abuse/Neglect and Unintentional Injury Prevention Efforts: Implications for Health Educators
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Abstract
The purpose of this article is to describe the importance of integrating efforts in the areas of child abuse/neglect and unintentional injury prevention. The common risk factors, illustrated by a working model, necessitate a more comprehensive approach to prevention efforts. Health educators can be key players in this process through participation on child death review teams, development of integrated and targeted programs in schools and in the community and by being a part of successful advocacy efforts.

Introduction
Children, arguably our country’s most precious resource, die or are harmed every year because of unintentional and intentional injuries. According to the National Safe Kids Campaign (1998), unintentional injuries are the leading cause of death and disability among children ages 14 and under in the United States. Data show that one out of every four children, or more than 14 million children ages 14 and under, sustain injuries that need medical attention each year. The leading categories of risk for unintentional injury deaths among children include motor vehicle injuries, being pedestrians and bicyclists, drowning, fires and burns, suffocation, poisoning, choking, unintentional firearm injuries, and falls. It has been shown that younger children, males, minorities and poorer children suffer disproportionately from unintentional injuries.

In terms of intentional injuries, a 1998 US National Research Council publication, “Violence in Families: Assessing Prevention and Treatment Programs,” reported that government surveys show every year nearly three million children in the United States are reported to child protective services as alleged victims of maltreatment. This includes neglect, physical abuse, sexual abuse, and emotional maltreatment. Over 1,000 children died from abuse and neglect in 1998 (The United States Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2000). Please note this manuscript will not focus on homicide or suicide deaths of older children per se in relation to intentional injuries. However, much of what is discussed in reference to intervention strategies may apply to these types of injuries as well.

There is a division that exists among injury prevention professionals that separates the worlds of unintentional injuries and intentional injuries, commonly known today as violence. The category of unintentional injuries is reserved for injuries that are considered “accidental” or done without harmful intent while intentional injuries are those caused by harmful intent, such as homicide, suicide, abuse, etc. However, the injury community is committed to include all injuries in its field of study. A recent Institute of Medicine Report, “Reducing the Burden of Injury” (1999), strongly endorses and reaffirms continued integration of all injury prevention activities, both unintentional and intentional, within a common framework of research and program development. The reasons cited for this integration include: 1) The surveillance systems that undergird injury prevention collect data on all injuries regardless of intent or mechanism; 2) The responsibilities for carrying out preventive interventions often involve the same programs and agencies; and 3) The epidemiologic evidence highlights the strong etiological role of several factors that cut across all injury categories. Examples of these factors include alcohol use and adolescent risk taking. Therefore, there are common prevention strategies for these two injury divisions.

Commonalties are shown as early as infancy. Data show there is an increased risk for infant injury death associated with higher parity and decreasing maternal age for both intentional and
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unintentional infant deaths (Cummings, Theis, Mueller, & Rivara, 1994).

Home visitation has been shown as an important component in the prevention of various types of injuries. Recent research has shown that women visited by nurses during pregnancy and the first two years of the child’s life had fewer child health encounters for injuries or ingestions (Kitzman, et al., 1997; Olds, et al., 1997). The study by Olds and colleagues (1997) was based on a 15-year follow-up of the women who received home visitation by nurses during pregnancy and infancy. The results showed that nurse-visited women were identified as perpetrators of child abuse and neglect significantly less often. Kitzman’s study (1997) showed that nurse-visited women held fewer beliefs about child-rearing associated with child abuse and neglect--a lack of empathy, belief in physical punishment, and unrealistic expectations for infants--than women in comparison groups who did not receive home visitations. The educational and emotional support provided by the nurses helped contribute to these differences. A more recent study by Olds et al. (1998) showed that the adolescent children of the unmarried and low socioeconomic women who received home visits during pregnancy and postnatally, reported fewer instances of running away, fewer arrests, fewer convictions and violations of probation, fewer lifetime sex partners, fewer cigarettes smoked per day, and fewer days having consumed alcohol in the last six months. The parents of nurse-visited children reported that the children had fewer behavioral problems related to the use of alcohol and other drugs. These findings have implications for both future unintentional and intentional injuries of these adolescents.

If indeed there are several commonalities between children’s unintentional and intentional injuries, how can the strategies for intervention be better integrated and what are the implications for health educators? The histories of intervention types differ based on the type of injury defined. Interventions in unintentional injury have largely focused on targeting the injury vector and environment before an event happened (Peterson & Brown, 1994). The interventions have included active and passive measures that preferably address the host, agent, and environment. It has been estimated that as many as 90% of unintentional injuries can be prevented (National Safe Kids Campaign, 1998). The most successful interventions have been those that have addressed a combination of education, environmental improvements, engineering modifications, enactment and enforcement of legislation and regulations, economic incentives, community empowerment, and detailed program evaluation (National Safe Kids Campaign). Examples include use of seatbelts and car safety seats, usage of bicycle and motorcycle helmets, and prevention of poisonings (National Committee for Injury Prevention and Control, 1989).

Unlike unintentional injury prevention interventions, research into child abuse and neglect, the intentional injuries focused upon in this article, has focused on the social and human causes, rather than more environmental causes. This field targets the stresses of society and the limited emotional and material resources of the maltreating family (Peterson & Brown, 1994).

Integration Model

Peterson and Brown (1994) have developed a working model that addresses an integrated intervention approach for both childhood unintentional and abuse and neglect injuries. The model is shown in Figure 1. Physical injury defined in this model is that pertaining to unintentional injury and physical abuse and neglect. The model includes background and immediate contributors to injury. These contributors are classified as sociocultural variables, caregiver-based variables, and child-based variables. In reference to the background contributors, the sociocultural variables encompass poverty, chaos, crowding and change in residence. The caregiver-based variables include abused or risk-taking characteristics, emotional disturbance, substance abuse, being young and single, unrealistic expectations of children, and supervision/discipline patterns. The child-based variables include being 0-4 years of age, nonrhythmic (a child with irregular eating and sleeping patterns), distractible, and a high activity level. All of the background variables represent historical or continuous influences that separate them from the immediate contributors, which tend to be concrete specific factors that act as discrete triggers for abuse or precipitators of injury. The authors acknowledge that later work on the model

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Figure 1. Contributors to Unintentional Injury and Child Abuse and Neglect
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will be needed to clarify and refine the placement and interrelationships of individual factors. The immediate contributors to injury are sociocultural factors that encompass stress and isolation. Also included are caregiver-based variables of need for control and ineffective discipline and child-based variables of noncompliance and impulsiveness. The model emphasizes the fact that these background and more immediate variables contribute to both unintentional and abuse-neglect injuries in children. For example, based on the background factors, children are at risk for both types of injury if there exists poverty, chaos, crowding, and changes in residence. Many of these factors lead to social isolation and lack of social supports. This can lead to fewer adult resources for supervision to prevent unintentional injury. Likewise, this has also led to increased risk for child abuse and neglect. Risk also increases if the caregiver is immature, hostile, uses ineffective discipline and is substance abusing. Finally, the risk for children is enhanced if the child is noncompliant, aggressive, and has conduct problems.

The working model proposed lends itself to the development of prevention programs that should decrease both unintentional injuries and those related to abuse and neglect. For example, the proposed interventions for the background sociocultural variables include economic assistance and job training, family systems interventions and links for social services. Therapy, the use of help agents and/or community networking, education about children’s development norms and parenting skills training may be effective interventions related to the caregiver-based background factors. For the child-based variables, parental coping skills and child self-control techniques may be effective.

In terms of the immediate contributors to injury, effective interventions based on the sociocultural variables include drop-off centers for children, help agents, and community networking. Interventions for caregiver-based variables may include cognitive therapy and strategies for effective discipline. Interventions based on the child-based variables include rule adherence training, learning safety skills, and self-control. These interventions, working in a cohesive fashion, could lead to real decreases in unintentional children’s injuries and cases of abuse and neglect.

It makes intuitive sense that families who are not impoverished, have education and skills training in child development and parenting skills, therapy when needed, educated children about safety issues, and a network of help and support will have children who are better protected from both types of injuries.

The integration model has been used as the basis of a treatment intervention for women who are at risk for maltreatment due to low income status, child directed anger, and current use of physical discipline (Peterson, Gable, Doyle, & Ewigman, 1997). The curriculum content is characterized by including general skills such as problem solving, child management skills, and anger reduction in addition to an emphasis on building positive mother-child bonds and developing an understanding of the developmental changes the child experiences. Maintenance of skills is accomplished by networking group members, self-reinforcement, and a public commitment by group members to gentle parenting. The intervention also involves home practice and home visiting. Evaluation of the program is ongoing.

It is interesting that both unintentional injury prevention and efforts to reduce child abuse and neglect are becoming more focused on the sociocultural setting and the knowledge and skills of the family (Peterson & Brown, 1994). The use of a balanced ecological model that stresses individual responsibility for health within the context of broader social responsibility has been advocated in health promotion (Minkler, 1999).

More research is needed in the areas of parental processes and family-level socialization in order to effectively balance the intervention approach (Peterson & Stern, 1997). Based largely on studies in the maltreatment literature, these processes and socialization issues include supervision, communication, discipline, and teaching of rules (Peterson & Stern).

Unfortunately, there is no clear consensus on what constitutes appropriate parental supervision. This is very evident when studying child neglect. It is clear that caregiver supervision is essential for children to remain safe. However when does lack of supervision constitute neglect? When is an injury truly unintentional (i.e. pool drowning) or the result of caregiver neglect?
Studies have shown that health care workers can be reluctant to report cases of drowning and near-drowning to Child Protective Services (CPS). A recent study showed that of 95 childhood drowning and near-drowning victims hospitalized between 1981 and 1987 in Seattle Washington, only eight were reported to CPS (Feldman, Monastersky, & Feldman, 1993). Cases were significantly more likely to be reported if the child was younger or nonwhite, the family poor, the injury occurred in the bathtub, social work had been involved, and a prior CPS report recognized, or consideration of neglect was documented in the chart. It becomes obvious that no one has developed a clear definition of what are community standards for supervision of children. Therefore, much of what is defined as neglect due to lack of supervision or unintentional injury based on lack of supervision is not clear. Most injuries to very young children have some lack of parental supervision (Feldman, et al.). However, where do we draw the line between what is appropriate supervision of children and allowing children to develop age-appropriate independence? This should probably be based on the child’s developmental abilities, but the entire matter is still poorly defined and unresolved (Feldman, et al.)

In addition to supervision issues, there are several parent-child relationship difficulties that can lead to maltreatment (Peterson & Stern, 1997). These areas may include the lack of the parent as a reinforcer, more aggressive children resisting or responding negatively to parental intervention, coercive cycles of parent and child, children trying to evoke predictable maternal responses—even if this includes harsh discipline, and the need for maternal control.

The development and enforcement of injury prevention rules for children is important. However, the difficulty with this concept is parents often overestimate their children’s ability for linguistic control over behavior, impulse control, having memory of rules, and their ability to sustain attention (Peterson & Stern, 1997). Although consistent teaching of rules is important for children’s safety, parents need to be aware of children’s normal physical and psychological limitations to apply rules consistently in hazardous situations. For example, removing environmental hazards will be more effective for very young children than requiring them to remember a safety rule. It also becomes important for parents to consider their children’s motivations and points of view (Peterson & Stern).

The Role for Health Educators-Opportunities and Training

A major opportunity to discover more information about risk factors and related interventions that apply to both unintentional injuries and abuse and neglect in children may come through multidisciplinary child death review teams, which operate now in all states. Although the original intent of child death review teams was to address suspected child abuse and neglect cases, some have expanded to include deaths due to intentional and unintentional injuries. The teams often consist of medical examiners or coroners, law enforcement personnel, public health officials, court personnel, health care providers, and representatives from health and social agencies (Joly & Liller, 1999). The purpose of these teams is to review child death cases. Teams will vary as to what ages and causes of deaths are reviewed. However, through a multidisciplinary approach, teams can determine the causes and circumstances surrounding deaths. Through this process, intervention, including counseling and follow-up with surviving and at-risk siblings occurs, misclassifications of deaths are minimized, risk factors are identified, the effectiveness of and capability for criminal, civil, and social interventions for families with fatalities occurs, and there is interagency communication for management of death cases and for management of future nonfatal cases (Joly & Liller).

There is a real need for the involvement of health educators on child death review teams (Noland, Joly, & Liller, 2000). Health educators can provide a valuable service to such teams through conducting thorough reviews of the literature, using qualitative and quantitative research methods to analyze data, and applying the data to plan, implement, and evaluate targeted and integrated injury prevention programs.

Once interventions are developed, appropriate settings for implementation will need to be determined. In the community, health educators can collaborate with social work, mental health, and other health professionals to implement parenting classes. These classes should include information on child development, injury
prevention skills, and how to locate and access support networks. Another important conduit for health educators is the school system. Through health education classes, children should be taught at an early age injury prevention strategies and common risk factors.

Another role for health educators is through advocacy efforts. Policy and legislative changes can strengthen injury prevention efforts. Examples include the passage of child helmet and car safety seat laws, laws pertaining to effective residential pool fencing, and policies and laws related to support for social services and the prevention of child abuse and neglect.

Before health educators can become skilled in integrating approaches, they need coursework and practical experience in undergraduate and graduate health education programs. These programs should include topics such as the prevention and control of unintentional injuries, family and community violence, violence and public health policies, issues related to child, adult, and elderly maltreatment, and how to plan and evaluate programs that use comprehensive approaches. The University of South Florida College of Public Health is developing a certificate program in violence and injury prevention that will address those topics cited. The 13-15 hour certificate will be available for both College of Public Health students and community professionals. Mechanisms such as this allow for students and those health educators in the community to collaborate with other health and social service professionals and develop the necessary skills and expertise to develop, implement, and evaluate effective programs.

Conclusions
Prior research has shown the validity for integrating approaches to prevent child abuse/neglect and unintentional injuries. Some may argue that if we continue to use separate intentional and unintentional injury categories we do gain an interest in interdisciplinary collaboration (Overpeck & McLoughlin, 1999). However, we lose much more by the fact that new research (including what has been discussed thus far) shows that risk factors across all injuries have a great degree of overlap, regardless of the intent (Overpeck & McLoughlin). While it is understood that violence prevention may encompass broader issues than the reduction of injuries, there is still a need for the integration of efforts so that more comprehensive strategies can be developed.

As for the future, health educators, researchers and practitioners should be forward thinking and integrate methods that will decrease children’s injuries, regardless of motive. Collaboration among professionals is key, whether through child death review teams, development of school and community programs, or advocacy efforts. It is important to remember that how we protect and interact with our children today will contribute greatly to how their children fare in the future.

References


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