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Parenting and family support within a broad child abuse prevention strategy

Ronald J. Prinz*
University of South Carolina

Child maltreatment prevention can benefit from public health strategies

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By definition, child maltreatment (CM) by a family caregiver is parenting gone awry. That prevention of CM would not directly involve the strengthening of parenting is not an easily defended position. However, it is also widely accepted that broader contextual conditions and factors, including those associated with pronounced poverty, adversely affect families and parenting, and exacerbate risk for CM. Parenting-focused intervention is not the only piece needed in a prevention strategy, but it is a critical piece nonetheless. Another contextual consideration, often overlooked, is the collective modeling and contagion effect of parenting across the entire community, for better or worse. Coercive and problematic parenting practices do not arise in a vacuum, nor do pro-social ones. Interventions

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* Correspondence concerning this article should be addressed to Ronald J. Prinz, Parenting & Family Research Center, University of South Carolina, 1233 Washington Street, Columbia, SC 29208. Electronic mail may be sent to prinz@mailbox.sc.edu.

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to improve parenting are important to CM prevention but need to be embedded in a broader public health strategy.

Parenting-Focused Intervention and Support

Parent and family-based preventive interventions have a rich history and evidence base, but the terms referencing these interventions in the CM field and among policymakers are sometimes narrow and potentially misleading. For example, the term *parent education* crops up from time to time. Parent education stereotypes parenting intervention and misses the range and depth of parent consultation/intervention. When a parent consults a primary care provider about their child's health problem, we would not construe the physician's or nurse's service narrowly as *health education*. Similarly, parenting interventions go substantially beyond education to address challenges that parents want to solve, improvement of parent–child relations, alternatives to coercive practices, and parental stress reduction. The term *parent training* also has less than ideal connotations. Historically, parent training as a concept and approach originated in the 1960s to displace more traditional child therapy. Rather than implying that parents needed training because of deficiencies in parenting, the presumption was that parents could be trained analogous to the training of mental health professionals to conduct therapeutic activities at home and throughout the week, which provided more intensive and ecological impact than what a professionally trained child therapist could accomplish in one or two hours per week. Nonetheless, the parent training label has gone mostly by the wayside to avoid unintended negative connotations. In this article, I use the term *parenting-focused interventions* to denote interventions which directly target the improvement of parenting and parent–child interaction.

Several evidence-supported, parenting-focused interventions share a number of key features in common. Examples of these interventions include, but are not limited to, Helping the Noncompliant Child, the Incredible Years, Parent Management Training Oregon, Parent–Child Interaction Therapy, SafeCare, and Triple P. These and other established family-based interventions all have the following attributes in common:

Theoretically Driven: The interventions are grounded in empirically derived theories about child development, family interaction, developmental psychopathology and resilience, and change processes. Theoretical foundations include social-learning and social–interactional theory, cognitive-behavioral principles, attribution theory, attachment theory, and family systems concepts.

Action-Focused: More than just talk, parents actually do things during the intervention, in session, and at home.

Problem-Solving Oriented: The interventions address specific challenges faced by each parent, work toward solutions, and accomplish this task in ways that typically build on child and family strengths.

Specific Parenting Strategies: Going beyond abstractions, the interventions offer parenting strategies that are specific, concrete, and practical.

Collaborative Goal Setting: Typically, goal setting is conducted collaboratively between the parent and the intervention provider, with the latter assuming a consultative rather than a prescriptive stance.

Adoption of a Positive Frame: Collectively, evidence-based parenting interventions are

characterized by the adoption of a positive frame. This takes the form of a non-judgmental attitude toward the parent, building on parent and child competencies, an emphasis on expanding positive child behaviors to displace problematic ones, and a professional style reflecting optimism, encouragement, and patience.

The delivery of evidence-based parenting support interventions varies in terms of settings (e.g., clinic; community center; home visitation; primary care; Head Start or preschool), intensity (from a few contacts to many), and format (individual consultation, group program, online, media promotion). Such interventions aim to build positive practices to replace reliance on coercive ones, to increase parental satisfaction and empowerment, and to strengthen parent–child bonds.

Poverty and Child Maltreatment

Undoubtedly, conditions associated with poverty exacerbate families' challenges and CM rates. The connections between poverty and CM nonetheless are complex. For parents, stressors emanate directly from lack of resources (e.g., food, shelter, health care, child care, education) and indirectly from the many sequalae and correlates of poverty such as high-crime neighborhood, toxic environment, and substance-use problems. Such stressors disrupt and undermine parenting and heighten risk for CM and prolonged involvement with the child welfare system.

The Fourth National Incidence Study of Child Abuse and Neglect documented a number of years ago that children residing in low socioeconomic status (SES) households were 3 times more likely to be physically abused and 7 times more likely to be neglected compared with children in higher SES households, at least based on official child protective services (CPS) data. John Eckenrode and colleagues recently reported a clear association between income inequality and substantiated CM at the county level, which suggests that there is a broader contextual effect of economics beyond child poverty. All of that said, most parents residing in poverty circumstances do not become CPS cases. Many parents in low-income families provide adequate-to-strong parenting.

Poverty takes a toll more generally on child well-being, with CM being only one way in which this plays out. There are sufficient reasons to address facets of poverty without depending on CM prevention as the prevailing justification. Strategies and policies are supportable in their own right to address housing needs, eliminate hunger and undernourishment, secure medical homes and easy access to quality health care, and standardize the universal access to child-development-promoting child care and preschools. Nonetheless, psychologist Leroy Pelton makes the point quite eloquently that the provision of a wide array of material supports and concrete services has the potential to reduce the incidence of child maltreatment, at least among families experiencing pronounced poverty. We can add to the mix greater access to quality treatment services for parental substance-use problems across the economic spectrum.

Justification for a Public Health Approach to Parenting Support

We know that problematic practices by parents, including parenting that crosses the line into the CM range, is far more common than CPS data would lead us to believe. In a carefully

conducted telephone household survey conducted by Des Runyan and colleagues, mothers self-reported physically abusive behaviors by themselves and their spouses/partners toward their children at a rate greater than 40 times higher than the official substantiated rate of physical abuse. In our own telephone survey work with households having at least one child under age eight, we found that 10% of the surveyed parents self-reported spanking using an object on a *frequent* or *very frequent* basis. Furthermore, we found that 49% of the surveyed parents self-reported parenting which relied heavily on coercive discipline practices for child misbehavior.

Problematic parenting behaviors, then, are occurring in many more families than those caught up in the CPS system. We want to prevent CM in part because of its deleterious effects on child development, but such effects are not limited to CPS (or soon-to-be CPS) cases. Reliance on coercive and physically abusive parenting practices undermines child development, is widespread, and requires a public health response.

More generally, a third or more of parents in the community lack self-confidence in aspects of everyday parenting. Accordingly, the incidence of children's social, emotional, and behavioral problems, which can be mitigated by family-based intervention, is substantial.

The widespread nature of parenting difficulties suggests the need to adopt a public health approach to optimize reach and prevalence reduction. Just like with smoking and drunk-driving, CM prevention can benefit from public health strategies, granted that parenting and family functioning is quite complex. Reaching large segments of the population is critical to prevention, and it is no different in the parenting area. The possibility of stigma, however, can be a real deterrent to uptake. Parents typically do not sign up for programs that explicitly espouse child abuse prevention, with the possible exception of either mandated services or differential response (alternative) programs. Normalizing participation in parenting support interventions is essential. The goal of normalization has been achieved in the area of childbirth classes, where one sees parents from all walks of life (i.e., economic; racial and ethnic; family configuration). Somehow, first-time expecting parents do not feel that their participation is stigmatizing or indicative of shameful ignorance about pregnancy and childbirth.

Achieving such normalization and destigmatization in the parenting area is easier said than done. Our public health strategies will need to be multifaceted, including smart use of the media. We can learn something from safety campaigns. Several years ago, parking lot footage played repeatedly on CNN of an abusive parent caught in the act was both alarming and informative. The parent first buckled the young child into a car seat located in the backseat and then proceeded to pummel her with fists. Somehow even an abusive parent had been affected by public health messaging to secure the child properly in the car seat.

If we adopt a public health strategy for parenting support, then many service and community sectors can contribute including but not limited to primary care, education, preschool and child care settings, mental health, public health, social services, juvenile justice, non-governmental and philanthropic organizations, and the faith community. The parenting-focused aspects of CM prevention can readily serve other goals concurrently, such as prevention of childhood social, emotional, and behavioral problems; reduction of risk for adverse adolescent outcomes (e.g., substance use; delinquency; academic failure); and

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parental engagement for school readiness. By amassing and targeting several such goals that are all served by parenting-focused interventions, the strategy creates efficiencies while promoting broader, more normative engagement of parents.

Public Health Strategy for Parenting Support

Much of the quite large scientific database on parenting/family-based interventions is composed of clinical trials addressing early intervention, treatment, and to some extent, prevention. Most of the researchers, myself included, were trained in clinical psychology, social work, or other disciplines that focus heavily on strategies for helping one family at a time or in small groups. Our training often incorporated neither a public health perspective nor community-wide strategies for prevalence reduction. Adoption of a public health approach is a relatively new development in the prevention of CM and other child/family adverse outcomes.

It is thus useful to consider what might be required for a public health strategy in parenting support. The overarching goal of such an approach to prevention is to achieve prevalence reduction. Indeed, reach is important. Communities can do a number of things to improve reach. The first is to make parenting support easily accessible by parents.

Another way to increase reach is to make use of a variety of deliver options, increasing the likelihood that parental preference is met and that agencies with different delivery modes can contribute. Home visitation is one such delivery option, but many parents either do not want workers in their home or are concerned about potential stigma. Individual consultation is another option, which can take place in a number of settings (e.g., community center; primary care; preschool/kindergarten; clinic) and can be scheduled to take into account parental time constraints. Group-delivered programs meet some parents' needs. Low-intensity interventions delivered to large groups can be used to normalize parenting support and help parents see where they might benefit from additional programming.

The strategic use of media is another hallmark of successful public health efforts. In the parenting support arena, media can normalize the seeking of consultation for parenting, provide positive modeling of pro-social and non-coercive parenting practices, and activate appropriate support-seeking behavior on the part of parts. I also suspect that the use of media has the potential to contribute to the building of a positive contagion effect when it comes to parenting that promotes child well-being.

It is an open question whether adopting such a public health strategy could make a dent in child-maltreatment related indicators at a population level. Several years ago, our group conducted a controlled study to test this proposition. We undertook the experiment with both trepidation and wild optimism. To our knowledge at the time, no place randomization study had been published in the CM prevention area.

The study made use of the Triple P—Positive Parenting Program system developed by Matthew Sanders and colleagues at the University of Queensland. Based on over 30 years of studies on the various interventions contained within Triple P, this system offered the various elements of a public health strategy that I described earlier, including a media component. Despite power constraints associated with having only 9 Triple P counties and 9 comparison counties, the study showed that large effects could be produced on child out-of-home placements, child hospital-treated

maltreatment injuries, and CM substantiations.

The population study demonstrated initial proof of concept, namely that community-wide parenting support is a viable strategy for CM prevention. This type of study sorely needs to be replicated, although getting communities, states, and funders to embrace a place randomization design is not easy. Recognizing that our study was a first attempt of its kind and is something to build on, I believe that developments in the field since then might make it possible to achieve even greater impact. At the time we undertook the experiment, the field of implementation science had not yet been infused into prevention. Several aspects of implementation not enacted in our study are ones that I would recommend going forward, such as extended preparatory planning with administrators and supervisors prior to training, building supportive organizational climate, institutionalizing quality assurance processes, and taking early steps to promote sustainability.

A public health approach to prevention does not have to translate exclusively into universal prevention. Universal access to parenting support is important, but this does not mean every parent in the population needs to participate in the same intensity, or even any, level of parenting support. A blended approach to prevention makes the most sense, which means indicated, selective, and universal preventive interventions are combined in an organized framework. Blended prevention also provides a way to integrate other services beyond parenting-focused ones for families with multi-problem needs. In the March 2015 special issue of *Child Abuse & Neglect*, Michael Wald made this case quite well. Analogous to indicated prevention, some families need support in relation to basic needs (i.e., food; housing; medical care) and parental substance-use problems, mental health disorders, or other specific conditions.

Dual intervention for parental substance-use problems and parenting represents a huge challenge for prevention, CPS, and society. Emily Neger and I recently published a review of studies examining the dual treatment of substance-use problems and parenting difficulties. Besides discovering how few systematic intervention studies there are in this area, we found modest support for the contention that the two domains interact. That is, substance-use problems obviously undermine parenting, but it may also be true that substance-use problems themselves are affected by challenging child behavior problems made worse by ineffective parenting.

Finally, a public health approach to CM prevention can benefit from linking parenting-focused interventions to broad community mobilization strategies. Efforts like Strong Communities (developed by psychologist Gary Melton and colleagues), which seeks to change the culture within neighborhoods to one of mutual engagement and assistance, are compatible with interventions that champion and promote pro-social parenting and positive contagion for the raising of healthy children.

Conclusion

A strong argument can be made for adopting a public health approach to CM prevention, and more generally, to community-wide parenting support. Given the critical role parenting plays in child development, a strategy that normalizes and de-stigmatizes parenting support, can yield multiple benefits. Bridging parenting-support efforts across service sectors, settings, and goals is a promising strategy to create efficiencies and effect CM, child behavioral health, and risk for subsequent youth adverse outcomes.

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The two-pronged approach of strengthening parenting across the community and addressing the most toxic aspects of poverty is a potentially powerful combination.

Keywords: parenting support; prevention; public health strategy; evidence-based intervention

Suggestions for Further Reading

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