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Commentary

Violence and Health: The Challenges of How We Talk About, Conceptualize, and Address Violence

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This issue of *CJNR* recognizes violence as a multifaceted, complex threat to health, in which environmental factors, biology, social response, and social situation all play a role. This is particularly true of family-related violence. Given such complexity, it is not surprising that research in the field has moved slowly. A number of obstacles stand in the way of its progress in terms of how we talk about, conceptualize, and address violence.

Perhaps the most fundamental difficulty for violence research is the lack of a common language within the field (National Institutes of Health, 2004). Without a common language it is not clear whether terms such as abuse, maltreatment, aggression, and hostility are synonyms or are elements of a typology of violence. Further, without a clear definition, individual words can carry several meanings, as in the case of "bullying," which, as Tremblay (2006) points out, can be thought of as both an *indicator of* violence and a *precursor to* violence.

The absence of a common language leads to a second challenge — that of fully conceptualizing violence in terms of its predictors, trajectories, influencing factors, and outcomes. In the absence of a comprehensive model, violence is often thought of in narrow terms — for example, by type, without consideration of other issues, such as degree or extent of maltreatment (Paz, Jones, & Byrne, 2005). These myopic views have, until recently, hampered the movement of violence research into areas such as genetics (Dionne, Tremblay, Boivin, Laplante, & Perusse, 2003) and the brain (Weaver et al., 2004). Likewise, narrow thinking has, until lately, prevented researchers from examining how these factors might work in combination — for example, by investigating the interaction of genetics and the environment (Caspi et al., 2002).

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The challenge of conceptualizing violence leads to a third problem, and perhaps the most complex — how best to address violence? Such a challenge contains two areas of concern: finding the right treatment, and finding the right way to deliver it. On the first point, while there is evidence that specific targeted interventions (e.g., parenting programs) address target behaviours (e.g., nurturing behaviours), it is unclear that proven interventions provide positive outcomes in the local community similar to those achieved under research conditions where they were developed (Chinman et al., 2005). Further, it is becoming increasingly obvious that such interventions alone are insufficient to alleviate the multifaceted problems of violence (e.g., Hughes & Gottlieb, 2004). A much broader range of supports (e.g., social, educational, and health care services) may be necessary.

Recent reviews (e.g., Statham, 2004) have argued that children living with/or experiencing abuse need a holistic, multi-agency approach and intensive, targeted support within a framework of universal programs. While many clinicians in the field would concur with the spirit of this position, few researchers have tested the effects of combined interventions. This may be because such approaches are fraught with complications, involving conceptualization, operationalization, instrumentation, consistency, measurement, and data-collection strategies that can affect the nature, quality, and accuracy of data (Edens & Douglas, 2006; Jones, Cross, Walsh, & Simone, 2005). Further, not much is known about how best to *combine* strategies (Chinman et al., 2005). Specifically, we understand very little about the optimal ways of *prioritizing* or *sequencing* the different targeted supports. We have done little to identify the types of *universal* programs that would be useful, when they should be offered to maltreated families in need of multiple supports (e.g., parenting, housing, and mental health services), or whether their effects continue over time.

There is growing evidence to support the use of parent training for families who have abused their children (Tomlinson, 2003). However, these short-term targeted interventions are thought to need further long-term, wrap-around supports to address relationship problems, depression, low self-esteem, harmful substance use, and financial problems. Yet there is little evidence available to answer the questions: What services provide the best *wrap-around support* for a wide range of needs? Should they be generic or specialized? How and when should they be offered? Can needy families effectively accommodate interventions designed to address substance use and financial matters at the same time?

Such questions raise the second research problem regarding how to address violence: How best to deliver the treatment? What are the best ways to bring together different services, from different sectors, with different agendas (e.g., adult mental health services and child protection)

in order to work towards common goals (Bell, 2001; Jones et al., 2005; Kerwin, 2004; Sloper, 2004)? Partnerships present numerous challenges (political, financial, logistical, etc.) that have received little attention from researchers (Hughes, Sommerfeld, & Kay-Raining Bird, 2005). In addition, research has generally failed to explore critical issues such as a community's capacity to deliver multiple services to families living with violence, or the effects of different situational factors within a community on the effectiveness of interventions. We have also generally ignored the varying impact of multiple services on a family when delivered in different ways — for example, either as disconnected services or as coordinated or integrated services through team efforts (Chinman et al, 2005; Sloper).

Clearly, while much progress has been made in the field of violence research, how we talk about, conceptualize, and address violence presents problems for continued advancement. Like violence itself, these are complex research challenges whose resolution calls for the collaboration of a broad range of stakeholders (policy-makers, clinicians, agencies, etc.) rather than researchers working alone (Chinman et al., 2005; Spoth & Greenberg, 2005). Violence research can no longer be carried out in isolation. The time has come to build strategic partnerships and map out much more relevant, partnership-based research agendas.

References

Bell, L. (2001). Patterns of interactions in multidisciplinary child protection teams in New Jersey. *Child Abuse and Neglect, 25,* 65–80.

Caspi, A., McClay, J., Moffitt, T., Mill, J., Martin, J., Craig, I., et al. (2002). Role of genotype in the cycle of violence in maltreated children. *Science, 297,* 851–854.

Chinman, M., Hannah, G., Wandersman, A., Ebener P., Hunter, S. B., Imm, P., et al. (2005). Developing a community science research agenda for building community capacity for effective preventive interventions. *American Journal of Community Psychology, 35*(3/4), 143–157.

Dionne, G., Tremblay, R., Boivin, M., Laplante, D., & Pérusse, D. (2003). Physical aggression and expressive vocabulary in 19-month-old twins. *Developmental Psychology, 39*(2), 261–273.

Edens, J. F, & Douglas, K. S. (2006) Assessment of interpersonal aggression and violence: Introduction to the special issue. *Assessment, 13*(3), 221–226.

Hughes, J., & Gottlieb, L. (2004). The effects of the Webster-Stratton Parenting Program on maltreating families: Fostering strengths. *Child Abuse and Neglect, 28*(10), 1081–1097.

Hughes, J., Sommerfeld, D., & Kay-Raining Bird, E. (2005). Collaboration: You can talk the talk, but can you walk the walk? *IMPRint* (Newsletter of Infant Mental Health Promotion, Department of Psychiatry and Community

Health Systems Resource Group, Hospital for Sick Children, Toronto), *43* (Fall), 9–11.

Jones, L., Cross, T., Walsh, W., & Simone, M. (2005) Criminal investigations of child abuse: The research behind "best practices." *Trauma, Violence, and Abuse, 6*(3), 254–268.

Kerwin, M. L. (2005). Collaboration between child welfare and substance-abuse fields: Combined treatment programs for mothers. *Journal of Pediatric Psychology, 30*(7), 581–597.

National Institutes of Health. (2004). *Preventing violence and related health-risking social behaviors in adolescents: An NIH state-of-the-science conference.* Available online: http://consensus.nih.gov/2004/2004YouthViolence-PreventionSOS023html.htm

Paz, I., Jones, D., & Byrne, G. (2005). Child maltreatment, child protection and mental health. *Current Opinion in Psychiatry, 18*(4), 411–421.

Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services. *Child: Care, Health and Development, 30*(6), 571–580.

Spoth, R. L., & Greenberg, M. T. (2005). Toward a comprehensive strategy for effective practitioner-scientist partnerships and larger-scale community health and well-being. *American Journal of Community Psychology, 35*(3/4), 107–126.

Statham, J. (2004). Effective services to support children in special circumstances. *Child: Care, Health and Development, 30*(6), 589–598.

Tomlinson, B. (2003). Characteristics and evidence-based child maltreatment intervention. *Child Welfare, 82*(5), 541–569.

Tremblay, R. (2006). Prevention of youth violence: Why not start at the beginning? *Journal of Abnormal Child Psychology, 34*(4), 480–486.

Weaver, I. C. G., Cervoni, N., Champagne, F. A., D'Alessio, A. C., Sharma, S., Seckl, J. R., et al. (2004). Epigenetic programming by maternal behavior. *Nature Neuroscience,* 7(8), 847–854.

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