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REVIEW

Health promotion model for childhood violence prevention and exposure

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Aims and objectives. To discuss the Health Promotion Model for Violence Prevention and Exposure and intervention strategies for implementation.

Background. Violence causes physical and psychosocial harm to children. Because little collaboration exists between specialties in the USA, a model that incorporates both a public health and psychosocial approach is needed to assess the risk for exposure to violence and the effects of violence as well as developing prevention strategies. Prevention and intervention includes primary, secondary and tertiary levels that focus on either the community or individual. However, primary and secondary prevention, such as anticipatory guidance and screening, can be implemented by both community and primary care nurses.

Methods. A review of the literature and on-line resources focusing on children's exposure to violence provided the basis for discussion of the commonalities and differences between the public health and psychosocial approach to assessing, preventing and intervening with children exposed to violence. This discussion led to the development of the proposed model.

Conclusions. This model can identify more children at risk for social, physical and psychological harm because of exposure to violence. Implementing prevention or treatment interventions can decrease the impact of violence on children.

Relevance to clinical practice. This model can be implemented by public health, psychiatric and primary care nurses by incorporating the model into the well-child exam, school screenings and after-school programs. Collaboration between specialties will increase referrals for participation in anti-violence programs or treatment interventions.

Key words: children, health promotion, nurses, nursing, prevention, violence

Introduction

Currently, more than 70% of school-age children from low-income communities in the USA have observed domestic violence, assaults, arrests, drug deals, gang violence and shootings (Kliewer *et al.* 1998, Miller *et al.* 1999). In addition to witnessing violence, 877,700 children aged 10–24 were injured from violent acts in 2002 [Central Drug Control

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(CDC) 2004]. Homicide is the second leading cause of death in this age group. The public health approach to this problem focuses on identifying prevalence rates, risk factors and protective factors. Nurses can use this information to identify groups of children who are at-risk for exposure to violence and provide community-based prevention programs. However, psychological characteristics of the child and the child's ability to cope with an exposure to violence will also assist the nurse in implementing prevention strategies. Ideally, collaboration between public health approaches and psychosocial approaches will maximize the identification of children at risk and the effectiveness of preventive interventions.

Aims

This paper proposes a Health Promotion Model for Childhood Violence Prevention and Exposure and recommends strategies to prevent or treat those exposures (Fig. 1). Suggestions for implementing this model in practice are also presented.

Method

Relevant material included in this paper was identified through a search of Medline (1966–2005), Cinahl (1995–2005) and PsychINFO (1995–2005). Search terms included combinations of violence, witnessing violence, prevention and nursing. Searches were limited to preschool, children and adolescents. Papers were also obtained from references listed in publications that met the above criteria. In addition to research databases, the Google web search engine and clinical reference books were used to enhance the clinical perspective of the proposed model.

Results and discussion

Health promotion and levels of prevention

Health promotion involves motivating someone to improve their well-being and actualize their health potential (Pender 1996). Primary care, school, public health and home-care nurses work with individuals to engage them in activities, such as stress management, that will alter their lifestyle and improve their health. These nurses can also implement strategies to detect violence, prevent injury as a result of violence, or maintain optimal physical functioning when an injury has occurred. Prevention and intervention includes three levels, primary, secondary and tertiary, that can prevent an exposure to violence or diminish its effects through active and passive interventions. Primary prevention, which focuses on taking action to prevent exposure, involves implementing health-promotion activities to a group of children or a child in an effort to avert engagement in violence and protect the child from injury [Hartman & Davey 2001, US Department of Health and Human Services (USDHHS) 2001, Porter 2003, Gordes 2004]. Primary prevention involves both active and passive strategies. Active strategies require change on the part of the recipient and include anticipatory guidance, after-school programs, conflict resolution classes and assertiveness training. Passive strategies do not require voluntary behaviour change but achieve changes through external controls such as gun control policies and environmental changes (McCarthy & Hobbie 1997, Sege *et al.* 1997, Mair & Mair 2003). Secondary prevention is the early detection of the condition and prevention of sequela. Screening individuals and communities for an increased risk of exposure to violence so that interventions can be implemented that will decrease

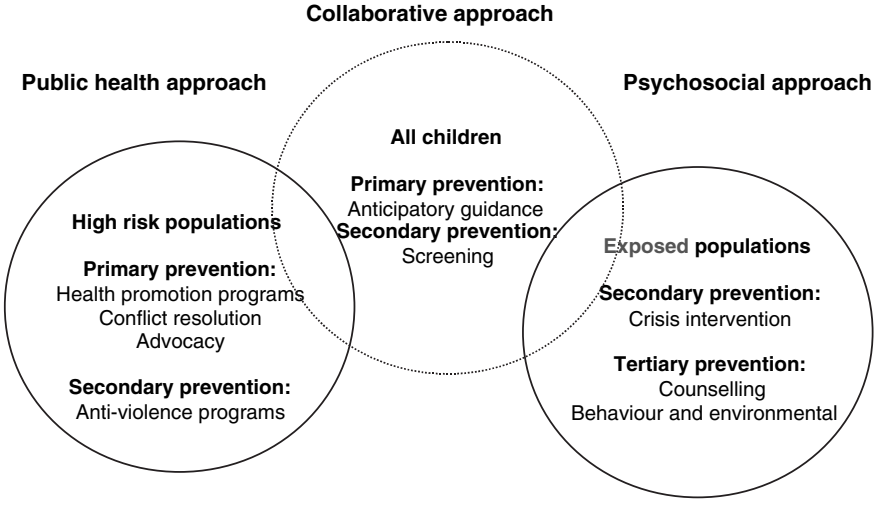

Figure 1 Health promotion model for childhood violence prevention and exposure.

the effect of violence is the key secondary prevention strategy (Gordes 2004). Secondary prevention involves measures that are taken when violence is present or suspected (Hartman & Davey 2001). In addition to screening, anti-violence programs and crisis intervention can be used as means of secondary prevention. Tertiary prevention aims to minimize long-term impact and is exemplified in the rehabilitation and prevention of further incidences of exposure to violence through counselling, stress reduction and modifying unsafe situations (Hartman & Davey 2001). The Health Promotion Model for Childhood Violence Prevention and Exposure incorporates the public health and psychosocial perspectives and a collaborative approach. Each of these approaches will be explained.

Public health approach

In the public health approach, prevention is targeted to communities at-risk for exposure to violence (Jones 1997, USDHHS 2001). In the USA, these high-risk communities include low-income neighbourhoods, areas with gangs, high levels of neighbourhood crime, drugs, or broken homes (divorce) (USDHHS 2001). Children from these high-risk communities are more likely to become witnesses, victims, or perpetrators of violence. However, programs targeting these risk factors may prevent violence. A public health approach to preventing violence involves nurses working in public health agencies as well as in schools, clinics or churches. Nurses working in these settings may work independently or collaboratively to implement primary and secondary prevention strategies. Interventions focusing on health promotion, conflict resolution, screening and advocacy can be implemented with individuals, communities, or systems to reduce violence exposure (Keller *et al.* 2004a, b).

Primary prevention

Health promotion programs: Individual risk factors can be addressed through school-based programs or community based programs. School-based prevention programs may focus on promoting active listening, assertiveness, perspective taking and conflict management (DeJong 1994, Cooper *et al.* 2000, Foshee *et al.* 2000). These skills are taught through role-playing, group dialogue, or other learning strategies that require student participation. Those programs, which show success of preventing violence (decrease suspensions or less school-related injuries), can be incorporated as part of a curriculum throughout a school system and supported by health departments.

Conflict resolution: Skills learned through school-based programs can be used in preventing conflict within the home. Conflict between adolescents and parents can lead to hostility; however, little is known about approaches used to resolve conflict. Focus groups with middle school children and their parents examined the thinking of parents and adolescents about conflict and conflict resolution in their relationships (Riesch *et al.* 2003). These adolescents, who viewed their parents as the initiator of most conflict, handled conflict by trying to dissipate it and take steps to prevent future conflict. For example, adolescents stated that not yelling or agreeing to stop yelling and come back later after both parties have time to cool down, improving communication techniques and enhancing problem-solving are ways to prevent conflict. According to the parents, opportunities to instil a sense of responsibility in the adolescent and struggling about their role boundaries as the adolescent matures give rise to conflict. To solve conflict, parents suggested setting clear expectations, negotiating and cooling down before the situation escalates.

Information pertaining to preventing family conflict is beneficial to public health nurses when assisting adolescents and parents in preventing or solving conflict. Nurses can assess whether a family is at risk for conflict by asking general questions about the parent–child relationship and focusing on how rules are established within the family or what types of activities the child enjoys when away from home. Answers to these questions may alert the nurse to a lack of parental guidance, lack of parental involvement in activities, or exclusion of the child in family decisions, which may lead the child to be involved in unsupervised activities outside of the home including violence. Information about family dynamics is also beneficial to a school-based crisis team, which intervenes when rumours of gang violence are circulating or when the team is preplanning a response for intruders on school property (Kline *et al.* 1995). Both of these measures could prevent potential disaster such as homicide.

Advocacy

Policy development can change individual risk factors or environmental risk factors without requiring an active behavioural change in the child (Friis & Sellers 1999). Nurses can advocate for policies and programs that prevent violence and promote healthy development of children (Jones 1997). Policies beneficial for decreasing violence include gun control, funding for prevention programs and tougher sentences for perpetrators (Temple 2000).

Secondary prevention

Primary preventive approaches may not always be successful and public health nurses need to intervene immediately with secondary preventive measures once a child has been exposed to violence.

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Anti-violence programs: Strategies for prevention and early intervention with children exposed to violence may be accomplished through anti-violence programs aimed at enhancing protective factors. Early intervention programs such as those offered by the YMCA or Big Brothers/Big Sisters of America (BBBSA) not only promote a safe environment for the child but also strengthen communication and decision-making skills, provide encouragement in academics and involve supportive adults who disapprove of the use of violence (Grossman & Garry 1997, YMCA 2003). Children participating in these programs show increased academic performance, improved family and peer relations, decreased gang activity and decreased drug abuse.

Psychosocial approach

The psychosocial approach focuses on diagnosis and treatment of the child exposed to violence. Violence is viewed as a stressor and, secondary and tertiary intervention focuses on the child's ability to cope with this stressor along with parental involvement in the coping process. A psychosocial approach to assessing and preventing violence is initiated on an individual level by primary care providers, clinic nurses and counsellors. Short-term counselling and encouraging behaviour and environmental changes can be facilitated by primary care providers and clinic nurses. However, long-term or intense counselling should be provided by a certified counsellor.

Secondary prevention

Crisis intervention: Families of children who have experienced violence, such as child maltreatment, domestic violence, or school crisis, are stressed and thus seek crisis intervention from health-care providers (Kline *et al.* 1995, Cowen 1998). During crisis intervention, the nurse assists the family by identifying what each member understands about the experience and how they feel (Porter 2003). One type of crisis intervention provides at-risk families a break from childrearing and a safe environment for their children. This type of program has shown a significant decrease in parental stress and stress related to caring for a child with temperament or behaviour problems (Cowen 1998). Children, who have experienced a crisis in the school setting, need a safe place to express emotions evoked by the situation and then to return to a normal school routine in order to sublimate their reactions (Kline *et al.* 1995). Children and their families may find that expressing their emotions in a safe environment through a crisis intervention program provides freedom from a stressed situation.

Tertiary prevention

Counselling: Parents and children identified as having difficulty coping with violent events may benefit from counselling (Groves 1995). Counselling for parents and children includes:

1 reviewing the facts and details of a violent event;
2 informing parents about expected behaviours associated with witnessing violence such as worries about safety, sleeping difficulties, feelings of loneliness (Osofsky *et al.* 1993), depression and anxiety (Martinez & Richters 1993);
3 assistance in helping families understand the need to re-establish household routines to restore family stability;
4 encouraging use of strategies such as drawing or playing that allow the child to express his or her feelings;
5 encouraging communication between the parent and child;
6 modelling communication methods that can be used with the child encountering frightening events.

Changing goals, improving self-confidence, developing and evaluating plans of how to approach threatening situations can be accomplished through counselling (Kendall 1994). During counselling sessions, the child is taught to identify emotions and his or her somatic response to these emotions. The child is also taught relaxation techniques, the use of self-talk and verbal self-direction when confronted with anxiety-provoking situations and how to evaluate and reward himself or herself. Once the child learns these skills, he or she can practice these new skills in hypothetical and real situations. The FACE YOUR FEAR Club, was successful with children who had been verbally and physically traumatized on their way to school in northern Belfast (Stewart & Thomson 2005). Counselling was provided to the traumatized girls with reinforcement from the school and parents. Counselling sessions focused on reducing trauma-related fear, increasing physical–emotional control and restoring social connections. This was accomplished through activities that conveyed a welcome atmosphere, physical activities that recognized the mind–body link in trauma, story telling, art activities and discussions. After two months, parents and teachers expressed that group counselling resulted in decreased sleep difficulties, more interest in playing with friends and improved emotional support. Other studies have also shown that treatment gains in counselling are maintained (Kendall 1994, Kendall & Southam-Gerow 1996).

Behaviour and environmental changes

Some children may misinterpret some aspects of a violent situation. For instance, aggressive children are more likely to interpret their peers' behaviour as aggressive (Dodge & Tomlin 1987). These aggressive children are likely to base present decisions on past experiences. To assist children in

learning how to decrease their exposure to violence, the nurse can help the child realize that he or she possesses non-violent skills that can be used in threatening situations. One way to aid the child in realizing these qualities is having the child work through hypothetical dilemmas. For example, if a child is presented with a situation in which a friend insults the child and demands a fight, the nurse can discuss how the child feels in this situation, ask the child for solutions and suggest other strategies for solving the problem (Stringham 1995). Once the child realizes there are alternatives to every problem, he or she may be able to apply this same problem-solving technique to situations involving strangers. Children will also learn behaviours to decrease anxiety in stressful situations as well as problem solving when encountered with a violent situation. Parents and children who exhibit symptoms associated with difficulty in coping with the violent event for more than six months, or who have experienced particularly traumatic events, or are physically unsafe should be referred to mental health providers for further counselling and treatment (Groves 1995).

Collaborative approach

The public health approach is traditionally viewed as promoting the well-being of a community and the psychosocial approach promotes the individual's well being, these approaches overlap. However, a collaborative approach is advantageous in initiating primary and secondary prevention strategies, such as anticipatory guidance and screening, which can be implemented either on a community level or one-on-one. For example, a clinic nurse might provide parenting information that would decrease a child's likelihood of encountering physical discipline, such as spanking. Information on time-out, withholding privileges, or ignoring behaviour that does not cause physical harm could be presented through parenting classes at a community centre, via media, or during an office visit. Also, parents and children can receive information on preventing victimization by a bully by avoiding situations that might escalate into violence or informing an adult that someone is physically or verbally threatening them. All nurses can collaboratively provide primary and secondary prevention in the means of anticipatory guidance and screening.

Primary prevention

Anticipatory guidance: anticipatory guidance prevents exposure to violence by providing children and parents information on not viewing violent television programs, movies, computer and video games, improving problem solving skills, preparation for managing peer pressure and societal events and discussing parenting styles. In a study conducted during routine office visits, 291 parents of children aged 15–24 months were taught to use time-out as an appropriate disciplinary practice (Sege *et al.* 1997). In addition, information on reducing the viewing of violent television was presented to 261 families of three- to five-year-old children. Compared with a control group, who received standard anticipatory guidance, parents receiving information on violence prevention were more likely to recall this information 2–3 weeks following an office visit. After receiving information on time-out, mothers who had not used a time-out in the past were more likely to do so. However, there was no significant change in television viewing habits. This study shows that anticipatory guidance is able to provide changes in discipline practices at least on a short-term basis. Anticipatory guidance for adolescents should include information about problem-solving, forced sexual encounters during a date, gang activities and loss of self-control because of drug use (McCarthy & Hobbie 1997). Parents can also be taught to be role models and maintain communication with their child. Teaching parents to encourage their children to talk about their anger, discussing ways to deal with conflict, disapproving of fighting, giving children positive messages such as 'I love you' and spending time each day with their child and their child's friends can decrease violence (McCarthy & Hobbie 1997, USDHHS 2000).

Secondary prevention

Screening: Anti-violence programs typically target high-risk neighbourhoods but the effects of violence are not always visible. Therefore, the nurses must screen all children and take steps to intervene to aid the victim. To inquire about a child's exposure to violence, the parent can be asked non-threatening questions such as 'The media tells of many incidents of violent acts in our neighbourhood. Do you ever witness any violent acts? Are you worried about your child's safety? What behavioural changes have you observed in your child? Is there a gun in your home? How do you discipline your child if he or she misbehaves?' Children can be asked the following questions. 'How often do you fight with other children? What do you do to prevent getting into a fight? Has an adult ever hit you? Have you ever seen anyone carrying a weapon?' Those parents and children responding that they have witnessed violence or engaged in violence can be further a questioned about the event and their feelings related to the event.

Stringham (1995) provides a system for assessing the risk of violence. Assessment findings pertaining to domestic violence and street-fighting are categorized based on frequency of exposure, attitude toward violence and presence of

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physical injuries. Categories range from no risk for violence (category 0) to significant risk for violence (category 3) and interventions are based on these categories. A positive screening can trigger the nurse to implement interventions, such as teaching children to walk away from fights, improving family communications, discussing safety concerns, developing non-violent ways to handle emotions and ensuring a child's physical safety.

Training and knowledge of nurses: Although nurses have the opportunity to identify children exposed to violence, some nurses may lack the knowledge of screening procedures and thus fail to provide appropriate treatment or initiate prevention programs. Only 33% of nurses with formal interpersonal violence education screened every patient seen in the hospital, school, or community-based health-care centres (Glaister & Kesling 2002). Barriers to nurses completing screening included insufficient time, belief that only physical violence is a health concern, lack of knowledge about how to ask the appropriate questions and respond to the person's answers and unfamiliarity with referral options or resources (Glaister & Kesling 2002).

Limitations of self-reports: nurses who screen children in the community setting must be cautious about the limitations of self-reports used to identify children exposed to violence. Some children may acquire a defensive attitude as a way of coping with violence and may deny experiencing symptoms related to the violent exposure (Phelps *et al.* 2002). Males or children in certain cultures may not reveal emotions associated with experiencing violence because they have been taught that such a behaviour is socially unacceptable. Finally, children have varying attention spans, reading ability and language skills that may make completing a self-report difficult (Phelps *et al.* 2002).

Implications of the model

This collaborative model can be implemented by public health, psychiatric and primary care nurses, in various settings such as health departments, schools, community centres, clinics and homes. Each nurse can focus on that part of the model that pertains to their area of specialty while being aware of areas of prevention that can be addressed by nurses in other specialties. Collaboration between public health and primary care nurses will be needed for implementation of some primary and secondary prevention strategies. Implementation of this model within a practice site should receive support of all nurses involved and can be accomplished by educating peers about the benefits of the model, such as decreased exposure to violence, increased identification of those exposed and treatment of those upon whom violence had had an impact. The collaborative portion of the model could easily be incorporated into well-child and school examinations. Screening questions could be added to routine history questions asked at the beginning of each examination. Topics of discipline, problem-solving and violence prevention can be discussed throughout the visit in addition to other well-child topics. Referrals to a public health nurse can be made when screening reveals a high-risk child that may benefit from conflict resolution or a prevention program. Referrals to a psychiatric nurse or practice specializing in behaviour modification can be made for those children who have been impacted or traumatized by violence.

Testing of this model can focus on assessing the outcomes of prevention and treatment programs as well as the effect of witnessing violence or victimization. Both process and outcomes of these prevention programs can be evaluated. Process evaluation can include the number of participants, whether information pertaining to preventing exposure to violence was provided to the child, who provided the information and the amount of time that the program devoted to violence prevention. Outcomes evaluation can include behaviour changes in children such as decreased reports of fighting, access to weapons in the home and neighbourhood, changes in parental spanking, decreased conflicts among children during after-school programs, drug abuse and bullying. School nurses and educators can assess the success of screening strategies by measuring the change in number of reports of fighting, school suspensions, nurse visits because of physical injuries as a result of conflict and the number of weapons brought to school by children. Primary care and home-care nurses can also assess for behaviour changes in the child as well as how many parents use non-physical means to discipline their children, implement safety precautions in the home (i.e. gun control) and spend time each day talking with their children. Multidisciplinary research can evaluate whether funding for prevention programs and screening causes behavioural changes in children that lead to decreases in the number of children exposed to violence, victims and referrals for psychiatric counselling. Using a collaborative approach in studying violence acknowledges the importance of nurses investing their time in implementing prevention and treatment programs thus increasing the long-term success of these strategies.

Implementation of the model may be hindered because of a lack of understanding of services provided by various specialties within nursing. Services provided within the community, such as after-school programs, may not be familiar to a nurse practicing within an office setting. In addition, not knowing how to refer children to these

programs may prevent a nurse from suggesting these programs. Likewise, public health nurses may not be aware of counselling, behaviour programs, or crisis interventions within their city to which children can be referred, thus inhibiting nurses to intervene. Even when programs are well known within a city, referring children takes time, which adds another demand on the nurses. Also, follow up on referrals involves added time to a nurse's busy day. Prevention programs may struggle to exist because of a lack of funding or lack of personnel. Many programs begin with federal assistance and without sufficient enrolment of children and continued advocacy from nurses some of these programs may cease to exist. Despite the barriers, implementation of this model can promote the well being of children, which in turn promotes healthy families.

Conclusion

Violence affects most children in the USA. Nurses, other health-care professionals and educators have the opportunity to identify and intervene with those who are exposed to violence by using a collaborative public health and psychosocial approach. The Health Promotion Model for Childhood Violence Prevention and Exposure can guide the nurse in preventing; detecting and counselling children exposed to violence and is applicable in numerous practice settings. Whether providing a health promotion program, advocating for policy changes, or providing counselling to a child impacted by violence, all professionals must work to deter violence and its impact.

Contributions

Study design: TS, BP; data analysis: TS, BP and manuscript preparation: TS, BP.

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