Child maltreatment : prevalence and risk factors

Euser, E.M.

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General Discussion

‘Those who are enamored of practice without science are like a pilot who goes into a ship without rudder or compass and never has any certainty where he is going’

Leonardo da Vinci

Introduction

The current series of studies aimed to identify prevalence estimates and determinants of child maltreatment. We started with an introduction on the relation between child maltreatment and attachment problems (Chapter 1), we reported the findings of the first national child maltreatment prevalence study in the Netherlands (Chapter 2), and described the interaction between common risk factors for child maltreatment (Chapter 3), and finished with a meta-analytic review of how child maltreatment and other risks affect the development of attachment relationships (Chapter 4).

Our prevalence estimates indicated 107,000 children as victims of child abuse and neglect in the Netherlands in 2005. As maltreatment is likely to have life-lasting consequences such as an increased risk for mental health problems and a higher chance to abuse own children, this prevalence figure points to the importance of prevention and treatment of child abuse and neglect.

In this chapter we will discuss the role of Dutch policy making in the services provided for maltreating families. This is followed by an overview and evaluation of recent clinical treatment and prevention programs in the Netherlands. We start this chapter with some general implications for research on child maltreatment.

Implications for research

Prevalence rate estimation

One of the important issues in reliably estimating child maltreatment is the source of information about the abuse experiences. Previous research in the Netherlands relied exclusively on self-reports, as is the case for the great majority of international studies on child maltreatment prevalence. Although self-report studies provide valuable information, several important shortcomings limit their scope. One major limitation concerns the selected samples used by self-report studies. A great deal of the studies included only college students, who are a non-representative part of the population. Many studies have small sample sizes, which limits generalization to the population. Moreover, it is often the case that non-validated and single-item questionnaires are used to measure child maltreatment. Most importantly, self-report studies suffer from retrospective biases, which tend to be stronger with sensitive topics such as child maltreatment. These tendencies to process information in a distorted way, for example because of the influence of the participants' current mood on the memory of past experiences,

affect perception and report in uncontrollable ways. All these flaws may explain the large variation in prevalence estimates found in self-report studies; in the case of sexual abuse the estimates range from 2.5% to more than 70%. The current state of the methodology of child maltreatment research points to the need of large and methodologically rigorous studies (Gorey & Lesley, 1997).

As an alternative to self-report studies, prevalence studies in the United States developed an approach relying on professional informants as sources of information (the National Incidence Studies; NIS), in addition to CPS records. Our prevalence study (see Chapter 2) –the first of this nature in Europe- used this approach. More than 1,100 carefully selected professionals from various occupational branches reported their suspicions of child maltreatment. The random sample of organizations, the broad representation of occupational branches, the nationally representative distribution of the sentinels, and the training in reporting child maltreatment cases are among the merits of this approach. Although our study revealed that this approach can be successfully adapted to the Dutch situation and provide us with reliable prevalence estimates, our work had certain limitations to be resolved in the future.

To obtain more reliable prevalence estimates in the future, thorough training of professionals working with children should be stimulated and further developed, especially for the report of sexual abuse cases. The quality of the sentinel approach strongly relies on the quality of the evidence that informants can provide for their suspicions of child maltreatment. Correct signaling of abuse and instruction in accurate descriptions of abuse situations should be the focus of this training (see also below).

Furthermore, a broader range of occupational branches is needed to obtain information about all cases of maltreatment. Our study included sentinels from policy forces, shelters for battered women, child day care, general practitioners, well-baby clinics, primary and secondary education. Research has shown that evaluations of child abuse cases are linked to profession, both with respect to type of cases and to the evaluation of case characteristics such as severity, although agreement was rather high (Giovannoni & Beccera, 1979). It is for example likely that pediatricians observe a relatively high proportion of cases of sexual and physical abuse. In the NPM-2005 pediatricians were invited but declined to participate because of time constraints. In addition, they were concerned that our study would provide a possible underestimation of the number of child maltreatment cases, and the risk for underestimated (or overestimated!) rates is of course a concern for all research on child abuse and neglect (Sedlak & Broadhurst, 1996). The absence of this important occupational branch is very unsatisfactory, but it is

promising that pediatricians after publication of our report have indicated their willingness to participate in a future prevalence study of this type. Emergency units of hospitals and Bureaus Jeugdzorg can further increase the potential range of observers of maltreatment cases and should be included in future prevalence studies.

A more methodological issue to bear in mind is the difficulty to obtain information about non-response rate, and particularly passive non-response of sentinels (Sedlak, 2001). Training sessions are a good approach to teach and motivate sentinels to report potential cases, but it is reasonable to assume that less motivated sentinels are underrepresented at these meetings. One of the ways to prevent non-participation and to enhance the motivation is frequent phone contact with a central person per participating organization (Sedlak, 2001). Nevertheless, the participation of sentinels within organizations was very high in our study, demonstrating the motivation of sentinels to participate in this type of research. It was the response rate on the organizational level that was rather low, which forced us to draw a second random sample to include a sufficient number of organizations. As we noticed that in the participating organizations many sentinels were willing to participate, this suggests that the management boards of non-participating organizations were too restrictive when they declined the participation of their employees. For future prevalence studies, it would be effective if the apparently necessary conditions for organizations to participate, maybe financial compensation for the time invested in the study, were provided by the government.

Definition and identification of child maltreatment

It is difficult to reach consensus in the field about what exactly constitutes child maltreatment, and a single, satisfactory and encompassing definition of maltreatment seems to be a desideratum at present. Nevertheless, the NIS studies have made two important contributions in defining child maltreatment, as did our replication study. The first is a very explicit and detailed description of the definitions of the six subtypes of maltreatment (see Chapter 1). Importantly, in the training sentinels had the opportunity to discuss the boundaries of these definitions and were instructed how to apply them to their cases. The second is the evaluation of maltreatment cases on two dimensions: type and severity. The continuum of severity allowed sentinels to report less serious or clear-cut cases, which is an accurate reflection of the daily reality around child maltreatment. Future research should make attempts to include more dimensions, such as frequency of the maltreatment.

Given the existence of several subtypes of maltreatment, it is important that studies focus on all of these. However, the unequal distribution of publications over the various subtypes of maltreatment is very striking. The overwhelming majority of research efforts are invested in child sexual abuse, even though it is the least prevalent type of child abuse. In contrast, child neglect as the most prevalent type of child maltreatment in our study, has been given little research attention, a problem which has been described as 'the neglect of neglect' (Dubowitz, 2007). In Europe, there were even no self-report studies on neglect, which reflected the American situation (Dubowitz & Bennett, 2007; Lampe, 2002). This is worrisome, because child neglect may be uniquely related to devastating child outcomes, particularly in the cognitive domain but also in the domains of behavioral and socio-emotional functioning (Hildyard & Wolfe, 2002). In some studies neglect seemed for example related to more severe psychological problems than physical abuse (Gauthier, Stollak, Messé, & Aronoff, 1996). Differential impact is not only found for neglect; research on the consequences of specific types of maltreatment suggests distinguishable behavioral and psychological symptom clusters for each of the subtypes. Physical abuse was uniquely related to aggression towards others, sexual abuse with sexually deviant behavior, and emotional abuse to low self-esteem in adulthood (Briere & Runtz, 1990). However, empirical evidence shows that subtypes of maltreatment tend to go together (e.g., Edwards, Holden, Felliti, & Anda, 2003), making it less plausible that one specific subtype of maltreatment underlies one specific set of symptoms.

The co-occurrence of maltreatment types is another serious challenge for future prevalence studies. We observed that children on average experienced more than two types of child maltreatment and we had to prioritize the types to ensure that each child was included only once. Currently, evidence-based categorizations of child maltreatment types are lacking, although the study of Lau and colleagues (2005) showed that classifications based on hierarchy, severity and single or multiple types of maltreatment all showed predictive validity for three or more outcomes in adulthood. Co-occurrence of maltreatment types was strongly related to outcomes (Lau et al., 2005). Further research is needed to distinguish between psychological and behavioral profiles of combined subtypes of maltreatment (e.g. sexually and physically abused) and to enable comparisons between prevalence rates of (combined sets of) subtypes of abuse.

Implications for policy

According to the Convention for Children's Right, the treatment and prevention of child abuse and neglect is a governmental duty (see Euser, 2008). Prevalence rates and the identification of risk factors such as low SES and single parenthood (see Chapter 2 - 4) may function as an empirical foundation for these programs. The prevalence study described in this thesis was requested by the Dutch Ministries of Justice and Health for that purpose.

There is a trend of increasing governmental attention for child maltreatment in the Netherlands, in particular illustrated on two occasions in the recent past. The first, in 2005, was the addendum to law-article 247, formulating that violence in child rearing is prohibited (Burgerlijk Wetboek, Artikel 247). This statement served as an important signal that the Dutch society morally *and* legally rejects violence from parents and professional caregivers to children as an accepted way of parenting or teaching. Physical discipline is related to negative child outcomes, such as aggression and behavior problems (McLoyd & Smith, 2002). Furthermore, intervention and prevention programs show that parents can learn to discipline in a consistent but child-friendly manner (for an example, see Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2008). The second illustration is the new Ministry for Families and Youth, the first of this kind in the history of The Netherlands. This Ministry symbolizes the family as a *political* topic that deserves attention in its own right. This focus is justified if we take into account the high rates of parenting problems, leading to high psychological and financial costs for the individual citizens and for society at large. Moreover, institutionalized political interest in child and family affairs may mobilize powerful sources of change, as was recently demonstrated for the waiting lists of CPS services that have been shortened dramatically due to strong political attention.

Toward an integral continuum of care: Raak

Among the many governmental reforms that have been implemented in the past years in the Dutch mental health services, the one that is most directly and influentially related to the prevention and treatment of child abuse is a policy implementation called Raak, that we will briefly describe here.

Child maltreatment is a very complex problem, asking for a delivery of integral and comprehensive services to families with serious problems. However, the Dutch child and youth mental health services are historically rooted in private initiatives, leading to a wide range of different and fragmented service providers (Van der Linden, Ten Siethoff, & Zeijlstra-Rijpstra, 2005). The main goal of Raak,

the Dutch acronym for Reflection and Action group Child Maltreatment [Reflectie- en Actiegroep Aanpak Kindermishandeling] was to make the interaction between all institutes (e.g. municipalities, managers, services providers) involved in the care for families with problems more transparent and coordinated (see www.raak.org). From 2003 to 2006, four regions in the Netherlands piloted this initiative to streamline the efforts and attempted to provide an effective continuum of care composed of an integrated delivery of evidence-based services. Hermanns (2003) describes the five main levels of a continuum of care, ranging from universal prevention to specialized diagnostics and treatment in case of signs of maltreatment. On each of these levels, the involved professionals have responsibilities: information and advice, signaling, referral to services, providing care, and coordinating all service efforts (Kooijman, 2007). The Raak initiative was based on a list of 35 indicators, derived from a literature study on effective or promising interventions in the field of child maltreatment (Hermanns, 2003; Kooijman, 2007).

Parallel to the implementation of Raak several other important processes took place, which makes it difficult to evaluate the specific influences of Raak. For example, during the Raak-period a national implementation of a reporting code was established, a public campaign was started to enhance the awareness of professionals and the community about CPS agencies, additional budget was created for the treatment of parenting problems, and the preparations for coordinated comprehensive Centers for Families (Centra voor Jeugd en Gezin) were started (Hermanns & Ter Meulen, 2007; Van Burik & Van Vianen, 2007). Nevertheless, Hermanns & Van Ter Meulen (2007) recently tried to evaluate Raak, and we will summarize the results here.

Their evaluation of the 35 goals showed that the four regions in which Raak took place made a start with trying to reach many of the goals, but none of the regions fulfilled all of them. However, almost all of these 35 goals were implemented in at least one of the regions. The authors mentioned as the most important results of Raak an increasing awareness of child maltreatment by professionals; a structural approach of universal, indicated and selective prevention; an increased participation of very-difficult-to-reach families, and improvements in the professional training with respect to reporting guidelines and signaling child maltreatment. The development of good practices for treatment *after* child abuse and neglect was minimal (Hermanns & Ter Meulen, 2007). Restricted resources, the low participation rate of general practitioners and hospitals in the development of policy and best practices for maltreatment and long waiting lists for the CPS agencies were identified as important barriers for Raak (Hermmans & Ter

Meulen, 2007). The researchers concluded that not the content of Raak, but rather the increased attention for child maltreatment as a consequence of Raak can be considered its most effective ingredient (Hermanns & Ter Meulen, 2007). The emphasis on stronger coherence of service providers and other participating institutions (such as municipalities) resulted in more transparent tasks and responsibilities of all participating institutes.

Although policy aims to decrease child maltreatment rates, the actual observation is that reporting rates increased over time (Jaarverslag AMK, 2008). The annual reports of CPS agencies showed that in the past few years, the overall number of reports to CPS increased; a trend that is continuing (Jaarverslag AMK, 2008). This increase has been interpreted as a plausible outcome after more publicity of CPS agencies and better signaling systems of child abuse and neglect, and three of the four Raak-regions observed an increase in the number of reports by professionals during the Raak period (Hermanns & Ter Meulen, 2007).

To conclude, it is hopeful that Raak was effective in stimulating organizations to join their forces in reducing child maltreatment. The influence of Raak on the reduction of child maltreatment reports can not be measured currently because the intervention is too broad and multilayered and no randomization with a set of control regions took place. The evaluation of Raak should be high on the agenda of science and policy alike.

Training of professionals

Our prevalence study showed the importance of professionals' ability to signal and report child maltreatment. We plea for a national policy that obliges educational institutes to train future professionals who come in contact with families and children in signaling and reporting child maltreatment, a model that is already used in the United States. Continued education on maltreatment is needed: extra training and refresher courses for professionals in the field are needed to keep the knowledge and skills up-to-date and permanently alert to signals of abuse or neglect. The development of an individualized e-course for professionals in child maltreatment is an example of potentially good practice (see www.thenextpage.nl), although the effectiveness of this type of training has not been examined yet. The association between training in signaling child maltreatment and reporting rates should be a topic of future research.

Reporting child maltreatment

In the Netherlands individuals do not have a legal obligation to report child maltreatment. This is reflected in the daily practice: our study showed that

the majority of the maltreatment cases never come to the attention of CPS agencies. Only 12.6% of all maltreatment cases known in the field by professionals were also reported to CPS. Clearly, Dutch Child Protective Services currently do not serve as registration centers where reliable prevalence estimates of child abuse and neglect in the Netherlands can be obtained. Nevertheless, our study also showed that our country has no higher prevalence rates than the United States, with a system of mandated reporting. Among the merits of the Dutch approach are that thresholds to ask for advice are low, and that mental health services are not charged to provide legal evidence for a maltreatment case. One of the major drawbacks of the Dutch system, a potential passivity in taking action in case of maltreatment, is partly being resolved with the recent national implementation of reporting codes. These codes guide professionals in structuring the necessary steps to contact CPS agencies or to initiate other types of help. These reporting codes also function as a framework for professional responsibility, showing that suspicions of child maltreatment cannot be without consequences, both in a moral and in a formal sense.

Socio-economic policy

Our prevalence study demonstrated the impact of socio-economic antecedents of child maltreatment. A very low parental education was even found to be the strongest risk factor for maltreatment, and parental unemployment was the second highest factor, increasing the risk for maltreatment five times. A socio-economic policy focused on the improvement of living conditions of children in deprived areas is an important tool in the reduction of child maltreatment rates (Hermanns, 2008; Mutsaers, 2008; Van IJzendoorn et al., 2007). In the United States, many studies are conducted on the association between policy implementations and child maltreatment outcomes (e.g., Dunifon, Kalil, & Danziger, 2003), an area of study that is not strongly developed yet in the Netherlands.

Chapter 3 of this thesis shows the clear need for policy-making to focus on the socio-economic position of ethnic minority families, which are strongly overrepresented in the lowest socio-economic strata of our society. Poverty is not a mere financial situation; it is also a social and physical experience, and related to more psychophysiological stressors (Evans & English, 2001). Dutch research on poverty (Armoede Monitor, 2007) reveals that immigrant families are particularly at risk to live below the poverty line, which has important implications for children's mental and physical health. The financial position of refugee families is even more alarming; half of this group has a family income of 850 Euros a month or less, which is approximately a third of the Dutch average income

(Vluchtelingenwerk, 2009). In sum, improving the financial situation of these families is likely to reduce child maltreatment rates, both in minority and native families.

Implications for clinical practice

As was shown in the previous section, policy making is important to guide organizations in effectively treating child abuse and neglect, and preventing child maltreatment cases in the future. Chapter 4 described the impact of child maltreatment on disorganized attachment. Even in comparison to high-risk non maltreated children who are living in deprived families suffering from risks such as poverty or maternal substance abuse, maltreated children showed more disorganized and less secure attachment patterns. Only children from families with as much as five risk factors showed similarly high levels of disorganized attachment. Disorganized attachment is a strong risk for psychopathology at a later age. To minimize the consequences of child abuse and neglect, evidence-based treatment programs are thus urgently needed. As will be described below, there is a paucity of abuse-specific treatment programs in the Netherlands and more efforts are needed to establish evidence-based mental health services for victims of child maltreatment. In contrast, programs that aim to prevent child abuse are relatively well established. In what follows, we will briefly evaluate three of these main prevention programs in the Netherlands.

Evidence-based treatment programs

Empirically supported treatment programs tend to have several characteristics in common (Saunders, Berliner & Hanson, 2003, p 104-105; Chaffin & Friedrich, 2004; Thomlison, 2003). First, these programs are goal-directed; address specific and measurable problems; include a treatment plan, and the repeated measurement of outcomes is assessed with acceptable tools. Second, the approach is pre-structured in the sense that specific techniques and procedures are used, and that the therapeutic components follow sequential stages. Third, the main emphasis of these programs is on skill building to manage emotional problems and behavioral disturbances. Finally, these programs make often use of techniques that repeatedly practice these skills with feedback of the therapist. For interventions with children four additional characteristics are regularly included: skills for emotion identification, processing, and regulation; anxiety management skills; skills for the identification and alteration of maladaptive cognitions; and problem solving skills (Saunders et al., 2004, p. 105).

Unfortunately, the effectiveness of treatment on maltreated children and their parents has rarely been studied by randomized controlled trials and Chaffin and Friedrich (2004, p. 1198) conclude that "most services provided to abused children and their families are not based on any clear evidence that the services actually work". Furthermore, in the majority of the intervention studies risk factors for child abuse were addressed as outcomes such as rates of out of home placement, problem behavior levels or financial resources (MacLeod & Nelson, 2000), rather than direct measures of child maltreatment reports (Mikton & Butchart, 2009). In general, single-outcome evaluations are often obscured by the complex histories of maltreated children and the multiproblem presentation of these types of families (Saunders, Berliner, & Hanson, 2004).

Of the limited knowledge base currently available, Saunders and colleagues (2004) evaluated the evidence base of 24 family, parent-child or parent-focused treatment programs for child physical or sexual abuse. Of these 24 protocols, 16 had at least some empirical evidence for their effectiveness in reducing child maltreatment. Only the trauma-related behavioral cognitive therapy received the highest score as a well-supported and efficacious treatment, as demonstrated by at least two randomized controlled trials. The majority of the programs (n = 14) was evaluated as supported and acceptable treatments with demonstrated effectiveness for other problems, but did not have available evidence for efficacy in the treatment of child abuse problems at present. One of these is Eye Movement Desensitization and Reprocessing (EMDR), which is broadly used in the Netherlands for the treatment of children's traumas. Attachment holding therapy as critically described in Chapter 1, was evaluated as a 'concerning treatment' with potentially harmful consequences (Saunders et al., 2004). The general conclusion was that the evidence base for treatments is small, even for the more well-known therapies (Saunders et al., 2004).

In the Netherlands, services for treatment of child abuse are limited. In contrast to the United States, treatments are for the greater part not 'abuse-specific', most specialized services are exclusively focused on child sexual abuse, and the restricted number of interventions available is not widely disseminated (Berger, Ten Berge, & Geurts, 2004). However, there are also several promising initiatives such as the 'Horizonmethodiek' (see Huiskes & Plugge, 2004) for sexually abused children and their non-abusive parents. Evaluative clinical research showed that sexual behavior problems, fear, anger and dissociative problems strongly decreased in victims after the treatment (Berger et al., 2004; Bicanic, 2002), but a randomized controlled trial has not been conducted yet. Another example is the psycho-educational course called 'Let op de Kleintjes' (see Scoop,

2003) for victims of domestic violence. Preliminary effects were measured in a small group of children that participated in the program, who showed significant behavioral improvements, although internalizing problems remained high (Berger et al., 2004; Scoop, 2003). Randomized and large(r) studies are needed to provide stronger evidence for the effects. The introduction of effective interventions from abroad and the adaptation of existing Dutch interventions to become more appropriate for the treatment of child abuse are opportunities to increase the range of services for abused children and their parents (Berger et al., 2004).

Evidence-based prevention programs

This thesis sheds light on determinants of child maltreatment. Our prevalence study in Chapter 2 and 3 highlighted two socio-economic risks: very low parental education and unemployment. Family composition also influences prevalence rates: single parent families, stepfamilies and large families were at increased risk for child abuse. The meta-analysis in Chapter 4 pointed to the impact of cumulative risk: families with five risk factors had more disorganized and less securely attached children than children from families with four or less risk factors. Ethnicity was identified as a risk factor in Chapter 3, but only for refugee families and not for traditional immigrant families. As described in the same chapter, screening, prevention and treatment of trauma in refugee families is badly needed. Programs focusing on decreasing these antecedences of maltreatment are likely to improve the life of children in difficult circumstances.

Overview and effectiveness of prevention programs

Recently, a report of the World Health Organization systematically synthesized all the existing systematic evidence of child maltreatment prevention programs and distinguished seven types of prevention programs: 1) Early childhood home visitation programs 2) Parent education programs 3) Child sexual abuse (CSA) prevention programs 4) Abusive head trauma prevention programs 5) Multi component interventions 6) Media based interventions 7) Support and mutual aid groups (Mikton & Butchart, 2009). Early childhood home visitation, parent education, abusive head trauma and multi component interventions were evaluated as promising approaches for the prevention of child maltreatment (Mikton & Butchart, 2009). Noteworthy is that the randomized controlled trials reported significantly lower effect sizes than quasi- or non-experimental designs, which can be due to an artificial inflation of the effects of quasi- and non-experimentally designed studies (see Bakermans-Kranenburg, Van IJzendoorn, & Juffer, 2003). A meta-analysis of prevention programs on child abuse (MacLeod &

Nelson, 2000) showed moderate effects of maltreatment prevention programs. Longer and more intense format produced better results: the lowest effect sizes were found for programs with a duration of less than 6 months and fewer than 12 home visits (Macleod & Nelson, 2000).

In the Netherlands, a database with effective interventions against child maltreatment is presented by the Netherlands Youth Institute (NJi). Six prevention programs are included in the database. One is a specific program that teaches 10- and 11- year-old children about sexual experiences, body ownership and related topics (Marietje Kesselsproject). The second is a novel and experimental type of uninvited help that is offered to parents with major parenting problems and a low ability to reflect on their own parenting practices (in Dutch called 'bemoeizorg') and is not yet evaluated. The results of the third program, a Dutch pilot of Parent Child Interaction Therapy, will only be available in 2012. We will highlight the three other programs included in the database that are carried out in the Netherlands in families at risk for child abuse and neglect: Triple P (e.g., Sanders & Dadds, 1996), VoorZorg (e.g., Kooijman, Struif, Van Coeverden, Krijnen, & Van Leerdam, 2008; Olds, Henderson, Chamberlin, & Tatelbaum, 1986) en Stevig Ouderschap (Bouwmeester, 2006).

Three Dutch prevention programs

Triple P

Triple P is an Australian parenting program, designed to treat behavioral and emotional problems in children between 0 and 16 years old (e.g., Sanders, 1999), with several levels of intensity (see Box 1). Triple P Pathways is a format specifically focused on families at risk for child maltreatment, with an increased emphasis on parental attributions and parental emotional processing. For more info about Triple, see Box 1 and www.triplep-nederland.nl.

The effectiveness of Triple P on parenting and child outcomes has been evaluated by many studies (studying most often Level 4, see Box 1): 11 case studies, 22 pretest posttest studies and 45 randomized controlled trials (De Graaf, Onrust, Speetjes, 2009). Two recent meta-analyses have summarized the findings of Triple P level 4 on parenting (De Graaf, Speetjes, Smit, De Wolff, & Tavecchio, 2008a) and on child behavioral problems (De Graaf, Speetjes, Smit, De Wolff, & Tavecchio, 2008b). The meta-analyses showed that Triple P Level 4 decreased dysfunctional parenting styles, improved parental competency (De Graaf et al., 2008a) and diminished disrupted behaviors in children (De Graaf et al., 2008b), with a wide variability in effect size of outcomes. Nowak and Heinrichs (2008) studied this variability and found that more distressed families and more intensive formats were moderators in the strength of triple P outcomes. An important shortcoming of all these evaluation outcomes is that they completely consist of parental self-report measures. Although large effects were found according to parental self-reports; only a few observational measures have been included, finding weaker effects compared to self-reports (Nowak & Heinrichs, 2008).

Recently, in a population trial, 18 counties in the United States were randomly assigned to Triple P as a public health approach aimed to prevent child maltreatment or to the usual services condition. A significant decrease in substantiated child maltreatment cases was found for the counties were Triple P system was implemented (Prinz et al., 2009). For the future, is it also important to see the results of evaluations done by several independent groups (see Chambless & Ollendick, 2001), not relying on the developers of this intervention.

Currently, several Dutch effectiveness studies are underway and a national monitor of outcomes of Triple P is forthcoming in 2009. Of specific interest is a current evaluation of the Pathways Triple P that is specifically focused on families at risk for child abuse (De Graaf, Onrust, Speetjes, 2009). One Dutch quasi-experimental study on Standard and Group Triple P (Level 4) has been

conducted, but the lack of a sizable control group precluded good comparisons (De Graaf, Onrust, Speetjes, 2009).

To conclude, Triple P shows promising results on self-reports, but these large effects are still not replicated in observational studies (Nowaks & Heinrichs, 2008). The effectiveness of Triple P for reducing child maltreatment is scarce, not conclusive, and in need of replication. Sound evaluation studies of Triple P in the Netherlands are not yet available, but may appear in the near future.

Box 1. *Description of Triple P*

Characteristics of the Triple P program	
Target group:	Parents and children 0-16 years
Aim:	Promoting positive parenting, decreasing behavior and emotional problems
Program content:	Five levels: 1: Universal Triple P media and informational strategies 2: Selected Triple P flexible, individual consultations or parenting seminars with large groups of parents 3: Primary Care Triple P 4 brief individual consultations for discrete behavioral problems 4a: Standard Triple P for children with serious behavior problems, not yet meeting diagnostic criteria: 10-session program for individual families 4b: GroupTriple P for children with serious behavior problems, not yet meeting diagnostic criteria: 5 parent meetings and 3 telephone sessions. 5: Enhanced Triple P services additional to level 4, for families specifically at risk that need more practice in, for example, mood management.
Theoretical foundation:	Social learning theory, behavior modification strategies, developmental psychology and psychopathology, self-regulation skills and social processing theory

Nurse Family Partnership program/VoorZorg

The Nurse Family Partnership Program (NFP, e.g. Olds et al., 1997; Olds, 2006) is a home visitation program with trained nurses designed to improve health, parenting, child development and parental education and employment. This program is introduced in the Netherlands, named 'VoorZorg'. For more information about the programs, see Box 2 or www.voorzorg.info.

Outcomes of NFP have been widely documented (for an overview, see Olds, 2006), results were found for parenting practices and maternal life course development (such as workforce participation), with the largest results for the more deprived groups of mothers. A randomized controlled trial showed a significant lower rate of official maltreatment reports for children that participated in NFP: 4% in the NFP group compared to 19% in the comparison group (Olds et al., 1997). VoorZorg just recently started in the Netherlands (see Oldhof & Prinsen, 2007), because of the promising results of the Nurse Family Partnership Program in reducing child maltreatment rates. At present, a three year randomized follow-up study (2006-2009) to evaluate its effects in our country is carried out (see Kooiman et al., 2008).

Box 2. *Description of Nurse Family Partnership Program*

Characteristics of Nurse Family Partnership (NFP) Program/VoorZorg	
Target group:	Parents with children from pregnancy to 2 years of age Criteria for participation in The Netherlands (VoorZorg): women 25 years or younger with no previous live births, less than 28 weeks pregnant, low education, mastery of the Dutch language, and informed consent. Additional criteria: no supportive social network, alcohol and substance abuse, mental health problems and attitudes about motherhood
Aim:	Improving outcomes on: pregnancy (by improving prenatal health) child's health and development (by sensitive care) parental life course (e.g. by planning future pregnancies, completing education, and assisting to find a job)
Program content:	Circa 30 home visitations of trained nurses
Theoretical foundation:	Attachment theory, self-efficacy theory, human ecology

Box 3. *Description of Stevig Ouderschap*

Characteristics of Stevig Ouderschap	
Target group:	High risk parents and children 0-4 years Focused on families at risk for child maltreatment and/or other serious child rearing problems. Screening by a questionnaire on several risk indicators, such as a history of maltreatment or social isolation
Aim:	Prevention of parenting problems, promotion of child development and stimulation of reflection on own parental developmental history
Program content:	Six home visits of trained nurses in the period from birth to 18 months of age. Several topics are discussed: parental developmental history, parenting experiences, expectations with respect to child development, social support and referral to adequate services.
Theoretical foundation:	Newberger and Baartman's theory about 'parental awareness' and Belsky' s ecological model

Stevig Ouderschap/Oké: Ouder en Kindzorg Extra

Stevig Ouderschap (resulting from research project Oké that evaluated this program) is a Dutch home-visitation program for at-risk families aimed at the prevention of parenting problems, the promotion of child development and stimulation of reflection on the own parental developmental history (Bouwmeester, 2006). See for a description of this program Box 3 or www.stevigouderschap.nl.

Project Oké has been evaluated in an experimental design with a follow-up test, and provided evidence for improvements in parental attitudes toward physical discipline (Bouwmeester, 2006). Moderate effect sizes were found for a decrease in parental Child Abuse Potential Inventory (CAPI) scores and child emotional and parent-reported behavioral problems (Bouwmeester, 2006). Direct measures of child maltreatment reports and observational measures of parenting behaviors were not included in the evaluation. No other studies on the effectiveness of Stevig Ouderschap have yet been conducted.

Conclusion prevention programs

It is promising that several prevention programs aimed at high-risk parents are implemented in the Netherlands. Prevention programs focused on high-risk families face several major challenges, such as the search for good selection measures and the composition of a suitable program content with the appropriate intensity level. Other difficulties are the lack of motivation of families for participation and to prevent the (usually high) drop-out rate. All efforts to develop evidence-based programs should therefore be appreciated. It is hopeful that in the Netherlands several efficacy studies are underway that may shed more light on the effective elements of these programs, enhancing their potential to improve the life of families in difficult circumstances.

Concluding remarks

To conclude, there are several promising prevention programs for child maltreatment, but the evidence-base for treatment after child abuse and neglect is still small, internationally and particularly in our own country. There is for example a strong need for the development of evidence-based programs for victims of child neglect. Research on efficacy, implementation and dissemination of evidence-based treatment programs in the Netherlands should be stimulated.

Our study clearly shows that child maltreatment is a major problem in the Netherlands. It is sad to see that in one year (2005) more than 107,000 children suffered from emotional, physical or sexual violence by their caregivers. We hope that the findings from the present thesis may serve as a strong motivation to join forces in the political, scientific and practical domain to promote positive parenting and reduce child maltreatment.

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