Editorial: The Violence and Addiction Equation Revisited

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In April 2010, Masood Zangeneh, Editor-in-Chief, invited me to act as a Special Projects Editor with this journal. The goal for these special projects initiatives is to highlight unique advances in various countries, to consider a broad spectrum of mental health and substance use issues, to spotlight research on emergent clinical issues, under-studied populations, and to bring together global-minded epidemiology, clinical, basic, and implementation science. There is a commitment to provide more parenting and pediatric research in the mental health and addiction areas. Considering that mental health and substance abuse occur and co-occur in contexts of vulnerabilities and resilience, there is an effort to be intervention-minded (screening, assessment, prevention, treatment), as well as to address for whom (moderators), and why (mediators) positive outcomes are obtained. In short, special projects are one effort to enhance coordination and coherence of the multiple factors and systems involved in the content areas of mental health and addiction problems. Finally, there is an intention to move evidence to usability, and to invigorate evaluation of the maintenance and sustainability factors, particularly in times of shifting priorities and resource scarcity. How efficient can we be with excellence? One example is the World Health Organization's VIP webinars series (violence, injury, prevention; http://www.who.int/violence_injury_prevention/en/) provided freely to global stakeholders.

The intention of IJMHA Special Projects is to be proactive in enhancing evidence usability. Knowledge translation (KT) is the exchange, synthesis and *ethically-sound* application of knowledge (e.g., Graham et al. 2006). Basic fidelity to both science and ethics principles are foundational to any assessment of quality of evidence, with arms-length peer review process assessing the ethics information presentation, the nature of engaged review boards, practice guidelines, referencing state-of-knowledge in systematic and meta-analytic reviews, and specifying the practical implications in a clear and tempered manner. There is a market pull (evidence it wants) and push (evidence it does not want), recognizing that faithful, yet flexible implementation is founded upon a long-term view of partnership, and that the implementation process of evidences is a long-term, multi-stage systematic process (Mildon and Shlonsky *in press*; Toth and Manly *in press*). As editor of

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special projects, I plan to pair key articles and their authors with broad exchange opportunities to provide useable extension learning for stakeholders in addiction, mental health, child welfare, shelter and housing services, and so forth. I look forward to working with the IJMHA interest group to craft creative and accessible modes for scholarly interaction.

And Now for Something Completely Different: A Bit About Me

My first experience with substance abuse was in church as a child at Easter mass, at a time when Spring finery (and white gloves) were worn. In front of our family was a lone homeless man in a pew, with all the common visual and olfactory signals. There is a kindly tradition of turning to those all around you, shaking hands, and wishing them peace. How appropriate! I very much wanted to shake this person's hand, but I feared the reaction of others—social comparison was absolute, no one was entreating this gentleman. My heart sunk as he looked around, and slowly recognizing no approach, turned and left. How sad! Not to be tempted to see this as isolated, the decades of work of Susan Fiske and colleagues has shown consistency across countries on how homeless are viewed within a quadrant of high versus low warmth, and high versus low competence. Across countries, they are placed in the low warmth and low competence, low within that quadrant with “disgust” the applicable affective categorization. In contrast, individuals with visible disabilities are in the high warmth, low competence quadrant, with “pity” as the operative affective stance (Fiske 2011). This intergroup, social cognition, and social emotions work is important to take into consideration as we look to service development, utilization and satisfaction.

Since life is filled with second chances, I found myself a decade later interested in clinical psychology, a university undergraduate, and engaging with the mentally ill and homeless population as a volunteer. My second entry to substance abuse work was in graduate school, looking for research on substance abuse patterns of maltreating parents, while compiling review articles on maltreatment-related interventions (Wekerle and Wolfe 1993; Wolfe and Wekerle 1993; Wekerle and Wolfe 1999) that led to an edited book during my first faculty position, with my graduate school colleague, Anne-Marie Wall, called “The Violence and Addiction Equation” (Wekerle and Wall 2002). At that time, the substance abuse researchers and clinicians had greater engagement with and intervention readiness for dealing with violence factors, than did the violence researchers and clinicians. Yet, parental substance abuse and mental health issues are prominent in maltreating families.

It is acknowledged that current child welfare cases are complex with indices of risk sharing similar outcomes and characteristics as substantiated maltreatment (Fallon et al. 2011). With complex cases, where the child is the client as with child welfare, parental mental health and substances provide a challenge. Resources are available on the US Department of Health and Human Services, Administration for Children and Families significant resource site, Child Welfare Information Gateway (<http://www.childwelfare.gov/>), as well as the US Substance Abuse and Mental Health Services Administration (<http://www.samhsa.gov/>), and its US National Center on Substance Abuse and Child Welfare (<http://www.ncsacw.samhsa.gov/training/default.aspx>); these provide toolkits, webinars, training opportunities, population outcome statistics, scientific literature updates, practice guidelines materials, and more at no cost to the subscriber. For example, from SAMHSA's data point features, diagrams illustrate the statistic that adult alcohol dependence is four times as likely to be a co-occurring issue (with mental illness), in contrast to when there is no mental illness (<http://oas.samhsa.gov/spotlight/Spotlight027AlcoholDependence.pdf>). It is suggested that providers working with individuals with either a substance use or a

mental health problem may want to consider screening for a co-occurring disorder and providing an integrated treatment program. The Wekerle and Wall (2002) contributors discussed such issues as sequencing of treatment, target of treatment, impact of substance treatment on non-targeted, but impacted, violence outcomes and so forth. Substance abuse, mental health and other caregiver vulnerabilities interact with partner violence to predict caseworker maltreatment substantiation decisions (Wekerle et al. 2009). Thorough assessment and collaboration among systems (substance services, police, shelters, child welfare, child and family mental health services) requires on-going attention to the literature and current practice trends.

Two-Issues on Risk and Resilience: The Impact of Childhood Maltreatment

The focus in these two issues is on child maltreatment—a robust risk factor for a host of poor outcomes (Wekerle 2011). Child maltreatment is a stressor event and a stressful lifestyle. Physical, sexual, emotional abuse and neglect all involve some level of attack to the child's body and mind. Maltreatment has been shown to cluster with other adverse childhood events and predict onset of DSM-IV disorders (Green et al. 2010), as well as persistence of disorders (substance, mood, anxiety; McLaughlin et al. 2010). These domains of at-risk health conditions appear logically clustered towards the psychological, physical, and interpersonal response to unrelenting high, and often unpredictable, daily stress from danger, violence and their threat while growing up. Maltreatment, a preventable adult action towards a child, places the victim in further contexts of vulnerability. For example, compared to matched controls, maltreated children find as adults their peak earnings are about \$5,000 less/year that, over time, is a sizeable financial impairment (Currie and Widom 2010). Importantly, females bear a greater breadth of burden as compared to maltreated males, showing significant less grade attainment, income, IQ test score (at young adulthood), and ownership (vehicle, home, bank account). In this US substantiated large-scale sample followed through adulthood, maltreatment is especially problematic for women's mental, physical, and financial health.

Within the types of maltreatment, emotional maltreatment tends to be under-attended for its impact on self-functioning, including stable, coherent self-view that supports self-care and counters suicidality (e.g., Cicchetti et al. 2009; Yates and Wekerle 2009). Negative social self-learning has also been identified as a core issue for adult children of alcoholics (e.g., Wall and McKee 2002; Webb et al. 1992). Emotional or psychological maltreatment is a pattern of interacting with children or a child (targeted or scapegoat role), reflecting the lack of emotional nurturance (e.g., never saying "I love you.") and positive discovery opportunities, as well as the presence of emotionally hurtful communications and interactions (e.g., consistently ignoring, denigration, Trickett et al. 2009). Often, condemnations of the child *as a person* are repeated and persist over time. The World Studies of Abuse in the Family Environment (WorldSAFE study; Sadowski et al. 2004), which utilizes common measures across surveyed countries, indicates that 25% of parents report that they "pulled the child's hair" in the past 6 months; and 15% to 44% of parents reported calling children names. According to the US National Survey of Children's Exposure to Violence (Finkelhor et al. 2010), 22.6% positively endorsed the single emotional abuse item that included frightened affect (getting scared or feeling really bad) about adult-to-child verbal abuse (called names; mean things said; told you weren't wanted). In terms of reports to child welfare, the US National Incidence Study places psychological abuse at 27% of the cases, and psychological neglect at 25% of the cases,

when using the corollary that demonstrated harm occurred to the child. When risk of harm (endangerment) is considered, a broader incidence is found: 36% of children are emotionally abused (Report available at: http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/nis4_report_congress_full_pdf_jan2010.pdf).

The World Report on Violence and Health (WHO; Krug et al. 2002) reports that partner violence and child maltreatment commonly co-occur. Intimate partner violence is abuse that occurs between two people in a close, typically romantic, relationship. The term intimate partner violence (IPV) reflects physical, emotional, and sexual abuse in a close relationship, with current and former spouses and dating partners; (www.cdc.gov/violenceprevention/pdf/IPV_Strategic_Direction_One-Pager-a.pdf). The Canadian Maternity Experience Survey (2006–2007; <http://www.phac-aspc.gc.ca/rhs-ssg/survey-eng.php>) found that 40% of the 15 to 19 year old mothers experienced physical and/or sexual partner abuse in the prior two years, and this group reported the highest pregnancy stress (e.g., moved to a new address, argued with partner more than usual). These younger women reported family, friends and health care providers as nearly equivalent information resources. When either the mother alone is a victim of IPV or when both parents engage in IPV, parental aggression to the child becomes more likely (e.g., Taylor et al. 2010). Substantiation of other forms of maltreatment was found at greater levels when partner violence was present alongside primary caregiver vulnerabilities (e.g., substance abuse; Wekerle et al. 2007). In some areas, exposure to IPV is a form of emotional abuse. From population survey, where 10.3% of US children were maltreatment victims; among 14 to 17 year old youth, more than one-third had seen their parent(s) assaulted (Finkelhor et al. 2010). According to the 2008 CIS statistics, where IPV exposure is separated out from other forms of emotional abuse, IPV exposure was a leading category of *substantiated* child maltreatment (34%); 9% of cases were substantiated as emotional abuse. The most common co-occurrences being IPV exposure and neglect (Public Health Agency of Canada 2010; Trocmé et al. 2010). According to the emotion regulation hypothesis (e.g., Stewart 1996; Stewart and Israeli 2002) self-harming (Jacobson and Gould 2007; Ross and Heath 2003; Laye-Gindhu and Schonert-Reich 2005) or aggressive behaviours (Gordis et al. 2009) may be an attempt to regulate (i.e., decrease or distract from) the experience of negative emotions (coping motive, Kuntsche et al. 2008; Grant et al. 2009; Cooper et al. 1992), among others. Substance use imparts physiological changes; escalating use patterns provide a psychological context that is perceived as effective, if not efficient, by the user.

However, the role of historical and on-going trauma is substantial in impairment (e.g., Gilbert et al. 2009; Wekerle 2011). When oneself is seen as negative, traumatic stress may heighten the overall negative burden load via: (1) over-experiencing negative self-emotions (i.e., shame, rejection, anxiety etc.: too many types, too frequently, too intensely); (2) over-engagement in self-punishing behaviours (e.g., self-harming acts; self-neglect); (3) re-victimization experiences, all in the context of (4) a lack of strategy, motivation, and practice in self-soothing. Adolescent dating violence (for a special issue, see Kerig 2010) is an issue overlapping with mental health and substance abuse in high risk populations (e.g., child welfare, juvenile justice; homeless), although accessing formalized support is less likely than receiving preventative services through school attendance. As with child maltreatment, effective and promising dating violence prevention programming exists (Wekerle and Tanaka 2010). The areas of the brain most sensitive to stress are those implicated in learning, memory, and “higher order” integration of emotions and thoughts needed to support executive functioning (Cicchetti and Curtis 2006; McCrory et al. 2010; Perry 2009). The chronic stress system dysfunction, from all maltreatment sources, challenges the core neurocognitive building blocks of emotional

regulation, such that reactivity to trauma triggers and ambiguous threats, as well as reasoned action to potential threats, do not proceed in optimal emotion-cognition-behavior communication (De Bellis 2001; DeBellis 2002; DeBellis et al. 2010; DePrince et al. 2009; Lee and Hoaken 2007). With a dominating, global negative self, investment in personal learning and agency and confident exploration of the environment is advanced as impaired, leaving a further challenge to resilient functioning. Early intervention may be key.

Evidence shows that experiences in the 1st years of life are extremely important for a child's healthy development and lifelong learning. How a child develops during this time affects future cognitive, social, emotional, and physical development, which influences school readiness and later success in life. Research on a number of adult health and medical conditions points to predisease pathways that have their beginnings in early and middle childhood. (<http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>)

The US Healthy People 2020, the US priority-setting initiative, identifies as new priorities those that are consistent with the UN Rights of the Child (UNICEF 2003) and Millennium Development Goals (<http://www.un.org/millenniumgoals/bkgd.shtml>), recognizing the needs for safety from violence, stable, safe and secure housing, and quality of life. This documents notes that adolescents (10–19 years) and young adults (20–24 years) represent about one-quarter of the US population and experiences during these developmental periods are foundational for setting in motion many adult chronic diseases. New target areas from earlier priority-setting include: (1) early and middle childhood; (2) adolescent health; (3) sexual minority persons' health, among others (http://www.healthypeople.gov/2020/top_icsobjectives2020/default.aspx). In our own work with the Maltreatment and Adolescent Pathways (MAP) longitudinal study (three papers in these two volumes report on the MAP sample; Goldstein et al.; Stewart et al.; Weiss et al.), a sizeable minority of these child welfare-involved youths self-report lesbian, gay and bisexuality; many youth endorse “don't know” in response to the sexual orientation question. In a US population survey, maltreatment is elevated in lesbian women (Bradford et al. 1994), with 19% reporting incest, 32% reporting childhood sexual abuse, and adult health issues are also reported (e.g., a third reporting daily tobacco smoking). The US Centers for Disease Control and Prevention identify two core public health goals: (1) prevention of violence to self and others; and (2) the promotion of safe, nurturing relationships. One area of particular challenge for youth with a history of child maltreatment, and especially childhood sexual abuse (CSA), is in the area of sexual relationships. Senn and Carey (2010) report that only CSA remains an individual predictor of adult risk (number of partners; proportion of unprotected sex episodes in a three-month period) when other forms of maltreatment and background factors are taken into account among females presenting to a publicly-funded clinic. Clearly, there is a greater need for understanding issues for under-studied groups and to conduct research directly with child welfare populations.

Not surprisingly, there are continuing calls for maltreatment prevention, especially in light of effective programs (e.g., MacMillan et al. 2009; MacMillan 2010). Emergent evidence suggests that in situations of increased predictability and structures for foster care youth (treatment foster care), stabilization of stress seems to be achievable (i.e., change from atypical to typical cortisol pattern, Fisher et al. 2007). This neurobiological resilience system reflects the adaptive capacity to interact with new environments and create new modes of responding and interacting that serve survival and development better (Cicchetti and Curtis 2006). This view draws heavily on the concepts of *neural plasticity*—wherein the experiences of the child fine tunes “the pattern of neuronal connections underlying the

brain's function" (Weisel 1994; p. 1647), and *self-organization*—the reorganization of targeted brain systems to support adaptation in functioning when subjected to new constraints in the environment (Cicchetti and Curtis 2006; Cicchetti and Valentino 2006). Thus, with adversity comes opportunity. These first two volumes target current learning on a key risk factor—child maltreatment—and its relationship to mental health and substance abuse risks, while looking for those windows of opportunity where resilience may be evoked.

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