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Received: 27 December 2022 | Revised: 9 June 2023 | Accepted: 18 August 2023

DOI: 10.1002/car.2847

ORIGINAL ARTICLE

Families of four-year-old children experiencing violence: A national survey of parents and public health nurses on help and support

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Abstract

Intimate partner violence (IPV) and child maltreatment (CM) – together referred to as family violence (FV) – often co-occur. In Finland, public health nurses play an important role in identifying FV. They regularly meet families and assess children's health until the child turns seven. This nationwide retrospective cross-sectional survey (FinChildren) aimed to describe and compare help and support needs in violent families from the perspectives of the parents of four-year-old children and public health nurses for advancing families' and professionals' collaboration in preventing FV. The data ($N = 7476$ families) included the responses of one parent from each family and public health nurses, caring for that certain family. The data analysis encompassed statistical methods. The results showed that 47.0% of the parents reported FV. The public health nurses assessed that 0.7% of the parents would have needed support for CM and 1.3% for IPV. They assessed that the parents involved in FV needed more support for their personal coping ($p < 0.001$) and intimate relationship ($p < 0.017$) compared with parents without FV. These parents were also found to have other support needs. We concluded that public health nurses recognise only a fraction of FV occurring in families. Risk assessment tools are needed to enable child and family professionals to better intervene in and prevent FV.

KEYWORDS

child maltreatment, cross-sectional study, family, helping, intimate partner violence, public health nurse, supporting

Key Practitioner Messages

- In families with small children, different forms of violence may occur simultaneously.
- Parents' other support needs, such as interaction between the parents and the child, interaction within the family, parents' mental wellbeing and mental health, may indicate risk for FV. Tools must be developed and used for screening for various problems in families.
- Early identification of families at risk and supporting them may help prevent FV recurrence.

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INTRODUCTION

Young children growing up in families involving intimate partner violence (IPV) are at an increased risk of exposure to child maltreatment (CM), meaning physical, emotional and sexual abuse and neglect (Brown et al., 2021; Easterbrooks et al., 2018). IPV itself is one form of emotional CM. These forms of FV all have increased risk of a wide range of health problems throughout the individual's lifespan (Brown et al., 2021; Dababnah et al., 2018; Kate et al., 2021). Children who are exposed to IPV or CM show more emotional and behavioural problems (Brown et al., 2021; Easterbrooks et al., 2018) and are at a higher risk of becoming involved in violence in later life, both as victims and perpetrators (Assink et al., 2018; Shields et al., 2020; Spencer et al., 2022).

The literature highlights several risk factors for child maltreatment. Poor parental mental health, antisocial behaviour, parents' substance use, financial problems and a parent's history of multiple-type maltreatment (especially among mothers) have been mentioned among the risk factors for CM (Doidge et al., 2017; Mulder et al., 2018; Rantanen, Paavilainen, et al., 2022). A meta-analysis showed that the strongest risk markers for physical IPV for both men and women were related to other acts of violence, both perpetration and victimisation, as well as factors pertaining to the intimate relationship itself, such as relationship dynamics (Spencer et al., 2022). Risk factor assessment and actual IPV and CM identification within a family are closely connected, as phases of the same process, and integrated with primary and secondary prevention perspective (see Rantanen, Paavilainen, et al., 2022). In cases of FV (including IPV and CM), it is difficult to know what exactly is happening in the family. Because of this, we need to know more about the whole process around FV.

The adverse effects of family violence cause the use of many services, including legal, health and social services (Dias et al., 2020; Notko et al., 2022; Ogbe et al., 2020), which stresses the importance of both prevention and identification of IPV and CM. However, of those experiencing IPV, only a small number seek help for violence. According to the 2019 Finnish National Crime Victim Survey (Danielsson & Näsi, 2020), 10% of those who experienced violence involving at least slapping reported the incident to the police. No difference was found between men and women in police reporting. Costa et al. showed that IPV occurring during the previous year was associated with missing healthcare appointments, particularly for those experiencing violence as both victims and perpetrators (Costa et al., 2019). However, informal social support may encourage IPV victims both to disclose their experiences and to seek appropriate help and treatment (Dias et al., 2020; Ridings et al., 2021). Dias et al. showed that both men and women victims receiving high social support from friends, family or significant others seek help care services less frequently when compared with victims with low social support. Ridings et al. (2021) highlighted the overall important role of social support (e.g., parents, friends and partners) in alleviating depressive symptoms, particularly among vulnerable caregivers.

Moreover, literature reveals some barriers to seeking services among both men and women. Based on a systematic review, the barriers to formal services (e.g., health services, criminal justice system) for the adult survivors of IPV in the United States were a lack of awareness of resources or victims' failure to identify their experience as IPV, challenges with access, fear of consequences of disclosure, personal barriers and systemic failures such as feeling that the victim is not believed or distrust in an agency/organisation, or experiencing marginalisation or discrimination (Robinson et al., 2020).

There is research evidence that FV often goes undetected in social and healthcare settings (Baird et al., 2019; Coulter & Mercado-Crespo, 2015; Leppäkoski et al., 2019; Soh et al., 2021). In addition, many who sought help were dissatisfied or found that they were left without help (Notko et al., 2022). This is because of the varying levels of knowledge, training and perceived ability to deal with the co-occurrence of CM and IPV among different professionals (Coulter & Mercado-Crespo, 2015). Further, there may be a lack of standardisation of processes, workplace instructions or clinical guidelines, or employees may not be aware of existing protocols or guidelines for identifying or responding to FV (Baird et al., 2019; Leppäkoski et al., 2019). Moreover, an Australian study by Soh et al. (2021) showed that although health practitioners recognised FV as a health issue, only one-fifth of them felt very confident in screening, supporting and referring patients with experiences of violence. The perceived barriers to addressing violence in families included time constraints and placing greater importance on screening for other health issues. However, effective training on CM and the use of guidelines are important for increasing public health nurses' knowledge and skills for identifying and intervening in child maltreatment (Suzuki et al., 2017). In addition, FV should be assessed broadly, particularly among parents of young children with other adverse life conditions (Ridings et al., 2021). It is also crucial to be aware and able to assess FV risk within families (Rantanen, Nieminen, et al., 2022; Rantanen, Paavilainen, et al., 2022).

Research evidence suggests that good quality parenting in early childhood is associated with positive mental and physical health over the long term (Bachmann et al., 2021; Bethell et al., 2019). Especially, families with very young children have described a variety of worries concerning issues such as parental challenges, the relationship between the parents and difficulties in obtaining support (Lepistö et al., 2022). Thus, parental worries should be systematically investigated by developing interventions such as discussions as early as possible (Lepistö et al., 2022). Moreover, there

is evidence that an instrument like BCAP (Brief Child Abuse Potential Inventory) could serve as a valid tool to detect child abuse in the general population (Ellonen et al., 2019) although further analysis is also needed. Another tool developed for risk assessment is a research-based mobile application (Family Needs Checklist, FNC), which parents can fill in before an appointment (Rantanen, Nieminen, et al., 2022). Self-reporting has been found more reliable than evaluations carried out by an outsider (Rantanen, Paavilainen, et al., 2022). Sprague et al. (2016), in turn, have presented that while, for example, many different IPV identification programmes are beneficial for identifying victims of abuse, it remains unknown as to whether these programmes prevent future episodes of abuse.

Legislation (e.g., Act on Child Custody and Right of Access, L361/1983) and agreements (e.g., Action Plan for the Istanbul Convention for 2022–2025, 2022) related to the service system require violence to be addressed. In Finland, disciplinary violence and other forms of intentional humiliation is prohibited by the law (L361/1983). Public health nurses are in key positions to prevent, identify and intervene in CM and IPV because they regularly meet families with small children in primary services. Further, in this nationally representative study, we will add to the existing knowledge base by describing help and support needs in families that have reported family violence (FV) (IPV and/or CM), and how public health nurses respond to these needs, and if there are risk factors which could be identified even before the FV acts emerge.

The present study

The aim of the present study was to describe the help and support needs in families with FV from the perspectives of the parents of a four-year-old child and public health nurses and compare these perspectives for the purpose of advancing families' and professionals' dialogue and collaboration related to preventing FV.

More specifically, the following questions were asked:

1. How common was it for parents to report family violence?
2. How did parents who reported FV need and receive help from different professionals and their loved ones in violent situations?
3. What kinds of differences were there in the need for support, expressing this need, and access to support for the parents' own coping and their intimate relationship between those parents who reported FV and those who did not?
4. How did the public health nurses identify parents' needs for support?

METHODS

Data collection and the study participants

This study is a nationwide retrospective cross-sectional survey (FinChildren) conducted by the Finnish Institute for Health and Welfare. In total, 290 municipalities in mainland Finland out of 295 participated in the data collection. The target group included all the families whose four-year-old child underwent an extensive health examination at a child health clinic in 2018. In Finland, child health clinic services are free of charge and offered for all children under school age and their parents. Extensive health examinations for four-year-old children are intended for the whole age group and both parents of the child. Families were requested to participate in the study in connection with the child's health examination at a child health clinic. Public health nurses served as contact persons in the municipalities. They were responsible for providing questionnaires to the children's parents (Finnish Institute of Health and Welfare, 2018). Both parents of four-year-olds were given an opportunity to fill out the questionnaire. The content of the questionnaire was the same for both parents. Furthermore, data were collected from the public health nurses using a form aimed at them.

There is no accurate knowledge of how many families had an opportunity for participating in the study because not all public health nurses recruited all their client families with a four-year-old child to the study. That is why the coverage of the families participating in the study was assessed in relation to the number of the completed extensive health examination for four-year-olds. During the data collection phase, in total 36,593 extensive health examinations were performed.

Overall, 17,009 families gave their consent on participating in the study (coverage 46%). There were answers from the public health nurses for a total of 16,270 families (coverage 44%, response rate from the families participating in the study 96%). In some of the families participating in the study, both parents filled out the survey, while in some cases, only one parent did, and in other cases, neither of the parents did. One or both parents of a total of 8720 children filled out the questionnaire (coverage 24%, response rate 51%). The total number of responses by the parents was 10,737.

The data in this study sample included those families for which there was an answer from both the parent who signed the consent form and the public health nurse. The total number of these 'pairs' was 7476 (coverage 20%, response rate 44%). The parents who signed the consent form were selected for this study sample because their presence at the child health clinic could be verified and a public health nurse had thus had an opportunity to assess their need for support.

Ethical considerations

The study adhered to the guidelines for good scientific practice published by the Finnish National Board on Research Integrity (2012) and the Declaration of Helsinki (2008) (World Medical Association, 2023). The municipalities were requested to provide a research permit prior to the data collection process. The families were informed about the study orally and in writing. Study participation was voluntary and the parents could choose to withdraw at any point. One of the child's official parents signed written consent on the participation in the study. The parents filled in their own forms independently and the public health nurse or another parent could not see the answers. The study was approved by the Ethics Committee of the Finnish Institute for Health and Welfare (773/2017).

Instruments

Our research data were part of the data set of the 2018 FinChildren study (which used to be called the Children's Health, Well-being and Services survey) in which parents were asked about issues such as welfare, health and functional capacity, lifestyle, the safety of the growth environment, and the need, availability and adequacy of services and support (Finnish Institute of Health and Welfare, 2018). The questions for public health nurses concerned information about the family's well-being and the need for support and services. Variables from both questionnaires, data sets of parents and public health nurses were selected for closer examination based on the aim of our study.

Variables

Parents' questionnaire

Six items were concerned with violence experienced by the child (CM). The parents were asked whether they personally, the child's other parent, or the parent's spouse or former spouse had been violent towards the child in the previous 12 months. The forms of violence were: 1) throwing, hitting or kicking an object in anger in front of the child; 2) leaving the child without care and attention for a longer period; 3) verbally threatening the child with violence; 4) calling the child names, belittling, severely criticising or otherwise verbally abusing the child; 5) pinching, pulling the hair or slapping the child; 6) kicking or hitting the child. The response alternatives were 'not once', 'once', 'sometimes', 'often'. The sum variable of CM was formed and coded as follows: a parent or some other close person has used at least one form of violence against the child at least once (yes/no).

The respondents were asked about intimate partner violence experienced by a parent (IPV) with four items. The parents were asked if they had experienced any of the following in their intimate relationship (the parent's current or former intimate relationship) in the previous 12 months: physical, emotional, sexual and financial violence. The response alternatives were yes and no. The sum variable of IPV was formed and coded as follows: the parent has experienced at least one form of IPV (yes/no).

Finally, the sum variable 'Family violence (FV)' was formed and coded as follows: the parent reported that the family has been involved in CM and/or IPV in the previous 12 months (yes/no).

Those parents who reported FV were asked 'Do you find you have received sufficient help in the violent situations you described above in the last 12 months?' The response alternatives were: 'Did not need it', 'I received adequate help', 'I received help but it was not adequate', 'I would have needed help but did not get it', and 'I would have needed help but I did not bring it up'. The response options 'I received help but it was not adequate' and 'I would have needed help but did not get it' were combined.

The parents were asked about their experiences of sufficient support with two items. The parent was asked: 'In the past 12 months, have you received sufficient support for your personal coping from professionals in different fields (including the child health clinic)' and 'In the past 12 months, have you received sufficient support for the intimate relationship from professionals….' The response options were: 'did not need it', 'I received adequate support', 'I received support but it was not adequate', 'I would have needed support but did not get it', and 'I would have needed support

but I did not bring it up'. The response options 'I received help but it was not adequate' and 'I would have needed help but did not get it' were combined.

The public health nurse's questionnaire

The public health nurses were asked: 'According to your overall assessment, does the family need support related to the following?' The issues to be assessed were: child maltreatment, intimate partner violence, parent's personal coping, parents' intimate relationship, the child's externalising psychological symptoms, the child's ability to interact or social skills, parent's mental well-being and mental health, parent's upbringing practices, basic care and nurturing of the child, interaction between the parents and the child, interaction within the family and providing daily routines based on the child's needs and interests. The response options were: 'not at all', 'some', 'a lot', and 'I cannot say'. The categories were combined as follows: the parent/family did not need the support ('not at all', 'I cannot say') and the parent needed the support ('some', 'a lot').

Data analysis

The data analysis used statistical methods. The prevalence of FV reported by the parents studied and the needs of the parents' support for violent situations were described using frequencies and percentages. Differences between groups were examined using cross-tabulation and the chi-squared test. First, we examined differences in the parents' needs for support from various professionals for their personal coping and intimate relationship, their expression of the need for support and the adequacy of support depending on whether or not the parent had reported family violence. Next, we examined how the families' needs for support for various issues regarding the child or the parent assessed by public health nurses differed from each other depending on whether or not the parent reported family violence. Finally, we examined how the public health nurses identified the needs for supporting parents' personal coping and intimate relationship in those parents who reported related needs in the present study and whether there was a difference in the identification of the needs based on whether or not the parent had reported family violence. Statistical significance was set at ≤ 0.05. The analyses were performed using IBM SPSS (Version 27 for Windows).

RESULTS

Characteristics of the parents

Of the parents (N = 7476) in this study sample, 91.1% were women and 8.9% men. Just over half of the respondents (51.7%) were aged 35 or over. Most (84.4%) of the parents also had other children in addition to the four-year-old. The majority (91.5%) of the parents lived with a spouse. The characteristics of the parents are presented in a table (Table 1).

Prevalence of family violence (FV) in the previous 12 months as reported by parents

Almost 10 % of the parents of a four-year-old child reported exposing to at least one form of IPV; 12.2% of men and 9.7% of women. Almost half of the parents reported that their four-year-old child has been subjected to at least one form of maltreatment (CM); 40.6% of men and 45.2% of women reported so. In total, 47.0% of the parents reported FV (IPV and/or CM); 43.0% of men and 47.3% of women (Table 1).

Parents' experiences of receiving help in violent situations

Those parents who reported FV (N = 3503) were asked about their needs for receiving help from different professionals and loved ones in violent situations in the previous 12 months. The parents reported that they rarely needed help from professionals. Of all parents who reported FV, in total 11.7% needed help from a nurse or a public health nurse and 9.4% from a social worker. Of the parents who needed help from a nurse (n = 396), 38.8% (n = 154) considered the help received as adequate and 49.0% (n = 194) had not brought this up. Of the parents who needed help from a social worker (n = 318), 45.0% (n = 143) considered the help received as adequate and 35.5% (n = 113) had not brought this up. Parents felt they needed help more often from their loved ones than from professionals. Of all parents who reported

TABLE 1 Parents' ($N = 7476$) characteristics and prevalence of family violence.

		n	%
Parents' backgrounds			
Gender	Men	660	8.9
	Women	6768	91.1
Age	< 35 years old	3595	48.3
	≥ 35 years old	3853	51.7
Number of children	4-year is only child	1150	15.6
	Other children in the family	6242	84.4
Number of adults	One adult in the family	632	8.5
	Two adults in the family	6789	91.5
Parents reported some form of intimate partner violence (IPV) at least once in the previous 12 months[a]			
All parents	No	6543	90.1
	Yes	721	9.9
By gender			
Men	No	567	87.8
	Yes	79	12.2
Women	No	5942	90.3
	Yes	636	9.7
Parents reported some form of child maltreatment (CM) at least once in the previous 12 months			
All parents	No	4111	55.2
	Yes	3338	44.8
By gender:			
Men	No	390	59.4
	Yes	267	40.6
Women	No	3702	54.8
	Yes	3050	45.2
Family violence (FV): Parent reported IPV and/or CM at least once in the previous 12 months			
All parents:	No	3948	53.0
	Yes	3503	47.0
Men	No	375	57.0
	Yes	283	43.0
Women	No	3556	52.7
	Yes	3197	47.3

[a]Not all respondents have been in a relationship in the previous 12 months.

FV, in total 49.3% needed help from a spouse and 42.7% from friends. Of the parents who needed help from a spouse (n = 1667), 76.7% (n = 1278) considered the help received as adequate and 5.5% (n = 91) had not brought this up. Of the parents who needed help from friends (n = 1446), 80.4% (n = 1162) considered the help received as adequate and 11.3% (n = 164) had not brought this up (Table 2).

Of all parents reported FV, in total 11.7% needed help from a nurse or a public health nurse (n = 396), 38.8% (n = 154) considered the help received as adequate and 49.0% (n = 194) had not brought this up.

The need for parental support, the adequacy of the support and bringing up the need for support

Of all the parents (N = 7476), those who reported family violence more frequently also reported a need for support for their personal coping and for their intimate relationship compared to the parents who did not report family violence. Correspondingly, of the parents who expressed a need for support and those who reported FV felt that they were less likely to receive adequate support for their personal coping and for their intimate relationship compared to others.

TABLE 2 Parents' ($N = 3503$[a]) need for help, adequacy of help received and bringing up the need of help in family violence (FV) situations in the previous 12 months.

	Did not need help (*n*) %	Needed help, in total (*n*) %	Needed help: And received adequate help (*n*) %	Needed help: And got help but it was not adequate/did not receive help at all (*n*) %	Needed help: But did not bring it up (*n*) %
From the different professionals:					
From a nurse, a public health nurse and so on	(2990) 88.3	(396) 11.7	(154) 4.5	(48) 1.4	(194) 5.7
From a doctor	(3270) 96.5	(118) 3.3	(46) 1.4	(13) 0.4	(59) 1.7
From a social worker, a family worker, etc.	(3065) 90.6	(318) 9.4	(143) 4.2	(62) 1.8	(113) 3.3
From other services (including the police, a shelter)	(3326) 98.2	(62) 1.8	(36) 1.1	(8) 0.2	(18) 0.5
From a professional in a telephone or online service	(3219) 95.3	(158) 4.7	(42) 1.2	(15) 0.4	(101) 3.0
Professionally organised peer support	(3243) 95.9	(140) 4.1	(28) 0.8	(20) 0.6	(92) 2.7
From the loved ones:					
From your spouse	(1712) 50.7	(1667) 49.3	(1278) 37.8	(298) 8.8	(91) 2.7
From your friends and others close to you	(1938) 57.3	(1446) 42.7	(1162) 34.3	(120) 3.5	(164) 4.8

[a]Those parents who had reported family violence (= intimate partner violence (IPV) and/or child maltreatment (CM)).

TABLE 3 Parents' ($N = 7476$) need for support, adequacy of support received and bringing up the need for support in relation to family violence (FV).

	Support for personal coping			Support for intimate relationship		
	Did not report FV *n* (%)	Reported FV *n* (%)	*p*-value[a]	Did not report FV *n* (%)	Reported FV *n* (%)	*p*-value[a]
Of all participants						
Need for support			<0.001			<0.001
Parents who did not need support	2848 (72.4)	1679 (48.1)		3333 (84.9)	2401 (69.0)	
Parents who needed support	1083 (27.6)	1811 (51.9)		593 (15.1)	1081 (31.0)	
Of those who needed support						
Adequacy of support received			<0.001			<0.001
Parents who received adequate support	640 (59.1)	728 (40.2)		269 (45.4)	284 (26.3)	
Parents who did not receive adequate support	443 (40.9)	1083 (59.8)		324 (54.6)	797 (73.7)	
Bringing up the need for support			<0.001			<0.001
Parents who brought up the need for support	787 (72.7)	1093 (60.4)		342 (57.7)	457 (42.3)	
Parents who did not bring up the need for support	296 (27.3)	718 (39.6)		251 (42.3)	624 (57.7)	

[a]*p*-values <0.05 denote statistically significant associations.

Moreover, the parents who needed support and reported FV also less frequently brought up their support needs for personal coping and for their intimate relationship than the others (Table 3).

The need for parental support assessed by public health nurses

Of the families where a parent had reported FV, the public health nurses identified 0.7% as needing support due to CM and 1.3% as needing support due to IPV. However, the public health nurses assess that the parents who reported FV needed support more often than others due to the following issues: the parent's personal coping and intimate

TABLE 4 Families' needs for support according to the public health nurse's assessment.

According to the public health nurse's assessment, the family needs support…	Parent reported family violence (FV)	Families that need for support according to the public health nurse's assessment *n*	%	*p*-value[a]	Answers of the public health nurses *N*
Child maltreatment (CM)	No FV	13	0.3	0.029	3892
	Yes FV	24	0.7		3454
Intimate partner violence (IPV)	No FV	8	0.2	<0.001	3859
	Yes FV	46	1.3		3426
Parent's personal coping	No FV	742	19.1	<0.001	3895
	Yes FV	1006	29.2		3451
Parent's intimate relationship	No FV	297	7.7	<0.001	3866
	Yes FV	480	14.1		3416
The child's externalising psychological symptoms	No FV	430	11.0	<0.001	3900
	Yes FV	635	18.3		3461
The child's ability to interact or social skills	No FV	604	15.5	<0.001	3907
	Yes FV	640	18.5		3457
Parents' mental wellbeing and mental health	No FV	301	7.7	<0.001	3894
	Yes FV	501	14.6		3440
Parent's upbringing practices	No FV	383	9.9	<0.001	3885
	Yes FV	532	15.5		3443
Basic care and care of the child	No FV	65	1.7	0.165	3888
	Yes FV	73	2.1		3455
Interaction between the parents and the child	No FV	214	5.5	<0.001	3891
	Yes FV	306	8.9		3452
Interaction within the family	No FV	266	6.9	<0.001	3878
	Yes FV	468	13.6		3442
Providing daily routines based on the child's needs and interests	No FV	109	2.8	0.024	3885
	Yes FV	129	3.7		3445

[a] *p*-values <0.05 denote statistically significant associations.

relationship, child's outward psychological symptoms, the parents' psychological well-being and mental health, family's upbringing practices, parent–child interaction and interactions among the family members (Table 4).

Finally, we investigated how the public health nurses identified the need for parental support among the parents who reported the need for support in relation to their personal coping and intimate relationship. The public health nurses assessed that approximately one in three parents needed support for their personal coping among those parents who reported having support needs. However, the public health nurses assessed that the parents who reported family violence had a need for support slightly more often than those parents who did not report. Correspondingly, the public health nurses assessed that there was a need for support related to the parents' intimate relationship in one in five parents among those parents who reported this support need. The public health nurses assessed that there was this need for support among parents who reported FV slightly more often compared to those parents who did not report it. Moreover, we separately investigated how the public health nurses assessed the parents' support needs among those parents who reported a need for support and also reported having brought this need up. In this context, the public health nurses assessed the need for support among those parents who reported FV slightly more frequently than among all the parents reporting the need for support and FV. Among the parents who did not report FV no changes related to identifying the need were observed (Table 5).

DISCUSSION

Our study results clearly show that according to parents' self-reporting, FV is quite common. Public health nurses very rarely noticed support needs related to FV. However, they reported families' support needs related to other issues, such

TABLE 5 Need for parental support identified by the public health nurse when a parent reported the need for support.

		Personal coping According to the assessment of a public health nurse a parent …			Intimate relationship According to the assessment of a public health nurse a parent …		
		Did not need support *n* (%)	**Needed support *n* (%)**	***p*-value[a]**	**Did not need support *n* (%)**	**Needed support *n* (%)**	***p*-value[a]**
Parents who reported the need for support	and parent did not report family violence (FV)	726 (68.2)	339 (31.8)	<0.001	464 (79.9)	117 (20.1)	0.017
	and parent reported family violence (FV)	1080 (60.4)	709 (39.6)		794 (74.6)	270 (25.4)	
Parents who reported the need for support and brought it up	and parent did not report family violence (FV)	524 (67.6)	251 (32.4)	<0.001	269 (80.1)	67 (19.9)	<0.001
	and parent reported family violence (FV)	606 (56.0)	477 (44.0)		305 (67.8)	145 (32.2)	

[a]*p*-values <0.05 denote statistically significant associations.

as coping and intimate partnership. Problems in these issues are risk factors of FV, especially CM (Rantanen, Nieminen, et al., 2022). Public health nurses in our study noticed more of these support needs in families with FV compared to other families. It could be said that they noticed some causes for concern in the families with FV. Previous research (Baird et al., 2019; Leppäkoski et al., 2019) shows that not all cases involving IPV and CM are revealed because of professionals' inadequate knowledge, training and perceived ability to deal with the matter. Public health nurses may feel uncomfortable about asking their clients about violence, even when they suspect it. They may also place greater importance on screening for other health issues (Soh et al., 2021).

Although the results of the present study indicate that public health nurses poorly identify the existence of FV compared to parents' self-reporting, they nonetheless identified other support needs in the families they met. According to the public health nurses, those parents who have reported FV more often needed support for many other issues such as their child's behavioural problems, the parents' psychological well-being and mental health, and the family's child-rearing practices. However, public health nurses identified only about 20%–45% of support needs compared to families' self-reporting.

Nurses may recognise that there is something strange and alarming going on in the family but cannot quite pinpoint this. We can conclude that although it seems that public health nurses identify family violence insufficiently, they nevertheless recognise that families involved in FV have other support needs. The factors mentioned above can be risk factors leading to FV if not intervened.

Despite FV being quite common in our national data, parents quite rarely (12%) felt that they need support from professionals. Many of them also did not speak about it to professionals, even when they felt that they needed help. Families with FV needed support for their relationship and coping twice as often than families without FV. Many factors prevent seeking help and getting support from different providers. Parents may have believed that support services were not available for them. Although parents reporting FV need more support for their intimate partnership and coping than other parents, they receive less of it. This may be due to not wanting to broach the topic of FV occurring in the family, perhaps out of fear of disclosing the FV. Some may also have had negative experiences of the services they have received previously, such as marginalisation or discrimination (Robinson et al., 2020).

Our results showed that about two-fifths of the parents affected by FV reported that they needed help from their loved ones and half of them from their spouses in situations involving family violence. An explanation for these low shares could be that the parents did not deem the violence particularly serious, the victims did not identify their experiences as IPV or they feared the consequences of disclosing the violence (see also Robinson et al., 2020). Furthermore, about three-quarters of the parents regarded the help they had received from the spouse as adequate. It can be concluded that in situations involving violence, many trusted their spouses more than different professionals. This is a worrying result as it may indicate that the respondent is being pressurised into remaining silent by their spouse. However, Dias et al. (2020) have suggested that informal social support also plays a significant role in IPV victims' decision to use health care.

Moreover, the recognition of health problems related to FV can be a complex issue as experiencing or committing acts of violence is a sensitive topic. Many keep silent about their experiences for a variety of reasons, such as a fear of the consequences of disclosure (e.g., fear of escalated violence) or a personal barrier (e.g., self-blame) (Robinson et al., 2020). In assessing the risk of CM, the comprehensive and compact checklist (FNC) can be used by parents or

caregivers as a self-referral instrument with an option to use the instrument as a basis for joint discussions with professionals.

CONCLUSIONS

FV was quite common as reported by parents. Only a small part of those who reported FV felt that they needed help from professionals in violent situations. Even among those who needed help, a large part left the need for help unreported. A significantly larger proportion felt that they needed and received help from their loved ones, and the need for help was also significantly less often left unreported to them.

Parents who reported FV needed support for their own coping and their relationship almost twice as often as other families. More often than others, they felt that the support received was insufficient and left the need for support unreported more often than others.

Public health nurses very rarely identified CM or IPV, but identified other types of support needs in families reporting FV more often than other families.

When looking at how often the health nurse identified the need for support for coping and the relationship when the parent reported it in the form, it was noticed that a large part of the families' support needs went unrecognised. However, health nurses recognised the need for support in families reporting FV slightly more often than in other families.

Implications for practice

The early recognition of FV and even risk of it could help decrease severe consequences related to this public health problem. Awareness of the serious long-term consequences of FV should encourage professionals to identify families at risk. Today, many tools are available for screening for families with different problems and issues worrying them. In Finland, using different tools – for example, FNC – to help recognise and respond to IPV and CM is at least technically easy because public health nurses and other professionals meet families regularly and assess child and family health until the child turns seven, at which point school health services will be responsible for children's health. Moreover, FNC can be used for primary prevention among the general population. Above all, there is a need to discuss any worries parents have systematically and in dialogue with families, and also ask clients and families about violence, whenever needed (Rantanen, Nieminen, et al., 2022).

Training could be a useful tool to promote healthcare professionals' ability and courage to identify and respond to IPV and CM. There is a need for harmonisation of care processes, workplace instructions and clinical guidelines (Rantanen, Paavilainen, et al., 2022). In the future, there is a need for developing multi-professional services that place the family at the centre and to receive the best professional help; ensuring that they are not left alone in making decisions and making support and help available. Confidentiality between families and healthcare professionals must also be ensured even in the most difficult circumstances.

Further research

In the future, it is important to collect evidence on the accuracy of instruments used for identifying families at risk of FV. In this context, it would be useful to collect data from users' (parents, health care practitioners) experiences in using these tools. The present study revealed that, based on the respondents' reports, the victims and perpetrators of violence included both men and women. Moreover, both genders reported CM, and some of its forms may have co-occurred with IPV. As a result, it might also be useful to gather gender-specific data on the parents' experiences in connection with child health clinic appointments for improving these services.

Limitations

Violence in families may be more common than the official statistics suggest. Community- and population-based victim surveys are one way of obtaining data on violence occurring in families. However, survey data are often biased due to a relatively low response rate. Researchers are also not told about family matters. However, using self-reported methods may add to our knowledge about FV cases that have not been officially confirmed for reasons such as the client's unwillingness to disclose the matter due to feelings of shame. Rantanen, Paavilainen, et al. (2022) suggested that self-reporting has been found more reliable than evaluations carried out by an outsider.

Furthermore, the scope of this study is limited, as the survey from which some data were used in the present study was not originally designed for the specific purpose of investigating FV. The parents' experiences of FV were only a small part of a broader welfare study.

ACKNOWLEDGEMENTS

We would like to thank the parents for providing their time on this important issue.

CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflict of interest.

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How to cite this article: Leppäkoski, T., Vuorenmaa, M. & Paavilainen, E. (2023) Families of four-year-old children experiencing violence: A national survey of parents and public health nurses on help and support. *Child Abuse Review*, e2847. Available from: https://doi.org/10.1002/car.2847