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Towards a socially sustainable society: Preventing intergenerational transmission of violence and malaise through an ecological approach to health and wellness promotion

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2013 Laurea Otaniemi

Laurea University of Applied Sciences
Otaniemi

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Degree Programme in Health Promotion
Master's Thesis
May 2013

Laurea University of Applied Sciences
Otaniemi
Master of Health Care
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Abstract

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Year 2013 Pages 136

The need for reform of the Nordic welfare society is driven by changes and diversification in ecology, economy, demography, working life, technology and interaction, which present opportunities and challenges for sustainable development and societal innovation. Finland has implemented an international research project in years 2011 to 2013 to analyse global economic changes and solutions to sustainable development in the preparation of the Finnish Government Foresight Report.

This thesis aims to contribute to the sustainability discourse. The study provides an international context and integrates the associations between social sustainability, early experiences underlying the social determinants of health and wellbeing, and the intergenerational transmission of interpersonal violence and malaise.

The method of the thesis is an article-based hermeneutic literature review in the areas of social sustainability, health promotion, human development, violence prevention and ethics. The impact of human social brain development, attachment relationships as well as stress and emotion regulation in the early years on the developmental trajectory, overall life course and building of resilience is explored. The saliency of health communication, gender specificity and cultural competence in health promotion are discussed in relation to three original papers on women's violence prevention programmes in Finland.

The literature and emerging empirical evidence suggest that substantial gains for individuals and society can be made from integration of underlying mechanisms influencing the social determinants of health in implementation of the sustainability agenda. An adaptation of Glass and McAtee's (2006) multilevel web of causation model and a synopsis of the risk regulators and regulatory systems for violence are proposed in the synthesis of the study. Recommendations for future research are outlined for the development of knowledge-based social ecological practice in health and wellness promotion, early prevention and intervention for social sustainability.

Keywords: social sustainability, social determinants of health, health and wellness promotion, violence prevention, resilience

Laurea-ammattikorkeakoulu **Tiivistelmä**
Otaniemi
Master of Health Care
Degree Programme in Health Promotion

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Kohti sosiaalisesti kestävää yhteiskuntaa: Terveyden edistämisen ekologinen näkökulma väkivallan ja pahoinvoinnin ylisukupolvisen välittymisen ehkäisemiseen

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Pohjoismaisen hyvinvointiyhteiskunnan uudistamistarpeen tekijöitä ovat ekologian, talouden, väestörakenteen, työelämän, teknologian ja vuorovaikutuksen muutokset ja monipuolistuminen. Ne tuovat mukanaan mahdollisuuksia ja haasteita kestävälle kehitykselle ja yhteiskunnalliselle innovaatiolle. Osana valtioneuvoston tulevaisuusselonteon valmistelua toteutui vuosina 2011–2013 kansainvälinen tutkimushanke, joka analysoi maailmantalouden muutosta ja kestävän kasvun ratkaisuja.

Tämän opinnäytetyön päämääränä on edistää kestävyyskeskustelua. Tutkimus tarjoaa kansainvälisen kontekstin ja integroi tietoa sosiaalisesta kestävyydestä, terveyden sosiaalisten määrittäjien taustalla olevista varhaisista elämänkokemuksista sekä ylisukupolvisen väkivallan ja pahoinvoinnin välittymismekanismista.

Tutkimus on luonteeltaan artikkelipohjainen hermeneuttinen kirjallisuustutkielma, jonka aihealueina ovat sosiaalinen kestävyys, terveyden ja hyvinvoinnin edistäminen, ihmisen kasvu ja kehitys, väkivallan ehkäiseminen ja etiikka. Tutkimuksessa tarkastellaan varhaisen sosiaalisen aivokehityksen, kiintymyssuhteen, stressin ja tunteiden säätelyn vaikutuksia kehitys- ja elinkaareen sekä resilienssin kehittämiseen. Tutkimus sisältää myös terveysviestinnän, sukupuolierityisyyden ja kulttuuriosaamisen merkityksen tarkastelua liittyen kolmeen artikkeliin naisen väkivallan ehkäisytyöstä Suomessa.

Kirjallisuuteen ja empiiriseen näyttöön perustuva tutkimustieto osoitti, että voidaan saavuttaa merkittävää hyötyä yksilö- ja yhteiskuntatasolla integroimalla terveyden sosiaalisten määrittäjien taustalla olevat tekijät kestävän kasvun mallin toteuttamiseen. Tutkimuksen synteesissä esitetään muokattu malli Glass ja McAteen (2006) monitasoisesta syy-yhteyssuhde-mallista (eng. web of causation) sekä yleiskatsaus väkivallan riskien säätelytekijöistä ja säätelyjärjestelmistä. Jatkotutkimusaiheeksi sosiaalisen kestävyyden vahvistamiseksi nousi tietoon pohjautuvan sosiaaliekologisen lähestymistavan kehittäminen terveyden ja hyvinvoinnin edistämisessä, ennaltaehkäisyssä ja varhaisessa puuttumisessa.

Avainsanat: sosiaalinen kestävyys, terveyden sosiaaliset määrittäjät, terveyden ja hyvinvoinnin edistäminen, väkivallan ehkäiseminen, resilienssi

List of Original Publications

The thesis is based on the following original papers, which are referred to in the text by Roman numerals (I–III).

I **Väkivallan ehkäisytyö on avainasemassa kotoutumisessa [Violence Prevention Work Supports Integration]. Introducing the MaSu Project.**

Tanja Harju

RIKU, Victim Support Finland, 1/2011, pp. 20-22.

II **Good Practice for the Prevention of Abuse and Violence by Women – The Demeter Programme**

Tanja Harju

Co-author Marjo-Riitta Karhunen

The 12th ISPCAN European Regional Conference on Child Abuse and Neglect: Challenging social responsibilities for child abuse and neglect

Tampere, Finland, 18-21 September 2011.

III **Intercultural Dialogue, Women's Empowerment and Violence Prevention – The MaSu Project**

Tanja Harju

Co-authors Marjo-Riitta Karhunen & Britt-Marie Perheentupa

The 7th NASPCAN Nordic Congress on Child Abuse and Neglect: Child abuse and neglect in a cross-cultural perspective: Possibilities and challenges

Bergen, Norway, 14-16 May 2012.

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1 Introduction

The thesis, *'Towards a socially sustainable society: Preventing intergenerational transmission of violence and malaise through an ecological approach to health and wellness promotion'*, comprises an international and interdisciplinary hermeneutic literature review in the areas of social sustainability, health promotion, human development, violence prevention and ethics, a discussion of three papers by the author on two women's violence prevention programmes in Finland, and a proposed adaptation of Glass and McAtee's (2006) web of causation model.

As part of Finland's Government Foresight Report process, an international research project was implemented in years 2011 to 2013 to analyse global economic changes and solutions to sustainable development. The vision of the project is to build Finland in a manner that enables safeguarding of the conditions for a good life for current and future generations (Prime Minister's Office, 2012). The research aim of the present thesis is to contribute to the sustainability discourse by providing an international context and integrating the associations between social sustainability, early life circumstances underlying the social determinants of health and wellbeing, and the intergenerational transmission of violence and malaise. The main theme of the study is health, which is recognised by the United Nations (2012a) as the key precondition, indicator and outcome of sustainable development. The general hypothesis of the present study is that environmental failure in early childhood results in biopsychological adaptations that impact an individual's sense of self, self-regulation, capacity for connection to self and others, and resilience. Early environmental failure is posited as a critical determinant of psychological and physiological ill health across the life course with a subsequent decline in sustainability.

Traditionally, health research and practice has focussed on the diagnosis and management of disease in individuals and populations. The observation by Lalonde (1974) that some individuals and groups are more healthy than others led to the identification of lifestyle factors on health behaviours and the impact of social determinants of health. More recently, there has been a shift in research and practice towards understanding of the underlying mechanisms involved and how protective factors may lead to positive health outcomes. Macdonald (2002) nominates the issue of violence and its effect on health as 'the ultimate public health challenge' (p. 293). In this thesis the empirical and theoretical literature on human health and wellbeing is explored and an integrated social ecological approach to the prevention and treatment of intergenerational ill-being, originating in early experiences of shock and developmental trauma and manifesting as violence or malaise, is introduced.

Social ecology is the study of people in an environment and the influences on one another (Hawley, 1950). The social ecology of health identifies the complex interactive web of social, psychological, and structural determinants of health and is a paradigm for effective,

efficient, and equitable health care (Tones & Tilford, 2001; Stokols, 1996). Bronfenbrenner states:

> 'Human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate environment.' (1994, p. 1643)

According to Bronfenbrenner (1994) the primary scientific aim of the ecological approach is not to claim answers, but to provide a theoretical framework that facilitates further progress in discovering the processes and conditions that shape the course of human development. Social policies and programmes enable actualisation of unrealised human potentials by providing the stability and resources for flourishing.

There is a significant and growing body of research on violence and health (see Krug et al., 2002, for a review). Violence is a global issue with a substantial burden on individuals, families, communities and health care systems worldwide. Violence prevention is both an aim and an outcome of sustainable development. The science exists to collectively raise a much less violent and more compassionate generation (Ryan, 2005). Interpersonal violence is predictable and preventable; however we need to learn to overcome the impediments to its prevention. A social ecological approach to health-promotive violence prevention takes into account the inputs of the physical environment, the social environment, and the cultural environment as well as the settings for action at macro, exo, meso, and micro levels. Bronfenbrenner envisions a broader hope for humanity as follows:

> 'Species *Homo sapiens* appears to be unique in its capacity to adapt to, tolerate, and especially to create the ecologies in which it lives and grows. Seen in different contexts, human nature, which I had once thought of as a singular noun, turns out to be plural and pluralistic; for different environments produce discernible differences, not only across but within societies, in talent, temperament, human relations, and particularly the ways in which each culture and subculture brings up the next generation. The process and product of making human beings human clearly varies by place and time. Viewed in historical as well as cross-cultural perspective, this diversity suggests the possibility of ecologies as yet untried that hold a potential for human natures yet unseen, perhaps possessed of a wiser blend of power and compassion than has thus far been manifested.' (1979, p. xiii)

Historical and intergenerational trauma has inflicted a soul wound of cumulative, unresolved grief on the people of Finland. In recent centuries Finland has endured domination by neighbouring powers, disease epidemics, civil and world wars, loss of land, forced relocation, poverty, massive emigration, radioactive fallout, economic recession, and unemployment contributing to high levels of alcoholism, heart disease, mental health disorders, domestic

violence, suicide, and homicide. In my clinical experience over a ten-year period as a violence prevention worker and as a third generation immigrant with a personal family history of war trauma, refugeeism, poverty, and loss, I have witnessed firsthand the profound impact of childhood traumatic experience manifesting as a trajectory of intergenerational violence, abuse and neglect towards the self and/or others. Personal and professional experience has strengthened my commitment to increase my handprint in actions towards sustainable human development, and my conviction that violence is preventable. In my opinion health promotion has an ethical imperative to lead responsible and sustainable action for violence prevention. There is an urgent need to establish the evidence base for health-promotive violence prevention, and to advocate violence prevention as an aim and outcome of sustainable development for the alleviation of unnecessary human suffering and ill health.

The thesis is divided into five parts. Chapter 2 provides an interdisciplinary overview and theoretical foundations of the relevant literature on social sustainability, health and health promotion, theories of attachment, stress and emotion regulation, resilience, the concept of violence and its prevention, and the ethical context for health-promotive violence prevention. The review of the literature forms the main part of the thesis. The purpose, research questions, theoretical framework and pre-understandings of the study are presented in Chapter 3. The methods of the study are presented in Chapter 4, including an overview of the hermeneutic circle and an analysis of the validity and reliability of the thesis work. Chapter 5 discusses the significance of health communication, gender and culture in health and wellness promotion in relation to three original papers on women's violence prevention programmes in Finland, and presents an adaptation of Glass and McAtee's (2006) multilevel web of causation model, an outline of risk regulators and regulatory systems for violence, ethical considerations of the study, and future prospects for research. The thesis concludes in Chapter 6 with a synopsis of the implementation of knowledge-based social ecological practice in health and wellness promotion, prevention and early intervention as a strategic goal of social sustainability. The thesis represents the independent enquiry of the author and no financial assistance was received. The findings and conclusions expressed herein are those of the author and do not necessarily represent those of the Laurea University of Applied Sciences or other organisations that are referred to in the thesis.

It is the responsibility of every individual and every generation to work together towards a better, humane society. Readers of this thesis are wholeheartedly invited and challenged by the author to live their own hermeneutic circles in the quest for knowledge, reflection, wisdom, responsibility, and ethical action.

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2 Review of the Literature

This chapter presents a hermeneutic literature review of research, theories and practice in the fields of sustainable development, health and health promotion, human development, violence prevention, and ethics.

2.1 Towards a Socially Sustainable Society

The 2010s present challenges and opportunities for societal innovation and sustainable development. Globalisation, demographic change, changes in technology and interaction, regional diversification, changes in employment and working life, pluralisation of society, and ecological trends are growing pressures for structural reform of sustainability deficits in the Nordic welfare society system. Finland's Ministry of Social Affairs and Health has published a strategy for social and health policy titled '*Socially Sustainable Finland 2020*'. The vision is that Finland in 2020 will be a socially sustainable and vibrant society, in which balanced development is founded on equality; mental and material wellbeing; and economic, social and ecological sustainability (Ministry of Social Affairs and Health, 2011a, pp. 4-5).

According to the Finnish strategy, a socially sustainable society is one that treats all members of society fairly; reinforces participation and a sense of community; supports health and functional capacity; and provides the security and services required by its members, underpinned by a functioning social protection system including income support, health and social welfare services, preventive action, occupational health, and gender equality. The three primary strategic choices are a strong foundation for welfare, access to welfare for all, and a healthy and safe living environment (ibid., p. 4). Reducing violence is a strategic national goal with the aim to find an efficient nationwide model for preventing violence, which will also serve to strengthen a sense of community and internal security (ibid., p. 13).

A report by the Ministry of Social Affairs and Health (2011b) examines the measurement of social sustainability and possibilities for social simulation in Finland. The report observes the difficulties of defining, comparing or modelling contributory factors of social sustainability in quantitative terms for assessment and forecast, taking into consideration dimensions of public policy such as income and health disparities, poverty, access to welfare, and indirect and intergenerational impacts on public health, social cohesion and trust. A common indicator framework of basic measures and indicators with common procedural principles is proposed. A perceived problem of social sustainability is that many contributory factors infer negative costs in the short term in spite of bringing positive investments in the long term. The critical issue is to determine a level of sufficiency for the size, timing and targeting of public investments in the material as well as immaterial dimensions of social sustainability to foster viability and overarching system sustainability (ibid., p. 8).

2.1.1 Social Sustainability

The widening, deepening, and accelerating worldwide interconnectedness in all aspects of contemporary life is described as *globalisation* (Held et al., 1999, p. 2; Castells, 1996). *Sustainable development* has been defined by the World Commission on Environment and Development in 1987 as 'development that meets the needs of the present without compromising the ability of future generations to meet their own needs'. The objectives of sustainable development are meeting basic needs for all and ensuring equitable opportunities for all, the meaning of which emerges from an interactive process of dialogue and reflection (Jordan, 2008). Models of sustainable development are founded on systems thinking and long-term planning and they commonly represent the interrelationship between environmental, economical, and social dimensions of sustainability (see e.g., Hecht et al., 2012; Colantonio, 2008, 2009; Blewitt, 2008; McKenzie, 2004). Five different models representing the core pillars of sustainable development are illustrated in Figure 1. The balance between these pillars has evolved from an emphasis on environmental aspects in the 1980s to mid 1990s, through economic aspects in the late 1990s, to a growing recognition in the 2000s of social aspects (Colantonio, 2009) and Indigenous reconciliation (Miller, 2010).

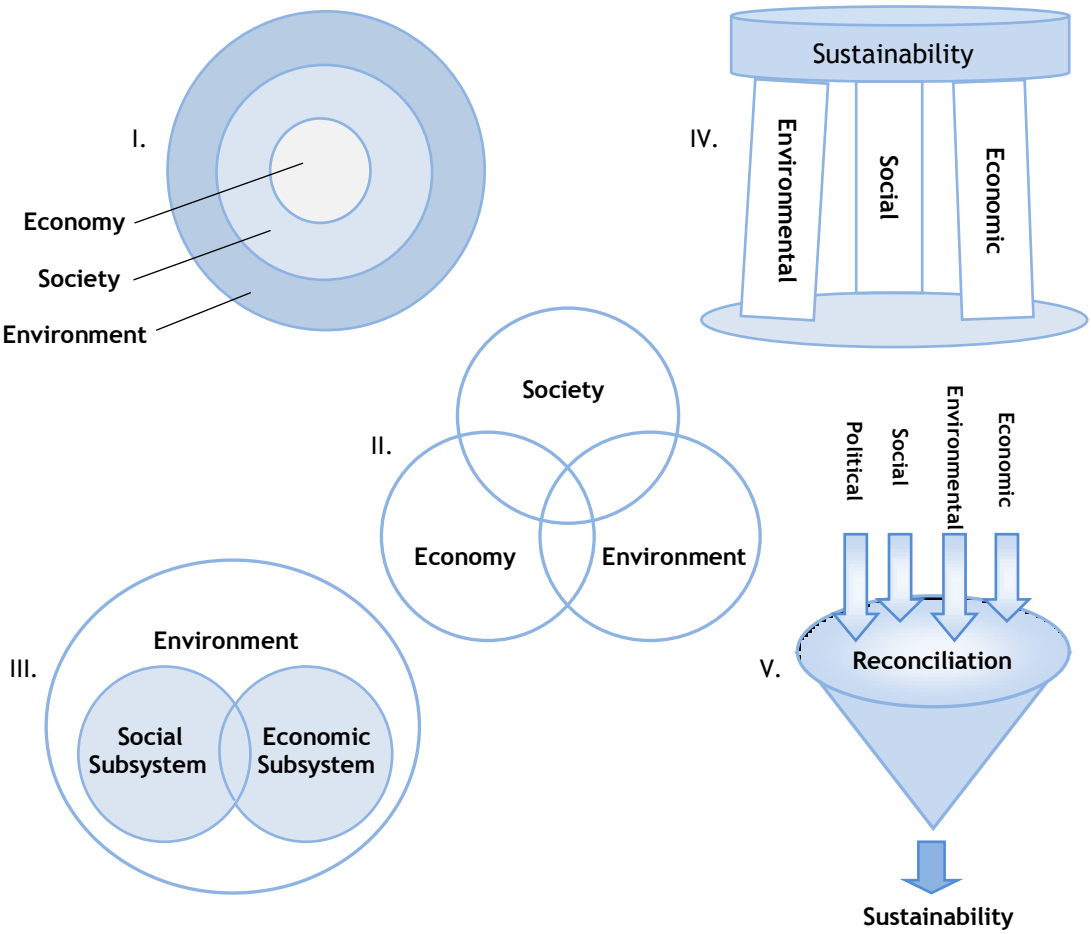

Figure 1: Different Models of the Core Pillars of Sustainable Development.
Source: I. and II. McKenzie, 2004 (pp. 4-5); Hodgson, 2008. III. Thwink, 2012.
IV. Gerber, 2010. V. Miller, 2010 (p. 193).

In 2000 the United Nations adopted eight measurable Millennium Development Goals (MDGs) representing human needs and basic rights to be achieved by 2015 in addition to broad commitments to human rights, good governance and democracy (United Nations, 2000). The MDGs are to halve extreme poverty and hunger, to achieve universal primary education, to empower women and achieve gender equality, to reduce mortality for the under fives by two-thirds, to reduce maternal mortality by three-quarters, to reverse the spread of major diseases (especially HIV/AIDS and malaria), to ensure environmental sustainability, and to create global development partnerships with targets for trade, aid, and debt relief. As of the 2012 Millennium Development Goals Report, three important targets on poverty, slums and water had been achieved three years ahead of schedule. UN Secretary-General Ban Ki-moon validated that these results represented a tremendous reduction in human suffering, and he called for strengthening of global partnership to prevent the current economic crisis from reversing progress in reducing poverty (United Nations, 2012b).

Social capital is basic to the wellbeing of societies (Putnam, 2000; Helliwell et al., 2009). Although the sustainability discourse has increasingly recognised *social sustainability* as a fundamental dimension of sustainable development, a consensus of the meaning and scope of the concept remains unclear (Colantonio, 2008; see also e.g., Sachs, 1999, Polese & Stren, 2000; Baines & Morgan, 2004; McKenzie, 2004; Littig & Griessler, 2005; Magis & Shinn, 2009; Weingaertner & Moberg, 2011). Colantonio (2009) defines social sustainability as:

> 'how individuals, communities and societies live with each other and set out to achieve the objectives of development models, which they have chosen for themselves taking also into account the physical boundaries of their places and planet earth as a whole'.

Social sustainability is both a means and an end (McKenzie, 2004). Dillard and colleagues (2009) view social sustainability as both (a) the processes that generate social health and wellbeing now and in the future, and (b) those social institutions that facilitate environmental and economic sustainability now and for the future (p. 4). Baines and Morgan (2004) provide the following list of commonly accepted components of social sustainability:

- meeting basic needs
- overcoming disadvantage attributable to personal disability
- fostering personal responsibility, social responsibility and regard for the needs of future generations
- maintaining and developing the stock of social capital to foster the trusting, harmonious and cooperative behaviour needed to underpin civil society
- equitable distribution of opportunities in development in the present and future
- acknowledging cultural and community diversity and fostering tolerance, and
- empowering participation on mutually agreeable terms in influencing choices for development and in decision-making. (p. 97)

It is proposed that the humanisation of sustainable development will continue to evolve in future with higher affluence of communities and societies and extension of the action focus from the importance of basic needs towards softer themes (Blewitt, 2008). The inter- and intralinkages between traditional and emerging themes and indicators of social sustainability add complexity to the understanding, measurement and promotion of sustainable development (Colantonio, 2008). Traditional or 'hard' themes and domains of social sustainability include human rights; basic needs such as housing; education and skills; employment; equity; poverty; and social justice. Emerging or 'soft' themes and domains of social sustainability include demographic change (ageing, international migration and mobility); empowerment, participation and access; identity, sense of place and culture; health and safety; social capital; social mixing and cohesion; and wellbeing, happiness and quality of life (Colantonio, 2008, 2009; Sen, 1985, 1992; Coleman, 1988, Elkington, 1994; Wackernagel & Rees, 1996; Layard, 2005).

As a country becomes more prosperous, there is a decline in the approximation of gross domestic product (GDP) as an indicator of performance (Seligman, 2011). GDP is a measure of the volume of goods and services that are produced and consumed, irrespective of whether the source is human development or human suffering. There is a growth in GDP also as a result of events that negatively impact the quality of life and the environment, including natural disasters, accidents, divorce, alcohol and cigarette sales, casino profits, crime, technological obsolescence, or longer commutes to work. Seligman states that 'the aim of wealth should not be to blindly produce a higher GDP but to produce more wellbeing' (ibid., p. 96). Levels of happiness, trust, and social connectedness have declined as GDP has increased, whilst rates of ill health, depression, and anxiety have risen (ibid., pp. 222-223). Thus there is a need to measure the way citizens experience their lives to supplement objective indicators, such as GDP and measures of health and the environment, that steer societal decisions and innovation (Diener & Seligman, 2004; Diener et al., 2009a). Huppert and So (2009) propose seeking an international operational definition of flourishing and applying this definition to advance understanding of the correlates, causes and consequences of social change and wellbeing.

The aim of sustainability assessment is to inform and improve strategic decision-making; however there is a shortage of specific social sustainability assessment (SSA) methodologies (Colantonio, 2008). Sustainability assessment is often conducted through extended sustainability impact assessments (SIA), environmental impact assessments (EIA) and strategic environmental assessments (SEA) that incorporate specific social issues (e.g., Barrow, 2000; Saunders & Therivel, 2006; Colantonio, 2008; Gasparatos et al., 2008; Glasson, 2009). Colantonio (2008) states that traditional indicators of social sustainability comprise mainly quantitative, mono-dimensional, static, descriptive, product-based, target oriented factors, while emerging indicators are both quantitative and qualitative, multidimensional, inter-

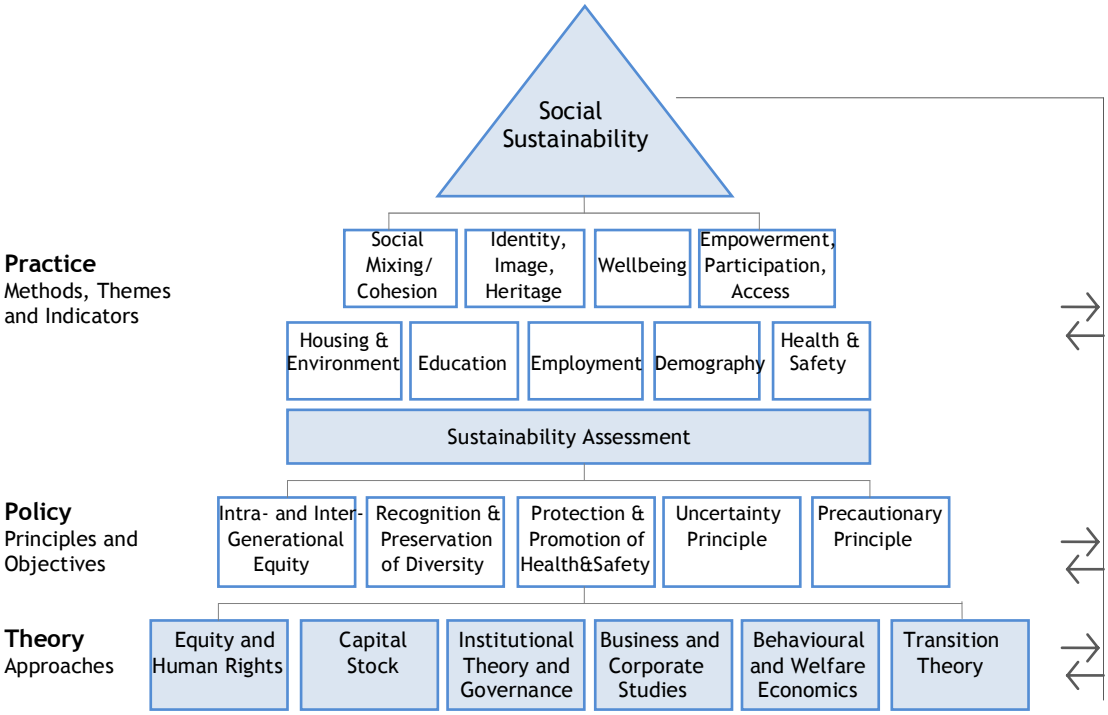

Figure 2: Social Sustainability Assessment Framework (SSAF).
Source: Colantonio, 2009. Used with kind permission of Dr Andrea Colantonio.

generational with uncertainty, strategic, processual, and driven by principles and objectives. The theory, policy and practice of Colantonio's social sustainability assessment framework (SSAF) are illustrated in Figure 2. According to the draft framework, sustainability assessment is founded on principles and objectives including intra- and intergenerational equity, diversity, health and safety promotion, uncertainty and precaution. Practice for social sustainability comprises traditional themes such as environment, housing, education, employment, and demography as well as emerging themes such as identity and heritage, empowerment, participation, access, social cohesion, wellbeing, and health and safety.

The United Nations Rio+20 Conference on Sustainable Development held in June 2012 recognised the critical linkages between sustainable development and health. '*The Future We Want*' conference outcome document highlighted better health as a 'precondition for, an outcome of, and an indicator of all three dimensions of sustainable development'. The document underlined the importance of action on the social and environmental determinants of health to create inclusive, equitable, economically productive and healthy societies, stating: 'We call for the full realisation of the right to the enjoyment of the highest attainable standard of physical and mental health'. The document further advocated universal health coverage, including policies to prevent, protect, and promote public health, to fight poverty and to build more resilient and prosperous communities through sustainable human and economic development enhancing health and social cohesion (United Nations, 2012a).

According to Himanen (2010, 2012) Finland needs a paradigm shift from a reactive welfare state to a proactive, inclusive welfare society. Himanen claims that the root cause of the prospective EUR 10 billion Finnish budget deficit is an ethical sustainability gap in the welfare state (2012, p. 61). The 2010s is viewed as a time for societal revolution in which thinking changes direction towards positive promotion of holistic health and wellbeing for the next half century, as opposed to the malaise reduction and removal of deprivation that has characterised Finland's welfare state during the past 50 years. Himanen raises greater psychological wellbeing as an important goal, citing that one-fifth of the Finnish population have been diagnosed with mental illness, and that the cost of production loss due to occupational malaise and early retirement due to reduced capacity to work totals EUR 25 billion annually, or approximately half of the Finnish Government budget (Ahonen et al., 2010; as cited in Himanen, 2012, p. 43). Gerhardt (2010) posits that in Western societies human relationships have become subordinated to material and technical productivity and growth with concomitant highly stressful and competitive environments, reshaping certain aspects of brain development and neurotransmitters. Gerhardt reports that the impact of stress is to deplete levels of the calming neurotransmitter serotonin and to raise levels of the motivational neurotransmitter dopamine, producing more self-centred and coping behaviours. Moreover, Western society is seen as an impoverished emotional culture characterised by the decline of family, community, and caring and the erosion of social virtue, respect for others, self-discipline, and responsibility for long-term wellbeing (Gerhardt, 2010, pp. 10-15).

St James Ethics Centre (2009) in Australia has conducted a world first project, a narrative in what citizens believe about the fundamental values and principles of a good society and the ethic of caring. The narrative defines caring in terms of 'engaged relationship, connection and integrity. Insufficient caring is when the relationship is primarily experienced as disconnection, fragmentation and aloneness' (p. 60). Identified clusters of the conversation included equity, justice and human rights; meeting citizens' basic needs; independence, self-determination and autonomy; respect; safety and security; problem solving, reflection and creativity; tolerance and diversity; reaching one's potential; care and compassion; responsibility and accountability; community and contribution; leadership, role models and mentors; and sustainability in the long and short term (p. 25). Identity loss, low self-worth, mental illness, use of drugs and alcohol, aggression, and stress and exhaustion were identified as situations and circumstances that could potentially diminish the quality of the caring relationship (p. 65). One participant commented that 'it is society's role to enable the caring, not to do the caring' (p. 116). The Scandinavian countries were valued in the report for their social welfare and social justice policies and services. For example, Finland was viewed in a positive light and seen as 'an intelligent, compassionate society' (p. 139). Himanen (2012, p. 128) promotes worthiness and a dignified human life as the goal, value system and cultural framework of sustainable development for the Finnish welfare society.

2.1.2 Health and Human Flourishing

Health is a social, political, and economic driver as well as one of the fundamental rights of every human being. The word *health* derives from the Old English word *hælan* which means 'wholeness, a being whole, sound or well', indicating that health concerns the whole person and his or her integrity (Naidoo & Wills, 2009, p. 4). The World Health Organization (WHO, 1948) has interpreted a positive definition of health in its Constitution as 'a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity'. According to WHO (1986),

> 'To reach a state of complete physical, mental, and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the object of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities.'

The positive definition of health describes a state of wellbeing, whilst the negative definition of health describes the absence of disease or illness. *Wellbeing* is a dynamic process that can be fed by virtuous circles of feedback between external conditions, psychological resources, good psychological functioning and good feelings day-to-day and overall (Thompson & Marks, 2008). *Disease* is the existence of some pathology or abnormality of the body which is capable of detection, and *illness* is the subjective experience of loss of health. *Ill health* is used as an umbrella term referring to the experience of disease plus illness (Naidoo & Wills, 2009, p. 5). Health care systems are sometimes reduced to 'illness care systems' (Evans, 1994, p. 4; Himanen, 2012, p. 36). Health interventions may enhance or undermine physiological and immune function, or give rise to positive placebo effects (Evans & Stoddart, 1994, p. 52).

Health assets are positive properties that constitute a state of health. Various groups, societies, cultures, and professional disciplines portray differences in opinion about the constitution of health. The Western scientific medical model of health prescribes a relatively narrow view of health based on the Cartesian dichotomy of health or disease and applying clinical techniques to specific parts of individual bodies or minds (e.g., Seedhouse, 2001). This is contrasted with the view of Chinese medicine, in which health is the result of an inter-connected and elaborate system of physical and emotional interactions and processes (e.g., Maciocia, 2009; Ting & Jas, 2009). The *social ecology of health* is a contemporary paradigm for effective, efficient, and equitable health care that recognises the complex and interactive web of social, psychological, and structural determinants of health (Tones & Tilford, 2001). Social ecology is the study of people in an environment and the influences on one another (Hawley, 1950; see also Lewin, 1931, 1935; Bronfenbrenner 1979, 1994, 2004). A social ecological approach to health takes into account the inputs of the physical, social, and cultural environments and the settings for action at macro, exo, meso, and micro levels.

Conversely, traditional medicine and public health are seen as continuing to emphasise the individualistic behaviour approach in the etiology and management of disease and in the promotion of health generally (Tones & Tilford, 2001; Stokols, 1996). Bickenbach and Glass (2009) warn against the medicalisation of individual problems that are reflections of broader social conditioning and cultural tensions. General health recommendations and actions such as a balanced diet, alcohol in moderation, no smoking, more exercise, less stress, and better medical care are simplistic explanations of health that offer incomplete solutions to complex phenomena. Labelling of health behaviours as individual lifestyle choices may lead to victim blaming and ineffective informational and educational strategies for control (McLeroy et al., 1988; Evans & Stoddart, 1994).

It has been acknowledged that in modern societies 'many diseases may in fact have a *social etiology*, meaning that the underlying cause of the disease lies in the sociocultural environment' (Crosby et al., 2011, p. 234, original emphasis; Marmot & Wilkinson, 2005). The *social determinants of health* constitute the structural determinants and conditions of daily life, including homes, communities and towns; nutrition and shelter; sanitation; access to health care and education; social security; work and leisure conditions; and supportiveness of the social environment. The social determinants of health are primarily responsible for health inequities within and between countries (Evans & Stoddart, 1994, pp. 51-52). The Commission on Social Determinants of Health (CSDH, 2008) defines *health inequity* as unfair, systematic differences in health that are judged to be avoidable by reasonable action. *Equity in health* (Whitehead, 1992) refers to the ideal of providing a fair opportunity for all people to enjoy health to their fullest potential. The scope of *health literacy* should be expanded to include the ability to access, understand, evaluate, and communicate information on the social determinants of health (CSDH, 2008, p. 189; Nutbeam, 2000; Kickbusch, 2002). The web of causation (Glass & McAtee, 2006) links the proximal, distal, biological and social influences of social inequities on health and disease (Simons-Morton & McLeroy, 2011).

Emerging evidence in epigenetic studies supports that genes are triggered into activity by the environment (e.g., Carey, 2012; Wong & Craig, 2011; Chahwan et al., 2011; Jablonka et al., 2005, 2009; Paul, 2010; Ridley, 2004). Baird stated that 'genes determine *who* may get sick within a population, but environmental factors determine the *frequency* of sickness among susceptible' (1994, p. 143, original emphasis). Social factors operating at critical windows of vulnerability in individual development may embed themselves in the biology of an individual, contributing to an increased risk of many different health problems (Hertzman et al., 1994; Hertzman, 1997). Berkman and colleagues (2000) argue that the mechanism for impact of social forces on health behaviour is psychological states and traits including self-esteem, self-efficacy, and security; physiological stress responses; health damaging or health promoting behaviour; and exposure to infectious disease agents (p. 846). The assets and risks associated with health protective factors or adverse factors may be additive or even multiplicative.

A given health behaviour, such as smoking or not smoking, may be 'an individual *action*, but it may not be an individual *choice*' (Evans & Stoddart, 1994, p. 50, original emphasis). Problems in adult society, including major public health epidemics such as obesity, heart disease, diabetes and mental health problems as well as economic participation and criminality, often have roots in the early years of life (CSDH, 2008). Disease-specific health care interventions and policy responses may therefore not reach deeply enough to have significant effect (Evans & Stoddart, 1994, p. 46). Experiences in early childhood lay critical foundations for children's life trajectories and opportunities for health through the mechanisms of interpersonal competence, skills development, education, and occupational opportunities. The timing of programmes and services is recommended as early in life as possible as younger children tend to benefit more from early child development interventions than older children. Interventions should also target pregnant and lactating mothers and adolescent girls. Gender equity, through maternal empowerment, education, and income, has been shown to contribute to child survival, health, development and educational attainment. The importance of breastfeeding is emphasised (PPHCKN, 2007; Black et al., 2008). Additional policies include family-friendly social protection, the balance of home and work life, and averting acute threats to the development of young children including abuse, child labour, trafficking, and war. (ECDKN, 2007; CSDH, 2008)

A more comprehensive approach to early life is needed for healthy development during the early years to provide the essential building blocks for a flourishing life, including the physical, social/emotional, and language/cognitive domains. Children need safe, healthy, supporting, nurturing, caring, and responsive living environments (CSDH, 2008; ECDKN, 2007). For example, the Scottish Government (2010) has adopted '*Equally Well*', a holistic and transformational agenda that prioritises early intervention for redressing the underlying causes of health and other inequalities. The underlying interventions to tackle health inequalities include consistent parenting, safe and nurturing early years, supportive education, opportunity, decent housing, social networks, self-esteem, and an internal locus of control. The framework for the agenda promotes a sense of coherence (Antonovsky, 1979, 1984) as an internal resource that fosters people's assets and capacities for health and wellbeing. The *sense of coherence* is founded on an individual's understanding of the world as a comprehensible place and gained through an infant's earliest attachment experiences of appropriate and consistent responses for comfort, food and changing from caregivers (Scottish Government, 2010, pp. 7-8). Australia's Queensland Government (2012) has developed the '*Social and Emotional Early Development Strategy*' (SEEDS) for the promotion of attachment and social and emotional wellbeing in childhood. Investments in the early years provide powerful potential to reduce health inequities within a generation in terms of reducing the escalating chronic disease burden in adults, reducing costs for judicial and prison systems, and enabling more children to grow into healthy adults with positive contributions to society, both socially and economically (CSDH, 2008; ECDKN, 2007; Engle et al., 2007; Lynch, 2004).

A socially just society is one with equal opportunities for balanced engagement in daily occupations that enable fulfilment of essential needs, which determine positive health and wellbeing and are thus a precondition of sustainability (Townsend & Wilcock, 2004; Voydanoff, 2005). The term *occupational deprivation* is used by Wilcock (1998) to describe an inability to participate in meaningful activities for prolonged periods of time as a result of factors outside of individual control. Children and adults least involved in organised activities exhibit more symptoms of withdrawal, inability to get along with others, and lower self-esteem (Hofferth et al., 2009). Examples of factors contributing to occupational deprivation include social and geographic isolation, economic constraints, unemployment, retirement, disability, incarceration, forced dislocation, cultural differences, and sociopolitical conditions resulting in repression or conflict (Whiteford, 2004). On the other hand, the accelerated rhythms of daily life are a source of stress, anxiety and depression (Ginsburg, 2006, pp. 10-11; Zuzanek, 2009, p. 220). Children's health and wellbeing are susceptible to the influence of being a 'hurried child' (Elkind, 2001; Hofferth et al., 2009). Environmental determinants impacting children's health behaviours and wellbeing include sedentary lifestyles, high screen time, neighbourhoods lacking in walkability and safety, two parents working, and availability of high-fat food, among other factors (Crosby et al., 2011, p. 233).

The identification of *life balance* as a variable impacting psychological wellbeing and overall health introduces a new approach for disease prevention, health promotion, and social policy (e.g., Christiansen & Matuska, 2006; Bloom & Van Reenen, 2006; Allan et al., 2007; Bryson et al., 2007; Drago, 2007; Premeaux et al., 2007; Matuska & Christiansen, 2008). A balanced lifestyle is defined as 'a satisfying pattern of daily occupations that is healthful, meaningful, and sustainable to an individual within the context of his or her current life circumstances' (Matuska & Christiansen, 2008, p. 11). A state of imbalance, on the other hand, occurs when occupational engagement fails to meet the physical, social, mental, or rest needs of the individual and there is insufficient time for own family, social, and community interests (Wilcock, 1998, p. 138). Matuska and Christiansen's life balance model promotes five dimensions of daily activities for greater life satisfaction and less illness or chronic disease: (1) basic instrumental needs for sustained biological health and physical safety, (2) regarding and self-affirming relationships with others, (3) feelings of engagement, challenge, and competence, (4) creation of meaning and a positive personal identity, and (5) organisation of time and energy to enable important personal goals and renewal (2008, p. 11). These dimensions are related to Seligman's *wellbeing theory* (2011, p. 16), which highlights the five elements for flourishing as positive emotion, engagement, meaning, positive relationships, and accomplishment.

Mental health is defined by the World Health Organization (1981) as 'the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive,

affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.' Seligman (2011, p. 183) states that it is commonplace not to be mentally ill, but to be stuck and languishing in life. The state of *flourishing* is satisfied when an individual meets all three core features of wellbeing (positive emotions, engagement/interest, and meaning/purpose), in addition to at least three of six additional features of wellbeing (self-esteem, optimism, resilience, vitality, self-determination, and positive relationships) (Huppert, 2009; Huppert et al., 2009; Huppert & So, 2009). These features are in agreement with the core dimensions of human wellbeing (autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance) identified by Ryff and Singer (1996, 1998, 2001; see also e.g., Jahoda, 1958: Berkman et al., 2000; Seedhouse, 2001; Huppert et al., 2005; Seligman, 2011). Mastery is a state that increases longevity, decreases morbidity, results in a better prognosis when illness occurs, and decreases lifetime healthcare costs. The opposite of mastery is *learned helplessness*, which refers to the resulting sense of powerlessness and resignation when an individual is conditioned to learn that nothing he or she does will alter an event (Overmier & Seligman, 1967; Seligman et al., 1967, 1968; Seligman, 2011).

According to Seligman 'the time has come for a new prosperity, one that takes flourishing seriously as the goal of education and of parenting' (2011, p. 97). A meta-analysis by Chida and Steptoe (2008) showed that a sense of psychological wellbeing is associated with increased health and longevity later in life. Repeated episodes of individual and collective stress and helplessness, on the other hand, may set off a cascade of processes involving higher cortisol levels and long-lasting inflammation (e.g., Dettling et al., 2000; Heim et al., 2000; Gitau et al., 2001a, 2001b; Mason et al., 2001; Seligman, 2011). In a recent European study of national wellbeing, flourishing was more prevalent in Northern Europe than in Southern/Western Europe or Eastern Europe. Denmark lead Europe, with 33 per cent of its citizens flourishing, followed by Switzerland (27%), Finland (26%), Norway (25%), Ireland (24%), Austria and Cyprus (23%), Sweden (22%), the United Kingdom (18%), Spain (17%), Belgium and the Netherlands (15%), Slovenia (13%), Poland, Estonia and Germany (12%), France, Hungary and Ukraine (9%), Slovakia (8%), Bulgaria and Portugal (7%) and in last place Russia with 6 per cent of its citizens flourishing (Huppert and So, 2009).

The UK '*Foresight Report*' (The Government Office for Science, 2008) proposes that human wellbeing can be described as a natural bell-shaped curve from very low (corresponding to mental disorder such as anxiety or depression) to very high (corresponding to flourishing), with the majority of people having moderate levels of wellbeing. This view concurs with arguments by Rose (1992) that risk factors for disease fall on a bell-shaped spectrum, and that the incidence of disease is greater for a large number of people exposed to a low risk than for a small number of people exposed to a high risk. Huppert (2009) suggests that intervention at the population level, rather than a focus on those identified at risk, can shift

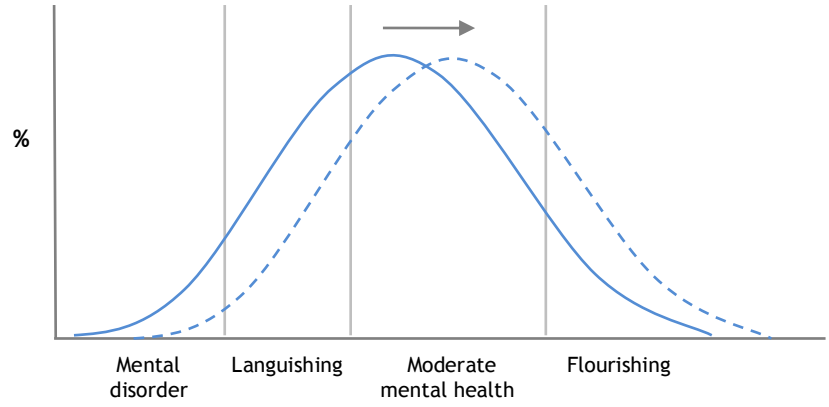

Figure 3: The Effect of Shifting the Mean of the Mental Health Spectrum.
Source: Huppert, 2009. Used with kind permission of Professor Felicia Huppert.

the entire mental health spectrum to a higher level of psychological resources, resulting in an increased prevalence of moderate mental health and flourishing (see Figure 3 above). The need for an international operational definition of flourishing is highlighted to advance understanding of the correlates, causes and consequences of flourishing and to examine the impact of social change or policy interventions (Huppert & So, 2009, p. 6; European Commission, 2009; Stiglitz et al., 2009; Diener et al., 2009b, 2010).

Social cooperation acts as a driving force in the evolution of human health and development. Gerhardt (2010) advocates awareness and acceptance of the inner emotional life and inter-dependence of the self and others as the foundation for an empathic, emotionally literate and moral society. Acts of kindness are cited by Seligman (2011) as producing the single most reliable momentary increase in wellbeing. The ethic of caring and empathic relationships are related to Fonagy and colleagues' concept of mentalisation (2002) and Siegel's concept of mindsight (2010, 2012). *Mentalisation* is 'the process by which we realise that having a mind mediates our experience of the world' (Fonagy et al., 2002, p. 3) and *mindsight* is the ability to 'sense the flow of energy and information as it is shared between people in relationships, as it flows through the neural circuits of the body, and as it is regulated by the mind' (Siegel, 2012, p. 22-1). Siegel conceptualises wellbeing as a triangle in which the three primes of the system are mind, brain, and relationships. Integration of these elements is the definition of good health, while impaired integration results in chaos and/or rigidity. Health is seen as a state of interpersonal sharing of empathic relationships, a regulated and coherent mind, and the embodied mechanism of the nervous system (ibid., pp. 4-1 – 4-7).

Masten and colleagues (1990) define *resilience* as 'the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances'. The biological resilience or vulnerability of an individual is dependent on the interaction between the social and physical environment with genetic endowment, mediated by health effects of

psychosocial support, emotional nurturance, self-esteem, and sense of personal adequacy or control (Robertson, 2012; Berkman et al., 2000; Luthar et al., 2000; Dutton, 1986; Marmot, 1986; House et al., 1988). Cacioppo and colleagues (2006, 2008) promote social resilience as the capacity to foster, engage in, and sustain positive social relationships and to regulate stressors and social isolation, which contribute to negative cycles of self-defeating behaviours. The importance of social bonds or their absence as correlates of disease and mortality has been highlighted by studies of stress and protective factors against stress (e.g., Dantzer & Kelley, 1989; Sapolsky, 1990, 1992). Rose (1985) argues that while distal social conditions are more difficult to observe, they are ultimately more important in determining disease rates in populations because they facilitate the expression of individual susceptibility such as genetic predispositions, personality characteristics, or individual behaviours.

Middleton postulates that crime and the fear of violence is a major cause of public ill health (2003, pp. 313-314). According to Middleton the causes of crime and the causes of ill health are often the same, including poverty and low educational attainment. Intimate partner violence, although widespread and with serious consequences for health and wellbeing, remains widely ignored in policies and services (WHO, 2005). Indeed, Macdonald (2002) nominates the issue of violence and its effect on health as 'the ultimate public health challenge' (p. 293). Middleton describes an increase in recorded incidents as a necessary and welcome indicator of successful recognition of the problem and willingness to address it (Middleton, 2003, p. 318). In Finland, a national domestic violence strategy has been developed (Ministry of Social Affairs and Health, 2008). The health and social care system has an important role in tackling crime and domestic violence through identifying problems, treating victims and rehabilitating offenders.

The outcome of the World Conference on Social Determinants of Health held in Brazil in 2011 urged member states to further reorient the health sector towards reducing health inequities and to develop and support policies, strategies, programmes and action plans that address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation. It was recognised that more needed to be done to accelerate progress in addressing the unequal distribution of health resources and conditions damaging to health at all levels. Key strategies include improving the wellbeing of girls and women and the circumstances in which their children are born, putting major emphasis on early child development and education for girls and boys, improving daily living and working conditions, creating social protection policy supportive of all, and creating conditions for a flourishing older life. The policies to achieve these goals involve civil society, governments, and global institutions (CSDH, 2008, p. 2). The needs to reaffirm the political will to make health equity a shared goal and responsibility and to safeguard population health, regardless of economic downturns, were further recognised. (WHO, 2012)

2.1.3 Integrating Health Promotion and Social Sustainability

Health promotion is a broad term that was first used in the 1970s by Lalonde (1974). Nutbeam (1988) has defined health promotion as 'the process of enabling people to take control over the determinants of their health and thereby improve their health' (pp. 1-2). According to Nutbeam, health promotion represents a comprehensive social and political process that includes both *upstream* actions directed towards changing social, environmental and economic conditions – the three pillars of sustainable development - to alleviate their impact on public and individual health, as well as *downstream* actions directed at strengthening the skills and capabilities of individuals. Three milestones are identified in the development of health promotion (Kickbusch & Payne, 2003). The first milestone commenced in the mid-nineteenth century with the improvement of sanitary conditions and tackling of infectious diseases. The second milestone was the release of the Lalonde Report (Lalonde, 1974), leading to a shift in the understanding of disease causation and setting the stage for health promotion efforts. The third and current milestone focuses on integrating the ecological determinants of health in promoting health for all (Syme, 1996).

Lalonde (1974) observed that the influence of lifestyle on health was greater than that of human biology, genetics, environmental toxins, or access to appropriate health care, estimating that as much as 50 per cent of premature illness and death may be accounted for by individual health risk behaviours. It was argued that the development of various chronic diseases - including heart disease, diabetes, and cancer – could be prevented by replacing high risk behaviours (e.g., tobacco use, poor diet, and a sedentary lifestyle) with healthy behaviours (e.g., avoiding tobacco use, a diet moderate in fat and calories, and regular physical activity). It is now recognised that an individual's ability and willingness to adopt healthy behaviours depends significantly on his or her wider life circumstances (Breslow, 1999). McLeroy and colleagues (1988) identified three levels of influence for health-related behaviours and conditions: (1) the individual or intrapersonal level, (2) the interpersonal level, and (3) the population level encompassing public policy, social capital, and institutional factors. Using the ecological perspective as a point of reference, health promotion is viewed as 'planned change of health-related lifestyles and life conditions through a variety of individual, interpersonal, and population-level changes' (Fertman & Allensworth, 2010, p. 5).

The World Health Organization has played the pivotal role in proposing a broader agenda for health promotion. The World Health Assembly at Alma Ata in 1978 committed all member countries to the principles of '*Health for All 2000'* that by the year 2000 all the people of the world should attain 'a level of health that will permit them to lead a socially and economically productive life' (WHO, 1978). The main principles for health promotion were summarised in the '*Copenhagen Document'* as follows:

> 'Health promotion involves the whole population in the context of their everyday life, rather than focusing on people at risk for specific diseases. It is directed towards action on the causes or determinants of health to ensure that the total environment which is beyond the control of individuals is conducive to health. Health promotion combines diverse but complementary methods or approaches, including communication, education, legislation, fiscal measures, organisational change, community development and spontaneous local activities against health hazards.' (WHO, 1977)

Health professionals particularly in primary health care have an important role in nurturing and enabling health promotion (WHO, 1984). The equal importance of health promotion work and traditional medical professionals is recognised (Davies & Macdonald, 1998). In addition, the World Health Organization (1985) has identified that improvements in lifestyles, environmental conditions and health care will have little effect if the following fundamental conditions are not met:

- peace and freedom from the fear of war
- equal opportunity for all and social justice
- satisfaction of basic needs, including food and income, safe water and sanitation, housing, secure work and a satisfying role in society
- political commitment and public support.

The recognition and evolution of health promotion was ratified by the World Health Organization's first global health promotion conference in Canada in 1986. The '*Ottawa Charter'* identified key action areas for health promotion as (1) strengthening individuals with information and personal skills to make informed choices, (2) strengthening community action and decision-making, (3) reorienting health services away from treatment and care and improving service access, (4) building a healthy public policy towards social and economic change, and (5) creating supportive environments. (WHO, 1986)

Health promotion activities are increasingly conducted in a comprehensive combination of mixed strategies at global, national, regional and community levels. The charter has been strengthened in succeeding conferences held in Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005) and Nairobi (2009). The *'Nairobi Call to Action for Closing the Implementation Gap in Health Promotion'* (WHO, 2009) set the gold standard for health promotion strategies and actions in the 2010s, declaring that health promotion is 'a core and the most cost-effective strategy to improve health and quality of life'. Implementation gaps result in a failure to realise the untapped potential of health promotion and in avoidable illness and suffering, perpetuating profound social and economic impacts on people's lives. Five key strategies and commitments for closing the implementation gaps within health and development in evidence, policy, practice, governance, and political will were identified:

- *Building capacity for health promotion* – strengthening of leadership and workforces to sustain health promotion infrastructure and capacity at all levels
- *Strengthening health systems* – mainstreaming of health promotion in all levels improves the overall performance of health systems to support equity in health
- *Partnerships and intersectoral action* – enhancement of participatory processes between and beyond sectors to effectively address the determinants of health and achieve health equity
- *Community and individual empowerment* – sharing of power, resources and decision-making to assure and sustain conditions for equity in health
- *Health literacy and health behaviours* – building and applying knowledge and interventions based on health, social and cultural needs. (WHO, 2009)

The 8th Global Conference on Health Promotion (8GCHP) will be held in Helsinki, Finland in June 2013. The Conference will assess aims and achievements for health promotion globally from Ottawa to Nairobi, addressing and identifying effective options for action, available processes, mechanisms, and tools under the theme of Health in All Policies (HiAP).

Health promotion is inherently multidisciplinary, integrative and collaborative. Labonte (2003, pp. 285-288) views the role of health promotion professionals in sustainable development decision-making as interdisciplinary interpreters of biomedical, behavioural and socioenvironmental systems in creating health or disease. In this light, the aim of health promotion is to articulate value-based strategies that sustain humans by seeking and seeding interdisciplinary commonalities, while consciousness raising conflicts. The unique contributions of health promotion professionals to sustainable development discussions are summed by Labonte as:

- a broad construction of health, particularly the role of political/economic equity in creating individual and population health
- the limitations of scientific data and the ethics of decision-making when epidemiological data are equivocal
- the limitations of individual lifestyle-based strategies, discipline boundaries of medicine and traditional infectious disease control
- the relationship of empowerment to personal and community health, and its implication for sustainable development decision-making processes. (ibid.)

Healthy, egalitarian societies have the best health and greater social cohesion and social capital. Understanding of the precise mechanisms linking social inequality to ill health remains incomplete, however it is postulated that relative inequality in relation to others gives rise to stress and insecurity, raising the risk of disease (Wilkinson, 1996; Wilkinson & Marmot, 2003). *Empowerment*, the ability to exercise choice, informs an emergent knowledge

that individual health is enhanced by the act of organising to alter conditions of relative powerlessness (Labonte, 2003, p. 287). Need is a relative concept and its definition varies over time in accordance with changes in national legislation, changes in local policy, the availability of resources, and the patterns of local demand. Demand for health and social care services often exceeds supply, and therefore services need to be rationed or prioritised according to specified criteria and the evidence base. Needs may be classified into four categories: (1) normative needs that are defined by experts, (2) felt needs or what people want, (3) expressed needs or what people say they need, and (4) comparative needs that are defined by comparison between similar groups of clients (Ewles & Simnett, 2003, p. 103).

The use of health promotion models and approaches in professional practice helps to prioritise strategies and to develop new perspectives. Each theoretical model makes assumptions about health, society and change and raises different aims, intervention methods, practitioner skills and means of evaluation (Caplan & Holland, 1990; Beattie, 1991; Downie et al., 1996; Tones & Tilford, 2001; Naidoo & Wills, 2009). The objective of health promotion programmes is twofold: (1) to provide planned, organised and structured activities and events that support individuals to make informed decisions about their health, and (2) to advocate policy, legislative, environmental, and organisational changes at various levels of government and organisations. The three levels of health promotion intervention are primary prevention, secondary prevention and tertiary prevention (see Figure 4). Health promotion programmes are planned for a priority population (previously called a target population), which constitutes a defined group of individuals who share some common characteristics related to the health concern being addressed. The settings for health promotion programmes to reach children, adults, families, and communities include schools, neighbourhoods, workplaces, health care organisations, and prisons. (Fertman & Allensworth, 2010, pp. 6-7)

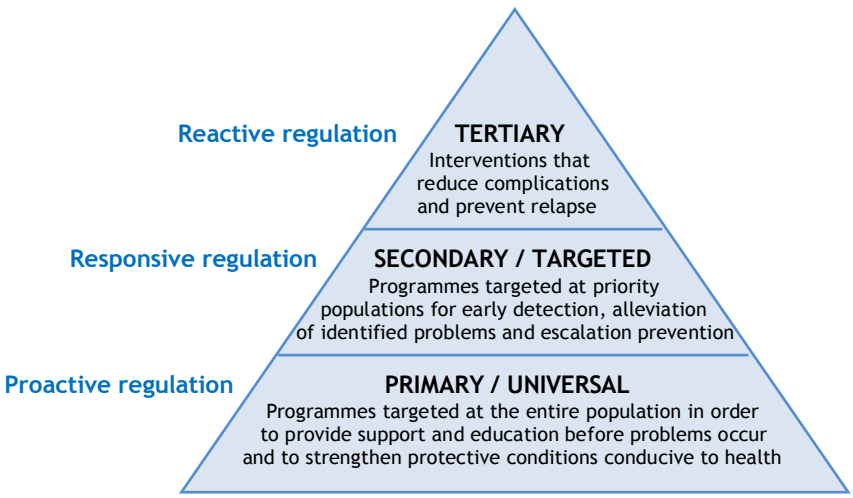

Figure 4: The Pyramid of Health Promotion Interventions. Source: Adapted from Bromfield and Holzer, 2008. Used with kind permission of the Australian Institute of Family Studies.

Quality assurance is embedded in health-promotive practice and helps to improve standards, identify cost-effective activities, demonstrate worth to external agencies and ensure satisfaction of stakeholder requirements. The process of quality assurance is a continual assessment and improvement of practice, in comparison to *evaluation* which refers to the assessment of outcomes at a specific point in time (Naidoo & Wills, 2009). Indicators of quality as appointed by The European Quality Instrument for Health Promotion comprise (1) the framework of core health promotion principles, (2) project development and implementation, (3) project management, and (4) sustainability (Bollars et al., 2005). The core principles of quality interventions in health promotion are:

- *Equity*: equal access and/or equal benefit from services
- *Effectiveness*: achievement of intended objectives
- *Efficiency*: achievement of maximum benefit for minimum cost
- *Accessibility*: ease of availability to users in terms of time, distance and ethos
- *Appropriateness*: matching of services with user requirements
- *Acceptability*: satisfaction of reasonable expectations of users
- *Responsiveness*: adaptation to the expressed needs of users (Speller et al., 1997a; as cited in Naidoo & Wills, 2009, p. 283).

Hagalund and colleagues (1993, 1998) presented the Supportive Environments Action Model (SESAME), an action-oriented quality assurance model for dynamic planning to create supportive environments for health (see Figure 5). The model employs a universal and logical spiral process of actions in stages: planning (including identification of needs and problems, building of alliances, and development of targets, strategies and evaluation), implementing, and improving (including renewal, reinforcement and/or reorientation of solutions). Evidence-based practice in public health programmes is grounded on the use of scientific approaches for decision-making (Lewis, 2008).

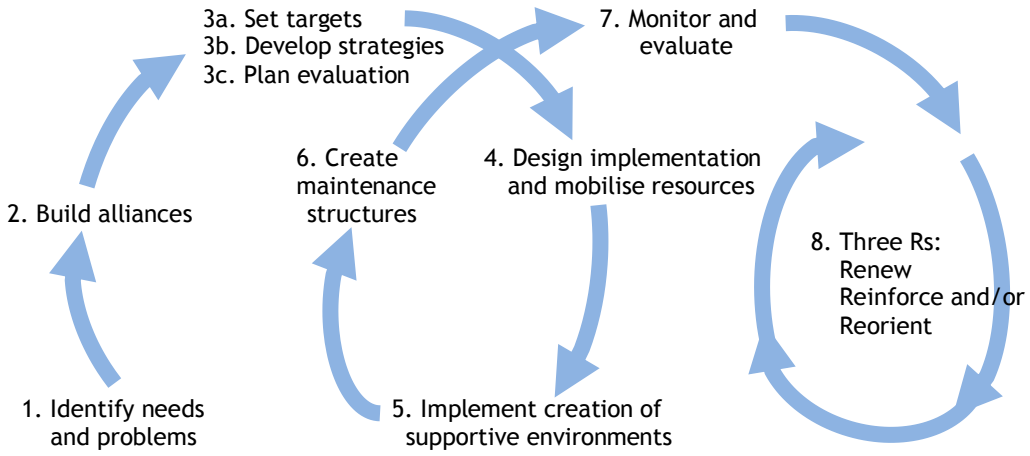

Figure 5: The Supportive Environments Action Model (SESAME).
Source: Hagalund et al., 1993; as cited in Hagalund et al., 1998 (p. 106).

Evaluating health promotion is a complex task. Interventions often involve immediate and distal effects, such as shifts in knowledge or attitudes and changes in lifestyle, as well as multiple partners and types of activities each with their own objectives. It is important to establish evidence of what works in health promotion (i.e., outcome evaluation) and to understand how and why these things have worked (i.e., process evaluation) (Nutbeam, 1996, 1998; Macdonald et al., 1996; Nutbeam & Harris, 1998). The failure to take latent effects into account may result in serious misinterpretations of the effectiveness of health interventions (Hertzman et al., 1994; Speller et al., 1997b). Long-term, comprehensive interventions are difficult to predict, control and evaluate by conventional experimental designs such as randomised controlled trials (RCTs), which have been the gold standard of the systematic review process utilised in evidence-based medicine. In the ecological health promotion context the evidence base combines experimental and observational studies and quantitative and qualitative information from epidemiological, behavioural and social science, to provide insight into human experiences and the health-promotive or health-demotive environmental and organisational impacts of intervention. This knowledge is important in explaining programme success or failure and subsequent changes in health determinants and health outcomes, and for successful replication and dissemination of innovations (IUHPE, 1999, pp. 8-9). Examples of theoretical frameworks for programme development and evaluation include the logic, PRECEDE-PROCEED, diffusion of innovations and MATCH models (e.g., Simons-Morton & McLeroy, 2011; Lewis et al., 2008). The application of inappropriate assessment methods, overemphasis on individual behaviour change outcomes, and pressure on resources have been nominated by Speller and colleagues (1997b) as risks in health promotion.

King and colleagues (2012) commented on the future of health promotion in a meta-review of the impact of the Ottawa Charter for Health Promotion on its 25th anniversary in 2011. Identified strengths and opportunities of health promotion included models of good practice, intersectoral collaboration, availability of educational resources and the use of social media to engage the public in building upon the lifestyles approach. Identified weaknesses included the view that health promotion was too traditional, under-theorised and lacking in political focus in the face of competing perspectives. Gaps in evidence highlight the need for health promotion indicators and measurements, implementation of practice-based evidence, and overcoming of barriers such as avoidance of stigma and resistance to sensitive issues. The report recommended that health promotion should be regrouping, re-theorising and reflexive during the current economic downturn to be responsive to emerging opportunities. The role of the media in communicating health promotion and acknowledging social determinants of health was also noted. According to King and colleagues, ‘health promotion is regarded as a social change mechanism’ and ‘considered an impetus for moving other social movement agendas forward’ (2012, p. 12). Gerhardt (2010) asserts that the challenge now is to integrate the scientific knowledge about human development and wellbeing with action, for ‘only then will we have a chance of moving towards the right solutions’ (p. 18).

2.2 On Being, Belonging, and Becoming Human

Humans are open beings with physiological, mental, and emotional systems that are developed in relationships and permeated by other people in social pedagogical processes. To become a human being with a sense of self requires attuned reflection through the eyes and minds of caregivers in early life and in socially co-constructed interactions across the lifecourse. Humans are neurobiologically wired to attach to another human being for safety, security, and solace. The three greatest human needs for life satisfaction and balance are *being* (the need for self-awareness), *belonging* (the need for relationships), and *doing* (the need for accomplishment) (Potter-Efron, 1998). The patterns of relating to others and adapting to experiences throughout the lifespan shape and are shaped by individual brains as well as the collective nervous system that is formed in relationship bonds. (Gerhardt, 2004; Sunderland, 2006)

This section reviews the human nervous system, social brain development, attachment theory, emotion regulation, the stress response, and resilience.

2.2.1 Social Brain Development

Advancements in neuroscience have demonstrated the sensitivity of human brain development to external influences in early childhood, starting in utero and with lifelong effects. The developing brain is sculpted by the environmental conditions to which foetuses and infants are exposed, including the quality of prenatal and postnatal nutrition, the quality of care and attention received in mother-child bonding, and the quality of social relationships and language environment. The development of the cortex, and in particular the prefrontal part linking the sensory areas of the cortex with the emotional and survival-oriented subcortex, evolved as human social interactions became more emotionally complex and sophisticated (e.g., Schore, 1994; Gerhardt, 2004; Mustard, 2007; Paul, 2010). According to MacLean's (1973, 1990) concept of the *triune brain* (Figure 6), the human brain is structured by evolution into three interconnected regions or levels each with specific areas of control and responsibility. The lowest level is the *reptilian brain*, comprising the brain stem and cerebellum, and it preserves and stabilises the most basic life functions including respiration and temperature. The reptilian brain is fear driven and takes over in situations of danger or threat with a focus on survival, physical maintenance, dominance, preening, mating and hoarding. The middle brain, termed the mammalian emotional brain or *limbic system*, includes the thalamus, hypothalamus, amygdala, cingulate gyrus, insula, and hippocampus and is important for emotions, instincts, attention and affective memories. The limbic system is responsible for social bonding and nurturing. The highest level is the neo-mammalian brain or human *neocortex*, which performs higher cognitive functions such as planning, speech, judgement, and rational thought (Maciocia, 2009, pp. 156-158, 306-310).

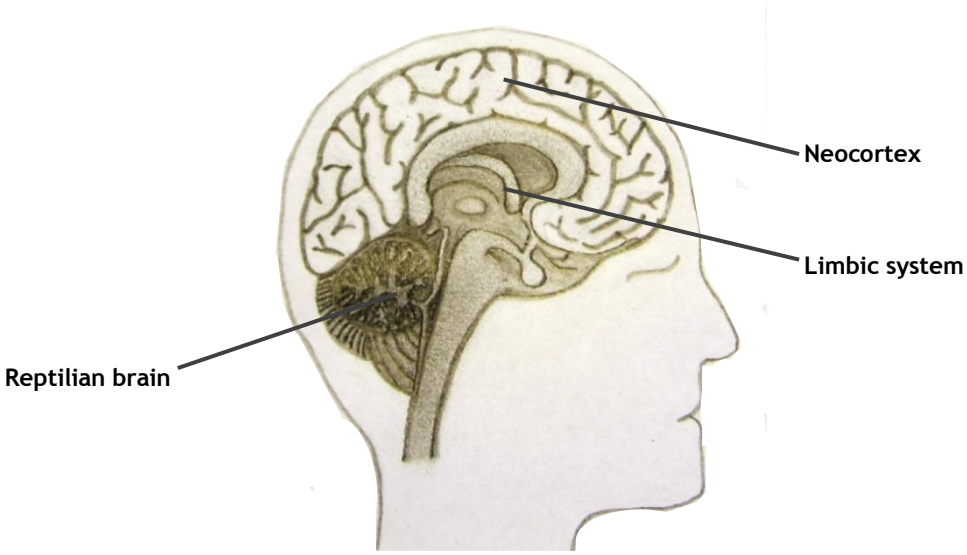

Figure 6: The Human Brain.
Illustration by Tanja K. Harju. Source: Adapted from Maciocia, 2009 (p. 157).

The brain is divided into two hemispheres, which are divided into four lobes (frontal, parietal, temporal and occipital). The left and right hemispheres are connected by the corpus callosum that facilitates communication between the two sides of the brain. The limbic system forms the inner border of the cortex and is sometimes referred to as a fifth lobe. There are vast interconnections and mutual dependence between the neocortex and limbic system and limbic regulation is essential to the normal mammalian development of the cortex (Lewis et al., 2000). The outermost layer of the cerebral cortex is termed the grey matter, a compact structure mainly composed of the cell bodies of neurons. The white matter below is composed mainly of the myelinated axons of the neurons, which connect to different regions of the central nervous system. The association areas of the cerebral cortex are responsible for encoding sensory information and commanding movement. The integration of sensory information typically occurs in the parietal, temporal and occipital lobes of the right hemisphere, which is more spatial, abstract, and artistic. Language abilities are typically localised in the parietal, temporal, and occipital lobes of the left hemisphere, which is more linear, rational, and verbal. The planning of actions and movement as well as abstract thought is localised in the frontal lobe or pre-frontal association area. The motor areas are located in the frontal lobes of both hemispheres, with each hemisphere being connected to and controlling the contralateral side of the body. (Jones, 2011, pp. 42-53)

The structure of the *human nervous system* is illustrated in Figure 7. The nervous system is mainly comprised of nerve cells or neurons that conduct and transmit electrochemical signals. The nerves of the *central nervous system* connect the brain and spinal cord with the whole body via the *peripheral nervous system*, which is divided into a *sensory* division with exteroceptor and interoceptor branches and a *motor* division with somatic and autonomous

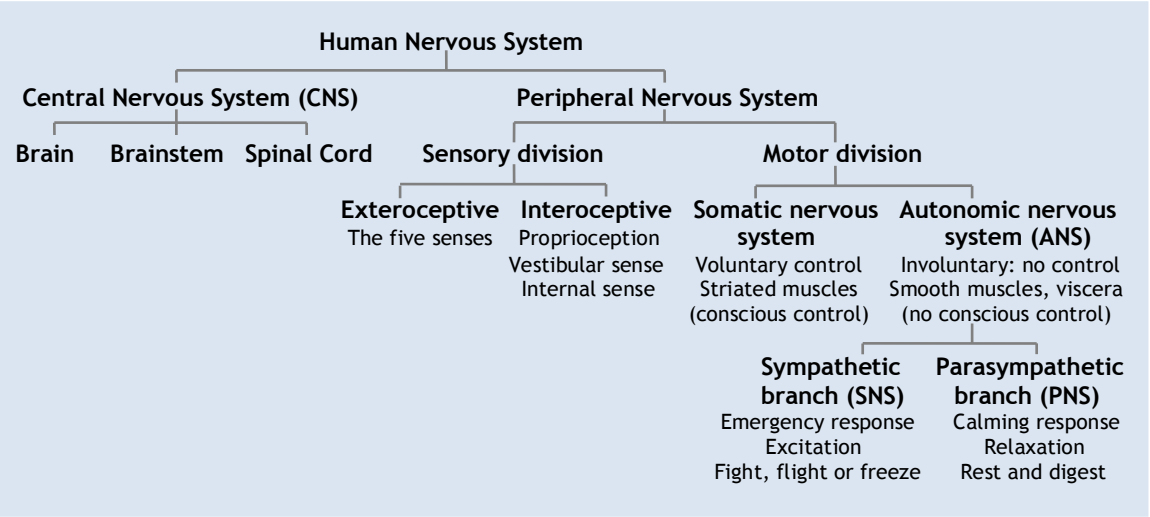

Figure 7: The Structure of the Human Nervous System.
Source: Adapted from Rothschild, 2006 (p. 37).

branches. The *autonomic nervous system* has two branches: the *sympathetic nervous system* (emergency response, controlling excitation) and the *parasympathetic nervous system* (calming response, controlling relaxation). Engagement of the sympathetic nervous system leads to an increase in heart and breathing rates, blood pressure, and body temperature and the movement of blood supply from stomach to limbs in preparation for action. Conversely, engagement of the parasympathetic system leads to a decrease in heart and breathing rates, blood pressure, and body temperature and the movement of blood into the digestive system in preparation for eating, sleeping and relaxation (Jones, 2011, p. 37). Gershon (as cited in Maciocia, 2009, p. 103) reported a second brain known as the enteric nervous system (ENS) or gut brain located in the oesophagus, stomach, small intestine and colon, which contain over one half of the body's nerve cells and one hundred million neurotransmitters, about the same number as is found in the brain. The two brains communicate and directly influence each other via the vagus nerve extending from the base of the brain into the abdomen. Clarke and colleagues (2012) showed that adult serotonin concentrations are regulated by the presence of gut bacteria during early life, suggesting that manipulations of gut microbiota by diet, antibiotics or infection may contribute to profound central nervous system changes.

Porges has evolved the *polyvagal theory*, an alternative understanding of the autonomic nervous system and fight, flight, and freeze reflexes. Porges' theory states that there are three basic neural subsystems that underpin the overall state of the nervous system and related emotions and behaviours. The most primitive system comprises the dumb vagus nerve and dorsal vagal system, targeting the internal organs with functions of immobilisation, metabolic conservation, and shutdown. The second system is the sympathetic nervous system, targeting the limbs of the body and having the function of mobilisation and enhanced action that supports fight or flight. The third system is the branch of the parasympathetic system

that regulates the mammalian or smart vagus nerve. The third system is the most recent in evolutionary terms and is neuroanatomically linked to the cranial nerves for facial expression and vocalisation and mediation of complex social relationship, attachment and bonding behaviours (Porges, 1995, 2003). Potential threats in the environment are evaluated by the nervous system via an unconscious process of neuroception, and the more primitive structures are inhibited by the social engagement system when the environment is perceived to be safe. Conversely, the limbic system is capable of hijacking the higher mental functions when necessary (Maciocia, 2009, p. 156).

Neuroscientific research has established that experiences of attachment, separation, and loss during early years directly affect the structural and functional development of the brain, nervous system and neuroendocrine system, forming *relational blueprints* with profound impact on lifelong patterns of relating (e.g., Schore, 1994, 1997, 2000, 2002, 2005; Siegel, 1999, 2010; Trevarthen, 2001). The human infant's responsiveness to human interaction is distinctive from other newborn mammals. Human brain development takes place outside of the womb and is therefore highly *experience dependent*; each new human is conditioned by the unique interactions and circumstances of the physical, social and cultural environment (Gerhardt, 2004, pp. 33, 38). Lewis and colleagues assert that the development of the brain is directed by attachment and limbic regulation, which gives coherence to neurodevelopment and ultimately determines the nature of a child's mind (2000, p. 86). According to Trimble:

> 'It is becoming increasingly evident that the limbic system and therefore our emotions play a role in cognition and personal knowledge. Emotion is no longer seen as a counterpart to reason in human cognition but rather as a collaborator, and indeed constructor of our reasons and thinking'. (2007, p. 50)

Siegel (2010) posits that parent-child interactions in the attachment context shape the emerging neural circuitry by supporting the development and integration of the child's developing brain, including fundamental processes such as emotion regulation, response to stress, autobiographical memory, and self-organisation. Experience leads to neural firing, activating genes that lead to protein production enabling the formation of new synaptic connections. At birth, the hippocampus, temporal cortex, prefrontal cortex and anterior cingulate are all immature and their growth and genetic development depends on good early experiences, which produce brains with more neuronal connections. The baby's brain more than doubles in weight in the first year of life. Genetic expression is facilitated by the increased glucose metabolism in the first two years, triggered by the baby's biochemical responses to social input by caregivers (Gerhardt, 2004, pp. 42-43). Siegel cites evidence that early experiences can change the long-term regulation of genetic material within the nuclei of neurons through the process of *epigenesis*, impacting emotional resilience and ability to adjust to stressful events later in life (2010, p. 42).

There is a critical period of social brain development in response to environmental experience during a sensitive window of opportunity before the age of three (Chugani et al., 2001). The most active parts of the newborn baby's brain are the brainstem and sensorimotor cortex. The newborn's priorities are the internal regulation of body systems and adaptation to external conditions, which are managed by emotional responses. The fear and self-defence system of the amygdala is one of the earliest parts of the emotional brain to mature as a response for survival. Smell, touch and sound are the newborn's first sources of comfort and pleasure (Gerhardt, 2004, pp. 33, 38-40, 44). The social brain is particularly linked to the right side of the brain, which develops prior to the left hemisphere, is dominant throughout infancy, is specialised in attachment functions and implicated in social-emotional acuity, implicit memory, stress regulation, intuition, empathy and morality (Schore, 2003). Social intelligence is especially sensitive to experiences between six and eighteen months when social brain regions become metabolically active, shaping the future behavioural repertoire of the individual (Chugani et al., 2001). The social brain is associated with the orbitofrontal cortex which matures between the ages of about ten months and eighteen months and is the area of the brain responsible for emotional intelligence (Goleman, 1996), together with other parts of the prefrontal cortex and anterior cingulate.

The baby displays the basics of emotion and self-regulation by seeking interaction with others, turning away from others when overwhelmed, or freezing when at risk. Physical holding and support by others leads to a relaxation of muscles and deepening of breathing. The autonomic nervous systems of the infant and caregiver resonate via the functioning of mirror neurons (Gallese et al., 1996; Rizzolatti et al., 1996; Rizzolatti & Sinigaglia, 2008; Iacoboni, 2009; Decety & Ickes, 2009). The baby becomes soothed through the caregiver's relaxed and coherent state, gentle stroking and calm rocking (Gerhardt, 2004), facial expression, audio-vocal communication and play (Trimble, 2007). Concomitant to development of the visual system, vision becomes the infant's main source of information about other people's feelings and intentions. Schore (1994) proposed that the positive, doting looks of the family are the key to developing the caregiver-infant bond and the most vital stimulus to the growth of the social, emotionally intelligent brain. The baby's sympathetic nervous system becomes aroused as he or she mutually gazes at the caregiver's dilated pupils and beta-endorphin, a pleasure neuropeptide that regulates glucose and insulin which facilitates neuronal growth, is released into the orbitofrontal region of the brain. At the same time dopamine is released from the brainstem and released into the prefrontal cortex, enhancing the uptake of glucose and helping new tissue growth. (Gerhardt, 2004, pp. 40-42)

The parasympathetic nervous system, on the other hand, is the vital inhibitory system that enables the growing child to stop doing something and to learn what behaviour is dangerous or unacceptable. The experience of shame is a particularly important mechanism of socialisation. The withdrawal of attunement by the caregiver through disapproving looks and

a cold tone of voice accompanied by verbal prohibitions such as ‘No!’ and ‘Don’t touch that!’ signal the threat of social isolation if the child does not comply with the group’s norms (Schore, 1994). There is a sudden change from sympathetic to parasympathetic arousal that triggers the release of stress hormones like cortisol, creating shame-bound effects such as a sudden drop in blood pressure, shallow breathing, postural collapse and blushing. In the event that caregivers fail to restore a state of attunement and regulation, the child may remain stuck in a state of stressful arousal. Highly charged and arousing experiences are registered in the amygdala, which coordinates instant reactions to perceived situations of danger such as the caregiver’s facial expressions of fear and anger. The caregiver’s looks have a powerful impact, especially in babyhood and toddlerhood, because the growing child is wholly dependent on the caregiver for regulation of physiological and psychological states and any threats to regulation place the child’s survival at risk. By toddlerhood the child uses social referencing, or distal interpretation of the parent’s facial expression, as a source of information to evaluate what is acceptable or unacceptable to do and feel (Gerhardt, 2004, pp. 47-49; Sunderland, 2006, pp. 92-93).

The baby’s means of communicating with others evolves from touch and visual dominance into verbal communication during the second and third years. There is a shift from right brain dominance towards the development of the left brain, which is specialised for sequential and verbal processing. New key areas of the brain, including the anterior cingulate (awareness of inner states), dorsolateral prefrontal cortex (working memory) and hippocampus (explicit memories), start to develop and play a critical role in the development of a verbal, narrative, and social sense of self that is a foundation of emotional security in adulthood. The expression and management of feelings become linked as the right and left sides of the orbitofrontal cortex start to integrate. This process is experience-dependent on the child’s important relationships during the second and third years of life. An *emotional vocabulary* is scaffolded by well attuned caregivers who validate the child’s current emotional state, enabling emotions to be integrated into higher functioning. In the event that feelings remain unsymbolised, because the connections between the hemispheres and levels of the brain have not been facilitated by responsive adult caregivers in talking about feelings or representing them accurately, the child will be unable to express and regulate feelings around others and instead rely on the nonverbal template of past experiences. Unaided by the left brain’s reflective and narrative capacities, the child’s sense of self will remain undifferentiated (Gerhardt, 2004, pp. 50-55; Kochanska, 2001; Kopp & Neufeld, 2003).

The child’s brain is structured as the most frequent and repetitive experiences form established myelinated pathways, whilst surplus connections start to die off in a process known as pruning (Greenough & Black, 1992). Brain regions responsible for basic life processes, sensory perception and emotion are moulded first and the frontal lobes and prefrontal cortex for higher order executive functioning, problem solving, planning, and decision-making

mature later. The brain does not mature until early adulthood, and it is posited that in adolescents and some young adults emotional information is processed through the lower order amygdala and limbic system rather than the developing prefrontal cortex (Fabian, 2012; Kambam & Thompson, 2009). Positive social interaction with others shapes the links between the prefrontal cortex and amygdala, strengthening the capacity to inhibit the fear conditioning responses of the amygdala and inoculating the individual against inappropriate anxieties and fears. Maciocia raises the connection between the brain and the gut brain, positing that dysfunction arising from emotional nurturing issues in particular and including pensiveness, sadness, grief, worry, fear, and shame, is seen as a common cause of stomach problems (2009, p. 108). The integration of emotions and sensory experience into higher functioning strengthens a state of consciousness and self-awareness, which allow the child to reflect on experience and consider alternatives before acting, enabling inhibition of arousal and suppression of spontaneous emotional behaviours such as aggression. In addition there is involvement of the limbic system in *salience*, or attention selectivity, and in *valence*, which refers to positive or negative feelings and intuitive approach or avoidance responses toward something (Maciocia, 2009, p. 308). The development of patterns of neurons make social interactions with others more predictable and organise experience, contributing to images of self with other and the fundamentals of inner emotional life (Gerhardt, 2004, pp. 44-45).

The combination of brain differentiation and integration forms a complex system with capacity for highly adaptive, flexible, and stable states of social functioning coexistent with mental health. Emotional wellbeing is associated with the prefrontal functions of bodily regulation, attuned communication, emotional balance, response flexibility, fear modulation, empathy, insight, moral awareness, and intuition (Siegel, 2010, p. 26). Seligman observes that human survival depends on collective abilities to join together with others in pursuit of a goal and to understand what others are thinking, sustaining the cohesiveness and social resilience of the group. The human social group has collective cognitive brain structures such as mirror neurons (Gallese et al., 1996; Rizzolatti et al., 1996) and action observation networks (Caspers et al., 2010) that reflect other minds, and the emotional brain structures that support the 'hive emotions' of love, compassion, kindness, teamwork, and self-sacrifice (Seligman, 2011, p. 145). The function of the brain's prefrontal cortex has been described as an *anticipation machine* (Siegel, 1999), *relationship simulation machine* or *social simulator* (Seligman, 2011), which allows humans to simulate social possibilities and then to choose the optimal course of action for harmonious and effective human relationships. Inner representations are an important source of emotional self-regulation for soothing and calming high arousal in the right brain and can be used to guide behaviour in future situations with similar types of emotional arousal. In the absence of internalised parental strategies or proxy attachment figures to support regulation, the individual becomes vulnerable to stress and dysregulation (Gerhardt, 2004, pp. 46-47).

2.2.2 Attachment Security and Traumatic Bonding

Bowlby's theory of attachment (1969, 1973, 1980) has contributed to a major revision in the understanding of how and why humans learn to relate. *Attachment* refers to 'the interactive regulation of biological synchronicity between organisms' (Schore, 2000, p. 23). Attachment theory provides a psychoneurobiological framework for understanding individual differences in early social, emotional and personality development (Thompson, 2000) and changes in neurochemistry and brain organisation (Schore, 2008). The *attachment system* is the behavioural system that becomes activated when an individual feels threatened, alarmed, danger, distress, or need. Infants exhibit innate *attachment behaviours*, an adaptive response to maintain physical or psychological proximity to caregivers for safety and protection (Howe, 2011). Attachment is basic to human survival and humans are biologically and psychologically wired to need other people (Hofer, 2005, 2006) as a safe haven from existential loneliness and despair and as a bioenergetic recharge from social interactions (Ainsworth et al., 1978; Belsky & Cassidy, 1994). The critical role of comfort in primate development was first discovered by Harlow and Woolsey (1958), who observed that the drive by infants for physical comfort was greater than that for food. The early idea that maturity was based on the ability to separate/individuate (Mahler et al., 1975) has been succeeded by the importance of the capacity for love and connection in relationships with others (Gerhardt, 2004, 2010; Szalavitz & Perry, 2010; Howe, 2011; Tatkin, 2011).

The seeking and maintaining of secure attachment bonds with significant others is an instinctive motivation throughout the human life. Attachment behaviour is most readily activated between the ages of six months and five years, which is the period of greatest vulnerability and highest dependence (Howe, 2011, p. 18). Infants and young children organise their behaviour to achieve proximity with the caregiver and a sense of felt security. Approach attachment behaviours to signal need include vocalising, cooing, burbling, sucking, smiling, visual tracking, eye contact, raised arms, and following the caregiver. Bowlby (1969) observed that babies around six months begin to display a series of adaptive behaviours in the presence of real or perceived distress upon separation or loss of a primary attachment figure, the initial reaction being protest with loud crying, clinging, attempts to follow or find the attachment figure, and anger. In prolonged loss or separation babies enter a state of despair marked by preoccupation, vigilance, loss of hope, grief, and withdrawal, eventually leading to detachment. The two main *attachment relationship styles* or adaptive regulatory behaviours to different parenting sensitivity are *secure attachment* and *insecure attachment*, which is further subdivided into avoidant, ambivalent/resistant, and disorganised/disoriented types (Ainsworth et al., 1978; Main & Solomon, 1986). Children fail to form attachments in environments in which carers are completely insensitive and forever changing, or in extreme cases of severe institutional deprivation such as Romanian orphanages, leading to the formation of defensive states that can sometimes become character traits. (Howe, 2011)

Table 1: Attachment Relationship Styles.

Attachment Style	Caregiver Responses	Infant Behaviour
Secure	Sensitive, responsive, consistent, attuned, reliable (e.g., prompt comforting when infant distressed, warm interested response to infant's wish to communicate or play, empathy and acceptance of infant's point of view)	Able to regulate emotions, seek help from others when distressed, adaptable to changing circumstances and able to explore their world
Insecure (avoidant)	Connected enough to protect the infant, but minimises the importance of attachment issues, can be dismissive of infant's attachment cues, insensitive to infant's signals and emotional needs	Shows little distress on separation, and minimal joy when reunited with caregiver, over-regulation of affect, avoidance of emotional intimacy and defensive focus on exploration
Insecure (ambivalent/ resistant)	Inconsistent or unpredictable emotional availability and response to infant's attachment behaviours and emotional needs (e.g., at times over-protective or over-stimulating and at other times rejecting or ignoring)	Overly engaged with attachment figure and may feel too anxious about caregiver's emotional availability to freely explore the environment
Disorganised/ Disoriented	Unresponsive, intrusive, hostile or violent (these parents may have experienced trauma themselves)	Chaotic and confusing behaviour (e.g., hypervigilant, freeze or fear when parent appears, dissociative behaviours)

Source: Jordan & Sketchley, 2009.
Used with kind permission of the Australian Institute of Family Studies.

The reciprocal response of caregivers to the infant's attachment system has been called the *caregiving system* (George & Solomon, 2008), a biological urge to care for, comfort, and protect one's young. The infant behaviour and caregiver responses typical of each attachment style are summarised in Table 1 above (Jordan & Sketchley, 2009). The goal of the caregiving system is to protect, regulate and respond to the child by mirroring and complementing the child's attachment system. Key behaviours of the caregiving system are retrieval, reaching, calling, grasping, restraining, following, smiling, soothing, and rocking. The infant's attachment behaviours are reinforced by the regular and repeated responses of a reasonably sensitive, consistent and available caregiver when the child feels in danger and seeks comfort, safety and emotional regulation (Cassidy, 2008). The child's attachment system and exploratory system are complementary and mutually inhibiting. When the child feels relaxed and secure, energies and behaviours can be directed into exploring the environment through play, social interaction, discovering new things, learning, being curious and creative. When danger threatens, anxiety is felt, or uncertainty arises, the attachment system becomes activated and play and exploration are deactivated. A similar complementary relationship exists between the attachment figure's caregiving system and the child's attachment system. When the parent's caregiving system becomes activated the child's attachment system can be deactivated, allowing the child to relax and explore at ease (Howe, 2011).

Children may have multiple attachment figures who endow parental love. Alloparenting, coparenting or cooperative breeding are natural models of childraising in many societies and

cultures (Hrdy, 2005; Music, 2011). Nevertheless, an overall hierarchy of attachment tends to exist and in most cases it is the mother who is the selective or *primary attachment figure* (Howe, 2011, p. 12). Bowlby (1973) theorised that repeated daily transactions with caregivers are aggregated into *internal working models*, or *representational systems* of self and other that lead to expectations about future interactions and guide cognition and behaviour in all subsequent relationships (Main & Solomon, 1986). Infants need to experience the caregiver as both available and sensitively responsive to their needs for the development of intersubjectivity, which forms the connection between attachment and self-regulation (Fonagy et al., 2002, pp. 126-127). The impact of caregiver enrichment or deprivation over the first 18 months of life is of particular influence for the individual's relational trajectory (Schore, 2005; Siegel & Hartzell, 2003; Fonagy et al., 2002) and capacity to engage in relational bonds across the lifespan (Waters & Cummings, 2000; Clulow, 2001; Malekpour, 2007; Gillath et al., 2008). Internal working models are seen as relatively stable (Collins & Read, 1994) and tend to be change-resistant across the lifespan, because they function outside of awareness (Crittenden, 1990).

Attachment relationships play a key role in the intergenerational transmission of deprivation or traumatic bonding. There are significant and long-term effects of early neglect, prolonged separation, loss and abandonment. Main and Goldwyn (1985) discovered that more important than an individual's actual experiences of childhood was the development of an internally coherent and consistent narrative. The Adult Attachment Interview (AAI) (George et al., 1985) is an instrument that elicits narrative histories of early experiences. The AAI defines four categories with respect to loss or trauma. Secure and autonomous individuals integrate early memories into a coherent and formative narrative. Insecure and dismissing individuals show avoidance by denying early memories and idealising or devaluing early relationships. Insecure and preoccupied individuals show confusion, anger, or fear in relation to attachment figures. Unresolved individuals show significant disorganisation with semantic or syntactic confusions in childhood narratives of childhood trauma or recent loss.

Trauma is defined by Levine as 'loss of connection – to ourselves, to our bodies, to our families, to others, and to the world around us' (2008, p. 9). William James stated that 'the great source of terror in infancy is solitude' (as cited in Bowlby, 1998, p. 52). Children require attuned experiences with a *good enough mother* (Winnicott, 1965) for internal development and the capacity for mentalisation. The infant grows from a state of coregulation to self-regulation through social biofeedback in the attachment context. Emotion is tempered into an organiser of a self-state by the mother's empathic expression as separate and different from the infant's primary experience. Activation of the attachment system in experiences of stress, neglect, and trauma is associated with an aroused, stressed, and dysregulated state and these responses remain activated if attachment behaviours fail to achieve the set goal of care, protection, and validation (Howe, 2011). Infants and children

with traumatic bonding from repeated experiences of separation, loss, or threat of abandonment or rejection are likely to feel anger and anxiety throughout childhood and into adulthood (Bowlby, 1973). When own needs for connection, attunement, trust, autonomy and love are not met (Heller & LaPierre, 2012) feelings of anger and aggression towards the attachment figure may arise as expressed in the form of hateful feelings, angry fantasies or actions for perceived maternal failures of protection (Howe, 2011, p. 16). Individuals with insecure attachment or disorganised states may also display problems with mentalisation, somatosensory awareness, and empathy (Fonagy et al., 2002; Gerhardt, 2004; Solomon & Tatkin, 2011; Heller & LaPierre, 2012). When the caregiver is frightened or frightening, the mother's feelings of fear, hatred, or rage and her image of the child as frightening or unmanageable become internalised by the infant. As this image undermines self-organisation, it must be externalised for the child to achieve a coherent self-representation.

Almond (2010) discusses the phenomena of *motherlove* and *ambivalence*, or the 'combination of the loving and hating feelings we experience toward those who are important to us' (p. 1). According to Almond, psychological and physical child abuse can be traced to maternal ambivalence that is unmitigated by object relatedness and love for the child as a whole other person, and not a clone or extension of the mother. Almond describes two adaptive behaviours of mothers to cope with maternal ambivalence. Mothers who adopt an *internalising solution* ('It's my fault') tend to feel guilty and take the blame for ambivalent behaviours, typically by punishing the self for real or imagined failures and trying harder and harder to be a good mother. Mothers who adopt an *externalising solution* (It's someone else's fault') tend to feel shame and rage and blame the child, who is seen as an embodiment of hated parts of herself or other important figures including parents, siblings, and intimate partners. Chodorow (1978) posits that the gender sameness inherent in the mother-daughter relationship is a particular source of vulnerability, because mothers tend to experience their daughters as more continuous and undifferentiated with themselves as compared with their sons. Almond suggests that choice and control of behavioural templates may be facilitated by the exposure of unconscious forces into conscious awareness, the absence of which may fuel a blind coercion towards destructive action (Almond, 2010, pp. 18-21).

Thus attachment bonding and relational blueprints have important significance for human wellbeing from cradle to grave. Attachment behaviour involves the seeking of proximity to the attachment figure as a secure base, resisting and protesting separations, and seeking safe haven by turning to the attachment figure in times of threat. Early vulnerability and the intergenerational transmission of abuse and neglect may stem from the poor establishment of agentive self-structure in primary attachment relationships. The major difference between attachment in childhood and adulthood is the role of the caregiver. In childhood the infant seeks comfort and protection from the parent as attachment figure, whereas in adulthood each partner respectively can both seek and provide care and comfort. (Howe, 2011)

2.2.3 Emotion Regulation and the Stress Response

The regulation of affect and response to stress are established in early relationships and mediate physical and psychological adaptation to the social environment across the lifespan. *Affects* are primary biological motivating mechanisms consisting of both emotions and feelings and understood as having primacy in human agency (Tomkins, 1995a, 1995b). *Emotions* are biological, universal and recognisable through facial expressions cross-culturally, whilst *feelings* are subjective and specific to culture, family, and individual characteristics. Ekman defines *happiness, sadness, anger, fear, and disgust* as the five basic emotions in terms of distinctive universal signals and preceding events, distinctive physiological responses, presence in other primates, quick onset, brief duration, automatic appraisal, and unbidden occurrence (Ekman, 1992; Ekman & Davidson, 1994). Maciocia cites the neurobiological view of human emotion as a 'pleasant or unpleasant mental state organ-ised in the limbic system of the mammalian brain' (2009, p. 303), in which facial and body movements, gestures and postures are the visible manifestation of neurotransmitter activity in the brain. LeDoux (1996) classifies two emotional responses systems in the brain: Type I (immediate, automatic, involuntary responses originating in the amygdala and acting as an early warning system to threats in the evolutionary experience of the species) and Type II (mediate, specific, voluntary responses involving the neocortex and cognition of past experience to the current situation). The first type of emotional response supports the Stoic belief that emotional responses are beyond control, and the second type lends support to the Aristotelian belief that emotional responses can be regulated. Mind-body dualism is rejected by Damasio (1994), who posits that somatic markers from the body are integrated in rational decision-making processes.

The domains of *emotional intelligence* include self-awareness, self-regulation, motivation, empathy, and social skill (Goleman, 1995; as cited in McKenzie & Hassed, 2012, p. 239). The development of emotional self-awareness and control are attributed to the social biofeedback model of parental mirroring (Fonagy et al., 2002, p. 161). Dynamic changes in internal affect state are behaviourally expressed by the infant and scaffolded by the parent's repetitive and saliently marked emotional presentation, establishing primary regulation and secondary representation of the infant's emotion states (e.g., Bion, 1962; Winnicott, 1967; Kohut, 1971; Mahler et al., 1975; Kernberg, 1984). Parents who react to the infant's negative affect expression by producing the same, unmarked emotion expression due to own unresolved inner conflicts will amplify the baby's negative state, leading to dysregulation rather than parental containment (Main & Hesse, 1990). The infant adopts a compliant stance leading to establishment of the *false self* structure, an empty self whose own constitutional state has not been validated (Fonagy et al., 2002, p. 196). The capacity for mentalisation is a core determinant of self-organisation and affect regulation. Winnicott (1965) argues that privation is experienced where the infant does not have an awareness of maternal care and mirroring is

marked but distorted, whereas in deprivation the infant has awareness of own needs and affective mirroring is unmarked and congruent, which is a risk for later pathological externalisation and violence (Fonagy et al., 2002, pp. 196-198).

Stress is defined by Verma and colleagues as 'real or interpreted threat to the physiological or psychological integrity of an individual that results in physiological and behavioural responses' (2011, p. 4). The *stress response* consists of activation of the autonomic nervous system and hypothalamic-pituitary-adrenal (HPA) axis, alterations in levels of anxiety, a loss of cognitive and affective flexibility, and inhibition of vegetative processes such as sleep, sexual activity, and endocrine programmes for growth and reproduction that may impede survival during a life-threatening situation (Gold & Chrousos, 2002; Phillips 2007). The normal range of arousal and physiological baseline of the stress response and emotional system are established in a social pedagogical process in the early life. *Dysregulation* refers to the 'somatoaffective, neurobiological condition that involves extreme negative alterations of the brain, the mind, and the body' (Solomon & Tatkin, 2011, p. 105). Social experience in an attachment context in developmental periods of neural plasticity facilitates the development of an interpersonal interpretive capacity of the social meaning of internal states in self and other, which plays a key role in the processing of social experience and genetic expression (Fonagy et al., 2002, pp. 141-142). Gerhardt claims that well-managed babies learn to expect a responsive environment, babies of depressed mothers adapt to low stimulation and a lack of positive feelings, and babies of agitated mothers adapt to hyperarousal (2004, p. 19).

Robertson outlines an applied relaxation approach in which stress and negative emotions are viewed as the reciprocal and spiralling interaction between certain thoughts, physiological reactions, and feelings (2012, pp. 152-177). Awareness of early warning signs in self and others is promoted as a key to breaking the chain of distress and enabling generalised and situation-specific relaxation. Typical early warning signs of stress or anxiety include:

- fidgeting such as hair twisting, nail biting, feet tapping, finger drumming
- moving or walking more quickly, acting agitated or pacing up and down
- rapid speech, tense voice, pausing less between sentences, changing pitch or volume
- rapid breathing, shallow breathing, irregular breathing, holding the breath, sighing
- changes in facial expression, particularly frowning, scowling, squinting, staring
- tensing other parts of the body, particularly clenching the jaw or grinding the teeth, tensing the neck or hunching the shoulders, clenching the hands into fists
- physiological sensations such as increased heart rate, trembling, sweating, nausea, butterflies in the stomach, choking, a dry mouth, a lump in the throat, hot flushes, blushing, dizziness
- worry such as thoughts or images about things going wrong or about inability to cope (Robertson, 2012, pp. 159-160).

Stress is viewed in Western culture as a 'loss of control' and in Eastern cultures as an 'absence of inner peace' (Tatkin, 2011, p. 169). Pert (1997. pp. 242-243) defines disease-related stress as a condition of information overload, in which suppressed trauma or undigested emotions form unprocessed sensory input so that the mind-body network has become blocked and cannot flow freely. As stress impedes autonomic processes such as breathing, blood flow, immunity and digestion that are regulated by peptide flow, vital emotional and physical information becomes indefinitely stored at the cellular level. The *allostatic load* (McEwen, 2000) refers to the total stress expenditure and is strongly influenced by relationships with others, in particular the primary attachment relationship. A heavy allostatic load is correlated with ill health of metabolic, cardiovascular, inflammatory, and autoimmune physiological systems. Chronic stress exerts a heavy toll on the body and mind (Rothschild, 2006).

The sympathetic nervous system (SNS) is activated under conditions of positive and negative stress, including sexual climax, rage, desperation, terror, anxiety/panic, or trauma. The hypothalamus stimulates production of corticotropin releasing hormone (CRH), which regulates the production of stimulating neurotransmitters and hormones such as noradrenaline, dopamine, and adrenaline to mobilise the body for fight or flight (Cannon, 1932). Discernible signs of SNS activation include increased respiration and heart rate, increased blood pressure, pupil dilation, pale skin colour, increased sweating, cold and possibly clammy skin, nausea and decreased digestion and peristalsis. The parasympathetic nervous system (PNS), on the other hand, activates during conditions of rest and relaxation, sexual arousal, happiness, anger, grief, or sadness. Discernible signs of PNS activation include slower and deeper respiration, decreased heart rate and blood pressure, pupil constriction, flushed skin colour, dry and warm skin, increased digestion and peristalsis. In response to signals of danger the pituitary stimulates the adrenals to release cortisol, the body's stress hormone. When fight or flight is successful, the amygdala's alarm is titrated by cortisol and the nervous system is returned to a state of homeostasis. When fight or flight is not possible or unsuccessful the amygdala remains activated and the SNS continues to prepare the body for fight or flight, resulting in chronic hyperarousal of the autonomic nervous system. Symptoms include a hyper startle response, hypervigilance, and difficulty staying asleep, which are indicators of posttraumatic stress disorder (PTSD) (Rothschild, 2006, pp. 98-101).

The *traumatic stress response* is conceptualised as 'alteration of the biochemical stress response system in the brain that changes an individual's ability to respond efficiently and efficaciously to future stressors' (Wilson et al., 2011, p. 87). The affected brain regions include the HPA axis, amygdala, hippocampus and prefrontal cortex. Maldevelopment of these regions in child maltreatment is related to an altered developmental trajectory of information processing and emotion regulation with deficits in cognitive capacity, attention, and executive functioning (ibid.). According to Solomon and Tatkin (2011, p. 218), the limbic-

hypothalamic-pituitary-adrenal axis has importance to treatment because of its central role in adaptation to stress and threat. Programming of the HPA axis in utero and psychobiological dysregulation in mothers with very young children may be important factors initiating the metabolic responses and altering sensitivity to the depression and anxiety inducing effects of stressful life events (Verma et al., 2011; Schechter et al., 2004; Glover & Connor, 2002; Henry, 1993). Moreover, trauma-associated dysregulation of the HPA axis in parents may be a marker for an increased risk for intergenerational transmission via parenting behaviour with young children (Schechter et al., 2004; Wand et al., 2001).

Verma and colleagues (2011) report that although the primary physiological response to stress in both males and females is fight or flight, there are biological and psychological differences in stress reactivity and responses for men and women (Kudielka & Kirschbaum, 2005; Lundberg, 2005; Kajantie & Phillips, 2006). Chichinadze and colleagues (2011) studied the responses of males to threatening stimuli in the environment that lead to reactive defensive intermale aggression induced by stress and fear, or offensive intermale aggression induced by frustration. They found that adrenaline and dopamine are the best inductors of aggressive behaviour, and that testosterone cannot be considered as an in situ inducer of aggressive behaviour. Autonomic sympathoadrenal and HPA axis responsiveness are greater in men due to the attenuation of these pathways by female sex hormones and attachment caregiving processes in women. Taylor and colleagues (2000) propose that the female behavioural responses are marked by a pattern of tend-and-befriend in response to stress. *Tending* involves nurturant activities towards the self and offspring to promote safety and reduce stress and *befriending* is the creation and maintenance of social networks that may aid this process (p. 411). Furthermore, Beck (1983) posits that depression in association with stressful life events may be predicted by elevated levels of the personality characteristics sociotropy and autonomy. *Sociotropy* reflects an increased need to secure attachments in interpersonal relationships by pleasing others to avoid disapproval; while *autonomy* reflects an increased need for independence and freedom by controlling others to reduce the possibility of failure.

Biopsychological dysregulation in close relationships involves processes of engagement and disengagement that tend to escalate over time (Solomon & Tatkin, 2011, p. 116). Tatkin (2011) describes the dynamics of intimate relationships with regard to parts of the nervous system that he calls the loving brain (the 'ambassadors' or the higher, social brain) and the warring brain (the 'primitives' or the amygdala, hypothalamus, pituitary and adrenal glands, and dorsal motor vagal complex or dumb vagus) (see Table 2). The loving and warring brains are referred to by Siegel (2010, p. 26) as the high road and the low road respectively. The primitives of the warring brain identify dangers and threats inside and outside the body. Threat signals are picked up by the amygdala, in which the right side responds to dangerous facial expressions, voices, sounds, movements, and postures, and the left side responds to

Table 2: The Loving and Warring Brains in Action.

Brain 'Ambassadors' and their Actions	Brain 'Primitives' and their Actions
Ventral vagal complex (smart vagus): Exerts a calming effect by slowing the cardiovascular and respiratory systems	***Amygdala:*** Pick up threat signals (e.g., dangerous words and phrases; dangerous faces, voices, sounds, movements, postures, smells)
Hippocampus: handles short-term and long-term memory, controls anti-stress hormones, and tracks location and direction	***Hypothalamus:*** Releases chemicals in the brain and gives instructions to the pituitary and adrenal glands to release stress chemicals into the body; signals the need to fight, flight, or freeze
Insula: Provides awareness of internal bodily cues (e.g., gut feelings), including cues associated with attachment and empathy	***Pituitary and adrenal glands:*** Receive commands from the hypothalamus to release stress chemicals
Right brain: Nonverbal and intuitive; specialises in social and emotional processing (e.g., empathy) and body awareness	***Dorsal motor vagal complex (dumb vagus):*** Reacts to stress or danger by extensively slowing the cardiovascular and respiratory systems
Left brain: Verbal and logical: specialises in processing detailed information and integrating complex sounds and word meanings	
Orbitofrontal cortex: Serves as the moral and empathic centre, communicates with ambassadors and primitives alike, keeping them in check	

Source: Adapted from Tatkin, 2011 (pp. 27, 34).

dangerous words and phrases. The hypothalamus directs the pituitary and adrenal glands to release stress response hormones adrenaline and cortisol for action. Adrenaline signals readiness for the fight or flight response, while cortisol helps adapt to stress by reducing inflammation and damage in the body. Physical or emotional injury and threat can trigger the dorsal motor vagal complex to shut down, resulting in responses including loss of blood from the face, loss of muscle tone, ringing in the ears, stomach pain, slumping or drooping of posture, collapse, or fainting.

Intimate partners can 'make love and avoid war' by developing and maintaining an 'owner's manual' for one another and for their relationship (Tatkin, 2011, pp. 26-43). Awareness and understanding of early attachment blueprints supports the reciprocal provision of protection and safety in intimate relationships as well as the rapid correction of insecurity and threat to the relational bond. Partners may provide clues about their default settings with regard to physical proximity, emotional intimacy, and issues of security during the courting phase of a relationship. The relational blueprints are activated when the relationship becomes permanent in either or both partners' minds. In the absence of awareness of self and other, partners may ruminate that they chose the wrong person, or develop a tendency to wish the other would listen to them, change, or do things their way, contributing to a vicious cycle of relational conflicts founded on misattunements and unmet needs (Tatkin, 2011, pp. 46-47, 67; Fisher et al., 2005). Gottman and Silver (2004) rate *contempt*, which is a form of psychological abuse including disgust, condescension, and sarcasm, as the strongest predictor of divorce. Contempt erodes the intimate relationship and influences behaviour disorders in children (Katz & Gottman, 1993).

Tatkin (2011) hypothesises that children who receive lots of positive attention and social interaction with adult brains develop more integrated brains than deprived children. Children and adults with integrated and well-regulated orbitofrontal cortices, left and right brains, smart vagal systems, breath and vocal control, and communication skills are more resilient and better able to handle emotions and impulses (pp. 48-49, 71). Deprivation of early affect-regulative mirroring interactions by attachment figures may be implicated in the etiology of affective and dissociative disorders and pathologies of the self. Fonagy and colleagues (2002, p. 251) posit that many common symptoms and problems, such as impulsivity, emotional dysregulation, and the predominance of primitive defences, are due to absence of mentalistic functioning in the self as agent. Negative states may stem from traumatic memories, conscious or unconscious mental representations of real or imagined interpersonal conflicts and interactions, or socially unacceptable desires generating intolerable feelings of fear, anxiety, helplessness, guilt, shame, anger, or rage (ibid., p. 295). Emotion dysregulation has been associated with sexual offending (Gillespie et al., 2012).

Neuroplasticity describes the 'capacity for creating new neural connections and growing new neurons in response to experience' and can occur throughout the lifespan (Siegel, 2010, p. 5). Individual experience, interpretation, and recovery from trauma are influenced by developmental status at the time of the traumatic event (van der Kolk & Sapporta, 1991). The impact of both traumatic experience and neuroplasticity may be greatest at periods of major reorganisation and integration of biological and behavioural systems of the individual, including early childhood and adolescence (Yates, 2004, p. 51). The importance of mutual eye contact and reading facial expressions of social cues for brain development and empathic attunement is emphasised (e.g., Goleman, 1995; Gerhardt, 2004; Szalavitz & Perry, 2010; Solomon & Tatkin, 2011; Tatkin, 2011); loss of eye contact interrupts social scaffolding and shifts the individual into a more internal, static, and historical perspective (Tatkin, 2011, p. 145). Furthermore, the restorative benefits of nature are advocated to ameliorate the effects of information processing demands and stress on mental fatigue (Kaplan, 1995).

2.2.4 Social Ecology as a Foundation for Resilience and Growth

The study of people in an environment and the influences on one another is known as social ecology (Hawley, 1950). The inputs of the physical environment, the social environment, and the cultural environment and the settings for action at macro, exo, meso, and micro levels are taken into account by a social ecological approach. The ecological environment comprises a set of nested structures that are embedded like a set of Russian dolls (Lewin, 1931, 1935; Bronfenbrenner, 1979, 1994, 2004).

The emergence of a bioecological explanation of human social behaviour highlights human infancy and adolescence as critical periods in the development of the social brain and

biological systems involved in emotional regulation. Humans are first and foremost social beings, and brain development in infancy is founded on learning to perform in socially acceptable ways. The theory of primary love explains the early cathexis and fundamental role of human contact in child development (Balint, 1939, 1965). Gerhardt (2004) purports that love is essential to brain development in the early years of life. The earliest relationship shapes the baby's nervous system, scripting a relational blueprint - the invisible infant story of each individual life history - that is carried within and enacted throughout our close relationships. Although not consciously recalled, infancy is not forgotten because it is psychologically and physiologically structured into the body and informs characteristic ways of relating, expectations, and coping (Gerhardt, 2004, pp. 14-15). Siegel (2010) advocates that people can develop more compassion and understanding both for the self and the other person in the relationship by knowing about the different functions of the brain (p. 13). The 'ABC's of attachment' - attunement, balance, and coherence – are facilitated by the ability to move within the dyadic diaspora of supportive, empathic emotional relationships to create feelings of safety, security, and contingency. The underlying processes include eye contact, facial expression, tone of voice, gestures, bodily posture, and timing; internal regulation of physiological processes; and integrated, organised, and adaptive brain functioning (Siegel & Hartzell, 2003).

Emotional resilience is defined as 'positive adaptation in the context of significant challenges, variously referring to the capacity for, processes of, or outcomes of successful lifecourse development during or following exposure to potentially life-altering experiences' (Masten et al., 2009, p. 119). The opposite of resilience is vulnerability. According to Graham a solid neural foundation for resilience is built by healthy early conditioning in the brain, embedding a buffer against the effects of external stressors and traumas later in life (2013, pp. 4-5). Reivich and Shatté classify four main types of cumulative risk factors that typically call for resilience and may cause stress-related symptoms or mental health disorders and impair the quality of life: (1) overcoming childhood problems, such as experiencing abuse or neglect or coming from an impoverished or broken home, (2) living with daily hassles and minor adversities such as relationship arguments, difficulties at work, and challenges of everyday living, (3) recovering from major setbacks such as redundancy, financial problems, bereavement, separations, serious illness, being the victim of violence or other serious crime, or experiences of natural disasters, war or terrorism, and (4) reaching out for greater meaning and purpose (2002, p. 15).

Protective factors that foster resilience include resonant relationships; healthy self-esteem and self-acceptance; emotion self-regulation; somatic equilibrium; and response flexibility (Graham, 2013). Long-term psychological resilience is supported by prevention and resolution of social problems, building of social skills, strengthening relationships, and improving social support networks (Robertson, 2012, p. 245). Graham (2013) and Robertson (2012) advocate

mindfulness-based practice that emphasises acknowledging and accepting unpleasant thoughts and feelings rather than trying to eliminate or avoid them through experiential avoidance, which may lead to more serious problems in the long term (Robertson, 2012, pp. 6-9). *Mindfulness* is defined by McKenzie and Hassed (2012) as 'the practice of paying attention – knowing where our attention is and being able to choose where to direct it' (p. 1). Mindfulness practice has been shown to exert a positive influence on health, wellbeing, and happiness (Kabat-Zinn, 2005; Peterson, 2006; Williams & Penman, 2011). Examples of mindfulness-based practice include acceptance-based, positive psychology approaches to stress management (e.g., Penn Resiliency Programme (PRP), Reivich & Shatté, 2002; Acceptance-Based Behaviour Therapy (ABBT), Roemer & Orsillo, 2009; Relaxation Response, Benson & Proctor, 2010; Master Resilience Training (MRT) Programme, Seligman, 2011).

Empathy is an evolutionary phenomenon that gives insight into another's state of being and facilitates the bonding of people to one another (Rothschild, 2006, p. 34). When the process of empathy is not conscious, however, vicarious emotional contagion can exceed one's ability to moderate, leading to strong emotional and somatic impact (ibid., p. 29). The term *compassion fatigue* is applied when an individual suffers as a result of serving in a helping capacity (Figley, 1995). *Primary traumatisation* refers to the impact of a traumatic incident on the immediate victim of the incident. *Secondary traumatisation* involves suffering by eyewitnesses of a traumatic incident or by family members and significant others due to a loved one's trauma. *Vicarious traumatisation* involves experience of the client's trauma by the practitioner in his or her nervous system. *Burnout*, on the other hand, describes the impact or overload of work that leads to ill health or a negative outlook on life (Rothschild, 2006, pp. 12-15). Practitioners who are working with stressed and traumatised individuals and are unaware of the state of their own body and mind are at high risk for compassion fatigue, vicarious traumatisation, and burnout. Rothschild advocates the importance of mindfulness, regulation of the symptoms of autonomic nervous system arousal that originate in the client's states, and self-care (ibid., pp. 103-104).

The practitioner may also experience *countertransference*, which refers to the practitioner's reactions to the client that have roots in the practitioner's own past trauma or history of suffering (Rothschild, 2006, pp. 18-19). Rothschild observes that it is common for internalised interpersonal and relational patterns and dynamics from the past to arise and be re-enacted within relationships, necessitating awareness by the practitioner of own feelings as separate from those of the client. Rothschild suggests that the somatic impact of work stress can be reduced by the use of unmirroring techniques that counter the intrusive impact of empathic attunement, such as sitting up straight, crossing or uncrossing legs, blinking, taking a deep breath, exhaling, changing breathing, tensing specific muscles, taking a drink, writing some notes, stretching, visiting the restroom, or moving around (ibid., pp. 93-94). Other contributing factors and costs of compassion fatigue, vicarious traumatisation and burnout

include general workplace problems such as inadequate management, long working hours, heavy client loads, undercompensation, colleague and administrative conflicts, workplace bullying, lost work hours due to sick days and leave, worker's compensation claims, early retirement, harm to relationships with family and friends, and substance abuse (ibid., p. 11).

Posttraumatic growth refers to the perception of positive benefits that may emerge over time after trauma, for example positive change in the sense of self, improved interpersonal relationships, a positive philosophy of life (Tedeschi & Calhoun, 1996, 2004; McGrath & Linley, 2006; Abreu et al., 2009), less controlling behaviour, letting go of burdens and worries, focusing on the present (Stone, 2005; Williams et al., 2005), changes in spirituality (McColl et al., 2000), reprioritising what was important in life, engagement in a healthy lifestyle, and developing unselfish concern for others (Gillen, 2005). On the other hand, trauma may be associated with negative outcomes such as psychological distress or support for retaliatory violence and radical political attitudes post terrorism (Hobfoll et al., 2007). *Vicarious growth* refers to the positive consequences of the caring professions. *Compassion satisfaction* describes the sense of fulfilment or pleasure derived by practitioners from doing their work well, including helping and engaging with others, contributing to the work setting, contributing to the greater good of society (Stamm, 1999, 2002, 2005), social connectedness, and social responsibility (Joseph & Linley, 2008).

Abreu and colleagues advocate the identification and analysis of both positive and negative emotion regulation in rehabilitation and health care after trauma (2009, p. 229), and the use of positive psychology (Csikszentmihalyi & Csikszentmihalyi, 2006; Eid & Larsen, 2008) to amplify the strengths and coherence of the individual rather than to repair the weaknesses (Diener & Seligman, 2002; Seligman, 2005, 2011; Seligman & Csikszentmihalyi, 2000). *Optimism*, or the tendency to view events and conditions with positive expectations, can affect adaptation after trauma and disability (Grote et al., 2007). Pessimists are more likely to respond using denial and avoidance, whilst optimists use planning, problem-focussed coping, reframing, and acceptance (Scheier & Carver, 1992) and have lower risk of developing clinical depression compared with pessimists (Isaacowitz & Seligman, 2001; Scheier et al., 1986). Heller and LaPierre (2012) argue that focusing on and analysing problems may increase nervous system disorganisation and emotion dysregulation, which is at the core of vulnerability to stress, and thus may contribute to increased fragmentation and retraumatisation. Complementary somatic and cognitive methods to support self-regulation of the autonomic nervous system and emotions as well as the capacity for connection to self and others are recommended. As we develop more compassion for ourselves and our loved ones, we also widen the circle of compassion beyond our immediate environment and 'change the course of cultural evolution in a positive direction' (Siegel, 2010, pp. 260-261).

2.3 Health-Promotive Violence Prevention

Violence is both predictable and preventable, and health promotion has a crucial role to play in addressing the causes and consequences of violence (Krug et al., 2002; Macdonald, 2002; Ryan, 2005). This section presents a review of the concept of violence, risk factors for violence, psychopathological dynamics of intra- and interpersonal violence, and the case for violence prevention.

2.3.1 The Concept of Violence

The World Health Organization defines *violence* as:

> 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.' (Krug et al., 2002, p. 5)

Violence is a global issue with a substantial burden on individuals, families, communities and health care systems worldwide. Violence occurs in all social classes and cultures; however it is more prevalent in some communities than in others. The consequences of violence can be immediate as well as latent, often lasting for years and across generations after the initial abuse. Krug and colleagues (2002) classify violence into three broad categories (see Table 3)

Table 3: A Typology of Violence.

CATEGORY OF VIOLENCE	DEFINITION	EXAMPLES
Self-directed violence	Violence inflicted by a person upon himself or herself	**Suicidal behaviour** **Self-abuse**
Interpersonal violence	Violence inflicted by another individual or by a small group of individuals	**Family and intimate partner violence:** violence largely between family members and intimate partners, usually, though not exclusively, taking place in the home **Community violence:** violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home
Collective violence	Violence inflicted by larger groups such as states, organised political groups, militia groups and terrorist organisations	**Social violence:** crimes of hate committed by organised groups, mob violence **Political violence** includes war and related violent conflicts, terrorist acts, state violence and similar acts carried out by larger groups **Economic violence** includes attacks by larger groups motivated by economic gain – such as disrupting economic activity, denying access to essential services, or creating economic division and fragmentation

Source: Adapted from Krug et al., 2002 (pp. 6-7). Used with kind permission of WHO.

according to characteristics of those committing the violent act: self-directed violence, interpersonal violence, and collective violence. These three broad categories are divided into further subcategories to reflect more specific types of violence including suicidal behaviour, self-abuse, family and intimate partner violence, community violence, social violence, political violence, and economic violence. (Krug et al., 2002, pp. 5-7)

There is no single factor that explains the causes of violence. The complex interaction of individual, relationship, community, and societal risk factors and protective factors affecting violent behaviour is represented in the *ecological model for understanding and preventing violence* (see Figure 8). The ecological model views interpersonal violence as the product of multiple levels of influence on behaviour. (WHO, 2004, pp. 4-5; Krug. et al., 2002, pp. 12-15)

- The first level of the ecological model identifies individual biological and demographic factors that increase the likelihood of being a victim or a perpetrator of violence, such as prior history of maltreatment as a child, psychological or personality disorder, substance abuse, and history of aggressive behaviour or having experienced abuse.

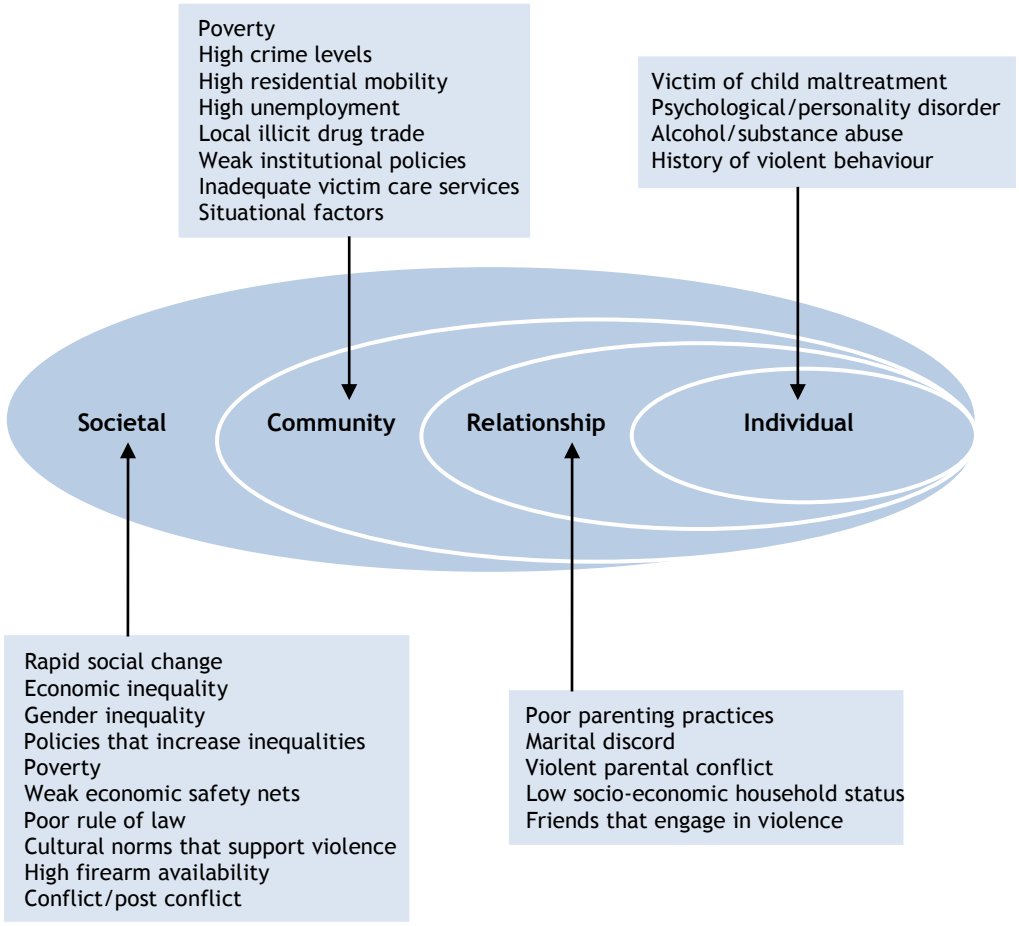

Figure 8: Ecological Model Showing Shared Risk Factors for Subtypes of Interpersonal Violence. Source: WHO, 2004 (p. 4). Used with kind permission of WHO.

- The second level of the model explores how close social relationships with family members, intimate partners and peers increase the risk for violent victimisation and perpetration of violence, including poor parenting practices, marital discord and violent parental conflict, low socio-economic status, and use of violence by peers.
- The third level of the model identifies the characteristics of community settings such as schools, workplaces and neighbourhoods that are associated with violence, including poverty, crime levels, population density and mobility, unemployment, weak institutional policies, local drug trafficking or gun trading, inadequate victim care services, or widespread social isolation.
- The fourth and final level of the model examines larger societal factors that encourage or inhibit violence, such as the influence of economic and social policies on the level of socio-economic inequalities between groups and the provision of safety nets in society. Societal factors also include rapid social change, the availability of weapons, poor rule of law, political conflict or a history of violent conflict, social and cultural norms such as those relating to male dominance over females, parental dominance over children, and cultural norms that support violence as an acceptable method of conflict resolution.

The ecological model can be applied to identify and cluster intervention strategies at the four different levels. The World Health Organization (2004, p. 3) observes the frequency of specialised interventions that focus on a single subtype of interpersonal violence. From a developmental context, violence may be caused by different factors at different stages of the life cycle. However, there is increasing evidence that a set of common causes and risk factors underlies the different subtypes of interpersonal violence. Prevailing cultural norms, poverty, social isolation, alcohol abuse, drug abuse and access to firearms are risk factors for more than one type of violence and therefore some at risk individuals experience multiple types of violence. As a result, addressing risk factors across the levels of the ecological model may contribute to a decline in more than one type of violence (Krug et al., 2002, pp. 14-15).

Family violence, which is also known as domestic violence, occurs in all societies and cultures and can take different forms (see Table 4). Family violence is divided into violence against intimate partners, child neglect and abuse, sibling abuse, and elder abuse (see e.g., Krug et al., 2002; Ryan, 2005; for a review). As a phenomenon family violence causes tremendous suffering and pain, as partners, children or elders are repeatedly abused, injured or humiliated by the very people who should love and protect them. *Intimate partner violence* refers to 'any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship' (Krug et al., 2002, p. 89). Various types of abuse typically co-occur in the same relationship; physical violence is generally accompanied by psychological abuse and various controlling behaviours, and in one-third to over one-half of cases by sexual abuse (ibid., p. 91).

Table 4: Forms of Domestic Violence.

EXAMPLES OF FAMILY AND INTIMATE PARTNER VIOLENCE	
Physical abuse	hitting, slapping, kicking, choking, pushing, punching, beating, biting, pinching, scratching, hair pulling, burning, poisoning
Sexual abuse	forcing sex on an unwilling partner, demanding sex acts that the victim does not want to perform, withholding sex
Economical abuse	not paying bills, refusing to work and support the family, refusing to give money to the victim, not letting the victim work, interfering with the victim's job
Psychological abuse	**Verbal abuse:** constant criticism, making humiliating remarks, mocking, name-calling, yelling, swearing, interrupting, changing the subject, not responding to what the victim is saying, silent treatment **Isolation:** making it hard for the victim to see friends and relatives, monitoring phone calls, monitoring social media, reading mail, controlling where the victim goes, taking the victim's keys or wallet **Coercion:** making the victim feel guilty, pushing the victim into decisions, sulking, manipulating children and other family members, always insisting on being right, making up impossible 'rules' and punishing the victim for breaking them **Harassment:** following or stalking, constantly checking up on the victim, embarrassing the victim in public, refusing to leave when asked **Abusing trust:** lying, breaking promises, withholding important information, being unfaithful, being overly jealous, not sharing domestic responsibilities **Threats and intimidation:** threatening to harm the victim, the children, family members and pets, using physical size to intimidate, shouting, keeping weapons and threatening to use them **Emotional withholding:** not expressing feelings, not giving compliments, not paying attention, not respecting the victim's feelings, rights and opinions, not taking the victim's concerns seriously **Destruction of property:** destroying furniture, punching walls, throwing things, breaking dishes **Self-destructive behaviour:** abusing drugs or alcohol, threatening suicide, cutting, eating disorders, gambling, stealing, driving recklessly, deliberately doing things that will cause trouble

Source: Adapted from International Child Abuse Network, 2012.
Used with kind permission of Yes ICAN.

The World Health Organization has reported two patterns of intimate partner violence:

- *Common couple violence*: a moderate form of relationship violence, where continuing frustration and anger occasionally erupt into physical aggression
- *Battering*: a severe, repetitive and escalating form of violence characterised on the part of the abuser by multiple forms of abuse, terrorisation, threats, and increasingly possessive and controlling behaviour. (Krug et al., 2002, p. 93)

Intimate partner violence occurs in all countries irrespective of social, economic, religious or cultural group. Denial and the fear of being socially ostracised often prevent partners from seeking help (ibid., p. 96).

Child abuse and neglect is a global problem that occurs in a variety of forms and is deeply rooted in cultural, economic and social practice (Krug et al., 2002, p. 59). The WHO Consultation on Child Abuse Prevention drafted the following definition of child abuse:

> 'Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power'. (WHO, 1999, p. 8)

The categories, definitions and examples of child abuse and neglect are summarised in Table 5. Neglect can occur only in cases where reasonable resources are available to the family or caregiver, and is thus distinguished from circumstances of poverty (Krug et al., 2002, p. 60).

Table 5: A Typology of Child Abuse and Neglect.

CATEGORY OF ABUSE	DEFINITION	EXAMPLES
Physical abuse	Those acts of commission by a caregiver that cause actual physical harm or have the potential for harm	**Severe physical punishment**: hitting the child with an object (not on buttocks), kicking the child, burning the child, beating the child, threatening the child with a knife or gun, choking the child **Moderate physical punishment**: spanking the buttocks (with hand), hitting the child on the buttocks (with object), slapping the child's face or head, pulling the child's hair, shaking the child, hitting the child with knuckles, pinching the child, twisting the child's ear, forcing the child to kneel or stand in an uncomfortable position, putting hot pepper in the child's mouth
Sexual abuse	Those acts where a caregiver uses a child for sexual gratification	Rape, forcing sex on the child, demanding the child to perform sex acts
Emotional abuse	The failure of a caregiver to provide an appropriate and supportive environment, and including acts that have an adverse effect on the emotional health and development of a child	Restricting the child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other nonphysical forms of hostile treatment, yelling or screaming at the child, calling the child names, cursing at the child, refusing to speak to the child, threatening to kick the child out of the household, threatening abandonment, threatening evil spirits, locking the child out of the household
Neglect	The failure of a parent to provide for the development of a child – where the parent is in a position to do so – in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions	Noncompliance with health care recommendations, failure to seek appropriate health care, deprivation of food resulting in hunger, the failure of a child to thrive physically, exposure of children to drugs, inadequate protection from environmental dangers, abandonment, inadequate supervision, poor hygiene, deprivation of an education

Source: Adapted from Krug et al., 2002 (pp. 60-65). Used with kind permission of WHO.

According to an international study by Gilbert and colleagues (2008) on child maltreatment in high-income countries, about 4 to 16% of children are physically abused and one in ten is neglected or psychologically abused. Official rates for substantiated child maltreatment were estimated to indicate less than one-tenth of the actual burden. The authors noted that neglect had received less scientific and public attention, but was at least as damaging as physical or sexual abuse in the long term. The study found serious and long-term consequences of child maltreatment on mental health, drug and alcohol misuse (especially in girls), risky sexual behaviour, obesity, and criminal behaviour. Due to the high burden the study called for increased investment in preventive and therapeutic strategies from early childhood (e.g., Liu, 2011). Ryan (2005) reports that a substantial amount of child sexual, physical and emotional abuse is perpetrated in sibling relationships, yet child protection has focused on adult-child relationships (Ryan et al., 1996; Wiehe, 1996; Renner, 2012).

The *corporal punishment* of children, or physical discipline administered in forms such as hitting, slapping, punching, kicking or beating, is socially and legally accepted in many countries and a significant phenomenon in families, schools and institutions for young offenders. Corporal punishment results in the injury and death of thousands of children each year in the short term. In the longer term, research has shown the positive correlation of corporal punishment in the development of violent behaviour and with other problems in childhood and later life (Krug et al., 2002). The United Nations '*Convention on the Rights of the Child*' underlines that corporal punishment is incompatible with the Convention, requiring states to protect children from 'all forms of physical or mental violence' while they are in the care of parents and others (United Nations, 1989). Sweden was the first country to prohibit all forms of corporal punishment of children in 1979 and followed by many more states (Krug et al., 2002, p. 64), including Finland in 1983 (Child Welfare Act 417/2007; Finlex). The Ministry of Social Affairs and Health in Finland (2010) has enacted '*DON'T HIT A CHILD!*', a national action programme to reduce corporal punishment of children in years 2010-2015. A Finnish survey by the Central Union of Child Welfare in 2007 of 1,000 respondents aged 15 to 79 years reported that 73% of Finnish women and 68% of Finnish men had sometimes used physical punishment of children. Overall, one in four Finns considered the physical disciplining of children as an acceptable behavioural modification technique, despite the fact that corporal punishment had been banned in Finland for 25 years. The survey hypothesised increased use of intoxicants by women as a contributing factor in abuse by women. Families with immigrant backgrounds and faith communities are seen as at risk populations, in which misdiagnosis based on cultural or racial stereotypes may be common.

The World Health Organization (2004) proposes that a public health approach addressing child maltreatment, intimate partner violence, sexual violence, youth violence and elder abuse as a whole and meeting the shared needs of people affected by violence for medical, psychological and social welfare services will reduce all forms of interpersonal violence.

2.3.2 Risk Factors for Violence

Violence is a multifactorial and dynamic phenomenon that cannot be understood in reductionist terms. Various theories on the causes of interpersonal violence, including biological/organic (Johnson, 1996), psychopathological (Greene et al., 1994; Dutton, 1994), family systems (Margolin et al., 1996), behavioural/social learning (Skinner, 1953; Bandura, 1973, 1977, 1986; Mihalic & Elliot, 1997; Adachi & Willoughby, 2011), and feminist (Sugarman & Frankel, 1996; Lenton, 1995), can best be understood as additive rather than competing (see Cunningham et al., 1998, for a review). Current developmental theories of violence and aggression emphasise biological and psychosocial factors, in particular during adolescence (Liu, 2011). Ferguson and Dyck (2012) posit a paradigm change in aggression research to diathesis stress models of aggression instead of social cognitive approaches. Hypotheses about the underlying factors of domestic violence include:

- anger and poor impulse control trigger violent responses to relationship problems
- violence is a manifestation of a dysfunctional relationship
- violence is a learned behaviour emanating from the offender's family of origin
- offenders have diagnosable psychological problems or personality disorders
- men are socialised to accept violence as a means to resolve conflicts
- a culture steeped in sexism provides a blueprint for men to use violence to control their intimate partners. (Paymar & Barnes, 2009, p. 13)

Each of these causal theories will result in different interventions and treatment approaches, such as gender-specific counselling, group counselling, psychotherapy, marriage counselling, and restorative justice (ibid.). Practitioners should complete a risk assessment on the effect of a proposed intervention or treatment model on the safety of victims before adopting any approach (Yang & Mulvey, 2012).

Addressing intimate partner violence is an opportunity to reduce the intergenerational transmission of violence related to witnessing or experiencing violence as a child. Table 6 summarises the factors that have been put forward as being related to the risk of a man perpetrating abuse against an intimate partner. According to the World Health Organization (Krug et al., 2002, pp. 97-99), the risk factors linked to the likelihood of physical violence against a partner include age, low income, family poverty in childhood and adolescence, low academic achievement, aggressive delinquency at the age of 15 years, witnessing or suffering abuse during childhood, and alcohol abuse. Violent partners were also likely to be emotionally dependent, insecure and low in self-esteem, and to have poor impulse control, anger and hostility problems, depression, and high scores on certain scales of personality disorder including antisocial, aggressive and borderline personality disorders. At the relationship level, men with abusive tendencies experience greater levels of marital conflict or discord in the relationship, poverty, overcrowding, stress, frustration, hopelessness and a sense of

Table 6: Factors Associated with a Man's Risk for Abusing His Partner.

FACTORS ASSOCIATED WITH A MAN'S RISK FOR ABUSING HIS PARTNER	
Individual factors	Young age Heavy drinking Depression Personality disorders Low academic achievement Low income Witnessing or experiencing violence as a child
Relationship factors	Marital conflict Marital instability Male dominance in the family Economic stress Poor family functioning
Community factors	Weak community sanctions against domestic violence Poverty Low social capital
Societal factors	Traditional gender norms Social norms supportive of violence

Source: Krug et al., 2002 (p. 98). Used with kind permission of WHO.

inadequacy for having failed to live up to their culturally expected role of providers. It has been observed that the women in these relationships may also be codependent, making it more difficult for them to leave violent or otherwise unsatisfactory relationships (ibid.). *Stalking* describes an intentional pattern of repeated intrusive and intimidating behaviours in the physical or cyber environment that causes the target to feel harassed, threatened and fearful. Stalking is associated with a variety of biological, psychological, and cultural factors and is generally refractive to conventional psychological treatment (Miller, 2012).

Societies often distinguish between 'just' and 'unjust' reasons for abuse and 'acceptable' and 'unacceptable' levels of violence. Buss and Duntley (2011) present an evolutionary approach to explaining intimate partner violence that anticipates predictable forms of sexual conflict in mating relationships. Gender roles may be used as cultural justification for violence, for example if a husband feels that his wife has failed to show obedience and respect or overstepped her limits. Triggers for partner violence by men against women in both industrialised and developing countries include not obeying the man, arguing back, not having food ready on time, not caring adequately for the children or home, questioning the man about money or girlfriends, going somewhere without the man's permission, refusing the man sex, and the man suspecting the woman of infidelity (Krug et al., 2002, pp. 94-95). The World Health Organization reports on studies of the frequency of wife beating which have shown a higher prevalence of wife beating in societies where men have economic and decision-making power in the household, where women do not have easy access to divorce, and where adults routinely resort to violence for conflict resolution (ibid., p. 100). Levinson (1989) further proposes that protection from wife beating is offered by female workgroups, which provide women with a stable source of social support and economic independence from their

husbands and families. According to the World Health Organization (Krug at al., 2002, p. 100) additional factors such as war, conflicts or social upheavals might contribute to higher rates of partner violence, due to easy access to weapons and disruptions to social relations, including the roles of men and women. Women are often more independent and take on greater economic responsibility during economic and social disruption, whereas men may be less able to fulfil their culturally expected roles as protectors and providers. According to the World Health Organization, most abused women are not passive victims and adopt active strategies to optimise their own safety in the marriage and that of their children in the home. The factors that can keep women in abusive relationships may include fear of retribution, a lack of alternative means of economic support, concern for the children, emotional dependence, a lack of support from family and friends, hope that the man will change, or the stigmatisation associated with being unmarried. Leaving an abusive relationship is a process, not a single event and most women leave and return several times before finally deciding to end the relationship. Recognition of the victim's process of denial, self-blame and suffering and of the phenomenon of bilateral couples violence can aid understanding and reduce judgementalism about partners who return to abusive situations (ibid., pp. 95-96).

There is less violence by intimate partners in communities with sanctions, including formal legal sanctions and moral pressure for neighbours to intervene, and access to sanctuaries, either in the form of shelters or family support. The World Health Organization (Krug et al., 2002, p. 99) hypothesises that intimate partner violence will be highest in societies where the status of women is in a state of transition. Where women have a very low status, violence is not needed to enforce male authority. On the other hand, where women have a high status they will probably have achieved sufficient collective power to change traditional gender roles. Thus partner violence is usually highest at the transitional point where women begin to assume nontraditional roles or to enter the workforce, and this risk should also be assessed within the integration of families with immigrant backgrounds. Additional community factors also include norms related to male authority over women, family privacy norms, rates of other violent crime, and social capital. Overall, the risk of partner violence is increased by structural inequalities between men and women, rigid gender roles and notions of manhood linked to dominance, male honour and aggression (ibid., p. 100).

The risk factors for child abuse and neglect can be assessed at all levels of the ecological model for understanding violence: the characteristics of the individual child, the caregiver or perpetrator, the family, the local community, and the social, economic and cultural environment. According to the World Health Organization, the factors increasing a child's vulnerability to child abuse and neglect include young age, sex, prematurity, twinhood, and disability. In most countries boys are reported to be at higher risk than girls for harsh physical punishment, whilst girls are at higher risk than boys for infanticide, sexual abuse, educational and nutritional neglect, and forced prostitution (Krug et al., 2002, pp. 65-66). Caregiver and

family characteristics increasing the risk of abusing and neglecting children include young age, single parenthood, poverty, unemployment, low education, poor physical and mental health, overcrowding, unstable family environment and lack of support networks. In most countries women report using more physical discipline than men; men are the most common perpetrators of life-threatening head injuries, abusive fractures, other fatal injuries, and sexual abuse (for a study of sexual abuse of children by women, see Denov, 2003; Grattagliano et al., 2012). Parents more likely to abuse their children physically also tend to have a greater incidence of prior history of victimisation by abuse, intimate partner violence in the home, low self-esteem, poor control of their impulses, mental health problems, substance abuse, antisocial behaviour, disrupted social relationships, an inability to cope with stress, stress resulting from job changes, loss of income, health problems, isolation and difficulty in reaching social support systems. Furthermore, these parents are reported to display unrealistic expectations about child development, less supportiveness, affection, playfulness and responsiveness to their children, greater irritation and annoyance in response to their children's moods and behaviour, as well as controlling and hostile behaviour. (Krug et al., 2002, pp. 66-68)

Scholarship on abuse by women and studies of the risk factors associated with a woman's perpetration of family violence are limited (see Straus, 2011, for a review). Schechter and colleagues (2004) found that the psychobiological dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis of mothers exposed to violent trauma may be a marker for increased risk of intergenerational transmission via frightening/frightened maternal behaviour with young children. Peled's (2011) review of the literature on maternal child abuse suggests that it increases following domestic violence, and may also be related to women's developmental history and attachment style. Cross and Campbell (2011) posited that women's aggression is inhibited by fear, an adaptive mechanism that reduces exposure to physical danger; however in intimate partnerships oxytocin induces fear-reducing effects and has a possible role in women's aggression and perpetuation of the cycle of violence.

Community factors raising the risk of child abuse and neglect include high levels of poverty, unemployment, population turnover, and overcrowded housing as well as low social capital or social investment in the community. Repeated exposure to violent video games is a causal risk factor for increased aggressive behaviour, cognition and affect and decreased empathy and prosocial behaviour (Anderson et al., 2010). At the societal level family life is affected by the role of cultural values and economic forces in shaping family choices, cultural norms surrounding gender roles, inequalities related to sex and income, parent-child relationships and the privacy of the family, child and family policies such as parental leave, maternal employment and child care arrangements, preventive health care for infants and children, the strength of the social welfare system as a safety net for children and families, the criminal justice system, and larger social conflicts and war. (Krug et al., 2002, pp. 68-69).

2.3.3 Psychopathological Dynamics of Intra- and Interpersonal Violence

Developmental psychopathology provides a conceptual framework for understanding the mechanisms of intra- and interpersonal violence and for integrating diverse theoretical paradigms including aspects of psychoanalytic, neo-analytic, psychosomatic, biological, and behavioural approaches (Yates, 2004). A developmental model clarifies how early traumatic experiences can lead to vulnerabilities in adaptive functioning, predisposing the individual to turn toward injury of self and others as a compensatory regulatory and relational strategy in the negotiation of social interactions. In particular, attachment theory (e.g., Bowlby 1969, 1973, 1980; Ainsworth et al., 1978; Main & Solomon, 1986, 1990; Hesse & Main, 2000) and the organisational theory of development (e.g., Sroufe, 1990, 1996; Fonagy et al., 1991; Fonagy & Target, 1995, 1997; Fonagy et al., 2002) can contribute to a developmental understanding of the widely observed association between childhood trauma and interpersonal violence. Violent behaviour toward the self or others is a nonspecific symptom of psychological distress. The development of regulatory capacity is experience-dependent on the role of the caregiver as an emotional and behavioural regulator for the child in early relationships, and disruptions in infant-caregiver dyadic regulation contribute to subsequent psychopathology. (Yates, 2004)

Psychopathological perspectives allocate a central role to parental loss and deprivation in the formation of adaptive self-destructive and self-stimulating regulatory strategies. Early trauma predisposes the individual to experience intense anxiety and to engage in defensive processes for the management of anxiety (Yates, 2004; Heller & LaPierre, 2012). Janet (1889) posited that the integration of intense affect in trauma is hindered by dissociative defences that interfere with cognition and formation of a personal narrative of the traumatic event (van der Hart & Horst, 1989). Freud (1920, 1926) hypothesised a traumagenic model and repetition compulsion, in which defences to avoid retraumatisation are mobilised through the intense anxiety and sense of helplessness evoked by a traumatic event. Klein (1976) described a reversal of voice, whereby the aim of repetition is to gain a sense of control over the original experience and to facilitate its experiential integration. Yates (2004, p. 46) describes contemporary neo-analytic interpretations of psychoanalysis that posit the shaping of adaptation by internalised experiences of early relationships, rather than by inner drives and conflicts.

There is a significant and growing body of research on the importance of mentalisation as a determinant of cognitive, emotional and social functioning. *Mentalisation* is defined as ‘the process by which we realise that having a mind mediates our experience of the world’ (Fonagy et al., 2002, p. 3). Fonagy posits that all infants search for and need to find their own mind or intentional state in the mind of the caregiver. When the caregiver provides good enough contingent mirroring of affect, the child’s internalised self-representations will connect to the primary, procedural self-states of the constitutional self. Failure of this function in the case of nonreflective, neglectful, or abusive caregiving leads to the development of

alternative regulatory and relational strategies by the infant for containing thoughts and feelings (Winnicott, 1967). An *alien self* comprising the mind of the incontingently responsive caregiver and its absent, misattuned, or malevolent image of the child is internalised and remains unassimilable into the constitutional self. Moreover, in severe maltreatment the internalised alien part of the self will be persecutory and represent insecurity of attachment and persistent danger of self-harm (Fonagy et al., 2002, pp. 358-360). The alien self has functional equivalence to the symbiotic mother described by Mahler (Mahler et al., 1975).

Infants and preschool children function in a nonmentalising mode of psychic equivalence and pretend functioning where external reality is compromised. The poor establishment of agentive self-structure in early childhood and resultant experience of internal chaos creates a constant need in any attachment relationship for *projective identification*, the process of externalisation of the alien self in order for the self to be coherent. The self achieves a temporary sense of control and security for as long as the internalised, hostile alien self is expelled onto the other, resulting in perpetually disorganised close relationships. A developmental crisis may occur in late adolescence and early adulthood, when the struggle for separation and independence arises and the alien self may no longer be externalised in interactions with the caregiver. Terrorised by own thoughts and feelings about lost identity when separated from the caregiver, the adolescent or young adult may exhibit dramatic manipulations or act out as a compensatory regulatory strategy, including self-destructive or suicidal forms of behaviour. Some individuals find a physical other onto whom the alien self may be projected as a way of controlling mental states, creating physical dependence on the significant other as a vehicle for externalisation of hateful, denigrating, and destructive impulses. Because the other is needed for self-coherence there is an intense fear of physical abandonment, as abandonment is equated with reinternalisation of the intolerable, alien self-image and ensuing destruction of the self. (Fonagy et al., 2002, pp. 474-477)

Theory of mind or *empathic inference*, the capacity to interpret the behaviour of self and others by attributing mental states such as beliefs, intentions, and desires, is the means of acquiring an understanding of others as psychological entities, known as *intentional stance* (Dennett, 1987; Ickes, 2009) and thus making human action meaningful and predictable. Mentalisation acts as a buffer that allows the simulation of additional explanations for unexpected events, thus forestalling threatening conclusions and automatic behavioural responses (Fonagy et al., 2002, p. 362). Dutton and White (2012) argue that broad spectrum attachment insecurities, including fearful and preoccupied attachment style, negative emotionality, and borderline personality disorder, constitute the major psychological predictor of intimate partner violence in adolescents and adults. The proposed mechanisms that increase the likelihood of aggression and intimate partner violence in insecurely attached adolescents and adults include alterations in the appraisal of threat due to an inability to call on internalised memories of parental support, poor emotion regulation, and

impulsivity. A history of neglect in infancy and consequent absence of mentalistic functioning in the self as agent, coupled with intense shame generated within an attachment relationship, becomes a potent trigger for violence. In the event that shame-generating experiences of humiliation cannot be ameliorated via mentalisation, unmentalised shame is subsequently experienced as ego-destructive shame-based identifications that threaten destruction of the self (Fonagy et al., 2002, p. 198; Scheff & Retzinger, 2001) and/or pride-based counter-identifications that attempt to disguise shame with virtue (Heller & LaPierre, 2012).

Self-injurious behaviour or self-mutilation refers to self-inflicted, direct, deliberate, and socially unacceptable destruction or alteration of body tissue that occurs in the absence of conscious suicidal intent or pervasive developmental disorder (Yates, 2004, p. 39; Krug et al., 2002, p. 185). Self-injury may serve an intrapersonal regulatory function in response to intrapsychic distress and/or an interpersonal regulatory function for the manipulation of the interpersonal environment (Guralnik & Simeon, 2001). Examples of self-injurious behaviour include cutting, scratching, burning, peeling, or sticking needles into one's skin; pulling one's hair compulsively; banging one's head; biting oneself; hitting one's arm; gouging one's throat or eyes; self-blinding; and the amputation of fingers, hands, arms, limbs, feet or genitalia (Favazza, 1999). Reasons for engaging in self-mutilation include releasing tension, discharging anger toward the self and/or others, decreasing dissociative symptoms (especially depersonalisation and numbing), self-medicating or self-soothing, establishing self-other boundaries, communicating distress, manipulating the interpersonal environment, and relieving feelings of alienation, isolation, and anguish (Briere & Gil, 1998; Simeon & Favazza, 2001; as cited in Yates, 2004).

The lifetime prevalence of self-injurious behaviour in the general population is approximately 10 to 15%, peaking during late adolescence and early adulthood. Significant rates of self-injurious behaviour are reported in individuals with personality disorders (specifically borderline and antisocial personality disorders) or psychoses, eating disorders, and posttraumatic stress disorder. Women are 1.5 to 3 times more likely to self-injure than men and some 5 to 10% of individuals engage in repeated episodes of self-injury (Favazza, 1999). Conversely, men are on average 3 times more likely to commit suicide. Self-injurious behaviour and suicidal behaviour involve very different factors (Krug et al., 2002, pp. 186-188). Fonagy and colleagues suggest that girls and women who have a history of maltreatment self-harm more often than do males because the image of the mother-caregiver resides within their own female body. Men, on the other hand, can more easily externalise the alien self and the thoughts that it represents onto others (Fonagy et al., 2002, p. 476). This dynamic may also be implicated in the prevalence of violence in lesbian relationships (see e.g., Lie & Gentlewarrior, 1991; Renzetti, 1992; Coleman, 1994). In all, there is an accumulating body of evidence to support integration of the developmental psychopathological perspective in future research and intervention efforts in intra- and interpersonal violence prevention.

2.3.4 The Case for Violence Prevention

In its guide to implementing the recommendations of the '*World Report on Violence and Health*', the World Health Organization adopts four overarching themes:

- violence is dealt with as a whole
- an ecological model is used to help understand the causes, consequences and prevention of interpersonal violence
- a public health approach is promoted for multisectoral prevention activities
- violence prevention is addressed as distinct from crime prevention.
  (WHO, 2004, p. 3)

Public health aims to provide the maximum benefit for the largest number of people. A public health approach to interpersonal violence prevention requires the involvement of multiple sectors and disciplines. The steps involved in the approach are the systematic collection of information to define the scope and characteristics of the problem; identification and research of the risk and protective factors that increase or decrease the likelihood of violence; development and evaluation of interventions to determine what works in preventing violence; and implementation and evaluation of effective and promising interventions in a wide range of settings (ibid., p. 5). Public health interventions are implemented at three levels of violence prevention:

1. *Primary prevention*: aims to prevent violence before it occurs
2. *Secondary prevention*: immediate responses to violence, such as emergency services, hospital care, or treatment for STDs following a rape
3. *Tertiary prevention*: approaches that focus on long-term care in the wake of violence (such as rehabilitation and reintegration) and attempts to lessen trauma or reduce the long-term disability associated with violence.
   (Krug et al., 2002, p. 15)

A sustainable and ecological violence programme comprises universal interventions aimed at the general population; selected interventions aimed at risk groups; and indicated interventions aimed at perpetrators who have already demonstrated violent behaviour (ibid.). A criminal justice approach to preventing violence aims to deter violent behaviour at the individual level with the threat of punishment for violence acts. According to the World Health Organization (2004, pp. 5-6) the criminal justice approach is not sufficient for the primary prevention of interpersonal violence at the population level and should be supplemented by the public health approach, which addresses the underlying relationship, community, and societal factors that exert a long-term influence on the likelihood of violence and treatment of harm following violence.

Table 7: Health Consequences of Child Abuse.

HEALTH CONSEQUENCES OF CHILD ABUSE	
Physical	Abdominal/thoracic injuries Brain injuries Bruises and welts Burns and scalds Central nervous system injuries Disability Fractures Lacerations and abrasions Ocular damage
Sexual and reproductive	Reproductive health problems Sexual dysfunction Sexually transmitted diseases, including HIV/AIDS Unwanted pregnancy
Psychological and behavioural	Alcohol and drug abuse Cognitive impairment Delinquent, violent and other risk-taking behaviours Depression and anxiety Developmental delays Eating and sleep disorders Feelings of shame and guilt Hyperactivity Poor relationships Poor school performance Poor self-esteem Posttraumatic stress disorder Psychosomatic disorders Suicidal behaviour and self-harm
Other longer-term health consequences	Cancer Chronic lung disease Fibromyalgia Irritable bowel syndrome Ischemic heart disease Liver disease Reproductive health problems such as infertility

Source: Krug et al., 2002 (p. 69). Used with kind permission of WHO.

There are profound consequences of abuse, impacting the health and wellbeing of individuals as well as the flourishing of entire communities and societies. Living in a violent environment has long-term detrimental effects on a person's sense of self-esteem and functional ability to participate in society. Different types and multiple episodes of abuse are cumulative, leading to even greater impact on physical and mental health. In addition to the human costs, violence imposes an enormous societal economic burden in terms of lost productivity and increased use of health and social care services (Krug et al., 2002; WHO, 2004; WHO, 2010a). Ill health caused by child abuse and neglect constitutes a significant portion of the health burden globally. Williams and colleagues (2012) postulate that psychological aggression is perceived by victims as more harmful than physical abuse. Evidence highlighting important direct acute and long-term consequences of child abuse is presented in Table 7 above (Krug et al., 2002, p. 69). Major adult forms of illness are related to experiences of childhood abuse; the World Health Organization cites the apparent causal mechanism as the adoption of behavioural risk factors including smoking, alcohol abuse, poor diet and lack of exercise.

Liu (2011) emphasises early health risk factors that influence negative behavioural outcomes such as prenatal and postnatal nutrition, tobacco use during pregnancy, maternal depression, birth complications, traumatic brain injury, lead exposure, and child maltreatment, positing an increased likelihood of childhood externalising behaviours, aggression, violence, juvenile delinquency, or adult criminal behaviour. Krug and colleagues (2002, pp. 69-70) review studies demonstrating short- and long-term psychological damage resulting from child abuse. Children may display pre-clinical symptoms; some may have serious psychiatric symptoms such as depression, anxiety, substance abuse, aggression, shame, or cognitive impairments including attention deficits; while other children may meet the full criteria for psychiatric illnesses that include posttraumatic stress disorder, major depression, anxiety disorders and sleep disorders. The cost of child abuse and neglect to individuals, families, communities and societies is enormous. In addition to direct costs associated with treatment, including visits to the hospital and doctor and other health services, there are a range of indirect costs related to lost productivity, disability, decreased quality of life and premature death. These costs are borne by institutions such as the criminal justice system; social welfare organisations in investigating reports of child maltreatment and protecting children from abuse or organising foster care; the education system due to disruptive behaviour, bullying and violence; and the employment sector due to bullying, absenteeism and low productivity (ibid.).

A summary of health consequences associated with intimate partner violence is found in Table 8. Victims of physical or sexual abuse in childhood or adulthood experience ill health more frequently with regard to physical functioning, psychological wellbeing and the adoption of further risk behaviours including smoking, physical inactivity, and alcohol and drug abuse. (Krug et al., 2002, pp. 100-102). A history of violence has been associated with increased risk of depression, anxiety and phobias, physical injury, suicide attempts, psychosomatic disorders, gastrointestinal disorders, irritable bowel syndrome, reproductive health consequences, and chronic pain syndromes. The experience of pain is highly complex and comprises many interactive dimensions, including physiological, sensory, affective, cognitive, behavioural and psychosocial (Jones, 2011). Violence during pregnancy has been associated with miscarriage, late entry into prenatal care, stillbirth, premature labour and birth, foetal injury, and low birth weight, which is a major cause of infant death in the developing world. Victims of intimate partner violence may be unable to care for themselves and their children adequately or to pursue employment. Krug and colleagues report consistent evidence that family violence is more common in families with many children. The impact on children who are often present during family altercations of witnessing violence is of serious concern. According to the World Health Organization (Krug et al., 2002, p. 103), witnessing violence between parents places children at a higher risk for emotional and behavioural problems including anxiety, depression, poor school performance, low self-esteem, disobedience, nightmares, and physical health complaints. In fact, these children commonly exhibit many of the same behavioural and psychological disturbances as children who are themselves abused.

Table 8: Health Consequences of Intimate Partner Violence.

HEALTH CONSEQUENCES OF INTIMATE PARTNER VIOLENCE	
Physical	Abdominal/thoracic injuries Bruises and welts Chronic pain syndromes Disability Fibromyalgia Fractures Gastrointestinal disorders Irritable bowel syndrome Lacerations and abrasions Ocular damage Reduced physical functioning
Sexual and reproductive	Gynaecological disorders Infertility Pelvic inflammatory disease Pregnancy complications/miscarriage Sexual dysfunction Sexually transmitted diseases, including HIV/AIDS Unsafe abortion Unwanted pregnancy
Psychological and behavioural	Alcohol and drug abuse Depression and anxiety Eating and sleep disorders Feelings of shame and guilt Phobias and panic disorder Physical inactivity Poor self-esteem Posttraumatic stress disorder Psychosomatic disorders Smoking Suicidal behaviour and self-harm Unsafe sexual behaviour
Fatal health consequences	AIDS-related mortality Maternal mortality Homicide Suicide

Source: Krug et al., 2002 (p. 101). Used with kind permission of WHO.

Behaviour change is a complex process involving environmental, psychological, social, and cultural factors. Effective contemporary intervention strategies are seen to require an understanding of the social ecology of violence (Hong & Espelage, 2012), bidirectionality of violence (Eisikovits & Bailey, 2011; Dutton, 2012), cultural sensitivity (Haj-Yahia, 2011), and a paradigm change to neurobiological correlates of violence perpetration (Pinto et al., 2010; Twardosz & Lutzker, 2010) and stress models of aggression (Ferguson & Dyck, 2012). Programme matching is suggested as a means of improving success rates (Cunningham et al., 1998). Gerhardt (2010) disclaims popular assumptions that behaviour is genetically directed, or that people respond to rational argument and can change behaviour by using logic or willpower. Tones' health action model (HAM) suggests that health decisions and actions are influenced by beliefs, values, self-concept, self-esteem, motivation, and expectations of others' reactions (Tones, 1987; Tones & Tilford, 2001).

The stages of change model (Prochaska & DiClemente, 1982) integrates the role of personal responsibility and choices with social and environmental factors that impact health-related behaviour change. The model illustrates the cycle of change as a revolving door through which people rotate more than once before emerging to a permanent new state. At the pre-contemplation state that precedes entry into the change cycle, there is a lack of awareness, acceptance, or motivation of the need to change. The change cycle comprises stages of contemplation, commitment, action, maintenance, relapse and re-entry into the cycle, or eventual exit and settling into a new behaviour. The model enables customising of health interventions to a particular motivational and behavioural state. Weak or insufficient supporting evidence is reported for the impact of batterer programmes (Babcock et al., 2004); stage of change is not a strong predictor of programme outcomes (Gondolf, 2011). Marshall and Burton (2010) nominate four factors associated with the effectiveness of group treatment processes for offenders: therapist characteristics, clients' perceptions of the therapist, the therapeutic alliance, and the group climate of treatment. Tatkin observes that the growth of security in the change process is enhanced by acceptance, high regard, respect, devotion, support, and safety; change from fundamentally insecure to fundamentally secure is not possible under conditions of fear, duress, disapproval, or threat of abandonment (2011, p. 69).

Cunningham and colleagues (1998) purport that methodologically rigorous research is the key to developing violence intervention techniques and increasing the success rates of intervention programmes in reducing violence and crime. Operational definitions of success vary widely in scope, from participation in anti-violence programmes and reduction in recidivism to cessation of physical violence. The dependent variables of success are typically either attitudes, behaviours or symptoms, however the measurement of success is problematic because of the effect of social desirability and the potentially negative consequences of honest disclosure. Furthermore, it is recognised that cessation of physical violence may be accompanied with escalation of other abusive behaviours such as verbal insults. The measurement of violence and abusive behaviours in the community over the long term is seen as the most ecologically valid way to define success, however no satisfactory and nonreactive pre/post instrument has yet been developed. The combined use of official records, male self-report and female self-report is recommended. Cunningham proposes the following strategies in the evaluation of interventions: use of control groups or other techniques (e.g., comparing different intervention strategies or the same programme under different conditions), eliminating rival plausible hypotheses, use of large samples, use of representative samples, attending to (or at least measuring the impact of) attrition, measuring treatment adherence, measuring treatment dosage, selecting valid outcome measures, and engaging in long-term follow-up. (Cunningham et al., 1998, p. vii)

2.4 The Ethical Context for Health-Promotive Violence Prevention

Violence is a sensitive issue requiring rigorous attention to ethical considerations in research and practice. This section provides an overview of ethical theories and ethical decision-making, and the ethical dimensions of health promotion and research practice.

2.4.1 Ethical Theories and Ethical Decision-Making

Normative ethics consists of attempts to apply ethical theories and principles to actual ethical dilemmas. Esler (2007) describes the development of a pluralist approach to ethics and makes a distinction between act-focussed and person-focussed ethical theories (p. 47). Theories of *act-focussed ethics* include prescriptive theories such as deontological approaches and the ethics of justice, and consequentialist theories such as teleological approaches. Theories of *person-focussed ethics*, on the other hand, include character-based theories such as virtue ethics and relationship-based theories such as the ethics of care.

The terms deontological and teleological are derived from the Greek *deontos* ('of the obligatory') and *teleios* ('brought to its end or purpose') (Reamer, 2006, pp. 65-66). *Deontological theories* posit that certain actions are inherently right or wrong, good or bad, based on a sense of duty and without regard for consequences. The best known deontologist is the eighteenth-century German philosopher Kant, who believed that all humans have the capability for rational reasoning and will for moral action. In the *ethics of justice* or rights-based theory the fundamental language and framework for ethical guidelines is based on rights such as the rights to life, liberty, expression, property, and protection against oppression, discrimination, intolerance and invasion of privacy (e.g., Rawls, 1971; Smart & Williams, 1973; Donagan, 1977; Beauchamp & Childress, 2001).

Teleological theories view the rightness of any action by the goodness of its consequences. The two major teleological schools of thought are egoism and utilitarianism. Egoism holds that when faced with conflicting duties people should maximise their own good and enhance their self-interest. Utilitarianism is based on the pursuit of the greatest benefit, advantage, pleasure, good or happiness of the greatest number and the prevention of mischief, pain, evil or unhappiness, including physical, psychological, emotional, cultural and spiritual aspects (Bentham, 1781; Mill, 1861; as cited in Hugman, 2005, pp. 6-7). Action may maximise utility in an individual case or a particular act (act utilitarianism) or for the society as a whole, including the long-term consequences if the case is generalised or treated as a precedent (rule utilitarianism) (Hugman, 2005, pp. 6-7). The greatest good may be measured in terms of the aggregate good itself (good-aggregative utilitarianism) or in terms of the greatest good for the greatest number (locus-aggregative utilitarianism). A central problem with

utilitarianism is the bias by which factors may be considered and weighted as a result of different life experiences, values or political ideologies (Reamer, 2006, pp. 66-68).

Evaluation of scientific value and risks in the humanities and social and behavioural sciences is a question of normative evaluation of values and not a utilitarian cost-benefit analysis. The perspective of *virtue ethics* purports that an ethical person has virtuous values and character traits (such as integrity, truthfulness, generosity, loyalty, sincerity, kindness, compassion and trustworthiness) and acts in a manner consistent with them (Reamer, 2006, p. 30). Beauchamp and Childress (2001) posited that the moral foundation of professional practice is founded on the five core virtues of compassion, discernment, trustworthiness, integrity, and conscientiousness and the four core moral principles of autonomy, nonmaleficence, beneficence, and justice. The *ethics of care* (Gilligan, 1983) emphasises the importance of relationships in ethics and moral decision-making including the need for care, emotional commitment, and willingness to act on behalf of significant others. The ethical principle of communitarianism proposes that ethical decisions should be based primarily on what is best for the community and communal values, such as the common good, social goals and cooperative virtues, as opposed to individual self-interest (Beauchamp & Childress, 2001).

Ethical problems arise when the practitioner faces a situation involving a difficult moral decision, but is clear about the right course of action. *Ethical dilemmas*, on the other hand, occur when the practitioner faces a choice between two equally unwelcome alternatives that may involve a conflict or moral values and the right course of action is not clear (Banks, 2006, pp. 12-13). Whether issues are interpreted as technical matters, ethical problems or ethical dilemmas depends on the practitioner's moral sensitivity or perspective of the situation, the priority given to different values, the level of experience in making ethical judgements, and possibilities for discussion of different perspectives and possible courses of action with colleagues or in supervision sessions. Ethical dilemmas of direct practice with individual clients, families, and small groups include issues such as confidentiality and privacy, self-determination and paternalism, divided loyalties, professional boundaries, conflicts of interest, termination of services, and the relationship between professional and personal values. Ethical dilemmas of indirect practice involve resource allocation, government and private sector responsibility for social welfare, compliance with regulations and laws, and whistle-blowing in activities including research and evaluation, social policy and planning, administration, community organising and advocacy (Reamer, 2006, pp. 87, 123). *Ethical decision-making models* guide systematic thinking through ethical dilemmas (Bowles et al., 2006, p. 197) and may be classed into rational, virtue ethics, pluralistic prescriptive, transcultural integrative, inclusive and 360-degree models (see Bowles et al, 2006, for a review). Bowles and colleagues propose that personal awareness and critical reflection, as characterised by dialogue, openness, mutual respect and focus on the goals of the profession, are key skills for ethical practice and moral action.

2.4.2 Ethical Issues in Health Promotion

Health promotion is a value driven activity (Davies & Macdonald, 1998, p. 211) that involves people and requires the practitioner to make a series of value judgements about the health and wellness of the individual and society as well as the grounds and means for intervention. Health promotion forms an integral part of social, economic and political development and health promotion programmes or policies initiate 'concentric ripples' (Rootman & Ziglio, 1998, p. 202) of impact on wellbeing, productivity, and lifestyles. An ethical approach to public health is founded on a multilevel, ecological systems perspective to understand diverse causation and to develop effective strategies for prevention or amelioration (Schneider & Stokols, 2009, pp. 85-86). The value system for health promotion is founded on respect for human dignity, human rights, and social justice. The making transparent and explanation of underlying value judgements with open, honest and forthright communication is advocated by Seedhouse (1997). Cribb and Duncan state that in applying ethics to health promotion or health care more generally, 'our capacity to create, end, and change human life challenges our conceptions and understanding of what it is to be human' (2002, p. 273).

Ethical issues in health promotion include respect for autonomy, avoidance of harm, (Cribb & Duncan, 2002, p. 274), the degree of individual responsibility for health, the extent of persuasion to make healthy choices, evidence of sufficient effectiveness of interventions, the legitimacy of state intervention on the health environment (Naidoo & Wills, 2009, p. 85), the scarcity and prioritisation of resources, multiple accountability, the potential for diametrically opposed views of various participatory parties, and lack of accepted procedures for reviewing ethical questions (Rootman & Ziglio, 1998, pp. 193, 202). Cribb and Duncan examine the ethical justification for intervention, claiming that weak levels of persuasion may be justified for particular social goals and stronger forms of interference or coercion for public health threats (2002, p. 282) in terms of the twin concepts of utilitarianism and paternalism (Tones & Tilford, 2001). Deontological or duty-based approaches to ethical dilemmas lead to an emphasis on individual rights and responsibilities, while utilitarian or consequential approaches focus more on collective health outcomes. There is a risk that health promotion activities may actually widen health inequalities by only reaching people who have the time, money and education to adopt health information and take health action. Integral to health promotion is knowledge and understanding of diversity, culture, and the impact of racism. Marginalised groups who may have less resources to change lifestyles or lobby for social and political change include children and youth, the aged, people with physical or mental health problems, people with disabilities, immigrants, and Indigenous populations, among others.

Violence is a highly sensitive issue and the scientist, practitioner, or decision-maker requires moral courage to identify, intervene and advocate in matters of abuse and neglect. In the case of family violence, the worker's task is to secure the safety of all individuals, provide

appropriate treatment or referral to services, and address possible ethical dilemmas that clients are struggling with. In particular, value conflicts may arise when a practitioner is providing services to a client whose cultural or religious beliefs support behaviours or activities (for example, concerning the rearing of children) that are in conflict with the values of the profession or the worker (Reamer, 2006, pp. 33-35). Traditional gender stereotypes, gender-based victim ideology, and the gender bias of workers in the helping professions may impede the clinical recognition of abuse by women. Implicit denial of women's potential for mental, physical and sexual aggression may contribute to underrecognition of the problem and perpetuation of the cycle of violence.

It is critical that health promoters clarify their ethical principles, consult codes of practice and apply ethical decision-making models in health and wellness promotion work. Banks (2006, p. 150) calls for critical reflection on practice. Reflective practitioners are confident about their own values and how to put them into practice; integrate knowledge, values and skills; recognise and analyse ethical dilemmas and conflicts in their practice; learn from experience; and are prepared to take risks and moral blame. A practical checklist of questions for health professionals to clarify ethical issues when faced with alternative courses of action (Seedhouse, 1988) is presented in Table 9 below.

Table 9: An Ethical Grid Tool for Making Ethical Decisions in Health Promotion.

(1) Central Conditions in Working for Health
Will I be creating autonomy in my clients, enabling them to choose freely for themselves and direct their own lives?
Will I be respecting the autonomy of my clients, whether or not I approve of their chosen direction?
Will I be respecting all people as equal, without discrimination?
Will I be working with people on the basis of needs first before any other wants?

(2) Key Principles in Working for Health
Will I be doing good and avoiding harm?
Will I be telling the truth?
Will I be minimalising harm in the long term?
Will I be honouring promises and agreements?

(3) Consequences of Ways of Working for Health
Will my action increase the individual good?
Will my action increase the good of a particular group?
Will my action increase the good of society?
Will I be acting for the good of myself?

(4) External Considerations in Working for Health
Am I putting resources to best use: what is the most effective and efficient action to take?
What is the degree of risk attached to the intervention?
Is there a professional code of practice that has a bearing on this?
How certain is the evidence on which this intervention is based?
Are there any disputed facts?
Are there any legal implications? If so, do I understand them?
What are the views and wishes of those involved?
Can I justify my actions in terms of the evidence I have before me?

Source: Adapted from Seedhouse, 1988.(as cited in Ewles & Simnett, 2003, p. 51; and Naidoo & Wills, 2009, p. 89).

2.4.3 Ethical Principles of Research

The professional competence of a researcher includes mastery of the knowledge, research methodologies, and professional ethics of the field. The National Advisory Board on Research Ethics in Finland (TENK), an expert body founded in 1991 and nominated by the Ministry of Education, is mandated to promote discussion and disseminate information about research ethics in Finland and to take initiatives concerning research ethics (Decree 1347/1991). The Board has issued '*Good scientific practice and procedures for handling misconduct and fraud in science*' to which all research must comply (TENK, 2002). A commitment to comply with the research guidelines has been made by the multidisciplinary scientific community of universities, research institutions, universities of applied sciences and funding agencies. An additional set of guidelines on the ethical principles for research in the humanities and social and behavioural sciences was issued by the Board in 2010 (TENK, 2010).

Scientific research must comply with good scientific practice for the research to be ethically acceptable, reliable, and credible. The researcher is responsible for the ethical and moral considerations in a study. According to guidelines issued by the National Advisory Board on Research Ethics in Finland (TENK, 2002), good scientific practice requires:

1. following modes of action endorsed by the research community, i.e. integrity, meticulousness and accuracy in conducting research, in recording and presenting results, and in judging research and its results.
2. applying ethically sustainable data collection, research and evaluation methods conforming to scientific criteria, and practising openness intrinsic to scientific knowledge in publication of findings.
3. taking due account of other researchers' work and achievements, respecting their work and giving due credit and weight to their achievements in the carrying out of research and publication of results.
4. planning, conducting and reporting research in detail and according to the standards set for scientific knowledge.
5. determining and recording questions relating to the status, rights, co-authorship, liabilities and obligations of the members of a research team, right to research results and the preservation of material in a manner acceptable to all parties before the research project starts or a researcher is recruited to the team.
6. reporting the sources of financing and other associations relevant to the conduct of research and publishing of findings.
7. observing good administrative practice and good personnel and financial management practices.

The special characteristics relating to good scientific practice in different disciplines are specified in the codes of practice issued by learned societies and professional organisations.

There are three components of ethical principles of research in the humanities and social and behavioural sciences: the autonomy of research subjects, avoiding harm, and privacy and data protection. (TENK, 2010)

2.4.3.1 Autonomy of Research Subjects

Participation in research should be voluntary and based on informed consent by each and every subject, with the exception of research that is conducted on published and public information and archived materials. Research involving minors should balance the right of children to be treated equally and as individuals and to influence matters pertaining to themselves to a degree corresponding to their level of development (Section 6 Paragraph 3 of the Constitution of Finland; Article 12 of the UN Convention on the Rights of the Child, 1989) with the right of a guardian to decide on matters relating to the person of the child (Section 4 Paragraph 1 of the Child Custody and Right of Access Act, 361/1983; Finlex). For studies involving subjects under the age of 15, an ethical review must be requested if the study is to be conducted without a guardian's separate consent or without informing a guardian.

Subjects should receive the following information about a study: (1) the researcher's contact information, (2) the research topic, (3) the method of data collection and the estimated time required, (4) the purpose of data collection and method of archiving for use in secondary research, and (5) the voluntary nature of participation. Subjects may ask for additional information regarding the study such as its scientific orientation, protection of confidential data, and publication of the results. An ethical review must be requested from the ethics committee if a study deviates from the principle of informed consent. (TENK, 2010)

2.4.3.2 Avoiding Harm

Research must be conducted in such a way as to minimise any negative effects and risks to subjects. Social research may generate information on the improper functioning of social institutions and the use of power. Consequences following the collection, storage, and publication of data may result in possible harm.

Avoidance of mental harm includes respect for the human dignity of subjects and respectful treatment of study findings in research publications. The sensitivity of a subject matter and the limits of privacy are determined primarily by the research subjects themselves, who may regulate participation by avoiding matters and questions that are considered to be damaging or harmful. For example, physical fatigue, annoyance, embarrassment, or fearfulness experienced by the subject can be sufficient grounds for the researcher to discontinue participation in the study by the subject.

Avoidance of financial and social harm includes systematic observation of ethical principles regarding privacy and data protection in the handling and storing of confidential information. Research results should be reported in a respectful and nonjudgemental way with the use of comprehensive data, systematic analysis, and balanced presentation of different perspectives. An ethical review must be requested from the ethics committee if a study contains risks of harm beyond the limits of normal life. (TENK, 2010)

2.4.3.3 Privacy and Data Protection

The right to protection of privacy is mandated by the Constitution of Finland. The objective in research ethics is to find a balance between confidentiality and the openness of science and research. The Personal Data Act (523/1999; Finlex) includes provisions on the processing of personal data, defined as 'any information on a private individual and any information on his/her personal characteristics or personal circumstances, where these are identifiable as concerning him/her or the members of his/her family or household' (Section 3). It is good practice in research to make a data management plan describing how data containing identifiers will be protected or identifiers removed, whether signing a pledge of confidentiality will be required from persons using or processing the personal data, and the plan for archiving the data for secondary research or destroying personal data after the study has been completed. The protection of data with identifiers must be carefully planned, including the collection, archiving, transfer, copying and destruction of paper and electronic materials. Principles concerning the protection of privacy do not apply to published data or materials in the public domain.

Research data may not be used or distributed for other uses besides research, such as revealing information about individual subjects to authorities, the media or for commercial purposes. An exception is the obligation of every citizen to reveal information that assists to prevent an imminent serious crime. Furthermore, the obligation to confidentiality may be inapplicable if a researcher finds that 'there is a child for whom it is necessary to investigate the need for child welfare on account of the child's need for care, circumstances endangering the child's development, or the child's behaviour' (Section 25 of the Child Welfare Act, 417/2007; Finlex). In the event that a researcher decides to make a report on the basis of the Child Welfare Act, it is deemed good practice to inform the subjects in question of this intention.

The need to collect research data containing identifiers may be reduced by careful archiving of data for secondary research purposes, which allows the possibility for the validity of information and scientific findings from the data analysed in a study to be tested and critically evaluated by the scientific community. The archiving of data with cultural, historical and/or scientific value for secondary research is of particular importance. The

protection of privacy should be ensured through anonymisation measures and regulation of access to data, including strict conditions on the secondary use of data and the signing of a pledge of confidentiality. Direct identifiers such as name, address, or ID and indirect identifiers such as age, place of residence, workplace, or profession should be recoded, categorised, masked or removed from archived data. The need to protect privacy and to present subjects in a non-identifiable way in research publications should be evaluated on a case-by-case basis. The statistical reporting of findings in quantitative research is not associated with risk of identification. In qualitative research, the identifiability must always be evaluated and any identifiers in the published samples or quotations from the data should be masked or omitted. Individual subjects and the research target should be treated in a respectful manner in research publications and critical findings should be explained analytically without a labelling or judgemental attitude. (TENK, 2010)

2.4.4 Ethical Review

The scope of ethical review covers post-graduate research, and the compliance of thesis work with the ethical principles is the responsibility of thesis supervisors. Research plans including any of the following features must be submitted by researchers to ethical review:

1. The study involves an intervention in the physical integrity of subjects.
2. The study deviates from the principle of informed consent. Ethical review is not required if the research is based on public documents, registries or archived data.
3. The subjects are children under the age of 15, and the study is not part of the normal activities of a school or an institution of early childhood education and care, and the data are collected without parental consent and without providing the parents or guardians the opportunity to prevent the child from taking part in the study.
4. The study exposes research subjects to exceptionally strong stimuli and evaluating possible harm requires special expertise (for example, studies containing violence or pornography).
5. The study may cause long-term mental harm (for example, trauma, depression, or sleeplessness) beyond the risks encountered in normal life.
6. The study can signify a security risk to subjects (for example, studies concerning domestic violence).

Ethical review may also be requested by a researcher if required by the research subject, the funding agency, a cooperation partner, or a scientific journal for publication of the study. A statement on the ethical acceptability of a planned study is given by ethics committees. The involved organisation grants the permission to conduct the study, and individual research subjects give consent to participate in the study. (TENK, 2010)

2.5 Summary

The literature and emerging empirical evidence suggest that substantial gains in understanding the social determinants of health and wellbeing can be made from better knowledge of underlying mechanisms in the intergenerational transmission of violence and malaise. A summary of key points from the review of the literature is presented below.

1. Finland needs a paradigm shift from a reactive welfare state to a proactive, inclusive welfare society (Himanen, 2012). Finland's strategic vision in 2020 is to be a socially sustainable society with balanced development founded on equality; mental and material wellbeing; and economic, social and ecological sustainability. The core pillars of the strategy are a healthy and safe living environment, a strong foundation for welfare, and access to welfare for all. Reducing violence is a strategic national goal with the aim to find an efficient nationwide model for preventing violence and strengthening a sense of community and internal security (Ministry of Social Affairs and Health, 2011a).
2. The social ecology of health is a multilevel paradigm for health and wellness promotion that recognises the complex and interactive web of social, biological, psychological, structural and cultural determinants of health. Many diseases have a social etiology, and health inequities within and between countries are primarily caused by the social determinants of health (Tones & Tilford, 2001; Marmot & Wilkinson, 2005; Crosby et al., 2011). The issue of violence and its effect on health has been nominated as 'the ultimate public health challenge' (Macdonald, 2002, p. 293).
3. Western societies have evolved an impoverished emotional culture in which human relationships have become subordinated to material and technical productivity and growth (Gerhardt, 2010). The foundations of an empathic, emotionally literate and morally sustainable society are founded in awareness and acceptance of interdependence of the self and others and human inner emotional life. To become a human being with a sense of self requires attuned reflection through the eyes and minds of caregivers in early life. Early experiences lay critical foundations for life trajectories and opportunities for health. The structural and functional development of the brain, nervous and neuroendocrine systems is directly affected by experiences of bonding, separation, and loss during early years (Schore, 1994; Siegel, 1999; Gerhardt, 2004, 2010; Trevarthen, 2001).
4. The earliest organisation of social brain structures is grounded in the dominant right side of the brain before the age of three, forming relational blueprints with an enduring effect on relational capacity and mental wellbeing (Schore, 1994, 1997, 2000, 2002, 2005; Siegel, 1999, 2010; Chugani et al., 2001). The processes of attachment and limbic regulation give coherence to neurodevelopment (Lewis et al., 2000) and are implicated in social-emotional acuity, implicit memory, stress regulation, resilience, intuition, empathy and morality (Schore, 2003).

5. The development of self-organisation and regulatory capacity is experience-dependent on the role of the caregiver as an emotional and behavioural regulator for the child in early relationships. Infants who receive responsive, positive attention and social interaction with adult brains develop more integrated and well-regulated brains and mentalistic functioning in the self as agent compared to deprived children (Fonagy et al., 2002; Gerhardt, 2004). Early maldevelopment or injury of the limbic HPA axis, amygdala, hippocampus and prefrontal cortex is related to impulsivity; emotional dysregulation; deficits in cognitive capacity, attention, and executive functioning; depression; and anxiety (Wilson et al., 2011; Tatkin, 2011; Solomon & Tatkin, 2011; Glover & Connor, 2002). Protective factors that foster resilience include resonant relationships; healthy self-esteem and self-acceptance; emotional self-regulation; somatic equilibrium; and response flexibility (Graham, 2013; Robertson, 2012).
6. An ecological approach to human development and recognition of the role of infant mental health as a key social determinant of health are needed to provide the essential building blocks for a flourishing life. Investments in the early years provide action to reduce health inequities within a generation, in terms of enabling more children to grow into healthy adults with positive contributions to society and reducing the escalating chronic disease burden. The effects of inaction on early environmental failure are detrimental and last more than a lifetime (CSDH, 2008; ECDKN, 2007; Lynch, 2004). Interventions should be made at the population level rather than a focus on those identified at risk, to shift the entire mental health spectrum to a higher level of psychoogical resources and flourishing. The population approach offers considerable total public health benefit with strategies to target regulatory, economic, physical, social, and cultural environments at societal and community levels as well as behaviours at the individual level (Rose, 1992; Huppert, 2009). Reducing health inequities is an ethical imperative requiring commitment, ethical leadership, and policy coherence.
7. Violence is both predictable and preventable and it imposes a substantial burden on individuals, families, communities and health care systems worldwide. There is no single factor that explains the causes of violence and malaise. The ecological model for understanding and preventing violence views interpersonal violence as the complex product of multiple levels of individual, relationship, community, and societal influences on behaviour (Krug et al., 2002; WHO, 2004; Ryan, 2005). Theories on the causes of interpersonal violence encompass biological/organic, psychopathological, family systems, behavioural/social learning, and feminist frameworks and can best be understood as additive rather than competing (Cunningham et al., 1998). A paradigm change in aggression research from social cognitive approaches to diathesis stress models of aggression has been posited by Ferguson and Dyck (2012).
8. A history of deprivation and disruptions in infant-caregiver dyadic regulation and poor establishment of agentive self-structure, coupled with shame-generating experiences of

humiliation and/or pride-based counter-identifications, becomes a potent trigger for violence and malaise. Intimate partner violence in adolescents and adults is predicted by attachment insecurities including fearful and preoccupied attachment style, alterations in the appraisal of threat, poor affect regulation, impulsivity, and borderline personality disorder (Dutton and White, 2012; Yates, 2004). The absence of mentalistic functioning and resultant experience of internal chaos creates a constant need for externalisation onto others to achieve a temporary sense of control and security. The developmental struggle for separation and independence from the caregiver in late adolescence and early adulthood may manifest in destructive and self-stimulating regulatory strategies, including violent behaviour, substance abuse, eating disorders, addictive behaviour, self-injury, and suicide. Physical and emotional dependence on a significant other is likely to be created in intimate partnerships as a vehicle for externalisation of destructive impulses. Intense fear of abandonment contributes to a cycle of psychological, physical and/or sexual abuse because the other is needed for self-coherence (Fonagy et al., 2002).

9. Health is not merely a state of physical survival, but an opportunity for individuals and communities to thrive in responsive, supportive, nurturing, and caring living environments. Health and wellness promotion is a mechanism for social change and the creation and maintenance of healthy environments underpinning the social determinants of health in the present and future. A multilevel, ecological systems perspective that is founded on diverse understanding of causation fosters an ethical approach to public health and the development of effective strategies for prevention or amelioration (Glass & McAtee, 2006; Schneider & Stokols, 2009). Health promotion has a crucial role to play in addressing the causes and consequences of violence through education, prevention, and protection measures (Macdonald, 2002). There is a need for health promotion indicators and measurements, implementation of practice-based evidence, and overcoming of barriers such as avoidance of stigma and resistance to sensitive issues, including violence (King et al., 2012).
10. The World Health Organization calls for a proactive, scientific, comprehensive and collaborative approach to violence prevention and treatment involving the public and private sectors from industrialised and developing countries. To date, priority has often been given to secondary and tertiary responses to violence by providing support to victims and punishing offenders (Krug et al., 2002; WHO, 2004). A more sustainable response to violence promotes nonviolence, reduces and prevents the perpetration of violence, and changes the circumstances and conditions that give rise to violence (WHO 2004; 2008; 2010a; 2010b). The high opportunity for environmental and behavioural modification during critical prenatal, perinatal, and postnatal developmental windows is emphasised, supporting an early framework that integrates biosocial interactive processes and protective factors in violence prevention and research efforts (Liu, 2011).

3 Purpose of the Study and Research Questions

The research aim of the thesis is to contribute to the sustainability discourse by:

1. exploring the underlying mechanisms of the social determinants of health and their association with sustainable development;
2. organising and making more coherent emerging ideas about the relationship between health, safety and wellbeing and the intergenerational transmission of violence and malaise as well as the role of health and wellness promotion in violence prevention;
3. communicating the synthesis of those ideas to a wider audience in a common and accessible voice.

The main question of the study is:

How do we foster health and wellbeing for a socially sustainable society?

The sub-questions of the study are:

What is the significance of health communication in health-promotive violence prevention?

What is the significance of gender in health-promotive violence prevention?

What is the significance of culture in health-promotive violence prevention?

The theoretical approach of the study is social ecological, merging social pedagogical and bioecological perspectives of human development and growth in which the social dimensions of sustainability and health are seen as prerequisites for wellbeing. The social pedagogical perspective is a dynamic, holistic and interdisciplinary approach towards people and their daily living conditions (Kornbeck & Rosendal Jensen, 2009). The bioecological perspective recognises that individuals are dually influenced by their biological inheritance and by various microsystems and macrosystems (Bronfenbrenner, 2004).

The basis for pre-understanding and interpretation is formulated in the following principles by Nelson Mandela (Krug et al., 2002, p. ix):

- Foundations for human health and wellbeing are established during the early formative years and validated across the lifecourse.
- Violence can be prevented, and the roots of violence and fear must be addressed for prevention to be effective.
- A legacy of safety and security is the result of collective consensus and public investment.

4 Methods

The research method for the thesis is an article-based hermeneutic review of the literature. The hermeneutic approach to literature review and the methodological considerations of the study are presented in this chapter.

The original idea for the thesis topic was developed in late 2009 around the themes of violence prevention and health promotion. The impetus to broaden the thesis topic to include social sustainability was inspired by the 2011 release of '*Socially Sustainable Finland 2020*', a strategy for social and health policy by Finland's Ministry of Social Affairs and Health (2011a). The article-based format for the thesis was proposed by the thesis supervisors in early 2012, on the basis of the author's work and experiential knowledge as a child protection and violence prevention worker since 2003 and as an expert and coordinator in an immigrant women's violence prevention programme as of 2010. Three papers published in 2011 and 2012 were selected by the author to provide an empirical perspective to the thesis content and research process. The thesis title, '*Towards a socially sustainable society: Preventing intergenerational transmission of violence and malaise through an ecological approach to health and wellness promotion*', was formulated in late 2012 during the final writing phase of the literature review. The thesis was submitted and accepted in May 2013.

4.1 The Hermeneutic Circle

Hermeneutics involves the process of creation of interpretive understanding, which is posited by Heidegger (2002) as an inseparable interweaving of self understanding and world understanding. Interpretation is the essential nature of understanding in human science research (Grondin, 1994). According to Smythe and Spence, 'the key purpose of exploring literature in hermeneutic research is to provide context and provoke thinking' (2012, p. 12).

The hermeneutic approach to literature review is an alternative to the structured approach of a systematic review (Chalmers & Altman, 1995; Smythe & Spence, 2012). Boell and Cecez-Kecmanovic (2010) argue that in most cases it is not possible to achieve an unbiased, complete and reproducible selection of the literature following a structured approach, which by definition requires the research question to be fixed prior to starting the literature review. Boell and Cecez-Kecmanovic claim that because databases have limited coverage and search terms are generally indeterminate, structured database searches are inadequate and result in a failure to capture all relevant records as well as a low precision of retrieved results. The authors observe that especially in the social sciences and humanities, research questions are less rigorous and likely to evolve as the literature review progresses.

The process of reflexive understanding is a dynamic and contextually interwoven dialogue with the embedded historical and cultural reality of the person (Hekman, 1986). Viewing the review of the literature as a hermeneutic process facilitates a continuing re-interpretation and more comprehensive re-information of the research area and research problem as each new paper is read and interpreted. The distinctive characteristics of a hermeneutic approach to literature review are:

- a broad range of relevant literature spanning time, discipline, genre, culture and context
- exposition of own prejudices by the researcher in literature selection and refinement
- emergent thinking is provoked by the literature in a dialogical partnership
- the identification of meanings through a focus on language and the collectivity of thinking (Smythe & Spence, 2012, pp. 22-23).

The research process is illustrated below in Figure 9 as a hermeneutic circle (Gadamer, 1979), in which the iterative process of understanding is cyclical and generally open-ended in nature. The interconnected stages of the hermeneutic circle are searching, sorting, selecting, acquiring, reading, identifying, and refining. Learning comprises movement back and forth between understanding of individual texts and the whole body of relevant literature, which in turn is built up through the reading of individual texts (Heidegger, 1966). Different skills and techniques are associated with each stage of the hermeneutic circle, in which all stages together inform the literature review process (Boell & Cecez-Kecmanovic, 2010). Smythe and

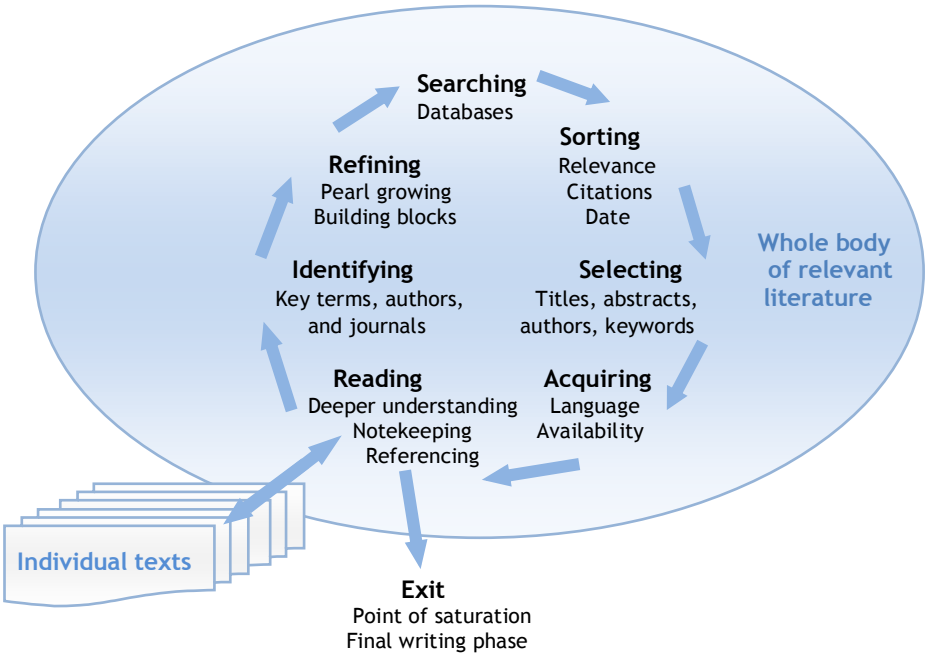

Figure 9: The Hermeneutic Circle of Reviewing Literature.
Source: Adapted from Boell and Cecez-Kecmanovic, 2010.

Spence (2012) posit that there should be congruence between the manner of reviewing literature and the particular research methodology. The authors raise concerns over expectations of recency in literature selection that may preclude valuable insights from different sources, the use of standard research structures and editorial format requirements that may be inappropriate with methodology, and a technical reliance on keyword-guided searches rather than the depth of thought in the research process (see e.g., Ihde, 1998; Smythe, 2005).

In hermeneutics new understanding and insights are created through interplay (Gadamer, 1979) between the prejudice of fore-understanding and the critical re-interpretation of information with dialectical use of question and answer and looking through a different lens. Heidegger (2002) conceptualised the three components of fore-understanding - fore-having, fore-sight and fore-conception - as the pre-understanding, vision and idea of what will be encountered. The researcher's relatedness (Heidegger, 1992) towards a particular text is a hermeneutic phenomenon of inclination and insight that is personified as:

> 'a feeling, a knowing, a readiness to read and re-read... To read in a hermeneutic way is to be attuned and engaged. One brings a willingness to be surprised, openness to difference and courage to make the leap into the space of thinking' (Smythe & Spence, 2012, p. 17).

Health promotion is a value driven activity and the health-promotive researcher works as facilitator and interpreter in accordance with the core values of respect for human dignity, human rights, and social justice (Davies & Macdonald, 1998). In the present study the researcher's attunement to the hermeneutic process was a holistic and embodied experience encompassing the domains of cognition, experiential thinking, emotion and intuition. Integral to the formulation of understanding was grace (Vanhoozer et al., 2006; Gadamer, 1979), or 'the act of handing over self to await the coming of a thought while at the same time being an active player in seeking new thoughts' (Smythe and Spence 2012, pp. 19-20).

4.2 Methodological Considerations

The thesis is an investigative research study for the purpose of synthesising and communicating knowledge and ideas about human development and health-promotive violence prevention for social sustainability. The research approach of the study uses interpretative and process-based methods, which aid knowledge development and are congruent with the principles of health promotion. The thesis is presented in an article-based format that converges violence prevention work in Finland with literature from around the world to support the hypothesis that early experiences are critical determinants of health across the lifecourse. The method is a hermeneutic dialogical process consisting of a review of the

literature and empirical reflection of clinical experience and tacit knowledge. The literature review of the thesis spans more than four hundred relevant articles, books, reports, documents, and presentations in English pertaining to the research topic and read over a three-year period in years 2010 to 2012. The main method of sourcing material was a citation pearl growing strategy (Boell & Cecez-Kecmanovic, 2010), with the reading of key sources serving as a starting point in the identification of the most relevant material for further searching. The bibliographic databases and search engines ScienceDirect, Google, and Amazon were used and combinations of search words included violence, abuse, neglect, violence prevention, social ecology, sustainable development, social sustainability, health, health promotion, mental health, well-being, flourishing, neurobiology, attachment, affect regulation, emotion regulation, arousal, stress response, relaxation response, trauma, resilience, and hermeneutic literature review. In addition, a systematic review was made of all articles published in the key academic journal *'Aggression and Violent Behavior'* in years 2010 to 2012.

The thesis has assembled diverse approaches and theory in an organised and coherent structure to be shared with policy makers, researchers, practitioners, and the general public. The study procedure was documented and the data was collected from different sources and grouped into categories by theme. Notes and summaries were made during the reading process and the material was organised by topic. The most challenging and time-intensive phase of the study was the writing of the literature review, requiring skills in critical analysis, synthesis of divergent perspectives from different forms of data, and political sensitivity. The decision to commence writing of the final report near the end of the research process, or at the exit point of saturation in the hermeneutic circle, was made as a methodological means of maintaining openness and engagement between fore-understandings and the questions that arose in reading, thinking and working life.

The research aims, process and outcomes of the study are evaluated in terms of quality factors in Table 10. Establishment of the objectivity and reproducibility of the study protocol is limited due to the nature of hermeneutic interpretation and to researcher bias (Smythe & Spence, 2012; Boell & Cecez-Kecmanovic, 2010). The validity of the study was improved through the process of critical reflection of the collected data and original articles. Moreover, the reliability and validity of the thesis was enhanced by the methodological triangulation of three different approaches in the study:

1. *Theoretical*: a critical review of a body of interdisciplinary literature
2. *Empirical*: an analysis of three original papers from the working life
3. *Developmental*: a proposed framework model adaptation and outline of its application.

The study satisfies quality criteria for relevance, efficacy, effectiveness, efficiency, globality, sustainability, integration, equity, accessibility, subsidiarity, systematisation, collectivity and authenticity (Deccache & Laperche, 1998). The thesis exemplifies a high degree of innovation

Table 10: Evaluation of Quality Factors in the Study.

QUALITY FACTORS IN THE STUDY AND THEIR JUSTIFICATION	
Relevance	+ The choice of research topic is relevant and socially responsible. + The study aims at answering identified social and societal needs. + The study adopts an investigative approach, makes critical analysis and produces new knowledge.
Efficacy	+ The methodological process is built upon the collection and processing of public information of which the efficacy has been proven or is promising. + The study connects the themes of the Degree Programme to professional development, working life and society.
Effectiveness	+ The study process meets its objectives in methodological terms, communicative terms and organisational collaboration. + The information is organised and shared in a coherent manner.
Efficiency	+ The study process makes efficient use of existing resources. + The study is low cost. - The study is labour- and time-intensive.
Globality	+ The study process is concerned explicitly and simultaneously with different aspects (health, social, environmental, political, cultural). + The study adopts an international perspective and strategy.
Sustainability	+ The study process is continuous in time by the same researcher with sharing of competence to develop the operating environment. + The study demonstrates political sensitivity. + Ethical considerations are taken into account in the study.
Integration	+ The study process makes sense of divergent perspectives and different forms of data. + The study combines theoretical knowledge with tacit knowledge. + The integrative strategy of the study ensures that concerns for health promotion and prevention are included in other activities. + The study demonstrates network competence.
Equity and accessibility	+ The study strategy concerns and aims at reaching all people. + The study demonstrates gender and culture sensitivity. + Open dialogue is utilised to motivate shared commitment to objectives. + The virtual environment is utilised for collection and dissemination of information.
Subsidiarity	+ The study strategy acknowledges the roles and positions of various concerned organisations and contributors. + The study builds on an interdisciplinary approach that encourages sharing of roles and tasks.
Systematisation	+ The study demonstrates communication expertise with clear and logical written presentation, oral presentation and visual material. + The study contributes to development of the field. + Dissemination of the study aims at reaching all concerned persons.
Collectivity	+ The study process and strategy is interdisciplinary. + The study implies a broad and integrative view of concerned social and health care disciplines.
Innovativity	+ The study strategy adopts a positive attitude towards change processes and social innovation. + The study proposes an adapted multilevel model for social sustainability. + The study achieves continuous monitoring and analysis of society and social networks, and generation of innovative ideas for added social value.
Authenticity	+ The study process and strategy is reliable with triangulation of methods and continuous critical reflection and analysis of own work. + The study makes an original contribution to knowledge and scholarship on a sustainability solution.

Source: Adapted from Deccache & Laperche, 1998 (pp. 157-158).

and usability and is a pioneer in article-based research within Finnish universities of applied sciences. The advantages of the thesis are the interdisciplinary integration, international context, knowledge generation, dissemination of theoretical and empirical knowledge and applicability of the study as well as the professional development of the researcher. The study has a solid research orientation in partnership with academic and clinical work. The knowledge created through the thesis process is applied to respond to socially significant issues, develop new models in the field, and foster solutions to problems. The limitations of the thesis are the labour- and time-intensity of the methodology in relation to the ambitious aims, triangulation of methods and wide scope of the study topic.

The hermeneutic dialogical process of the research methodology may be represented as a social ecological hourglass design as shown below in Figure 10. The hourglass model illustrates that the study is dynamically informed by a continuous, interaction-based and sustainable process of development between mediating mechanisms and outcomes of population health occurring over time. The intervention focus in this study is on health communication and interventions for intergenerational violence prevention. The hourglass model may also be applied to the wider society. In this instance there is a back and forth movement oscillating from a broad spectrum to a narrow gauge and back again between the mediating mechanisms of early development, self-regulation, and resilience and the outcomes of wellbeing, health and safety, and social sustainability for present and future generations. The running of sand and turning of the hourglass represents the positive feedback loop of public investment in health-promotive intergenerational violence prevention on the sense of security, improved health outcomes, and reduced costs at individual and societal levels. The stagnation of sand in either end, on the other hand, reflects a deficit in public health investment and neglect of the social determinants of health for one or more population cohorts.

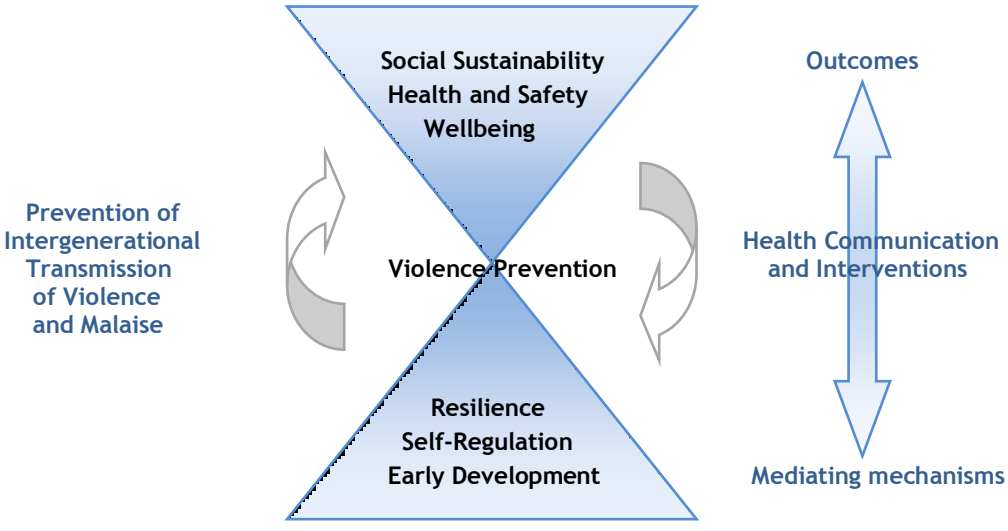

Figure 10: Social Ecological Hourglass Design of the Research Methodology.

5 Discussion

This chapter comprises reflection on the study sub-questions and the three original papers of the thesis (I-III), a proposed adaptation of Glass and McAtee's (2006) multilevel web of causation model with a synopsis of risk regulators and regulating systems for interpersonal violence, a review of ethical considerations, and prospects for future research.

The original papers of the thesis were published in 2011 and 2012 within the author's work as a coordinator and expert in the women's violence prevention programmes at Maria Akatemia/ Maria Akademi, which is a Finnish non-profit research, development and education centre for the wellbeing and inner growth of human beings and communities. The organisation has origins in the Foundation for Social Pedagogy founded in 1984 by psychotherapists Antti-Veikko Perheentupa and Britt-Marie Perheentupa and it is non-governmental and independent of any political or religious ideology. Maria Akatemia's research, development and education activities include societal advocacy, promotion of solidarity between generations and gender specificity, professional training, work community services, individual and group counselling, and project work. The organisation has focus on the social dimension of sustainable development, in particular the fostering of ethical leadership and the strengthening of health and its social determinants based on a psychodynamic and family-centred concept of the human being. Maria Akatemia has two preventive intervention programmes for violence by women: the Demeter Programme (since 2003) and the MaSu Project (2010-2013). Both programmes are funded by Finland's Slot Machine Association (RAY).

5.1 Health Communication and Violence Prevention (I)

The first paper, titled '*Väkivallan ehkäisytyö on avainasemassa kotoutumisessa' [Violence Prevention Work Supports Integration]. Introducing the MaSu Project*' (Appendix 1), was submitted in March 2011 and published in April 2011 as an unpaid news article in RIKU, the Finnish professional peer-reviewed periodical produced by Victim Support Finland ('*Rikos-uhripäivystys*' in Finnish) on violence prevention research and practice. The paper was the first media article about the MaSu Project, an intervention programme for the identification and intervention of violence by women with immigrant backgrounds in Finland. The aim of the article was to introduce the project to professional and volunteer workers in the Finnish violence prevention field by raising the saliency of violence by women and by giving information about the new intervention programme. The RIKU periodical is a credible and influential communication channel and a principal source of information on violence prevention and victim support services in Finland. The periodical is published as an open source online edition at <www.riku.fi> in addition to a print distribution of 3,000. Articles are mainly published in Finnish, with some information in Swedish and/or English languages.

Multiculturalism introduces new opportunities and challenges for the society in the planning and implementation of violence prevention work. The MaSu Project is an innovative development project around issues of immigrant women's wellbeing, abuse and violence. The name MaSu derives from a combination of the first two letters from two Finnish words, '*maahanmuuttajataustainen*' (with an immigrant background) and '*suomalainen*' (Finnish). The concept behind the name symbolises the process of acculturation and a meeting of cultures. In addition the name forms the Finnish colloquial word '*masu*' (belly), conjuring associations of pregnancy, childbirth, nurturing, nutrition, and a women's healing circle. MaSu targets immigrant women living in Finland who use violence or fear that they may have abusive tendencies against the intimate partner, child, or self. The goal of the project is to build an intercultural service model that lowers the intervention threshold and improves the uptake of services by minority groups for the prevention of family violence. The project is directed by Maria Akatemia and implemented in collaboration with NGOs, parishes, and organisations in the health, social and education sectors. Special attention is given to culture-bound violence and corporal punishment, in which women often have a central role. It is important that people working with immigrant families not only recognise the various forms of violence and malaise experienced by children, adults and communities, but also have resources to deliver professional, culturally sensitive and gender-specific services that support integration and solidarity between generations.

In Finland, the number of families with immigrant backgrounds and intercultural families has grown rapidly during the past two decades. The lack of knowledge about ill-being, aggression and violence experienced and perpetrated by people with immigrant backgrounds was raised in the article through the following rhetorical question: Does integration produce well-being, or ill-being, and how to break the cycle of abuse for the next generation? The article contained information in Finnish and English languages and its message was that violence prevention work supports the integration of immigrants into society and prevents marginalisation. Violence occurs in all social groups and cultures and is typified by shame, guilt, secrecy and fear. As a complex and multidimensional phenomenon, violence may be difficult to recognise. Violence includes violation of basic human rights and needs, psychological and physical abuse, corporal punishment, culture-bound violence, and racism, among others. The special needs of culturally diverse families and groups may be poorly recognised or understood in general, and service delivery may not be culturally sensitive or gender-specific. Immigrants often lack service information, may be ashamed of disclosing issues such as family violence to outsiders, and may have a high threshold to seek help.

At the time of writing, some 50 women representing twenty nationalities had participated in the project's preventive activities and crisis support services. Participants had confirmed the need for women to speak out about abuse and violence and they had raised topics and experiences such as isolation and lack of friends; relationship problems; challenges in

disciplining children; women's health issues; family reunion issues; finding study places and employment; being bullied; trafficking; arrests for assault; escape from forced marriage; marital rape; divorce; and shame. The topic of violence is highly sensitive and therefore it is essential that women's voices and stories can be heard and understood humanely without negative judgement or condemnation. Educating women about the perpetration of abuse and empowering them to take responsibility for violence prevention was perceived to have substantial potential for intergenerational prevention.

Communication of information is a core function of health promotion strategies. According to Haider and colleagues, 'the success of public health interventions, especially those promoting behavioural change, rests on effective communication' (2005, p. 1). The Guide to Community Preventive Services (2012) has defined *health communication* as 'the study and use of communication strategies to inform and influence individual and community decisions that enhance health'. The scope of health communication includes health promotion, disease prevention, enhancement of the quality of life, health care policy, and the business of health care in messages and materials delivered to intended audiences of individuals, communities, health professionals, special groups, and policy makers. Methods of health communication to promote health and to direct the public discourse around health comprise media literacy, media advocacy, public relations, advertising, individual and group instruction, education entertainment, and partnership development (U.S. Department of Health and Human Services, 2012, p. 4). Health communication utilises broad-spectrum intervention in the use of the mass media such as the internet, press, radio and television with capacity to reach a large audience, and narrow-gauge intervention such as posters, leaflets, videos and other health promotion resources to reach service users. The availability of new technologies and use of social media is expanding access to and delivery of health information, which raises issues about accuracy of information, equality of access, and effective use of the new tools and channels (ibid., p. 2). Social marketing refers to strategic marketing practices that 'influence social behaviours not to benefit the marketer, but to benefit the target audience' (Kotler & Andreasen, 2003; as cited in the Guide to Community Preventive Services, 2012). The potential for health communication strategies to shape health behaviour and influence health status may be exponentially increased in future as a result of the present boom in social media, media-related technology and informatics (Clark & McLeroy, 1998, pp. 29-30).

The health communication process includes a continuous loop of planning and strategy development; pretesting of concepts, messages, and materials; implementation; and assessing effectiveness and making improvements. The needs and perceptions of the intended audience may evolve as the programme progresses (U.S. Department of Health and Human Services, 2012, pp. 12-13). The media plays a pivotal role in defining values and social norms, and the relationship between the media and public health is complex. The mass media can raise consciousness about health issues, contextualise an issue within a value framework,

position health on the public agenda, convey simple information and messages, and support behaviour change in the presence of other enabling factors including motivation. Concurrently, the mass media cannot convey complex information, teach skills, shift attitudes or beliefs, or change behaviour in the absence of other enabling factors (Tones & Tilford, 2001; Ewles & Simnett, 2003; Naidoo & Wills, 2009). In addition to health communication, an ecological approach to sustainable health and wellness promotion should also address changes in health care services, technology, regulations, and policy (U.S. Department of Health and Human Services, 2012, p. 3; Steckler et al., 1995). Effectiveness of communication in health promotion merges the key elements of interaction and information. The effectiveness of media use can be enhanced through the use of integrated campaigns, presentation of new information, use of an emotional context, linking of the message with popular values, use of celebrities, and presentation of information in a personally relevant form (Naidoo & Wills, 2009, p. 196). Ewles and Simnett (2003, pp. 205-206) highlight the need for health promotion resources to use unbiased information in plain language and to avoid patronising, authoritarianism, victim blaming, racism, and sexism.

Four main models of the effects of the media on health include (1) a linear causal model in which the media has an immediate and direct effect on its audience, (2) a two-step or diffusion of innovations model in which mass communication influences key opinion leaders who then spread ideas to others through interpersonal communication, typically through an S-shaped trajectory, (3) a uses and gratifications model in which people actively select and interpret communications to meet their own needs and existing values or beliefs, and (4) a cultural effects model in which the media has a key role in creating beliefs and values about health, ill health, and medicine (as cited in Naidoo & Wills, 2009, pp. 185-190). The MaSu Project is an innovation to which the diffusion of innovations theory (Rogers, 2003, 2004) may be applied. According to Rogers, an *innovation* is 'an idea, practice, or object that is perceived as new by an individual or other unit of adoption' (2003, p. 12). The adoption of innovations has significant impacts on the health outcomes and wellness of the communities and population. *Diffusion* is 'the process in which an innovation is communicated through certain channels over time among the members of a social system' (ibid., p. 5). Diffusion describes convergence or divergence as two or more individuals move toward each other or apart in the exchange of information and meanings given to certain events. The promotion of violence prevention often requires changes in perceptions, attitudes, behaviours, and practices among individuals, families and communities. Appropriate and culturally sensitive diffusion methods are therefore essential components for the efficacy of health-promotive violence prevention and intervention.

Diffusion of innovations is a useful tool for the identification of societal norms in general or the value system and accepted practices of a target community in particular. The focus of the diffusion of innovations theory is on understanding the modes and processes of social roles,

norms, networks, and interpersonal communication among members of social systems, and how new ideas and behavioural change spread throughout the community over time. Innovations are adopted by different people at various rates, and more rapid adoption can be optimised through the promotion of relative advantage, cost, compatibility, complexity, ability to be sampled as a trial run, and ability to be observed (Haider et al., 2005, p. 3). People may be categorised into five separate types in accordance with their role in the process of innovation adoption: (1) innovators, (2) early adopters, (3) early majority, (4) late majority, and (5) laggards. Furthermore, non-governmental health workers, government health officers, and educators in the field may act as change agents and opinion leaders to facilitate innovation decision processes leading to health promoting behavioural changes (Haider et al., 2005, pp. 3-4) and serve as role models whose innovative behaviour is imitated by other members of the social system (Rogers, 2003, p. 27). Five *stages of change* have been observed in the process of adopting innovations:

1. *Knowledge:* the existence of the new idea is acknowledged and the individual begins to have some understanding of it
2. *Persuasion:* certain attitudes or emotions are held toward the new idea, and they may be either positive or negative
3. *Decision:* engagement by the individual in activities leading to a choice of the adoption or rejection of the new idea
4. *Implementation:* exploitation of an innovation by an individual with application of the new idea or practice in daily life
5. *Confirmation:* the seeking of reinforcement or confirmation of the innovation by the individual when inconsistent messages appear (Haider et al., 2005, pp. 2-3).

The process of diffusion is a highly social process and a potential enabler in fostering health awareness, health education, decision-making, healthy practices, and health care (Haider et al., 2005, p. 5). The majority of people are influenced to adopt or reject an innovation based on the subjective experience of other like individuals who have already adopted the innovation in a process of modelling and imitation. Interpersonal social exchange occurs most frequently between two *homophilous* or similar individuals who share certain attributes, such as beliefs, education, and socioeconomic status. When two individuals have identical grasp of an innovation, however, there is no new information to exchange and diffusion cannot occur. The nature of diffusion therefore requires a degree of *heterophily* or diversity between the two participants in the communication process (Rogers, 2003, pp. 18-19).

The significance of health communication in health-promotive violence prevention can be examined in relation to the multilevel ecological model. At the individual level, health communication can influence individuals' awareness, knowledge, attitudes, self-efficacy, skills, and commitment to nonviolence and behaviour change. At the organisational level,

organisations can participate in violence prevention programmes, nonviolence messages can be transmitted to group members, and organisational policy changes can be adopted to support individual behaviour change. At the community level, violence prevention programmes can raise awareness, promote changes in attitudes and beliefs, and foster group or organisational support for nonviolent behaviours. The involvement of community opinion leaders and policymakers can be an effective strategy in influencing community change. At the societal level, action can be prompted for the building and maintenance of safe physical, economic, cultural, and information environments, the support for sustainable social norms, values, attitudes, laws and policies against all forms of violence, as well as the addressing of barriers or systemic problems such as discrimination or poor access to care (U.S. Department of Health and Human Services, 2012, pp. 3-4). As a complex, sensitive and controversial topic, effective health communications about violence and violence prevention should be issued by a reliable source to ensure that users trust the information received (ibid., p. 34).

Therefore intercultural interaction in a trusted environment offers benefits to support the process of diffusion in violence prevention work. The rate of diffusion and adoption of the innovation may be improved by emphasising the benefits of a particular innovation and by making the innovation complementary to the societal norms of the community. The practitioner should be sensitive to the phenomenon of pro-innovation bias or the assumption that a programme should be diffused and accepted by all members of the community. The main limitation of diffusion of innovation is the potential for blaming an individual or group for rejection of a new behaviour, rather than identifying the effect of the wider social system. In addition, there may be inequities in the diffusion of information or adoption of health promoting practices (Haider et al., 2005, p. 6).

5.2 Gender and Violence Prevention (II)

The second paper, titled '*Good Practice for the Prevention of Abuse and Violence by Women - The Demeter Programme*' (Appendix 2) was submitted in March 2011 and presented by lead author Tanja Harju at 'The 12th ISPCAN European Regional Conference on Child Abuse and Neglect: Challenging social responsibilities for child abuse and neglect' in Tampere, Finland in September 2011. The Demeter Programme ('*Demeter-työ*' in Finnish) is a preventive women's violence intervention programme addressing family and intimate partner violence by women. The name of the programme refers to the ancient Greek goddess of growth and motherhood. The programme was developed at Maria Akatemia by psychotherapist Britt-Marie Perheentupa based on a gender-specific, family-centred and psychodynamic approach, and it has been funded by Finland's Slot Machine Association (RAY) since 2003. The goals of the programme are to investigate the dynamics of psychological and physical abuse perpetrated by women through practice-based hermeneutic research, and to integrate the empirical theory and intervention model developed in the programme in violence prevention practice.

Gender is a mediating variable in the cycle of violence perpetration and victimisation according to biological, psychopathological, family systems, social learning and feminist theories. The gender-based approach to violence and interventions is an area of controversy in the academic and public discourse on domestic violence (e.g., Straus, 2011, Eisikovits & Bailey, 2011; DeKeseredy, 2011; Dutton, 2012). In spite of growing recognition of the phenomena of violence by women and bilateral intimate partner violence (e.g., Straus, 1979, 1980, 1993, 1997, 1999, 2011; Dutton, 1986, 1994, 2006, 2012; Dasgupta, 1999, 2002), the reductionist portrayal of intimate partner violence has resulted in a denial of violence by women and of mutual complicity in violent couples (Dutton, 2006). Common couple violence is perpetrated by both women and men in heterosexual and same-sex partnerships. However, the escalating type of battering and more severe forms of injury show a greater incidence of assaults by men (Krug et al., 2002, p. 89). The Duluth model is a psychoeducational approach that has been adopted worldwide for the treatment of male perpetrators (DAIP, 2011). A central assumption in the model is that men can change violent behaviour because beliefs about male dominance and the use of violence to control are cultural and not innate (Paymar & Barnes, 2009, p. 15). The model hypothesises societal, cultural and institutional support for men's violence, citing that violence by women is a necessary response and resistance to controlling violence used by men. Battering in same-sex intimate relationships is attributed to the context of larger social oppression. The Duluth model has been criticised as a gender-polarising approach and a gender-neutral revision of the model has been suggested (Graves, 1996).

Human social sustainability is built in the early years on the primary role of the caregiver as an emotional and behavioural regulator for the child and his or her structural and functional social brain development of regulatory capacity (Schore, 2008). Maternal stress, maternal abuse, maternal loss and ambivalent maternal behaviour in the early years are important determinants of health outcomes and contribute to psychological and relational disorders and compensatory regulatory strategies (Almond, 2010; Cori, 2010; McBride, 2008; Poulter, 2008; Talge et al., 2007; Edelman, 2006; Engel, 2005; Secunda, 1990; Lerner, 1985; Chodorow, 1978; Mahler et al., 1975; Winnicott, 1965; Klein, 1946). A critical question in intergenerational prevention is whether there is different impact in children who witness violence perpetrated by the mother than in children who witness the victimisation of the mother (Dasgupta, 2002, p. 1382). Violence by women - in particular violence by women against children – is a primordial taboo and often goes unnoticed in health and social services. Clients are not systematically asked about own use of violence and detected cases of maternal abuse are typically serious and late interventions. The helping relationship may be obstructed by mothers' deep feelings of guilt, shame, and fear of children being taken into custody. It has been suggested that positive support for parenting may help to reduce harsh, punitive, abusive or neglectful behaviour that harms children and perpetuates vicious cycles of insecurity and regulatory incapacity across the generations. Gerhardt believes that the real source of many parenting difficulties is the separation of work and home, or public and

private. The isolation of mothers in their homes, without strong networks of adult support and without variety in their daily routines, has created depression and resentment towards parenting (2004, p. 22). Women have faced the conflicting choice between working life or children, when the evidence is that they want both (Newell, 1992).

A system of advocacy for women who use violence in intimate relationships and their children is needed; these women may be unfairly excluded from services because the philosophical basis and infrastructure of anti-domestic violence agencies rely on female victimisation (Dasgupta, 2002). Debate exists over conjoint couples treatment and family counselling for intimate partner violence. Violent couples frequently wish to stay together, however marriage counselling is often deemed ineffective in the situation where one partner is a batterer and has power over the other. Paymar and Barnes (2009) hypothesise that men and women use violence in very different ways and therefore require a different intervention and treatment response. A separate gender-specific counselling programme may be appropriate for women who use violence without themselves being abused (Graves, 1996). On the other hand, Stith and McCollum (2011) posit that single gender treatment may not be effective for all types of partner violence and that in selected situations conjoint treatment may enhance safety and conflict resolution. Raising communal and societal discussion about the saliency of violence by women is a catalyst for caregivers to develop awareness of helping services and to strengthen hope and commitment to intergenerational prevention and change. The ecological nested framework offers a sound approach for domestic violence as it allows analyses from a multilayered and interactive perspective (Krug et al., 2002; Dasgupta, 2002; Dutton, 2006).

Maria Akatemia's Demeter Programme provides prevention and treatment services to women who have abusive tendencies or fear that they may be abusive towards the intimate partner and/or children. The intervention model includes three phases: a national violence helpline for women, exploratory one-to-one counselling sessions, and professionally facilitated peer support group processes. The client's situation and the family's safety are assessed during the initial call to the helpline and referral for individual counselling sessions is offered. The purpose of one-to-one counselling is to establish holding of the client through dialogue about the client's life narrative and abusive behaviour. Counselling fosters the client's restoration of self-dignity, responsibility for stopping abusive behaviour, motivation for behavioural change, and case management with the client's support networks including an assessment of the need for child welfare services. After three counselling sessions continuation is generally recommended in facilitated peer support group processes, further counselling sessions, and/or psychotherapy. The emphasis of the intervention process is on understanding the connection between one's family history and the inner life script as a trigger for destructive impulses and violent behaviour. Gender-specific group work in particular provides an effective support process for the reparative experiences of empathic connectedness, sharing of childhood narratives, understanding of the mother-daughter relationship, self-acceptance,

and love for one's inner child. Emotions including anger, fear, grief, jealousy, guilt, shame, and existential terror as well as joy, satisfaction, gratitude, humility, and pride are collectively identified and analysed to discover new insights and alternatives to individual thoughts and behaviour. The experience of being seen, heard and known in an attuned environment increases self-esteem and awareness, which in turn fosters respect, empathy, and accountability towards both self and others for a violence-free lifestyle.

The main outcome of the Demeter programme has been a decrease in aggressive impulses and violent behaviour by women as clients have gained awareness of own inner scripts and received interpersonal support for change and growth. Critical reflection of practice and collaborative learning by the entire multidisciplinary team of workers has been used to generate an experiential theory of violence dynamics. The programme developer and mentor Britt-Marie Perheentupa (2010) has postulated five defence strategies that may act to sustain violent behaviour: emotional sterilisation, emotional encapsulation, persecutory inner pyre, mother internalisation in a glass sarcophagus, and embodiment of suffering. Key attachment relationships and primal love in early years have been shown to have long-term effects on self-esteem, inner scripts, and interpersonal relations. It has been found that every perpetrator in the programme has witnessed abuse or experienced deprivation of primal love during childhood. Violence is a complex and collective phenomenon that is learned and expressed in human interactions; therefore human interactions also provide the basis for unification and healing. The programme's preventive model and theory can be applied at the individual, family, community and societal levels to prevent violence and intergenerational transmission of abusive tendencies. In addition to services for clients Maria Akatemia provides specialist consultation, professional training, and supervision for practitioners.

The Demeter Programme has been commended by the 12th International Society for Prevention of Child Abuse and Neglect (ISPCAN) European Regional Conference on Child Abuse and Neglect in Tampere, Finland in 2011 as a model of good practice. The theory and model developed at Maria Akatemia in the Demeter Programme meets the national recommendations by Finland's Ministry for Social Affairs and Health (2008). The pioneering work by the programme helps women perpetrators to stop violence; develops service and care models; educates workers and fosters cooperation between municipalities, NGOs, and parishes; and contributes to the knowledge base in the area of violence by women. As the focus of most interventions has traditionally been on violence by men against women, it is important for workers to recognise own gender-related attitudes and possible biases in violence prevention and treatment. Gender-specific training in practice-based knowledge for workers in the helping professions is an enabler for effective interventions when family violence is suspected. Furthermore, knowledge of gender-specific violence dynamics and self-awareness of own inner scripts are promoted as professional quality factors and an important means to prevent vicarious traumatisation and burnout among workers.

5.3 Culture and Violence Prevention (III)

The third paper, titled '*Intercultural Dialogue, Women's Empowerment and Violence Prevention – The MaSu Project*' (Appendix 3) was submitted in January 2012 and presented by lead author Tanja Harju at the '7th NASPCAN Nordic Congress on Child Abuse and Neglect, Child abuse and neglect in a cross-cultural perspective: Possibilities and challenges' in Bergen, Norway in May 2012. The MaSu Project is a development project implemented by Maria Akatemia in Finland in 2010 to 2013 for the identification of and intervention in family violence by women with immigrant backgrounds. The project is a continuation of the Demeter Programme, which was developed at Maria Akatemia by psychotherapist Britt-Marie Perheentupa and has researched the dynamics of psychological and physical abuse by women since 2003. Correspondingly with the Demeter Programme, the MaSu Project provides services to women who have abusive tendencies or fear that they may be abusive towards their intimate partners and/or children. The project methods combine selective and universal prevention efforts targeted at the first level to women with immigrant backgrounds through a national violence helpline for women, exploratory one-to-one counselling sessions and facilitated peer support group processes; at the second level to practitioners through specialist consultation, professional training, and supervision; and at the third level to the population in general through advocacy and interactional discussion events open to all. In the first two years of the MaSu Project, some 95 women representing thirty nationalities had participated in the project's intercultural preventive activities and crisis support services.

Culture is a mediator of violence and provides a context for intervention. *Culture* is defined as the 'ways of life, shared behaviour, social institutions, systems of norms, beliefs and values, and the world view that allows people to locate themselves within the universe and give meaning to their personal and collective experience' (Corin, 1994, p. 101). The concept of *cultural relativism* refers to the derivation of meaning of cultural norms and values within a specific social context. The ways of thinking, behaving and living – including the expression and transmission of violence and abuse – are culture-specific and dynamic phenomena that may typically remain invisible within one's own relationships and cultural boundaries. The intergenerational legacy of inherited ideas, beliefs, values, knowledge and traditions that bind people together are located within the *cultural blueprint* (McMurray, 2003, p. 277). Tacit and explicit cultural differences permeate a range of socially defined characteristics, such as those relating to age, gender, sexual orientation, occupation or socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief, disability, or disease (McMurray, 2003; Bradby, 2001). Health-related issues such as child-rearing practices, diet and eating habits, a sense of past, present and future, responses to stress and death, and attitudes to health care services and practitioners are often prescribed and replicated by cultural norms. Draguns (2008) posits that multiculturalism exists not only in the social diaspora but also on the intrapsychic level, as individuals participate in both culturally

distinctive milieu and the mainstream sociocultural environment. The family is perceived to act as a locus between the individual and the community for wider social tensions and transformations, which may contribute to particular challenges for intercultural couples and families (Shelling & Fraser-Smith, 2008). Culture change occurring over time or through migration reveals the protective and detrimental aspects of family and community life. The range of responses to a stressful event or situation by people with culturally diverse backgrounds is related to cultural conceptions of the human being and the world (Corin, 1994).

Cultural sensitivity is defined as acknowledgement that cultural differences affect individuals' health status and health care. *Cultural competence* refers to the ability to understand, communicate with, and interact effectively with people of different cultures and includes four components: (1) awareness of own cultural worldview, (2) attitude towards cultural differences, (3) knowledge of different cultural practices and worldviews, and (4) cross-cultural skills. *Cultural appropriateness* refers to conforming to a culture's acceptable expressions and standards of behaviour and thoughts. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot-testing (Fertman & Allensworth, 2010, p. 425). The combination of ethnocentrism and universalism presents a challenge for communication and interpretation in multicultural interventions. Unsafe cultural practice refers to actions that diminish, degrade or disempower an individual's cultural identity and wellbeing (Williams, 1999). Practitioners from the same culture may accept the physical expression of health-related symptoms instead of recognising psychosocial origins and components of behaviour (Corin, 1994, pp. 112-113). On the other hand in cross-cultural health care interactions there is a tendency for practitioners to focus on technical preoccupations as an avoidant defence mechanism, in response to anxiety that is generated by witnessing and holding the client's emotional pain and experiences of social difference (Gunaratnam, 2003, pp. 119-120). The practice of ethnic matching is advocated by Papadopoulos and Lees (2002) to promote cultural competence, access and cooperation.

Repositioning the interdependency of relationships is of essential relevance to sustainability and may be fostered by an ethic of care (Robinson & Vaealiki, 2010). 'Truly multicultural societies institutionalise understanding and tolerance of one another's cultural beliefs and practices in the context of daily living, and in planning for a future in which all cultures will be sustained' (McMurray, 2003, p. 279). The scaffolding of education with a pedagogy of cultural relativism is advocated as the major strategy for achieving cultural safety (McMurray, 2003) and effecting reconciliation at the operational level (Miller, 2010). The building blocks of *cultural safety* are cultural awareness, cultural sensitivity and a commitment to cultural preservation and protection informed by an understanding of the equality of difference (McMurray, 2003). The need to redress barriers to health and wellness and encourage the sustainability of Indigenous cultures is advocated. McMurray describes the Indigenous health

gap is described as 'untenable... at a time when the non-Indigenous people of the world are enjoying increasingly better health' (ibid., p. 277). Blewitt (2008) purports the support and protection of ecological, economic, social and cultural diversity, which provide the seeds for new opportunities and maximise options for coping with the effects of future change.

The MaSu Project fosters intercultural dialogue between individuals and groups with culturally diverse backgrounds to make visible the actions, attitudes, values, and beliefs concerning violence. *Intercultural dialogue* is defined as:

> 'a process that comprises an open and respectful exchange or interaction between individuals, groups and organisations with different cultural backgrounds or world views. Among its aims are to develop deeper understanding of diverse perspectives and practices; to increase participation and the freedom and ability to make choices; to foster equality; and to enhance creative processes' (European Institute for Comparative Cultural Research, 2012).

Intercultural dialogue encounters or processes may act as a facilitator for the societal and cultural diffusion of innovation. An ethic of listening in which people have a voice fosters the creation of an open space for deepening of awareness, suspension of judgements, and openness to change (Robinson & Vaealiki, 2010). According to Corin (1994, pp. 119-129), culturally and socially acceptable and appropriate intercultural programmes should build and reinforce on a community's strengths and insights as well as respect social definitions of privacy frontiers, the rules for giving and receiving support, and appropriate channels for action. Corin posits that the most important factor for promoting mental and physical health and mitigating stress is the sense of belonging to a given setting. People develop various responses and coping styles in different social and cultural spheres such as family, religion, school, work, leisure, and associations. Contradictions between traditional cultural norms and socially desirable behaviour modelled by the mainstream population may give rise to inner conflicting obligations for people with culturally diverse backgrounds, and contribute to a potential risk of family violence between intimate partners, generations, siblings, or in-laws. Attempts to modify attitudes and behaviour should be based on an understanding of cultural origins and significance, present functions, and central or peripheral position within the interconnected life of the community. Conversely, well-intentioned but culturally inappropriate actions may contribute to a collective sense of inadequacy, inferiority or vulnerability.

It has been found that every perpetrator in Maria Akatemia's Demeter and MaSu programmes has witnessed abuse or experienced deprivation of primal love during childhood. Key attachment relationships and primal love in early years have been shown to have long-term effects on self-esteem, inner scripts, and interpersonal relations. It is postulated that for immigrants and Indigenous peoples the processes of relocation and acculturation with associated experiences of unresolved grief, loss, isolation, shame, and rejection may be a risk

for traumatic adaptation and psychopathological bonding (Boss, 1999). Clients in the MaSu Project often begin the counselling process in a state of incongruity that may arise on three levels: from inner conflict, interpersonal conflict, and cultural conflict. *Culture shock* describes the condition of disorientation and attendant helplessness that may be experienced in response to removal from accustomed habitat and confrontation with new rules of living (Oberg, 1958). Empathic communication that is characterised by attunement and dialogue instils hope and solace (Draguns, 2008). Empathic counselling stimulates the mobilisation of endorphins and the strengthening of the immune system (Grawe, 2004), alleviates distress, restores equilibrium with family and community, supports adaptive coping, promotes problem solving and decision-making, and enhances personal efficacy and quality of life (Draguns, 2008). The avoidance of cultural encapsulation in services is promoted through respect for historical roots and background, cultural difference, holistic thinking, interdependency, a collectivist perspective, the relevancy of the social support system to psychological health, interdisciplinary cooperation, system flexibility, and recognition of racism and cultural bias (Pedersen, 2008, pp. 8-9).

The outcomes of the MaSu Project have been an increased knowledge of the forms and effects of violence and a decrease in abusive behaviour by immigrant women as they have gained awareness of own inner scripts and received interpersonal support for change and growth. Preliminary results have suggested that the MaSu Project's facilitated intercultural dialogue processes had increased the recognition of violence by women with culturally diverse backgrounds and by practitioners, promoted cultural sensitivity, and raised cultural competence. Furthermore, intercultural dialogue had strengthened the universal bond between women from all cultures and walks of life as an empathic basis for equality and solidarity. The transition of women's and girls' gender roles in family and society has been acknowledged as a risk factor for heightened interpersonal conflict, and therefore parallel initiatives that support men's empowerment and solidarity between generations are of critical importance to women's empowerment and violence prevention programmes.

Interdisciplinary and intercultural cooperation is necessary to search and develop methods for the identification, intervention and prevention of risk factors and promotion of family safety and wellbeing. The method of facilitated intercultural dialogue is promoted as an enabler for participation, building trust and safety, sharing information, raising awareness, and promoting health literacy. The theory and model developed at Maria Akatemia support the diffusion of violence prevention for good practice in early intervention and treatment. By addressing the shortage of culturally sensitive health information and services, it is hoped to build dialogue between and within the majority and minority populations and to strengthen a sense of community, integration and trust in the society.

5.4 An Ecological Approach to Sustainable Health and Wellness Promotion

Health behaviour is the result of multidimensional interactions taking place in the broader social and environmental context over time. Krieger (1994) posited the question of the whereabouts of the presumed 'spider' responsible for the web of causation in risk factor epidemiology. Sustainable health and wellness promotion is facilitated by an understanding of regulating social factors and the processes underlying their biological embodiment (Glass & McAtee, 2006). There is a need to reorientate theories, research and practice from the simple linear causal thinking that is characteristic of a mechanistic world view, toward a more complex and contextual representation that accounts for the multiple causation of biological and social interactions throughout the lifecourse. Glass and McAtee (ibid., p. 1653) have proposed a multilevel framework as an extension and modification of the 'stream of causation' metaphor, which has adopted the symbol of a running stream to signify the chain of causal influences from upstream social factors to downstream individual factors (McKinlay, 1979).

The multilevel framework comprises axes of time and nested hierarchical structures, within which the 'sphere of health-related behaviour and action moves through time from infancy to old age' (Glass & McAtee, 2006, p. 1653). The social and biological nested hierarchies form a landscape above and below water respectively along the river of life. The social hierarchies encompass micro, meso, macro and global spheres of action from family and social networks through communities, national and ecological dynamics. The biological hierarchies encompass genomic, molecular, cellular and system levels of the human body. Upstream factors are located at the left of the time axis commencing with critical events that occur at conception and in early life, and downstream factors are located at the right of the time axis concluding with late life. The social and biological hierarchies are constituted in the human action of the individual person, synergised through the integral expression of unique opportunities and constraints in circumstances. The concept of embodiment describes the 'sculpting of internal biological systems that occurs as a result of prolonged exposure to particular environments' (ibid., p. 1655).

Following Glass and McAtee, the present study proposes an adaptation of the web of causation model to stimulate ongoing discourse and research. Three modifications to the conceptualisation of Glass and McAtee's model are proposed, as illustrated in Figure 11:

1. a shifting of the axis of nested hierarchies from the left to the centre of the model
2. a re-viewing of embodiment and human action as an integrated unity at the centre of the model, constituting the unique human agent who is shaped by and shapes the triad of opportunities, constraints and expression
3. a modification in the form of the biological and social hierarchies from a rectangular to an oval shape, in recognition of the dynamic and spiral-like processes that generate individual and population patterns of health and wellness.

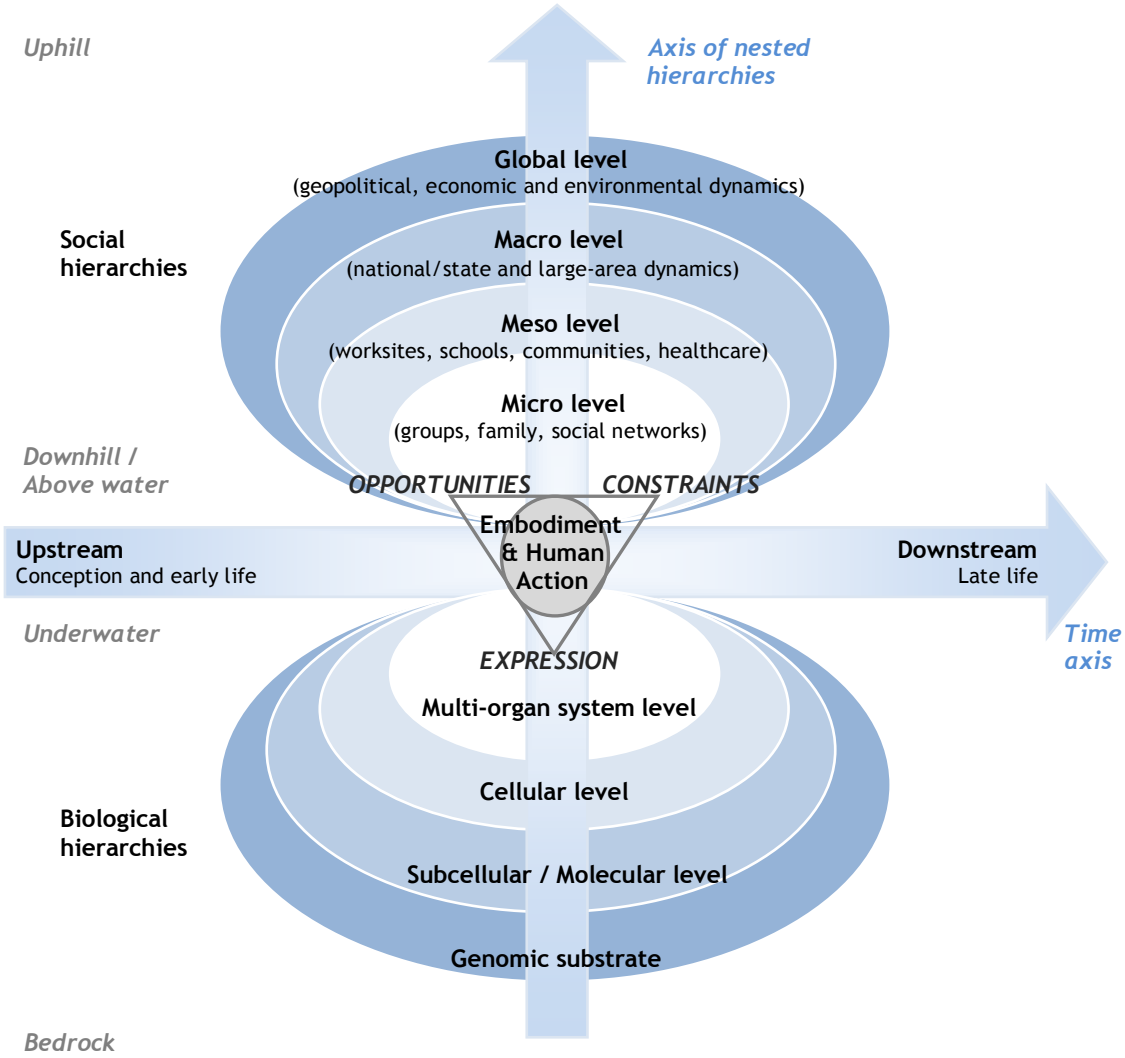

Figure 11: An Ecological Framework for Sustainable Health and Wellness Promotion.
© Tanja K. Harju, 2013. Adapted from Glass and McAtee, 2006 (p. 1653).

The proposed adaptation conceptualises the life trajectory as a dynamic process, in which the sphere of embodiment moves across time at the interface of outer and inner worlds. Metaphorically the design represents human development as a process of pearl growing. The evolving organism of the pearl is nurtured while it grows within two shells from grains of sand in concentric layers, portraying the social and biological hierarchies. Each pearl is unique in form and may be linked in a generational string. Every human being engages in a unique lived experience, in which the human person is more than and different from the sum of the parts. The environment is both inseparable from, complementary to, and evolving with the person. Health in this metaphor is the open process of human being, belonging and becoming, involving the co-creation of meaning and identity.

The model provides an ecological framework to organise areas of convergence in the multi-level interdisciplinary research of human behaviour and development. Risk regulators act as mediating structures or variables for the classification of relatively stable features of the social and built environment that influence individual action (Glass & McAtee, 2006, p. 1659). An application of the above model for violence prevention is proposed below (Figure 12) for critical evaluation and further discussion. The outline includes the following variables of risk regulators and the biopsychological substrate of regulatory systems that are most likely to be relevant to violence prevention and intervention.

Risk regulators for violent behaviour:

- *Material conditions*
  (e.g., rapid social change, poverty, unemployment, conflict/post conflict, crime)
- *Conditions of family and community*
  (e.g., victim of child maltreatment, marital discord, poor parenting practices, physical or mental illness, high mobility, inadequate victim care services)
- *Cultural norms*
  (e.g., cultural norms that support violence, firearm availability, media violence)
- *Conditions of work and education*
  (e.g., bullying, occupation, socioeconomic status)
- *Psychosocial hazards*
  (e.g., psychological/personality disorder, alcohol/substance abuse, separation, loss)
- *Laws, policies and regulations*
  (e.g., gender inequality, weak safety nets, poor rule of law)

Regulatory systems for violent behaviour:

- *Social brain maldevelopment*
  (e.g., prefrontal cortex, HPA axis reactivity, hyper- or hypoarousal of fight/flight/freeze responses)
- *Attachment insecurity*
  (e.g., traumatic bonding, toxic sense of self, self-disorganisation, inability to connect in resonant relationships)
- *Emotion dysregulation*
  (e.g., poor recognition/expression of anger, fear, sadness; terror, shame, contempt)
- *Relational blueprint*
  (e.g., limbic implicit memory, poor empathic inference, shame-based identifications and/or pride-based counter-identifications, valence i.e. approach/avoidance)
- *Vulnerability*
  (e.g., self-rejection, somatic disequilibrium, weak resilience, inflexibility of responses)

These variables were identified in the literature review (see Chapter 2) and empirical evidence (see Chapter 5) of the present study, with particular reference to the World Health Organization's ecological model for understanding and preventing violence (WHO, 2004, pp. 4-5; Krug. et al., 2002, pp. 12-15). Specific causal effects and feedback loops are not shown due to the complex interaction of risk factors and protective factors affecting violent behaviour and to maintain diagram simplicity. Following Glass and McAtee's application to the study of obesity (2006, pp. 1661-1664), violence is viewed as a good example for application with the web of causation metaphor due to (1) the high cost and limited evidence-based effectiveness of individually focussed behaviour treatments, (2) the important role of environmental, social and cultural factors in shaping violence, and (3) the need to incorporate the biological substrate in explaining the phenomenon of violence.

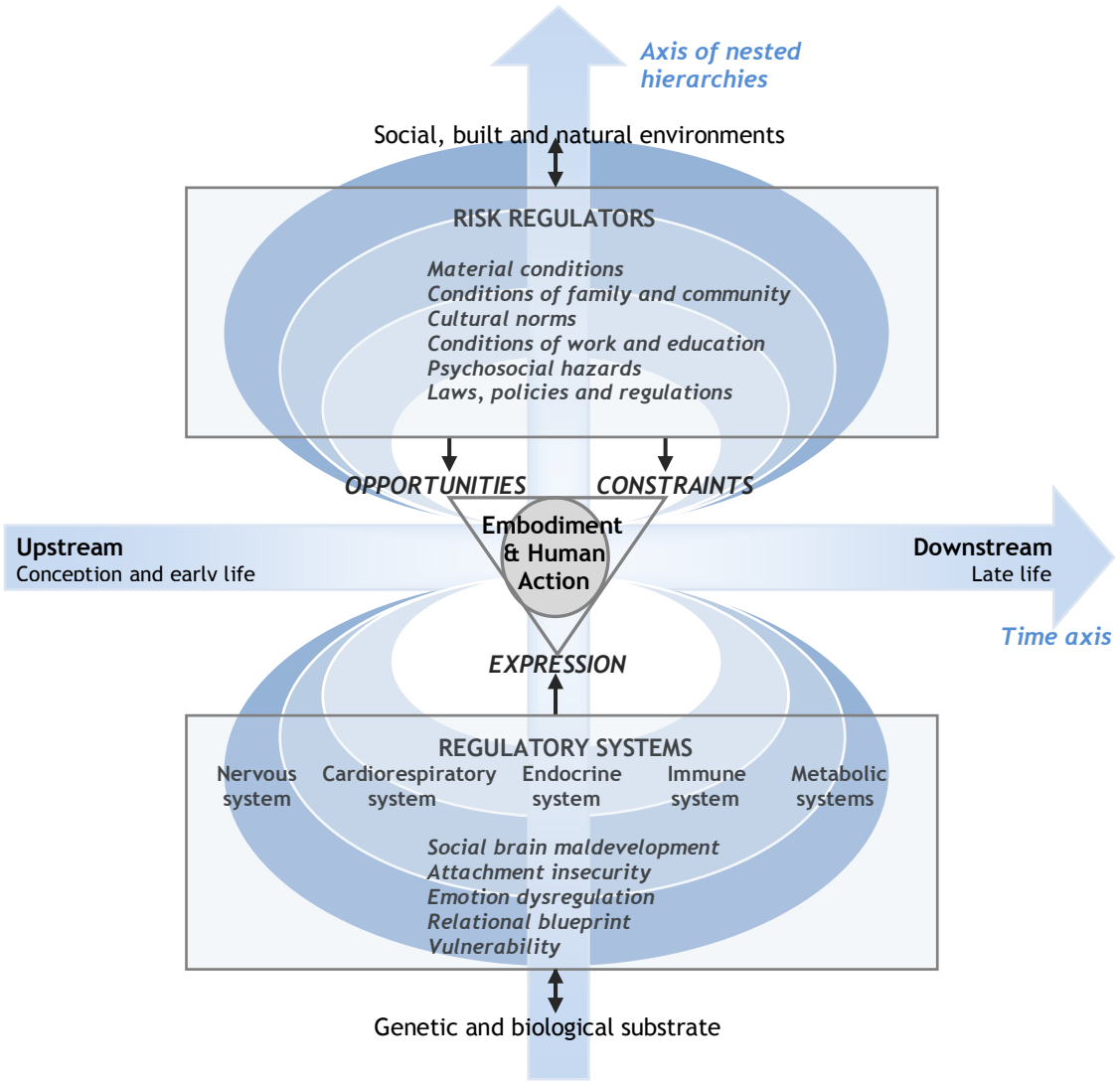

Figure 12: An Application of the Ecological Framework Showing Risk Regulators and Regulatory Systems for Violence. © Tanja K. Harju, 2013.
Adapted from Glass and McAtee, 2006 (pp. 1661, 1663); WHO, 2004 (p. 4).

5.5 Ethical Considerations

Interpersonal violence is a sensitive issue requiring close attention to ethical considerations in research. The chosen method for the present study is an article-based literature review. The thesis explores and synthesises work that has already been done and published and is therefore ethical practice. The main ethical issues in literature reviews involve:

- the accurate and fair treatment of existing research (including issues of misrepresenting results, plagiarism, and academic fraud)
- selection/publication bias and literature accessibility
- the ethics of the research included in the review
- respect of original study participants' consent and confidentiality
- permissions to use and reproduce materials, and
- conflicts of interest.

The thesis innovatively integrates a wide scope of research in the public domain from different disciplines and develops arguments about future prospects for study to contribute to the sustainability discourse. The duplication of research questions that have already been addressed, on the other hand, could be unethical.

The thesis raises a fundamental ethical issue for the future neurosociety, namely the utilisation of social neuroscientific knowledge for the conscious shaping of human nature. The emerging evidence of cognitive, sensory and emotive neural blueprints that unconsciously direct behaviour challenges the perception of free will. Individuals may not necessarily be in control of their actions, even though they are ultimately responsible for them. Other ethical concerns in the fields of sustainable development, health promotion and violence prevention include questions of national security, individual safety, equality, social stability, equal access, individual rights, individual choice, coercion, fostering welfare dependencies, boundaries of competence, and dual relationships.

The Western code of ethics is based on a preference for individualism rather than collectivism as the preferred worldview. Therefore interventions may promote an independent and separated self as the healthy ideal across cultures, with an emphasis on selfishness and lack of commitment to the group. The pluralistic societal context requires policy makers, groups and individuals to refrain from cultural encapsulation and make values explicit. There may be unintentional cultural bias in the provision of services including directive, paternalistic, and authoritarian interventions (Pedersen, 2008). Ethical dilemmas may arise between professional ethical guidelines and the cultural context, for example in issues of childrearing. Feshbach and Feshbach (2009) highlight that individual differences exist within any ethnic group and that all ethnic groups have engaged in negative behaviours. The present study supports that social sustainability is founded on equality and interconnectedness in all aspects of life.

5.6 Future Prospects for Research

Given the vast quantity of literature and research on health and development, it was not possible for this thesis to cover all contributions and perspectives on social sustainability, health promotion, and violence prevention. The thesis has, however, appropriated a considerable collection of different theoretical and practical approaches within the scope of the study and proposed an adapted model of Glass and McAtee's (2006) web of causation, stimulating ongoing discourse and research in the field.

The evidence base for health-promotive violence prevention needs to be established. Knowledge of complex underlying mechanisms in the intergenerational transmission of violence and malaise is accumulating. There is no best research strategy and further research should continue to apply quantitative, qualitative and hybrid approaches and designs.

1. Funding should be directed into research, implementation, continuity, and permanency of evidence-informed early prevention intervention programmes and services.
2. International consensus should be reached on the indicators and measurement of social sustainability and wellbeing.
3. The neurosociety, social sustainability, flourishing, mentalisation, affect regulation, blueprints, and resilience are important constructs that require further investigation.
4. There is a need for more and better quality longitudinal studies of health and wellbeing extending across the lifecourse and across more than one generation. Researchers should focus on the social determinants of health and the development, meaning and function of health behaviours over time, rather than exclusively on form.
5. It is necessary to initiate new studies and recruit cohorts born recently to study the long-term effects of social brain development in early childhood, attachment relationships and regulatory capacity; the increasing prominence of psychopathology in adolescence and young adulthood; and intervention outcomes.
6. Planning of intervention programmes should target pregnant and lactating mothers, infants, children, and dating teenagers to support the early prevention of inter-generational risk.
7. Researchers should focus on the development and application of theories and approaches attuned to social and cultural diversity. Some protective factors, risk factors and developmental outcomes may vary by characteristics such as age, gender, sexual orientation, birth order, diet, physical appearance, occupation or socioeconomic status, religious or spiritual belief, disability, disease, ethnic origin or migrant experience.
8. The scope of gender issues should continue to be diversified to include studies of violence by women, especially against children. There is minimal research on female perpetration outside of incarcerated samples.

6 Conclusion

Sustainable development recognises the widening and deepening interconnectedness in all aspects of life and portends to the accelerating impact of change. The growing social, cultural, intellectual and technological complexity of modern society give new lenses to develop and evolve ecological reform, based on understanding of the nature and dynamics of collective human processes and the biological correlates of nurturing environments. The core principle of social sustainability is to safeguard human dignity and the needs of future generations. Health is the key precondition, indicator and outcome of sustainable development. The aim of the present study was to contribute to the sustainability discourse by examining how to foster health and wellbeing for a socially sustainable society. Interdisciplinary knowledge of underlying mechanisms in the intergenerational transmission of violence and malaise was explored and synthesised in the literature and article-based review of social sustainability, health promotion and violence prevention. Additionally, an adaptation of Glass and McAtee's web of causation model (2006) was developed to illustrate the dynamic biological embodiment of risk factors and regulatory systems for violence in an ecological framework for sustainable health and wellness promotion. The synthesis offers a substantial contribution to understanding, further researching and promoting the social determinants of health and wellbeing within social sustainability and sustainable development.

The research highlighted the impact of environmental failure in the early years on the intergenerational life trajectory. To become a human being with a sense of self and capacity for empathic connection requires attuned reflection through the eyes and minds of caregivers in early life. Deprivation in the infant-caregiver relationship lays critical foundations via traumatic bonding, social brain maldevelopment, emotion and arousal dysregulation, dysfunctional relational blueprints, vulnerability, and maladaptive infant mental health, manifesting as compensatory regulatory strategies and psychological and physiological health inequities across the lifecourse. Family life is of central importance in passing on and sustaining the legacy of emotional and relational culture. Parenting, care and education from conception to young adulthood should enable and protect human health and sustainability for current and future generations, rather than perpetuate unhealthy and unsustainable ways of living. 'No longer is it nature versus nurture but nature via nurture' (Ridley, 2004, pp. 3-4).

Health promotion is concerned with the health and wellbeing of populations as a whole, and interpersonal violence and malaise imposes a major burden on that wellbeing. In the words of Nelson Mandela, violence is:

> 'a legacy that reproduces itself, as new generations learn from the violence of generations past, as victims learn from victimisers, and as the social conditions that nurture violence are allowed to continue. No country, no city, no community is immune. But neither are we powerless against it.' (as cited in Krug et al., 2002, p. ix)

Violence can, and must, be prevented. With respect to health-promotive practice, this study has discussed the significance of health communication, gender and culture with reference to three original papers on women's violence prevention programmes in Finland, and made recommendations for future research for the development of evidence-based social ecological practice in health promotion, prevention and early intervention. The movement of violence prevention and treatment has traditionally focussed on violence by men against women; yet violence is often reciprocal, and the intergenerational pattern of violence is continual and additive or even multiplicative unless a conscious effort is made to break the cycle. A major priority is to engage all sectors – at the community, national and global levels – to commit themselves to the sustainability agenda. Leaders and interdisciplinary experts in health promotion make an important contribution by establishing evidence-based practice and policies to build healthy environments, lobbying a proper allocation of resources to prevention efforts, and building important partnerships between sectors and countries. In Finland the voluntary sector has implemented a substantial amount of violence intervention research and practice. Mainstream resources are essential to maintain public and political awareness raising and development of the capacity for universal programme delivery. For truly sustainable outcomes, promotion of the social determinants of health and early prevention of vulnerabilities at the population level is mandatory action.

The thesis questions the hegemony of the independent self and proposes an ecological paradigm for human growth and sustainable development. The historical path of human progress - from agricultural origins and industrialisation to the informational and digitally networked society - is accompanied by an increasing preoccupation of the conscious mind with complex social interactions and information processing, requiring greater use of conscious thinking capacity. Concomitantly, traditional social structures and temporal rhythms that have scaffolded a sense of order and narrative coherence to human life are in a state of flux. As a consequence, contemporary life has contributed to the increasing reliance on unconscious emotional, relational and cultural blueprints for automatic responses and actions. These blueprints are based on implicit memories hardwired into the brain's neural pathways in utero and in early childhood, which is the most important developmental phase of life. The ability to deal with life events effectively and without resorting to self-limiting or destructive behaviours is known as resilience, and is reinforced in nurturing environments. The quality of the early environment in determining social brain development, attachment security, regulatory capacity and resilience is a social determinant of health and therefore an issue of human rights demanding social responsibility and protection.

The emerging knowledge in the field of social neuroscience may be applied to advance human development in the vanguard of progress. The future neurosociety – in which the influence of the social neuroscience of empathy is embedded in all dimensions of daily life – may yield a new way of being in our selves, relationships, groups and society as a whole (Decety & Ickes,

2009; Lynch, 2007, 2009; Restak, 2006). It has been reported that more than 2 billion people worldwide are afflicted with brain-related illnesses including addiction, anxiety disorders, obesity, chronic pain, depressive disorders, sleep disorders, hearing loss, attention disorders, Alzheimer's disease, epilepsy, vision disorders, schizophrenia and psychosis, stroke, Parkinson's disease, and multiple sclerosis (Lynch, 2007; NeuroInsights, 2007). Neuroplasticity and 'neuro-enablement' (Lynch, 2007, p. 5) have the potential to enhance mental health and functional capacity through improved cognitive, emotional, sensory and relational capabilities, thus enhancing human productivity, growth and flourishing.

The future neurosociety presents transformational opportunities for societal innovation, health and wellness in which the ethic of the neurosociety is one of connectedness, compassion and caring (Carr, 2011). I hope that this thesis has fostered readers with the knowledge, inspiration and courage to increase their handprint in actions towards socially sustainable human development.

7 Acknowledgements

This thesis was carried out at Laurea University of Applied Sciences in Finland in years 2009 to 2013. I have been privileged to have had the opportunity to work with many wonderful persons who have supported my work and offered valuable advice during the thesis process.

First of all, I wish to express heartfelt gratitude to my supervisors Paula Lehto and Anna-Liisa Pirnes who have patiently and compassionately guided and supported me throughout my studies. I am indebted to the reviewer of the thesis Mirja Villman.

Much appreciation goes to the World Health Organization, International Child Abuse Network, Australian Institute of Family Studies, Dr Andrea Colantonio at the Oxford Institute for Sustainable Development (OISD), and Professor Felicia Huppert at the Well-Being Institute, University of Cambridge, for graciously granting permission to use their material in the thesis.

I wish to express my sincere thanks to lecturers Soile Juujärvi, Kaija Pesso, Eeva Honkanummi, Sari Haapa, Kaija Heikkilä and Päivi Immonen-Orpana for their passion and their dedication to promote ethics, leadership and sustainability in health promotion and social pedagogical practice. I extend my warmest thanks to my fellow health promotion students Anu Nordlund-Knuutila, Carmen Stahl, Agatha Hagan, Osei Ansah Bonsu, Irene Arnau Martín, Sara Asteljoki, Tomi Tynkkynen and Päivyt Makkonen, for our valuable discussions and your constructive comments and kind support.

My appreciation is also due to all of my former teachers and fellow classmates for their contribution to my learning trajectory in the science and art of optometry at the University of New South Wales, Sydney and University of California, Berkeley; and in social pedagogy at Helsinki Metropolia University of Applied Sciences and Manchester Metropolitan University.

I am also indebted to the members of the Aalto University Camp for Societal Innovation (ACSI) including Markku Markkula, Pirjo Ståhle, David Caton Roberts, Heikki Hallantie, Ehsan Baha, Martijn Aslander, Wim van Petegem, Jenni Heinonen, Inka Saini and Krista Petäjäjärvi, among many others. Thank you for kindling a global networking culture at the forefront of social innovation.

I express my sincere gratitude to Maria Akatemia/Maria Akademi and to all of my co-workers in the Demeter and MaSu women's violence prevention programmes over the years. I am grateful to my mentors Britt-Marie Perheentupa, Marjukka Hakkola and Irma Siltanen for their wisdom and guidance. I would like to thank Marjo-Riitta Karhunen, co-author of two of the original papers, for her contribution and comments on the manuscripts. I am also indebted to Leena Koiso-Kanttila, Katja Ilola, Marjatta Grahn, Kirsi Haavela, Raija Hänninen, Kaisa Hirn, Hanna Kommeri, Anne Lindholm-Kärki, Maria Lindroos, Hannele Nyström, Laura Perheentupa, Annikka Poussu-Pyykkönen, Inke Rosilo, Carola Smeds, Annika Stadius, Eivor Wallinvirta and

Tua Weckström-Lundell for their support and encouragement. The women's violence prevention programmes are funded by Finland's Slot Machine Association (RAY), which is kindly acknowledged.

My sincere thanks go to my clients and to all other participants in the women's violence prevention programmes for their engagement and trust.

My thanks are also due to my cooperation partners, friends and leaders in the field, including Maria Kaisa Aula, Saba Ayub-Riipinen, Anu Castaneda, Kaisa Enakimio, Silja Havu, Terhi Hildén, Salla Hyvärinen, Ari Inkinen, Rebwar Karimi, Vida Kessey, Ljudmila Kettunen, Hanna Kinnunen, Merit Lindén, Saido Mohamed, Mulki Mölsä, Anita Novitsky, Oge Oguejiofor-Eneh, Antti Palmu, Miika Peltonen, Erja Rusanen, Eeva Suomenaro, Emnet Tarer, Kostas Tassopoulos, Tanja Tejada, Fatima Usman, Marjo van Dijken and Dwayne Woodroffe, among many others. Thank you to all of you for making this world a better place, one day at a time.

I wish to express gratitude to Kazuko Kuratomi for the development of the Shindo Japanese bodywork method and to my Shindo instructor Rauli Pitkänen and Shindo assistant instructor Anne Mustala for their holistic wisdom, guidance, and compassion. The practice of Shindo somatic awareness, movement, postures, breathing, tapping, vocalisations, and touch has integrated my emotional and physical wellness, and as a Shindo assistant instructor I am continually inspired to help others through their own healing journeys.

I am grateful to my partner Markku Havukainen for his love and devoted support throughout the years. I wish to thank my dearest friends Santhi King, Miia Koski, George Panagakis and Miia Prowse for their genuine caring and interest in my work and wellbeing.

Finally, my deepest thanks and love go to my parents Helka and Tuure Harju in Australia, for valuing education and for giving me the freedom to travel my own life paths, and to my late grandmother Elma Ahola and my late uncle Keijo Ahola in Finland, for showing me the power of positivity and perseverance in the wake of adversity. It is my family who have taught me the meaning of love, resilience and flourishing in everyday life and grounded my homecoming across time and space.

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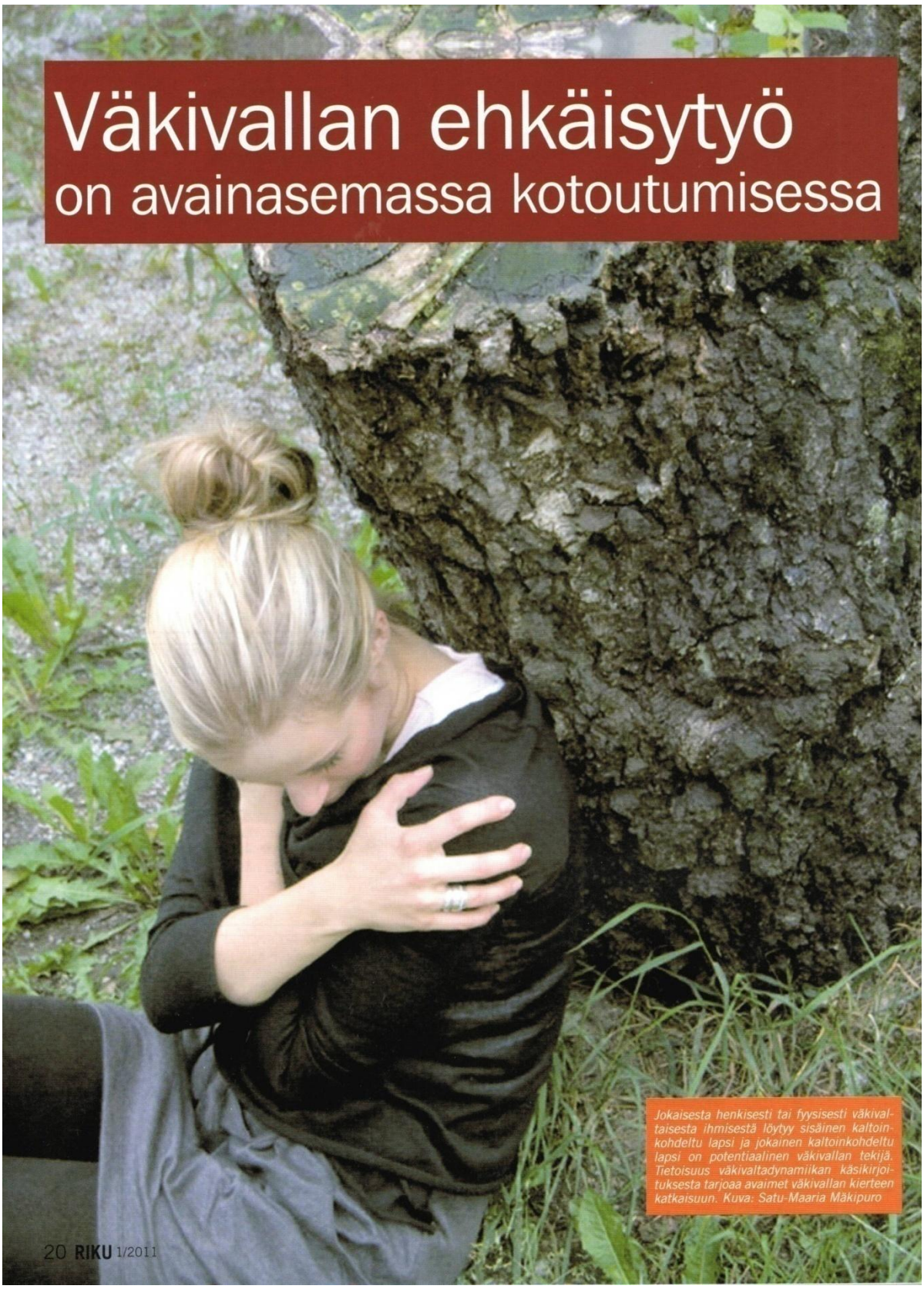
Original Papers

Appendix 1


Väkivallan ehkäisytyö
on avainasemassa kotoutumisessa
Jokaisesta henkisesti tai fyysisesti väkivaltaisesta ihmisestä löytyy sisäinen kaltoinkohdeltu lapsi ja jokainen kaltoinkohdeltu lapsi on potentiaalinen väkivallan tekijä. Tietoisuus väkivaltadynamiikan käsikirjoituksesta tarjoaa avaimet väkivallan kierteen katkaisuun. Kuva: Satu-Maaria Mäkipuro
20 RIKU 1/2011

Teksti: Tanja Harju

Maahanmuuttajataustaisten naisten käyttämän väkivallan tunnistamiseen ja kohtaamiseen kehitetään ennaltaehkäisyn mallia

Väkivaltaa esiintyy kaikissa sosiaaliryhmissä ja kulttuureissa. Ilmiönä se on moninainen ja vaikeasti tunnistettavissa: sitä ovat henkinen ja fyysinen väkivalta, rasismi, perheen tai suvun kulttuurista juontuva väkivalta, ruumiillinen kurittaminen ja ihmisen perustarpeiden laiminlyöminen. Myös maahanmuuton haavoista syntyy vihaa ja aggressiota tulijan kohdatessa pettymyksiä ja hylkäämistä uudessa asuinmaassa. Maahanmuuttajien kynnys lähteä hakemaan apua ongelmiin on korkea ja he saattavat hävetä perheessä tapahtuvan väkivallan kertomista perheen tai suvun ulkopuolelle. Monikulttuurisuus asettaakin yhteiskunnalle uusia vaatimuksia väkivallan tunnistamiseen, ehkäisyyn ja hoitoon.

Väkivaltaa voidaan tarkastella ihmisoikeuskysymyksenä ja sukupuolten välisenä tasa-arvokysymyksenä. Suomessa väkivallan käyttö perheessä on lain mukaan rikos, josta tekijän tulee ottaa vastuu. Sekä väkivallan tekijöillä että uhreilla on oikeus saada apua kulttuuritaustastaan ja sukupuolestaan riippumatta. Maahanmuuttajamiesten käyttämään väkivaltaan on kehitetty lähestymis- ja auttamistapoja, ja väkivallan uhreiksi joutuneille maahanmuuttajanaisille ja lapsille on kehitetty tukimuotoja. On tasa-arvokysymys nostaa esille maahanmuuttajataustaisten lasten ja perheiden erityisen tuen tarve tilanteissa, joissa naisten käyttämä väkivalta tai sen uhka ovat havaittavissa.

Apua maahanmuuttajataustaisten naisten väkivaltaan

Maria Akatemia ry käynnisti vuonna 2010 Raha-automaattiyhdistyksen rahoittaman nelivuotisen MaSu-projektin, jonka päämääränä on maahanmuuttajataustaisten naisten ja lasten tukeminen väkivallan ehkäisytyön kautta. Projektissa kehitetään ennaltaehkäisevän väkivaltatyön mallia maahanmuuttajataustaisten naisten käyttämän väkivallan tunnistamiseen ja kohtaamiseen yhteistyössä seurakuntien, järjestöjen ja sosiaali-, terveys- ja opetustoimen kanssa.

Palvelut suunnataan Suomessa asuville maahanmuuttajataustaisille naisille, jotka käyttävät tai pelkäävät käyttävänsä väkivaltaa sekä maahanmuuttajaperheiden kanssa työtä tekeville ammattilaisille. Projektin erityistavoitteena on kehittää kulttuurisensitiivisiä malleja puuttua eri kulttuurien harjoittamaan väkivaltaan ja kuritusväkivaltaan, jonka toteuttamisessa naisilla on usein keskeinen asema. Projektilla vahvistetaan maahanmuuttajataustaisten ja kantasuomalaisten naisten keskinäistä vuorovaikutusta tarjoamalla mahdollisuuksia kohdata ja jakaa kokemuksia.

MaSu-projekti on jatkoa Maria Akatemian Demeter-työlle, jossa on erikoistuttu RAY:n tuella vuodesta 2003 naisen henkisen ja fyysisen väkivallan kysymyksiin psyko- ja perhedynaamisen ja sukupuolierityisen viitekehyksen kautta. Demeter-työn kolmivaiheinen malli asiakkaille sisältää valtakunnallisen Avoin linja -puhelinpäivystyksen sekä yksilökeskustelut ja ohjatun vertaisryhmätoiminnan Helsingissä ja Tampereella. Työstä saadun kokemuksen pohjalta on kehitetty teoria väkivallan dynamiikasta ja naisen sisäisestä käsikirjoituksesta. Sen mukaan juuret naisen väkivaltaan löytyvät varhaisesta vuorovaikutuksesta ja alkurakkauden puuttumisesta, joka laukaisee ja toistaa henkisen ja fyysisen väkivaltakierteen.

Sukupuolierityinen lähestymistapa väkivallattomuuteen

Psykoterapeutti **Britt-Marie Perheentupa** on kehittänyt sukupuolierityisen teorian ihmisen sisäisestä kasvusta. Ihminen kasvaa ja kehittyy vuorovaikutuksessa. Sukupuolieron oivaltaminen on osa identiteetin eheytymisprosessia ja toimii ihmisen elämässä voimavarana. Naistietoisuus ei ole kulttuurisidonnaista, vaan se on kollektiivinen ja universaali alkuvoima, joka on läsnä jokaisessa naisessa. Naisyhteyden vahvistamiseksi on tärkeää tutkia ja ymmärtää, mitkä tekijät haavoittavat naisten välistä vuorovaikutusta, ja mikä vuorostaan vapauttaa naisen alkuvoimaisuutta.

” Opettamalla ja auttamalla naisia edesautetaan kaikkien perheväkivallan osapuolten turvallisuutta, hyvinvointia ja terveyden edistämistä.”

Maria Akatemia on saanut väkivallan ehkäisytyössään hyviä tuloksia monikulttuurisista ohjatuista keskustelutilaisuuksista ja vertaisryhmäprosessista. Eri kulttuuritaustaisten naisten välinen yhteys ja naistietoisuudessa vahvistuminen ovat tukeneet naisia heidän käsitellessään oman sukupolviketjun käsikirjoitusta, elämän käännekohtia, pahoinvoinnin ja tunteiden tunnistamista ja hallintaa, parisuhteiden kipupisteitä ja lasten kasvatuksen haasteita.

Väkivalta on ehkäistävissä!

Tietoisuus väkivaltadynamiikan käsikirjoituksesta tarjoaa avaimet väkivallan kierteen tunnistamiseen, kohtaamiseen ja katkaisuun. Opettamalla ja auttamalla naisia edesautetaan kaikkien perheväkivallan osapuolten turvallisuutta, hyvinvointia ja terveyden edistämistä.

Ammatti-ihmiset ovat keskeisessä asemassa naisen väkivallan ehkäisytyössä. Tietoiseksi tuleminen itsestään ja omasta väkivaltadynamiikastaan on jokaisen eettinen tehtävä ja ammatillinen laatutekijä, joka auttaa myös toisia kasvamaan vastuuta kantaviksi ihmisiksi. Maria Akatemia tarjoaa teemailtoja, koulutusta (Naisen väkivalta – aikamme kipeä kysymys alk. 6.10.2011), työnohjausta ja konsultointia terveyden- ja sosiaalihuollon sekä opetustoimen ammattilaisille ja vapaaehtoistyöntekijöille.

Lähde: Perheentupa, Britt-Marie 2010. Tietoisuuden tie alkurakkauteen – väkivalta on ehkäistävissä.

www.maria-akatemia.fi

Introducing the MaSu Project

Violence prevention work supports the integration of immigrants into society and prevents marginalisation. The number of families with immigrant backgrounds and intercultural families in Finland is growing rapidly. The special needs of multicultural families are, in general, poorly recognised or understood in our society and service delivery may not be culturally sensitive or gender specific. In particular, knowledge is lacking about ill-being, anger and violence experienced and perpetrated by women with immigrant backgrounds. Does integration produce well-being, or ill-being, and how to break the cycle of abuse for the next generation?

Maria Akatemia ry, a non-profit organisation founded by psychotherapist Britt-Marie Perheentupa for research, development and education in Finland, is specialised in the recognition and treatment of women's ill-being and violence. The association is independent of any government, political ideology or religion and it aims to promote the wellbeing and inner growth of individuals, families, society and working life. Maria Akatemia has two RAY-funded programmes for the prevention of violence by women: Demeter (since 2003) and the MaSu Project (2010–2013).

Intercultural dialogue promotes integration

MaSu is an awareness project around issues of women's wellbeing, abuse and violence. The name of the project comes from two Finnish words, maahanmuuttajataustainen (with an immigrant background) and suomalainen (Finnish). The goal is to promote immigrant integration by building an intercultural service model for the prevention of violence by women in collaboration with NGOs, parishes and health, social affairs and education organisations. Special attention will be given to culture-bound violence and corporal punishment, in which women often have a central role.

The model will aim to lower the intervention threshold in abuse and violence by families with immigrant backgrounds and to strengthen collaboration between all involved parties. It is essential that people working with immigrant families recognise the various forms of violence used by women, men and communities and have resources to deliver professional, culturally sensitive and gender specific services.

Women speak out about abuse and violence

MaSu targets immigrant women who are living in Finland and have abusive tendencies against the self, intimate partner or child. The services include events for intercultural dialogue, a national hotline, counselling and support groups for women who use violence, and consultation and training for professionals, students and volunteers working with immigrant women and families.

To date, some 50 women representing twenty nationalities have participated in the project's preventive activities and crisis support services. Topics raised by the women have ranged, among others, from relationship problems, challenges in disciplining children, women's health issues, experiences of being bullied, being arrested for assault and lack of friends to questions such as family reunion, study places and employment, escape from forced marriage, marital rape, divorce and shame.

Educating women about the perpetration of abuse and violence and empowering them to take responsibility for violence prevention has an important preventive impact. Preliminary results suggest that the MaSu Project's facilitated processes have raised the recognition of violence by women, and promoted cultural awareness and the universal bond between women from all cultures and walks of life.

Tanja Harju from Australia welcomes women from all cultures to Maria Akatemia. Photo: Hannele Nyström

For further information or to make an appointment, please contact Tanja Harju, Project Coordinator, tel. 045 326 9495, tanja.harju@maria-akatemia.fi

Avoin linja hotline for women who use violence, tel. 09 7562 2260. Hours of operation: 4–6 pm on Tuesdays and Thursdays, 12–2 pm on Fridays. Languages: Finnish, Swedish and English. ■

www.maria-akatemia.fi/masu

Appendix 2

The 12th ISPCAN European Regional Conference on Child Abuse and Neglect
Challenging social responsibilities for child abuse and neglect
18–21 September 2011
Tampere, Finland

Abstract

Good practice for the prevention of abuse and violence by women – The Demeter Programme

Tanja Harju (Maria Akatemia ry, Finland)

Co-author: Marjo-Riitta Karhunen (Maria Akatemia ry, Finland)

The Demeter Programme is a violence prevention model that has been developed by Maria Akatemia non-profit organisation in Finland since 2003 and funded by Finland's Slot Machine Association (RAY). The programme has targeted women who have abusive tendencies such as maternal child abuse and neglect and intimate partner violence. The name of the programme is derived from the Greek Demeter, ancient goddess for growth and the hope that it brings.

The Demeter preventive model includes three phases: the Avoin linja national hotline, exploratory one-to-one counselling sessions and facilitated group processes. More than 600 women have participated as clients in the model during years 2003 to 2010. Critical reflection of cases and collaborative learning has been used to develop an experiential theory of violence dynamics based on a gender specific, family-based and psychodynamic approach. Women who have participated in the programme have experienced decreased aggressive impulses and violent behaviour towards the self, child and/or intimate partner.

Wider implementation of the preventive model is recommended across all health, social care, education and religious settings and helping organisations with the policy supports for societal change. Workers have an ethical duty to recognise and report suspected cases of child abuse and neglect and to refer all family members, whether male or female, and victims and/or perpetrators, for crisis support services.

Knowledge of gender specific violence dynamics and violence prevention intervention methods is a professional quality factor, and an important means to prevent vicarious traumatisation among workers. Multiprofessional cooperation, non-violence education, workplace supervision and child protection policy need to be developed for effective and equitable intervention in cases of maternal child abuse and neglect.

Keywords: maternal child abuse, neglect, child protection, gender specific, violence by women, violence prevention

Appendix 3

The 7th NASPCAN Nordic Congress on Child Abuse and Neglect
Child abuse and neglect in a cross-cultural perspective: Possibilities and challenges
14–16 May 2012
Bergen, Norway

Abstract

Intercultural dialogue, women's empowerment and violence prevention – The MaSu Project

Tanja Harju (Maria Akatemia ry, Finland)

Co-authors: Marjo-Riitta Karhunen, Britt-Marie Perheentupa (Maria Akatemia ry, Finland)

The MaSu Project 2010-2013 is a development project by Maria Akatemia against family and intimate partner violence by immigrant women. The project is a continuation of the Demeter Programme, which was developed by psychotherapist Britt-Marie Perheentupa and has researched the dynamics of psychological and physical abuse since 2003. MaSu supports women's integration and empowerment in Finland and is named from two Finnish words, *maahanmuuttajataustainen* (with an immigrant background) and *suomalainen* (Finnish).

MaSu targets women with immigrant backgrounds who are living in Finland and have physical and/or emotional abusive tendencies towards the self, child and/or intimate partner. The objective is to develop a gender specific multiprofessional service model for violence prevention. Special attention is given to culture-bound violence and corporal punishment, in which women often have a central role.

Services include interactive events, the Avoin linja helpline, exploratory counselling sessions and facilitated support groups for women who use violence, as well as consultation and training for professionals, students and volunteers working with immigrants. To date, some 95 women representing thirty nationalities have participated in the project's multicultural preventive activities and crisis support services.

The project is based on psychodynamic, existential and family systems frameworks and it raises individual, group and societal awareness about inner scripts and cross-generational transmission of abusive tendencies. Results of the Demeter and MaSu programmes have shown that every victim of physical, emotional and/or sexual abuse is a potential perpetrator of violence. The theory and model facilitate early intervention and good practice in family and child protection services.

Keywords: intercultural dialogue, corporal punishment, maternal child abuse, gender specific, violence by women, violence prevention