

Treatment for Abused and Neglected Children: Infancy to Age 18

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ATTRIBUTION

The Department of Health and Human Services acknowledges the contribution of Harold P. Martin, who was the author of *Treatment of Abused and Neglected Children*, August 1979 and Bruce Fisher, Jane Berdie, Jo Ann Cook, and Noel Day, who were the authors of *Adolescent Abuse and Neglect: Intervention Strategies*, January 1980.

PREFACE

The Child Abuse Prevention and Treatment Act was signed into law in 1974. Since that time, the Federal Government has served as a catalyst to mobilize society's social service, mental health, medical, educational, legal, and law enforcement resources to address the challenges in the prevention and treatment of child abuse and neglect. In 1977, in one of its early efforts to achieve this goal, the National Center on Child Abuse and Neglect (NCCAN) developed 21 manuals (the *User Manual Series*) to provide guidance to professionals involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families. Some manuals described professional roles and responsibilities in the prevention, identification, and treatment of child maltreatment. Other manuals in the series addressed special topics, for example, adolescent abuse and neglect.

Our understanding of the complex problems of child abuse and neglect has increased dramatically since the user manuals were developed. This increased knowledge has improved our ability to intervene effectively in the lives of troubled families. Likewise, we have a better grasp of what we can do to prevent child abuse and neglect from occurring. Further, our knowledge of the unique roles key professionals can play in child protection has been more clearly defined, and a great deal has been learned about how to enhance coordination and collaboration of community agencies and professionals. Finally, we are facing today new and more serious problems in families who maltreat their children. For example, there is a significant percentage of families known to Child Protective Services (CPS) who are experiencing substance abuse problems; the first reference to drug-exposed infants appeared in literature in 1985.

Because our knowledge base has increased significantly and the state of the art of practice has improved considerably, NCCAN has updated the *User Manual Series* by revising many of the existing manuals and creating new manuals that address current innovations, concerns, and issues in the prevention and treatment of child maltreatment.

This manual is intended to serve as an orientation to the issues surrounding the treatment of sexually abused, physically abused, and neglected children. It is intended to primarily assist:

- ✍ Beginning therapists (or therapists unfamiliar with child maltreatment) who are interested in acquiring a greater understanding of treatment issues related specifically to child maltreatment.
- ✍ Individuals (e.g., social workers, probation counselors, law enforcement officials, health care professionals) who may not be involved in therapy with abused children, but who desire a greater understanding of therapeutic issues and processes.
- ✍ Therapists providing services to maltreated children, who wish to improve their skills, knowledge, and abilities in conducting therapy.

Additional information on the treatment of child sexual abuse and child neglect is available in two other manuals in this series, *Child Sexual Abuse: Intervention and Treatment Issues* and *The Role of Mental Health Professionals in the Prevention and Treatment of Child Abuse and Neglect*.

It is important to note that this manual does not substitute for formal training in providing psychotherapy for abused and neglected children.

ACKNOWLEDGMENTS

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The Department of Health and Human Services acknowledges the contribution of Harold P. Martin, who was the author of *Treatment of Abused and Neglected Children*, August 1979 and Bruce Fisher, Jane Berdie, JoAnn Cook, and Noel Day, who were the authors of *Adolescent Abuse and Neglect: Intervention Strategies*, January 1980.

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INTRODUCTION

Providing therapeutic interventions for abused and neglected children requires:

- ✍ an understanding of normal child development and the processes of abnormal development or psychopathology as well as an ability to assess the severity and types of behavioral, emotional, developmental, and psychological problems that abused children present;
- ✍ familiarity with the major issues common to abused children; and,
- ✍ the skills necessary to manage these types of cases.

Providing treatment to abused children is a significant undertaking requiring clinical training and education. This manual provides an overview of the therapeutic issues for professionals in the fields of social work, family therapy, psychology, psychiatry, criminal justice, and child development; it may serve as a supplement for students and professionals interested in this area of practice. It does not substitute for training in providing psychotherapy for abused and neglected children. Throughout this manual, multiple references have been used to encourage readers to continue their education and training in the areas of child development, child maltreatment, assessment of children, and therapeutic interventions with children.

This manual provides an overview of child development followed by a description of the relatively new field of developmental psychopathology that “refers to the study of clinical dysfunction in the context of maturational and developmental processes.”¹ Developmental psychopathology is founded on recognizing the value of normal development throughout childhood and acknowledging that many childhood life events and experiences (i.e., maltreatment) can distort this development. Therefore, it is the responsibility of the therapist to:

- ✍ understand the various contexts in which the abused child/client exists;
- ✍ assess clients within their environments and identify dysfunctional behaviors, emotions, and cognition; and,
- ✍ provide interventions that address identified problems and assist adaptation and a return to healthy functioning.

In addition, there is special emphasis on several unique issues that have been found to be common “disruptions” to abused and neglected children.

In most cases, the framework for this manual consists of classifications of child development into:

- ✍ intrapersonal development (developmental processes within the child);
- ✍ interpersonal development (developmental processes between the child and others in his/her life);
- ✍ physical development (physical, body, and motor development);
- ✍ sexual development (development of sexual behavior, thoughts, and feelings); and,

☞ behavioral conduct development (management of behavior, self-control, and regulation).

It is acknowledged that the developmental processes of children cannot adequately be separated into such categories, primarily because the process of healthy functioning relies on the integration of these factors and because these classifications overlap in many areas.

Additionally, for the convenience of readers of this manual, these categories have been separated into some, but not all, of the major developmental processes that occur throughout childhood. For example, it has long been argued that the development of a child's self-concept, self-esteem, or self-image is a product of one's perception of him/herself, based on the perception of others, which is also called the "looking-glass self."²³ To assert that the developing child's self-concept is based solely within any single domain would be false. A child develops an image of him/herself as a thinking and feeling individual (intrapersonal), as an individual in relation to others (interpersonal), as big, strong, small, or weak (physical), as a sexual being (sexual), and understands that his or her behaviors have consequences for him/herself as well as for others (behavioral conduct). Therefore, these classifications are used for the purposes of presenting an overview of development, examining the maladaptive consequences of child maltreatment, and discussing therapeutic interventions.

CHILD DEVELOPMENT AND PSYCHOPATHOLOGY

To understand abused and neglected children, it is important to have a basic understanding of the common developmental tasks of childhood. Without this understanding, the inexperienced clinician may draw erroneous conclusions regarding problems that are in the realm of normal behavior, *or* he/she may fail to identify a problem that could have significant consequences for the child's current or future adjustment. For example, attempting to provide therapeutic intervention for a 3-year-old boy with nocturnal enuresis may cause frustration, anger, and undue pressure on the child, resulting in continued problems in bladder control and possibly exacerbating problems in other areas of his life. However, an understanding of child development would indicate that it is common for a 3-year-old male not to attain complete nocturnal bladder control. Such understanding would enable the clinician to explain to the child's parents that this situation is not abnormal and thus, remove the inappropriate perception of the child as having "a problem." On the other hand, the failure to identify or treat this same condition occurring in a 9-year-old child may contribute to his/her sense of despair or embarrassment about the "problem," possibly impairing the older child's social and emotional development. It is vital, therefore, that all child clinicians should have a basic understanding of child development in order to provide therapeutic services to children, especially those who have been abused and neglected.

CATEGORIES OF DEVELOPMENT

The categories of child development are grouped into intrapersonal development, interpersonal development, physical development, sexual development, and behavioral conduct development. Brief descriptions of the process of child development are provided, followed by a description of the major achievements/milestones according to each category. It is the intent of this section to give an overview of common patterns in child development.

Intrapersonal Development

Central to the process of human development is the organization, representation, and stability of an intrapersonal or "self" system.⁴ Many different theories of this self system exist. For example, Freud identified the individual's structural system (i.e., the id, ego, and superego); Erikson depicted it as ego; and attachment and object-relations theorists described it as the process of separation and individuation (e.g., internal representation, object permanence). This is not to suggest that these are the only explanations for the intrapersonal process in human development. Several theorists assert that primary influences to an individual's human development are partially or exclusively external to the self. The work of these theorists includes many of the behavioral, cognitive-behavioral, and social learning descriptions of human development.^{5,6}

Kegan states that the process of intrapersonal development is central to all other forms of development, but that it cannot be simply encapsulated within a single unifying domain.⁷ He also indicates that individuals progress through life with specific goals and through specific eras or stages. The theme of this progression is the achievement of several age/development-related tasks, supported by ever-changing environments or cultures, with the goal being development of self. For children, intrapersonal development progresses from the infant's capacity to create a preliminary concept of identity, to a sense of self, to his/her relationship with a primary caretaker.

- ☞ An **infant's** world consists almost entirely of his/her relationship with his/her caretaker and the environment provided by that caretaker. Eventually this identity, the evolving self, changes and becomes qualitatively different from past forms as the child enters new relationships and internalizes past relationships. This includes the infant's departure from his/her perception of the world from

the perspective of the primary caretaker to newer and broader environments, and a greater reliance on a developing sense of self.

- ✍ For a **toddler**, this is initially a reformulation of self as a member of a family, in which the young child has an opportunity to practice interpersonal relations within a secure and confined (bounded) set of relationships and then as a child within a group of same-age children (i.e., peers at school).
- ✍ For a **school-age child**, intrapersonal development is manifested as a more independent agent with the capacity for the child to produce, negotiate, and achieve in a form yet further separated from his/her early primary relationships. There is again the reliance on internal capacities and his/her self, rather than on past relationships such as those with the child's mother or father. In a sense, a school-age child becomes his/her own agent, rather than a member of a family or a child of a parent.
- ✍ With the coming of **adolescence**, a child begins to establish a formal sense of identity wherein higher order processes engage and truly become internal. Typically, self-sufficiency will not occur until late adolescence. Teenagers usually practice independent decision making, relationships, and emotional processes while under the domain of the parent. By late adolescence or early adulthood, however, it is the expectation within our culture that individuals should possess the capacity to function independently, manage emotions and behaviors, cope or adapt to adversity, and begin their own families. The hallmark of this period is the establishment of a meaningful interpersonal relationship (e.g., cohabitation, marriage) and the development of a family.

Interpersonal Development

Interpersonal development is the ongoing process by which a child relates to others in his/her life and creates and adapts to relationships.

- ✍ Immediately after birth, an **infant** demonstrates the capacity to engage in interpersonal relationships. Although the first few weeks of life are characterized by a minimum of initiated interpersonal actions toward others, the newborn is actively engaged in relationships. Simple responses such as crying, tracking visual stimuli, and responding to voices are attempts by the infant to interact with others within his/her environment. Although relatively unsophisticated, these attempts are important in obtaining attention and caretaking. Failure to receive attention could result in neglected conditions. For example, an infant who cannot elicit regular responses from his/her primary caretaker is less likely to be held, picked up, nurtured, fed, have his/her diaper changed, or receive other types of assistance.

As an infant matures, his/her ability to interact socially with others becomes more sophisticated. At 2 months of age, an infant responds with a social smile evoked by a familiar face. The relationship with a primary caretaker is the infant's first meaningful interpersonal relationship. This relationship, often described as the primary attachment relationship, is the source of security from which the infant begins to explore the world and other relationships.

The attachment process is fundamental to the interpersonal development of the individual.⁸ An infant who is securely attached to his/her primary caretaker (when this relationship is stable, consistent, and nurturing) has more freedom to begin to establish other relationships, broaden opportunities for new experiences, and develop important interpersonal skills (e.g., maintaining eye contact, cooing, reaching out). An infant who does not possess a secure attachment to his/her primary caretaker demonstrates difficulties in interpersonal relations ranging from passivity to increased anxiety and avoidance in the presence of strangers to decreased responsiveness.

- ✍ During the **preschool** years, a child begins to broaden his/her relationships to include all immediate family members (both parents and siblings), some extended family members, and substitute caretakers (preschool teachers and day care staff). These are the dominant interactions of a preschool-age child. When a preschool-age child begins to understand his/her position in relation to others, he/she separates out his/her relationship with his/her primary caretaker. The child establishes him/herself in roles of playmate, brother or sister, grandchild, etc. The child is also provided some rudimentary expectations of how to relate to these individuals. For example, a preschool-age child is expected to share, take turns, help a sibling, and not hurt other children. He/she learns that obedience to these expectations results in praise and acceptance, while failure to obey results in disapproval and punishment. When he/she begins school, the child is expected to broaden his/her relationships with others. However, a school-age child begins to function as an independent individual and separates from prior familial relationships.
- ✍ A **school-age** child, acting as his/her own agent, establishes, develops, and maintains relationships with peers. The emergence of “best friends” is often seen at this age, a preference toward playing with specific peers because of their unique attributes or similar interests. While there is a continued sophistication in the development of relationships with family members, the school-age years mark a period during which a child’s interests are often directed toward friends and classmates. There are also indicators of continued complexity within the relationships the child has with peers, including the expectation of mutuality; inclusion and exclusion from groups (which gives rise to cliques, clubs, and social groups); beginning development of trust and shared secrets; and interpersonal alliances (e.g., buddies, pals, best friends). These alliances serve as the foundation for the next major advance in interpersonal relationships during the adolescent years—the development of complex interpersonal relationships.
- ✍ Adolescence begins the period in which children first have the capacity to engage in relationships with others focused on shared internal thoughts and feelings. This may be accomplished initially by extending prior “best friend” relationships. Friends expect that both will provide intimate information and respect the rights and vulnerabilities of holding such information. This relationship characteristic is the basis for relationships with the opposite sex, specifically the beginning of meaningful boyfriend/ girlfriend relationships.

During **adolescence**, interpersonal constructs such as peer groups, “dating,” and “going steady” are established. Being part of a same-sex group and conforming to the group’s norms are significant aspects of the adolescent’s life. The adolescent begins to explore interpersonal characteristics such as mutual attraction, affection, sexual arousal, and the consistent appraisal of a relationship. Although these early boyfriend/girlfriend relationships occasionally result in long-term relationships, more frequently they are short-term. As a result, they become a means to explore the capacity of existing within an intimate interpersonal relationship; developing skills (communication, problem-solving, etc.); and maintaining relationship satisfaction. These skills become indicators of later successful marital relationships, which serve as the foundation for the establishment of a family.

As many human development theorists have noted, the forming of a satisfactory and functioning marital relationship completes a cycle—birth of a child within a family, development of this child within the family, the child as an adolescent or young adult selecting a partner, and the creation of a family from which another generation of children will be born.

Physical Development

- ✍ **Infants** are totally dependent at birth. Visual acuity is poor, eye muscles are weak, and the infant’s field of visual focus is short and limited. Hearing is developed in the uterus, with newborn infants

displaying a capacity to turn their heads toward sound almost immediately after birth. Average infant length and weight is approximately 20 inches and 7 1/2 pounds, respectively. Boys are slightly longer and heavier than girls. Survival of the newborn is enhanced by several innate reflex abilities (protective head turning, startle reflex, grasp, rooting, and sucking), but the newborn infant is almost completely dependent on a caretaker to provide nutrition and comfort.

As the infant begins to grow, physical changes are dramatic, with significant gains in most areas made during the first few weeks and months. With this rapid rate of physical development, there is a pattern of development from the general to the specific—from the overall use of the body to a gradual acquisition of use of distinct body parts (e.g., arms to hands to fingers).

Infants typically double their birth weight after 5 months and triple their birth weight by their first birthday. At 1 year of age, they have increased in size by 50 percent (approximately 30-35 inches) and grow an additional 5 to 7 inches during the second year. Sleeping patterns are often irregular. The infant possesses a short sleep cycle and wakes one to three times during the night. The age at which infants begin to sleep through the night varies considerably, although this is typically accomplished by the age of 1 to 2 years. Motor development makes rapid gains during the first 2 years of life, with the achievement of sitting without support and standing (at approximately 6 months of age), crawling (at around 7 months of age), walking (at approximately 1 year of age), and climbing stairs (at approximately 18 months of age).

As the **toddler** grows older and begins to master walking, there is an increase in exploration, which facilitates even greater physical development. Through exploration, the toddler begins to improve both gross motor skills (arms and legs) and fine motor skills (hands, fingers). Although there continues to be wide variation in height and weight, an established pattern of growth begins that is distinct for both boys and girls. This growth trajectory has been plotted for children 2 to 18 years by the National Center for Health Statistics.

By the age of 2 1/2, the toddler is able to throw a ball, jump in place, hop on one foot, and display rudimentary drawing skills. By age 4, the child can catch a bounced ball, draw a figure, and walk heel-to-toe. During this period, a child also acquires the ability to provide for his/her own health maintenance (under the supervision of a parent). He/she can dress him/herself, brush his/her teeth, and comb his/her hair. A well-balanced diet is essential for continued physical development. For many parents, this may be difficult because some children develop irregularities in their eating patterns (e.g., avoidance of certain foods, craving for favorite foods). Sleep patterns become more stable; at this age, a child typically sleeps through the night and requires 10-12 hours sleep each night.

A common problem for preschool-age children is the risk of accidental injury. This may be the result of the child's ability to explore his/her environment without having the cognitive capacity to make risk judgments. Therefore, the caretaker must ensure that dangerous materials are kept out of reach, that consistent supervision is provided, and that the home environment is adapted to reduce accidental injuries (e.g., electric outlets have protective covers; breakable or glass objects are moved out of reach, etc.).

There is a broad range of ages during which children become toilet trained; boys are typically slower to train than girls. Pediatricians recommend that toilet training be initiated no earlier than 18 months of age. This is due primarily to the physical limitation of the child (muscle control). But the process of toilet training is far more than physical capacity. The process also involves intellectual, emotional, and family supportive resources to manage this complex developmental task.

- ✍ Most **school-age** children (ages 5-10) have established gross and fine motor skills, consistent control of their bowels and bladders, and can demonstrate physical mastery in a variety of areas. Both gross and fine motor skills become considerably more developed as the child grows older. Eye-hand coordination and manual dexterity become precise as is demonstrated by the development of printing and cursive writing skills. Gross motor skills have developed to enable the child to master complex tasks such as riding a bicycle, skating, swimming, climbing, and running. A child of this age is expected to maintain a broad range of daily living skills, including caring for his/her own personal hygiene (dental care, bathing, grooming, etc.) and selecting appropriate clothing (casual versus formal, cool versus warm weather).

Although there is still risk of accidental injury, this risk is no longer based on issues related to the household environment (e.g., ingestion of poison). During this period, accidental injuries tend to occur more as a result of the external environment and the child's involvement in dangerous versus safe activities. Bicycle riding safety skills, fire safety, and prevention of water-related accidents should be stressed.

Sleep patterns have been established; 10-12 hours of sleep are required each night. Because children of this age are so active, it is essential that they maintain a regular and balanced diet.

- ✍ The **adolescent** years mark significant changes in a child's physical development, primarily because of the onset of puberty. These changes include development of primary sexual characteristics (i.e., changes in males and females that contribute to reproductive maturity) and secondary sexual characteristics (e.g., the growth of additional body hair and changes in voice pitch and body shape).

Sexual Development

One of the most fundamental aspects of every individual is his/her sexuality. The process of sexual development and its relationship to the knowledge, behavior, and attitudes of children is a natural and complex interactive phenomenon. From birth, children are exposed to an ever-changing sexually oriented society that profoundly influences their development in a variety of ways. Factors such as intrafamily dynamics, extended and intergenerational family relationships, school relationships, peer relationships, and the media may have an immediate and long-term impact on a child's total development. Sexual adjustment results in individuals who, at every stage of their life cycle, are confident, competent, and responsible in their sexuality.

The discussion that follows describes milestones in the individual's sexual development:

- ✍ During **infancy**, many children engage in repeated self-stimulation of the genitals, with periodic erections for boys and vaginal lubrication with girls. Children at such a young age also seek physical affection and closeness (e.g., hugging, touching) through contact with their primary caretakers. This behavior is not directly sexual, but it is a source of physical contact that is pleasurable to the infant and young child.
- ✍ During the **preschool** years (ages 2-5), children have developed a sense of their ability to stimulate their genitals and will frequently engage in "masturbatory" behavior. A child's verbal skills have developed to the point that he/she can identify and label body parts and functions, although these terms are usually rudimentary in form. Many young children enjoy the physical sensation of nakedness and often display a sense of "body exhibitionism" (especially around bath time). Perhaps most importantly, it is common for children of this age to begin to explore their bodies and compare their anatomies to their peers. Within a school or day care setting, this behavior often occurs in places such as shared toilet facilities.

The combination of verbal ability, cognitive development, and sexual/body exploration also marks the beginning stage of inquiry. Children may begin to ask their parents about differences in bodies, where babies come from, and about appropriate terms for body parts. This phase is often the first and most natural opportunity for parents to begin to communicate with children about reproduction, sexual norms and communication, and the family or cultural values associated with sexual behavior and ideas (e.g., hugging, touching, cuddling).

- ✍ For **school-age** children, the level of sophistication has increased significantly. Both boys and girls have the interest and verbal capacity to exchange sexual ideas and feelings. Additionally, for most children, the process of self-stimulation or masturbation may continue, although typically this behavior is relegated to a more private situation. Sexual exploration may continue within sex play or sexual modeling, although much of this behavior is kept hidden from the view of adults.
- ✍ During **adolescence**, the onset of puberty and physical changes occur in boys and girls between 10 to 14 years of age. Girls tend to progress through pubertal changes earlier than boys. This is facilitated by a broad range of hormonal and physical changes, including breast development, menarche, and hair growth for girls, and viable sperm production, facial hair growth, and voice change for boys. Traditionally, adolescence also brings about a significant increase in the need for privacy and a shift away from discussing sexuality with parents. Concurrently, there is an increase in talking about sexual thoughts and feelings within the same-sex adolescent peer group. The establishment of opposite-sex intimate relationships (i.e., boyfriend/girlfriend) also brings the opportunity for sexual expression and sexual relationships.

Behavioral Conduct

In examining the developmental process of a child's behavioral conduct, it should be noted that there are a wide range of behavioral styles and patterns of behavior. However, there are at least two major themes consistent throughout the child's and adolescent's development—the acquisition of self-control or self-discipline and the adoption or adherence to rule-governed behavior.

In general, it is the responsibility of parents, the family, the school, peers, and other groups in the child's environment (e.g., neighbors, relatives, youth groups) to assist the developing child to gradually acquire the ability to control his/her own behavior and adhere to specific rules. To achieve satisfactory late adolescence or adulthood, the individual must have acquired these characteristics to a sufficient degree so he/she can maintain and regulate his/her own behavior within interpersonal relationships. This ability enables the individual to participate in relationships such as friendships, intimate spousal relationships, coworker relationships, and/or continuing relationships with the family of origin.

There are a broad range of behaviors that demonstrate the child's transition through the process of acquiring these skills and several periods throughout childhood with common behavioral conduct issues. This section identifies some of the major developmental transitions through the use of several common behavioral examples:

- ✍ One characteristic of **infants** is the absence of any sense of self-control or adherence to rules. Thus, a newborn is completely dependent on his/her primary caretaker and must rely on the caretaker to regulate almost all aspects of his/her life, including eating, sleeping, protection from danger and harm, etc. However, a few days after birth, caretakers begin to impose changes to the infant's schedule to comply with adult behavioral patterns and social dictates. These changes may take the form of encouraging the infant to stay awake during the day in order to sleep more at night, beginning to schedule eating or nursing to regular intervals, and being involved in daytime activities

and play rather than at night. Gradually, during the first 2 years of life, caretakers impose rules and begin to expect the infant to regulate his/her own behavior within certain specific limits (e.g., eating at mealtimes, engaging in interactive play, sleeping through the night).

- ✍ With **toddlers**, caretakers face the challenges of oppositional and defiant behavior, characterized by the child's frequently saying "no" to requests or directions. Kegan states that this phase of childhood is the demonstration of a very healthy developmental change.⁹ As a representation of his/her autonomy, a 2-year-old child learns that he/she has the capacity to make decisions independent of the primary caretaker. Although few would argue that a 2-year-old child should make any decisions of importance, it is important to recognize that the child is no longer completely dependent on his/her primary caretaker for all aspects of life. By strongly asserting "no," the toddler establishes his/her right to make decisions on his/her own, and thus, takes an important step away from complete dependence on his/her caretaker. The child is symbolically asserting that he/she is no longer a dependent, voiceless infant. Making decisions is very important for the child's emerging autonomy.
- ✍ The objective for **preschool-age** children is the acquisition of self-control within the domain of their immediate family as well as understanding and complying with family rules. Many family rules imposed on a preschool-age child are manifested in a manner unique to each family, but are built on common family themes. For example, parents may have a household rule that the child is to stay out of the garage unless supervised by an adult—the underlying theme being that "certain places or things are for adults and may be dangerous to young children." In a second example, the parents do not allow their preschooler to strike another child in the family. Here, the underlying theme is that "it is not acceptable to hurt others."

By providing rules and the expectation that stated rules are to be obeyed, the family begins to help the preschool-age child master his/her own behavior. The family is providing a structure within which rules can be tested and followed. Not only must parents provide rules and expectations for young children, they must be rational and consistent in the enforcement of those rules. Fairness and consistency help to promote self-control and positive self-esteem. Additionally, by providing reasons for the rules, parents help the preschool-age child benefit from sound decisions as well as begin to serve as behavior models. The child also soon learns that he/she may suffer the "natural consequences" of impulsive behavior and poorly reasoned decisions. An important aspect of this stage of development is the ability of the parents to gauge what decisions their child is capable of making (i.e., those involving minimal risk) and what decisions they should make for their child (i.e., those involving high risk).

- ✍ As children enter the **school-age** years (approximately age 5 to adolescence), they begin to assert themselves as individuals separate from the family. During the school day, the child is required to continue this process of behavioral self-control and adherence to rules imposed by school teachers and other school personnel. Typically, the school replaces the structure of the home, with teachers acting as substitutes for parents by establishing and enforcing environmental rules. Throughout the elementary school years, teachers impose greater expectations for the child by demanding that he/she spend more time completing academic tasks, decreasing the amount of free-time or play time, and expecting the child to regulate his/her own behavior (with close supervision). Ideally, the parents and family are developing parallel expectations for the child within the home and school environment.

As a form of assistance in structuring their world and managing impulsive behavior, children often spend an inordinate amount of time establishing themselves in comparison to their peers. During this stage, the child becomes very concerned with his/her physical abilities compared to the physical abilities of his/her classmates, often attending to status concepts such as "best," "last," "worst," "smallest," etc. A child is perceived as having high status if he/she has a socially desirable quality

(e.g., if the child is the fastest runner or the smartest in class). On the other hand, the child is perceived as having relatively low status if he/she exhibits a socially undesirable quality (e.g., poor eyesight, obesity).

The comparison process also creates important changes for school-age children with regard to interpersonal relations. Competition is often the hallmark of school-age children because they view it as a test of who is best at a given task. Rules surrounding competition reflect a child's attempt to manage his/her own behavior through the adoption of his/her own self-governed rules. The establishment of groups from which the child is included or excluded is another example of the comparison process. Boys may build forts, which have prohibitions against girls, while girls may engage in activities at the exclusion of boys. Such actions continue to provide for the development of self-control and adherence to socially tied rules. Many of these rules, however, are created by the child or his/her peers and are supported by adults and the media.

✍ **Adolescents** have some ability to regularly maintain behavioral control and relatively superficial relationships. An adolescent can satisfactorily manage most aspects of his/her life and make daily decisions without consulting his/her parents. An adolescent should have a basic understanding of the reasons for culturally or environmentally imposed rules as well as an ability to adhere to those rules.

Two significant changes occur during adolescence. The first concerns the transition from externally imposed to internally regulated rules and expectations. That is, rather than complying with demands, expectations, or instructions provided by parents, teachers, or other authorities, an adolescent begins to shape his/her own self-defined demands, expectations, and instructions. In many situations, these self-imposed rules may be the same as those imposed by others (e.g., compliance within a school setting, managing health status), but some rules may be significantly different from those previously imposed. Adolescents often desire and require greater personal freedom, resulting in greater autonomy in making decisions about such issues as music, clothing, and social contacts. Parent/adolescent difficulties often arise when the authority of the parents to manage the adolescent's life conflicts with his/her newly developed authority to manage him/herself.

As stated previously, successful parenting of an adolescent requires that the parents relinquish some authority and allow the adolescent to make age-appropriate decisions (i.e., those that involve relatively low risk). However, the parents retain the right to make other decisions (i.e., those that involve relatively high risk). This process involves the second major change for developing adolescents—the ability to communicate with others from a position that assumes to regulate their thoughts, emotions, and involvement in interpersonal relations.

By demonstrating internal control, an adolescent begins to assert him/herself as capable of maintaining intimate relationships with others (e.g., girlfriends and boyfriends). The adolescent is able to negotiate relationships independently with parents and others. The demonstration of this internal control is not always consistent or stable, which suggests periods of perceived instability, irrational thinking, and/or emotional overload. Often, an adolescent perceives the involvement of authorities (especially parents) as an insult to his/her integrity (the adolescent sees him/herself as independent from parental domain) and rebels against such perceived intrusions. With consistent regulation of both external behavior and internal representations of him/herself, an adolescent begins the transition to adulthood.

Developmental Psychopathology

Everyone experiences some type of problem, trauma, disadvantage, or distress during their childhood. If trauma or distress is common to childhood, it becomes important to examine the manner in which children cope with these experiences and the ways in which they continue to function and interact with themselves and with others. Some children appear to be devastated by these types of events, whereas other children appear to thrive and continue regular daily functioning with relative ease under what would usually be considered severely adverse conditions.

What is clear is that there are many common events that pose risks to a child's ability to manage adequately him/herself and his/her relationships with others. What remains unclear is how a child may manifest abnormalities or psychopathology. Additionally, to be aware of what is "abnormal" or "pathological," it is essential for the professional to understand what is "normal" or healthy within the individual. With children, development results in frequent and regular changes according to some general patterns and trends. Therefore, any attempt to understand the relationship between normal and abnormal within an individual child must also take into account his/her developmental status. If professionals assume that adaptation (the ability to alter one's typical method of functioning to fit new circumstances) is a normal and healthy part of a child's development, then it could be argued that maladaptation is the failure of the child to cope with events in his/her life and/or exhibit a means of coping, which results in dysfunction.

CONSEQUENCES OF ABUSE AND NEGLECT

Child maltreatment is a multidimensional and interactive problem involving the child and the multiple environments in which the child exists. Garbarino presents the “Ecological System” (see Figure 1), which provides a means to identify and describe the environments in which the child exists.¹⁰

The first context is identified as the *microsystem* and is composed of individuals or structures that have ongoing and daily contact with the child. “For children, *microsystems* are the places they inhabit, the people who live there with them, and the things they do together.”¹¹ Therefore, common *microsystems* for the developing child might include home and family, school, neighborhood friends, and peer groups.

The next system, the *mesosystem*, is defined as the relationships between *microsystems*. It is optimal for a child’s development to live within an environment in which there are many *mesosystem* connections, such as parental involvement in school and church functions, multiple child and sibling social contacts within the neighborhood, etc. In contrast, the deprived child’s environment might have relatively few *mesosystem* connections and consist of problems that may detract from the child’s life, such as parents’ chronic complaints about school and the child’s teacher, neighborhood suspicion and distrust, and few neighborhood peer relationships.

The last system, the *macrosystem*, consists of the broad ideological or institutional patterns within a particular culture or subculture. These patterns may be easily identified by common factors, such as ethnicity or religion, or they may be more difficult to determine, but still important, factors within the culture such as attitudes toward corporal punishment, the value of education, gender-based perceptions of family roles, etc.

Garbarino’s model also views the child as an active part of his/her environment, facilitating change while being responsive to external stimuli. This model addresses the ever-changing and developing environments of the child, rather than viewing the child as a static organism. Finally, this model enables clinicians to identify those factors that increase the likelihood of abuse occurring (i.e., risk factors) and decrease the likelihood of abuse occurring (i.e., compensatory factors). (See Table 1.)

The following sections describe consequences of each form of child maltreatment (i.e., physical abuse, child sexual abuse, and neglect). The previously described categories of intrapersonal, interpersonal, physical, sexual, and behavioral conduct are used to describe the consequences of maltreatment.

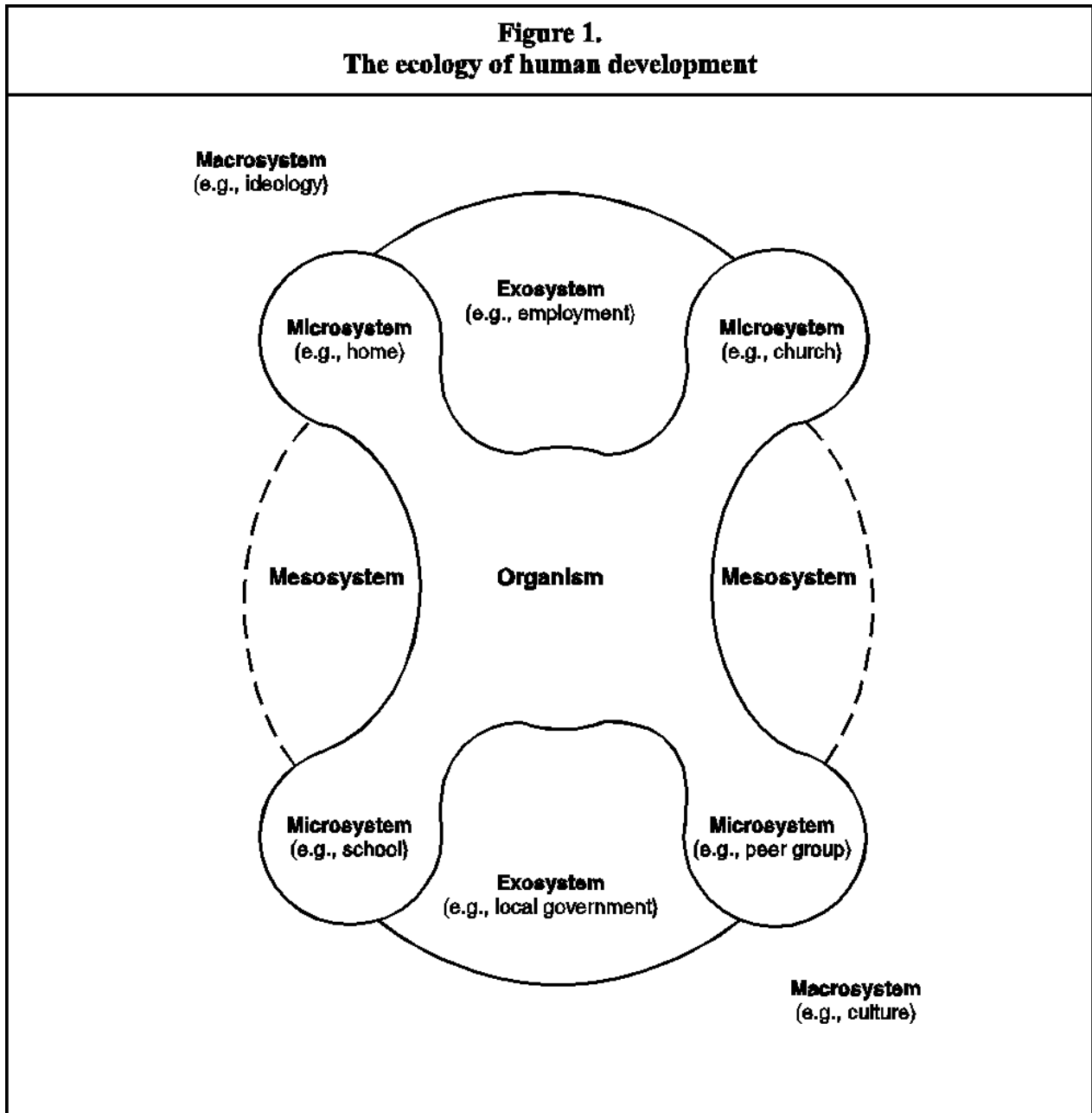
PHYSICAL ABUSE

Salter, Richardson, and Kairys state that, “Abused children have learned that their world is an unpredictable, often hurtful place. The adults who care for them may be angry, impatient, depressed, and distant. Further, they can be transformed, without warning, into hostile, violent persons.”¹²

Consequences Within the Intrapersonal Category

Our knowledge of child development tells us that the most significant factor within a child’s life is his/her relationship (i.e., attachment) to his/her parents. Within our society, this attachment is typically a mother/infant/child relationship, because most fathers have not yet taken equal responsibility for the caretaking of young children. Given the significance of this relationship, much has been written about the consequence for the intrapersonal development of a child when his/her parent is physically abusive.^{13 14}

Figure 1.
The ecology of human development



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Table 1

Determinants of Abuse: Compensatory and Risk Factors

	Ontogenetic Level	Microsystem Level	Exosystem Level	Macrosystem Level
Compensatory Factors	High IQ Awareness of past abuse History of a positive relationship with one parent Special talents Physical attractiveness Good interpersonal skills	Healthy children Supportive spouse Economic security/ savings in the bank	Good social supports Few stressful events Strong, supportive religious affiliation Positive school experiences and peer relations as a child Therapeutic interventions	Culture that promotes a sense of shared responsibility in caring for the community children Culture opposed to violence
Risk Factors	History of abuse Low self-esteem Low IQ Poor interpersonal skills	Marital discord Children with behavior problems Premature or unhealthy children Single parent Poverty	Unemployment Isolation; poor social supports Poor peer relations as child	Cultural acceptance of corporal punishment View of children as possessions Economic depression

Reprinted with permission from: J. Kaufman and E. Zigler, "The Intergenerational Transmission of Abuse," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (New York: Cambridge University Press, 1990).

Crittenden and Ainsworth argue that it is the need and goal of the human infant to establish and maintain an ongoing relationship with an adult caretaker.¹⁵ Through this relationship, the infant is able to meet his/her physical needs (warmth, nutritional sustenance, protection, etc.) and begin to develop predictable patterns of behavior that influence later aspects of his/her development. Typically, this relationship is very predictable and responsive (e.g., as in parents reacting to the cries of their infant). This relationship leads to a subjective perception of security on the part of the infant. In the case of a physically abusive parent, the infant's attachment to the parent disrupts the child's internal beliefs of him/herself and his/her world. As a result, a child develops a perception of him/herself as incompetent, feels bad about him/herself, and considers him/herself unworthy of the love of another. Additionally, a pattern may develop of expecting pain or injury from others, distrusting closeness, and being wary or suspicious of others.

Older children who have been abused often demonstrate some type of affective problem (e.g., depression, sadness, anxiety). Lynch reported that maltreated children look unhappy and take little pleasure from their environment.¹⁶ This reaction may be related to alterations in the abused child's ability to interpret his/her own as well as others' emotional and social actions. Some research has found that abused children are limited in their ability to perceive their own and other children's intentions and actions, and they may have difficulty interpreting the emotional expressions of others. This finding suggests that abused children may develop a pattern of denying certain emotional responses (i.e., conflicting feelings), which often generalize to a broader range of affective responses. Although this blunted affective ability and response may be useful in coping with the psychic pain of

being abused, it inhibits the range of emotional responses, and hence, impairs an important part of a child's development.

Consequences Within the Interpersonal Category

Physically abused infants appear to respond adversely to maltreatment and then begin to adapt to their environment. Crittenden found that when in interaction with their mothers, abused infants were more difficult (e.g., crying more often, more irritable) than other infants and that this pattern of behavior was related to the immediate interpersonal behavior, rather than the infant's innate temperament.¹⁷ Crittenden further suggests that during the first year of life, abused infants learn to accommodate their mother's behavior without complaint.¹⁸

By establishing a pattern of behavior that transforms anger to superficial cooperation, many infants and older children become passive, fearful, vigilant, and compliant. This finding complements research using the "Strange Situation" paradigm, in which physically abused infants and young children demonstrate a pattern of anxious/avoidant attachment to their abusive parent. Such infants are described as rejecting or being angry toward their mothers, although this pattern of behavior is not always consistent. Therefore, the infant may be angry and rejecting at one time while appearing superficially cooperative at another time. An example of this behavior is demonstrated by an infant who alternates between wanting to be held and nurtured and then resists attempts by his/her caretaker to hold or cuddle the child. This pattern of behavior becomes a means of adapting and coping with his/her attachment relationship.

An interpersonal characteristic observed in many older physically abused children is their tendency to care for their abusive parents.¹⁹ That is, these children often engage in actions that serve to meet the needs of their parents and result in the child providing some caregiving. Additionally, these children may also provide similar caregiving to younger children within the family and thus demonstrate secondary assistance to their parents (by fulfilling a parental role). Role reversal offers a means for the child to acquire positive meaning and appreciation within his/her life and yet maintain closeness to the attachment figure.

Studies have shown that physically abused children tend to interact with their peers either by being overly hostile and aggressive or by exhibiting excessive withdrawal and avoidance of other children. The reasons why one child responds in one way while another child responds in a different way are not yet clear. Galdston suggests that abused children have a need for recognition and attention from adults.²⁰ Green argues that heightened aggressiveness may reflect an identification with the child's abusive parent in an attempt to avoid anxiety and feelings of helplessness.²¹ Also, aggressiveness may be a result of parental modeling, with the abused child demonstrating a pattern of behavior that he/she has learned from the abusive parent(s).

Whether aggressive or avoidant, it appears that physically abused children frequently have significant problems in their ability to develop and sustain peer relationships. In their review, Mueller and Silverman state that "the very heart of peer relations, a felt equality between partners, involved developing a working model of relationships that was based on sharing, equality, and non-exploitation. The experiences of abuse and neglect seem antithetical to developing such a model."²²

Consequences Within the Physical Category

In an extensive 5-year study, Martin reported that slightly more than half of the 58 physically abused children he studied had some type of neurological impairment.²³ Additionally, approximately one-third of the children studied had an impairment that was significant enough to handicap everyday functioning. Similar neurological, sensory, and/or psychomotor problems have also been identified by other researchers investigating the consequences of physical abuse.^{24 25 26}

There are some delays in motor skills development in young children exposed to physical abuse. Martin reported some gross motor skills deficits.²⁷ It is difficult to determine if these motor delays are the direct result of actions related to the abuse (e.g., hitting, pushing, or punching) such as might result from neurological impairment, or if these motor delays are the result of a home environment that does not provide sufficient opportunity to use and master these skills. Martin suggests that physically abused children come from a home environment in which exploration and normal risk taking are discouraged, thus impairing their development in this area.²⁸

Consequences Within the Sexual Category

Little is known about the sexual problems of children who have been physically abused. As adults, these children may have difficulty developing trust in relationships involving sexual intimacy. Some children who have been physically abused have also been sexually abused.²⁹ Those children may demonstrate negative consequences of both types of abuse. Physically abused children who have also been sexually abused may possess some type of sexual behavior problem.

Ryan presents a model of cognitive factors that may develop as sexual offending behavior.³⁰ In reviewing this model, some of these factors (e.g., denial, minimalization, and retaliation fantasies) may also be present in victims of physical abuse. Individuals who perceive sexual offending behavior as an assertion of power rather than solely as a deviant sexual behavior might argue that factors that contribute to the need for a demonstration of force and power also contribute to the development of sexual offenders.^{31 32} If this is the case, physical abuse may make such a contribution.

Consequences Within the Behavioral Conduct Category

Salter, Richardson, and Kairys argue that physically abused children do not behave any differently than other children under another type of stress.³³ These researchers also report that children's reactions to distress can be described "in one of two ways: 'internalizing' or 'overcontrolled' (i.e., inhibited, shy, anxious) behaviors and 'externalizing' or 'undercontrolled' (i.e., acting out, aggressive) behaviors."³⁴ Although this finding may be true, children have a developmentally limited verbal capacity; they must rely on a specific set of symptoms to express distress. Therefore, they may engage in internalizing behaviors, in externalizing behaviors *or* in both. What is of interest are those behaviors that are unique to, or more likely to occur with, physically abused children.

One such symptom or behavior that is commonly reported as a consequence of physical abuse is the increase in aggressive behavior. Both verbal and physically aggressive behavior have been reported by studies investigating physically abused children. The process of being raised in an environment in which physical abuse is used as a common response to problems, feelings, and conflicts impairs several important developmental functions (e.g., problem-solving, accepting delayed gratification, and impulse control).³⁵ Without the opportunity to learn these functions, children use methods or respond in ways that utilize mechanisms modeled for them within their family (i.e., aggression). Therefore, when placed in a situation in which he/she experiences conflict, negative affect, or a problem, an abused child resorts to some type of verbal or physical hostility as a means to a resolution or to fulfill his/her unmet needs.

It appears from reviewing their behavior, that there are two primary response patterns that children use in coping with the distress of living with an abusive parent. The first response is a negative, resistant, verbally and behaviorally hostile pattern. The second response is a fearful, passive, and compliant pattern. However, it has not yet been shown that abused children adopt these patterns across all daily interpersonal situations. For example, while an abused child may adopt these patterns of behavior in relation to his/her abusive parent, he/she may react differently (outside the bounds of these patterns) when interacting with peers or other adults. Again, the common interpersonal response and action appears to center on the relatively quick move toward aggression and hostility. The specific reasons for this response are unclear, but they may include displaced parental anger, increased

vigilance and the expectation of aggression from others, social modeling of aggressive problem-solving, and a limited range of conflict resolution abilities.

CHILD SEXUAL ABUSE

Consequences Within the Intrapersonal Category

In reviewing the empirical research on the responses of children who have been sexually victimized, some type of intrapersonal disturbance is consistently reported. The reasons may be related to Finkelhor's traumagenic dynamics of powerlessness, betrayal, and/or stigmatization.³⁶ A victimized child may feel unable to protect him/herself, vulnerable to invasion from others, different from others (which may lead to a sense of isolation), and may develop a sense of low self-esteem. If the abuse is intrafamilial, he/she may also feel a sense of betrayal from the abusive parent or sibling or betrayal on the part of nonabusive parents for failing to provide adequate protection.

Victims of child sexual abuse also report symptoms of fear, anxiety, isolation, and a perception of low self-esteem. Porter, Blick, and Sgroi suggest that these symptoms may result from the child perceiving him/herself as "damaged goods," which is characterized by an overall sense of poor self-image.³⁷ Though these symptoms have been supported with female victims, the evidence is less clear with male victims. Some studies appear to support similar responses with boys, but their findings remain inconclusive.

Consequences Within the Interpersonal Category

Many problems within the realm of social functioning and interpersonal relationships have also been noted in victims of child sexual abuse. Some of these problems include using illegal drugs and alcohol, having difficulty in school, and running away from home. Such problems are often associated with attempts to avoid an abusive home environment.³⁸

Finkelhor's traumatic dynamic of betrayal is described as manifesting itself through a sense of distrust in others and conflicted relationships with others as shown through reactions of fear and hostility.^{39 40 41} Many victims of sexual abuse possess this sense of distrust or wariness toward others, perhaps as a reaction to fear of being victimized in the past, not trusting their decision-making abilities regarding dangerous sexual situations, and/or attempting to avoid revictimization. Interestingly, research examining victims of abuse has shown that past victims of sexual abuse are at increased risk of revictimization.^{42 43 44}

Consequences Within the Physical Category

Many studies that have examined the physical consequences to children as a result of sexual abuse indicate that for both female and male victims there are an array of injuries including some type of injury to the genital area that can result from sexual abuse.^{45 46 47} As a result of their abuse, certain children acquire some type of direct injury (e.g., vaginal or anal laceration or tear or acquisition of a sexually transmitted disease) that requires medical attention or, they develop a secondary problem associated with this initial injury. Examples include the onset of enuresis or encopresis and/or recurrent problems with urinary tract infections.

In addition to the direct injuries resulting from their abuse, many children develop some type of somatic or psychophysiological problem that may be related to their abuse. Spencer and Dunklee describe a sample of boys who reported somatic complaints including sleep disturbance, nightmares, or bedwetting.⁴⁸ Similarly, the Tufts New England Medical Center study reported significantly more somatic complaints in the children they assessed.⁴⁹

In the second study, common problems identified included sleep disturbance, nightmares, and phobias.

During the past few years there has been an increase in research attempting to link child sexual abuse and post-traumatic stress disorder (PTSD).⁵⁰ Many abuse victims exhibit symptoms such as dissociation, nervousness, anxiety, and flashbacks commonly associated with PTSD. However, a clear relationship has yet to be established between child sexual abuse and PTSD. Because of the wide range of responses to abuse, some children present some symptoms of PTSD; others may present most or all of the PTSD symptoms (and be diagnosed as having PTSD), and other children exhibit no symptoms.

Consequences Within the Sexual Category

A consistent finding in research describing consequences of child sexual abuse is the increase in sexualized behavior in children. Two studies using standardized measures of assessment have indicated that abused children tend to be more involved with sexual ideation and behavior. The Friedrich et al. study reported nearly three-fourths of the boys and slightly more than two-fifths of the girls exhibited some type of sexual problem (e.g., masturbating too much, masturbating in public, talking about sex too much).⁵¹

In a Tufts' New England Medical Center study, approximately one-fourth of the younger age group (4-6-year-olds) and one-third of the older age group (7-13-year-olds) were elevated on a sexual behavior scale (which included items about excessive sexual curiosity and open masturbation).⁵² In a smaller sample of 14 boys referred to therapy for sexual aggression, Friedrich and Leucke identified 11 of these boys as having a history of being sexually victimized.⁵³

Several clinical case studies report a variety of sexual behavior problems in children with a history of sexual abuse, including problems with sexual acting-out, an exaggerated interest in sexuality, and an increased interest in sexual material.^{54 55 56} Finally, several researchers have argued that having a history of being sexually abused may contribute to the development of being a sexual offender (either as a juvenile, adult, or both).^{57 58 59}

It is important to note that although sex offenders may possess a relatively high prevalence of child sexual abuse, this *does not* mean that every child who has been sexually abused will become a sex offender. Making such an assertion fails to account for the fact that most victimized children have no later sexual interest in children or that there are sexual offenders without a history of having been sexually abused as a child. Furthermore, such an assertion oversimplifies the broad range of factors that lead to the development of sexual offending behavior. For example, Ryan states that victim responses such as “patterns of denial and minimalization, power and control behaviors, irrational thinking, irresponsible decision making, retaliation fantasies, deviant sexual arousal, aggression, secrecy, and preoccupation with or reenactment of one’s own victimization” may influence the child’s development from being a victim to being a victimizer.⁶⁰

In summary, both empirical research and clinical case studies indicate that one consequence of being sexually victimized is an increase in sexualized behavior. This behavioral sequela has been reported in both male and female victims and includes an increase in sexual ideation and fantasies as well as an increase in sexualized behavior. Although research with sex offenders suggests that there may be a relationship between being sexually abused and being a sexual offender, conclusions suggesting a causal relationship are faulty.

Consequences Within the Behavioral Conduct Category

One of the most common findings for male victims is a wide array of behavioral disturbances. Although this same range of behavioral disturbances is not as pronounced with girls, this does not reflect an absence of behavioral problems for girls. Psychological research shows that boys tend to express distress through externalization and girls through internalization. Numerous studies provide empirical support for the presence of some type of behavioral disturbance (e.g., aggression, delinquency, hyperactivity) with sexually abused children.⁶¹

62 63

An extensive study conducted by the Tufts' New England Medical Center was one of the first to use standardized measures in examining sexually abused boys and girls. This study reported that nearly half of the oldest age group (7-13-year-olds) showed substantially elevated levels of hostility on scales of aggression and antisocial behavior on the Louisville Behavior Checklist. Similarly, approximately one-sixth of the younger age group (4-6-year-olds) were reported as having elevated scores on these same scales of aggression and antisocial behavior.⁶⁴ Finally, DeFrancis reported that slightly more than half of the child victims showed behavioral disturbances such as defiance, disruptive behavior within the family, and fighting with siblings.⁶⁵ In addition, there have been several clinical reports of aggressive behavior, including firesetting and destruction of property, delinquency, verbal explosiveness, and argumentativeness.

In summary, although not all victims of sexual abuse demonstrate problems with behavioral disturbance, research suggests that some type of behavioral problem is a relatively common consequence. Furthermore, it appears that this behavioral response is more common in male victims than in female victims, with parents more likely to react to behaviors that are externally disruptive.

CHILD NEGLECT

Child neglect is the most frequently occurring type of child maltreatment and probably the least understood because of several definitional issues as well as difficulty in substantiating anything but severe neglect.

Consequences Within the Intrapersonal Category

By failing to recruit a consistent and adequate caretaker, the infant or young child will be unsuccessful in achieving the goal of establishing and maintaining an ongoing relationship with an adult caretaker. The consequences of such a failure may be profound. Typically, by relating to a caretaker through a repeated series of interactions, the infant or young child begins to develop a set of expectations regarding the nature of future interactions. These expectations become the basis for the internal representation of the caretaker and of him/herself.⁶⁶ That is, we construct ourselves, in part, from a series of interactions with individuals in our lives. Those closest to us usually have the most significant influence.

As a child grows older, these series of interactions are integrated within beliefs about him/herself, his/her thoughts and activities in relation to others, and perceptions of his/her competency. Harter suggests that this self-evaluation of competency, originating in initial relationships with caretakers, becomes the source of stability for one's self-system. Without a stable initiating environment or consistent support from primary caretakers throughout childhood, the development of a child's sense of self is adversely affected.⁶⁷

Neglected children often experience a loss of placement of themselves in relation to other people; this may manifest in symptoms of withdrawal, depression, passivity, and disorientation or confusion. Neglected children may become helpless and passive; they tend to roam aimlessly when placed in a situation in which they are temporarily separated from their parent(s).⁶⁸ Additionally, in their study, Howes and Espinoza report that neglected children appeared to display less affect, either positive or negative, in their peer encounters, which suggests a blunted affect.⁶⁹

Helfer argues that being raised in a neglected environment results in several intrapersonal problems, including living within an environment where needs are not consistently met. This type of environment disrupts the child's ability to develop the capacity for delayed gratification.⁷⁰ Additionally, decision making and problem solving are rarely adequately modeled with the child having limited opportunities to practice these skills. Finally, a neglected child never fully develops the capacity for control over his/her feelings and actions. In other words, a neglected child never learns that he/she can control his/her behavior. This failure may lead to impulsive behavior in conjunction with a thought or feeling,

Consequences Within the Interpersonal Category

It is argued that many neglectful mothers have difficulty providing adequate care for their children because of their own past histories of maltreatment.⁷¹ These mothers have difficulty coping with the demands of an intimate relationship, and they may not understand the necessary cues and interactions because of their own emotional instability. Therefore, because of their inability to function effectively as well as their impaired relationships, these mothers do not have the capacity to engage in healthy attachment relationships with their children. Consequently, their children never acquire basic interpersonal skills and may grow up to perpetuate an intergenerational transmission of relationship dysfunction.

Main and Goldwyn state that the dysfunctional characteristics identified with abusive mothers (e.g., poor or unsympathetic response to distress, self-isolation, or poor impulse control) are found in neglected children as young as 1 to 3 years of age.⁷² Further, women with histories of victimization in childhood, but who did not maltreat their own children, had strong marriages, positive self-esteem, and had made a conscious acknowledgment of their past maltreatment. This finding suggests that one road to recovery from maltreatment is the development and maintenance of intimate relationships in adulthood and the acknowledgment of past maltreatment.

When interacting with peers, neglected children tend to be withdrawn from schoolmates or to relate to peers in a disorganized, active, or aggressive manner. These children may exhibit fewer positive play behaviors such as offering, sharing, showing, accepting, throwing, and following. A problem in peer relationships is supported by Hoffman-Plotkin and Twentymen, who report that neglected children tend to be more withdrawn than physically abused children and nonmaltreated children.⁷³ Additionally, their research suggests that both physically abused and neglected children exhibit less prosocial behavior than nonmaltreated children.

Such findings are consistent with other research that reports that neglected children directed fewer positive behaviors toward their peers, initiated fewer interactions, and were involved in simpler forms of play.⁷⁴ Problems in peer relationships are consistent with Helfer's description of what occurs when a child is raised in an abnormal environment. That is, if denied a healthy environment, a child never learns to trust others, has difficulty in selecting friends, and is often engaged in conflicts with others because of limited interactional skills.

Consequences Within the Physical Category

One obvious physical consequence of being neglected is deprivation of the fundamental nutritional needs required for healthy development. Very little has been written on the nutritional deficits associated with neglected children. Helfer discusses some of the consequences of malnutrition and growth retardation in the context of child abuse and neglect and identifies a variety of child and family problems associated with deprived backgrounds.⁷⁵ Excluding diseases and medical problems, which are associated with some type of growth failure or malnutrition (e.g., metabolic disorders, intestinal disorders, or hepatic diseases), Helfer reports that many studies that identify physical problems associated with a significantly reduced caloric intake indicate that neglected children tend to make significant gains in both weight and nutritional status after identification and implementation of a medically related treatment regimen. However, throughout their childhood (and probably adulthood) their stature remains short and their physical health is identified as somewhat fragile.

Secondary to malnutrition are the numerous developmental limitations and incapacities related to neglected children. Several studies indicate that the presence of severe neglect, usually associated with malnutrition, has major consequences for the achievement of many important early childhood developmental milestones as well as for intellectual and psychological functioning later in the child's development. Elmer, Gregg, and Ellison report that many of these children experienced behavioral disturbances and mental retardation.⁷⁶ This finding is supported by other research that has identified school and academic problems, delays in the development of language abilities, and social immaturity as effects of child maltreatment.

It appears that neglected children suffer long-term consequences if their neglect includes some type of malnutrition. These consequences appear to impair physical growth and development as well as intellectual and psychological functioning throughout childhood.

Consequences Within the Sexual Category

Finkelhor suggests that an important risk factor for child sexual abuse is parental absence and/or unavailability.⁷⁷ He states that characteristics such as parental separation or divorce, mother's employment outside the home, and a disabled or ill parent may increase the risk for sexual victimization. This seems a reasonable assertion, given these characteristics play an important role in the parent's ability to act as a caretaker and supervisor of the child. Consequently, it may also mean that parents who fail to care adequately for their children (i.e., neglectful parents) may also place their children at risk for sexual abuse.

Consequences Within the Behavioral Conduct Category

As stated earlier, one set of behavioral responses that neglected children appear to possess is passivity, social withdrawal, and isolation. Helfer argues that many of the child's basic interpersonal characteristics/traits (developing interpersonal relations, controlling behavioral impulses, and reacting to feelings without consideration of the consequences) are affected by child abuse and neglect, and that as a result, these traits are impaired both at the time of the maltreatment and later in life.⁷⁸ Problems with withdrawal and passivity are also suggested by Crittenden, although this research focused on mother/infant relations.⁷⁹ The reasons for a pattern of passivity, withdrawal, and isolation are unclear. However, one possible reason is that neglected children do not have a strong sense that they can have a meaningful impact in obtaining the cooperation of others. As has been demonstrated in interactions with their neglecting caretaker, neglected children learn that individuals are nonresponsive to their needs. This realization leads the neglected child to believe that relationships with others are not an effective means to have his/her needs met *or* that his/her needs cannot be met by others. This results in a decrease in attempts to initiate or develop relationships and a perspective that such behavior may be futile. The final step in this process, then, becomes passivity and withdrawal characteristic of ineffective interpersonal relations.

ASSESSMENT OF CHILD MALTREATMENT

The primary consequence of child maltreatment is the development of "dysfunction" within the developing child—that is, the "functioning" of abused children is set apart or becomes difficult as a result of having experienced abuse and/or neglect. Dysfunction may result in immediate impairment, problems in adjusting to the abusive experience, or it may occur as problems later in development. Therefore, the goal of therapeutic intervention is

to address the problems or conflicts within the child's current functioning and/or conflicts that are likely to impair functioning in the future.

Therapists work toward providing abused or neglected children with skills or understanding so that they may be better equipped to interact successfully with others (e.g., family, friends, teachers) and deal with their own thoughts and feelings. As stated earlier, in order to do this, therapists must understand basic child development (so they can know what is normal or typical) and psychopathology (so they can know what is not normal or typical). From this base of information, the informed therapist is able to discern which presenting problems are "dysfunctional" and determine if these problems require therapeutic intervention. A careful assessment of the child in his/her environment is key to this process.

Typically, the complexity of cases involving child maltreatment requires multidisciplinary input. Many communities have established teams to assist in the assessment of child abuse and neglect cases. These teams may include a pediatrician or other health care provider, a child protective services (CPS) caseworker, a law enforcement officer, an educational psychologist, a child development specialist, a substance abuse specialist, a mental health counselor, and other social service professionals. In conducting an assessment, the therapist needs to tap the resources of the team. If a team does not exist, consultation with professionals representing the key disciplines is strongly recommended. If the therapist and family represent different cultures, it is equally important for the therapist to consult with a professional knowledgeable about the family's culture.

ASSESSMENT OF THE CHILD WITHIN THE CONTEXT OF HIS/HER ENVIRONMENT

The maltreatment of children does not occur within a vacuum. In nearly every case, it is important to assess the functioning, strengths, and needs of a child within several contexts. Usually the dominant context of the abused child is the child's immediate family. However, there are also many other contexts or cultures that may have a greater or lesser influence on the abused child depending on the child's age (social networks, extended family, etc.).

In many cases of child maltreatment, therapists have a negative perception of the family (i.e., parents) because of the harm they have caused the child. The therapist may be angry or think less of the child's parents if they are the source of the child's maltreatment. However, the therapist should negate neither the importance of the family (from the perspective of the child) nor each family member's ability to contribute important information concerning the child's level of functioning. Whether or not they are involved in the abuse, parents are usually one of the most informed sources of information about the child's daily functioning and presenting problems. Similarly, an assessment of the child's functioning within settings such as school, social gatherings, daily after school activities, and day care provide information about the maltreated child from several sources and in several environments. One benefit of developing a multienvironment, multisource assessment of the child is that patterns of behavior, identified across contexts, increase the validity of the presence of a particular behavior or characteristic. For example, reports from a parent that a child is frequently belligerent and noncompliant might be supported by reports from his/her teacher that indicate that the child is frequently involved in physical fights with peers, has temper outbursts, and refuses to complete schoolwork. A valid conclusion that could be drawn from these reports is that this child possesses a relatively stable pattern of oppositional or defiant behavior.

Using multiple sources of information to assess an individual's functioning is not unique to clinical assessment or to child abuse.^{80 81 82} The rationale for this approach is fairly simple—in most cases, abused children do not exhibit a uniform pattern of behavior in response to their abuse. In fact, the response of many children to being victimized may not constitute a significant problem or be sufficiently problematic to require psychological intervention. Therefore, by using multiple sources of information to identify dysfunctional patterns of behavior, the child therapist can focus attention on those behaviors that require intervention. It is important to point out that not all abused children require therapeutic intervention and, when provided, treatment should focus on problems that may impair current or future functioning.

ISSUES TO BE CONSIDERED IN ASSESSMENT

As previously described, individual development progresses in an orderly manner that is common to all humans.⁸³

Additionally, there is a continuity to each person's development, which, although it may be subject to periodic changes or fluctuations, is present throughout his/her childhood. Sroufe and Rutter argue that "disordered behavior does not simply spring forth without connection to previous quality of adaptation..." and that "change, as well as continuity, is lawful and, therefore, reflective of coherent development."⁸⁴ When applying these concepts to child maltreatment, it becomes apparent that the clinical assessment of a child must examine the child and the presenting problem (consequences of abuse) in relation to the child's developmental status and capacity for adaptation. This approach is essential for developing treatment plans appropriate for a specific child's developmental needs. For example, it would be foolish to implement a verbal mode of therapy for a preverbal child, and conversely, it would be just as ineffective to attempt parent training (traditional child discipline skills as might be effective with a preschool-age child) for the parents of a 16-year-old client.

As a child changes and adapts throughout his/her childhood, the manner in which he/she expresses dysfunctional or distressing behavior also changes.⁸⁵ Therefore, the process of identifying psychopathology throughout childhood must be specific to the developmental status of the child. Thus, the therapist must possess a broad knowledge of child development (to understand normal and abnormal behavior throughout childhood). The therapist also needs to use assessment instruments that are sensitive to different age groups. Most published child clinical measures report age limitations for administration and clinical interpretation, and many offer age-specific scores. The most common examples are measures that assess a characteristic that is expected to change throughout childhood. These include the following:

- ✍ intelligence/development assessments (e.g., Kaufman Assessment Battery for Children or Wechsler Intelligence Scales for Children-III);
- ✍ developmental status assessments [e.g., Bayley Scale of Infant Development (BSID)];
- ✍ adaptive behavior measures [e.g., Denver Developmental Screening Test or Vineland Adaptive Behaviors Scales (VABS)]; and
- ✍ behavioral checklists [e.g., Child Behavior Checklist (CBCL)].

Often, measures that assess specific characteristics such as sadness, anxiety, fear, etc., do not have age-specific standardizations. Thus, the clinician may erroneously administer an assessment measure to a child who does not have the intellectual or emotional capabilities to accurately report about him/herself. For example, a child's ability to provide information on self-esteem is inconsistent until the child is between the ages of 7 or 8.⁸⁶ Before age 7, the child's developing self-esteem makes qualitative changes, and the child's ability to provide such an internalized evaluation is inconsistent. It is suggested that the validity and reliability of a child's report of internal states (e.g., feelings, thoughts, perceptions) does not become stable until the child is between 6 to 8 years of age.⁸⁷

Ethnicity and Socioeconomic Status

In general, the therapist should exercise caution when assessing children and families belonging to a different cultural, ethnic, and/or socioeconomic group. Assessment measures typically do not account for different ethnically or culturally based behaviors, such as language usage and culturally based belief systems. For example, it may be easy to interpret quiet and withdrawn behaviors on the part of a client as passivity and/or dependency when, in fact, the origins of the behavior may stem from culturally derived beliefs about polite and respectful

interactions with perceived authority. In part, this may mean that the assessment instruments are not well suited for populations that are different from the majority population. For example, children engage in a variety of diverse behaviors along many different continua, including age, sex, and ethnic group. As a result of socioeconomic, cultural, and familial factors as well as association with traditional beliefs and a limited awareness of existing mental health systems, different ethnic groups may encourage or discourage a specific form of child behavior. Thus, ethnically diverse children may exhibit ethnically diverse behavior.

A problem results when assessing a child for the presence of a behavioral, emotional, or psychological problem. By failing to be culturally sensitive to the specific behaviors exhibited by a specific ethnic group (or child of a specific cultural heritage), the clinician may erroneously identify the presence of a problem when one does not exist. For example, a clinician may be very concerned about the sexual behavior (and possibly marriage) of a young adolescent Laotian or Thai girl. However, within this girl's culture, early marriages may be culturally appropriate and expected with social stigma attached to a girl who has not become married during her adolescence. Conversely, a child of a specific cultural group may be experiencing significant distress and exhibiting this distress in a culturally acceptable manner, but the clinician may fail to acknowledge or identify this distress because of his/her lack of knowledge about the cultural group. Assessing children and families who are not a part of the majority culture without regard to their ethnic, cultural, and/or socioeconomic distinctions may result in significantly flawed information and, in turn, result in decision making and case management based on flawed information.

There have been several attempts on the part of test developers to be sensitive to children of diverse cultural and ethnic backgrounds and, in fact, a few standardized measures have developed alternative scoring and norms specifically for different subgroups. Examples of these scoring techniques include the addition of sociocultural percentile ranking for the Kaufman Assessment Battery for Children and supplementary norms for emotionally disturbed children on the VABS. The VABS also has supplemental norms for hearing-impaired children. Other researchers have developed ethnically specific norms for child assessment measures already in use. Some researchers have developed translated versions of commonly used instruments, while other have developed ethnic-specific norms for these same groups.⁸⁸ Finally, a few assessments have been developed to specifically address the unique characteristics and qualities of different subgroups [e.g., alternative means of assessment such as the System of Multicultural Pluralistic Assessment (SOMPA) and the Black Intelligence Test for Cultural Homogeneity.]^{89 90} Although there have been many efforts to make the assessment of children more ethnically and culturally sensitive, these tools have yet to demonstrate reasonable validity and reliability.

Social Desirability and Reporting Bias

When acquiring assessment information from any source, it is always important to attempt to explore and understand potential bias in the reporting of the data about a client. One source of bias involved in acquiring information directly from clients is known as social desirability, that is, the likelihood that people will provide information so that they will be perceived favorably by the interviewer, assessment administrator, or therapist.⁹¹ This phenomenon also has been reported and investigated in clinical research involving children.⁹²

An example of how a child might exhibit socially desirable behavior is demonstrated by the child who is very compliant, polite, and attentive during the initial contact with the therapist. This is often described as a "honeymoon phase"—the child is not yet comfortable within the therapeutic relationship and exerts control over his/her "typical" behavior to present him or herself as "likeable" or "pleasing." Even this phase offers clinical information because it demonstrates that the child has the ability to exert some short-term control over his/her behavior.

Another source of reporting bias involves a parent who denies the existence of a problem and/or is reluctant to provide complete information to the clinician. When parents are accused of harming their child or placing their child in a dangerous situation, they may be very suspicious of the clinician's intent and/or involvement. For

example, parents may deny the presence of a significant behavioral problem because they are concerned that their child may be removed from their care. By limiting the amount of information they disclose, these parents may be attempting to protect themselves from the perceived or real threat of losing custody of their child. Furthermore, although parents may be good reporters of behaviors and events concerning their child (e.g., fights, bullying, being suspended from school), they may not be as accurate about less tangible characteristics (e.g., sadness, anxiety, fears). Therefore, a parent may evaluate his/her child on the basis of significant or major events (e.g., noncompliance, chronic fighting) rather than present a more comprehensive representation of the child.

Finally, although children usually demonstrate a consistent pattern of behavior, some children respond well in some environments and less well in other environments. For example, a child can be cooperative and compliant within the daily routine and structure of the classroom environment, but he/she has chronic problems in less structured environments (e.g., playground, home, neighborhood play). In circumstances such as these, a teacher may report that a child has no problem in completing schoolwork, getting along with peers, or in relating to adults. This report results in a limited and incomplete picture of the child and his/her behavior.

Professional Roles in the Assessment Process

Because of the multidisciplinary nature of child abuse and neglect, effective case management, assessment, and treatment require that the professional has a clear understanding of his/her own and other professionals' roles and responsibilities. Because professional roles often overlap and provide similar or the same services, these distinctions are often difficult to make. For example, when interviewing a maltreated child, many professionals may interact with the abused child in a similar manner, but for different purposes. Law enforcement officers may interview the child to determine if the offender should be arrested; attorneys may interview a child to determine whether to prosecute a case; child welfare caseworkers may interview a child to determine whether the child's safety in the home is at risk; a psychologist may interview a child for an assessment; and a therapist may interview a child to begin to understand the child's perspective about the abuse and to support the child's resilient responses.

Acknowledgment and respect of the unique responsibilities of the professionals involved in cases of child abuse and neglect is essential. The management of each case requires establishing and maintaining open communication among professionals to minimize the duplication of services, obtain complete assessment information, and develop treatment and case management plans. The amount of cooperation and coordination among professionals directly affects the experiences of the child in "the system."

Use of Standardized Measures

During the past 30 years, there has been consistent debate regarding the benefits of the clinician's judgment versus the use of actuarial methods.^{93 94} Using standardized assessment techniques and combining these techniques with sound judgment based on clinical experience and training has been shown to be the best approach. Therefore, the clinician must become familiar with assessment instruments, their development, applicability to different populations, psychometric properties, and limitations. The clinician can obtain this knowledge by attending special training sessions or workshops, by pursuing formal education, and/or by having formal supervision. Usually, it is sound clinical practice for a clinician to use an unfamiliar measure under the supervision of some other professional who is familiar with its use. The clinician should also invest some effort to acquire understanding of the applications of the measures to be used. By using a new or unfamiliar measure in conjunction with a familiar or more well-known measure, the clinician can begin to develop an understanding of the new instruments in relation to a well-understood instrument.

Multiaxial Assessment

Multiaxial assessment is comprised of information from many different sources including the following:

- ✍ direct assessment of the child,
- ✍ projective assessments,
- ✍ cognitive assessment,
- ✍ clinical interviews with the child,
- ✍ parents' reports,
- ✍ family assessment,
- ✍ other professionals' reports, and
- ✍ physical assessment.

With the exception of physical assessment (typically conducted by trained medical personnel), discussion follows on all of these sources.

ASSESSMENT INFORMATION FROM CHILDREN

Perhaps the most important single source of information comes from the abused or neglected child. Often, information about the child's level of functioning, skills, needs, and/or problems can be acquired simply by asking or observing the child. There are several standardized instruments that can be administered directly to the child and interpreted by the trained clinician. Although obtaining assessment information directly from the child may present problems concerning validity and reliability (especially with younger children), the experienced clinician can still acquire much information from this process, especially when this information is supplemented by parent, teacher, or other assessment data. The following is a brief overview of some common techniques and measures. None of the instruments described in the following sections should be considered exhaustive nor comprehensive. Rather, they are simply a sample of techniques within several common categories. The reader is cautioned that the material in this manual represents an overview of issues related to child maltreatment and is in no way meant to replace formal training in social work, psychology, counseling, psychological assessment, or any other discipline.

Behavioral Report and/or Observation

A few behavioral/observational and screening measures for the more common childhood disturbances are presented in this section. It is important to note that the results of a single measure should not form the basis for diagnosis or treatment recommendations. Rather, proper assessment involves cross-situational data from multiple sources.

- ✍ **Anxiety.** Several behavioral/observational tools measure such as the Behavioral Avoidance Test, Teacher's Rating Scale, and the Observer's Rating Scale of Anxiety have been found to be reliable and valid measures of child anxiety. Additionally, there are several child self-report measures that appear to be valuable, including the State-Trait Anxiety Inventory, the Children's Manifest Anxiety Inventory, and the General Anxiety Scale for Children.

- ✍ **Depression.** The CBCL and the Personality Inventory for Children assess a variety of symptoms commonly associated with childhood depression. The Child Depression Inventory is designed to acquire information directly from the child by inquiring about the presence and severity of most of the childhood depression symptoms.
- ✍ **Attention Deficit Hyperactivity Disorder (ADHD).** One of the most frequently used measures of assessment of ADHD is the Conners Rating Scale, which has been shown to be fairly accurate in discriminating hyperactive from nonhyperactive children. This measure is typically administered to parents and/or teachers and is often supported through clinical interviews with the child, parent, and teacher. The CBCL has several items that reflect symptoms associated with ADHD and has a specific factor that has been labeled hyperactivity.

Casual Observations

Within the therapeutic or assessment setting, one of the more informative sources of information involves direct observation of the child before and after the appointment. This approach may include observing the child and the parent or caretaker sitting in the waiting room, walking to or from the appointment, interacting with other children and agency personnel (e.g., receptionist, other therapists). These observations allow the clinician to examine how the child engages with other individuals while not being formally evaluated. These pseudonatural observations are often informative because they reveal behaviors and actions that the child may conceal or inhibit during the assessment or therapy session.

PROJECTIVE ASSESSMENTS

Although empirical research has consistently demonstrated that projective techniques fail to demonstrate an adequate level of reliability and validity, clinicians continue to use these forms of assessment. Therefore, the question regarding why clinicians continue to use a form of assessment that has consistently proven to yield unreliable or invalid data. One possible reason is the relative ease of use of these instruments, supported by the ease with which they can be informally interpreted. Similarly, when using a projective assessment instrument, a clinician may selectively interpret the test materials, adapting them to “fit” the case. Therefore, after repeated administrations and selective interpretations, a clinician may develop the belief that the projective measure has accurately provided valuable information about several cases and thus, artificially elevate the validity of the projective measure.

Projective assessment techniques offer a unique opportunity to interact with the child in a semistructured format. These techniques allow the child to direct the conversation by either responding to a stimulus presented by the clinician or to direct the topic through a drawing or action. The following projective assessment techniques can all be adapted to facilitate communication either as part of the formal administration or immediately afterward in conjunction with an interpretation.

Projective Drawings

There are several variations of projective drawings that incorporate the use of a figure, person, or other images (e.g., house, tree, family). Each of these forms of assessment centers on providing the child with a basic set of instructions, which is typically kept to a minimum. The child is provided with paper and a pencil, crayons, or markers. The child is then provided the opportunity to draw a representation of what was asked of him/her. For example, Hammer suggests requesting the child to draw a house, then a tree, and finally, a person.⁹⁵ The house is drawn to elicit or arouse associations with the home or family and consequent familial relationships. The tree symbolizes life and growth, and is reported to reflect the child’s relatively deeper and more unconscious feelings about him/herself. Finally, the person is reported to represent the self-representation of the child within the family

and/or environment. Other forms of human figure projective assessments include Kinetic Family Drawing and the Draw-A-Person.^{96 97}

Projective Storytelling/Apperception Tests

The Thematic Apperception Test (TAT), for 5- to 18-year-olds, developed by Murray, and the parallel Children's Apperception Test (CAT), developed by Bellack, are designed to reflect internal states or constructs of the child.⁹⁸ ⁹⁹ With the TAT, the test administrator shows the child a card with a drawing or photograph and asks the child to tell a story about what he/she thinks is happening in the picture. The child then creates a story, which is believed to be representative of his/her cognitive-emotional processing. The TAT has approximately 20 separate pictures or cards, all or some of which may be administered to the child. The CAT, administered in a similar manner, was designed specifically for children and has themes more common to children. CAT presents animals in the pictures rather than human representations.

Rorschach

The Rorschach, for use with 5- to 18-year-olds, consist of 10 cards with black on white or multicolored images on each card. The test administrator gives each card, one at a time, to the child and asks the child what he/she sees in the inkblot. The child then describes his/her perception while the administrator records the verbatim response. The child may see a single percept or several connected or unconnected percepts on each card. After completing this phase, the test administrator then reviews each card again, asking for clarification about how the child perceived each card. There have been several different scoring systems developed for the Rorschach, with specific scoring for children. The most popular scoring system has been developed by Exner.¹⁰⁰

COGNITIVE ASSESSMENTS

The overall objective of intelligence testing is to provide an index of a child's intellectual functioning in relation to other children within his/her age group. Because intelligence is such a significant factor in a child's development, any concern about cognitive deficits should be identified and addressed. The child's intellectual functioning influences the approach to treatment. Certainly, not every abused or neglected child should receive an intellectual assessment. But if limitations in the child's intellectual capacity impair the ability to obtain, process, or retain information acquired from therapy, then alternate therapeutic plans may be necessary. For example, a child with a significant learning disability and a poor ability to verbally mediate thoughts and ideas is probably not well-suited to a verbal or didactic therapeutic plan.

In addition to the overall objective of providing information about intellectual functioning, intelligence tests offer a means of assessing other areas of the child's functioning. By providing a structured environment, the evaluator can assess the child's ability to stay on task, follow directions, and change from format to format. Because most intelligence tests begin with relatively simple items and then become increasingly difficult, the evaluator also has the opportunity to observe the child's response to frustration and failure.

Finally, intelligence tests often use items that require some type of social judgment. For example, on the Wechsler Intelligence Scale for Children-III (WISC-III), the subtest on comprehension asks questions about how a child might react in certain situations (e.g., "What would you do if you were at the movies and you saw a fire?" "What would you do if a child, smaller than yourself, tried to fight with you?"). This scale asks the child to provide an underlying rationale for common phenomenon (e.g., "Why should you trust a friend?" "Why is it better to give money to a well-known charity than to a beggar on the street?"). By responding to these questions, the child often reveals his/her values, cognition, and perceptions of the world and others.

A common criticism of intelligence tests involves their applicability to children of ethnic minorities. Several studies have demonstrated that intelligence tests are inappropriate and unfair for lower socioeconomic groups and children of ethnic minorities. Although these biases appear to be relevant to all intelligence tests, some test developers have attempted to minimize this phenomenon by reducing the culturally biased items, decreasing the verbal component of the tests, and providing specific norms for certain ethnic minority groups.¹⁰¹ Nevertheless, the clinician should be cautious when using intelligence tests with lower socioeconomic groups and children of ethnic minorities.

As a rule, the use of intellectual assessments for clinical purposes is restricted to professionals (psychologists, psychometrists) who have formal training in the application, administration, and interpretation of these assessment tools. However, some professionals without formal training may attempt to interpret or reinterpret reports of an intellectual assessment. Obviously, this practice is unethical and belies the underlying rationale for all assessments—the careful and informed use of an assessment measure for specific and appropriate purposes.

Bayley Scales of Infant Development (BSID)

The BSID is used to acquire a multidimensional assessment (i.e., mental, motor, and behavior indices) of infants and toddlers from birth through approximately age 2 years. A highly trained administrator presents the infant with a series of brief, individual tasks that increase in developmental complexity. By determining how many of these tasks the infant can perform successfully, the administrator compares the infant's demonstrated developmental ability to standardized scores. Although the BSID is the most popular measure of infant development, it is only indirectly related to intelligence and has not been shown to be a good predictor of later intelligence for all infants. However, infants who score very poorly on the BSID have demonstrated significant difficulty in later years.

Wechsler Series of Intelligence Tests for Children

These intelligence assessment instruments, the Primary Preschool Scale of Intelligence-Revised (WPPSI-R) for 3- to 6-year-olds and the WISC-III for 6- to 15-year-olds, were developed to yield an overall intelligence score (full-scale IQ) and to provide a means to assess both verbal and performance IQs. Both of these instruments are administered directly to the child by a trained clinician (typically a psychologist, educational psychologist, psychometrist) and yield three scores—a performance IQ, a verbal IQ, and a full-scale IQ. Both the performance and verbal IQs consist of several subtests that assess different cognitive abilities. The full-scale IQ is a combination of the performance and verbal scores. (All three scores have a mean of 100 and a standard deviation of 15.)

Kaufman Assessment Battery for Children (K-ABC)

The K-ABC, for 3- to 12-year-olds, was developed to more accurately reflect research in the area of children's intelligence, which suggested that an individual's intelligence was better assessed by examined mental processes than by verbal and performance domains. As a result, the K-ABC has a mental processing composite score consisting of simultaneous processing and sequential processing. In addition, the K-ABC yields an achievement score, based on six school-related subtests. The K-ABC also provides supplemental norms for hearing-impaired children and children from different sociocultural backgrounds.

CLINICAL INTERVIEWS

The clinical interview is a common method for obtaining information directly from a child. The interview may take on a variety of forms, including a nondirected play session, an open-ended dialogue, a verbal account of client history and presenting problems, and a structured psychiatric diagnostic interview. Perhaps most frequently, a clinician may combine several of these interview approaches in developing a broad base of

information (both observational and reported) concerning the child. Interviews are also dependent on the developmental status and abilities of the child.

Nondirective Play Sessions

Play sessions that are nondirective and that require little verbal information from the child are most beneficial for young children. Typically, during the play session with a preschool or early school-age child, the clinician will assess the child's expressive and receptive language ability. The play session will help to answer questions such as the following:

- ⌘ Does the child have the capacity to engage in pretend or symbolic play?
- ⌘ Can he/she adopt roles and characteristics during play?
- ⌘ Does the child engage easily during the first assessment session?
- ⌘ Does he/she require a period of reacquaintance at the beginning of each assessment/therapy session? (For example, frequently children who are angry or hostile exhibit play behaviors that reflect these feelings; they may attempt to break or destroy toys, attack or attempt to injure the clinician, and engage in extensive discussion of killing or fighting.)

With children of all ages, it is usually best to use toys as a part of the clinical interview. These toys may include dolls, small play figures, drawing equipment (e.g., pens, markers, crayons), blocks, marbles, cars and trucks, etc. Because it is difficult to predetermine which type of toys a child might enjoy playing with, it is usually best to have a small assortment of toys that have traditionally appealed to a child.

For the evaluator, one objective is to use toys as a means of eliciting conversation from the child and to engage the child in some type of cooperative activity. Certain toys or objects are more conducive to this task than others.

For example, dolls, play figures, and blocks can easily be incorporated into play involving people, homes, friends; musical instruments and computer games may inhibit the interaction between the child and the evaluator. By using a limited assortment of toys and manipulative objects, the experienced clinician/evaluator can also develop a common set of expectations regarding a child's interaction with those toys. For example, when provided with a small house and a family of play figures, most children will begin to manipulate these toys in a manner that reflects their perception of family interaction. Stereotypically, this interaction may include the mother cooking dinner in the kitchen, the father going off to work, etc. If the child begins to use these toys in an atypical manner, this behavior may reflect the child's perception of a family constellation or structure. This might be exemplified by the child living with a divorced single-parent mother who chooses to exclude the father in play and have the father on the periphery of the play session.

There are two important issues to remember when conducting a play session with a child. The first issue is that there are no specific goals or objectives within the session, other than the careful observation and examination of the child. It may not be beneficial to establish a specific task as part of the play session because this approach may inhibit the child's demonstration of internal processing in favor of accomplishing the task. The second issue involves incorporating or facilitating the child as the leader of the play session. This can be structured by having the therapist/evaluator demonstrate that he/she will follow the lead of the child in playing with whatever toys the child would like to use. For some children, the process of taking the lead in a play situation may not be easy or comfortable. Certain children may require encouragement to explore the boundaries of what they can play with and to test their freedom to choose a pretend situation in which to play. It is important that the therapist/evaluator refrain from interjecting the direction or form of play and that they remain as a willing and responsive playmate (and an observing and examining evaluator).

Structured Psychiatric Diagnostic Interviews

One alternative in obtaining information about a maltreated child is the use of a structured diagnostic interview. Typically, these instruments involve administering a detailed set of questions about the child by first interviewing the parent or child's caretaker and then interviewing the child. Because they require the child to report about internal states and to respond to questions primarily within a verbal format, these interview methods are not appropriate for children who have not reached school-age.

Most of these instruments have adapted the child psychiatric diagnoses of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (DSM-III-R) to specific behaviors and then developed a set of questions that determine if the behaviors presented by the child fulfill specific diagnostic criteria.¹⁰² These interviews commonly are administered to the parent or caretaker; this information is then confirmed, supplemented, or rejected based on a second interview with the child. The final determination of whether the child has a formal DSM-III-R diagnosis is based on information acquired from either or both of these sources of information.

Three of the most common structured diagnostic interviews are the Diagnostic Interview Schedule for Children (DISC) for 6- to 18-year-olds, the Schedule for Affective Disorders and Schizophrenia (K-SADS) for 6- to 18-year-olds, and the Diagnostic Interview for Children and Adolescents (DICA).^{103 104} Clinicians and evaluators familiar with these instruments will have a general format by which to inquire about specific troublesome presenting behaviors. By being familiar with one or several of these instruments, the clinician or evaluator can quickly identify or eliminate the presence of a psychiatric disorder or, if necessary, question further about a problem area. The basic format of these interviews is typically sequential and information-oriented (versus rapport-oriented). However, they can be adapted to fit the needs of the individual clinician. For example, a clinician concerned about the presence of an affective disorder can begin asking questions from the affect/mood disturbance portion of the K-SADS. However, parents appear to be better at reporting external, behaviorally manifested problems about their children (e.g., aggression, crying) than they are at reporting problems that are more intangible (e.g., low mood, anxiety, grief).

ASSESSMENT INFORMATION FROM PARENTS

One of the most common sources of information about a child is the child's parents or caretakers. Usually, parents have the most consistent and reliable perspective of their child and are invested in providing valuable information. For a comprehensive assessment of a child, it is essential to interview each parent and obtain information about the child's functioning in a variety of settings (e.g., home, neighborhood, school, or church). Parents, like all reporters, are subject to bias in providing information about their child. Therefore, it is important to assess both the information provided by a parent and the parent's ability to provide valid and reliable information. Several standardized child assessment measures have been developed for parents to complete concerning their child. Some of these measures are discussed below.

The Child Behavior Checklist (CBCL)

Developed by Achenbach and Edelbrock, the CBCL is a 118-item instrument that asks parents to report the presence and frequency of a wide range of behavioral problems.¹⁰⁵ This instrument has different norms for both boys and girls within three different age groups (2- to 3-year-old children, preschool-age children, and school-age children). It yields different scores on several factor-analytic narrow-band scales (e.g., delinquent, sex problems, withdrawal, or hyperactivity) as well as three social competence scales. Scores are plotted on a child behavior profile, which has T-scores in which clinically significant problem behavior is indicated by more than 20 points above the mean ($T > 70$). The benefits of the CBCL are the frequency of its use with child clinical populations, its application to a large and diverse number of children, separation of norms with regard to both age and sex,

and the relative ease of administration. The CBCL may be used as a means to assess both pre- and posttreatment functioning to determine the effectiveness of the treatment program and achievement of individual treatment goals.

The Vineland Adaptive Behaviors Scales (VABS)

The VABS is usually administered within a structured interview format, asking parents about behaviors of their children.¹⁰⁶ The VABS provides developmental information about the child's level of functioning within three domains—communication, daily living skills, and socialization. For children younger than age 6, the VABS also provides information about gross and fine motor skills. There is an adaptive behavior composite, which reflects scores in each of the individual domains. For children aged 5 and older, the VABS identifies maladaptive behaviors in relation to an age-appropriate normative group.

FAMILY ASSESSMENT

One of the most essential elements in understanding a child is the assessment of his/her family. Traditionally, the family is the most consistent and important contributor in a child's life. It is important for clinicians to remember that as children develop within their family system, the family as a whole goes through a process of changing and adapting. In addition, interactions and dynamics within a family are multidimensional. Parents not only have an important influence on their children; children also have a significant influence on their parents. Given this information, an accurate assessment of a child should also include information from and about the child's family.

It is acknowledged, however, that with abused and neglected children, such an assessment may not always be possible.

The Purpose/Intent of Family Assessment

Without a clear understanding of the problems, capacities, and abilities of the entire family, it is difficult to determine a treatment plan for the child. The general purpose of a family assessment should be to acquire a more complete understanding of the child within the environment in which he/she lives. This assessment includes gathering information about the family's values and experiences, particularly experiences related to loss and grief in recent years. Additionally, because one of the primary outcomes of the assessment process is the identification of problems, strengths and needs, and capacities, the parents (and family as a whole) reflect these characteristics for the child. For example, it would be unwise to identify a problem and suggest a therapeutic response to that problem that is beyond the capacity of the child or the family. Thus, a recommendation to increase the structure and responsiveness to a child-related problem of noncompliance is inappropriate if it is beyond the parents' abilities to implement the recommendations because of poor parenting skills and/or the parents' own disorganization. Finally, through a family assessment, the clinician has the opportunity to examine the parents and assess their abilities and problems.

Standardized Measures of Family Assessment

Several measures of assessment are available that reflect many different areas of family functioning. Most of these measures assess constructs such as family cohesion, independence, power, and adaptability. Two of the more common standardized measures of family assessment are the Family Adaptability and Cohesion Evaluation Scales (FACES) and the Family Environment Scale (FES). The FACES consists of 20 items and measures 3 dimensions of family behavior as follows:

- ✍ adaptability—the extent to which the family system is flexible and subject to change,
- ✍ cohesion—the emotional bonding that family members have towards one another, and
- ✍ communication.

The FES consists of 90 items and has 10 subscales that assess different social and environmental characteristics within a family. These include the following:

- ✍ Relationship dimensions
 - cohesion
 - expressiveness
 - conflict

- ✍ Personal growth dimensions
 - independence
 - achievement orientation
 - intellectual
 - active/recreational orientation
 - moral/religious emphasis

- ✍ System maintenance dimensions
 - organization
 - control

There are many other valuable, standardized family assessment measures that are not included in this section. The interested reader is encouraged to explore texts that assess family assessment measures.¹⁰⁷

Clinical Interviews

In conducting a clinical interview with a family, it is important to use many skills concurrently. The clinician must be able to:

- ✍ observe interactions between family members;
- ✍ assess relative position and power within a family in terms of hierarchy, roles, and boundaries;
- ✍ provide and respond to specific questions;
- ✍ record information about family history, background, symptoms, and characteristics; and
- ✍ attend to their own position within the clinical interview.

Perhaps foremost among these tasks is the observation of each family member separately as well as the observation of the family as a combined unit.

Because the standardized assessment of family interactions are typically beyond the ability of many clinicians, a less formal assessment of family interactions is usually undertaken. By conducting a clinical interview with the child and family together, the clinician can assess a variety of child/family interactions and factors. For example, if a family member is absent, this raises the question of position within the family, commitment to family activities, and perceived sense of membership in the family.

Often during a family clinical interview, one individual emerges as a spokesperson for the entire family. Typically, this is a parent who responds to general family-directed questions or takes the lead in clarifying information. However, the clinician should be alert to an imbalance in relationships within the family (e.g., a single member dominating the conversation, speaking over other members, responding to questions directed to other family members, or reframing responses in his/her own words).

In many cases, adults and older children present themselves (either verbally or behaviorally) in a socially acceptable and desirable manner, but some children, especially very young children, may be less skilled or conscious of this process. Children often talk and act in a manner that is more consistent with their actions in a nonclinical or natural setting. Therefore, it is important that the clinician refrains from focusing solely on the identified child or on the parents throughout the family assessment session. The clinician must also incorporate all members into the interview, either by direct questioning or by requesting their perspective on the topic being discussed.

SUPPLEMENTAL INFORMATION

In addition to the child and the child's immediate family, other professionals are able to provide important information about abused and neglected children. This section identifies the potential contributions that school personnel, social service workers, and foster parents can make in assessing the functioning of the child, developing treatment plans, and assisting in case management.

Teachers/School Personnel

Because a child spends a great deal of time within the school setting, teachers and school personnel have the opportunity to observe him/her within a variety of school-related settings. Interviewing teachers about a specific child often yields information about social skills, peer relations, intellectual ability, cooperative skills, behavior management techniques, attentiveness, emotional stability, and response to authority. Teachers can provide information about their observations of a child within a classroom setting, on the playground, at the cafeteria, and before and after school. Teachers are also able to provide general information about the child's daily living such as cleanliness, eating habits, grooming, and problems related to encopresis or enuresis. Furthermore, because schools typically attempt to maintain regular contact with parents, teachers are often able to provide supplemental information about their interactions with the child's parents. This may include an assessment of the parents' level of involvement, concern about parenting ability, and overall stability of the parents.

The Child Behavior Checklist/Teacher Report Form

This behavioral checklist was developed as a parallel form of the parent version of the CBCL. It has similar behavioral problems scales and internalizing and externalizing factors. By comparing a child's score on both the parent- and teacher-reported version, the assessor can acquire a more comprehensive assessment of the identified child.

Child Welfare Caseworkers

Typically, child welfare caseworkers are required to obtain sufficient information about children in their caseload to be able to determine the level of risk to the child and the child's treatment needs, offer opinions to the court, and develop and administer therapeutic and reunification plans. To accomplish these tasks, caseworkers must rely on information provided by a broad spectrum of sources familiar with the maltreated child. These sources may include foster parents, caretakers who are relatives of the child, home visiting agencies, or law enforcement agencies, etc.

Because caseworkers usually have large caseloads, it is difficult for them to maintain intensive and consistent contact with all their cases. Therefore, caseworkers may not be able to provide abundant direct information about a child, but be an excellent source of indirect information. Because of their position, caseworkers are often the center of the flow of information about a child. Therefore, they may be informed of the child's behavior from a variety of sources and be able to integrate this information in making informed case management decisions.

Foster Parents/Supplemental Caretakers

One assessment problem for children in substitute care (e.g., those in foster care or those receiving care or temporary shelter care) concerns the ability of a new caretaker to provide valid and reliable information.¹⁰⁸ In situations in which a child is exhibiting a severe or acute problem such as suicidal ideation, hallucinations, or aggressiveness, this becomes fairly easy to identify. However, most problematic behaviors require consistent exposure to the child in order to assess the severity and stability of possible problem behaviors.

An example is the child who, after being placed in a foster home, demonstrates a poor appetite and gradually begins to lose weight. This reaction might be the child's expression of distress as a result of being separated from his/her family or reflective of sadness or depression, anxiety resulting from not feeling safe in an unusual environment, a lack of familiarity or dislike of a new type of food, or the beginning of an eating disorder. Without consistent exposure to the daily activities of this child, it would be difficult to determine the cause of the appetite and weight loss. However, a foster parent or supplemental caretaker (i.e., family friend, grandparent or other relative) may be able to provide such information after having this child in his/her care for a sufficient period of time. The minimum amount of time for a caretaker to be able to report on a child's behavior is approximately 4 to 6 weeks.^{109 110 111} This time frame enables the child's caretaker to report on a pattern of daily behaviors (i.e., daily living skills) as well as a range of potential dysfunctional behaviors.

ASSESSING RISK OF HARM TO SELF AND/OR OTHERS

As part of the assessment of any new client, it is essential to determine the client's potential to harm him/herself and/or others. The difficulty in acquiring clinical information directly from the child client may require consultation with other important people in the child's life (e.g., parents, teachers, child care providers). It is important to investigate both the child's behavior *and* the motivations or cognitions related to his/her behavior.

Because of the child's limited intellectual abilities, he/she may engage in dangerous or harmful behavior without a clear understanding of the consequences of his/her actions. For example, a younger child may be excited by fire and be very interested in playing with matches. However, he/she may have a poor appreciation of the potential damage he/she could cause by burning him/herself or property. The assessment of danger to self and/or others should be conducted directly with the child and with other people who have contact with the child. In addition, the mental health professional should inquire about any prior aggressive, suicidal, and/or other dangerous/harmful behaviors (e.g., playing with knives, playing with matches, climbing tall trees). This should be done in the early stages of therapy (optimally during the first session), and any potential harm to self or others should be incorporated into the treatment plan. In addition, any concern about harm to self or others requires regular reevaluation and specific actions to address this concern (e.g., increased supervision, evaluating placement appropriateness).

Suicide

Although the threat of suicide among children is relatively low, it is nonetheless important to make a clear and focused inquiry regarding the child client's potential to harm him/herself. The mental health professional should directly ask the child if he/she has ever thought about hurting him/herself in any manner and/or taken any action that could result in death or serious harm. Although some professionals may feel uncomfortable about such a line of questioning, the difficulty in correctly predicting suicidality based only on behaviors and reports from

others is great. It is not unusual for a child to harbor thoughts of self-harm and not discuss them with friends, parents, or siblings. Therefore, it is strongly recommended that the therapist make a direct inquiry of the child's threat to harm him/herself. Similarly, the therapist may also want to inquire about past thoughts or desires that are reflective of hopelessness, sadness, having "given up," and passive statements about suicide (e.g., "Maybe it would be better if I weren't around"). Careful and conscious inquiry should also be made of parents and other individuals who are familiar with the child. This line of inquiry should include questions about dangerous behaviors (e.g., running into the street, playing with sharp objects) and previous statements concerning suicide.

Whenever a concern is raised about suicide, it is important to carefully evaluate the situation and take appropriate action. This may involve increasing supervision, removing dangerous objects from the child's environment, increasing therapeutic contact, and/or evaluating the need for psychiatric hospitalization.

Self-Destructive Behavior

In some situations, the child may have no discernable intent to commit suicide, but nevertheless engages in behaviors that are dangerous, potentially harmful, and/or "risky" (e.g., climbing tall trees or buildings, ingesting nonfood substances, cutting skin with a knife or other sharp object). These types of behaviors may reflect underlying self-destructive tendencies and should also be carefully assessed in a manner that is similar to the assessment for suicide. While the intent of these behaviors may not necessarily be suicidal, they may result in significant injury and/or death.

Danger to Others

Often, a child who experiences intense hostile affects but has limited ability to verbally mediate his/her feelings may express him/herself through behavior. This may result in acts of aggression directed toward specific individuals (i.e., the individual with whom the child is angry) and/or displaced anger towards others. Special concern is raised about actions of aggression that may be directed toward younger or weaker individuals in the child's environment (e.g., a younger sibling, babies). The therapist should inquire about the history of aggression, whether the aggression is planned or impulsive, the seriousness of the assault on others (i.e., whether injury occurred), the use of weapons, and the frequency of such aggressive acts. This may also require investigation into the child's living environment and the parents' ability to manage acts of aggression (e.g., level of supervision, assessment of parenting skills). A specific plan should be developed to ensure that the aggressive child will not have the opportunity to become aggressive to younger children and that he/she can be placed in a setting that can manage his/her assaults. This may require an evaluation of the appropriateness of the child's placement and alternative living situations. Special concern is raised for a child who has a history of engaging in sexually aggressive acts. Such a child may require extra supervision and careful case management decisions.

Revictimization

A frequent symptom of some children who have been sexually abused is to engage in sexually inappropriate behaviors. These behaviors may include increased masturbation, exposing themselves, increased sex play with peers, and/or being seductive with adults. Such behaviors, which arise from the child's distorted perceptions of appropriate interactions with others, may result in this child being at increased risk of being revictimized. The therapist should inquire about the presence of any type of sexually inappropriate behavior and carefully observe the child during the clinical interview for behaviors that may be inappropriate. Parents should be asked about the type and frequency of their child's sexual behaviors within the home, with specific attention to the family's sexual attitudes and values. In addition, the parents' ability to recognize inappropriate sexual behaviors should also be assessed. This may include an examination of the parents' ability to supervise their child and degree of concern of their child's sexuality. As with other forms of harm to the child, a specific program should be developed to address sexuality, sexual safety, and appropriate sexual boundaries.

THERAPY

Therapy is the art and science of helping children make sense of their feelings, thoughts, and behavior and learn how to control their behavior and improve interactions with others. It is art because it calls on the therapist's creativity, intuition, and spontaneity. It is a science because therapy with abused and neglected children is based on theory, research, and clinical studies. The goals that need to be accomplished and the techniques or interventions that help children address and grow beyond the experience of abuse and neglect are gleaned from theory and clinical literature, research, and experience. This chapter addresses theoretical orientations to therapy, the role of the therapists, rights and responsibilities in therapy, the therapeutic process, the stages of therapy, and treatment modalities. Some of the most common treatment issues and concerns about children who have experienced maltreatment are discussed in a later chapter.

THEORETICAL ORIENTATIONS

A number of theoretical orientations offer useful insight for working with abused and neglected children.

Developmental theories deal with the following:

- ✍ normal child development,^{112 113 114 115}
- ✍ effects of attachment and loss on children,¹¹⁶ and
- ✍ impact of normal and abnormal life experiences.^{117 118}

Interpersonal theories include:

- ✍ how significant relationships influence the child's identity, perceptions, beliefs and interactions, such as object relations theory, self psychology, and ego psychology;^{119 120 121 122} and
- ✍ the function of the therapeutic relationship and the use of countertransference.^{123 124 125}

Cognitive and behavioral theories explore:

- ✍ the relationship between feelings and behavior and how changes can occur;^{126 127}
- ✍ how negative feelings become associated with the child's perceptions of the abuse;¹²⁸ and
- ✍ how developmental sequencing of phenomena such as cognition, motivation, and affect impacts a child's power to reorganize experience.¹²⁹

System theories deal with:

- ✍ the importance of the family and the society in which the child lives;
- ✍ interrelationships and their impact on the child;^{130 131 132} and

- ☞ useful and practical interventions with family, school, and community.

Abuse and victimization theories explore:

- ☞ the effects of sexual and physical abuse on children,
- ☞ prevalence and vulnerable populations,¹³³
- ☞ perpetrator dynamics,^{134 135 136}
- ☞ grooming behaviors,¹³⁷ and
- ☞ long-term effects of abuse and neglect.^{138 139 140}

ROLE OF THE THERAPIST

The therapist has an important role in helping a child recover from the effects of abuse and neglect. The therapist serves a number of functions, including:

- ☞ helping the child address issues related to abuse and neglect,
- ☞ serving as a model for appropriate adult/child relationships,
- ☞ working to improve family relationships, and
- ☞ supporting positive and productive peer relationships and support systems.

The therapist's initial function is to establish rapport and develop a trusting relationship that will help the child address the thoughts, feelings, and behaviors that are generated by abuse and neglect. The therapist promotes the child's awareness and understanding of abuse dynamics, encourages growth and development beyond the role of victim or the inappropriate identification with the offender, and supports the child's individuality and personal integrity. The therapist teaches the child to care for him/herself, think about his/her behavior, and make choices that maximize his/her safety. The therapist also needs to help the child regain trust, faith, and investment in meaningful relationships.

As an adult, the therapist models appropriate behavior including nurturing, affection, and the expression of feelings. The therapist gives the child the opportunity to explore issues of trust, acceptance, affiliation, and emotional intimacy. The child can integrate the therapist as a role model for safe and nurturing relationships. The therapist also shares the child's hope, excitement, and curiosity about life in order to help his/her client reinvest in his/her future.

The therapist models and maintains good clinical boundaries. He/she understands the vital bond between child and parent and does not attempt to take the place of the parent. Instead, the therapist helps the child and parent interact appropriately and offers alternative problem-solving models for parent-child relationships. The therapist also helps the child to be as realistic and practical as possible when relating to parents with problems. It is a difficult task to help a child to be realistic, while not taking away his/her hope for change and improvement in his/her parents.

Although clinical interventions and psychotherapy with parents is beyond the scope of this manual, it is vital that every effort be made to improve and maintain the child's relationships with family members. Children need to

express a full range of feelings regarding their family members. The therapist can be more helpful by remaining neutral and empathetic to the child's situation than by taking angry and punitive stances toward parents and unavailable family members. Conjoint therapy with a parent and child, family therapy, or role-playing family interactions when no parent is available can help the child attain a realistic and pragmatic approach to his/her parents and family. Formal training in the processes and dynamics of these various treatment modalities is encouraged prior to their use.

One of the most important functions of the therapist is to facilitate the child's investment in a positive and protective support system that continues to be available to the child when therapy ends. Children who have been abused or neglected may not know how to interact appropriately with people who could be supportive, helpful, and appropriate for social interaction. Children need to learn social and interpersonal skills that will facilitate their interaction with peers and adults. Individual therapy can begin this process by offering a supportive environment in which to address the child's experience, needs, and abilities and by allowing the child to learn to interact appropriately with an adult. Therapy offers the child an opportunity to verbalize and explore many of the issues or concerns typical of victims of abuse and neglect. It also offers the child an opportunity to practice expressing feelings and to learn behaviors that can generate appropriate responses from adults and peers. Group therapy can further this process by allowing a child to participate in a group of his/her peers who have had similar experiences. This group experience can help the child realize that many of his/her behaviors or reactions are typical for children who have been abused or neglected. Group therapy allows the child to practice and modify many of the skills he/she has learned in individual therapy. These skills include listening, sharing, responding with interest and empathy, and demonstrating age-appropriate concern and affection. It is much easier to insert corrective information or action when a therapist witnesses a problematic interaction than when he/she learns about that problem later. Many of these skills that can be utilized in a neighborhood or school setting increase the child's likelihood of finding appropriate and responsive friends.

Participation on team activities can increase cooperation and appropriate social interactions and can offer esteem-building experiences for the child. Participation in social and school groups allows the child an opportunity to apply and practice his/her acquired social skills and relate to other children as a peer rather than as a victim of abuse or neglect.¹⁴¹

CLIENTS' RIGHTS IN THERAPY

Children, and all consumers of therapy, have certain rights that must be maintained during the course of therapy. These include the right to an abuse-free environment, the right to ask questions about therapy and receive an answer that they understand, the right to expect that therapy is helpful, and the right to be treated as a unique individual.

Abuse-Free Environment

An abused child comes to therapy with the knowledge that some adult misused his/her knowledge, power, and experience to take advantage of the child. As an adult, the clinician is in a position of implied power and has knowledge and experience that can help the child. This power, knowledge, and experience differential needs to be clarified and used appropriately. The role of the therapist is to protect the child; listen and respond to the child in a manner that generates growth and development; model appropriate adult/child interaction, and help the child learn safety, protection, problem-solving and communication skills. The therapist will need to set appropriate limits and adhere to boundaries that protect the child as well as him/herself.

A national survey found a significant number of cases of therapist/client sexual intimacies involving minor children.¹⁴² The ages for boys who were abused ranged from 1 to 16, with age 12 1/2 the average. The ages for girls who were abused ranged from 3 to 17, with 13 3/4 the average. This is an issue that must be monitored

carefully. Children must also be made aware that there is possibility of being sexually abused by a professional. Therapists must report this type of abuse to the proper authorities.

Protection and Limit-Setting

The therapist may need to define appropriate and inappropriate behavior for the child. A child who attempts to expose his or her private body parts needs to be stopped. The therapist needs to explain that behavior is not necessary or acceptable. The therapist can explain that children only need to show their body parts under special occasions such as medical exams. Attempting to touch the therapist's private body parts or peeking under clothing also needs to be defined as unacceptable behavior. Natural consequences, logical consequences, shortening the session so the child can behave appropriately for a short period of time, taking a "time out" to relax, or stopping the session are all methods that can be used effectively with children. Threats to end the session or to discuss a child's behavior with the parents are usually ineffective. However, the child's parents need to be informed of the therapist's plan for addressing problematic behavior. The therapist will need the parents' cooperation, support, and willingness to follow up with a discussion. Parents will also need to support the need for therapy and insist that the child return to subsequent sessions. It is important to clarify the rules and discuss the consequences with the child so that he/she understands the intention and purpose of discipline. This discussion should take place before the therapist imposes any consequence. It should be made clear that the therapist will continue to work with the child to help him/her use therapy. The overriding goal is to demonstrate to the child that no problem or behavior is so disturbing that it cannot be addressed.

Within the therapeutic relationship, a child will often attempt to create the same power structure found in the abusive family. Many children can be demanding and authoritarian, and they may make threats or suggestions that challenge the therapist's authority and role. Usually, these actions are the child's attempts to find out how the therapist will respond. Often, a therapist will feel angry or powerless and may feel that he/she is being bullied or manipulated by the child. It is important for the therapist to identify the type of behavior that elicits these kinds of reactions. Feelings about the behavior need to be expressed to the child with the therapist also demonstrating problem-solving responses to that behavior. Thus, the child can become aware of how his/her behavior may generate strong reactions in others and begin to expect consequences that do not include abuse. At these times, clinical supervision is particularly helpful to the therapist in processing his/her reactions to the child/family and in developing strategies for future sessions. Sometimes a child does not have the skills to develop a relationship based on reciprocal interactions and respect. In these cases, the therapist can educate the child about relationships, manners, and social skills.

Terminology and Communication

The therapist needs to use words and terms that are understandable to the child. A 3-year-old child will need to hear different words and phrases than a teenager. It helps to be able to understand and utilize many different developmental and experiential languages in order to translate psychotherapeutic concepts into explanations that make sense to children.

A therapist who works with abused and neglected children need to use words and terms that accurately describe abuse and neglect. Words and expressions that either minimize or overdramatize the experience can create the impressions that the therapist just doesn't understand the child's situation. Exaggerated statements, such as "Well, you survived abuse; you can survive anything," or "I'm so mad at your dad for doing that to you," say more about the therapist than about the child's experience.

Categorizing and reacting to the child's experience or feelings before the child has had a chance to express him/herself often confuses the child or elicits a response the child feels is expected by the therapist. It is often more productive to ask the child to describe what happened and how he/she felt about the experience. The

therapist should then help the child come to his/her own estimations of the experience by asking the child if the experience was helpful or hurtful, happy or sad, scary or pleasant, or any combination that helps the child identify and express his/her feelings. The therapist can ask, "How do you feel about that?" or "Do you ever feel angry about what happened?" or "What would you say to a child who was in that situation?" The therapist can also help the child talk about the experience by asking "What is the most frightening thing that ever happened to you?" or "When was a time that you felt strong and powerful?" In this way, the therapist can get a sense of the child's inner world and gain some insight into the child's thoughts and feelings.

A willingness to entertain the possibility that "bad" or harmful experiences can happen to children allows a therapist to attend to the indicators of abuse and neglect. The therapist's ability and willingness to ask about abuse and neglect gives children permission to talk. The therapist's ability to explore the experiences related to abuse and neglect, including any pleasurable feelings associated with sexual abuse, allows the child to evaluate and correct any distortions and inaccurate perceptions he/she may have about acceptable or unacceptable behavior. The child also learns to manage his/her fear, anxiety, sense of powerlessness, and anger.

The therapist needs to be able to talk explicitly about sexuality with the child, the family, and with other professionals.¹⁴³ Therapists who work with children who have been sexually abused need to feel comfortable talking about the maltreatment, feelings of shame, injuries, secondary gains, sexuality, and sexual feelings. It is important for the therapist to be able to explain these processes to the child and the parents in language they can relate to and understand. A therapist who is comfortable clarifying adolescent slang terms or a young child's descriptive phrases for his/her body parts or behaviors will help the child feel comfortable when talking about a difficult subject.

Information

Children, as do all clients, have the right to ask questions about their treatment and receive answers that make sense. This allows them to experience some sense of control in the therapeutic process, something they did not experience during the abuse. This means speaking a language that children and parents understand when discussing symptoms and effects of abuse and by refraining from using therapeutic jargon or terminology that is not familiar to most clients. Children need to have their symptoms explained to them in developmentally appropriate language. Often, metaphors or examples are helpful for explaining the repercussions of abuse or neglect. Clients need to have a clear answer to their questions and therapists can fulfill this need by asking the child or parent if the answer was helpful to them.

Helpful Interventions

In addition to information about the purpose of therapy, the therapist needs to tailor interventions to the client's needs and abilities. Interventions must be useful to the child and parent or they will lose their motivation to attend the sessions. Clarifying the purpose and intent of the intervention and making it relevant to the child's current situation are two methods that facilitate the client's interest and involvement in therapy. Asking the child or parent to evaluate the effectiveness of therapy also helps the therapist learn if the interventions are useful.

Individuality

Children and parents have the right to be treated as individuals who have issues and experiences that are unique to their experience. By making assumptions or telling the client how he/she feels, the therapist overlooks the client's need to be treated as a special person. Asking the client to confirm or deny a hypothesis helps the client feel that he/she is part of the discovery process. Mentioning that some victims have felt a certain way about what has happened to them can give a child permission to consider if he/she feels that way too. Telling a child how all victims think, feel, or behave is presumptuous and decreases the child's sense of integrity and individuality.

THERAPIST RESPONSIBILITIES

There are certain responsibilities that the therapist must fulfill that need to be clarified and discussed with children and parents. These responsibilities include client confidentiality and the therapist's reporting requirements, clear discussion regarding eligibility and payment for services, specific appointment times and cancellation policies, and periodic discussion regarding the length of therapy and the need for services.

Confidentiality

Clients need to trust the therapist, feel free to confide information and concerns, and feel comfortable exploring difficult issues and subject matter. Explaining different forms of confidentiality (e.g., doctor/patient, attorney/client, priest/parishioner) to children and parents will facilitate their understanding of the scope and purpose of treatment. In statements about confidentiality, therapists should be certain that their clients are aware that the following must be reported by professionals (as specified by State law) if they are suspected:

- ✍ child abuse,
- ✍ intention to commit suicide,
- ✍ intention to commit homicide, or
- ✍ threat of homicide.

The therapist needs to tailor his/her explanations about reporting responsibilities to the child's ability to understand what needs to be done. For example, a therapist might tell a young child that part of his/her job is to make sure that the child is safe and that no one is hurting the child or touching him/her in ways that are wrong. The therapist needs to clarify with the child the types of touching that are inappropriate and make sure he/she understands the concept of inappropriate or hurtful "touch." There are many books about safety, touch, and prevention that can be useful for teaching this concept. The therapist should explain that if the child says that someone is hurting him/her, the therapist will tell someone, such as the police or caseworker, so that the abuse will stop. The therapist can reiterate that it is not "ok" for someone to hurt or abuse a child, and that it is important for the child to tell someone if he/she needs help with this problem.

It is important that the child know that the therapist will not disclose information without notifying the child of the need to do so. It is also important that the child understands that the confidentiality privilege is held by the parent or adult guardian; the therapist will not keep secrets about the child's safety and well-being. However, parents do ask about therapy and want to know how their child is doing and if their child is making progress.

The therapist can explain to the child and to the parents that he/she will update the parents and keep them aware of the child's progress in therapy by talking about the issues that are being addressed. The therapist can also help the child learn to talk to the parents about certain topics and concerns by having the child present during discussions about the child's progress with the parents.

A child also benefits from knowing that information will not be discussed with his/her friends or acquaintances.

In small towns, or even in large cities, it may be important to discuss with the child what kinds of behavior would be appropriate if the therapist and child meet in a public place. It is especially important to discuss confidentiality when a child in therapy may be involved in activities, such as sports or dance, in which the therapist's family members also participate. In such cases, it is important to respect the child's statements regarding privacy and his/her need for anonymity while maintaining the importance of the therapeutic relationship.

Often, a child will feel more comfortable acknowledging his/her therapist in public after he/she has been in therapy for a period of time, and what initially seemed problematic is no longer an issue. The child may have disclosed his/her situation to enough friends that he/she is no longer self-conscious, or the child feels secure enough to acknowledge the therapist, wave, and move on to a more compelling activity.

Adolescents may appreciate knowing that the therapist will not approach them in public or discuss the therapy outside the therapeutic setting. An adolescent may feel more comfortable if he/she knows that he/she does not need to acknowledge and greet his/her therapist if they should meet in a public place, especially if the therapist is with friends or family members.

Children may also need to know that the therapist is not available for social activities or to fill the role of foster parent or friend. The therapist is an ally, resource, and role model for appropriate adult/child relationships; he/she is a professional who maintains appropriate boundaries and abides by rules and regulations.

Release of Information

Children often feel more comfortable talking about their issues and behaviors when they know that the therapist does not talk about his/her client outside the treatment setting. Only certain professionals, such as caseworkers or other professionals working with the family, should be privy to knowing if the child is in therapy. This information is exchanged after a release of information has been signed by the appropriate person, either the child or the child's legal guardian. Issues regarding access to the client's files need to be discussed, including the possibility of information being subpoenaed in the event of a criminal or juvenile court investigation.

Clarification of Fees and Services

Therapists need to be clear and specific about charges for services, including fees for written reports, court involvement, and extended telephone conversations. It is helpful to have written agreements with clients and referring agencies (e.g., city and county government, CPS, foster care, or adoption) about fees for services, sliding scales, billing procedures, and cancellation policies. A periodic review and evaluation of the fees that are owed for therapy allow the client to plan for payment and make decisions that are responsible and practical. Each State has specific rules and regulations about how old a child must be before he/she can contract for services.

Clients need to know the date and time of their next appointment. The therapist needs to explain the cancellation policy and the impact that cancellations have on the client's access to services. The therapist also needs to give advance notice when he/she will not be able to meet with the child. Except in emergencies, a notice of at least 1 week allows the client to prepare for the therapist's absence. The therapist has a responsibility to inform the client of planned vacations or leaves of absence and allow enough time for the child to explore any feelings that may be related to interruption of therapy. The therapist may want to make arrangements for a colleague to be available if the child needs attention. This consideration enables the child to feel confident that his/her therapeutic needs will be met and that his/her needs are important.

Evaluation of Progress

The therapist has a responsibility to discuss the approximate length of time the child or parent may require therapy. The therapist also needs to allocate time with the child or parent/guardian to evaluate the need for continued service. Premature termination can be damaging to the child or adult; likewise, prolonging therapy beyond the client's need for treatment is also unethical. Periodically discussing the goals and objectives of therapy and evaluating progress helps the client feel that he/she is making progress and is capable of making decisions and accomplishing the tasks of therapy.

THE THERAPEUTIC RELATIONSHIP

A number of factors contribute to a successful therapeutic relationship with a child. The following concepts are especially important in developing the kind of relationship that supports a child's exploration of the issues related to abuse and neglect.

Trust

Trust is a difficult issue for many abused and neglected children. A child who has been physically or sexually abused by a known or trusted person may be cautious in developing relationships. An abused child needs to form a trusting relationship with the therapist; that relationship must be secure enough to allow the child to begin to explore the actual abuse. The establishment of such a relationship requires great patience from the therapist, who may feel pressure from other parties involved with the child (e.g., CPS caseworkers and parents) to "make the child deal with the ... abuse" before the child is ready to do so.¹⁴⁴ A child will test the therapeutic relationship, calling upon the therapist to repeatedly demonstrate that he/she is willing to respond and attend to the child's needs and behaviors.

Safety

Two very important goals in helping children recover from abuse and neglect relate to their future safety:

- ✍ Help the child internalize the right to safety and protection.
- ✍ Find ways to help the child cope with similar events in the future.

Attending to the child's physical safety and emotional safety during therapy helps the child begin to address these issues and fosters the development of the therapeutic relationship.

Physical Safety

Physical safety is often missing from the abused or neglected child's experience. Parents or caretakers may not have paid attention to the child's environment or behavior that was dangerous to the child's safety and well-being. Thus, physical safety in the therapy room and during the session is often necessary and symbolic for the child.

Abused and neglected children often come to believe that they are unworthy of attention or that their safety and protection is not important. Some children develop a facade of invulnerability and take risks that can be dangerous or life threatening. Abused and neglected children may not care about the outcome of their behavior or may try to hurt themselves. Some children may not have learned to recognize that some actions and behaviors are dangerous and life threatening.

Assessing the child's self-destructive behaviors and need for protection is an ongoing process. A young child, or a child with limited experiences or capacity to process information, may seek protection from the therapist as

a primary means for establishing trust and a sense of security. Physically abused children may use provocative behavior to test the therapist to see if the relationship will include physical pain or punishment. Abandoned or neglected children may be surprised to find that the therapist is capable and willing to pay attention to their needs and behaviors. Sexually abused children may behave in a seductive manner or make inappropriate statements or comments to test the therapist's boundaries and reactions to see if he/she will respond to the child in a sexual manner.

The therapist needs to assure the child's physical safety in the following environments:

- ✍ **Home and Social Environment.** A child must be safe in his/her home and social environment in order to benefit from therapy. The therapist needs to ensure the safety of the child in the home at the initial intake and periodically throughout the therapeutic relationship about the safety of the child.
- ✍ **Therapeutic Environment.** The clinician can ensure physical safety in the therapy session by maintaining an accident-free therapy room and by watching the child carefully as he/she uses the therapeutic toys and furniture. The clinician should help the child in and out of chairs; reach for toys and items on top shelves; and manage climbing, aggressive, and destructive behavior. The clinician must intervene in aggressive acting out between peers and help the child resolve conflicts in violence-free ways. Interventions that demonstrate that the therapist is there to protect the child from injury and attend to his/her physical and emotional needs help the child begin to internalize his/her right to safety and protection. The therapist becomes a role model for adult awareness and introduces behavior that attends to the child's safety and well-being.

The therapist can use many methods to help the child understand and internalize the concepts of safety and protection. For example, "What if" games are useful for determining the child's self-protective capacity and emotionally charged concerns regarding safety. In addition, Kreiger notes the following:¹⁴⁵

- ✍ Communicate in word and action that the child is worthy of protection.
- ✍ Discuss past traumas and possible ways to avoid those dangers in the future.
- ✍ Enter into the child's fantasy play and, within that context, introduce a protector.

Emotional Safety

A child separated from his/her family, or whose family has been disrupted by the discovery of abuse or neglect, needs to focus his/her energy on determining what will happen next and on maintaining emotional equilibrium. Some children who have experienced a loss may feel frighteningly sad, alone, and needy. Other children may feel strongly hostile toward themselves and others. Other children may have feelings of despair, worthlessness, and defectiveness.

Schmale and Engle add a fourth state that is much less intense in emotional tone and more energy-conserving.¹⁴⁶

This state is characterized by withdrawal and vague sensations of numbness, emptiness, and hypochondriacal concerns. These various stances may indicate that the child's energy for responding and interacting is depleted. The child needs to feel that his/her world is safe and somewhat predictable before he/she will have the physical or emotional energy to attend to the tasks of therapy. In such cases, the therapist or other professional can use the following to help children feel emotionally safe:

- ✍ Help the child become familiar with his/her new surroundings and circumstances.

- ✍ Remind the child of his/her strengths and accomplishments.
- ✍ Teach and practice problem-solving skills, including:
 - asking questions,
 - seeking help from adults and peers,
 - identifying choices and options within the new situation, and
 - planning for contingencies.
- ✍ Acknowledge the frustration and challenges of a difficult situation.

It is important to identify and support the methods or strategies that the child uses to care for him/her self during and after the abuse. A child can begin to take pride in those attempts and recognize that he/she did the best he/she was capable of doing in a difficult situation. This supports the child's attempts at managing an unmanageable situation and allows the child to hear that his/her attempts were important and worthy of recognition. When a therapist identifies and focuses on a child's weaknesses or inadequacies, the therapist loses a means of connecting with the child based on strength, respect, and esteem. The therapist also risks forcing the child to deny or defend his/her thoughts, feelings, and behaviors. As a result, the child may become entrenched in counterproductive behaviors and may resist intervention.

Pacing the exploration of the abuse over a period of time and placing the abusive experiences in the context of the child's overall life experience is more therapeutic than listing all the details and memories in one or two sessions. Most children will not have access to all the details or memories on demand and it is overwhelming for a child to confront the entire abuse experience at one time. Most children will resist.

A therapist monitors and addresses emotional safety by paying attention to the clues the child gives about his/her ability to manage his/her feelings and behavior during therapy. A child will not benefit from being pushed to his/her emotional or cognitive limits. When a child is pushed beyond his/her cognitive/emotional limits, he/she will have little or no energy left to soothe or comfort him/herself. The child may demonstrate this depletion of ego strengths or defenses by regressing, acting out at home, or refusing to participate in therapy. The following clues may indicate that the child is having difficulties with the subject:

- ✍ behavior changes, including distracting or avoidant behavior;
- ✍ attempts to change the topic of conversation;
- ✍ somatic complaints;
- ✍ complaints of boredom; or
- ✍ change in affect.

The therapeutic experience can be organized so that it does not overwhelm or exhaust the child. Some ways in which the therapeutic session can be structured are as follows:

- ✍ Examine one aspect of the abuse at a time.

- ✍ Create cycles of work and rest or play.
- ✍ Break the discussion into small increments that provide a sense of accomplishment at completing a task.
- ✍ Incorporate esteem-building experiences into the therapy session.
- ✍ Differentiate between past and current experiences.
- ✍ Allow the child time to reflect and think about new information.
- ✍ Allow the child to choose and discuss emotionally manageable subjects.

Identifying and attending to life experiences that were not abusive or neglectful is also an important part of therapy. This helps the child place the harmful experience in context and shows that maltreatment is only one of many factors or experiences that has impacted his/her life. The child then can identify skills and arenas that he/she is competent enough to manage or master.

Focusing on both positive and negative experiences can enhance the child's sense of self. Attending to life experiences that do not include being abused helps the child expand his/her sense of self and identity. This allows the child to integrate the experience into an overall sense of self that is not based solely on victimization. It also initiates the grief process that many children need to experience in order to let go of old images, expectations, behaviors, and feelings.

Resistance

Many behaviors that are initially perceived as resistance are really behaviors that are geared to monitor and manage anxiety generated by recall of the abuse experience. Fidgeting, fooling around, interrupting, asking inappropriate questions, and straying from the topic or task all need to be considered as possible coping behaviors that help a child disengage from his/her painful feelings and thoughts generated by the abuse.

The ego defenses or defensive maneuvers that a child uses to protect him/herself from overwhelming stimuli or memories related to the abuse experience need to be acknowledged and used so the child feels validated, capable, and able to survive in the best way he/she knows how. A child seldom lets go of a defense mechanism, a defensive shield, or protective maneuver simply because he/she is told to do so. Tailoring interventions that facilitate the child's ability to process the experience and manage the anxiety and stress that are generated are important. A child will change his/her behavior when he/she feels capable of managing his/her world without that behavior. Most children will often do this at their own pace.

A child who is not willing to participate in therapy will not benefit from the therapeutic experience. However, there are many ways to help a child feel more comfortable about participating in therapy. These include the following:

- ✍ empathizing with the child's frustration or fears about therapy;
- ✍ clarifying therapy and what will happen, including providing information that therapy does not mean the child is "crazy";
- ✍ setting goals that are useful to the child; and

- ✍ contracting for a certain number of sessions with the option to continue counseling if necessary.

It is important to note, however, that not all resistant behavior means the child is unwilling to participate in therapy. Furthermore, the child may not understand what is expected of him/her within the therapeutic relationship. The child will benefit from clear descriptions of the purpose and benefits of therapy as well as clarification of how to think about and respond to questions, including the options of “not knowing” or “not wanting to say (yet).” It is also helpful for the clinician to explain and delineate appropriate behaviors in therapy, including appropriate therapist/child behavior. The clinician should also explore any fears or concerns that the child might have about therapy.

ORGANIZATION AND STRUCTURE OF SESSIONS

The organization, structure, and process of the therapy can make major contributions to the therapeutic relationship. Developing a format for the session, clarifying the use of time within the session and attending to content and process experiences are important in effective therapy.

Format

Developing a format or routine for the therapeutic session allows the child to accomplish the tasks of remembering, talking about the abuse, and discharging accumulated emotions. The child will begin to depend on the format established by the therapist. The format helps the child organize his/her thoughts, feelings, and behavior and feel comfortable about discharging his/her emotions, exploring their circumstances and history, and learning how the abuse has affected him/her.

It is important to clarify the topics that will be covered, such as “What happened to you, and how you feel about it?” The therapist needs to emphasize repeatedly that he/she is there to help the child. The therapist can tell the child that his/her role as therapist is to help the child with any questions or concerns he/she might have about the abuse. This allows the child to begin to expect help from the therapist and to challenge the therapist when the child does not feel that the therapist is being useful. Clarifying how time will be used within the therapy session is also important.

Use of Time

Most therapy is organized within a specific time frame, usually the therapeutic hour. Within this time frame the therapist needs to accomplish the following:

- ✍ reestablishing rapport and exploring current issues with the child,
- ✍ addressing issues relevant to abuse or neglect,
- ✍ making the therapy relevant to the child’s daily life,
- ✍ exploring the child’s feelings about the therapeutic experience, and
- ✍ providing closure on the therapeutic experience.

The therapist and child need enough time to reestablish rapport, catch up on what has happened during the week, discuss and evaluate the work done in the last session, address current issues relevant to the child’s growth and development, discuss and explore issues relevant to the abuse or neglect, and generate closure so the child can

function effectively after completion of the therapeutic session. The therapeutic session should include time to organize the new information gleaned from the session and discharge some of the emotions that may have been generated during the session. Developing a pattern of interaction that facilitates the beginning, middle, and end of the session is a useful tool for socializing the child into the therapeutic process.

Opening and closing rituals can facilitate the process of disclosure and help the child manage his/her emotions. By turning on the light in the therapy room, pushing the young child's chair in and making sure he/she is safe and comfortable, asking an adolescent how he/she feels, the therapist demonstrates rituals that connote to the child that the session is going to begin.

Closing rituals help the child "put away" the work completed during the counseling session. Closing rituals symbolize that the work of therapy, including the remembering, reexperiencing, and processing has been accomplished. The child can then move on to routine tasks and activities. Putting toys away symbolizes that the therapy session has been concluded.

When a child has used anatomical dolls for demonstration or learning about body parts, it is important to reclothe the dolls and put them in a location that the children notes is safe. Often, a child will want to separate the doll that represented him/herself in the demonstration from the doll that represented the abuser. Allowing the child to determine where the dolls need to be placed in order to be safe can symbolize to the child that he/she determine what needs to be done so the child can be safe and protected.

Asking the child what he/she did in therapy and helping the child identify the issues he/she explored leaves him/her with a sense of accomplishment. Asking an abused or neglected child if he/she has any questions can give the child a sense of control over the final topic to be discussed in the session. It also allows the child to seek information that may not have been addressed during the session. When it becomes a routine, the question-and-answer period reminds children that the session is almost over.

When the session has been concluded, the therapist can say: "I am going to turn off the light and close the door on the work we have done today." Some children will want to turn off the light and shut the door themselves. The therapist may want to remind the child of what to do in order to have a safe and happy week, such as "Tell someone if you need help."

Content

The content of sessions includes the discussed topics, the details of the conversations between child and therapist, and the information the child shared with the therapist about the abusive or neglectful incidents. Exchanging information and helping the child feel comfortable about recalling details of the abuse or sharing feelings about the experience is the cognitive work of therapy. Addressing the facts of the experience helps the child gain insight and perspective about the abuse or neglect.

Process

Process focuses on the child's interaction over time. It attends to the ways in which the child invests and reacts to the relationship with the therapist. The child's behavior and ability to interact with the therapist change over time. During the early phase of therapy, the child may be anxious and have difficulty attending to content-related tasks. The child will need to be encouraged and reinforced for participating in therapy.

During the middle phase of therapy, many children express their appreciation of and dependency on the therapist. The child may experience feelings of abandonment or rejection when the therapist is not available for a session. During this phase, the difficult work of internalizing role models and grieving for losses is completed.

When the child enters the termination phase he/she is investing in outside relationships and developing interests in activities that may interfere with therapy. The children may need to renegotiate the session time when it interferes with a group or school activity. This investment in activities and relationships in the “real world” is an indication the child has benefitted from the therapeutic experience. He/she has learned and is willing to trust that there are people who can and will respond to him/her in a satisfying manner. This coming together and separation is a natural process of growth and development, and both the child and therapist should have positive feelings about the occurrence.

STAGES OF THERAPY

The process of therapy is often divided into four distinct phases—intake, a beginning phase, middle or processing phase, and consolidation or termination phase. However, the work of the various phases is often woven into the session and is carried out throughout the entire therapeutic process.

Intake Phase

In most cases, a child is brought to therapy for two basic reasons:

- ✍ The child is showing symptoms of having been abused or neglected.
- ✍ The parents are concerned about how the child is affected by the abuse or neglect.

The intake assessment determines the child’s need for therapy. This determination is based on the symptoms generated by the abuse and the conditions that were part of the abuse. The intake assessment involves learning as much as possible about the presenting problem as well as the child’s symptoms and their severity.

Symptoms are changes in the child’s usual demeanor and behavior. These changes can be subtle or dramatic. The immediate symptoms that the abuse generates are often manifested behaviorally. They may be similar to symptoms in the DSM-III-R for PTSD, anxiety disorders, depression, or conduct disorders. A child’s attitudes about him/herself or about the people in his/her life may change. These deeper esteem and belief-related symptoms can affect character formation and generate long-term and lasting effects.¹⁴⁷ These symptoms, or changes in behavior or attitudes, are communicating to the world that there is a problem and that the child needs help.

Determining the Child’s Need for Treatment

Not every child needs therapy; therefore, it is important to determine the child’s need for treatment during the intake stage. A range of factors may offset the child’s confusion, anger, and fear following an abusive incident and allow the child to resume a regular lifestyle with little repercussions from the abuse. These include the following:

- ✍ stable and responsive parents/caretakers;
- ✍ the ability to communicate the experience to a caring, responsive listener;
- ✍ parents’/caretakers’ ability to tolerate and respond appropriately to the child’s expression of feelings;
- ✍ stable yet flexible home environment;

- ✍ history of appropriate nurturing and protection; and
- ✍ absence of major problems in the parental/caretaking relationship.

If the parents are concerned about the child's well-being or are having difficulty managing their own feelings about the abuse of their child, it is often useful to offer support and information that will help them cope with the disclosure of abuse. Educating the parents about how to respond appropriately to their child and identifying behaviors that might indicate the child would benefit from therapy at a later date can offset some parental fears.

Taking a History

Before initiating therapy, it is essential to acquire some basic information about the client, the circumstances of the maltreatment, current functioning, and the current living situation. Taking the time to discover what all the significant adults in the child's network think "happened" is a good strategy for learning about the family.

A psychological evaluation can be an invaluable tool for understanding the child's social, emotional, and cognitive realms. A thorough psychological evaluation includes contact with the relevant parties who have information and insight into the child's behavior and emotional state. Specific testing can clarify emotional function and impairment as well as identify cognitive strengths and limitations. This type of information enables the treatment provider to tailor interventions to the child's emotional and cognitive abilities. Although this is most easily accomplished as part of a complete psychological evaluation, often therapists do not have access to the resources for such an evaluation.

When a formal evaluation is not possible, it is strongly recommended that the therapist acquire extensive information during the intake process. The intake process incorporates the acquisition of significant child and family background information and assesses various aspects of this information to determine the potential impact on the delivery of therapeutic services. This may include an assessment of subtle factors that may support therapeutic efforts (e.g., family stability, parental coping skills) or basic factors (e.g., transportation, family finances).

A good tool for gathering a complete family history is developing a genogram/family tree with the family. A clinician can assess specific, intergenerational information in many areas by asking appropriate questions as part of the development of the genogram. These areas include marital histories, the role of extended family, the educational norm for the family, use of drugs/alcohol, history of mental illness or criminal activity, significant losses for the family and the child, and significant relationships in the family system. The process of gathering the information also allows the clinician to identify the family historian and spokesperson.

Developing a Treatment Plan

After completing the assessment or intake phase, the clinician should prepare a plan that outlines the goals and objectives of treatment and lists the methods that will be used to address the symptoms of abuse or neglect. The estimated time for achieving the objectives should be noted. Whenever possible, the child and parents/caretakers should participate in the development of the treatment plan. Participating in the plan's development helps the child and parents feel part of the therapeutic process. Often, children and parents are more willing to participate for the length of time necessary to complete the treatment plan when they have had a part in clarifying the symptoms and learning about the tasks necessary to address those symptoms. The treatment plan should be reviewed periodically and modified when necessary. Again, this process should be undertaken with the help of the child and parents.

The major goal of therapy is to address the symptoms generated by the abuse. The goals and objectives of therapy need to be concrete, practical, and realistic. Expected changes in behavior should be quantified so that progress can be monitored in objective, observable terms. Therapists must make the presenting problem understandable to the child and family. Placing the symptoms in a context removes the negative assumptions attached to behavior that seems out of control and arbitrary. Addressing the conditions that contributed to the abused or neglected child's vulnerability to victimization is another important goal of treatment. An additional goal is to enhance the child's strengths and abilities that will enable him/her to accomplish developmental tasks.

Determining the Prognosis

Therapists determine the treatment prognosis or outcome by the parent's, family's, and child's ability to use therapy.

Parental factors that affect the child's progress in therapy include the following:

- ✍ ability and willingness to respond adequately to the child's needs;
- ✍ willingness to learn new behaviors that support safety and protection of children;

- ✍ ability to address issues related to child abuse and neglect, including personal issues related to their own childhood victimization; and

- ✍ minimal impairment of functioning, especially substance abuse and other addictive behaviors.

Family factors that affect the child's progress in therapy include the following:

- ✍ willingness to accept the abuse as a family problem;
- ✍ a solution-oriented approach to the problem rather than a blame-oriented approach to the victim;
- ✍ commitment and affection among all family members, including the victim; and
- ✍ ability to communicate in a manner that facilitates sharing thoughts, feelings, and problems.

Child factors that affect the progress in therapy include the following:

- ✍ willingness to participate in therapy;
- ✍ ability to acknowledge the experience of abuse or neglect;
- ✍ capacity to use therapy, including genetic make-up, level of functioning, and phase of development;
- ✍ the content and intensity of the event(s); and
- ✍ accumulated life events and history of prior trauma.

Some factors may interfere with the parents' and child's ability to benefit from treatment and may contribute to further victimization. It is important to address the following factors at intake or early in treatment so they do not interfere with the therapeutic process:

- ✍ confusion or lack of understanding about the purpose of therapy;

- ✍ unrealistic expectations regarding change;
- ✍ minimal commitment to therapy;
- ✍ lack of resources, including transportation and child care; and
- ✍ feelings related to court imposed or court-ordered therapy.

At the initial intake, as in all stages of therapy, it is important that the therapist create a strong alliance or connection with the parent or caretaker. Parents need to understand that they are very important to the child and that their support and behavior will often determine how a child utilizes therapy. The parents' cooperation will give the child permission to trust the therapist and disclose and discuss difficult information about him/herself, the family, and the abuse. The therapist must convince the parents that their input is needed and valuable and that therapy is most beneficial when parents share their ideas and concerns as well as support and participate in the experience.

The child also needs to know that his/her needs will be addressed in the treatment plan. It is important the child understand that the goal of therapy is to help him/her understand what has happened and he/she was affected by the experience. The child also needs to understand that the goal of therapy is not to "change" him/her so that the parents are happy.

Gil notes three tasks that must be accomplished by the end of the initial interview:¹⁴⁸

- ✍ First, the caretaker needs to be validated for his/her interest in the child's well-being and willingness to take the risk of making an appointment, keeping it, and sharing his/her feelings and concerns with the therapist.
- ✍ Second, it is important to summarize the content of the interview so that the caretaker and child recognize that they have been understood.
- ✍ Third, it is important to set a context for ongoing therapy. The therapist needs to outline a normal course of treatment for the child.¹⁴⁹

Beginning Phase

The beginning phase of therapy focuses on establishing trust and rapport, determining the child's current level of functioning and coping style, and making therapy useful to the child. As was discussed in the first section of this chapter, establishing rapport and trust are the first steps in developing a therapeutic alliance.

The therapist needs to establish a relationship with the child based on the child's interests and needs. In this way, the therapy is child-centered and determined by the child's interest, capacity, and willingness to participate. However, therapy cannot be child-driven. The child must be guided into understanding and awareness; he/she benefits from a clear plan and appropriate interventions. Being able to show how therapy can be useful in all realms of life facilitates the child's willingness to utilize the various therapeutic tasks.

As stated previously, it is important to be able to communicate with children of all ages. Understanding the number of words and ideas that a child can tolerate and respond to assists the therapist to plan his/her educational and therapeutic interventions. Repeating key phrases and connecting thoughts and feelings with symbolic representation helps the child incorporate the therapeutic experience on all levels. Metaphors based on a child's

interests and stage of development help the child relate to his/her experience with perspective and objectivity.¹⁵⁰
¹⁵¹ It is also helpful if the therapist is familiar with the music, movies, and activities that interest various age groups. Information about important subjects such as television shows, action figures, sports, cars, and clothing styles helps to establish rapport and offers a medium by which to communicate values, behavior, and the future.

Middle Phase

In the middle or processing phase of therapy, there are two major tasks that the therapist helps the child accomplish—identifying how the child has been affected by the abuse and identifying ways to cope productively with his/her symptoms. In carrying out these tasks it is important for the therapist to prepare the child for “reliving” or “reexperiencing” the abuse and the feelings which may arise as a result of the abuse or neglect.

Those struggling to recover from the trauma of abuse attempt to resolve four fundamental questions:

- ✍ What happened?
- ✍ Why did it happen?
- ✍ Why did I behave as I did, then and since then?
- ✍ What will I do if something like this happens again?

Even a child who exhibits no current symptoms of the abusive experience benefits from help in answering these questions.

Facilitating resolution of the abuse includes clarifying insights, correcting distortions, placing responsibility for the abuse more objectively, acknowledging attempts to manage the abuse experience(s), and supporting positive and productive behavior.

In order to accomplish this objective, the therapist needs to help the child access the memories of abuse or neglect; identify the sensations, thoughts, feelings, and beliefs that were generated by the abuse or neglect; and develop productive responses and behavior that enhances a positive self-image.

Accessing the Abuse Memories

Discussing the details of the abuse helps the child think about his/her experience. As the child articulates his/her unexpressed feelings and hidden thoughts, the child shares his/her personal experience of the abuse. Discussing details of the abuse can help children dispel some of the myths that were created about disclosure such as, “No one will believe you,” or “People will laugh and think it’s your fault.” Talking about the abuse diminishes the intensity of the memories and allows the therapist to join with the child in understanding his/her experience.

Sensations

Physical and/or sexual abuse assaults the body with stimuli and creates sensations that can be fearful, painful, or overwhelming. Abuse arouses all the senses—sight, sound, touch, smell, and taste. These sensory memories are stored and may become stimuli for flashbacks, nightmares, phobic behavior, or panic attacks. Various factors such as lighting, location, temperature, presence of other people during the abuse, as well as physical sensations need to be noted. Pleasurable sensations (sexual abuse) can be overwhelming for the child and can become frightening, especially when the child understands that the occurring behavior is wrong. These stimuli need to

identified, assessed, and explained to the child so that he/she understands that his/her reactions are often related to actual experience.

Thoughts and Feelings

The ability to think about the harmful experience and recognize feelings and behavior generated by those thoughts allows children to make distinctions, decisions, and choices. Thinking about their experience means gathering information that explains why the abuse occurred. It means comparing information and assessing the accuracy of that information. Thinking about the experience, discriminating between feeling safe or unsafe and recognizing abusive behavior enables the child to identify problematic situations and make choices that can help him/her remain safe from harm. As the child recognizes that he/she has the ability to think and choose, he/she begins to feel better about him/herself and feel more powerful and in control.

Discharging feelings generated by the abuse is an important component of the treatment process. Identifying, acknowledging, and sharing feelings about the experience can help the child recognize the relationship between feelings and self-esteem, self-worth, and behavior. A child benefits from therapeutic experiences that allow him/her to act out his/her feelings, exaggerating his/her responses until those responses are intense enough that the child feels they represent how he/she felt at the time of the abuse. Techniques, such as hitting a pillow or punching bag, using batakas or encounter bats, or writing down all their feelings and throwing them in the wastebasket can help the child discharge some of his/her pent up emotions and begin to let go of those emotions.

It is also important to teach the child socially acceptable means of expressing him/herself. These methods include direct communication, assertiveness, and negotiation. A child needs to know that hitting something, such as a pillow, may be an acceptable release for his/her feelings. However, hitting someone, such as a child or parent, is not an acceptable outlet. Haaken and Schlaps note that the patient is not simply a vessel that has been filled up with bad experiences, and consequently, can be emptied out and refilled with remedial messages.¹⁵² These researchers emphasize that the manner in which the therapist listens and reacts to the child in the process is more central to sustained therapeutic change than only abreacting traumatic experiences and reassurances.

Often, a child has heard that he/she was supposed to say “no” or “run away or “tell someone.” The child may feel guilty that he/she did not do those things. The child may also feel inadequate. A child needs to realize that feeling “scared” or “angry” or “confused” may have inhibited his/her ability to respond. If the perpetrator used threats or violence, the decisions a child made at the time of the abuse may have been critical to his/her physical or emotional survival. A child may benefit from exploring the choices he/she made during the abuse incidents and may need to determine that he/she made the best choices possible given the nature of the situation. A child may also need to acknowledge that the behavior necessary during the abusive incidents or before disclosure may no longer be useful to him/her.¹⁵³

Beliefs

When a child is overwhelmed by sensory stimuli, he/she attempts to make sense of or find order and meaning for the experience. For a young child, or a child whose understanding is limited by his/her cognitive and emotional experience, these explanations are often primitive or inaccurate. However, these explanations or attributions are still important to identify.

Attribution theory suggests that, when negative events occur, blaming oneself for the event (internalizing responsibility) results in depressed feelings whereas blaming others (externalizing responsibility) results in anger.¹⁵⁴ When a child believes that the cause of the abuse was something to do with him/her, rather than something to do with the perpetrator, the child blames him/herself for the abuse. A child who internalizes the cause of the abuse and believes the abuse was his/her fault has a difficult time feeling good about him/herself. The

child experiences the abuse as a loss of self-esteem. Simply telling the child “It wasn’t your fault” is not useful and may distance the youngster (“You don’t really know”). The child must come to that conclusion on his/her own.

A child who externalizes the cause of the abuse, who thinks that the abuse occurred because of something about the perpetrator or the people who did not protect the child, does not have the same sense that something is “wrong” with him/her. However, this child may feel angry and experience a sense of emptiness and wonder about his/her worth and value. A child who feels that the abuse has changed his/her value may also think the abuse has changed his/her prospects and opportunities for the future. This child may feel hopeless and discouraged. A child who thinks that the abuse has marred him/her or made him/her different from other children feels differently about him/herself and his/her body. The child often projects these thoughts and feelings onto other people.

By clarifying and challenging the accuracy of the child’s beliefs about the cause of the abuse and exploring the significance, that is, the meaning that the abuse held for the child or the beliefs that the child has about how the abuse has affected or changed him/her, the therapist helps the child move beyond the role of victim. An abused and neglected child needs to examine his/her beliefs in light of a new perspective—he/she was not responsible for the abuse.

Beliefs have a major impact on a child’s behavior. A change in beliefs about the self can generate changes in behavior, which in cyclical fashion, reinforce new more positive, beliefs about oneself and others. These more positive and productive beliefs or expectations about the self, other, and the world are a self-confirming prophecy.

What one expects and believes to be true is often what one recognizes and also determines how one responds. As a child begins to evaluate his/her beliefs about him/herself and begins to think of his/her reactions to the abuse or neglect in more sympathetic and favorable terms, the child often feels more hopeful and is more willing to try to make changes in his/her behavior. This, in turn, confirms a more positive sense of self and elicits more positive responses from other people.

TERMINATION PHASE

The consolidation or termination stage of therapy addresses integration or utilization of the abused child’s new thoughts, feelings, and perceptions about him/herself as well as the new skills and behaviors that he/she has developed over time. At this point, the child has experienced most of the acute pain and grief generated by the abuse. The child is beginning to experiment with new ideas, feelings, and behaviors. In this final phase of therapy, it is important to identify the child’s concerns and encourage him/her to take risks. In many ways, the outcome is less important than the attempt.

Gil notes that the therapist should encourage his/her clients to take controlled risks in the following areas:¹⁵⁵

- ☞ **Ask questions.** Ask for clarification, state one’s opinion, and make choices and decisions.
- ☞ **Exercise options.** A child can be encouraged to think about what he/she wants and make decisions about how he/she wants to accomplish that goal. A child can be encouraged to think about how he/she wants to behave and evaluate the outcome of his/her behavior and, if necessary, make changes.
- ☞ **Seek help.** Initially, a child learns to ask for help in therapy. During the consolidation/termination phase, the child needs to practice that skill in other areas of his/her life. A child needs to identify those adults and peers who can be helpful and responsive to his/her needs.

- ✍ **Develop problem-solving skills.** Most children will continue to have problems. They need to know that this is perfectly normal; what matters is how they resolve their problems. A child needs to know how to define the problem, generate options, attempt solutions, and continue until the problem is solved. A child often benefits from acknowledging that he/she is “human” and that people make mistakes. This is part of learning, trying, and growing. A child also enjoys hearing that his/her therapist also sometimes makes mistakes.
- ✍ **Seek rewarding exchanges.** The child must be able to seek out rewarding exchanges and avoid situations that he/she knows are dangerous or repetitive of abusive interactions. The child needs to feel worthy of positive interactions, believe that he/she is desirable, and that he/she deserves rewarding interactions with adults and peers.
- ✍ **Seek affiliation.** The child should be strongly encouraged to seek affiliation with others. It is important to encourage the child to participate in social and community activities, develop hobbies and interests that help him/her connect with other children, and join teams and clubs that are of interest to them. The child needs to practice developing relationships with viable adults who will carry on the nurturing, interest, and attention that has been provided in therapy. In this way, the child learns to distinguish between helpful and hurtful behaviors, and he/she develops a support system and role models for relationships.
- ✍ **Transfer skills and terminate therapy.** In this final phase, the child transfers the knowledge and skills he/she has acquired in therapy to other areas of his/her life. For example, a child uses the therapeutic relationship as a model to evaluate his/her new teacher’s interest in his/her academic accomplishments. In a second example, an teenaged girl decides that she is not ready for a sexual relationship and is able to tell her boyfriend that she is worth “waiting for.”

Often, the consolidation and termination phase is a time when a child replays his/her ambivalence about attachment, dependency, and autonomy. The child may vacillate between wanting therapy to “get over with” and feeling fearful that he/she will not be able to manage without his/her therapist. The child benefits from hearing that change is often difficult, and saying goodbye to a therapist can feel somewhat like saying goodbye to a parent. The child also benefits from hearing that terminating a therapeutic relationship is a kind of loss that happens when he/she is ready to move on to another phase in his/her life.

Sometimes, a child terminates his/her therapeutic relationship before he/she has integrated new thoughts, feelings, and skills that will increase his/her esteem, safety, and affiliation. In these cases, it is helpful to have an “open door” policy. The child is encouraged to contact the therapist if he/she needs help, wants to schedule a followup appointment, or continue therapy.

LONG-TERM ISSUES

The therapist also needs to be aware of possible long-range issues for maltreated children, so he/she can help him/her recognize when additional therapy may be indicated. These long-term issues include developmental milestones, such as puberty, when sexuality and relationship issues begin to be dominant themes for children; marriage with issues of trust, affiliation, and intimacy; and pregnancy and childbirth, which often trigger concerns about protection and safety for the young child, issues of loss and grief, and questions about parenting.

The following factors can have an impact on the length of time necessary for resolution of the experience of child abuse and neglect:

- ✍ the responses of relatives, friends, professionals, and the community;
- ✍ physical damage and/or permanent injury;
- ✍ loss of a parent from prosecution or abandonment;
- ✍ separation from the family and placement outside the home;
- ✍ parents' inability to accept the child's experience of abuse;
- ✍ parents' unresolved issues from childhood; and
- ✍ investigation and participation in the criminal justice system.

TREATMENT MODALITIES

The following modalities are effective in helping children and their parents learn about the effects of abuse and neglect. A thorough assessment enables the clinician to determine which method will best meet the child's needs.

Sometimes children participate in more than one modality, either in incremental steps or concurrently. For example, some children benefit from concurrent individual and group therapy. They have the opportunity to work on interpersonal skills in individual therapy and reap the rewards of appropriate interaction during group. Psychoeducational groups that present information about the causes and effects of abuse and neglect and offer the opportunity to explore one's experience can be an effective means of educating parents and introducing topics for them to explore in individual or group therapy.

Primary Prevention Programs

The purpose of primary prevention programs for children is to help the child become knowledgeable about his/her rights to safety and protection. Because children are known to be more seriously affected by prolonged abuse, knowing what abuse is and encouraging disclosure early in the abuse experience is a prevention goal well worth the effort.¹⁵⁶ In many communities, prevention programs are initiated in preschool and day care settings and in elementary school. Prevention programs give the child permission to talk about abuse and neglect and help the child understand what to do if abuse is occurring in his/her life.

There is reason to believe that, in many situations, a child is not able to behave in the way that prevention programs recommend, (e.g., "Say no, run, and tell").¹⁵⁷ However, offenders report that a (child's) threat to tell someone would have the greatest impact on deterring abuse. This message to children may be among the most important that safety education programs can deliver.¹⁵⁸

Play Therapy

Play therapy is an effective modality that helps the child express feelings, act out behaviors, and gain mastery and control over memories and feelings generated by the abusive or neglectful experience. A child uses play to manage his/her fears and anxieties about the abuse, express his/her feelings about what happened to him/her, and demonstrate their knowledge and understanding about relationships. Play therapy allows the child to represent symbolically those events that generate fear and anxiety and helps the child move toward resolution and integration of the frightening experience.

Play therapy is especially effective with children who do not have the verbal or cognitive skills necessary to participate in a more direct approach to discussing their feelings. A child who is developmentally or emotionally

unable to express him/herself verbally can benefit from an experience that allows him/her to demonstrate his/her feelings, fears, and attempts at mastery.

Themes that are repeated during play therapy should be studied. Interventions need to be developed to help the child gain a sense of mastery and control over an overwhelming experience. It is incumbent upon the therapist to interpret this play material in a manner that adds insight and meaning to the child's experience and facilitates resolution or closure of the traumatic event.

Individual Therapy

Usually, individual therapy is the child's first introduction to treatment. It is an opportunity for the child to interact with a supportive and knowledgeable adult and develop a relationship that models appropriate adult/child relationships. Individual therapy also allows the therapist time to assess and evaluate the child's interpersonal skills and help the child learn age-appropriate and engaging behaviors to interact with peers.

The goal of individual therapy is understanding, integration, and resolution of those experiences that affect development, interaction, and safety. Individual therapy is most beneficial in helping children address developmental issues of trust, mastery and control, and identity. Individual therapy generally is helpful in supporting disclosure of abuse and neglect, helping the child identify issues related to their experience, and in resolving intrapersonal issues.

A child who will testify during a criminal proceeding can benefit from individual therapy. It can help the child address his/her fear and anxiety related to confronting the perpetrator and testifying in front of strangers. Most children are also less likely to be affected by or incorporate other victims' circumstances than are children who have participated in group therapy before having to testify.

Group Therapy

Group therapy is especially helpful for decreasing isolation, improving social skills, and monitoring and intervening in problematic interactional patterns of behavior. Group therapy also allows the child to identify and learn from peers and group leaders and helps the child learn new and possibly more effective ways of interacting and communicating about his/her circumstances. Group therapy can facilitate participation with a supportive and understanding peer group and allow the child to practice many of the skills that will improve his/her ability to affiliate and evaluate relationships. Additional benefits provided by group therapy include normalization of the experience by hearing similarities in victims' feelings and responses to abuse or neglect, corrective capitulation of the primary family group, development of socializing techniques, acquisition of the sense of belonging, and catharsis.¹⁵⁹

Group therapy is not warranted for a child who is unable to manage his/her impulsive behavior. This child would be disruptive in group or unable to gain acceptance. A child with limited social skills often needs individual therapy to prepare him/her for the social experience of group therapy.

Family Therapy

Family therapy is most helpful when the family is willing and able to view the abuse or neglect as an issue that needs to be addressed by all the members in the family. Family therapy is an opportunity to explore roles and relationships, help family members recognize the impact that their behavior has on each other, and increase family cohesion and belonging. Family therapy can facilitate problem solving and improve communication between

members. Family therapy seems most helpful after the individual family members have addressed their intrapersonal and developmental issues in individual or group therapy.

Family therapy is often an effective tool to help family members address feelings related to reunification (when the child or offending parent has been removed from the family) and develop new behaviors that help each family member feel capable of contributing and benefiting from living together.

Family therapy is not warranted when adults, especially if they are perpetrators of abuse, are unwilling to take responsibility for their behavior. Issues of blame, anger, and violence can be addressed in a family therapy format, but each individual participant must feel safe and capable of eliciting protection, if necessary.

SUMMARY

Therapy is one of many important strategies to help abused and neglected children move beyond the role of victim and continue their progress toward positive and productive adulthood. Therapy with abused and neglected children is often demanding and challenging. However, it offers the immediate reward to the therapist of knowing that he/she is making every effort to help the child and the family who are struggling to overcome the effects of abuse and neglect. For this reason, therapy is a valuable service and a major contributor to the well-being of maltreated children and their families.

TREATMENT ISSUES FOR ABUSED AND NEGLECTED CHILDREN AND SPECIALIZED INTERVENTIONS

There are a number of concerns or issues common to children who have been abused and/or neglected. This section presents some of the most common treatment issues for maltreated children and identifies some related interventions.

PHYSICAL HEALTH CONCERNS

Children often have a number of health or health related concerns that are generated by abuse or neglect. A child who has been physically abused may complain of difficulties opening and closing his/her mouth, noting that he/she was slapped or hit on the side of the head. The child may also complain of earaches or stomachaches, fearing that these areas of the body were damaged when the child was beaten. The child may have lost teeth or hair. He/she may have broken bones or internal injuries that require a hospital stay. A child who has been sexually abused is often concerned that any invasive sexual contact, especially vaginal or anal penetration, may have caused internal damage. The child may also fear having contracted an “invisible” sexually transmitted disease.

The issues of body integrity, sexual or physical adequacy, injury or scarring, and concerns about any changes in the body that might have resulted from abuse and neglect need to be explored with the child. Symptomatic behavior such as encopresis, enuresis, or psychosomatic aches and pains are also important to identify and explore during therapy.

Sexually Transmitted Diseases and Fear of Acquired Immunodeficiency Syndrome (AIDS)

Sexually transmitted diseases are not uncommon occurrences in child sexual abuse. Generally, diseases are determined at the time of the medical exam and treated with appropriate medication. Currently, few cases have been documented of human immunodeficiency virus (HIV) infection through sexual abuse. However, the increasing incidence of both HIV infection and sexual abuse suggests the need to follow guidelines for HIV-antibody testing of pediatric victims of sexual abuse.¹⁶⁰ A child who is known not to have experienced rectal, vaginal, or oral exposure to semen or HIV-positive body fluids can be assumed to be safe.¹⁶¹

Interventions related to this health concern include the following:

- ✍ testing the child for HIV antibodies if the child remains anxious or concerned,
- ✍ addressing the child’s fear and anxiety regarding test results, and
- ✍ using information and services for the child if the tests results are positive.

Sexual and Physical Adequacy

Some children worry that their bodies have been damaged by the sexual or physical abuse and that they are somehow inadequate compared to nonabused children. Issues of strength, body and muscle development, and size are especially important to children who have been physically abused.

A sexually abused boy may also compare his genitalia to the adult perpetrator's and worry that he is somehow inadequate because of the difference in size. A boy who has been molested by a female also worries that he is sexually inadequate or unable to satisfy a partner both emotionally and sexually. Many boys who have been victimized by males often worry about their sexual identity and fear that they are homosexual.

A sexually abused girl often worries about "virginity" and that partners in future relationships will be able to tell that she has been sexually assaulted. Some girls fear they will not be able to have children. For adolescent girls, fears about pregnancy from sexual abuse can motivate them to begin sexual relationships with boys their own age to "cover" for the possibility.

Sexually abused boys and girls are often confused about their sexuality and their desirability to members of the opposite sex. Often, victims report initiating sexual relationships to "prove" that they are adequate and capable of having sex. These relationships may be described as voluntary but are often initiated under duress and continue the process of victimization.

To intervene with these health concerns, the therapist can:

- ✍ address concerns about the body by having the child undergo a thorough medical exam;
- ✍ clarify anatomy, purpose, and function of the genitalia and sex organs;
- ✍ explain theories of sexuality and sexual orientation to the children his/her parents;
- ✍ offer support and encouragement to change relationships that are not reciprocal or satisfying;
- ✍ clarify age-appropriate interactions and intervene to protect the child if he/she is being exploited or abused;
- ✍ offer support and encouragement to support the child decision to refrain from engaging in sexual activity until he/she is physically and emotionally ready for the experience; and
- ✍ provide information on safe sex, sexual health care, and birth control to sexually active teenagers.

Pregnancy

Although pregnancy is a very rare occurrence among sexually abused children, the fear of pregnancy, the desire for an abortion, or the reality of carrying a fetus to term and undergoing delivery of the baby all provide a concrete focus for victims' fear of the body being affected or damaged by the experience.¹⁶²

In helping a child deal with the issues regarding pregnancy, the therapist should:

- ✍ provide support and reassurance to help the child integrate the experience of sexual abuse and pregnancy;

- ✍ address any changes in the body's functioning or appearance;
- ✍ address issues of guilt, blame, and responsibility; and
- ✍ address decisions made regarding care of the baby.

Scarring and Permanent Damage

Some children have scars or disfigurement from the abuse or neglect. Damage may serve as a continual stimulus, reminding the child of the maltreatment. These reminders need to be acknowledged and discussed in therapy.

To address these issues, the therapist can:

- ✍ have the child receive a thorough medical exam;
- ✍ examine experiences and feelings related to any time spent in the hospital;
- ✍ help the child who is disfigured by the abuse express his/her anger and sense of loss of a healthy and normal body;
- ✍ explore the child's embarrassment about injuries, possible envy of children who are not disfigured, and fear of rejection because of appearance;
- ✍ use role play and anticipatory planning to practice replies to questions people ask about injuries or scars;
- ✍ help the child develop responses to questions about their injuries that do not elicit fear, rejection, or pity; and
- ✍ help the child develop an identity that is based on behavior and accomplishments, rather than on body image.

Encopresis and Enuresis

Encopresis and enuresis may be behavioral indicators of abuse. Some victims have never managed to control elimination or their bladders, but other children, who were toilet-trained, become enuretic or encopretic with the onset of abuse. The former situations often are ones of chronic family dysfunction and chronic sexual abuse. In the latter, the incontinence is a regression to an earlier developmental stage.¹⁶³

The encopretic or enuretic behavior may be related to regression, anxiety, and misperceptions about the abuse and how the body functions. This behavior may also be an attempt to make the victim unappealing to protect against future assault.

When addressing these health related issues, the therapist can:

- ✍ Determine if there are any organic problems by having the child undergo a thorough medical exam with a pediatrician. For example, if there was anal tearing from sexual abuse, the child may initiate a cycle of constipation out of fear of having a painful bowel movement.
- ✍ Explain to parents the possible etiology of the behavior. Help the parents/caretakers understand that this behavior is related to the child's difficulties recovering from abuse.

- ✍ Identify and explore any unresolved safety and protection issues. A child who has mastered control of urination and bowel movements and then regresses and loses this mastery, often benefits from some extra attention, nurturing, and discussion about precautions the parents/caretakers have taken to protect and care for the child.
- ✍ Help the parents reestablish a toilet-training program, which is responsive to the age and developmental abilities of the child. Parents/caretakers may need to patiently implement a toilet-training program that was successful at a younger age and remind the child to use the toilet. Gradually, most children resume age-appropriate behavior.
- ✍ Explain to parents and caregivers that shame and punitive measures usually create more problems. Changing encopretic or enuretic behavior requires a strong parental alliance with the child and cooperation with medical and therapeutic professionals. Dysfunctional families may have a difficult time addressing a consistent, supportive program of toilet training with their child.

Psychosomatic Complaints

In the absence of any medical evidence, persistent fears and concerns that the child or the child's body is somehow "damaged" or less desirable than before the abuse require interventions suitable to psychosomatic complaints or stigmatization. Psychosomatic complaints can include headaches, stomachaches, feelings of tiredness or exhaustion, and vague aches and pains.

A child who has difficulty articulating his/her anger, fear, relief, loss, or sadness may develop aches and pains that express his/her discomfort. Psychosomatic complaints can often be identified as the child recounts the details of the assault(s). The child will state that he/she doesn't "feel good" or that he/she has a headache or stomachache. The child may state that he/she feels pain in his/her genitals or squirm in the chair or reposition him/herself to protect a vulnerable part of his/her body.

To address psychosomatic complaints, the therapist can:

- ✍ arrange for the child to have a thorough medical exam;
- ✍ help the child recognize the connection between his/her experience of abuse and his/her body sensations;
- ✍ facilitate the expression of emotions about abusive or neglectful experiences, including loss and depression; and
- ✍ support the child's need for nurturance and attention.

Sometimes, psychosomatic complaints are symbolic requests for nurturing and attention. When a child states that he/she needs to see the school nurse because he/she has a stomachache (after thinking about how much he/she misses his/her mother), the therapist can make the connection between what the child was thinking about and how he/she felt by asking the child what he/she was hoping for from the nurse. The therapist can validate the importance of having someone pay attention to the child's pain and the special need that the child has to be nurtured. Hopefully, the child will be able to recognize that his/her needs for attention and nurturing are legitimate and learn to negotiate to have those needs met without having to become physically ill or being vulnerable to abuse or exploitation.

In addition, the therapist can:

- ✍ Help the child learn to interact and socialize in a manner that facilitates receiving appropriate attention and nurturing. When a child's dependency needs and needs for acceptance and appreciation are met, the child may not need these symptoms. It is also helpful to ask the child to try to identify the area of the body that is the source of the pain or discomfort. Sometimes, a child will have misconceptions about the abuse, perhaps thinking that his/her stomach was injured from penetration. The child may also worry about disease or damage.
- ✍ Explain to the child how the body operates and what kinds of stress the body can accommodate. Some of the child's fears may be alleviated when he/she understands how the body functions.

DEVELOPMENTAL ISSUES

As stated previously, child abuse and neglect does not appear to affect each victim in a predictable or consistent fashion.¹⁶⁴ From the perspective of the child's psychological development, child abuse is more than an assault. The physical consequences are typically overshadowed by the associated disruption in the child's critical areas of attachment and development.^{165 166}

Attachment

Some argue that it is the disruption in attachment that is the main source of symptom formation and future problems. Many of the fundamental aspects of a person's emotional well-being, including trust, esteem, worth, efficacy, identity, relationships, and intimacy rest on a foundation of attachment to a responsive caretaker.

To deal with attachment issues, the therapist can:

- ✍ Ensure that the child experiences a consistent figure to whom he/she can relate. An ongoing relationship that is built over time is most useful in developing the trust that facilitates attachment. A child who establishes a connection and relationship with a responsive adult may be able to recover some of his/her ability to accomplish developmental tasks. This responsive adult can be the therapist, caretaker, teacher, or other appropriate adult available to the child on a regular basis.
- ✍ Model protective parenting and soothing responses to distressful experiences. The child can learn to nurture and respond to his/her feelings by practicing on dolls in the therapy room. As an example, the therapist can "play" with the doll and nurture the doll after the doll "experiences pain" from a doctor's shot. At first, the child may be the doctor and be impervious to the doll's pain. However, with the therapist modeling protective parenting and enacting soothing responses to the doll's tears and cries, the child learns how adults respond when a child is hurt.
- ✍ Reinforce the child's right to appropriate nurturing, attention, and protection. The therapist can ask, "Who took care of you when you were crying or hurt?" Often, the child will withdraw, become angry, or say he/she never needed any help. Then, the therapist can respond that all children need help sometimes and say, "I'm sorry no one was there to help you when you were crying or hurt. It is really hard to take care of yourself when you are small."
- ✍ Help the child explore the therapeutic relationship as a model for quality interaction.

- ✍ Educate the child about social behavior, including reciprocal relationships and prosocial responses to others. This kind of education facilitates a child's acceptance by peers and adults in the community and gradually decreases the child's dependence on the therapist as an attachment figure.

Mastery and Control

Abused and neglected children attempt to understand and manage fear, anxiety, and overwhelming feelings generated from the abuse. A children can feel shame and rage over his/her vulnerability. The inability to prevent abuse and the overwhelming feelings that are part of an abusive experience are often identified by the child as weakness and loss of control.

The therapist has two simultaneous tasks related to mastery and control issues ? clarifying the limitations regarding the child's ability to care for and protect him/herself and identifying the strengths and acknowledging the child's attempts to care for and protect him/herself.

The therapist can:

- ✍ Help the child acknowledge and accept his/her limitations by offering information about developmentally realistic behavior.
- ✍ Identify and acknowledge the child's attempts to protect or take care of him/herself during and after the abuse. This may include describing the child's symptoms and behavior as his/her attempt to call attention to the abuse or the child's attempt to manage his/her feelings about the abuse.
- ✍ Identify and support the child's abilities to accomplish developmentally appropriate tasks. Sometimes, a child will fantasize that he/she used extraordinary measures such as kicking, hitting, or knocking out the perpetrator to ward off the abuse or retaliate. The child may fantasize or repeatedly act out elements of the abuse in an attempt to gain some understanding and control over the experience. Talking about what a child his/her age is capable of doing, compared to what he/she wanted to do during the abusive experience, is one way of helping the child be realistic about his/her abilities. Acknowledging and describing his/her fantasies as a wish for power and a need for help can enable a child to accept his/her limitations and express his/her feelings about his/her powerlessness.
- ✍ Use interventions that help the child learn and master new skills. Support the child's willingness and attempts to learn new skills. Children need to know that everyone must learn how to do certain tasks. A child often benefits from hearing that the need to practice is a part of being human and that people are not born perfect. The therapist can connect making mistakes with being human and help the child learn to laugh and learn from his/her behavior.
- ✍ Use interventions that allow the child to practice decision making and experience a sense of control. The choices need to be constructed so that the child is not left with repercussions of shame or doubt about his/her abilities to handle situations.
- ✍ Help the child recognize dangerous situations and teach the child whom to ask for help. Helping a child connect with and use strong, appropriate, and protective adults can diminish his/her sense of vulnerability and powerlessness.

Impulse Control

A child with overwhelming fear and anxiety, as well as feelings of vulnerability and powerlessness, has difficulty managing his/her thoughts, feelings, and behavior. Thoughts may include suicidal ideation, destructive wishes, and fantasies with themes of retaliation and revenge. Feelings can include envy, hatred, fear, and anger. Often, a child who has been abused or neglected cannot manage his/her behavior and has difficulty delaying gratification of wishes. Sometimes, the child's behavioral reactions to situations seem to be out of his/her control. The child's behavior and communication may appear impulsive and unrelated to what is happening at the time.

Impulsive behavior includes exhibiting temper tantrums, being argumentative, and challenging authority or rules. Some children may verbally or physically attack their parent or caretaker, siblings, or peers. A child can feel angry with other children who have not been abused, whether family members or strangers. The abused or neglected child may damage property or hurt pets or younger children.

The therapist can:

- ✍ Help the child express the anger and rage associated with victimization. A child needs to learn how to express strong emotions. Discharging his/her feelings can reduce some of the intensity and overwhelming effects on behavior. Pounding on pillows, using action figures to fight out anger, tearing up paper, or smashing cans to demonstrate his/her feelings can sometimes free the rage and help the child identify his/her fears.
- ✍ Help the child develop vocabulary and language skills so that he/she can express his/her feelings. When a child can use words to express his/her feelings, he/she will not need to act out and dramatize his/her anger to the same degree. Once the child is more comfortable talking about his/her feelings, he/she can begin to think about how to express those feelings appropriately.
- ✍ Help the child identify the thoughts and feelings that precipitated his/her actions. Making the connection between the experience of abuse and subsequent behaviors can help the child begin to monitor his/her impulses.
- ✍ Address the issues of loss and powerlessness and, particularly with adolescents, probe for suicidal thoughts and plans.
- ✍ Support and educate caregivers to respond appropriately to acting-out behavior. The concept of regression can help the caretaker understand change in the child's behavior. The child will often revert to an earlier stage of behavior when he/she is feeling overwhelmed and unable to cope. This regression allows the child to depend on his/her caregiver and relearn that adults can be there to help him/her with problems or difficulties. Modifying behavior, teaching natural and logical consequences, and structuring the child's interactions and environment so he/she can better manage his/her behavior are important.^{167 168}

Identity

A child develops a sense of who he/she is and how to behave from the experiences that occur in his/her life. These experiences form a sense of self that affects how the child feels about him/herself and how he/she behaves toward others. The necessary components in establishing a positive identity include love, attention, nurturing, affection, intimacy, autonomy, power, and control. The experience of abuse or neglect impacts each of these areas. An abusive experience affects the child's identity, how the child behaves in order to have his/her needs met, and how the child responds and interacts with other people.

INTERPERSONAL ISSUES

A range of interpersonal issues must be dealt with in therapy. In this section the issues of identification with the aggressor, victimizing behaviors, intimacy, and betrayal are discussed.

Identification With the Aggressor

Theorists note that one way of dealing with and combating the experience of being a helpless victim is to become the powerful victimizer.^{169 170 171 172} A child often imitates another person who the child feels is strong and powerful; for many abused children this “someone” is the abuser. Unfortunately, the abusive adult did not teach the child appropriate problem-solving skills or methods for negotiating to fulfill needs and desires. In cases of sexual abuse, the child has learned inappropriate ways to satisfy the need for intimacy, control, and power. A child learns that intrusive and controlling behaviors are the norm and uses these behaviors for management of stress and anxiety, problem solving, and social and intimate interactions. The therapist must address loss, responsibility for the abuse, affiliation, and power and control in therapy sessions with the child.

The therapist can:

- ✍ Help the child identify the positive and negative behaviors that the child experienced with the perpetrator. The positive experience may generate a feeling of loss in the child. The child may need to mourn for what is missing in his/her life once the abuse has been disclosed. The therapist can express this loss for the child, and thus, give the child permission to acknowledge the experience. It is important for the therapist to identify the positive behaviors, attributes, or skills that the child has learned from the perpetrator.
- ✍ Focus on the abusive behavior rather than on the perpetrator. This helps the child feel more comfortable talking about what happened. Telling the child that the perpetrator’s *behavior* is wrong is far more effective than telling the child that the perpetrator is “bad.” When a child hears that a parent or someone they cared about is “bad,” the child often thinks that he/she needs to protect or justify his/her relationship and may protest and minimize the abuse. Expressing anger at the perpetrator often elicits the child’s loyalty and generates defensiveness from the child.
- ✍ Connect the child with appropriate adult role models in the community. This helps the child learn that he/she can benefit from a relationship without suffering abuse. This also facilitates and supports a shift in loyalty from the perpetrator to more available and appropriate role models.
- ✍ Help the child’s caregivers address issues of role reversal, boundaries, and setting limits. If the perpetrator was the disciplinarian in the family, and the nonabusive parent turns to the child to assume this role, the parent needs to know that the child is neither an appropriate role model nor has the skills for disciplining siblings. In these cases, the parent needs support and skills assume a disciplinary role and relieve the child of these responsibilities. Clearly defined limits on interacting with siblings and other children need to be stipulated.
- ✍ Educate parents about warning signals that indicate that the child is having difficulties managing anxiety, powerlessness, or anger. These warning signals include displaying intrusive and controlling behavior toward siblings, peers, and younger children; hurting or victimizing peers or younger children; and demonstrating aggressive or sexual acting out.

Victimizing Behaviors

A child who uses secrets, threats, intimidation, force, or weapons to secure access to a vulnerable child needs to be evaluated for unresolved issues related to physical or sexual abuse and protected from acting out his/her inappropriate behavior. Numerous articles have been written addressing the “abuse-reactive” child, adolescent, or juvenile perpetrator as well as aggressive or antisocial behavior.^{173 174 175 176} Developing empathy, a perspective on his/her own victimization, behavior management, and relapse prevention techniques, facilitate managing this behavior. Family therapy can provide a structure in which to develop and implement these skills.

In dealing with victimizing behaviors, therapists should address issues related to mastery and control, impulse control, and aggressive behavior.

Intimacy

Intimacy, the need and ability to feel close to a responsive and willing (age-appropriate) partner and be able to share one’s most personal thoughts, feelings, and behaviors, can be affected by abuse and neglect. An abused child is shaped, in part, by his/her age-inappropriate knowledge of sexual behavior and violent interaction, his/her experience of the perpetrator’s abuse of power and trust in a relationship, and his/her awareness of the impact and effects of emotional and physical manipulation. These experiences have an effect on the child’s ability to interact in an appropriate and responsible manner and can interfere with the establishment of positive, supportive relationships.¹⁷⁷

To help the child with issues related to intimacy, the therapist can:

- ✍ Work to increase the child’s investment in age-appropriate activities and relationships.
- ✍ Help the child increase his/her comfort with interactions such as talking, listening, and sharing.
- ✍ Support and encourage the child for interacting with others and developing close, reciprocal, personal relationships. Initially, the therapeutic relationship is a model for responsive, appropriate, and caring interaction. Help the child identify the qualities in the therapeutic relationship that can be expected or transferred to other relationships.
- ✍ Help the child manage his/her anxiety about connecting with others.
- ✍ Clarify and interpret positive and negative behaviors that support or interfere with developing meaningful relationships.
- ✍ Offer nurturance and support as the child invests his/her time and energy into meaningful relationships.
- ✍ Offer hope and guidance if the child feels rejected or loses an important friendship.
- ✍ Acknowledge the adolescent’s excitement and fascination with intimate relations. This is a natural part of the adolescent experience, and willingness to talk with the therapist about these feelings can indicate the establishment of trust in the therapeutic relationship.
- ✍ Discuss sexual concerns, questions, behaviors, health protection, and birth control.
- ✍ Interpret the adolescent’s sexual behavior in light of his/her history of maltreatment as well as in terms of normative issues (e.g., universal adolescent concerns about sexuality).

- ☞ Clarify the possible intentions, meanings, and consequences of the adolescent's behavior. Many adolescents welcome hearing that they can wait to have sexual relations until they are married or until they are absolutely certain that they are choosing to do so because they want to rather than to prove that they are unaffected by the abuse.

Betrayal

Betrayal occurs when a child realizes that what he/she understood to be real and acceptable turns out to be painful and emotionally damaging. When a trusted adult acts out his/her anger in a physically assaultive manner or uses the child for sexual and emotional needs, the child's expectation that adults will provide for his/her care and protection is violated.¹⁷⁸ A child who recognizes that he/she has been hurt or abused by an adult often has feelings of confusion and vulnerability. This can be profoundly negative and disruptive to the child's world view.¹⁷⁹ Betrayal by a physically or sexually assaultive parent may lead to disillusionment, distrust of others, hostility, and anger.¹⁸⁰

To help the child deal with feelings of betrayal, the therapist can:

- ☞ Help the child express his/her feelings about the abuse or neglect.
- ☞ Identify and talk about the adults who should have protected the child. Address issues of abandonment and feelings of rejection. Often, children are more negatively affected by abuse when they believe other people knew and took no action to protect them.
- ☞ Increase the child's ability to recognize hurtful and abusive situations. Instill the idea that children need help and have a right to protection. Help the child feel comfortable asking for and eliciting help from adults.
- ☞ Help the child identify similarities between the abusive experiences and his/her expectations regarding how adults will respond to children. This awareness can be related to the child's interaction with and expectations for the therapist, peers, and other adults in his/her life.

INTRAPERSONAL ISSUES

The effects of child sexual abuse and physical abuse can be understood as a combination of classically conditioned responses to traumatic stress and socially learned behavioral and cognitive responses to the abuse experiences.¹⁸¹¹⁸² Two main themes dominate the generation of symptoms— affective responses characterized by anxiety and behavior patterns that are the result of social learning processes. Treatment that is directed at altering the conditioned and the socially acquired responses to victimization will alleviate initial symptoms and reduce the likelihood of long-term or more serious disruptions in development.

Fear

Fear is generated when an external event threatens a child's safety or well-being. A child who expresses fear of the perpetrator, fear of retaliation, fear for his/her own safety, or fear of reoccurrence needs to be protected to the best of the professional's ability. Mandated reporting laws and emergency response and placement out-of-home (if the child's safety cannot be ensured in the home) can provide some protection for the child. Any current safety or protection issues that may be frightening the child warrant immediate assessment.

Trauma

Trauma occurs when the child is unable to manage the overwhelming affective reactions generated by the abuse.^{183 184 185 186} When a child becomes overwhelmed by his/her sensations, thoughts, or feelings about the abuse, the child is unable to make sense of this experience. The child continues to feel as if he/she is still in danger and repeatedly reenacts the abusive experience and continues to relive the event as if it were still occurring. The child's ability to feel safe and secure is impaired. He/she needs to develop strategies that enable him/her to feel that he/she can survive the experience. Sometimes, a child will behave in such a way that elicits reactions from others that resemble the abusive event. The child creates situations that replicate the abuse in an attempt to master overwhelming feelings and gain the sense that he/she has some control over the experience.

A child also offers symbolic representation of abusive experiences through his/her play, art work, dreams, and fantasy reconstruction. The child's art work may include actual information about the assault or representations of his/her sense of powerlessness. Play and fantasy reconstructions often include wishful or magical thinking, themes of anger, violence, and rescue fantasies.

In many ways, trauma is an open-ended experience that the child needs to address in order to gain understanding and closure. Trauma resolution comes about when there is sufficient processing for the information to be stored. That is, the event is remembered, the attendant feelings are neutralized, and control of the anxiety generated by the event is achieved. When a traumatic event is not resolved and remains either in active memory or defended by a cognitive mechanism, the diagnosis of PTSD is generally used.

To help the child work through the trauma, the therapist can:

- ✍ Help the child recall the details of the traumatic event.
- ✍ Help the child identify the sensations, thoughts, feelings, and beliefs generated by the experience.
- ✍ Help the child make the connection between what occurred during the abuse and how the child is feeling currently.
- ✍ Use interventions that provide a sense of completion and closure to the experience.
- ✍ Use techniques such as relaxation exercises and cognitive completion to help the child manage overwhelming experiences.^{187 188 189}

Anxiety

Anxiety is created when a child anticipates that a frightening or dangerous experience will reoccur. Sometimes, a child will remain in a state of anticipation, hyperalertness, or fearfulness when no immediate danger is present. In these cases, the child has often moved from the specific abuse experience to more generalized anxieties of circumstances or situations reminiscent of the abuse. Because anxiety is experienced as an intensely unpleasant state, the anxious individual is motivated to engage in responses to reduce or eliminate the anxiety. These coping responses may be behavioral; for example, avoidance of situations or persons associated with the anxious feelings. These responses may be cognitive; for example, compulsive or ritualized behavior that are attempts to render the anxiety-producing cues inert.¹⁹⁰

To help children work through the anxiety they experience, the therapist can:

- ✍ Provide support and encouragement for addressing a difficult task.

- ✍ Help the child relate the details of the abuse in a relaxed and matter-of-fact way.
- ✍ Encourage discussion about various aspects of the abuse experience. With a young child, play therapy can incorporate elements of desensitization, graduated exposure, modeling, and assertiveness training. The play interaction can be structured in a number of different ways, such as using puppets, dolls, art work, or story telling. The process is facilitated by gently encouraging and directing reenactment and discussion about various aspects of the abuse experience. This kind of desensitization is characterized by the gradual, imaginal presentation of a hierarchy of feared situations paired with relaxation and safety.¹⁹¹

A more direct approach is often useful with an older child.¹⁹² Graduated exposure and alleviation of emotional distress can be encouraged by helping the child talk about the abuse in therapeutic situations that are safe and supportive. Through a process of talking about abuse-related material in a regular and matter-of-fact way, the memories eventually lose the capacity to elicit arousal.

- ✍ Monitor the child's ability to talk about anxiety-inducing experiences. Berliner and Wheeler note that sensitivity and clinical judgment are required in determining at what rate to proceed in eliciting this material.¹⁹³ The child should not be forced prematurely to recall or talk about the abuse because the therapist and the therapeutic environment may become simply an aversive reminder of the abuse.
- ✍ Identify the source of the child's anxiety. This usually requires eliciting specific information from the child about the content of his/her intrusive memories, dreams, or nightmares or identifying cues that evoke anxiety responses.¹⁹⁴
- ✍ Initiate and model methods of managing difficult experience. Appropriate methods of managing anxiety, such as asking for help, talking about feelings, and expressing strong emotions need to be modeled by the therapist.
- ✍ Reinforce the child's attempts at effective coping responses.

Depression

Many of the methods developed to alleviate depression in children and adolescents are also useful for abused and neglected children.¹⁹⁵ In depression, one of the most important areas that needs to be addressed is repressed or pent-up feelings. Therefore, the therapist can:

- ✍ Identify the child's capacity and willingness to experience and express his/her feelings. For example, does the child have an adequate vocabulary? How did the parents/caregivers react when the child expressed his/her feelings or opinions? Does the child feel secure in expressing his/her feelings about the abusive experience?
- ✍ Facilitate awareness and identification of feelings.
- ✍ Acknowledge and encourage the expression of feelings. Support the child's utilization of various media including poetry, song, dramatic play, art, and written expression to express his/her feelings.

Lack of Expression of Feelings

The lack of verbal expression is a characteristic of an abused and neglected child. There are several reasons why the child says little about how he/she feels including the following:

- ✍ The child may not know how to express his/her feelings.
- ✍ The child may not have the language or verbal skills to express his/her feelings. For example, one 6-year-old girl who was both physically abused and neglected referred to her home as a “crying place.”
- ✍ The child may be unsure of his/her own ability (or others’ abilities) to tolerate and manage a display of feelings. The child may be unwilling to acknowledge or display his/her pain, fear, or sadness.
- ✍ The child may have a limited range of feelings or limited awareness of his/her feelings.
- ✍ The child may not feel or think that his/his feelings are “safe.”

To help the child express his/her feelings, the therapist can:

- ✍ Educate the child about feelings. Teach the four groups of feelings—mad, sad, scared, and happy.
- ✍ Model and demonstrate appropriate expression of a wide range of feelings. For example, the therapist can model anger or sadness about the child’s statement that no one responded when he/she was hurt. The therapist can reaffirm to the child the message, “I am here to help you now. I want to make sure you are safe and you get help when you need it.” The therapist can model pleasure as the child demonstrates new skills and abilities.
- ✍ Support the child’s attempts to manage his/her feelings about the abuse. Some children will not allow themselves to remember or reexperience the pain involved in the assault. This ability to ignore, dissociate, or not have feelings about the experience has been a useful survival technique. The child will not surrender this survival technique until he/she feels that he/she is absolutely safe from abuse.
- ✍ Routinely explore safety issues with the child.
- ✍ Make the distinction between how the child felt when the abuse occurred and how the child feels currently. Remind the child that he/she is able to manage better now that he/she is bigger, older, or in a safe place. This assurance helps the child recall the experience of being hurt and still remain connected to the present where he/she is more capable of asking for help and receiving protection.

Guilt, Blame, and Responsibility

An abused or neglected child has a very difficult time placing responsibility for the abuse where it belongs—with the perpetrator. It is often a constant struggle for the abused child to determine who is responsible for the abuse and to understand who is the victim and who is the aggressor.¹⁹⁶ It is more likely that the child will internalize responsibility and blame him/herself for the perpetrator’s abusive behavior. The following are some of the reasons why a child might blame him/herself for the abuse:

- ✍ The perpetrator may have said things to make the child feel responsible for the abusive behavior.
- ✍ The perpetrator may have cultivated a special relationship with the child and offered special rewards or privileges for the child’s cooperation or silence (particularly in cases of sexual abuse). The child may feel guilty and blame him/herself for enjoying the special treatment, especially if it interfered with seeking help quickly.

- ✍ The abused child may have experienced some covert power and feel guilty about using the secret to manipulate the perpetrator or other family members.
- ✍ The child may think his/her behavior provoked the abusive behavior. The behavior of a physically abused child is often provocative. The child may interact with parents in ways that elicit the parents' attention, even if that attention is negative and hurtful.
- ✍ The child may feel guilty about what happened after the abuse was disclosed, especially if the family has financial problems or is experiencing shame, sadness, anger, or loss from the removal of the perpetrator.^{197 198}
- ✍ The child may feel guilty if he/she experienced any physical pleasure from the abuse or acted out similar behaviors with peers or younger siblings. Assuring the child that he/she is "not to blame" for the abuse is not enough to convince the child that the abuse was not his/her fault.

To help the child work through guilt, blame, and feeling responsible, the therapist can:

- ✍ Discuss the child's relationship with the offender.
- ✍ Increase the child's understanding of why this kind of behavior is so hurtful to children.
- ✍ Educate the child about adult responsibilities (i.e., caring for and protecting children, knowing right from wrong, and using the child's body and mind appropriately—that is, to not hurt or trick the child) and why adults are assumed more responsible (e.g., they know more, they are more mature, they have more options, they are bigger, they control resources).¹⁹⁹ The child needs to know that the perpetrator is an adult and knows the difference between right and wrong. Often, the child understands the concept of right and wrong when he/she is reminded that the perpetrator asked him/her to keep a secret or hide the injuries from physical abuse.
- ✍ Explain the concept of consent to the child (i.e., when a person is afraid or doesn't understand what he/she is agreeing to or how to say "no," then the agreement is unfair).
- ✍ Help the child explore the reasons why he/she kept the abuse a secret, and why the child finally decided to disclose the abuse. The child needs to recognize that there were reasons why he/she was unable or unwilling to disclose the abuse and that these reasons do not make the child responsible for the abusive behavior.

Secrecy itself is a choice.²⁰⁰ The child may choose to keep the abuse a secret for a number of reasons. Perhaps the child did not think anyone would understand. Perhaps he/she made the decision not to tell because he/she thought that his/her family would be angry with the child, or perhaps the child did not tell because he/she believed that the abuse was his/her fault. The perpetrator may have threatened to harm the child or his/her family members or pets. Some children attempt to avoid the abuse rather than tell someone.

Whatever reasons the child had for keeping the secret, they imply that the child made a decision based on information that was available, whether that information was accurate or inaccurate. This means the child was capable of discriminating between options and deciding what to do. It is this decision-making capacity that needs to be maximized. Implicit in this experience is that the child needs to learn that he/she has choices and feels that he/she can make decisions to care for him/herself.²⁰¹ Therefore, the therapist should enforce this behavior as follows:

- ✍ Help the child understand that certain kinds of behavior contribute to his/her vulnerability. Be sure that the child understands that his/her behavior does not make him/her responsible for the perpetrator's decision to abuse. However, the child's behavior can result in a situation that leaves him/her vulnerable to exploitation or abuse. Berliner and Wheeler note two examples.²⁰² The child who believes she caused her molestation by asking her father where babies come from requires reassurance that her father's literal demonstration was a result of his disturbed thinking and behavior and that her conduct was completely normal. On the other hand, the child who has repeatedly returned to the neighbor's home, knowing of the possibility of molestation, or who has sought extra privileges in exchange for compliance with abuse can be gently helped to acknowledge that a choice was made. This child needs to understand why, at the time, it seemed the better or only alternative, and how this decision put the child in a vulnerable position.
- ✍ Educate the child about the prevalence of abuse in our society. A child who realizes that abuse does happen to other children seems to experience less self-blame than a child who feels that abuse is extremely rare.²⁰³
- ✍ Affirm the child's sense of power, rather than his/her status as victim.
- ✍ Educate the child in an age-appropriate manner about the physical nature of sexual response to explain the presence of physical pleasure (if applicable) and address feelings of guilt.

Loss and Grief

Loss and grief are major issues for an abused and neglected child. Grief can result from the loss of an important relationship (e.g., older brother, baby-sitter), from a legally mandated separation from the abuser (e.g., grandparent) or from an irrevocable change in the view of the person or role (e.g., "It's like I don't really have a dad").²⁰⁴ The child may need to mourn the abuse and the subsequent loss of personal integrity.²⁰⁵

A very young child who is separated from his/her primary caregiver for a period of time may respond in three progressive stages described by Bowlby:²⁰⁶

- ✍ protest,
- ✍ despair, and
- ✍ detachment.

The abused and neglected children often experiences grief and mourning and moves through stages similar to those identified by Kubler-Ross:²⁰⁷

- ✍ denial,
- ✍ anger,
- ✍ bargaining or ambivalence,
- ✍ depression,
- ✍ acceptance, and
- ✍ hope for the future.

A child who has experienced a disruption in his/her usual living arrangements or needs to adjust to a major change in his/her environment, needs to focus his/her energy on adapting and figuring out what is expected of him/her and what he/she can expect of others. Major changes in the child's immediate family or circumstances interfere with the necessary mourning process.²⁰⁸ The child needs to adjust to new conditions and become familiar with his/her surroundings, new relationships, and behavioral expectations before he/she will have the energy to address the deeper work of mourning the loss of an important relative or membership in the family.²⁰⁹

To help the older child work through loss, the therapist can:

- ✍ Talk with the child about any changes, including his/her adjustment to a new home or life without the perpetrator. Often, the child does not realize that he/she is in the middle of a major upheaval. The child benefits from hearing that change is a major challenge for most people.
- ✍ Explain that everyone needs some time to adjust to major changes. This gives the child permission to be accepted and understand him/herself and to express his/her difficulties adapting to the specific changes in his/her life.
- ✍ Prepare the child for the possibility that he/she may feel some powerful, perhaps confusing, feelings. It may confuse the child to miss the perpetrator and long to see or meet with the perpetrator. The child may report that he/she thinks about the perpetrator or an unavailable family member all the time. He/she may frequent places where he/she might "accidentally" run into the perpetrator or unavailable family member. This puts the child in a vulnerable position. He/she may be at risk for further abuse or could be emotionally hurt by the adult's inappropriate response to the attempted contact. This type of behavior needs to be monitored and restricted when possible.
- ✍ Help the child express powerful feelings of sadness, loss, and anger. These feelings need to be expressed and dealt with repeatedly throughout the course of therapy.
- ✍ Give the child permission to acknowledge his/her sadness and loss. Sometimes, a child may feel uncomfortable expressing sadness for someone who hurt or molested him/her. This is a natural ambivalence; the child needs permission to care about and long for connection or membership in a family.
- ✍ Help the child recognize the positive qualities or interactions with the perpetrator. Help the child express love, disappointment, hurt, and hope that the perpetrator will be able to change his/her behavior. Help the child express anger about the behavior or fear of the reoccurrence of abuse.
- ✍ Explain to the child the changes the perpetrator or other family members need to make in order for visitation or reunification to occur. The child needs to be informed of family expectations and aware of possible decisions regarding placement and reunification.
- ✍ Let the child come to his/her own realizations about his/her relationship with the perpetrator or other family members. It is usually better to let the child conclude at his/her own pace and ability that contact or reunification may not take place. If the perpetrator or other family members demonstrate that they are unable or unwilling to meet the child's needs appropriately, the therapist can then support and commiserate with the child.

Self-Worth, Self-Esteem, Self-Efficacy

Self-worth, self-esteem, and self-efficacy are all affected by abuse and neglect. Many abused or neglected children feel that they are unworthy of attention, protection, or nurturing. They have a limited understanding of their value as human beings and often feel inadequate and ineffective in their interaction with people. Low self-worth and low self-esteem often contribute to a pattern of interaction with peers and in relationships that increases the possibility of revictimization.

To help the child improve his/her self worth, the therapist can:

- ✍ Address issues related to mastery and control.
- ✍ Help the child develop self-image based on competence and realistic expectations of performance. This helps the child feel effective and hopeful about attempting new behaviors. Some children may see themselves as capable and adequate to the tasks of protecting and caring for themselves. Younger maltreated children can have an inflated self-image.²¹⁰ Though inaccurate, this inflated self-image may represent active defense mechanisms and a need for physical competence and control.
- ✍ Give the child permission to acknowledge his/her wishful thinking or difficulties without losing esteem.
- ✍ Teach the child that he/she has the right to be protected and cared for appropriately and that he/she does not need to be victimized to be loved.²¹¹
- ✍ Educate the child about the intricacies of social skills and educational tasks. The child may need support and information about appropriate behaviors. The child may need tutoring or may have to make up a grade in school because his/her fear, stress, or anxiety interfered with his/her ability to learn new educational skills.

Stigmatization/Damaged Goods

Children often experience intense concern about physical and emotional impairment resulting from abuse. The child may feel physically damaged, dirty, ruined, or no longer whole or perfect.²¹² The child may feel that others can tell that there is something wrong with the child or that he/she is somehow different from other children.

Victims may behave in ways that result in their bodies becoming damaged or dirty. The child may fail to bathe; have poor hygiene; or dress in sloppy, dirty, or unattractive clothes. The child may develop eating disorders such as overeating or undereating in an attempt to make him/herself less attractive to abuse and to feel that he/she has some control over his/her body.

To help the child deal with this concern, the therapist can:

- ✍ Talk to the child about what it is like to feel vulnerable or powerless.
- ✍ Help the child figure out what it would take to feel safe and strong. Sometimes, the child can identify activities (e.g., karate or self-defense classes) that can counteract the feelings of being damaged by the abuse. The therapist may need to suggest activities that help the child feel empowered and protected. Team sports and activities that build on current skills and interests are helpful.
- ✍ Develop therapeutic interactions that help the child to feel good about his/her participation in therapy. The goal is to develop a series of tasks that helps the child feel competent. The therapist can speak positively about the child's ability to explore issues in therapy, noting how difficult that can be and how strong someone needs to be to remember and talk about the abuse.

- ✍ Emphasize the positive aspects of the child's abilities and behavior. The therapist can identify the child's interests and strengths and build on these factors so that satisfying interactions and esteem-enhancing activities are developed and expanded.
- ✍ Support and encourage new interests and strengths so that they become a progressively larger part of the child's life while the memories of the abuse diminish in importance. This is a change in the child's identity from an abused child to a child who is capable and involved in positive activities.

Learned Helplessness

All children need to feel that they have some control over their behavior and what happens to them. When this sense of control is diminished from repeated abusive experiences, the child may lose the interest, energy, and drive to protect him/herself. A child who feels powerless may believe that there is nothing that he/she can do to counteract the abuse. The child may learn to submerge his/her true feelings, distrust his/her own perceptions, and deny his/her own reality. An abused and neglected child will often demonstrate fear, confusion, passivity, pessimism, hopelessness, and an inability to protect him/herself.

To help the child work through learned helplessness, the therapist can:

- ✍ Demonstrate care and concern for the child's welfare. In therapy, children need to experience adults who are willing to pay attention to their behavior and help them communicate their needs and wishes. The therapist needs to take special notice of the child. He/she needs to see and comment on how the child looks as well as how the child is behaving in the therapeutic relationship. The therapist should note the child's changes and accomplishments within and between sessions. Paying attention gives the child a model and permission to also pay attention.
- ✍ Screen for any victimization that the child is unaware of or unable to report. Ask the child about his/her day and activities, including the child's interactions with friends and other people in the neighborhood. The child may indicate that he/she is being rejected, bullied, or victimized.
- ✍ Teach the child the kinds of behaviors that are considered hurtful or inappropriate and help the child identify these behaviors and talk about them. The child also learns that the therapist is there to help and will respond with respect, concern, and take action on the information. As the child gradually learns that he/she is important, valuable, and worthy of protection, he/she may be more willing to seek help or, when needed, protect him/herself.
- ✍ Take steps to ensure the child's safety. This may include asking the parents or caretakers to implement more supervision, contacting teachers or school officials if the child is being teased or bullied on school grounds, and reporting any inappropriate or abusive touching to proper authorities.
- ✍ Emphasize that the child deserves to be safe and protected. The therapist can thread this theme throughout the session and remind the child when the session is over to tell someone if he/she needs help.
- ✍ Teach the child assertiveness, communication, and problem-solving skills. Generally, these skills have minimal use until the child has a frame of reference that allows him/her to understand the importance of standing up for one's safety and well-being. This positive frame of reference is based on increased self-esteem and self-worth.

By asking the child if he/she has any questions and reinforcing those questions with positive experiences, the therapist teaches the child to think about and ask for information. It takes courage to ask questions, especially if the child fears retaliation or humiliation. Permission to make mistakes also helps the child feel comfortable as he/she learns to make productive decisions. The therapist can set up role-playing situations and help the child practice asking for what he/she needs.²¹³ The therapist can model problem-solving skills and teach the child how to think about situations and problems. When the child asks questions, the therapist can state, "Let's figure it out," and take the child through the steps for problem solving and decision making. Learning how to determine adequate and appropriate responses when requests are denied and developing alternative ways to achieve goals are also helpful. For example, an adolescent who feels she is not dressed adequately compared to her peers may benefit from wardrobe planning, learning to sew, or the joys of thrift store shopping.

BEHAVIORAL ISSUES

There are a number of behavioral issues that require attention in the treatment of abused and neglected children. In this section, avoidant behavior, dependent behavior, aggressive behavior, and hypersexual behavior are discussed.

Avoidant Behavior

Some children will avoid contact or interaction with adults or other children in an attempt to try to protect themselves from abuse. This behavior may be the child's attempt to manage his/her anxiety about revictimization. However, this kind of behavior pattern often leads to isolation and alienation from peers and adults and can leave the child vulnerable.

Oftentimes, the child is undersocialized and feels stigmatized by the abuse or neglect. The child generally has low self-esteem, poor communication skills, and difficulties managing his/her feelings or behavior when in social situations. This child often appears quiet, watchful, and anxious in social settings. Although the child may be actively engaged in avoiding physical and social contact with peers and adults, he/she is often very lonely and longs for connection to other people.

A child who demonstrates avoidant behaviors is reticent in social situations and is fearful that he/she will say something silly or inappropriate or not be able to respond adequately. This child can benefit from participating in a supportive social and therapeutic group with children of the same age.

It is important to remember that the avoidant child is probably anxious about the interaction with the therapist. In working with a child who demonstrates avoidant behaviors, the therapist can:

- ✍ Begin establishing a relationship with the child in a slow and deliberate manner. This allows the child to feel comfortable and safe. The avoidant child may need a much longer beginning phase of therapy in which to develop rapport, trust, and realistic expectations. The clinician can offer reassurance that the child is not in trouble or not going to be penalized for anything that he/she might say.
- ✍ Monitor body language, vocal quality, and reactions to the child's statements. A calm tone of voice and willingness to slow the pace of the conversation can help the child attend to the information and process the experience.
- ✍ Give information about the format of the sessions and the therapist's availability, such as what will happen if an appointment is cancelled. It is important for the professional to remember that simply because the child avoids contact and interaction does not mean that the therapeutic relationship is

- unimportant. Many avoidant children come to depend on the therapeutic interaction and are quite bereft when the therapist cancels or needs to terminate the relationship.
- ☞ Choose activities that support the child's skills and abilities and enhance his/her self-esteem and competency. When a therapist asks the child for help arranging the playroom or deciding where to put the toys, these requests engage the child in an activity in which he/she feels productive and learns the way about the playroom.
 - ☞ Help the child retain a sense of control and decision making. Provide choices.
 - ☞ Use anticipatory planning, which not only tells the child what will happen but offers him/her options about how to respond or react. This increases the child's repertoire of behaviors and gives him/her choices.
 - ☞ Help the child develop coping skills that will allow him/her to manage his/her feelings and thoughts, memories, and disclosure about the abuse or neglect.
 - ☞ Remember that the child may only be able to give small amounts of information at a time. Therefore, the professional should allow periods of nondirected play between statements about abuse. This provides the child with the opportunity to manage his/her anxiety and allows the child to note and monitor the therapist's response to the disclosure. Davies and Montegna note that respecting the child's pace may seem time-consuming and tedious, but can result in a more effective therapeutic relationship.²¹⁴

Dependent Behavior

Children are dependent on adults for their care and well-being. Often, a child who has been abused or neglected by an adult upon whom the child relied to care and protect him/her will regress to a previous developmental stage that feels safer and more comforting. This normal coping behavior enables the child to regain emotional energy for his/her passage into a new phase or stage of development.

However, a dependent pattern of behavior is more pervasive than regressed behavior. A child who exhibits this dependent pattern of behavior often allows other people to make important decisions, such as whether or not the child is hungry or needs help. Dependent children who fear rejection may agree with people even when the child knows that these people are wrong. The child may volunteer to do things that are unpleasant or demeaning in order to get other people to like him/her. A dependent child is vulnerable to exploitation and revictimization because he/she has a tendency to attach to anyone who he/she feels attends to their physical or emotional needs. This pattern of behavior can create major long-term developmental and relationship problems.

Initially, a dependent child is "easy" to engage in therapy. The child is compliant, offers little resistance to developing a therapeutic relationship, and welcomes the chance to participate in therapy. However, upon observation, the dependent child is often indiscriminate in his/her attachment to adults, has few opinions or issues to discuss in therapy, and can appear to the therapist as a "good" child who is a pleasure to have in therapy. The challenge in working with a dependent child is to generate separation and individuation, to elicit a strong and determined response from the child, and help the child integrate a sense of self that is based on worth, abilities, and individuality.

In working with dependent children, the therapist can:

- ✍ Be nurturing while expecting and teaching the child to behave in an age- and/or developmentally appropriate manner. In this way, the therapist is “pulling” the child into maturity while protecting the child from his/her fears of rejection or abandonment.
- ✍ Be consistent and continuously provide support and encouragement. Usually, this child did not bond with his/her parent/caretaker or have the opportunity to attach to a stable and consistent caregiver.
- ✍ Practice problem-solving skills and help the child determine what it is he/she needs and wants.
- ✍ Reinforce questions, requests for information, and the development of interest and curiosity in outside activities and support systems.

Aggressive Behavior

A high percentage of severely aggressive children have histories of suspected child maltreatment. These children may be identifying with the aggressor, have pent-up anger and rage, or problems with impulse control that make it difficult for them to control their behavior. The child who acts out his/her aggression must learn to take responsibility for the consequences or outcomes of the behavior. The potential recipients of the child’s aggression need to be protected from this kind of victimization.

A child who exhibits aggression often has been raised in families that are characterized by harsh and inconsistent discipline, little positive parental involvement with the child, and poor supervision of the child’s activities.²¹⁵ Structure, planning, continuity, consistency, and a nurturing environment are all factors important in working with aggressive children.²¹⁶

Some parents may not be able or willing to deal with their child’s behavior. They may be resistant to interventions that feel as if they are being “told what to do” or “how to raise their children.” At these times, CPS involvement is crucial in engaging resistant parents and protecting any vulnerable children in the household. The aggressive child also needs to be protected. Regardless of his/her behavior, the child deserves protection from dangerous or inappropriate adult-child behavior.

Ongoing family problems or disruption contribute to an adolescent’s vulnerability to peer pressure. Peers supply the adolescent with the attitudes, motivation, and rationalizations to support antisocial behavior; peers also provide opportunities to engage in specific delinquent acts.²¹⁷ Many antisocial and aggressive adolescents already have a deviant peer group that reinforces their behavior.

In working with an aggressive child, the therapist can:

- ✍ Determine whether the child is currently being abused.
- ✍ Provide opportunities for the child to anticipate and plan for the resurgence of past feelings and experiences. This can help the aggressive child become aware of underlying feelings and pain and develop a plan for managing his/her reactions. In extreme cases, medication as well as higher levels of care, including hospitalization, day treatment, or residential care may be useful to the aggressive child.
- ✍ Ensure that the treatment of young males addresses the issue of body image and its relationship to the victim’s self image. Sebald notes that the child may require more physical space during casual conversations.²¹⁸ He also notes that touching can elicit a rigid and uncomfortable physical response. He raises two important questions about sexually abused males ? Do sexually abused males become

touch deprived? How can therapists develop treatment approaches that recondition sexually abused males to appropriate touch experiences?

- ✍ Teach a child to delay gratification, manage his/her impulsive behavior, and become aware of how his/her behavior affects others. This will help the child relate in more appropriate and acceptable ways to peers and adults.
- ✍ Assess if the child is a danger to him/herself or to others. The clinician must identify the problematic behavior as dangerous. Consequences to the recipient of the violence or to the aggressive child must be clarified. Risk taking, seeking out violent altercations, or assaulting others needs to be restricted. The therapist can portray these behaviors to the child as an indication of his/her need for protection. The therapist must connect the child's experience of abuse with the anger, rage, or rebellious behavior.
- ✍ Explore the benefits and liabilities of participating in a peer group that reinforces aggressive and destructive behavior.

In addition, the clinician must address sexually aggressive behavior immediately. The therapist must report this behavior to the appropriate authorities and use law enforcement and CPS interventions to guarantee that other children are not victimized. Interventions useful to address sexually aggressive behavior can be found in the sections on identity and victimizing behavior.

Hypersexual Behavior

Browne and Finkelhor describe premature sexualization as a process in which a child's sexuality (including sexual feelings, attitudes, and behaviors) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse.²¹⁹ In the same way that a physically abused child often demonstrates physically aggressive behavior as a coping and interaction style, the sexually abused child may also demonstrate sexualized behavior to express anxiety or socialization problems.

A children who has been sexually abused has been prematurely introduced to sexual behavior and often has been taught, reinforced, or rewarded for behaving in a sexual manner. The child may not be aware of how his/her behavior appears to other people. Most victims have little awareness that their behavior is seductive and may feel hurt or confused when people are put off by their behavior or are distraught and bewildered when adults accost them sexually.²²⁰ Suggestions for dealing with sexualized behaviors are provided in the following discussions.

Suggestive Sexual Behavior

Suggestive sexual behavior is learned behavior that is often reinforced by the perpetrator. It is disconcerting and sometimes frightening to parents. Many parents can become very punitive in their attempts to end this kind of behavior, but this approach can exacerbate the problem and alienate the child.

The therapist working with this type of behavior can:

- ✍ Help parents/caregivers intervene with inappropriate sexualized behavior, set limits on this type of interaction, and support and reinforce new behaviors.
- ✍ Help parents/caregivers understand that this type of behavior is not an uncommon response to sexual abuse and does not mean that the child is permanently damaged or going to become homosexual, a prostitute, or a child molester.

- ✍ Help the child address all the issues related to sexual abuse. This offers the child insight and an ability to manage his/her behavior in an appropriate manner.
- ✍ Bring provocative clothing, suggestive body language, and inappropriate sexual statements or innuendos to the child's awareness. This awareness is important to protect the child from inappropriate adults and from peers who can tease, ostracize, or make inaccurate assumptions about the child's motives or desires. By using examples of movie stars or rock stars to help explain how behavior and dress create an image, the therapist can help the adolescent understand the impact of his/her behavior without instilling a sense of shame or guilt.
- ✍ Provide sex education to the child by discussing the correct terminology for sexual body parts, functioning of genitalia, and normal sexual behaviors. Sex education can assist in correcting distortions in the child's knowledge or belief system regarding sexuality.

Once the child becomes aware of these sexualized behaviors and has been exposed to alternative behaviors that are more appropriate, then he/she can begin to choose how he/she wants to present him/herself to others.

Masturbation

Masturbation is a fairly common occurrence among children and adolescents. However, the sexually abused child may be more likely to demonstrate this behavior in inappropriate places and at inappropriate times. Masturbation is often an attempt to soothe stress and anxiety generated by the abuse.

A five-part plan for working with families/caregivers whose child exhibits compulsive masturbation includes:²²¹

- ✍ Assessing parental/caretakers' attitudes and behaviors related to the masturbation. Friedrich suggests that the parents/caretakers be educated regarding the possible relationship between sexual abuse and masturbatory behavior.
- ✍ Helping the parents/caretakers positively shape and reinforce the child's non-masturbatory time.
- ✍ Creating a time and place for the child to masturbate. Isolating the child with the masturbatory behavior may reinforce that method of soothing his/her anxiety. Replacing the masturbatory behavior with pleasant, socially acceptable and engaging behaviors may be more productive.
- ✍ Normalizing values and attitudes about masturbation.
- ✍ Dealing with the child's abuse experience because this, in part, is driving the masturbation.

SUMMARY

This section has identified many of the symptoms or issues common to abused and/or neglected children. Modifying these symptoms until the abused or neglected child is able to manage his/her thoughts, feelings, and behavior in a positive and productive or prosocial manner is the major goal of therapy. However, this major goal is reached by the accumulated mastery of more specific goals and objectives or interventions. The interventions noted in this section are only some of a wide variety of possible interventions that are useful to children. It is the therapist's responsibility and challenge to choose the most appropriate interventions for each individual child and to evaluate and modify the interventions when appropriate.

The child's ability to benefit from a specific intervention(s) is based, for the most part, on a willingness to utilize the new experience and information. This willingness, of course, is facilitated by a strong and helpful therapeutic relationship or alliance as well as by support from parents/caregivers, family members, and friends.

As is true when learning any new task, the beginning is always difficult; no one is perfect; and practice, practice, and more practice establishes confidence.

CASE MANAGEMENT

Successful intervention in the lives of abused and neglected children and their families requires the concurrent involvement of many different systems. Interventions aimed exclusively at the individual victim often ignore or underutilize the family and the environmental resources available to the child. This approach can perpetuate the child's experience of isolation and exacerbate his/her victimization.

A time-limited, hourly therapeutic session with a child will not guarantee his/her safety nor will it guarantee successful interactions in his/her home, school, or community. Careful assessment and utilization of family members and caregivers as well as liaison with school personnel, law enforcement and court-related personnel, and child welfare agencies increases the likelihood that the child will benefit from treatment, remain safe, and promote healthy relationships with others.

FAMILY MEMBERS

Inherent in good case management is the principle that the therapist must have a parent or guardian consent and sign a release of information form that gives the therapist permission to contact the appropriate parties whether they be friends, relatives, acquaintances, or professionals. The parent has the right to be informed of the purpose of each contact and the information received from the contact. The child has the right to be informed about how information is obtained and shared.

Parents

Parents of abused and neglected children can be their child's strongest ally or most serious detractor in the process of therapy. In order for the child to benefit from therapy, his/her parents need to support the use of therapy and be willing to provide the time and effort necessary to help the child maintain the therapeutic relationship.

For most children, the ability to use therapy depends on their parents' understanding of the therapeutic process and their parents' willingness to support and follow through with established goals and objectives. The therapist needs to engage the parents' cooperation, use the parents' strengths, and when necessary, advocate for appropriate resources to meet the parents' physical and emotional needs.

Parents often need information about the effects of abuse and neglect and the signs and symptoms that indicate that their child may need therapy. Parents need encouragement for facilitating their child's participation in therapy and ongoing support when the child's progress is slow or difficult. Many parents who have unresolved feelings related to their own history of child abuse, neglect, or abandonment need additional attention to help resolve some of their feelings before they can fully address the needs of their child. Parents who understand the therapeutic process and have reasonable expectations regarding the outcome of therapy are more supportive and practical about their child's feelings and behaviors. Parents who have a fairly objective perspective and a sense of hopefulness about recovery are more helpful to their children.

Siblings

Case management includes advocating for siblings in the family. Often, siblings benefit from services to help them understand the ramifications of abuse and neglect. It is also important to rule out any chance that they have also been victimized. Siblings often need help addressing the following issues:

- ✍ fear and heightened sense of vulnerability;
- ✍ confusion, guilt, or envy (“why not me?”), or self-blame for failing to protect the victim;
- ✍ embarrassment or shame; and
- ✍ misunderstandings regarding the abuse of children, including blaming the victim, scapegoating the victim, sexualizing the sexual abuse victim.

When the perpetrator is a family member, especially a parent, the siblings, as well as the primary victim, will need services to address the following:

- ✍ changes that may have occurred in the family;
- ✍ divided loyalty;
- ✍ anger at the victim for disclosing abuse; and
- ✍ learned behavior, including victimization of younger siblings, inappropriate problem-solving skills, and issues related to gender and the use of power.

Relatives

Relatives can be very helpful or harmful to a child or family that is attempting to resolve issues related to abuse or neglect. Relatives can be an important resource for overburdened and exhausted parents. They can offer comfort, support, and child care for parents who need a respite from the tasks of parenting.

However, relatives need to be screened for their ability to respond appropriately to the child and parent; they should be carefully evaluated for any history of inappropriate behavior that could suggest a propensity to abusive or neglectful behavior. Parents who were abused as children by a family member, including a mother or father, should be strongly advised against seeking care for their child from that family member. Sometimes, a parent will need to explore his/her own history of victimization before being able to understand the ramifications of continuing to socialize or depend on a family member with a history of victimizing children.

If a relative is to be considered as a possible placement for a child who has been removed from parental care, it is important that relative’s motives for caring for the child be evaluated. The relative’s desire to take care of the child may emanate from a sense of obligation or guilt rather than from a real interest in protecting and parenting the child. This can contribute to confusion and perhaps feelings of rejection in the child. The relative must be evaluated to determine his/her understanding of the abuse or neglect. The relative must be able to clearly understand the responsibility for the abuse and place this responsibility with the perpetrator. Any anger or confusion regarding the child’s disclosure needs to be clarified and corrected. Blaming the child for disrupting the family or generating a criminal prosecution will be damaging to the child and increase the child’s fear and anxiety and possibly symptom formation.

On the other hand, relatives need to understand the importance of the child's relationship with a parent or parent figure and refrain from denigrating the parent to the child. The relative should be evaluated to determine his/her willingness to utilize outside resources including social service caseworkers and therapists. The relative's willingness and ability to be more alert to family problems and make any changes necessary to address the problems needs to be explored. Most importantly, the relative's style of discipline needs to be explored and evaluated because family members often learn and use similar childrearing and disciplinary techniques.

A child who is placed with a relative needs to recognize and acknowledge the family connection and have some relationship with the intended caregiver. When a child is placed with an unfamiliar relative, conditions similar to foster placement may apply. The child who will reside with a relative needs to feel that he/she can discuss his/her feelings about the abuse or neglect, the absent parent(s), or changes in the family situation, including the placement with the relative without fearing repercussions or that he/she is jeopardizing his/her place in the family.

SCHOOL

Good case management includes liaison with school personnel, including the child's teacher, principal, school counselor, and school psychologist. School personnel have the daily responsibility of educating the child; they are a primary source of information about the child's social and educational skills. The school can be a "safe haven" and is often referred to by abused and neglected children as the one constant and predictable environment in which they felt competent and safe. School can also be "torture" when a child is teased and ostracized because his/her behavior is inappropriate or different from that of other children. Working together with school personnel can add important information to the overall assessment of the child's behavior and allows the therapist to utilize a support system that is already in place.

Teacher

The teacher is an important source of information about the child's social abilities and relationships. Many abused or neglected children have conflict-ridden or difficult interpersonal relationships. The teacher can provide selective and unique information about a child's behavior and can be engaged as a support person for changing problematic behaviors.

The therapist can address social skills and behavior management techniques in therapy and reinforce successful mastery only with accurate information from reliable sources. Explaining to a teacher that the child is receiving therapy for issues related to abuse or neglect can help the teacher understand any problematic behavior the child may be demonstrating in class. Consistent discipline techniques and responses to the child establish a familiar pattern of interaction with adults that helps the child learn to manage problematic behavior.

School Counselor

The school counselor can offer onsite support for emotional or behavioral problems. Coordination with school counseling services can assure that the child receives appropriate and consistent intervention. It can eliminate duplication of services while generating a "team" approach to intervention with children.

School counselors are often available on an emergency basis and can intervene in problematic behavior as it occurs. This timely response and ability to modify behavior problems before they escalate can decrease some of the stigma often generated by abuse or neglect. A child who complains of being teased or bullied on the school grounds can seek protection, and a child who behaves in a threatening or intimidating manner can be monitored and limited in his/her acting out behavior. An accurate report from the school counselor about the child's

academic and behavioral performance can enhance the therapist's awareness of the child's strengths and needs and help him/her plan useful interventions.

School Psychologist

A school psychologist can be particularly useful in developing an educational plan that addresses the abused or neglected child's academic performance. Academic testing and individualized educational plans can help assure that the child does not lose the benefits of a positive educational experience. It is helpful and important to explain to school personnel that the experience of child abuse or neglect can impair a child's cognitive functioning. This kind of information can help the school teacher, counselor, and psychologist consider learning plans that take into account the stress and anxiety the child may be experiencing from addressing emotional issues related to abuse or neglect.

CHILD WELFARE AGENCIES

It is incumbent on the therapist to work as part of a team with the child welfare caseworkers in order to ensure the safety and protection of the child. A positive and cooperative effort on the part of the therapist enables him/her to better advocate for the needs of the child, including the implementation of optimal, permanent plans.

Child welfare caseworkers typically coordinate all of the services provided to abused and neglected children and their families and are responsible for ensuring that effective and timely decisions are made in a case. This decision making can be influenced by the knowledge and opinion of the therapist, but only if the therapist has a good working relationship with the agency. To this end, it is important that the therapist maintains clear and accurate notes describing therapy sessions. The therapist is often called on to provide written opinions about issues (e.g., placement, custody, or need for ongoing therapy) involving his/her clients. Consistent documentation, that is, the keeping of progress notes or client session notes, facilitates the decision-making process and offers objective information to support recommendations made to the child welfare agency.

JUVENILE COURT

The therapist needs to be familiar with the juvenile court system that makes decisions about the safety and protection of children. Placement decisions, visitation policies, and criteria for termination of parental rights are all important concepts that may need to be explained to the child. The therapist may be asked to make reports (i.e., recommendations for placement or visitation) to the juvenile court. These reports often help the child welfare caseworker make decisions that are in the child's best interest. It is often useful to inform the child that the therapist does not get to "tell" the child welfare caseworker or juvenile court what to do. It is important that the child realize that the judge has the ultimate responsibility for any decisions about the child's living arrangement.

Substitute Care Placement

When a child is removed from his/her family and is placed in substitute care, he/she has many needs that must be met. The therapist can advocate for the child's experience to continue to be as safe, familiar, and as "normal" as possible in order to decrease the stress and anxiety generated by the move. The therapist needs to be aware of the child's social, emotional, and educational needs in order to advocate for a setting that will be suitable for the child. The therapist advocates for the child's social needs by sharing information about the child's style of interacting and skill at joining with adults and peers. The therapist can offer suggestions for helping the child feel comfortable negotiating for attention and resources. Finally, the therapist can help the child's caregivers interpret and respond to the child's behavior in a consistent and productive manner. Information about the child's educational abilities and extracurricular activities need to be available to the child's welfare caseworker and caregivers in order to ensure some feeling of continuity, predictability, and access to esteem-building activities.

At times, the therapist may need to advocate for a more intensive level of care for the child. The therapist may need to negotiate with the child welfare caseworker to have a psychiatric evaluation conducted if the child's emotional state or behavior warrants medication or hospitalization, a psychological evaluation if additional diagnostic information is necessary, or a medical evaluation if any physical problems seem to interfere with the child's stability and well-being.

The child welfare caseworker should always be notified if the child is a danger to self or others. Any suicidal or homicidal ideation or plans need to be passed on to the child welfare caseworker who has responsibility for the child. However, in such instances, the therapist has responsibility for facilitating hospitalization of the child (when appropriate) and for continuing involvement in the case.

Visitation

The therapist is often asked to make recommendations regarding visitation with noncustodial parents or caretakers. The child's needs and wishes must be considered as primary information. The child's concerns regarding safety and protection, feelings about the parent and the visits, and the child's interest and willingness to interact with the parent seeking visitation need to be considered. Again, a multidisciplinary approach that elicits information from the parents, the parents' attorneys, the parents' advocate or therapist if possible, and the child welfare agency is important.

Reunification

When reunification with the parents is a consideration, the therapist needs to be in close contact with the child welfare caseworker in order to relay information about the child's progress in treatment and to gain information to help prepare the child for changes in visitation or living arrangements. Recommendations regarding reunification, including information about the child's ability to trust the parent and feel safe and protected, need to be relayed to the child welfare caseworker. The therapist should advocate for appropriate departure from the foster home and a reasonable transition to termination of child welfare services.

Conjoint sessions with parents and child are useful at this time. During these sessions, the course of events can be reviewed, changes discussed, and parental responsibility verbalized and processed. The sessions also offer a forum for the child to share his/her concerns and for the parents to make a commitment to protect the child from further harm.

It is often useful to continue the child's therapy through the reunification process in order for the child to have a place to discuss adjustment to living with his/her family again and explore solutions to any problems that may arise.

Law Enforcement

When the child is involved in a criminal investigation, it is often helpful to advocate for timely and sensitive intervention with law enforcement personnel. The therapist can help the child feel comfortable about the interview by providing some pertinent details about the experience. Providing the officer's name and time of visit can help the child feel the officer is a somewhat familiar figure. Identifying the officer as a friend and a person who helps children can also ease some of the child's discomfort.

Educating officers regarding developmental considerations, including the use of language, skills that facilitate memory and recall, as well as personal skills that help the child feel comfortable and safe are important.

Encouraging the officer to explain to the child the process of investigating a case can help the child feel that he/she has not been forgotten or that his/her case was not important. For more information on the law enforcement officer's role, the interested reader is referred to *The Role of Law Enforcement in the Response to Child Abuse and Neglect*, another manual in this series.

Prosecution

Testifying in criminal court can be such a stressful experience that it keeps the child focused on the outcome of the criminal proceeding and deters resolution of the issues related to the abuse or neglect. Schetky and Green note that the fears expressed by child witnesses include:²²²

- ✍ the fear of retaliation by the defendant, particularly if the defendant has made threats to the child in the past;
- ✍ the fear that he/she will not be believed;
- ✍ feeling as if he/she (the child) is on trial, often reinforced by aggressive cross-examination, or guilt if the child blames him/herself for what happened; and
- ✍ humiliation and embarrassment from the nature of questions asked and the presence of the jury and press.

The child and family need to develop coping responses that ameliorate these fears. The therapist can help the family remain realistic about the criminal proceedings and can prepare them for the possible outcomes. Praising the child's effort, without emphasizing the content or outcome of the criminal court proceedings, can enhance the child's self-esteem and positive feelings about the experience. The therapist may need to advocate with the attorney prosecuting the case for the child who is expected to participate in a criminal proceeding. For a description of preparing a child for testifying in court, the reader is referred to another manual in this series entitled *Working With the Courts in Child Protection*.

CONCLUSION

Therapy alone will not eradicate child abuse and neglect. Clinicians must develop, organize, and use all the resources available to help children. Parents and family members, school, law enforcement, and child welfare personnel are all striving to protect children from trauma generated by abuse and neglect. A comprehensive and cooperative effort that builds on the skills and services in the community will improve the condition of abused and neglected children.

NOTES

1. A.E. Kazdin, "Developmental Psychopathology: Current Research, Issues, and Directions," *American Psychologist* 44(1989):180-187.
2. W. James, *Psychology* (New York: Fawcett, 1963 [Original work published in 1892]); and C.L. Jewett, *Helping Children Cope with Separation and Loss* (Boston: The Harvard Common Press, 1982).
3. S. Harter, "Developmental Perspectives of the Self System," in E.M. Hetherington, ed., *Handbook of Child Psychology: Social and Personality Development* (New York: Wiley, 1983).
4. *Ibid.*
5. A. Bandura, *Social Foundation of Thought and Action: A Social Cognitive Theory* (Englewood Cliffs, NJ: Prentice-Hall, 1986).
6. B.F. Skinner, *The Behavior of Organisms* (Englewood Cliffs, NJ: Prentice-Hall, 1938).
7. R. Kegan, *The Evolving Self: Problems and Process in Human Development* (Boston: Harvard University Press, 1982).
8. M.D.S. Ainsworth, et al., *Patterns of Attachment* (Hillsdale, NJ: Erlbaum, 1978).
9. Kegan, *The Evolving Self: Problems and Process in Human Development*.
10. J. Garbarino, *Children and Families in the Social Environment* (New York: Aldine Publishing Company, 1982).
11. *Ibid.*
12. A. Salter, C.M. Richardson, and S.W. Kairys, "Caring for Abused Preschoolers," *Child Welfare* 64(1985):343-356.
13. J.L. Aber, et al., "The Effects of Maltreatment on Development During Early Childhood: Recent Studies and Their Theoretical, Clinical, and Policy Implications," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (New York: Cambridge University Press, 1990).
14. M.D.S. Ainsworth, "Attachment and Child Abuse," in G. Gerber, C.J. Ross, and E. Zigler, eds., *Child Abuse Reconsidered: An Agenda for Action* (New York: Oxford University Press, 1980).
15. P.M. Crittenden and M.D.S. Ainsworth, "Child Maltreatment and Attachment Theory," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (New York: Cambridge University Press, 1990).
16. M.A. Lynch and J. Roberts, *Consequences of Child Abuse* (New York: Academic Press, 1978).

17. P.M. Crittenden, "Abusing, Neglecting, Problematic, and Adequate Dyads: Differentiating By Patterns of Interactions," *Merrill-Palmer Quarterly* 27(1981):1-18.
18. P.M. Crittenden, "Relationships At Risk," in J. Belsky and T. Nezworski, eds., *Clinical Implications of Attachment Theory*. (Hillsdale, NJ: Erlbaum, 1988).
19. R.E. Helfer, "The Developmental Basis of Child Abuse and Neglect: An Epidemiological Approach," in R.E. Helfer and R.S. Kempe, eds., *The Battered Child*, 4th ed. (Chicago: University of Chicago Press, 1987).
20. R. Galdston, "Violence Begins at Home: The Parents Center for the Study and Prevention of Child Abuse," *Journal of the American Academy of Child Psychiatry* 10(1971):336-350.
21. A.H. Green, "Psychiatric Treatment of Abused Children," *Journal of American Academy of Child Psychiatry* 17(1978):356-371.
22. E. Mueller and N. Silverman, "Peer Relations in Maltreated Children," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (New York: Cambridge University Press, 1990).
23. H.P. Martin, *The Abused Child: A Multidisciplinary Approach to Developmental Issues and Treatment* (Cambridge, MA: Ballinger Publishing Co., 1976).
24. M.A. Baron, R.L. Bejar, and P.J. Sheaff, "Neurological Manifestations of the Battered Child Syndrome," *Pediatrics* 45(1970):1003-1007.
25. J. Caffey, "On the Theory and Practice of Shaking Infants: Its Potential Residual Affects of Permanent Brain Damage and Mental Retardation," *American Journal of Diseases of Childhood* 124(1972): 161-169.
26. E. Elmer and G.S. Gregg, "Developmental Characteristics of Abused Children," *Pediatrics* 40(1967): 596-602.
27. Martin, *The Abused Child: A Multidisciplinary Approach to Developmental Issues and Treatment*.
28. Martin, *The Abused Child: A Multidisciplinary Approach to Developmental Issues and Treatment*.
29. C.B. Cole, "Differential Long-Term Effects of Child Sexual and Physical Abuse" (Ph.D. diss., University of Washington, Seattle, 1988).
30. G. Ryan, "Victim to Victimizer: Rethinking Victim Treatment," *Journal of Interpersonal Violence* 4(1989):325-341.
31. S. Brownmiller, *Against Our Will: Men, Women, and Rape* (New York: Bantam, 1975).
32. D.E.H. Russell, *The Politics of Rape: The Victims Perspective* (New York: Stein and Day, 1975).
33. Salter, Richardson, and Kairys, "Caring for Abused Preschoolers."
34. *Ibid.*
35. Helfer, "The Developmental Basis of Child Abuse and Neglect."

36. D. Finkelhor and A. Browne, "Initial and Long-Term Effects: A Conceptual Framework," in D. Finkelhor, ed., *A Sourcebook on Child Sexual Abuse* (Beverly Hills, CA: Sage, 1986).
37. F.S. Porter, L.C. Blick, and S.M. Sgroi, "Treatment of the Sexually Abused Child," in S.M. Sgroi, ed., *Handbook of Clinical Intervention of Child Sexual Abuse* (Lexington, MA: Lexington Books, 1983).
38. J.W. Reich and S.E. Gutierrez, "Escape/Aggression Incidence in Sexually Abused Juvenile Delinquents," *Criminal Justice and Behavior* 6(1979):239-243.
39. J. Briere, "The Long-Term Effects of Childhood Sexual Abuse: Defining a Post-Sexual-Abuse Syndrome," paper presented at the Third National Conference on Sexual Victimization of Children, Washington, DC, 1984.
40. C. Courtois, "The Incest Experience and Its Aftermath," *Victimology: An International Journal* 4(1979):337-347.
41. K. Meiselman, *Incest: A Psychological Study of Causes and Effects With Treatment Recommendations* (San Francisco: Jossey Bass, 1979).
42. M. DeYoung, *Sexual Victimization of Children* (Jefferson, NC: McFarland, 1982).
43. J. Herman, *Father-Daughter Incest* (Cambridge: Harvard University Press, 1981).
44. D.E.H. Russell, *Sexual Exploitation: Rape, Child Sexual Abuse, Sexual Harassment* (Beverly Hills, CA: Sage, 1984).
45. N.S. Ellerstein and W. Canavan, "Sexual Abuse of Boys," *American Journal of Diseases in Children* 134(1980):255-257.
46. S. Sgroi, "Kids with Clap: Gonorrhea as an Indicator of Child Sexual Assault," *Victimology: An International Journal* 2(1977):251-267.
47. M.J. Spencer and P. Dunklee, "Sexual Abuse of Boys," *Pediatrics* 78(1986):133-138.
48. *Ibid.*
49. Tufts' New England Medical Center, Division of Child Psychiatry, "Sexually Exploited Children: Service and Research Project," Final Report (Washington, DC: U.S. Department of Justice, 1984).
50. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed., rev. (Washington, DC: American Psychiatric Association, 1987).
51. W.N. Friedrich, A.J. Urquiza, and R. Beilke, "Behavior Problems in Sexually Abused Young Children," *Journal of Pediatric Psychology* 11(1986):47-57.
52. Tufts New England Center, "Sexually Exploited Children: Service and Research Project."
53. W.N. Friedrich and W.J. Luecke, "Young School-Age Sexually Aggressive Children," *Professional Psychology: Research and Practice* 19(1988):155-164.

54. A.W. Burgess and R. D. Conger, "Family Interaction Patterns Related to Child Abuse and Neglect: Preliminary Findings," *Child Abuse and Neglect* 1(1977): 269-277.
55. R.L. Geiser and M. Norberta, "Sexual Disturbance in Young Children," *The American Journal of Maternal Child Nursing* (May-June 1976):187-194.
56. D.B. Langsley, M.N. Schwartz, and R.H. Fairbairn, "Father-Son Incest," *Comprehensive Psychiatry* 9(1968):218-226.
57. J.V. Becker, "The Effects of Child Sexual Abuse on Adolescent Sexual Offenders," in G.E. Wyatt and G.J. Powell, eds., *Lasting Effects of Child Sexual Abuse* (Beverly Hills, CA: Sage, 1988).
58. N. Groth, "Sexual Trauma in the Life Histories of Rapists and Child Molesters," *Victimology: An International Journal* 4(1979):10-16.
59. R.I. Lanyon, "Theory and Treatment of Child Molestation," *Journal of Consulting and Clinical Psychology* 54(1986):176-182.
60. Ryan, "Victim to Victimizer: Rethinking Victim Treatment."
61. Friedrich, Urquiza, and Beilke, "Behavior Problems in Sexually Abused Young Children."
62. W.N. Friedrich, R. Beilke, and A.J. Urquiza, "Behavior Problems in Young Sexually Abused Boys," *Journal of Interpersonal Violence* 3(1988):1-12.
63. W.N. Friedrich, A.J. Urquiza, and R. L. Beilke, "Children from Sexually Abusive Families: A Behavioral Comparison," *Journal of Interpersonal Violence* 2(1987):391-402.
64. Tufts' New England Medical Center, "Sexually Exploited Children: Service and Research Project."
65. V. DeFrancis, *Protecting the Child Victim of Sex Crimes Committed by Adults* (Denver, CO: American Humane Association, 1969).
66. J. Bowlby, *Attachment and Loss*, 3 vols. (New York: Basic Books, 1969-1980).
67. Harter, "Developmental Perspectives of the Self System."
68. T. Gaensbauer and R.J. Harmon, "Attachment Behavior in Abused/Neglected and Premature Infants: Implications for the Concept of Attachment," in R.N. Emde and R.J. Harmon, eds., *The Development of Attachment and Affiliative Systems* (New York: Plenum Press, 1982).
69. C. Howes and M.P. Espinoza, "The Consequences of Child Abuse for the Formation of Relationships with Peers," *Child Abuse and Neglect* 9(1985):397-404.
70. Helfer, "The Developmental Basis of Child Abuse and Neglect: An Epidemiological Approach."
71. L.A. Sroufe and J. Fleeson, "Attachment and the Construction of Relationships," in W.W. Hartup and Z. Rubin, eds., *Relationships and Development* (New York: Cambridge University Press, 1986).

72. M. Main and R. Goldwyn, "Predicting Rejection of Her Infant from Mother's Representation of Her Own Experience: Implications for the Abused-Abusing Intergenerational Cycle," *Child Abuse and Neglect* 8(1984):203-217.
73. D. Hoffman-Plotkin and C. Twentyman, "A Multimodal Assessment of Behavioral and Cognitive Deficits in Abused and Neglected Preschoolers," *Child Development* 55(1984):794-802.
74. Howes and Espinoza, "The Consequences of Child Abuse to the Formation of Relationships with Peers."
75. R.E. Helfer, "Malnutrition and Growth Retardation ('Failure to Thrive') in the Context of Child Abuse and Neglect," in R.E. Helfer and R.S. Kempe, eds., *The Battered Child*, 4th ed. (Chicago: University of Chicago Press, 1987).
76. E. Elmer, G.S. Gregg, and P. Ellison, "Late Results of the 'Failure to Thrive' Syndrome," *Clinical Pediatrics* 8(1969):584-589.
77. D. Finkelhor, *Child Sexual Abuse: New Theory and Research* (New York: Free Press, 1984).
78. Helfer, "The Developmental Basis of Child Abuse and Neglect: An Epidemiological Approach."
79. Crittenden, "Abusing, Neglecting, Problematic, and Adequate Dyads: Differentiating by Patterns of Interactions."
80. A.A. Lazarus, *Behavior Therapy and Beyond* (New York: McGraw-Hill, 1971).
81. A.A. Lazarus, *Multi-Modal Behavior Therapy* (New York: Springer, 1976).
82. F.G. Bolton, L.A. Morris, and A.E. MacEachron, *Males at Risk: The Other Side of Sexual Abuse* (Newbury Park, CA: Sage, 1989).
83. J. Kaufman and E. Zigler, "The Intergenerational Transmission of Abuse," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (New York: Cambridge University Press, 1990).
84. L.A. Sroufe and M. Rutter, "The Domain of Developmental Psychopathology," *Child Development* 55(1984):17-29.
85. T.M. Achenbach, *Assessment and Taxonomy of Child and Adolescent Psychopathology* (Beverly Hills, CA: Sage, 1985).
86. Harter, "Developmental Perspectives of the Self System."
87. K.L. Bierman, "Cognitive Development and Clinical Interviews with Children," in B.B. Lahey and A.E. Kazdin, eds., *Advances in Clinical Child Psychology*, vol. 6 (New York: Plenum Press, 1983).
88. M. Rubio-Stipec, H. Bird, G. Canino, and M. Gould, "The Internal Consistency and Concurrent Validity of a Spanish Translation of the Child Behavior Checklist," *Journal of Abnormal Child Psychology* 158(1991):393-406.
89. J.R. Mercer and J.F. Lewis, *System of Multicultural Pluralistic Assessment (SOMPA)* (New York: Psychological Corporation, 1978).

90. R.L. Williams, "The BITCH-100: A Culture-Specific Test," paper presented at the meeting of the American Psychological Association, Honolulu, HI, 1972.
91. A.L. Edwards, *The Social Desirability Variable in Personality Assessment and Research* (New York: Dryden Press, 1957).
92. V.C. Crandell, V.J. Drandell, and W. Kratkovsky, "A Child's Social Desirability Scale," *Journal of Consulting Psychology* 29(1965):27-36.
93. R.M. Dawes, D. Faust, and P.E. Meehl, "Clinical Versus Actuarial Judgment," *Science* 243(1989): 1668-1674.
94. P.E. Meehl, *Clinical Versus Statistical Prediction* (Minneapolis: University of Minnesota Press, 1954).
95. E. Hammer, *The Clinical Application of Projective Drawings* (Springfield, IL: Charles C. Thomas, 1980).
96. R. Burns, *Kinetic-House-Tree-Person Drawings: An Interpretive Manual* (New York: Brunner/Mazel, 1987).
97. D. Harris, *Children's Drawings as Measures of Intellectual Maturity* (New York: Harcourt, Brace, World, 1963).
98. H.A. Murray, *Explorations in Personality* (New York: Oxford University Press, 1938).
99. L. Bellack, *The TAT, CAT, and SAT in Clinical Use*, 3rd ed. (New York: Grune & Stratton, 1975).
100. J.E. Exner, *The Rorschach: A Comprehensive System*, vol. 2, *Current Research and Advanced Interpretation* (New York: Wiley-Interscience, 1978).
101. A.S. Kaufman and N. L. Kaufman, *Kaufman Assessment Battery for Children* (Circle Pines, MN: American Guidance Service, 1983).
102. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.
103. A.J. Costello and C.S. Edelbrock, "Validity of the NIMH Diagnostic Interview Schedule for Children: A Comparison Between Psychiatric and Pediatric Referrals," *Journal of Abnormal Child Psychiatry* 13(1985):579-595.
104. J. Puig-Antich and W. Chambers, *Schedule for Affective Disorders and Schizophrenia for School-Age Children (Kiddie-SADS)* (New York: New York State Psychiatric Institute, 1978).
105. T.M. Achenbach and C.S. Edelbrock, "The Child Behavior Profile: Boys Aged 6-11," *Journal of Consulting and Clinical Psychology* 47(1978):478-488; and T.M. Achenbach and C.S. Edelbrock, "The Child Behavior Profile II: Boys Aged 12-16 and Girls Aged 6-11 and 12-16," *Journal of Consulting and Clinical Psychology* 47(1978):223-233.
106. S.S. Sparrow, D.A. Balla, and D.V. Cicchetti, *Vineland Adaptive Behavior Scales: Revised* (Circle Pines, MN: American Guidance Service, 1984).

107. N. Fredman and R. Sherman, *Handbook of Measurements for Marriage and Family Therapy* (New York: Brunner/Mazel, 1987).
108. A.J. Urquiza, et al., "Screening and Evaluating Abused and Neglected Children Entering Protective Custody," *Child Welfare*, in press.
109. A. McIntyre and T.Y. Keesle, "Psychological Disorders Among Foster Children," *Journal of Clinical Child Psychology* 15(1986):297-303.
110. A. McIntyre, et al., "Psychosocial Characteristics of Foster Children," *Journal of Applied Developmental Psychology* 9(1988):125-137.
111. A.J. Urquiza and S. Wirtz, "The Assessment of Children Entering Protective Custody: Result of the Screening and Evaluation Project," paper presented at the 10th Annual Conference on Child Abuse and Neglect, University of California Davis Medical Center, Sacramento, CA, 1991.
112. E.H. Erikson, *Identity, Youth and Crisis* (New York: Norton, 1968).
113. Kegan, *The Evolving Self: Problems and Process in Human Development*.
114. M.E. Lamb, *The Role of the Father in Child Development* (New York: John Wiley & Sons, 1976).
115. D.N. Stern, *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology* (New York: Basic Books, Inc., 1985).
116. J. Bowlby, *Attachment and Loss. Volume II. Separation: Anxiety and Anger* (New York: Basic Books, Inc., 1973).
117. E.J. Anthony and B. J. Cohler (eds.), *The Invulnerable Child* (New York: The Guildford Press, 1987).
118. S.E. Taylor, "Adjustment to Life Threatening Events: A Theory of Cognitive Adaptation," *American Psychologist* 38(1983):1161-1173.
119. M.S. Mahler, "The Selected Papers of Margaret S. Mahler: Separation-Individuation," (New York: Jason Aronson, 1979).
120. M.S. Mahler, F. Pine, A. Bergman, *The Psychological Birth of the Human Infant* (New York: Basic Books, 1978).
121. D.W. Winnicott, *Playing and Reality* (London: Tavistock, 1975).
122. *Ibid.*
123. A. Eldridge and M. Finnican "Applications of Self Psychology to the Problem of Child Abuse," *Clinical Social Work Journal* 13(1985):50-61.
124. J. Cashdan, *Object Relations Therapy: Using the Relationship* (New York: Norton, 1988).
125. H.F. Searles, *Counter-transference and Related Subjects* (New York: International Universities Press, 1979).
126. A.T. Beck, *Cognitive Therapy and the Emotional Disorders* (New York: New American Library, 1976).

127. G. Patterson, *Living with Children: New Methods for Parents and Teachers* (Champaign, IL: Research Press, 1980).
128. L. Berliner and J. R. Wheeler, "Treating the Effects of Sexual Abuse on Children," *Journal of Interpersonal Violence* 2(1987):415-434.
129. W.N. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families* (New York: Norton, 1991).
130. S. Minuchin, *Families and Family Therapy* (Cambridge: Harvard University Press, 1974).
131. J. Haley, *Problem-Solving Therapy: New Strategies for Effective Family Therapy* (New York: Harper Colophon Books, 1976).
132. B. Montalvo and J. Haley, "In Defense of Child Therapy," *Family Process* 12(1973):227-244.
133. D. Cicchetti, "How Research on Child Maltreatment Has Informed the Study of Child Development: Perspectives from Developmental Psychopathology," in D. Cicchetti and V. Carlson, eds., *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (New York: Cambridge University Press, 1990).
134. D. Finkelhor, *A Sourcebook on Child Sexual Abuse* (Beverly Hills, CA: Sage, 1986).
135. G. Ryan, et al., "Juvenile Sex Offenders: Development and Correction," *Child Abuse and Neglect* 2(1987):385-395.
136. N.A. Groth, "The Adolescent Sexual Offender and His Prey," *International Journal of Offender Therapy and Comparative Criminology* 21(1977):249-254.
137. L. Berliner and J.R. Conte, "The Process of Victimization: The Victim's Perspective," *Child Abuse and Neglect* 14(1990):29-40.
138. J. Briere, "The Long-Term Clinical Correlates of Childhood Sexual Victimization," *Annals New York Academy of Sciences* 528(1988):327-334.
139. J. Garbarino, E. Guttman, and J.W. Seeley, *The Psychologically Battered Child: Strategies for Identification, Assessment, and Intervention* (San Francisco: Jossey-Bass, 1987).
140. D.J. Gelinias, "The Persisting Negative Effects of Incest," *Psychiatry* 46(1983):312-322.
141. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families*.
142. T.R. Bajt and K.S. Pope, "Therapist-Patient Sexual Intimacy Involving Children and Adolescents. Special Issue. Children and Their Development: Knowledge Base, Research Agenda, and Social Policy Application," *American Psychologist* 44(1989): 455.
143. A. J. Einbender, "Treatment in the Absence of Maternal Support," in W.N. Friedrich, ed., *Casebook of Sexual Abuse Treatment* (New York: W.W. Norton & CO., Inc., 1991).
144. *Ibid.*

145. M.J. Krieger, "Developing an Internalized Protector," in W.N. Friedrich, ed., *Casebook of Sexual Abuse Treatment* (New York: W.W. Norton & CO., Inc., 1991).
146. A.H. Schmale and G.L. Engle, "The Role of Conservation ? Withdrawal in Depressive Reactions," in E.J. Anthony and E.P. Benedek, eds., *Depression and Human Existence* (Boston: Little, Brown and Co., 1975).
147. Briere, "The Long-Term Effects of Childhood Sexual Abuse: Defining a Post-Sexual-Abuse Syndrome."
148. E. Gil, *Treatment of Adult Survivors of Childhood Abuse* (Walnut Creek, CA: Launch Press, 1988).
149. C. Courtois, *Healing the Incest Wound: Adult Survivors in Therapy* (New York: W. W. Norton & Co., Inc., 1986).
150. R. Barker, *Using Metaphors in Psychotherapy* (New York: Brunner/Mazel, 1985).
151. J.C. Mills and R. J. Crowley, *Therapeutic Metaphors for Children and the Child Within* (New York: Brunner/Mazel, 1986).
152. J. Haaken and A. Schlaps, "Incest Resolution Therapy and the Objectification of Sexual Abuse," *Psychotherapy* 28(1991):39-47.
153. S. Lamb, "Treating Sexually Abused Children: Issues of Blame and Responsibility," *American Journal of Orthopsychiatry* 56(1985):303-307.
154. J.P. Shapiro, "Interviewing Children About Sexual Abuse," *Psychotherapy* 28(1991):55-66.
155. Gil, *Treatment of Adult Survivors of Childhood Abuse*.
156. Berliner and Conte, "The Process of Victimization: The Victim's Perspective."
157. *Ibid.*
158. J. Conte, S. Wolf, and T. Smith, "What Sexual Offenders Tell Us About Prevention: Preliminary Findings," *Child Abuse and Neglect* 13(1989):293-301.
159. *Ibid.*
160. I. Yalom, *The Theory and Practice of Group Psychotherapy* (New York: Basic Books, 1975).
161. Gillert, Durfee, and Berkowitz, "Developing Guidelines for HIV Antibody Testing Among Victims of Pediatric Sexual Abuse," *Child Abuse and Neglect* 14(1990):9-17.
162. M. Finkel, "Medical: Guidelines for HIV Testing of Sexually Abused Children," *American Professional Society of the Abuse of Children: The Advisor* 3(1990):8.
163. Porter, Blick, and Sgroi, "Treatment of the Sexually Abused Child."
164. K.C. Faller, *Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management and Treatment* (New York: Columbia University Press, 1988).

165. D. Cicchetti and R. Rizley, "Developmental Perspectives on the Etiology, Intergenerational Transmission, and Sequelae of Child Maltreatment," *New Directions for Child Development* 11(1981):31-55.
166. Cicchetti, "How Research on Child Maltreatment Has Informed the Study of Child Development: Perspectives from Developmental Psychopathology."
167. D.A. Wolfe, *Child Abuse: Implications for Child Development and Psychopathology* (Newbury Park: Sage, 1987).
168. G. Patterson, *Living With Children: New Methods of Parents and Teachers* (Champaign, IL: Research Press, 1980).
169. R. Dreikurs, *Children: The Challenge* (New York: Hawthorn Books, 1964).
170. A.W. Burgess, C. R. Hartman, and A. McCormack, "Abused to Abuser: Antecedents of Socially Deviant Behaviors," *American Journal of Psychiatry* 44(1987):1431-1436.
171. A.N. Groth, "The Adolescent Sexual Offender and His Prey," *International Journal of Offender Therapy and Comparative Criminology* 21(1977):249-254.
172. Herman, *Father-Daughter Incest*.
173. Porter, Blick, and Sgroi, "Treatment of the Sexually Abused Child."
174. T.C. Johnson, "Child Perpetrators - Children Who Molest Other Children: Preliminary Findings," *Child Abuse and Neglect* 12(1988):219-229.
175. G. Ryan, "Victim to Victim�er: Rethinking Victim Treatment. Seventeenth Annual Child Abuse and Neglect Symposium, 1988, Keystone, Colorado," *Journal of Interpersonal Violence* 3(1989):325-341.
176. R.E. Longo and A.N. Groth, "Juvenile Sexual Offenses in the Histories of Adult Rapists and Child Molesters," *International Journal of Offender Therapy and Comparative Criminology* 27(1983):150-155.
177. G. R. Patterson, B.D. DeBaryshe, and E. Ramsay, "A Developmental Perspective on Antisocial Behavior," *American Psychologist* 44(1989): 329-335.
178. Wolfe, *Child Abuse: Implications for Child Development and Psychopathology*.
179. A. Browne and D. Finkelhor, "The Impact of Child Sexual Abuse: A Review of the Research," *Psychological Bulletin* 99(1986):66-77.
180. W.N. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families* (New York: Norton and Company, 1990).
181. D.H. Schetky and A.H. Green, *Child Sexual Abuse: A Handbook for Health Care and Legal Professional* (New York: Brunner/Mazel, 1988).
182. Berliner and Wheeler, "Treating the Effects of Sexual Abuse on Children."
183. A.H. Green, "Children Traumatized by Physical Abuse," in S. Eth and R. Pynoos, eds., *Post-traumatic Stress Disorder in Children* (Washington, DC: American Psychiatric Press, 1985).

184. E.P. Benedek, "Children and Psychic Trauma: A Brief Review of Contemporary Thinking," in S. Eth and R.S. Pynoos, eds., *Post-Traumatic Stress Disorder in Children* (Washington, DC: American Psychiatric Press, 1985).
185. Green, "Children Traumatized by Psychological Abuse."
186. L. Terr, *Too Scared to Cry. Psychic Trauma in Childhood* (New York: Harper and Row, 1990).
187. van der Kolk, *Psychological Trauma* (Washington, DC: American Psychiatric Press, 1987).
188. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families*.
189. *Ibid.*
189. Cotton, *Stress Management: An Integrated Approach to Therapy* (New York: Brunner/Mazel, 1990).
190. M. Horowitz, *Stress Response Syndromes* (Northvale, NJ: Aronson Inc., 1986).
191. Berliner and Wheeler, "Treating the Effects of Sexual Abuse on Children."
192. D.H. Barlow, *Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic* (New York: Guilford, 1988).
193. Berliner and Wheeler, "Treating the Effects of Sexual Abuse on Children."
194. *Ibid.*
195. *Ibid.*
196. M. Rutter, C.E. Izard, and P. Read, *Depression in Young People: Developmental and Clinical Perspectives* (New York: Guildford Press, 1986).
197. G. Stovall and R.J. Craig "Mental Representations of Physically and Sexually Abused Latency Aged Females," *Child Abuse and Neglect* 14(1990):233-242.
198. P.P. Riecker and E.H. Carmen, "The Victim-to-Patient Process: The Disconfirmation and Transformation of Abuse," *American Journal of Orthopsychiatry* 56(1986):360-370.
199. Porter, Blick, and Sgroi, "Treatment of the Sexually Abused Child."
200. Berliner and Wheeler, "Treating the Effects of Sexual Abuse on Children."
201. S. Lamb, "Treating Sexually Abused Children: Issues of Blame and Responsibility," *American Journal of Orthopsychiatry* 56(1985):303-307.
202. *Ibid.*
203. Berliner and Wheeler, "Treating the Effects of Sexual Abuse on Children."
204. J.P. Shapiro, "Interviewing Children About Sexual Abuse," *Psychotherapy* 28(1991):55-66.
205. Berliner and Wheeler, "Treating the Effects of Sexual Abuse on Children."

206. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families*.
207. Bowlby, *Attachment and Loss*.
208. E. Kubler-Ross, *On Death and Dying* (New York: MacMillan Publishing Co., Inc., 1969).
209. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families*.
210. C.L. Jewett, *Helping Children Cope with Separation and Loss* (Boston, MA: Harvard Common Press, 1982).
211. *Ibid.*
212. J.I. Vondra, D. Barnett, and D. Cicchetti, "Self-Concept, Motivation, and Competence Among Preschoolers from Maltreating and Comparison Families," *Child Abuse and Neglect* 14(1990):525-540.
213. G.E. Wyatt and M. Newcomb, "Internal and External Mediators of Women's Sexual Abuse in Childhood," *Journal of Consulting and Clinical Psychology* 58(1990):758-767.
214. D. Davies and D. Montegna, "Practice: Strategies for Coping with Avoidant Children," *American Professional Society of the Abuse of Children: The Advisor* 3(1990):8.
215. L. Damon, J. Todd, and K. MacFarlane, "Treatment Issues with Sexually Abused Young Children," *Child Welfare* 66(1987):125-137.
216. Patterson, DeBaryshe, and Ramsay, "A Developmental Perspective on Antisocial Behavior."
217. A.E. Kazdin, "Treatment of Antisocial Behavior in Children: Current Status and Future Directions," *Psychological Bulletin* 102(1987):187-203.
218. Patterson, DeBaryshe, and Ramsay, "A Developmental Perspective on Antisocial Behavior."
219. J. Sebold, "Indicators of Child Sexual Abuse in Males," *Social Casework: The Journal of Contemporary Social Work* (1987):75-80.
220. Browne and Finkelhor, "The Impact of Child Sexual Abuse: A Review of the Research."
221. Faller, *Child Sexual Abuse: An Interdisciplinary Manual for Diagnosis, Case Management and Treatment*.
222. Friedrich, *Psychotherapy of Sexually Abused Children and Their Families*.
223. Schetky and Green, *Child Sexual Abuse: A Handbook for Health Care and Legal Professional*.

GLOSSARY OF TERMS

Abreaction - the verbal expression of unconscious thoughts or feelings, usually in the presence of a therapist.

Affiliation - the ability and willingness to feel a part of or connected to other people or groups of people.

Anatomical Dolls - specially made dolls that have genitalia specific to sex and age, that is, those dolls that represent adults have larger genitalia with pubic hair; the female adult doll also has developed breasts. In a clinical setting, these dolls are useful tools to help the child demonstrate sexual acts or help the clinician understand the child's curiosity and relationship to various body parts. Because these dolls are often used to represent the perpetrator and victim, special attention to the child's feelings and behavior is important when the dolls are utilized.

Anxiety - the persistent feeling that danger or harm is imminent.

Assessment - the beginning stage of therapy in which information is gathered that helps the professional understand the possible origins of the symptoms and decide the best methods in which to address and modify those symptoms.

Attachment Theory - a developmental theory that emphasizes the relationship between an infant and its caretaker(s). Typically, attachment theory states that the preliminary framework for relationship patterns is established through early childhood relationships (i.e., through interactions with parents and siblings), but this framework is malleable and subject to change throughout an individual's lifetime.

Attributions - beliefs or perceptions about the self, others, and the world that are derived from training, learning, or experience.

Behavioral Theory - initially established by John B. Watson, the theory that overt behavior is the sole basis for scientific psychology. Founded on operant conditioning principles, behavioral theory attempts to explain the cause-effect relationship between the class of stimulus variables and response variables, with reinforcement stimuli increasing behaviors and punishment stimuli decreasing behaviors.

Case Plan - the professional document that outline the outcomes, goals, and strategies to be used to change the conditions resulting in child abuse and neglect.

Case Planning - the stage of the child protection process whereby the caseworker and other treatment providers develop a case plan with family members.

Child Protective Services (CPS) - the designated social service agency (in most States) to receive reports, investigate, and provide rehabilitation services to children and families with problems of child maltreatment. Frequently, this agency is located within larger public social service agencies, such as the Department of Social Services of the Department of Human Services.

Clinical Supervision - allows the therapist to seek information and share his/her clinical experience with another professional who can offer guidance, knowledge, and support. Generally, the clinical supervisor is more experienced and can share insight gained from working with the client population. Supervision helps professionals become more realistic in their expectations for themselves and their clients. It also allows therapists to share the burden of hearing and responding to numerous disclosures of child maltreatment and know that some other professional is aware of the work being done.

Cognitive Functioning - awareness of objects, thoughts, or perceptions.

Cognitive Theory - as a development of behavioral theory, cognitive or cognitive-behavioral approaches aim to change behavior by changing an individual's cognition.

Confidentiality - a provision in all State child abuse and neglect reporting laws that protects the privacy of children and families by not permitting information about the findings of the child maltreatment report to be released to other agencies without permission of the family. In some States, members of multidisciplinary teams may receive information without a release from the family.

Conjoint Therapy - therapeutic approach whereby the therapist works with a pair of clients, generally parent/caregiver/victim, sibling/victim, perpetrator/victim (when appropriate), to facilitate communication and appropriate interaction and improve the relationship of the two individuals.

Content and Process - two forms of information that are useful in gauging a client's participation in therapy. Content includes the specific topics or information that are discussed in the session whereas process includes information about the client's behavior and interaction.

Countertransference - the conscious and unconscious emotional reactions of the professional to the client.

Developmental Milestones - important tasks and accomplishments that occur during the child's normal development including, but not limited to, walking, talking, toilet-training, school attendance, puberty, sexual interest and contact, marriage, and birth of children.

Developmental Psychopathology - the perspective of understanding problems and abnormal interpersonal processes within an individual within the context of that individual's developmental abilities and skills.

Documentation - information related to provision of therapeutic services. Generally, this information includes date of service, persons present during the session, brief description of topics covered, the client's responses to the subject matter, and the date of the next scheduled appointment. Suicide or homicide ideation, threat, or intent must be documented with appropriate responses, including all attempts to protect the client as well as intended victims. Any child abuse and neglect disclosures must be documented and reported to the appropriate authorities.

Ego Defenses - unconscious attempts such as denial, projection, rationalization, regression, intellectualization, and sublimation which are used to manage overwhelming emotions or experiences.

Encopresis - the incontinence of feces, which is not due to any organic defect or illness.

Enuresis - the involuntary discharge of urine, often occurring at night (often referred to as bedwetting or nocturnal enuresis).

Family Assessment - the stage of the child protection process when the CPS caseworker, community treatment provider, and the family reach a mutual understanding regarding the most critical treatment needs that must be addressed and the strengths on which to build.

Family Systems Theory - a view of how family members interact with one another in relationship patterns that promote and/or accommodate the functioning of the family as a unit (or system).

Family Therapy - the therapist and cotherapist, when possible, work with family members, including parents, siblings, and extended family members (e.g., grandparents) in a group setting to address the changes necessary to ensure the safety and protection of the children in the family, especially the identified victim. Any problems or confusion generated by the abuse or neglect are also dealt with.

Genogram - a diagram of family members and their relationship to each other. This chart is useful to help the client understand the intergenerational aspects of child abuse and neglect and helps the client acknowledge helpful or problematic familial relationships.

Good Faith - the standard used to determine if a reporter has reason to suspect that child abuse or neglect has occurred.

Group Therapy - treatment approach in which the therapist and cotherapist work with a group of clients similar in age and experiences (e.g., sexual abuse, physical abuse, parents of victims) to help them share their thoughts and feelings related to their situation. This approach is particularly useful with clients who feel alienated or different from their peers or who have isolated their feelings as well as clients who would benefit from learning more positive and productive ways for interacting with others.

Honeymoon Phase - As used in child welfare, this period, which may vary in length of time, reflects a child's attempt to exert control over his/her behavior (i.e., behaving appropriately) when placed in a new environment.

Ideation - the formation of images and objects in the mind.

Immunity - established in all child abuse laws to protect reporters from civil lawsuits and criminal prosecution resulting from filing a report of child abuse and neglect. Immunity is provided as long as the report is made in good faith.

Individual Therapy - treatment approach in which the therapist and client work together in a one-to-one relationship to address thoughts, feelings, and behavior generated by the experience of abuse or neglect.

Initial Assessment - the stage of the child protection case process when the CPS caseworker and other treatment providers determine the validity of the child maltreatment report, assess the risk of maltreatment, and determine the safety of the child and the need for further intervention. Frequently, medical, mental health, and other community providers are involved in assisting in the initial assessment.

Integration - therapeutic process wherein the client is able to utilize the new information gained during therapy and feels willing and comfortable in relying on this new information.

Interpersonal Development - developmental processes between the child and other persons in his/her life (e.g., parents, siblings, extended family members, or peers).

Interpretation - a hypothesis about seemingly random symptoms or behavior that is connected to meaningful experience. During interpretation, the client connects his/her symptoms with a reasonable explanation that helps him/her make sense of the experience.

Intimacy - the need and/or ability to feel close to other persons, especially an age-appropriate responsive and willing partner. The ability to feel intimate usually involves sharing one's most personal thoughts, feelings, and/or behaviors.

Intrapersonal Development - developmental processes that occur within the child (e.g., development of affects, empathy, or intelligence).

Learning Theory - in clinical work and therapy, learning theory is typically referred to as social learning theory, which assesses the synergistic effects of behavior, personal factors, and the environment. This may involve observational learning, modeling, and/or cognitions.

Mandated to Report - each State has listed professionals who must report child abuse and neglect to the proper authorities, usually law enforcement or CPS agencies. There are penalties for failing to report suspected abuse and neglect. Most professionals are protected from liability if they make a report that is unfounded after investigation as long as the report was made in the best interest of the child.

Metaphor - a phrase or story that represents themes and offers the client insight into his/her feelings, thoughts, and behavior.

Modalities - approaches to psychotherapy that include individual, group, or family therapy.

Multidisciplinary Team - established among agencies and professionals to mutually discuss cases of child abuse and neglect and aid decisions at various stages of the CPS case process. These teams may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams.

Out-of-Home Care - child care, foster care, residential care provided by persons, organizations, and institutions to children who are placed outside their families, usually under the jurisdiction of Juvenile/Family Courts.

Parent/Caretaker - person responsible for the care of the child.

Personality Disorders - the implication of inflexible and maladaptive patterns of behavior, of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

Play Therapy - a treatment approach in which the child utilizes play as a method to express feelings and understand the experience of abuse and/or neglect. Some tools useful for play therapy include dolls, dishes and imaginary food, baby bottles, blankets, trucks and cars, action figures, and doctor's kits. Other types of therapy that may be useful to a child who has experienced abuse and/or neglect include art therapy, dance and movement therapy, drama therapy, and sandtray therapy.

Prognosis - anticipated outcome for the client participating in therapy. Outcome is often affected by factors such as the client's developmental and cognitive capacity and ability, parent/primary caretakers' availability and response to therapy, and client's willingness to participate in and utilize the therapeutic relationship.

Psychoeducational Group - experience that both educates members of the group and allows them to explore their thoughts and feelings related to the information. Useful topics for parents of abused and/or neglected

children include protection, communication, discipline, childhood experiences and how they affect current parenting, child development, and realistic expectations for the child.

Psychopathology - the branch of medicine that deals with the causes and nature of mental disease.

Psychotherapy - a method of treatment designed to produce a response by mental rather than physical stimuli; it includes the use of suggestion, persuasion, reeducation, reassurance, and support as well as hypnosis and psychoanalysis.

Regression - behavioral state in which the client reverts to an earlier or younger developmental stage and demonstrates behavior such as increased dependency, soiling or wetting problems, or temper tantrums.

Risk Assessment - an assessment and measurement of the likelihood that a child will be maltreated in the future, usually through the checklists, matrices, scales, and/or other methods of measurement.

Role Play - therapeutic approach which presents the opportunity to “try out” various roles or positions that are unfamiliar or confusing to the client. Role play is also an opportunity for the client to practice skills (e.g., a teenager practicing “no” to a sexual activity for which he/she is not ready).

Social Desirability - the tendency for an individual to alter his/her response to a question in a manner that is consistent with his/her perception of the interviewer.

Social Skills Group - therapeutic experience that focuses on teaching types of social interaction that facilitate appropriate relationships with peers and responsible adults. Communication skills such as listening, asking questions, sharing information, learning assertiveness, resolving conflict, and learning behaviors that appropriately express nurturing and affection are often practiced within this type of group.

Stigma - negative meaning associated with experience or behaviors.

Strange Situation Paradigm - research protocol that assesses the strength of the emotional relationship (i.e., attachment) between a parent and infant by observing behaviors associated with parent departures and reunions.

Support Systems - individuals or groups of people who are helpful and responsive to the client. These individuals or groups may include family, friends, and professionals such as therapist, social worker/caseworker, or group member.

Symptoms - emotional or behavioral reactions to the experience of abuse and/or neglect.

Therapeutic Alliance/Therapeutic Relationship - the understanding that the client gains that the purpose of the interaction between therapist and client is intended to benefit the client and is organized to help the client explore and learn from painful and/or overwhelming experiences. The client’s willingness to accept and acknowledge the value of the therapeutic relationship is based on the therapist’s ability to be trustworthy, responsible, and useful to the client.

Transference - the unconscious transfer of feelings of hostility or affection from the client to the professional.

Traumagenic Dynamics - a model developed by Finkelhor that describes the short-and long-term sequelae of child sexual abuse (i.e., betrayal, traumatic sexualization, stigmatization, and powerlessness).

Treatment - the stage of the child protection process whereby specific treatment services geared to the reduction of risk of maltreatment are provided by mental health and other social services professionals.

Treatment Plan - prepared by the clinician to outline the goals and objectives of therapy. Goals are broad treatment issues, whereas objectives are more specific activities or tasks that will help the client achieve his/her goals.

Validation - acknowledgment that the client's thoughts and feelings are worthy of attention.

SELECTED BIBLIOGRAPHY

GENERAL OVERVIEWS

- Briere, J.N. *Child Abuse Trauma. Theory and Treatment of the Lasting Effects.* Newbury Park, CA: Sage Publications, Inc., 1992.
- Friedrich, W.N., ed. *Casebook of Sexual Abuse Treatment.* New York: Norton and Co., Inc. 1991.
- Friedrich, W.N. *Psychotherapy of Sexually Abused Children and Their Families.* New York: Norton and Co., Inc., 1990.
- Green, A. "Child Abuse and Neglect." In *The Clinical Guide to Child Psychiatry*, edited by D. Shaffer, A.A. Ehrhardt, and L.L. Greenhill. New York: Free Press, 1985.
- Haskett, M.E., Nowlan, N.P. Hutcheson, J.S., Whitworth, J.N. "Factors Associated With Successful Entry Into Therapy in Child Sexual Abuse Cases." *Child Abuse and Neglect* 15(1991):467-476.
- Haugaard, J.J. "Sexually Abused Children's Opposition to Psychotherapy." *Journal of Child Sexual Abuse* 1(1992):1-16.
- Layzer, J.I. and Goodson, B.D., "Child Abuse and Neglect Treatment Demonstration." *Children and Youth Services Review* 14(1992):67-76.
- Lutzker, J.R. "Behavioral Treatment of Child Neglect." *Behavior Modification* 14(1990):310-315.
- Seligson, A.G. "The Fallacy of Victimization in Treatment of Sexual Abuse." *Journal of Child Sexual Abuse* 2(1993):135-140.
- Wheeler, J.R., and Berliner, L. "Treating the Effects of Sexual Abuse on Children." In *Lasting Effects of Child Sexual Abuse*, edited by G.E. Wyatt and G.J. Powell. Newbury Park, CA: Sage Publications Inc., 1988.

THERAPY/TREATMENT APPROACHES

- Ammerman, R.T. "Behavior Modification and Child Abuse and Neglect, Current Status and Future Directions." *Behavior Modification* 14(1990):227-229.
- Baglow, L.J. "A Multidimensional Model for Treatment of Child Abuse: A Framework for Cooperation." *Child Abuse and Neglect* 14(1990):387-395.
- Carey, C. and Kerner, S. "The Utilization of Art-Focused Group Therapy for Sexual Abuse Victims." *Colorado's Children* 11(1991):1.
- Cattanach, A. *Play Therapy With Abused Children.* Philadelphia, PA: Jessica Kingsley Publishers, 1992.

- Cohen, J.A. and Mannarino, A.P. "A Treatment Model for Sexually Abused Preschoolers." *Journal of Interpersonal Violence* 8(1993):115-131.
- Dubowitz, H. "Costs and Effectiveness of Interventions in Child Maltreatment." *Child Abuse and Neglect* 14(1990):177-186.
- Figley, C.R. "Posttraumatic Stress Disorders. Part I: Empirically Based Conceptualization and Symptom Profile." *Violence Update* 2(1992):8-11.
- Goodman, G.S. and Aman, C. "Children's Use of Anatomically Detailed Dolls to Recount an Event." *Child Development* 61(1990):1859-1871.
- Pillari, V. *Scapegoating in Families. Intergenerational Patterns of Physical and Emotional Abuse*. New York: Brunner-Mazel, Inc., 1991.
- Reeves, C. "The Role of Milieu Therapy in the Treatment of Sexually Abused Children." *Child and Youth Care Forum* 22(1993):111-124.
- Rosenfeld, A. and Wasserman, S. *Healing the Heart: A Therapeutic Approach to Disturbed Children in Group Care*. Washington, D.C.: Child Welfare League of America, 1990.
- Williams, M.B. "Post-Traumatic Therapy Fostering Trust and Empowering Survivors." *Moving Forward* 1(1992):8-9.

CASE MANAGEMENT

- Ayoub, C.C., Willett, J.B., and Robinson, D.S. "Families At Risk of Child Maltreatment: Entry-Level Characteristics and Growth in Family Functioning During Treatment." *Child Abuse and Neglect* 16(1992): 495-511.
- Crittenden, P.M. "The Social Ecology of Treatment: Case Study of a Service System for Maltreated Children." *American Journal of Orthopsychiatry* 62(1992):22-34.
- Friedrich, W.N., Luecke, W.J., Beilke, R.L., and Place, V. "Psychotherapy Outcome of Sexually Abused Boys: An Agency Study." *Journal of Interpersonal Violence* 7(1992):396-409.
- Lynch, W. "The Follow-Up of Abused Children: A Researcher's Nightmare." In *Family Violence. An International and Interdisciplinary Study*, edited by J.M. Ecklelaar and S.N. Katz. Toronto: Butterworths, 1978.
- Madansky, D. and Santora, D. "Pediatrician-Therapist Cooperation in the Treatment of Sexually Abused Children." *Child Abuse and Neglect* 14(1990):277-279.

OTHER RESOURCES

ACTION for Child Protection

4724 Park Road
Unit C
Charlotte, NC 28203
(704) 529-1080

American Professional Society on the Abuse of Children (APSAC)

University of Chicago
School of Social Service
Administration
969 East 60th Street
Chicago, IL 60637
(312) 702-9419

Association for Sexual Abuse Prevention (ASAP)

P.O. Box 421
Kalamazoo, MI 49005
(616) 349-9072
(216) 221-6818

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect

University of Colorado Health Services Center
Department of Pediatrics
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

Child Welfare League of America (CWLA)

440 First Street, N.E.
Suite 310
Washington, DC 20001
(202) 638-2952

Childhelp USA

6463 Independence Avenue
Woodland Hills, CA 91367
(800)4-A-CHILD or (800)422-4453

Clearinghouse on Child Abuse and Neglect

Information

P.O. Box 1182
Washington, DC 20013
(703) 385-7565

Community Leadership to End Abuse of Children (CLEAC)

2211 Riverside Drive
Suite 14
Ottawa, Ontario, Canada
K1H 7X5
(613) 738-0200

Military Family Resource Center (MFRC)

Ballston Centre Tower Three
4015 Wilson Boulevard
Ninth Floor
Arlington, VA 22203
(703) 385-7567

National Center for the Prosecution of Child Abuse

1033 North Fairfax Street
Suite 200
Alexandria, VA 22314
(703) 739-0321

National Center on Child Abuse and Neglect (NCCAN)

Administration on Children, Youth and Families
Administration for Children and Families
Department of Health and Human Services
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National Child Abuse Coalition

733 15th Street, N.W.
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Washington, DC 20005
(202) 347-3666

National Children's Advocacy Center
106 Lincoln Street
Huntsville, AL 35801
(205) 532-3460

**National Committee for Prevention of
Child Abuse and Family Violence**
332 South Michigan Avenue
Suite 1600
Chicago, IL 60604
(312) 663-3520

**National Council on Child Abuse and
Family Violence**
6033 West Century Boulevard
Suite 400
Los Angeles, CA 90045
(818) 505-3422
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**National Resource Center on Child Abuse
and Neglect**
American Humane Association
63 Inverness Drive, East
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