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SPECIAL ISSUE

TREATMENT EFFORTS IN CHILD ABUSE AND NEGLECT

—by Susan Kelley

The past decade has seen a tremendous growth in the number of programs and clinicians specializing in the treatment of child victims, adult survivors, and perpetrators of maltreatment. While empirical evidence on the prevalence, nature, causes, and impact of child maltreatment has increased dramatically in recent years, there is currently little research on the efficacy of treatment approaches for victims or offenders. Given the lack of research on the outcome of treatment, it is difficult to say with scientific certainty if our treatment of victims and perpetrators is successful. Until results of carefully designed, experimental intervention studies are available, clinical insights and expertise which have rapidly developed in recent years must guide clinical practice, and are the basis for the articles in this special issue. We look forward to the day when we can present a special issue on the results of treatment outcome studies.

The Editors are pleased to present *Advisor* readers with articles from several leading experts in the field of child abuse. Since space does not permit coverage of all of the treatment topics that warrant discussion, we have attempted to address clinical topics which have not previously received the attention they merit. Articles included address therapeutic day care for physically abused children and children from violent families, intervention with substance abusing families, treatment of boy victims of sexual abuse, identification and treatment of child perpetrators of sexual abuse, and assessment and treatment of adolescent sex offenders.

We plan to publish one special issue each year, and would like to hear what themes you would like to see addressed. Please let us know your suggestions for future topics and authors for *Advisor* articles and special issues.

Guidelines for *Advisor* authors are now available by writing to our national office. All submissions undergo a peer review to determine which submissions are most suitable for publication in *The Advisor*.

PHYSICAL VIOLENCE AND PRESCHOOLERS

THE USE OF THERAPEUTIC DAY CARE IN THE TREATMENT OF PHYSICALLY ABUSED CHILDREN AND CHILDREN FROM VIOLENT FAMILIES

—by Catherine Ayoub

Introduction

Epidemiological studies of the incidence of physical maltreatment of children have highlighted the magnitude of what is now recognized as a serious and pervasive social problem. In 1989, at least 1200 and perhaps as many as 5,000 children died as a result of maltreatment, and over 160,000 children were seriously harmed (U.S. Advisory Board on Child Abuse and Neglect, 1990). The consequences of physical child maltreatment affect the individual child in serious and long term ways that can impede psychological and social functioning throughout the life span. Physically abused children are at risk for impaired intellectual, social, and academic functioning. They show disorders such as depression, anxiety, and social withdrawal as well as hyperaggressiveness, acting out, conduct disorders, hyperactivity, and delinquency (Howes & Espinosa, 1985; Wolfe, 1987).

Working with maltreated children in day care requires several major changes in approach and curriculum.

In addition to those children who are abused themselves, Gelles (1985) estimates that 3.3 million children are exposed to parental violence each year. For children who witness violence within their families without being victims themselves, significant behavioral consequences include hypervigilance, secretiveness, aggressive or extremely passive behavior, and often intense and persistent anxiety. Finally, there is evidence that transgenerational transmission of patterns of physical violence is common in both of these groups of children (Rutter, 1989).

Although both clinical and research attention to child physical abuse predates attention to other forms of maltreatment, intervention and prevention, especially with young physically maltreated children, have been limited and their success variable. In studies of abusive families, post-treatment reabuse rates of between 18.5% and 66% have been cited (Herrenkohl, Herrenkohl, Egolf, & Seech, 1979; Ferleger, Glenwick, Gaines, & Green, 1988). Given these alarming figures, treatment for children who have endured or witnessed violence is a critical concern.

Family Centered Treatment Programs for Maltreated Children

Historically, the treatment of physical abuse reflects a variety of theoretical formulations, from early efforts based upon parental personality characteristics (Steele & Pollack, 1976) to ecological (Belsky, 1980) and ecobehavioral models (Lutzker, 1984) that emphasize the multi-faceted and multiply-determined contexts leading to physical abuse. Most of today's multi-faceted intervention programs contain components from a number of these theoretical frameworks. One group of programs that have incorporated a variety of approaches has been called "family preservation" or "family-centered" treatment programs. These diverse programs include as primary goals the development of community networks to support and enhance families in order to prevent out of home placement and to promote family reunification in situations where placement was unavoidable; they also serve as monitors for family violence and provide assessment of the impact of violence on children.

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Family-centered treatment programs have met with moderate success in treating violent families. Their two pronged approach includes a child focused intervention component, such as therapeutic day care or day treatment, and a parent and family outreach and intervention component. This article will focus on the therapeutic day care component of such programs.

Therapeutic Day Care Component of Family Centered Treatment

A therapeutic day care program component of the service network for children from violent homes is usually part of an intervention framework that includes services based on an ecological model, with the family and the larger social contexts as appropriate targets for intervention. Services may include a variety of components such as child and adult counseling, behavioral parent training, traditional case management services, values clarification, individual mental health services, groups focused on violence prevention, problem solving groups, crisis intervention strategies, and therapeutic day care. In an effort to support the child's development, many centers also offer a variety of services to children on site, including speech and language remediation, child development assessments, and mental health consultation. In an effort to intervene with parents and other family members, these centers provide directly or network to obtain drug treatment, mental health services including psychopharmacology consultation for adults, job training, assistance with housing, child nutrition and food supplement programs, advocates and shelters for battered women and their children, and medical services.

The component of this service network that is the focus of the present discussion is either a part time or full time therapeutic day care center for young maltreated children. Some programs also offer private kindergarten placement and after school programs for older children. Because many young children are in day care today, the placement of children in a therapeutic day care program can be seen as a normalizing experience. Therapeutic day care can provide physically maltreated children and children from violent families with a consistent and nurturing environment. It offers them an alternative to the violence they have experienced or witnessed at home. Secondly, it allows for ongoing monitoring of the child who may still be at risk for physical abuse.

The emphasis in most therapeutic centers is on infants, toddlers, and pre-school children. Kinard (1982) found that maltreated children under the age of 3 are likely to exhibit more emotional prblems than those maltreated at a later age; these younger children have fewer coping mechanisms for defending against stresses in their lives. Based on these findings and ongoing experience, teachers in these special classrooms work with individual children at the children's own pace to help them develop a nurturing relationship with a day-care teacher. The teacher is responsible for making the children feel safe, for giving them a sense of love and belonging, for acknowledging their feelings, as well as for intervening with them to limit aggression or withdrawal with other children and adults in the classroom. Their goal is to provide the vulnerable child with a holding environment in which the child can begin to feel safe and explore alternatives to the affective and behavioral responses developed within the violent context.

Dealing with issues in the therapeutic classroom. Working with maltreated children in day care requires several major changes in approach and curriculum. In the therapeutic classroom, child behaviors are viewed collectively, as patterns providing clues about a child's approach to the world. Because the child's experience has been out of the norm, her behavior does not often carry an expected meaning or follow a predictable cause. Rather, behavior is an adaptive reponse to a difficult emotional and physical environment. The child should be observed over time, so that the meaning and stability of particular behavioral sequences becomes evident. If the symbolic meaning of an act is understood, intervention to alter or extinguish it can be more effective. Once the meaning and adaptive function of the behavior is clear, activities are reframed to help children with their individual issues.

An important difference between therapeutic and normative day care is the continual need to think about what patterns of behavior mean to the child and how they are used by the child to cope with fears, anxieties, and expectations generated by the child's special life experiences. In contrast to early childhood programs for non-traumatized children, therapeutic programs do not focus on group activities or specific educational tasks. Rather, they emphasize monitoring the social-emotional state of each child and meeting safety and security needs so that the child can begin to develop and sustain basic trust and engage in positive social interactions with peers.

Security and safety issues. The most basic concerns of maltreated young children are security and safety. Physically maltreated children often approach normal environmental tasks with limited emotional resources. Trust in relationships is frequently impaired as a result of the child's expectation that the setting and the adults and children in it are unsafe —that is, that they may expose the child to physical assault, failure to have basic needs met, violent encounters between others, unpredictable anger, or erratic adult caregiving. Safety and security needs are the most basic of human needs; if these are not well met, the individual will focus on them, ignoring needs up the hierarchy such as the need for love and belonging. As a consequence, failure to meet safety and security needs impairs the child's ability to develop secure attachments.

There is increasing evidence of the early effects of maltreatment, particularly as they pertain to the development of insecure attachments (Crittenden & Ainsworth, 1989). The vast majority of maltreated infants (70-90%) form insecure attachments to their caregivers (Carlson, Cicchetti, Barnett, & Braunwald, 1989). Young maltreated children have also been found to demonstrate unusual patterns of attachment; they often mix up approach and avoidance behaviors, appear apathetic, exhibit stereotypies, and are prone to noncontextual aggression toward their caregivers. Instead of forming a single organized strategy for maintaining proximity to caregivers, maltreated children are characterized by a marked disorganization of behavior in response to caregivers as the children assess new relationships.

Crittenden and Ainsworth (1989) hypothesize that these seemingly bizarre patterns of attachment result when the caregiver becomes a source of fear. For some children the lack of trust, combined with fear for physical safety, produces high anxiety when they are exposed to anything new, or even in making routine transitions between activities. For others abuse creates an absence of normal anxiety about new situations. As a consequence, attention to the individual child's responses is paramount in working with the physically maltreated child.

In an effort to counter disorganization and mixed approach-avoidance behaviors, children need to be told clearly in words and actions that they will not be allowed to hurt themselves or their peers, and that no one in the center will be allowed to hurt them. Abused children repeatedly need to hear that they are safe. Consistency and clear, firm limit-setting is key in the development of a sense of safety and security. It is sometimes difficult for staff to feel comfortable disciplining children whom they know are victims of violence. For the child, lack of limits may be perceived as another form of abandonment and as confirmation that violence cannot be controlled — that the world is a dangerous place. Kind, clear, firm, nonphysical and developmentally appropriate limits are an important part of a therapeutic environment.

Other guidelines in the classroom include an awareness of the child's need for structure and space. Routines are comforting for most children. Routines can be particularly comforting for chidren from unpredictable environments. Rituals, for example, are often important coping mechanisms in unsafe environments. Seemingly insignificant items (a coin, a piece of paper) can become precious objects of transition between home and day care. It is important not to diminish their value or to insist that they be removed. Similarly, a child who tries to hide items in a pocket may need to be given a concrete reminder of the day care setting to carry home. Routine and verbal preparation which allow children to move through such transitions with knowledge of what to expect can be a vital element in building trust.

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However, the young child is often unable to transfer skills learned in one context to another. For example, children who become less hypervigilant in the classroom may not be able to reduce their hypervigilance when they go on a field trip or outside to play. Maltreated children treat each new situation with suspicion until they can learn that they are safe; such learning may take repeated exposure to experiences. This means that teachers spend a good deal of time helping children learn and relearn basic social interaction skills in new settings.

Attachment issues and adult caregivers. Children with histories of maltreatment, particularly those involved in or exposed to ongoing violence, may tend toward extremes in relationships with adults. For example, a child may cling indiscriminately to one adult after another or immediately climb into a stranger's lap. All of these patterns can be understood as ways of coping with deficits in children's primary intimacy relationships. It is important to offer children struggling with these issues opportunities to explore close relationships with day care staff. There should be one consistent primary caregiver in each classroom who is available to the child with reasonable reliability. It is particularly important that there be a consistent response to the child when anxiety or other signs of distress are displayed.

A primary aim of the therapeutic day care setting is to support and elicit the development of alternative patterns of attachment depending upon the interaction between the young child and a continuous day care teacher. The first goal of intervention is to develop a warm, caring relationship with the child; the second is to support and instruct parents so they may extend similar interactions into their homes. These two interventions are aimed at influencing the child's development of positive models of attachment.

Aggression and peer interaction issues. Main and George (1985) found that maltreated toddlers responded to distress in peers with aggression, anger, fear, or attempts at a mechanical comforting movement. In contrast to other children, maltreated children were less likely to display empathic or genuinely comforting behaviors toward distressed peers. In a therapeutic center, vulnerable children learn to interact with peers and begin to experience positive peer interactions within the safe day care environment; this is a new experience for many children whose siblings as well as parents use physical violence in family interactions.

Toddlers and preschoolers who experience and/or witness repeated violence are prone to express aggression toward peers and adults when they reach the middle of their second year. As a result, the classroom atmosphere can become over-excited and chaotic quite quickly. The combination of caring and clear limits for aggressive behavior help children learn appropriate patterns of interaction.

Support and consultation in the classroom. Teachers perform more effectively when they have a mental health professional with whom they can consult. Consultation should be ongoing and separate from the interaction between the teacher and the parent's therapist, child's therapist, or case manager. Here is an example of a child who was supported through the active work of her teacher and the mental health consultant in the therapeutic classroom:

> Two-year-old Monique was described by her teachers as overactive, unable to sit through a meal or join her peers in "circle activities". She became easily frustrated, but she pushed away anyone who tried to assist her. Instead, she would fall down and cry. Her teachers tried rewarding her for even small successes and minimized efforts to correct her, but there was no improvement.
>
> When observed by the mental health consultant, Monique was noted to be hypervigilant, monitoring anxiously the activities around her. She would position herself in the corner of the room, and when anyone approached, she would defend herself by surrendering, crying, and falling to the ground. It was discovered that this child lived in a very violent home. Her father battered her mother; several siblings had been placed in foster care because they had been maltreated by the parents. Monique also had an older sibling who behaved aggressively toward her. Her behavior in day care could be understood as survival efforts that she had developed to cope with her difficult home environment.
>
> In working with Monique, it was important to help her maintain the behaviors she needed to protect herself at home, while providing an experience of safety at the therapeutic center. Monique's place at the table was changed to a corner position, with the safety of two walls behind her. Circle activities were done in an ellipse with her place against the wall next to "her" teacher. When staff persons approached Monique, they announced their intentions and moved very slowly. Within several months, Monique was less fearful and more trusting, although she still reverted to her old patterns when new situations arose. Her mother made a decision to move to a shelter for battered women with her children. Monique continued in the program during this time and it seemed to serve as a stabilizing force for her. As Monique and her mother worked together each week during "parents' day" classroom visitation, Mrs. C. learned some of the techniques that the staff had used and was able to begin to rebuild her relationship with her daughter.

Parent Involvement in Therapeutic Day Care Settings

When children enter therapeutic day care, they do so as part of a family. One aim of family centered treatment is to enhance each parent's ability to care for their child by providing outreach, individual and group support, and casework services to the family unit.

Parents are included in the classroom on a regular basis. By using the teacher as a role model abusive parents begin to change their interaction patterns with their children. The most effective techniques for working with parents are: (1) direct work with each parent; (2) opportunity for continuous practice at exercising judgements about parent-child interactions followed by feedback offered in a non-threatening context; and (3) parent-child interactional models and examples that are simple and tailored to each parent's needs (Crittenden, 1983). For example, one center holds a weekly "parents' day" during which parents spend time in group activities. Parents attend a support group and group therapy meeting in the morning, move on to parenting skills groups to discuss and practice parenting skills, followed by a visit with their children in the classroom. With permission, parents, children, and teachers are videotaped during classroom visits. The adults have a hot lunch together once the children are down for a nap, followed by a review of the classroom interactions including viewing videotapes either with an individual therapist or in group (depending upon the parent's comfort level). In addition, many parents are engaged in individual and parent-child interactional therapies; parents are encouraged to use techniques learned during parent day in their individual sessions.

Another key rule surrounding parent interaction at therapeutic day care is that violence, including any form of physical punishment, is not allowed. Any evidence of physical punishment of a child, or physical encounters between adults, are immediately stopped. A center's active role in condemning violence and informing authorities when children are at serious risk should be made clear to parents at the outset. Active, honest discussion with clients is essential, as is the development of institutional steps to aid reporting and build support for parents within the protective services system. Parental involvement in the reporting process is recommended whenever possible. Parental involvement can serve as an important stimulus for a family to acknowledge that there is a problem.

Many families do not change their patterns of violence. Attrition from child abuse and neglect treatment programs ranges from 40% to 60%. However, recent research (Willett, Ayoub, & Robinson, 1991) indicates that families that show signs of violence, physical child maltreatment, and/or parent-child interactional difficulties on program entry can improve their family functioning if they can be persuaded to stay in treatment for at least two years. Families must be prepared for long-term intervention. Children in violent families need outside support and treatment as well as monitoring during this time of change to ameliorate the

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practitioners in the field.

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Review #2: by Louanne Lawson

Somewhere there is a teacher who is trying to find a readable, useful textbook for a child abuse course; or a professional, new to the field, who is trying to figure out where to start; or a director of a child protection team who is trying to figure out why it's not working; or a lawyer who is trying to figure out a doctor who's trying to figure out a social worker who's trying to figure out a nurse who's trying to coordinate a system. These people should read this book.

They are unlikely to read it cover-to-cover, although they could: it is information-dense without being pedantic. They are more likely to use it as a reference manual to address particular problems. Bross and his colleagues provide profession-specific role descriptions and discuss dynamics of group process with those roles in mind. They share their expertise in setting up new teams, evaluating existing teams, even fixing dysfunctional teams.

The New Child Protection Team Handbook's most useful characteristic is its specificity. A professional could make setting-related changes to one of the many protocols or checklists presented in the book and apply it to a client who just walked into the room. There is, of course, the risk that a well-meaning but unseasoned worker could use the guidelines as a "cookbook" and make mistakes avoided by those with better clinical judgement. On the other hand, the handbook makes information gathered by experienced practitioners accessible to us all.

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MOVING?

Please notify the office in plenty of time so you don't miss any issues of *The Advisor* or the *Journal of Interpersonal Violence.*

RECENT RELEASES

Knudsen, D.D., & Miller, J.L. (1991). *Abused and Battered: Social and Legal Responses to Family Violence.* Hawthorne, N.Y: Aldine de Bruyter. 232 pages. $43.95, $21.95 paperback.

Patton, M.Q. (Ed). (1991). *Family Sexual Abuse: Frontline Research and Evaluation.* Newbury Park, CA: Sage. 248 pages. $36.00, $17.95 paperback.

Holmes, R.M. (1991). *Sex Crimes.* Newbury Park, CA: Sage. 160 pages. $32.00, $16.50 paperback.

Hollin, C.R., & Howells, K. (1991). *Clinical Approaches to Sex Offenders and Their Victims.* Somerset, NJ: John Wiley and Sons. 329 pages. $74.95

ASSOCIATE EDITOR'S NOTE

Would you like to see The Advisor *publish critiques or comparative reviews of materials other than books? We have discussed augmenting our regular book review section to include reviews of such things as videotapes, workbooks, assessment instruments, manuals, prevention materials, board games, play therapy and interview aids, etc. related to child abuse and child abuse treatment. Would this be useful to you in your work? If so, is there any category of material you would recommend we review? Any feedback from the membership on these questions would be greatly appreciated. Please address your response to my address listed in the front of the newsletter. In addition, we are now publishing a list of selected recent book releases, beginning with this issue. (MC)*

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negative consequences of their home environment. The hope is that through a network of child- and parent-focused supports, children living in violent families can be cared for in positive ways as their parents change their lives.

Endnote: The example and some of the content of this article was published in: Ayoub, C., Grace, P., & Newberger, C. (1990). Working with maltreated children and families in day care settings. In S. Cherazi, M.D., (ed.), *Psychosocial issues in day care.* Washington, D.C.: American Psychiatric Press, Inc.

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WI	52	AL	32	DC	17	KS	8	SD	1

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