

**FAMILY THERAPY REVIEW**  
**Preparing for Comprehensive and  
Licensing Examinations**

Edited by

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## Child Abuse and Neglect

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### TRUTH OR FICTION?

- \_\_\_ 1. Unintentional physical harm inflicted upon a child is considered physical abuse.
- \_\_\_ 2. Sexual "experimentation" between children is never considered sexual abuse.
- \_\_\_ 3. Keeping a child out of school for an extended period without reason is neglect.
- \_\_\_ 4. Keeping a child in close confinement is a form of emotional, not physical abuse.
- \_\_\_ 5. Physical abuse is the most common form of child maltreatment.
- \_\_\_ 6. Because of the parent-child conflict that characterizes adolescence, children between the ages of 12 and 15 are at the greatest risk of child maltreatment.
- \_\_\_ 7. Domestic violence is a risk factor for abuse and neglect.
- \_\_\_ 8. Physically disabled children are at increased risk of abuse.
- \_\_\_ 9. Parents who use drugs or alcohol are at no greater risk of abusing or neglecting their children than non-substance-abusing parents.
- \_\_\_ 10. Abused and neglected children are at greater risk of developing substance abuse problems than are nonmaltreated children.
- \_\_\_ 11. The majority of sexually abused children develop psychiatric disorders.
- \_\_\_ 12. The support of a nonoffending parent mitigates the negative effects of child sexual abuse.
- \_\_\_ 13. "Parenting training" programs are recommended for physically abusive parents.
- \_\_\_ 14. Cognitive-behavioral treatment for child abuse and neglect aims to heal the "relational trauma" that follows child maltreatment.
- \_\_\_ 15. Play sessions may help a child who requires a safe, nonthreatening setting to express his or her feelings associated with being abused.

Many of our ideas about child maltreatment—physical abuse, sexual abuse, emotional abuse, and neglect—have changed over the past four decades since the mental health field began

the serious empirical study of child maltreatment following the seminal paper, "The Battered Child Syndrome," in the early 1960s (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). We used to believe that the visible signs of abuse, the bruises and broken bones, were the ones that mattered most. Now we know that the invisible psychic wounds can be even more damaging and can forever change a child's sense of safety in the world. We used to think the abuse of children by strangers was more likely and harmful than abuse suffered at the hands of a parent. We have since learned that **child abuse** happens most often within families, and that the rupturing of the trust between a child and an abusive family member is at the core of what makes abuse often so developmentally disruptive and emotionally devastating to the child (Sheinberg & Fraenkel, 2001). We used to worry more about the kids who responded to trauma with overt signs of distress. Now we are equally concerned about the child who appears unaffected.

Although we have made progress in developing a more sophisticated understanding of child maltreatment, many questions remain, such as the degree to which abuse and neglect are responsible for adverse outcomes in children versus the influence of other preexisting characteristics of the child or his or her social environment, or of the often disruptive, traumatic impact on the child and family of disclosure and the events that follow. Along with some of the key questions that persist, this chapter summarizes an already extensive literature on the definitions, risk and protective factors, effects, and treatment of child abuse and neglect. In keeping with the focus of this text, this chapter emphasizes a family systems perspective on abuse and neglect.

1. The study of child maltreatment began in the \_\_\_\_\_ with pediatrician Henry Kempe and colleagues' seminal paper, "The Battered Child Syndrome."
  - a. late 1940s
  - b. early 1950s
  - c. early 1960s
  - d. late 1970s

## HOW ARE DIFFERENT FORMS OF CHILD MALTREATMENT DEFINED?

Definitions of *child maltreatment* vary according to the perspective taken, whether it be legal, psychological, epidemiological, or medical (Erickson & Egeland, 1996). In this chapter, we present definitions adopted by child welfare organizations, reflective of the types of maltreatment reported to such agencies. These definitions are largely consistent with definitions used in research on the causes, effects, and treatment of child maltreatment later reviewed in the chapter. Below are the definitions of the four main types of child maltreatment: physical abuse, sexual abuse, emotional abuse, and neglect.

2. An evaluation of a case of suspected child maltreatment would be primarily concerned with:
  - a. evidence that proves the parent intentionally hurt his or her child.
  - b. whether the child has suffered harm.
  - c. evidence that proves the parent did not know what he or she was doing.
  - d. all of the above.

## 18. CHILD ABUSE AND NEGLECT

### Physical Abuse

Child *physical abuse* but unrealized infliction, such as hitting, punching, kicking

3. A mother threatens to harm her child if he does not have his homework done. This is an example of:
  - a. physical abuse
  - b. emotional, not physical abuse
  - c. physical abuse
  - d. psychological abuse

### Sexual Abuse

*Sexual abuse* refers to any sexual activity between a child and an adult, whether or not limited to intercourse or commercially exploited.

4. Which of the following is not a form of sexual abuse?
  - a. two children having sex
  - b. showing a child pornography
  - c. sexual activity between a child and an adult who has given consent
  - d. sexual activity between a child and an adult who has given consent

### Emotional Abuse

*Emotional abuse* is a form of child abuse that involves a caregiver's repeated and intentional infliction of emotional harm on a child.

- close confinement
- verbal or emotional abuse
- other or unknown

Locking a child in a room is a form of physical abuse (verbal or emotional abuse) and is classified as a form of child abuse.

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### Physical Abuse

Child *physical abuse* is the intentional or unintentional infliction, or the intended (threatened) but unrealized infliction, of physical harm to a child by an adult as a result of, but not limited to, punching, kicking, beating, biting, burning, or shaking (Wolfe, 1999).

3. A mother threatens her child that she will physically hurt him if he doesn't stop misbehaving. This is an example of:
  - a. physical abuse only if she ends up hurting her child.
  - b. emotional, not physical, abuse.
  - c. physical abuse, even if she does not act on her threat.
  - d. psychological maltreatment, not physical abuse.

### Sexual Abuse

*Sexual abuse* refers to any sexual activity with a person when consent is not or cannot be given (Finkelhor, 1979). Because a child is not capable of granting consent, any sexual activity between a child and an adult is, therefore, abuse. Child sexual abuse, thus, includes, but is not limited to intercourse, fondling a child's genitals, exposing a child to genitalia (exhibitionism), or commercially exploiting a child through pornography or prostitution.

4. Which of the following is *not* considered sexual abuse or sexual assault?
  - a. two children of the same age, nonaggressively touching each other's bodies
  - b. showing a nine-year-old boy pornography when he has asked to see it
  - c. sexual activity between a man in his thirties and a mature, thirteen-year-old girl who has given consent
  - d. sexual activity between a woman in her thirties and a mature, thirteen-year-old boy who has given consent

### Emotional Abuse

*Emotional abuse* is behavior that compromises the psychological health of a child. Although all abuse may exact an emotional toll on children, certain acts center on emotionally abusive intents and consequences. Sedlack and Broadhurst (1996) in the Third National Incidence Study of Child Abuse and Neglect (NIS) classified three types of emotional abuse:

- close confinement
- verbal or emotional assault
- other or unknown abuse

Locking a child in a closet (close confinement), repeatedly denigrating a child with insults (verbal or emotional assault), or intentionally withholding food or assigning excessive responsibilities (other or unknown abuse) are all examples of emotional abuse according to this classification system.

5. All of the following are considered forms of emotional abuse *except*:
- giving a child responsibility of caring for his younger siblings after school until his siblings go to sleep.
  - repeatedly calling a child a "worthless idiot."
  - depriving a child of emotional nurturance.
  - depriving the child of regular meals.

### Neglect

Commonly thought of as an act of omission rather than of commission (Dubowitz, Black, Starr, & Zuravin, 1993; Wolock & Horowitz, 1984), *neglect* occurs when children's basic needs are not met (Black, 2000). Although physical and emotional neglect are the two forms of neglect most commonly discussed, Zuravin (1991) has identified as many as fourteen types of neglect, ranging from educational neglect to refusal to provide mental health care.

6. All of the following are considered types of neglect *except*:
- keeping a child out of school for an extended period of time.
  - not providing proper medical care for a child.
  - not providing adequate food for a child.
  - locking a child in a closet.
7. The term *child maltreatment* encompasses the following forms of abuse and neglect *except*:
- sexual abuse.
  - emotional neglect.
  - medical neglect.
  - custody battles.

### HOW COMMON IS ABUSE AND NEGLECT?

National studies indicate that close to three million children are harmed or endangered by abuse or neglect each year in the United States (Sedlack & Broadhurst, 1996). According to this estimate, 42 out of every 1,000 children are abused or neglected annually, a rate 85% higher than a comparable study found a decade earlier (Sedlack & Broadhurst). Neglect is the most prevalent form of maltreatment, representing 60% to 70% of all reports in two of the most widely cited national studies of abuse and neglect (Sedlack & Broadhurst; U.S. Department of Health and Human Services, National Child Abuse and Neglect Data System [NCANDS], 2002). The second most common form of child maltreatment is physical abuse (19%–22%), followed by sexual abuse (10%–11%) (Sedlack & Broadhurst; U.S. Department of Health and Human Services, 2002).

### AT WHAT AGE ARE CHILDREN AT GREATEST RISK OF MALTREATMENT?

When all forms of maltreatment are considered, children between the ages of 6 and 8 are at greatest risk of endangerment or harm, followed by children between 9 and 14 years of age (Sed-

lack & Broadhurst, 1996). Children between the ages of 6 and 8 are at greatest risk of maltreatment, twice as likely to be endangered as the latter are more at risk. Neglect is quite rare (although

### WHAT ROLE DO GENDER DIFFERENCES PLAY IN RATES OF CHILD ABUSE AND NEGLECT?

In a recent study (U.S. Department of Health and Human Services, 2002), differences were found in the rates of child abuse and neglect between males and females. Although this difference was not statistically significant, males, reporting trends with being a male versus a female, were the characteristics of child abuse and neglect. Faller (1999) found that girls are less likely to be reported to child abuse centers, because they are less likely to be reported to child abuse centers (Putnam, 2002).

Although girls are at greater risk to receive serious emotional abuse, a greater risk of emotional abuse and gender also exist in physical abuse, whereas boys are at greater risk of physical abuse (Putnam, 2002).

8. Over the past decade, the rate of child abuse and neglect has:
- decreased by 85%.
  - increased by 85%.
  - increased by 15%.
  - not changed.
9. Children ages 6–8 are at the greatest risk of maltreatment.
- 2–4
  - 4–6
  - 6–8
  - 12–14
10. Which of the following is the most common form of child maltreatment?
- sexual abuse
  - neglect
  - physical abuse
  - emotional abuse
11. Which of the following is true regarding child abuse and neglect?
- Boys are less likely to be reported to child abuse centers with their parents.
  - Most perpetrators of child abuse and neglect are family members.

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lack & Broadhurst, 1996). However, the risk of specific forms of child maltreatment is different for children of different ages. For instance, although school-aged (ages 6–8) children are nearly twice as likely to be endangered or harmed by maltreatment overall than are infants and toddlers, the latter are more at risk of neglect (Sedlack & Broadhurst). As another example, sexual abuse is quite rare (although it does occur) for children younger than age 3 (Sedlack & Broadhurst).

### WHAT ROLE DOES THE VICTIM'S GENDER PLAY IN RATES OF CHILD MALTREATMENT?

In a recent study (U.S. Department of Health and Human Services, 2002), few gender differences were found in the kinds of maltreatment for which children are at highest risk. One of the differences found was that girls are much more likely to experience sexual abuse than boys. Although this differential is explained by a perpetrator profile made up of mostly heterosexual males, reporting trends suggest that the difference is likely exaggerated. The shame associated with being a male victim of sexual abuse leads to underreporting in boys. In their study of the characteristics of disclosure of children believed to have been sexually abused, DeVoe and Faller (1999) found boys to disclose sexual abuse less often than girls. Additionally, boys are less likely to be represented in psychiatric samples, upon which incidence rates are typically based, because they are more likely to enter criminal justice or substance abuse treatment centers (Putnam, 2003).

Although girls are more likely to experience sexual victimization, boys are at slightly greater risk to receive serious injuries when abused (Sedlack & Broadhurst, 1996). Boys are also at greater risk of emotional abuse than girls (Sedlack & Broadhurst). A relationship between age and gender also exists. Girls are at greatest risk of physical abuse during the ages of 12 to 15, whereas boys are at greatest risk between the ages of 4 and 7 (U.S. Department of Health and Human Services, 2002).

8. Over the past decade rates of child maltreatment have:

- decreased by 5%.
- increased by 10%.
- increased by 85%.
- not changed.

9. Children ages \_\_\_\_\_ are most likely to be the victims of child maltreatment.

- 2–4
- 4–6
- 6–8
- 12–14

10. Which of the following is the most common form of child maltreatment?

- sexual abuse
- neglect
- physical abuse
- emotional abuse

11. Which of the following may explain low rates of sexual abuse in boys?

- Boys are less likely to report sexual abuse because of the intense shame associated with their experience of victimization.
- Most perpetrators of sexual abuse are heterosexual men.

- c. While girls may come to the attention of the mental health system, where a history of sexual abuse is likely to be identified, sexually abused boys may be more likely to enter the criminal justice system as a result of their abuse-related difficulties.
- d. all of the above
12. When girls are between the ages of 12 and 15 they are most at risk of being physically abused, in contrast to boys who are most at risk between \_\_\_\_\_ years of age.
- a. birth and 3
- b. 4 and 7
- c. 8 and 11
- d. 15 and 18, similar to girls

### WHO IS MOST LIKELY TO ABUSE OR NEGLECT CHILDREN?

Unfortunately, statistics show children are most likely to be maltreated by one or both parents. Mothers acting alone represent 40% of all perpetrators of child maltreatment. Both parents acting together represent the second most common category of perpetrators (19%), followed by fathers acting alone (17%; U.S. Department of Health and Human Services). Family relatives (e.g., siblings, grandparents, uncles, and aunts) are perpetrators in only 5% of all cases, followed by substitute caregivers (e.g., child care workers and foster parents; U.S. Department of Health and Human Services).

In summary, one or both parents are involved in approximately 75% of all maltreatment cases. However, a closer look at the specific forms of child maltreatment alters the findings on the perpetrator's relationship to the victim. For example, while mothers acting alone were responsible for 47% of neglect victims, they were the sole perpetrator in only 4% of sexual abuse cases (U.S. Department of Health and Human Services, 2002). In summary, risk assessment and other preventive measures must look closely at patterns of perpetration with respect to specific forms of abuse and neglect, not only at summary statistics for all forms of maltreatment combined.

13. A child is most likely to be abused or neglected by:
- a. a stranger
- b. a mother acting alone
- c. a father acting alone
- d. both parents

### HOW ARE CHILDREN AFFECTED BY MALTREATMENT?

The effects of abuse and neglect range from short-term (for example, short-lived periods of hypervigilance, impaired attention, emotional upset, and disruptive behavior) to long-term sequelae (such as chronic attentional and affect-regulatory difficulties, substance use disorders, and depression). Effects may be pervasive, impacting emotional, psychological, cognitive, and behavioral functioning, or circumscribed to one or more aspects of functioning. Although varying types of maltreatment share similar psychological and physiological consequences, in part because maltreated children often experience multiple forms of abuse and neglect, there

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are effects particular to specific forms of maltreatment. For example, cognitive and language delays may be prominent in physically abused children, whereas the betrayal of trust central to sexual abuse may lead to a variety of relationship problems (Edgeworth & Carr, 2000). A few of the short- and long-term effects of child maltreatment are as follows:

- affective disturbances (e.g., PTSD, depression)
- behavioral difficulties (e.g., aggression)
- cognitive impairments/academic problems
- relational difficulties
- medical problems/neurobiological alterations

## WHY DOES CHILD ABUSE AND NEGLECT OCCUR?

### Risk Factors

In recent decades researchers have attempted to identify **risk factors** likely to contribute to the occurrence of child maltreatment. Current theories, such as ecological models of maltreatment (Belsky, 1980), stress multiple contributors, including child, parent, family, societal, and other factors correlated with increased rates of child maltreatment. Although we have used the term *risk factor* as it appears in the literature, it is important to recognize that these are *correlational* findings, not *causal* conclusions, and to recognize the still preliminary status of much of this body of research. Furthermore, when examining aspects of families or social groups associated with abuse, it is important not to conclude that it is the whole family, or social group, that places a child at greater (or lesser) risk. Below are a few of those factors believed to make maltreatment more likely to take place:

#### *Child Risk Factors:*

- temperament labeled as "difficult" (Black, 2000)
- physically disabled (Wescott & Jones, 1999)

#### *Parent Risk Factors:*

- deficits in child management skills (Kolko, 1996)
- Inappropriate developmental expectations of child (Kolko)

#### *Family Risk Factors:*

- domestic violence (Rumm, Cummings, Krauss, Bell, & Rivara, 2000)
- stress (Emery & Laumann-Billings, 1998)

### Protective Factors

With a vast empirical literature documenting the debilitating effects of child maltreatment on the emotional, psychological, behavioral, and social development of the child, it is difficult not to suppose a clear cause and effect relationship between child maltreatment and poor outcome. However, although negative sequelae have been repeatedly documented, maltreatment as the sole or dominant causal agent has not. Chief among the evidence suggesting mediating factors that influence the development of certain outcomes is the finding that not all children suffer



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to make reports "immediately" or "promptly," typically within 48 hours of suspecting child maltreatment.

### When Does a Report Need to Be Made?

Although guidelines vary according to state, a report is typically mandated when you have "reasonable cause to know, suspect, or believe" that a child has been abused or neglected (National Clearinghouse on Child Abuse and Neglect Information, 2002). This means your decision to report is not dependent on actual knowledge of the abuse. For example, if you observe a pattern of bruises on a child client and suspect physical abuse, even after the child has attributed the bruises to falling down, you are required to report your suspicion; you do not need the child, the parent, or a witness to verify that the bruises were the result of physical abuse. Therefore, you are not to play the role of a forensic investigator, but rather act on your suspicions when you encounter information suggestive of child abuse or neglect. This is not to say that you should not make inquiries (such as asking a parent if bruises resulted from corporal punishment) that would assist in determining if a report should be made. Your concern should be to obtain information that will determine *if a report should be made, not whether abuse or neglect has occurred.*

With the exception of one state (Minnesota), child abuse or neglect must be reported regardless of when it occurred. For example, if a thirteen-year-old reported an incident of sexual abuse occurring at the age of 4, it must be reported.

- 18. Four-year-old Oliver displays repetitive, developmentally inappropriate sexual themes while playing. When Oliver's therapist asks him if anyone has ever done these things to him, Oliver begins to cry and refuses to answer. The therapist should:
  - a. keep asking Oliver questions until he feels comfortable to speak
  - b. make a report if he suspects that Oliver has been sexually abused
  - c. ask the parents if they can offer insight into Oliver's behavior
  - d. none of the above
- 19. A twelve-year-old discloses in therapy that she was sexually abused at the age of 5 and that the relative who abused her moved out of state years ago. The therapist should:
  - a. not report the abuse because the child is no longer in danger
  - b. report the abuse, regardless of the perpetrator's whereabouts
  - c. only inform the child's parents of the abuse
  - d. none of the above

### What About Violating Client Confidentiality?

Although a therapist and patient are protected by laws of confidentiality, close to half of the States include provisions that certain privileges (such as confidentiality) do not negate the duty to report in cases of child maltreatment. Accordingly, marriage and family therapists, social workers, psychologists, and other mental health professionals are typically mandated by law to report child maltreatment, even if it involves a breach of confidentiality.

One way to lessen the impact of reporting abuse on one's therapeutic relationship with a child or family is to involve the child and family in making the report. In many cases, child welfare will mandate the child and family to therapy; if you are already working with the family

neglect to report, the rking with children. ples of professionals y mandate reporters

and can maintain a collaborative relationship in spite of the need to report, they may be able to maintain trust and a positive alliance with you.

20. A teacher notices that Anne, a nine-year-old girl, arrives at school every day appearing unwashed and in tattered clothing. Anne also usually "forgets" her lunch and is often absent from school. What should her teacher do?
- Report her observations to a child protection agency
  - Make an appointment to visit Anne's home to assess for signs of neglect.
  - Tell Anne that she needs to dress appropriately and remember to bring her lunch.
  - none of the above.
21. Suspected abuse or neglect should typically be reported:
- within 48 hours.
  - within 48 hours only if the child is in imminent danger.
  - within 7 business days.
  - when all of the important details have been gathered.

## HOW ARE CHILD ABUSE AND NEGLECT TREATED?

Because many of the effects of child maltreatment are long-term and may accompany a child into adulthood (e.g., depression, anxiety, interpersonal difficulties), treatment of child victims can be seen as preventive of chronic disorders as much as it is a treatment of current difficulties. Additionally, the prevention of further maltreatment is often a critical component of treatment due to the child's continued dependency on the very caretakers who abused or failed to protect them from maltreatment. Beyond a treatment focus on children and their parents, interventions may also extend to the entire family and even broader influences, such as the community and school setting. In this section we review various approaches to treating child maltreatment, starting with those approaches with the broadest scope, inclusive of family and community influences, to those primarily focused on the child or parents.

22. Treatment of child victims differs from that of adult victims because:
- Children often remain in the care of their offenders and therefore prevention of further maltreatment is critical.
  - Others (e.g., parents) are often the focus of treatment of child maltreatment, not the child victims.
  - It is more concerned with preventing, rather than treating, abuse-related problems.
  - All of the above.

### Family Therapy

A family systems approach to child maltreatment is based on the premise that abuse and neglect occur within the context of family relationships. The goals of **family therapy** in the treatment of child maltreatment are to restructure relationships and belief systems in the family to alter the interactional patterns that contribute to abuse and neglect (Carr, 2000). The development of positive communication and problem-solving skills help the family avoid hostile and conflict-laden interactions while enhancing support and cohesion. Not only does

a family approach address further maltreatment, addresses the relationship (Sheinberg & Fraenkel or even nonoffending addressed in a family bond between the abuser is a core goal of family child maltreatment is abuse in boys (Friedman & Kolko, 1996; Nicol,

23. Family therapy
- the offender
  - the offender
  - the family and
  - all of the above
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  - all of the above

### Family-Based B

Primarily effective in behavioral psychology as the outcome of positive abusive parents, who increasing the likelihood (2000) describes the as similarly reinforce escalating interaction taught how to identify or punishing negative amassed substantial Henggeler, & Whelan

25. Which of the following behavioral patterns
- a mother who
  - a child ignores
  - a mother ignores
  - none of the above

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a family approach attempt to restore healthy boundaries and effect other changes to prevent further maltreatment, but because parents are so often the offenders, a family systems approach addresses the relational trauma that often follows maltreatment, particularly sexual abuse (Sheinberg & Fraenkel, 2001). The betrayal of trust and safety between the child and offending or even nonoffending parent is a core experience for the child victim and one which can be addressed in a family-centered approach (Sheinberg & Fraenkel). Likewise, strengthening the bond between the abused child and nonabusing family members who can support her or him is a core goal of family therapy. Although data about the effectiveness of family therapy for child maltreatment is largely lacking, empirical studies have supported its efficacy for sexual abuse in boys (Friedrich, Luecke, Beilke, & Place, 1992) and for physical abuse and neglect (Kolko, 1996; Nicol, Smith, & Kay, 1988).

23. Family therapy may be indicated when:
- the offender is a family member.
  - the offender is not a family member.
  - the family engages in "rigid" patterns of interaction.
  - all of the above.
24. Treatment of child maltreatment using a family-centered approach is likely to prioritize:
- the restructuring of family relationships.
  - looking for unconscious meaning in the child's play during family sessions.
  - adjunctive psychopharmacological treatment.
  - all of the above.

### Family-Based Behavior Therapy or "Parent Training"

Primarily effective in cases of physical abuse, this approach is based on the principles of behavioral psychology in which the occurrence of physically abusive behaviors are understood as the outcome of positive and negative reinforcement. **Behavior therapy** targets high-risk or abusive parents, who may pay attention to their children only when they misbehave, thereby increasing the likelihood that the child will continue to display negative behaviors. Corcoran (2000) describes the child's compliance immediately following physical punishment or abuse as similarly reinforcing for the parent. Behaviorally based parenting skills aim to disrupt the escalating interactional parent-child patterns capable of resulting in physical abuse. Parents are taught how to identify, encourage, and reward positive behaviors in their children while ignoring or punishing negative behaviors (Corcoran). This problem-focused, short-term treatment has amassed substantial empirical support as an effective treatment of physical abuse (Brunk, Henggeler, & Whelan, 1987; Wolfe, Edwards, Manion, & Koverola, 1988).

25. Which of the following interactions would be of interest to a therapist working from a behavioral perspective?
- a mother who is frequently frustrated with her children's teachers
  - a child ignoring another child who is trying to get their attention
  - a mother ignoring her child when he is behaving appropriately
  - none of the above

## Cognitive-Behavioral Therapy

Like behavioral therapy, **cognitive-behavioral therapy (CBT)** is often a preventive approach for physical abuse. CBT targets the tendency of abusive parents to attribute negative intentions to their children's behavior (Acton & During, 1992) and who hold unrealistic expectations of what their children are capable of (Kolko, 1996). Enhancing communication and problem-solving skills in dealing with their children's behavior are equally important aspects of parent-focused CBT approaches. For example, a parent who responds only to their child when they are "out-of-control," might feel that even though they are reluctant to use physical force, it is the only thing that will work. Problem-solving skills help the parent identify problems early on (when less coercive interventions are more effective) and consider a range of interventions, as well as their potential impact. These CBT interventions help the parent better understand their child's motivations, delay impulsive responses, and feel that they have choices beyond physical punishment. CBT with physically abusive parents is empirically supported (Corcoran, 2000). Studies have found CBT to improve parenting attitudes, reduce child abuse potential, parenting stress (a risk factor for abuse), and parent aggression (Acton & During).

26. All of the following are goals of cognitive-behavioral therapy (CBT) *except*:
- communication skill-building
  - working on negative attributions
  - increasing problem-solving skills
  - pairing a maltreated child with a more resilient peer

## Resilient Peer Treatment, Therapeutic Day Care, and Residential Treatment

Whereas CBT and behavioral approaches primarily focus on preventing offending parents from engaging in further maltreatment, the developmental and other concerns of child victims are addressed by child-focused treatments. **Resilient peer treatment (RPT)** is a child-focused approach that addresses the developmental problems of maltreated children by pairing withdrawn, maltreated children with outgoing, resilient peers in daycare settings (Fantuzzo et al., 1996). Targeting the cognitive and social-emotional development of child victims, **therapeutic day care** provides intellectual stimulation in the context of child-teacher relationships (Edgeworth & Carr, 2000). Children placed in **residential treatment** programs visit daily with their parents and experience safe, positive parent-child interactions. These child-focused approaches have been found to be "particularly effective" in cases of physical abuse and neglect (Edgeworth & Carr).

27. Child-focused treatments such as therapeutic day care and residential treatment have been found to be primarily effective for:
- sexual abuse
  - physical abuse
  - emotional abuse
  - all of the above

The aforementioned treatments represent the dominant approaches to the treatment and prevention of child maltreatment. Other treatments include: "**social support**" and "**social network**" approaches that target the social isolation that often characterizes abusive and, in

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particular, neglecting families (Gaudin, Wodarski, Arkinson, & Avery, 1990–1991); **play therapy** which provides children with a safe, nonverbal medium for telling their story of abuse and expressing feelings in the familiar world of play (Gil, 1991); and pharmacological treatments aimed to decrease hyperarousal, distractibility, and other biologically based reactions to maltreatment (Schwarz & Perry, 1994). Future interventions may increasingly integrate a number of these approaches. A recent review (Edgeworth & Carr, 2000) of available treatments indicated that a combination of individual-, parent-, and community-focused approaches are "probably synergistic rather than antagonistic in their effects" (p. 44).

28. Frieda is a young mother who is frustrated with her one-year-old child because he's not yet toilet trained. Which of the following approaches are best suited for Frieda?
- family therapy
  - psychopharmacology
  - resilient peer therapy (RPT)
  - cognitive-behavioral therapy (CBT)
29. Offending parents are the focus of all of the following treatment approaches *except*:
- family therapy
  - behavior therapy
  - resilient peer therapy (RPT)
  - cognitive-behavioral therapy (CBT)
30. A child-focused treatment is indicated when:
- a child has developmental or other difficulties
  - the offender was not a caretaker or family member of the child
  - the offending parent is in adjunctive therapy
  - all of the above

## GENERAL CONSIDERATIONS AND PROCEDURES FOR WORKING WITH FAMILIES AND MALTREATMENT

Although each approach reviewed above offers suggestions about managing the treatment and therapeutic relationship, here we will underscore important issues and procedures you should consider when treating families in which there has been abuse or neglect. It is impossible to do justice to the complexity of these issues and subtlety of these procedures in the space available; we recommend you read Sheinberg and Fraenkel (2001) or our even more detailed manual (Fraenkel, Sheinberg, & True, 1996).

### Forming and Maintaining a Positive Therapeutic Relationship

Most of these families will have had contact with the legal and child welfare systems prior to meeting you, and likely have found these experiences intrusive and unpleasant, even if carried out by well-meaning, sensitive professionals. As a result of the report of maltreatment, children may have been removed from the parents' care and placed in foster care or residential treatment. Many may have been referred by the courts or social services, and some may be legally mandated for treatment. When children have been removed, treatment may be one of the preconditions of children being returned to the parents. In addition, you may be required to file periodic reports to the referring agent, and the family is likely to receive ongoing

supervision by these larger systems agencies until it is determined that the child is no longer at risk.

As the therapist, these referral conditions present you with particular challenges to forming a trusting relationship with the offending parent, who is likely now wary of "helping professionals," as well as with the child, who may be afraid that if he or she reveals any further abusive or neglectful incidents, or even any negative feelings about the parent(s) or other family members, he or she will get the family into further trouble. A few procedures help with forming a positive, trusting, and productive therapeutic relationship:

- Distinguish your role as therapist from that of professionals involved in the forensic investigation. Your role is not to collect further information for legal purposes, but rather, to help the child recover from the abuse and ensure that the family has the skills and understanding that will decrease likelihood of further abuse and increase safety and emotional security.

- On the other hand, be clear that you are a mandated reporter and are therefore required to report suspected maltreatment. It is also important that you be open about whatever requirements you have to file progress reports. It is recommended that you co-write such reports with the client family, which usually represents an empowering, collaborative experience for them. Even reports of suspected further abuse can be done with the family, increasing the chance that they will maintain their sense of trust in you through this trying event.

- Invite parents and children to describe the often traumatic events they've experienced since the abuse was reported and respond with empathy. Oftentimes, the disruption experienced by the family following disclosure is more on their minds than the abuse itself, which may have occurred weeks or months—sometimes even years—ago.

- Indicate clearly from the outset that although the focus of your work with them will be to create a safe, abuse-free family context that will benefit both the child and the parents, you invite them to talk about whatever is of concern to them, as the abuse is only one part of their life story. In addition, encourage them to tell you when they feel they've talked about the abuse as much as they feel they "comfortably" can for now (a procedure we've called "talking about talking"). Get used to moving from direct discussion of the abuse to other topics and back again, letting family members take charge of this process as much as possible. Invite the family to be "critical consumers" of the therapy—ask them to give you feedback on your work with them. This encourages a sense of clients' "ownership" of the therapy, especially important when they did not choose to enter therapy.

- Invite family members to talk not only about the story of the abuse, but also about their individual and collective stories of pride (Sheinberg & Fraenkel, 2001)—their strengths, talents, positive coping skills, and the good qualities of their relationships. By helping families locate and build upon these aspects of resilience and strength, they will be better able to look carefully at aspects of individual and family functioning that represent risk factors for abuse. Solely focusing on the abuse creates an overwhelming sense of shame that is likely to reduce family members' ability to stay in treatment.

### Bringing Forth the Complexity in Family Members' Feelings

As we have noted, abuse and neglect challenge the fundamental assumptions and emotions family members hold about themselves and others. The abused child often wonders how someone often loving and protective of her could be abusive towards her (or allow others to abuse her). She may find herself confused by seemingly incommensurate feelings of attachment

and love on the one hand, and beliefs and feelings of a lovable child, and on the other, an abusive parent may be. Others, overly punitive towards their daughter may be angry versus her loving and protective. How she can simultaneously feel disgust about his behavior and her for disclosing the truth sooner, even when the child is safe.

As the therapist, it is important to help the full range of the family's set of feelings (for the father to the neglectful mother) be a "both-and" rather than a "either-or." They need not resolve the complex story and tell a simple tale of good

### Distinguishing

It is important to recognize the resources of their behavior. A nonoffending mother's behavior does not mean encouraging the child at risk for further abuse. Helping parents develop behavior toward the child that does not undermine parents' full responsibility for

Significant progress in the treatment of child abuse is the ability to recognize risk factors, capable of the prevention of adverse effects. Most offenders are strangers to the child and neglectful of child maltreatment. Despite the questions such as why maltreatment. Should victims of maltreatment recover.

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and love on the one hand, and fear and anger on the other. In turn, she may hold widely different beliefs and feelings about herself: she may on the one hand see herself as a good, intelligent, lovable child, and on the other, as bad, flawed, and deserving of mistreatment. Likewise, the abusive parent may be confused about her capacity to be loving and protective at times, and at others, overly punitive and rageful. The nonoffending parent whose husband sexually abused their daughter may be torn between her feelings of love and attachment for the husband versus her loving and protective feelings for her child. She may have difficulty comprehending how she can simultaneously still care for her husband and at the same time feel anger and disgust about his behavior. Likewise, she may basically support her child yet be upset with her for disclosing the abuse, and may be consumed with guilt for not detecting the abuse sooner, even when it was well hidden from her by the offending family member and the child.

As the therapist, it is crucial that you encourage family members to experience and express the full range of their emotions about themselves and others, rather than focus solely on one set of feelings (for instance, attempting to "empower" the child to feel angry at her abusive father to the neglect of her equally powerful positive feelings). We find it most helpful to adopt a "both-and" rather than an "either-or" frame, and to help family members recognize that they need not *resolve* the conflicts among their various emotions. In other words, abuse results in a *complex story* and therapists need to honor that complexity rather than attempt to reduce it to a simple tale of good and bad, right and wrong.

**Distinguishing Between Moral Clarity and Psychological Explanations**

It is important to recognize that in helping abusive parents gain insight into the psychological sources of their behavior, this does not condone or excuse the behavior. Likewise, honoring a nonoffending mother's continued attachment to the sexually offending father and husband does not mean encouraging her to act on those attachments when doing so would put the abused child at risk for continued abuse. It is important for you as the therapist to recognize that by helping parents develop a useful and empathic psychological explanation for the offending behavior toward the goal of preventing such behavior in the future, you encourage rather than undermine parents' capacity to develop greater moral clarity about their behavior and to take full responsibility for it.

Significant progress has been made in recent decades in the identification, prevention, and treatment of child maltreatment. Advances in operational definitions have led to improved ability to recognize and report child abuse and neglect. Identification of risk and protective factors, capable of influencing a child's response to maltreatment, has been critical to early prevention of adverse outcomes in child victims. As empirical study has dispelled the myth that most offenders are strangers, preventive interventions have accordingly shifted from "don't talk to strangers" classroom lessons to programs that target at-risk parents, the typical offenders of child abuse and neglect. Finally, though limited in its scope, the empirical study of the treatment of child maltreatment has demonstrated that maltreated children and their families can benefit from therapy. Despite such advances, considerable research is needed to answer remaining questions such as which treatment approaches are most effective and for which types of child maltreatment. Should the current rate of progress be sustained, children will be less likely to be victims of maltreatment and those who do suffer abuse and neglect will be more likely to recover.

## KEY TERMS

**behavior therapy:** A treatment approach based on the principles of behavioral psychology in which abusive or neglectful behaviors are understood as the outcome of positive and negative reinforcement. A core component of this treatment is parent training (see *parent training* below).

**child abuse:** A term which encompasses all forms of abuse including physical, sexual, and emotional.

**child emotional abuse:** Behavior which compromises the psychological health of a child.

**child maltreatment:** A term which encompasses all forms of child abuse and neglect.

**child neglect:** Failure to meet a child's basic needs.

**child physical abuse:** Actual or threatened physical harm to a child.

**child sexual abuse:** Sexual activity with a child when consent is not or cannot be given.

**cognitive-behavioral therapy (CBT):** A preventive treatment approach which aims to restructure maladaptive beliefs and enhance problem-solving skills of abusive or at-risk parents.

**family therapy:** A family-centered approach which aims to restructure family relationships and belief systems which contribute to abuse and neglect.

**mandated reporting/reporters:** Professionals, such as mental health professionals and physicians, mandated by law in most states to report suspected child maltreatment.

**parent training:** A parent-focused, behavioral approach (see behavior therapy above) to physical abuse. To prevent the recurrence of maltreatment, abusive parents are taught basic parenting and problem-solving skills.

**play therapy:** A child-focused approach which allows the child to work through difficult and conflicted feelings associated with experiences of abuse and neglect in the safe world of play.

**protective factors:** Child, parent, family, and community factors which help buffer a child from the effects of child maltreatment. Protective factors also minimize a child's risk of being a victim of maltreatment.

**residential treatment:** A treatment approach involving placing a child on a special unit where he or she can experience structured, positive interactions with his or her parents who visit daily.

**resilient peer therapy (RPT):** A child-focused treatment approach that involves pairing withdrawn, maltreated children with resilient peers.

**risk factors:** Child, parent, family, and community factors which increase the likelihood that the child will be adversely affected by experiences of maltreatment.

**social support/social network treatment:** An approach which aims to decrease the social isolation that often characterizes abusive and, in particular, neglecting families.

**therapeutic day care:** A child-focused treatment approach which addresses the cognitive and social-emotional developmental concerns of maltreated children by offering intellectual stimulation in the context of supportive, child-teacher interactions.

## DISCUSSION QUESTIONS

1. Why is it important to have operational definitions of abuse and neglect that are consistent across professions?
2. How might information about gender differences in the experience of child maltreatment be useful to therapists who work with children?

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3. Identify three reasons why "mothers acting alone" represent the most common perpetrators of child maltreatment.
4. You are to evaluate a twelve-year-old boy who has been a victim of ongoing neglect. Based on your knowledge of the potential effects of child maltreatment, identify five questions you might ask to assess the effects of the neglect he has experienced.
5. Frank is to evaluate a family's level of risk for child maltreatment. Applying your knowledge of risk factors for child maltreatment, identify three questions Frank should ask the family.
6. Emily is a seven-year-old girl who has been the victim of ongoing physical abuse. Considering the *protective factors* described in the chapter, identify three treatment goals that would help mitigate the effects of the abuse.
7. Ellen is a therapist whose client has disclosed having "gone too far" while punishing her son with a belt. The client is very upset about the belt marks left on her son's body. The client expresses that she does not want this to happen again and asks Ellen to help her work on controlling her anger. Does Ellen need to report this incident? If she does, how could she maintain her positive relationship with the client? Outline the reasons supporting your decision, and the procedures Ellen could follow to maintain a therapeutic alliance with the client if she did decide to report.
8. Eve, a thirteen-year-old girl, disclosed to her mother that her stepfather has been sexually abusing her over the past year. Her mother wants to help her daughter but feels it is "too much to believe" that her husband "could do such a thing." First, how might a family-centered approach help this family? Second, identify two treatment goals that a family therapist might have for this family.
9. Identify three ways in which problem-solving skills may help a physically abusive parent better relate to his or her child.
10. Identify three ways to form a positive therapeutic relationship with a family that has been legally mandated for treatment.

SUGGESTED FURTHER READING

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One of the first papers suggesting an "ecological" theory of the cause of maltreatment. The child's family, community, and environment are among the multiple contexts in which abusive and neglectful behaviors are understood from this perspective.

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The National Incidence Study (NIS) bases estimates on information from more than 5,000 professionals who come into contact with abused and neglected children in a variety of settings. The characteristics of victimized children, the relationship of perpetrators to victims, and other informative statistics are presented.

Sheinberg, M., & Fraenkel, P. (2001). *The relational trauma of incest: A family-based approach to treatment*. New York: Guilford Press.

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**Multiple Choice Answers**

1. c
2. c
3. b
4. b
5. c
6. a
7. c
8. d
9. c
10. b
11. a
12. d
13. b
14. d
15. b

16. c
17. c
18. b
19. b
20. a
21. c
22. c
23. a
24. b
25. d
26. a
27. c
28. c
29. d

**CHAPTER 18****Truth or Fiction Answers**

1. T
2. F
3. T
4. T
5. F
6. F
7. T
8. T

9. F
10. T
11. F
12. T
13. T
14. F
15. T

**Multiple Choice Answers**

1. c
2. b
3. c
4. a
5. c
6. d
7. d
8. c
9. c
10. b
11. d
12. b
13. b
14. c
15. a

16. d
17. d
18. b
19. b
20. a
21. a
22. d
23. d
24. a
25. c
26. d
27. b
28. d
29. c
30. d

**CHAPTER 19****Truth or Fiction A**

1. F
2. F
3. F
4. F
5. F
6. T
7. T
8. F

**Multiple Choice A**

1. d
2. b
3. b
4. c
5. b
6. a
7. d
8. d
9. c
10. c
11. c
12. a
13. b
14. a
15. d

**CHAPTER 20****Truth or Fiction A**

1. F
2. F
3. T
4. T
5. F
6. T
7. F
8. T