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AN EVALUATION OF TWO TREATMENT METHODS RELATED TO IMPROVING THE PARENTING SKILLS OF ABUSIVE MOTHERS

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William E. Scheurer, Jr.

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Richard C. Johnson

Major professor

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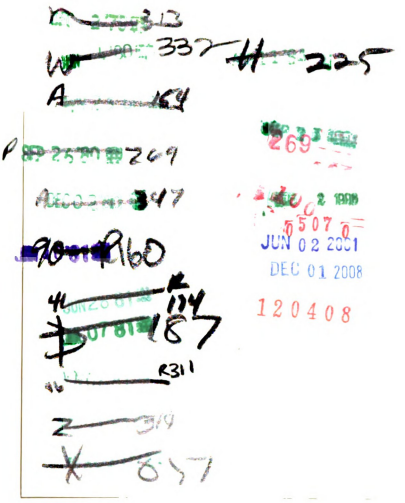
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AN EVALUATION OF TWO TREATMENT METHODS RELATED TO IMPROVING THE PARENTING SKILLS OF ABUSIVE MOTHERS

by

William E. Scheurer, Jr.

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ABSTRACT

AN EVALUATION OF TWO TREATMENT
METHODS RELATED TO IMPROVING THE
PARENTING SKILLS OF ABUSIVE MOTHERS

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William E. Scheurer, Jr.

The purpose of this study was to evaluate the effectiveness of a social learning therapeutic program for abusive mothers and their children. The program consisted of teaching these mothers (1) child development information, such as typical milestones, what kinds of behaviors are appropriate at certain ages, plus experiential homework assignments related to this area and (2) more effective behaviorally oriented child management skills, with an emphasis on non punitive techniques such as the use of positive reinforcement, extinction, shaping, etc. Experiential homework assignments were also included relative to the teaching of these skills.

Three basic areas were examined of both theoretical and practicial import in the treatment of abusive mothers: Will a behaviorally oriented treatment program have a more positive effect on (a) attitudes towards parenting? (b) the interpersonal relationship between mother and child? and (c) the self concept of the mother?

The rationale behind this program was that abusive mothers have a distinct lack of knowledge about child development and

effective child management skills, other than punishment. Parents who do not know how to reduce a child's crying, how to toilet train, etc., are driven to methods that only have short term advantages.

The social learning model on which this study is based has considerable power in the formulation of both causal agents and treatment strategies in child abuse. It requires the monitoring of specific behavior of both parents and child that ends in abuse. The idea is that if the immediate antecedents of abuse are properly identified, steps can be taken to modify the behavior they represent and possibly prevent abuse. Social learning theory is also useful for teaching parents how to modify their expectations concerning what the behavior of parents and children should be helping them learn more effective and non-punitive child rearing practices.

Twenty mothers of abused children were randomly assigned to either a behaviorally oriented treatment group (n = 10) or a client-centered treatment group (n = 10).

Thirteen therapists were also randomly assigned to treatment conditions. Seven women had 2 cases each and 6 women each had one case.

The behavioral treatment group consisted of directly intervening and focusing on the parent-child relationship. Activities included such things as teaching a mother how to use positive reinforcement instead of physical punishment. The client-centered treatment group consisted of allowing the casemother to discuss whatever issues may be bothering her in the context of an empathic

relationship with the therapist. No attempt was made to give direction to this therapy.

Hypothesis 1, that mothers who received the behavioral treatment will have more positive attitudes towards parenting, than mothers who received the client-centered treatment was measured by the Michigan Screening Profile of Parenting. It was tested using Small Sample t-tests and did not receive support. Results were in the predicted direction but not significant.

Hypothesis 2, that mothers who received the behavioral treatment will interact more positively with their child than mothers who received the client-centered treatment was measured by the Mother-Child Interaction rating scale developed for this study. Small Sample t-tests were completed on a pre and post test basis with no significant differences between or within groups obtained.

Hypothesis 3, that mothers who received the behavioral treatment will have a more positive self concept than mothers who received the client-centered treatment also was not supported. Small Sample t-tests were completed on the scores obtained from analyzing the Draw-A-Person Test according to a procedure developed by Goodenough and Harris (1963). The differences were however, in the predicted direction.

The failure to achieve statistical significance was examined in light of sampling, instrumentation, experimental manipulations, design and analysis, and theoretical considerations. The most probable non-theoretical explanations of the non-significant

results appear to be: (a) the conditions under which the measurements were taken, (b) the conditions which affected treatment implementation and (c) difficulty in keeping the treatments separate in each group.

Suggestions were made relative to future research efforts regarding various treatment modalities and consideration of procedures that are deemed necessary for the successful implementation of a child abuse program using volunteers. Such recommendations included: (a) designing clearer and more distinct treatment packages, (b) better standardization for evaluation and treatment implementation procedures, (c) more appropriate criteria for volunteer solution, training and supervision, (d) better evaluation methods, (e) who should be included in the treatment and (f) (f) insuring better working relationships between agencies.

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This dissertation represents the work of many different people. I wish to express my gratitude and warmest feelings for their help and support.

In particular I would like to thank Dr. Dick Johnson, whose incisive questions and research insight were instrumental in the development of this project. More importantly to me, his interpersonal warmth, genuine friendship, and patience made the tedious process of writing this study much more bearable.

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Another special person to whom I wish to express my gratitude is Ann Hallock, who assisted me in the selection and training of the parent-aides, and in locating appropriate cases for the treatments under investigation. I could not have completed the project without her.

To all the women who served as therapists in the study, a special debt of gratitude is owed. Their creativeness, enthusiasm and caring attitude toward their casemothers was a very special part of the program.

One person -- my wife Susan deserves special mention. She had the most difficulty task of anyone -- putting up with me. The last 4 years have been the most difficult period of my life and Susan's faith in me and our relationship make the earned doctorate as much hers as mine. I love her very much and look forward to our seeking out and meeting new challenges in the years ahead.

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CHAPTER I

INTRODUCTION

Need

Child abuse is increasingly being described as reaching epidemic proportions. It is recognized as a serious problem in Europe, Asia, Africa and Australia as well as North America (Justice and Duncan, 1975). In 1975, there were approximately 550,000 cases of suspected child abuse and neglect reported in the United States. Approximately 1 percent of American children are reported to be abused or neglected each year (Helfer and Kempe, 1976). There are also many cases that go unreported, especially the siblings of those who were reported. Therefore, the total percentage of those actually abused or neglected is undoubtedly higher.

Unlike most diseases where a cure or near cure is possible with time and relatively inexpensive treatment, the long term effects of child abuse and neglect are constantly with us in the form of retarded and disturbed children, learning disorders, behavior disorders, delinquency, teenage pregnancy, etc. The effects of abuse and neglect are cumulative.

Though the problem of child abuse has its roots in ancient history, it did not receive wide spread public recognition until 1961 when Kempe coined the term "the battered child" syndrome. Since that time, Kempe and Helfer have been leaders in defining the

problem. By 1975, there was convincing evidence that a turning point had been reached -- evidence that violence inflicted on children was beginning to be viewed as a public health problem which affected the entire society, not merely a medical and legal problem which affected individual parents and children. The federal government made long-term grants of millions of dollars available to programs designed to prevent child abuse, identify cases, and educate the community. The National Center on Child Abuse and Neglect was established with the signing into law of The Child Abuse Prevention and Treatment Act.

These developments seem promising, however so much remains to be done that a dent has hardly been made in the child abuse problem. Primary prevention programs, designed to keep abuse from occurring in the first place, are virtually non-existent. Secondary prevention programs, which focus on the treatment of parents to prevent repetition of abuse, are widely scattered and largely unevaluated (Justice and Justice, 1976).

Pessimism concerning the rehabilitation of parents who abuse their children still prevails; professionals and laymen alike have viewed abusing parents as beyond help (Gil , 1968). Individual psychotherapy has been described as unsuccessful and professional therapeutic efforts have remained limited. Reports of group therapy have also been lacking. Participants in treatment programs too often end up discussing better relations between and within professional agencies without addressing themselves to the abused child or the adults who are abusing him (Tracy and Clark, 1974). Hence,

professional opinions and both primary and secondary prevention programs with their corresponding evaluation seem limited.

Purpose

The purpose of this study was to evaluate the effectiveness of a social learning therapeutic program for abusive mothers and their children. The program consisted of teaching these mothers (1) child development information, such as typical milestones, what kinds of behaviors are appropriate at certain ages, plus experiential homework assignments related to this area and (2) more effective behaviorally oriented child management skills, with an emphasis on non punitive techniques such as the use of positive reinforcement, extinction, shaping, etc. Experiential homework assignments also were included relative to the teaching of these skills.

The rationale behind the development of this program was that abusive parents have a distinct lack of knowledge about the stages of child development, what children need at different ages, and more effective child management skills, other than physical punishment. Parents who do not know how to reduce a childs' crying, how to toilet train, what kind of behaviors they might expect from their child at certain ages, etc., are driven to methods that only have short term advantages. The goals of the program were: demonstrated ability in dealing with difficult child behaviors, increased use of positive methods and a more positively expressed attitude towards child rearing.

Hypotheses

H_1 Mothers of abused children, who have been treated with the Parent Education Program will have a more positive attitude towards child rearing than will mothers who were treated with the client-centered counseling program.

H_2 Mothers of abused children, who have been treated with the Parent Education Program will interact more positively with their child, than will mothers who were treated with the client-centered counseling program.

H_3 Mothers of abused children, who have been treated with the Parent Education Program will have a more positive self concept than will mothers who were treated with the client-centered counseling program.

Theory

Social learning theory is so named because of its concern with society's effect on the individual. The theory attempts to identify the psychological processes and techniques used to help individuals participate socially. Social learning theory has been outlined in a developmental context and psychologists, psychiatrists, and social workers have demonstrated how to apply learning theory to their fields (Bandura, 1969).

The social learning model has considerable power in the formulation of both causal agents and treatment strategies in child abuse. The model requires the monitoring of specific behavior of both parents and child that ends in abuse. The idea is that if the immediate antecedents of abuse are properly identified, steps can be taken to modify the behavior they represent and possibly prevent abuse. Social learning theory is also useful for teaching parents how to modify their expectations concerning what the behavior of

parents and children should be helping them learn more effective and non-punitive child rearing practices.

This program strived to move beyond diagnosis and etiological concerns to help abusive adults achieve competence in their roles as parents. In contrast to many popular theories that make assumptions about the pathology of abusing adults, a social learning analysis of child abuse makes the following observations:

1. Abusive adults have few skills to help them function competently as adults. They gain little satisfaction from their role as parents.

2. They control their children's behavior almost exclusively through punishment, because they lack knowledge of alternative means of controlling them.

3. Abusive adults have little knowledge in the area of child development so that the expectations they have of their children is grossly over estimated.

Review of Literature

Epidemiological Features of Child Abuse

Characteristics of the Abused Child

Child abuse is sometimes termed the "battered baby syndrome", suggesting that it is a problem involving infants and very young children. The problem most frequently occurred among children aged two months to three and-a-half according to Bennie and Sclare (1969) and Galdston (1975). But Gil (1970), found that only about one-third of the victims of abuse were under the age of three, while almost half were six or older. However, the first year of life remained the highest risk year -- approximately 13% of the cases occurred during the first 12 months. Recognition of child abuse as a

phenomenon of the older child -- the school child -- has been slow (Lynch, 1975). An explanation for this may be that although the most dramatic abuse occurs in the younger child, the most frequent abuse occurs in the school aged child. Somehow these children have been battered but managed to survive the high risk years.

Abuse definitely occurs among school age children as well as infants and babies. Most investigations, however, agree that the very young are at highest risk.

Six groups of children that are in special risk of abuse were identified by Bishop (1971). These include: (1) illegitimate children, (2) premature babies, (3) congenitally malformed babies, (4) twins, (5) children conceived during the mother's depressive illness, and (6) children of mothers with frequent pregnancies and excessive work loads. Justice and Justice (1976) found in their studies of abused children that one-fourth were born to depressed mothers and few (17%) were illegitimate.

Several studies in the United States, England and New Zealand indicate that the "average family size for abusing families substantially exceeds the national average" (Light, 1973). Gil (1970) reported that abused children were twice as likely to come from families with four or more children than was true for the population at large. At odds with these findings are reports from Bennie and Sclare (1969) and Justice (1975) stating that abused children are usually the youngest child or come from families with less than four children.

There is considerable evidence that children who are battered are difficult to care for and non-gratifying. These children often show disturbances of sleep and feeding, cry excessively and respond poorly to attempts to comfort them. A strong presumption exists that irritable babies, premature babies, hypersensitive babies, colicky and unresponsive babies are especially vulnerable (Harrington, 1972). The literature implies that even normal parents may abuse a particularly irritating or difficult child (Justice and Duncan, 1975). Martin (1972) and Flynn (1970) both state that the aggressive or obnoxious child would invite abuse from the most well adjusted of parents. No lasting physical effect on the children was expected in 90% (Gil, 1970) and 95% (Justice, 1975) studies on abused children. Most research also reports that one specific child is the target of abuse in an overwhelming percentage of abusing families (Thompson, 1971).

Physical, Neurological and Intellectual Characteristics of Abused Children

Little is known of the development of abused children. Mortality and gross morbidity are documented primarily in terms of mental retardation and severe brain damage. However, many theoretical generalizations about the development of abused children lack adequate substantiation. For example, is it true that abused children are difficult from birth and therefore provoke abuse? What is the prognosis for children with poor physical growth? What effect does the abuse or the abusive environment have on neurologic,

cognitive, social and emotional development of the child? These questions are only partially and tenuously addressed in the literature.

In a study by Elmer (1967) which placed emphasis on the morbidity of children who had been abused in the past, several tentative conclusions were drawn. Thirty percent of the abused children weighed less than 5½ lbs. at birth, suggesting that children who are more difficult to care for from the time of birth are more vulnerable to abuse. At the time of the study, one third of the children were below the third percentile for height or weight and slightly over 30 percent had signs of central nervous system damage. In addition, 57 percent had an intelligence quotient of 80 or less. The researchers recognized that their sample was small but insisted that the findings on these 52 children who had had multiple bone injuries was impressive. Of the 33 children who were seen in a follow up evaluation, the morbidity was 88 percent judged by the parameters of marked physical defects, mental retardation, serious speech problems or emotional disorders.

In 1968, the Denver Department of Welfare published a study of children with inflicted injuries. Of the 97 children, based on observations by child welfare workers, this study showed that nearly 70 percent of the children exhibited some physical or mental deviation prior to the reported injury, 20 percent were considered uncontrollable with severe temper tantrums, 19 percent were delayed in speech development and 17 percent showed mental retardation or learning disabilities. The children under 5 years of age were

described by welfare workers in terms such as whiney, fussy, chronically crying, demanding, stubborn, etc. One half showed indications of malnutrition or failure to thrive. The children over 5 years of age were seen typically as gloomy, unhappy or depressed. Conclusions drawn by the researchers include the following: abused children are difficult to care for and non-gratifying; the most likely target for abuse was a child who was overly active or who presented great problems in regard to supervision of physical care. The data in the report do not substantiate that these behaviors were congenital or characteristics of the children before the abuse occurred.

A follow up study was completed by Morse (1970) of 25 children who had been hospitalized 3 years previously for injuries judged to be the result of abuse or gross neglect. During that 3 year period, one third of the children were again neglected or abused. Only 29 percent of the children were within normal limits intellectually and emotionally at the time of the follow up: 42 percent were considered mentally retarded and 28% were significantly emotionally disturbed. Ten of 19 children were below the tenth percentile in height and weight.

Martin (1972) reported a 3 year follow-up study of 42 physically abused children. The evaluation included physical measurements, neurologic examination and developmental assessment. Thirty three percent of these children were found to be "functionally retarded", or IQ below 80. Forty three percent had neurologic damage, which was 3 times more frequent in children who were functioning in the retarded range than those with normal IQ's.

A history of skull fracture or subdural hematoma was found more than 4 times as frequently in the retarded as in the non-retarded children. Finally, 43 percent of the children with normal intellect had language delay, defined by language scores 15 or more points lower than their full scale or performance scores on formal testing.

In summary, the past research has provided little information about the fate of abused children. Appropriately, initial concern was with the mortality of this syndrome. While mortality and significant intellectual and neuromotor handicap have been well documented, the more subtle effects of child abuse have been primarily the subject of speculation.

A study which addressed this problem was completed by Martin, Beezley, Conway and Kempe (1973) who attempted to determine the physical, neurological and intellectual outcome of 58 children, who had been abused by their caretakers. It was found at a mean of 4.5 years after abuse 5 percent were microcephalic and 31 percent had heights and weights below the third percentile. Fifty three percent of the 58 children had some neurologic abnormalities, of which 31 percent were moderate to severe, 19 percent of the children had low birth weights, but, with one exception, these children were neither mentally retarded nor brain damaged. With regard to intellectual performance, the scores of the children with a history of head trauma and/or present neurologic impairment were significantly lower than the scores of the rest of the sample. However, when the influence of known brain damage was eliminated, environmental factors were found to be significantly related to IQ scores.

Furthermore, the authors contend that children who have been abused have experienced a variety of potentially detrimental influences in addition to the actual abuse. This includes a high frequency of home changes and the stability of the home -- such as unemployment, excessive disorganization, excessive use of physical punishment, etc. The implications of the study are stated in terms of treatment. The first priority must be that the child does not return to a family where abuse might recur. Additionally, the child should not be returned to an environment that has not changed but continues to be a damaging milieu, with family instability, punitiveness, deprivation, neglect, poor nutrition or emotionally disturbed parents. An attempt must be made to improve that environment and to insure that the child does not continue to live where his subsequent growth and development will be impeded and distorted.

Characteristics of Abusive Parents

Relationship to Victim

A considerable amount of epidemiological data on the characteristics of abusing parents was collected by Gil (1970). He found that 86.6 percent of the perpetrators of child abuse in his sample were parents or parent surrogates. The mother or mother substitute inflicted the abuse in 47.6 percent of the cases; the father or father substitute did so in 39.2 percent. In a study by Justice and Justice (1976) the mother was the perpetrator in 50 percent of the cases while the father was the perpetrator in 45 percent of the cases.

In the Gil study, 71.1 percent of the abuse was committed by biological parents, 13.6 percent by stepparents, 0.4 percent by adoptive parents, and 14.9 percent by foster parents, siblings, relatives or persons whose relationship to the victim was unknown. Furthermore, in Gil's sample, the child's biological father lived in the home in 46 percent of the cases; in almost one-fifth of the cases, a stepfather was in the home. The child's biological mother was not present in 12 percent of the cases, and no female was present in 1.74 percent of the cases.

Sex of Abuser

Gil's findings indicated that the perpetrator of the abuse was more likely to be female than male. Zalba (1971), however, found an even split between male and female abusers. In 50 out of 57 cases reported by Steele and Pollack (1969) the child's mother was the abuser. Gil (1970) however, notes that 29.5 percent of the children in his study lived in fatherless homes. Fathers or father substitutes were the perpetrators in approximately two-thirds of the incidents that occurred in homes containing a male parent. Thus in Gil's study, men perpetrated the abuse more often than did women, when a male parent was present: this finding is supported by data in the study completed by Justice and Justice (1976).

Age of Abuser

Most abusers range in age from 20-40, the typical child bearing, child rearing ages. Again Gil (1970) found that 71.2 percent of the mothers or mother substitutes and 65 percent of the fathers or father substitutes were in this age bracket.

Socioeconomic Factors

Bennie and Sclare (1969) reported that eight out of ten cases in their study were in low-income families. Seventy-seven percent of the fathers in Gil's sample were skilled or semi-skilled; 9.5 percent were white collar workers or professionals, and the occupations of 13.5 percent were unknown. Thirty-nine percent of the mothers were employed, 68.3 percent in skilled or semi-skilled jobs and 12 percent in white collar or professional jobs. Thus there is a general pattern of low occupational status among parents involved in reported cases of child abuse. It must be pointed out that reported cases of abuse give a misleading impression as to the socioeconomic and educational status of persons who inflict violence on children. This is so because "upper class" persons are able to get help from private doctors who are sometimes willing to let the abuse go unreported, while lower class persons must go to the public hospital, which is required to make a report. Although private physicians are required to report cases of abuse, they are less likely to do so. This would also seem to distort some of the data previously presented related to IQ and other physiological characteristics of abused children and their correlation to socioeconomic status.

Gil (1970) also found that 60 percent of his sample families received or had received public assistance. This finding is substantiated by Light (1973) who found that "the variable that shows up most frequently as somehow related to child abuse is father's

unemployment". This finding confirms a widely held theory that family stress related to unemployment ties into incidence of abuse.

Educational level usually finds abusive parents to have a high school diploma or less in about 75 percent of the cases (Gil, 1970; Justice and Duncan, 1975).

Sixty-five to eighty-five percent of the abusive parents are Caucasian and 15-25 percent are Black.

Emotional History

Abusive parents, by definition have problems concerning effective parenting. This may be related to lack of information and cognitive skills or to emotional factors. This difficulty has been described by Kempe (1975) as "serious problems in mothering". The emotional adjustment of these parents extend to areas outside of parenting and predate adulthood. Many histories of abusing parents include mental illness, juvenile court experience, criminality and foster home placement (Gil, 1970). There is also substantial data to state that these parents were also beaten as children themselves by their caretakers (Gil, 1970; Justice and Duncan, 1975). Deprivation of some type, but physical abuse or otherwise is found in approximately 85 percent of the sample cases. Social and behavioral deviance appeared in almost 43 percent of the mothers and 45 percent of the fathers (Gil, 1970). The percentage of severe emotional disturbance appears to be approximately 5 percent (Kempe, 1971).

Other Personality Characteristics

A profile of the abusing personality includes features such as isolation from others, poor self image, a high need for nurturing and a tendency to discount the importance of problems and solutions as well as other people and feelings.

Abusing parents lack support from family and friends. They are unable either to use or to help others (Helfer, 1968). Furthermore, they "have no one they feel they can turn to for advice or help, and have few social contacts that might be developed as a resource" (Justice and Duncan, 1975). It is also difficult for abusing parents to give and receive love in a normal manner due to the deprivation or abuse in their own childhood. They frequently choose mates with similar backgrounds and emotional difficulties (Justice and Justice, 1970, and Justice and Duncan, 1975).

These parents also have unrealistic expectations concerning their children. They seek satisfaction of unmet needs for comfort and nurture from their own child. These unmet needs for love and comfort are highly significant factors in the personality profile of abusive parents and underlie the high demands they place on their childrens' behavior. These demands for performance are not only great but are premature, clearly beyond the ability of the child to comprehend what is wanted and to respond appropriately. Parents deal with the child as if he were much older then he really is (Steele and Pollack, 1968). Often times, this translates into the parents behaving like children themselves and wanting their children

to act like parents. This phenomenon has been referred to as role reversal (Morris and Gould, 1963; Helfer, 1968).

This same pattern can be found in the abusive parents' family histories. Furthermore, it appears that the grandparents, too, were subjected to a constellation of parental attitudes similar to those previously described (Steele and Pollock, 1968). This pattern has been referred to as a "script for behavior" by Justice and Justice (1975) that has been transmitted from parent to child for at least three generations. Solomon (1973) offers a composite picture of the demographic features of the abused child and of abusing parents.

Abused Child

1. Average age is under 4 years; most are less than two.
2. Average death rate ranges from 5 to 25 percent; average age at death is slightly less than three years.
3. Average duration of exposure to abuse is one to three years.
4. Child's sex is not a factor.

Abusive Parents

1. Overwhelming majority are married and living together when abuse occurs.
2. Average age of abusive mother is 26; average age of abusive father is 30.
3. Father is the abuser slightly more often than the mother.
4. Mother commits the serious abuse more often than the father.
5. Most common instrument of abuse is the hairbrush.

Family Dynamics

1. Thirty to 60 percent of the abusing parents say they were abused as children.
2. High proportion of abused children were conceived before their parents' marriage.
3. Parents tend to marry young.
4. Parents tend to be socially isolated.

5. Forced marriages and unwanted or illegitimate pregnancies are common.
6. Financial difficulties are prevalent.

Setting, Circumstance, and Type of Abuse

According to Gil (1970) the most common location for child abuse is in the child's home. Abuse occurs more likely in a crowded home, in one in which the family is large or one in which unemployment is a problem. An excessive amount of environmental change and the constant readjustments it requires a family to make, often leaves the family without resources to bail itself out. Nearly all (85 percent) of the couples in the sample of Justice and Duncan (1976) had lived in their present home for less than one year at the time of the reported abuse.

Dinnertime appears to be the most frequently found period in which abuse occurs (Gil, 1970; Justice and Duncan, 1976). With regards to the circumstances surrounding the abuse, Thompson (1971) found that 57 percent of the incidents were an immediate or delayed response to a specific act of the child such as crying, wetting the bed, normal developmental problems. Serious misconduct on the part of the child such as stealing, fighting resulted in abuse in only 10 percent of the cases. The most common injuries appear to be welts and bruises, which were inflicted by hand or with instruments (Gil, 1970; Justice and Duncan, 1976).

In summary, abuse is most likely to be inflicted upon a young child, in his home, by his parent(s), who beat him in response to his behavior.

Causal Models of Child Abuse

A review of theories related to the causes of child abuse results in findings framed in terms of eight models: the psychodynamic model, the character trait model, the family structure model, the environmental stress model, the mental illness model, the social-psychological model, the psychosocial systems model and the social learning model.

A basic question involved in causation is whether people abuse children because they are driven by environmental pressures and the provocation of a child or they are predisposed to abusive behavior by psychological forces at work from within.

Each model contains a central core of determinants that is considered basic to causation. These determinants are viewed as sufficient to explain the occurrence of abuse and will now be reviewed according to each theoretical framework.

Psychodynamic Model

One of the earliest theories of child abuse relies on psychodynamic determinants to explain the problem. The lack of a "mothering imprint" or in other words, a person has been reared in a way, that precluded the experience of being mothered and nurtured is seen as the basic dynamic of the potential to abuse (Kempe, 1971). Thus, an incapacity exists in the adult's ability to mother or nurture his own child. Combined with this inability to nurture is an interplay of other dynamics: a lack of trust in others, a tendency towards isolation, a non-supportive marital relationship and excessive expectations toward the child.

One distinguishing feature of the psychodynamic model is that is assigns a secondary role to everything except the individual internal psychology. For example, subscribers to this model note that child abuse occurs in all socioeconomic classes. Poor people live under greater stress than persons with greater income, but if stress alone explained child abuse, then what explains the fact that the vast majority of lower income individuals do not harm their children?

No matter how much environmental stress there is, the act of abuse will not occur unless the psychological potential is present. This is an important implication of the psychodynamic model. That potential rests largely on whether a person was mothered as a child and thus acquired the ability to mother.

The psychodynamic model also gives recognition to a process referred to as "role reversal"; the parent expects the child to act like an adult and give the parent love and care rather than vice versa (Morris and Gould, 1963). The reasons for this behavior are stated in terms of the parents' own childhood, when his parents did not provide him with sufficient mothering and care and his needs for dependency were therefore unfulfilled. Often times abusing parents see their own rejecting mother or father in their child (Galdston, 1965). This again is a psychodynamic determinant of child abuse.

Many investigations (Spinetta and Rigler, 1972) have adopted the view that the adult who abuses demonstrates the kind of behavior he/she received as a child. This is possibly a partial explanation for the problem expression taking the form of violence in child abuse rather than in other kinds of disturbed behavior.

Character Trait Model

The character trait or personality model is similar to the psychodynamic one. However, the character trait model pays less attention to the factors which underlie the traits of the person who abuses. Labeling is used frequently to describe the way a person is. Thus, descriptions such as "parents who abuse their children are immature", or "impulse ridden" are included in this model (Spinetta and Rigler, 1972). Other terms used to portray abusive parents are "chronically aggressive", "suspicious", "distrusting and highly frustrated" (Melnick and Hanley, 1969; Sanders, 1972).

One author divided abusive mothers and fathers into three groups according to their psychological characteristics (Merill, 1962). The three groups were: chronically hostile and aggressive, rigid and compulsive, and passive-dependent. He further described people in these groups as in conflict with the world in general, lacking in interpersonal warmth and depressed and unresponsive as well as immature.

Identifying the personality or character traits that are typical of an abusing parent is likely to end up as a form of labeling unless they are associated with the context in which abuse occurs and the reasons the traits are present. In addition, description implies nothing about causality. Many people can be "branded" impulsive and immature but don't beat their children, thus there are limitations to this model unless considered in a larger context of environmental influences and the part the child may play in the abuse.

Family Structure Model

Although family systems concepts and family theory have not focused on the problem of child abuse, they offer considerable promise in terms of explaining the causes of abuse and designing therapeutic interventions. The model concerns itself with family alliances, coalitions, enmeshments and disengagements among family members. An example of how coalitions function in the area of child abuse is the following: a parent who sides with one child against the abused child or both spouses who side against the abused child (Gelles, 1973). Other arrangements in family structure may also result in abuse, such as a mother who is so invested in her child that her husband feels totally neglected and takes it out on the child in the form of physical abuse.

Scapegoating is another behavior often cited as resulting in abuse (Blumberg, 1974). Although the term may apply when a parent takes out his frustration on a child, it can also be used to describe the power struggles a child gets caught up in on an alliance that one spouse resents and makes the child pay for through physical injury. In addition, many cases of abuse find the father on the periphery in terms of his involvement with managing the children. This leads to resentment on the part of the wife toward both her husband and child. Since it is the child who demands her time and attention and is the easiest and most accessible target for her resentment, he is the one who gets hurt.

Environmental Stress Model

Gil (1970) sees child abuse as a multidimensional problem and places heavy emphasis on stress as the cause. He indicates that chance environmental factors such as poverty, poor education and occupational stress lead to abuse. These difficulties weaken the poor person's self control and result in violence against his own children. He advocates sweeping programs to educate the poor, improve their parenting skills and cure poverty as the answer for child abuse. It has been pointed out however, by Spinetta and Rigler (1972) that this explanation still does not answer the following question: Why do some parents abuse their children while others do not under the same stress factors? In addition, there are cases of abuse that occur in higher-income families, which have the resources to conceal abuse and deal only with the private section of the health delivery system, where child abuse is grossly under-reported. Obviously, when this demographic level is taken into consideration, the environmental and economic stress model alone is not enough to explain child abuse. A less adamant position was taken by Gil (1975) when he emphasized that poverty, per se is not a direct cause of child abuse in the home, but operates through an intervening variable, namely concrete and psychological stress and frustration.

There are other researchers who subscribe to the environmental and economic stress theory. According to Fontana (1964) child abuse is directly attributed to today's poor quality of life, increase in drug addiction and alcoholism. It is also argued that

intra family violence is more common among the working class and that child abuse is part of the style of physical discipline that poor people use (Steitmerly and Strauss, 1971). Again, this theory does not take into account the fact that most poor people, despite stress or style of discipline, do not physically abuse their children.

Mental Illness Model

Child abuse seems unthinkable to many people, and there is a tendency to regard the guilty as sick or mentally ill. However, the mental illness model really applies to only a fraction of abusive parents. The overwhelming majority of them do not suffer from hallucinations or delusional systems, which characterize what is regarded as psychosis or mental illness. According to Kempe (1971) no more than 5% of abusive parents are psychotic.

There are however, fairly frequent references to emotional disturbances, psychopathology, character disorder, personality disorders, and neuroses. Even before child abuse was identified by Kempe in 1961, other researchers used this terminology. Twelve infants with multiple fractures were studied by Woolley and Evans (1955), and it was found that they came from households with what was considered a high incidence of neurotic and psychotic behavior. The implication was that only a mentally ill parent willfully inflicts physical abuse on a child.

Since then, mental retardation and organic brain disturbances have also been suggested as the cause of some cases of abuse. Brain research indicates that the limbic system may be disturbed in

some people who are excessively aggressive and show tendencies toward violence (Lord and Weisfeld, 1974). Whether this disturbance accounts for some child abuse is still an open question. The fact remains that everything from neurosis to organic brain dysfunctions is included in the American Psychiatric Associations Diagnostic and Statistical Manual II and are classified as mental disorders. In this case, some psychiatrists and other physicians argue that abusive parents are mentally ill. However, investigators such as Zalba (1971) conclude that abusive parents do not easily fit any psychiatric classification. It is further noted by Freedman (1972) the difficulty in characterizing by use of psychiatric diagnosis parents who physically abuse or neglect their children. The attempts that have been made invariably reflect the use of skewed samples. When etiologic implications are attempted it is usually found that the incidence of psychosocial problems occur with the same frequency in other groups of parents as well as the abusive ones.

When is the term psychotic appropriate? The parent who does cruelly sadistic things to a child or batters the child unmercifully may appropriately be called mentally ill. Parents who torture a child with cigarette burns, who bite the child or administer bizzare punishment may well be behaving in response to hallucinations or crazy delusional systems. It is noted by Laury (1974) that some battering parents are mentally sick, and the child may become part of their distorted reality and delusional system.

Most investigators however, believe that the use of a medical model or psychiatric diagnosis to understand abusing parents

and design effective intervention strategies is unnecessary. Furthermore, branding these people as sick or mentally ill may work against their psychological development and emotional growth (Justice and Justice, 1976). It may cause them to flee from help because they feel that no one understands them, or provide them with a crutch or cop-out about the way they are and what they have done.

Social-Psychological Model

The social-psychological model was developed by Gelles (1973) and assumes that frustration and stress are important variables associated with child abuse. Stresses such as marital disputes and unemployment combine with other contributing factors such as the influence of social class and community (norms that sanction violence as a way to deal with problems) and the effects of "socialization experiences" in which parents act as role models for violence. Gelles believes that these experiences lead to psychopathic states, personality traits, poor control, etc. that contribute to the potential for abuse. The final set of events necessary for actual abuse is described as "immediate precipitating situations": e.g. a child misbehaves. The end product is a single physical assault, repeated assault, or "psychological violence".

There are two basic shortcomings in the Gelles model. First, he infers that investigators who follow a psychopathological model of intervention assume that all abusive parents are psychopaths and rarely treatable. Gelles mistakenly assumes that when investigators use the term psychopathology, they are referring to psychopaths. However, this is not the case. Although they may consider all

people who abuse as suffering from psychopathology, the number who are diagnosed as psychopaths is only about 5 percent (Kempe, 1971).

A second problem of Gelles model is that it fails to recognize the important symbiotic interaction between spouses and between parent and child in abusive families (Justice and Justice, 1975). These symbiotic relationships contribute to family conflict and often times manifests itself in the form of child abuse. The importance of this symbiosis will be discussed in the context of the model presented next.

Psychosocial System Model

The psychosocial system model takes into account the shifting dynamic forces at work in the family in which abuse occurs and in the environment and culture in which the family lives.

Abuse is the end result of a system of interaction between spouses, parent and child, child and environment, parent and environment and parent and society. What affects one, affects another (Justice and Justice, 1976).

The psychosocial systems model is primarily concerned with two systems: the family system and the larger system of family, environment, and culture. The larger system is depicted in terms familiar to public health: host, environment, agent and vector. It is an interactional model.

When the model is adapted to the problem of child abuse, the host represents the parents, the environment represents physical and social influences and stresses, the agent is the child and the

behavior he embodies, and the vector is the stimulus imported from agent to host that carries the cultural "scripting" which governs interaction between the two.

Abusing parents (the host of the problem of child abuse) are commonly described as seeking from the child satisfaction of their own needs for comforting and nurturing. Furthermore, it has been found that both husband and wife often compete to be taken care of in a culturally accepted manner (Justice and Justice, 1976). In public, the husband permits his wife to occupy this position so that he appears to be the strong decision-maker who is unaffected by problems no matter how severe. At home, however, he sits in front of the television set and expects his wife to bring him a beer or a drink. If one of his children asks him for permission to play across the street, for example, he replies, "Go ask your mother", because she is in fact the one who is usually the decision-maker at home.

The parents are locked into a shifting symbiotic relationship in which each seeks from the other satisfaction of his need to be cared for or nurtured. As a result, neither parent's needs are met and each may, at different times, turn to the child, no matter how young, to be the nurturer and decision-maker (Justice and Duncan, 1975). In the environment in which abuse occurs, the most frequent feature is change. A constant need to readjust is imposed on parent and child. Defenses drop, controls weaken. Isolation is common. The child and the stressful behavior or conditions he embodies are considered the agent that precipitates abuse. The

child is most commonly the immediate source of external stress for the abusing parent. The child's very proximity makes him an easy target for the parent whose frustrations spill over into physical aggression.

The vector in the psychosocial system model represents the "cultural scripting" of the parents and carries the stimulus from the agent to the host. Cultural scripts are spoken and unspoken assumptions about human behavior that result from culturally endorsed messages, injunctions, and myths about how people should act, feel and think (Justice and Justice, 1974). These scripts have a significant influence on the expectations of parents and their responses to children. Parents who are embued with the idea of having to be unfailingly loving to their child may be unwilling to admit their anger towards him. This can result in mounting hostility to the point where all that is needed to bring release is a provocative stimulus (Justice and Justice, 1976). Another cultural script relates to physical punishment as a necessary ingredient of child management. However, the line between physical punishment and child abuse is frequently a thin one.

The symbiotic quality of the relationships in the abusing family are described in transactional analysis terms by Justice and Justice (1976). Individuals who enter this type of relationship believe they are incapable of surviving on their own. Most abusing parents have early developmental histories that often result in an unsatisfying mother-child symbiosis. The battering parent often describes a history of severe emotional deprivation in childhood;

as a child his rights were not respected and he could not satisfy his own parents emotional demands (Kempe, 1969).

Coexistent with the belief in one's inability to survive alone is the idea that only one person in a relationship can have his needs met. Since both persons in a symbiotic relationship share this belief, there is a continuous struggle for the CHILD position. This struggle can occur between husband and wife, parent and child and at times grandparent and parent. Evidence of this symbiotic relationship factor is provided by Paulson (1968), who described a case of a three month old baby who died of malnutrition and dehydration because his mother fed him only when she and her husband got along well together. In TA terms, she was a PARENT to her infant only when her husband took care of her CHILD.

What happens in the abusing family, then is a constant struggle to be taken care of, with any and all forms of passivity escalated to whatever level is necessary. Thus, the parent beats his biological child into "obedience" because his own CHILD needs to be responded to.

Most parents never abuse their children and still maintain similar symbiotic patterns. The difference between these parents and abusing parents is the possession of some kind of internal brake that keeps them from turning to a child for nurturing. Unfortunately, abusing parents seem to lack that brake, perhaps because their own parents turned to them for nurturing when they were children. Thus when their own child fails them in the symbiosis, the failure seems to be the last straw and frustration turns to overt aggression.

Social Learning Model

In the social learning model, the emphasis is on the failure of abusive persons to acquire the skills to function adequately in the home and society. These individuals lack social skills, gain little satisfaction from their role as parents and are frequently ignorant of child development. They expect behavior too advanced for young children (Tracy and Clark, 1974). In addition, they have little knowledge of appropriate behavior for young children. For example, the present author had contact with a mother of an abused child, who thought her four year old daughter should be able to walk down three flights of stairs, out the door of the clinic and place money in a parking meter. They also have mistaken notions of how to rear children, how to encourage and guide them at different ages (Lystod, 1975).

Child abuse then, arises as an alternative behavior to more effective child management skills. Abusive parents have simply failed to learn alternative patterns of control. Parents who do not know how to reduce a child's crying, how to toilet train, or deal with temper tantrums, etc., are driven to methods that may have some short term advantages.

Advocates of the social learning model think that changes in feelings and attitudes may start by changes in what you do. Abusive parents must learn new ways of behaving to the child.

Most researchers think the social learning model is limited in accounting for the behavior of people who abuse, but that it has considerable power in the formulation of intervention and treatment

strategies (Justice and Justice, 1976). Learning theory itself lends itself to a behavior modification approach in working with parents and teaching them about child management. The social learning model, then, holds promise in working with parents who abuse. As an explanation of why abuse occurs, it has some usefulness but fails to account for several relevant influences, such as those described in other causal models.

In summary, it appears none of these models is complete in itself; they seem to overlap to some degree or take into account other factors that also play a part in producing child abuse.

While each model gives some basic underlying determinants in explaining child abuse, it seems that they all view the problem within an interactional framework to some extent. This includes personality and environmental variables, family structure and even society's norms concerning what is appropriate parent and child behavior.

Secondary Prevention

The discussion of treatment strategies to child abuse will begin with a review of secondary prevention approaches.

Much of the treatment of abusing parents in this country is done by lay persons. There are several reasons for this. First, treatment of abusing parents on an individual basis with psychotherapy not only takes too long, but has a lack of substantive evidence as to its effectiveness. Second, group therapy has not yet been extended to enough people who abuse to help all those who need

it. Third, relatively few professional therapists are interested in working with abusive parents, either because they feel unprepared to help these parents or because they can earn more by working with other kinds of clients. Fourth, the lay person is in a better position than the professional to provide some services to the abusive parents.

Lay Therapy

It is generally agreed that much of psychotherapy depends on the warmth, empathy and respect that one person shows while listening to another. There is also good reason to believe that, to gain maximum results, a person should have the special skills that can only be acquired through professional training. Two investigators, however, contend that some persons are naturally endowed with the qualities of a therapist and therefore need no special training (Carkhuff and Berenson, 1967). These individuals make the best lay therapists for abusing parents. Unlike the professional therapist, the nonprofessional goes into the home and provides a warm parent model for the abusing parent, who probably never had this kind of caring relationship. The lay therapist in the field of child abuse goes by many names -- parent aide, family aide, community aide. Some receive brief training, some do not. This "training" usually includes areas such as communication skills, child management techniques, value clarification and an overview of the problem of child abuse. They are prepared to spend a large amount of time for little or no pay and to become meaningfully involved in the lives of abusing families.

Parent aide is the term most commonly applied to the person who goes into the home of an abusing family and establishes a caring relationship. The parent aide may have to overcome the parents' suspicion and isolation and prove that she is available to reach out and offer comfort and concern even when it isn't convenient to do so (Hopkins, 1970).

At Colorado General Hospital, the federally funded Foster Grandparent Program has been a main source of parent aides. They were matched with parents by social and economic class. In addition to having good parenting and being a parent, the aide must be a "mild and loving individual who is not easily upset by an ungrateful, suspicious and often initially unwilling client" (Kempe and Helfer, 1972).

The lay workers in the Child Abuse Project of Sinai Hospital in Baltimore are called community aides (Barnes, 1974). In addition to being empathic listeners and behavioral models for abusing parents, the community aides serve as advocates for the parents to ensure they do not get lost or trapped in bureaucratic red tape.

Parent aides must be prepared to deal with crises. At some point, being an empathic listener and a good model will not be enough. It may be that before the parent aide can help a mother learn more effective "child management skills" or get "in touch" with her feelings, she has to assist in getting the heat turned back on in the house or put some food in the refrigerator.

Parent aides, then, must be prepared to address basic issues such as what resources can be tapped quickly during a crisis to meet the physical as well as emotional needs of abusing parents.

Because they are available when needed and are so intensely involved with abusing families, these aides are not only the cornerstone of child abuse treatment programs but often the initial factor in overcoming the isolation that characterizes so many abusive families. Unfortunately, many communities have still not developed similar programs to alleviate the problems of child abuse.

Self-help Groups

The growth of self-help groups in child abuse was stimulated by several factors: (1) the lack of professional help in many communities, (2) the inadequacy of services in general for abusive parents, and (3) the recognition that many abusive parents have a basic distrust of authority figures (including professionals) and some simply feel more comfortable around people who have the same problem. There may be no major changes in the parents feelings toward the child or in their understanding of why they abuse him, but their behavior changes: e.g., "I don't beat him anymore, but I can't say I really have any feeling or love for him" (Helfer and Kempe, 1972).

Learning to deal with anger and to redirect it is a major concern of self help groups. Although the parent does not always direct his anger toward the child (it may be toward another adult), he often becomes so frightened of his rage, which he has frequently vented on the child, that he is afraid of expressing anger toward anyone (Holmes, 1975). The self-help group offers the parent the opportunity to learn that he can express anger without destroying

a relationship with another person or losing control of himself. These groups are also effective for two other reasons: they help break up the isolation of abusing parents and the members bail each other out during a crisis.

A woman named Jolly K founded a group called Mothers Anonymous, which later became Parents Anonymous of California. She had been reared in 100 foster homes and 32 institutions, had been raped at age 11, had completed only five years of school and had been a prostitute. After two disasterous marriages, she tried to destroy both herself and the "little slut" she had brought into the world. Many professional people were against her attempts to assume a leadership role in the area of trying to do something about the dearth of services for abusive mothers. In 1974 the initial Parents Anonymous organization received a grant from the Children's Bureau to set up additional chapters. It now has 150 chapters and some 1,500 members. Its goals include: (1) redirecting anger onto objects other than children or other people, (2) learning to reach out to other people for help, and (3) altering destructive ways of viewing ones self and ones' children (Davidson, 1973).

Two major drawbacks of self-help organizations appear to be: (1) that the members "lack a model of healthy parenting" -- a person who understands child development and can provide examples of healthy ways to handle problems as they arise (Davidson, 1973) and (2) these groups do not address the problems of symbiosis and role reversal: teaching parents how to meet their own needs rather than depend on their offspring (Justice and Justice, 1976).

Self-help groups also appear to be in need of a system of evaluation and follow up. Nevertheless, Parents Anonymous provides a lifeline, particularly in time of stress and crisis, and thus performs an essential service.

Support Services

Supportive Services means all the resources that, although not specifically designed to be therapeutic, are a vital part of the secondary prevention of child abuse.

The visiting nurse has long had access to families that ordinarily do not have any contacts with professionals. The visiting nurse is qualified to provide support, aid, and human contact to abusing families. By being supportive and caring rather than critical and judgemental, the public health or visiting nurse can establish the kind of rapport with abusive parents that will make them accept new information about child management (Kempe and Helfer, 1972). In a sense, these nurses "mother" abusive parents in the same way lay therapists do, and they have the added advantage of being knowledgeable about health care. Finally, they can also serve as a valuable link between the abusing family and the agencies that serve them, by checking on their progress and making sure the abuse has not recurred.

The homemaker, like the visiting nurse, is sometimes welcome when other professionals are not. She can serve as a model for mothers who never had adequate parenting, teach these mothers the principals of home management and child care, and in the process

bring order and structure to homes that are frequently chaotic (Holten and Freedman, 1968). But perhaps most frequently she breaks up the isolation that so often characterizes abusive families and serves as a link between the family and the community.

Child care services are programs that either partially or completely take over the care of abused children: crises nurseries, co-op nurseries, day care nurseries, day care programs, and foster care.

Underlying the concept of crisis nurseries is the idea that parents should have a place to take their child when they feel they can no longer manage -- resources where preparation, planning, and expense for leaving the child would be minimal (Paulson and Blake, 1969). These resources would be available day or night, 365 days a year. At the present time, only a few crises nurseries are in existence but more are badly needed if abusing families are to be encouraged to seek help before abuse takes place or keep it from being repeated (Cohn, Ridge and Collingnon, 1975).

Another type of therapeutic program that does not separate parent and child is the co-op nursery. Usually staffed by volunteers, it is a place where the abusing parent can work and visit, and observe how children can be handled without physical discipline (Helfer, 1974). In addition, teaching parents to play with children is an important function of a co-op nursery. Through play therapy and "philiotherapy" (as the co-op program in Lansing, Michigan is called) parents get in touch with their own need to have fun and learn to let their children act like children: i.e., their expectations with regard to their children become more realistic.

Good foster homes are also usually the exception rather than the rule. Foster care is not at this time either socially attractive or financially rewarding (Kempe, 1973). Yet there is a dire need for facilities where a child can be cared for when it is unsafe to leave him in his own home. Foster parents receive small sums for taking in children who often are difficult to care for, primarily because they have been removed from their own homes. At present, children sometimes return home with more problems than they had originally.

A number of treatment programs for abusing parents include a parent education or child management component. Most parents who abuse their children have either erroneous or inadequate information about children's developmental needs and techniques for effective child management.

Much education on child rearing is given in conjunction with other programs and interventions of secondary prevention nature. For example, a program for abusive parents established at the Neuropsychiatric Institute of the University of California at Los Angeles has incorporated a child management class, which is taught by the nursing staff (Savino and Sanders, 1973). The staff emphasizes behavior modification techniques and uses Patterson and Gullion's book titled Living with Children to help parents modify their maladaptive behavior. Other materials used in similar programs, including this research project include Smith and Smith's Child Management and Gordon's Parent Effectiveness Training.

Another type of support service that plays an important role in secondary prevention is the statewide register, which records all reported cases of abuse, regardless of where they occur in the state. This central registry system has been used for some time for health problems such as cancer, and registers for child abuse were set up in some states in the 1960's. The register provides local protective service agencies with a central source for determining whether an abusive parent brought to their attention has ever been involved in child abuse elsewhere in the state or nation.

Just as child abuse registries should be interlinked among cities and states, hospitals need a cross-indexing system to identify suspected high-risk parents and children before injuries escalate. The Vulnerable Child Committee (VCC) was set up in the Brockton, Massachusetts area to promote early identification of high-risk children, using cross-indexing as one means to alert hospitals and social agencies to the cases (Lovens and Rako, 1975).

Another method of identifying high-risk cases and promoting secondary intervention is to color code the charts of children who are suspected of being subject to abuse. The South End Community Health Center in Boston uses charts with red covers for children who may be at high risk (Hass, 1975). This permits easy retrieval and periodic review of the chart without using identifying names or diagnostic terms.

Casework Counseling

If any group can be called the infantry in the war against child abuse, it is the protective service agency caseworker. The responsibilities of these people run the gamut from investigation of homes and removing children from them to family counseling. It is a job with many roles; some are successful; others are not. One of the first hurdles confronting the caseworker is how to establish a relationship with the abusive parent. Abusive families are difficult to work with -- a discouraging thought for a caseworker whose caseload is already extremely heavy. Often workers can't help but feel accusatory or vengeful for what parents have done to their child. They also feel uneasy about interfering in the time-honored sanctity of the parent-child relationship. This all adds up to a situation in which workers may find themselves confronted by people who don't like them, who are threatening them, and whom they find it hard to like (Davoren, 1975).

If the caseworker is successful in establishing a relationship with the parents, he must then begin to deal with several areas. One of his first tasks is to explore more fully the factors that precipitated the abuse. Once these factors have been identified, he and the parents can work together to change the situation or at least devise ways that will help the parent control his abusive behavior. The worker can also begin encouraging them to break out of their isolation and expand their lives by engaging in more satisfying activities. However, when it is clear to the caseworker that a child is not safe at home, he must accept the burden of placing the

child in foster care or, in some instances, attempting to terminate parental rights.

Davoren (1975) lists certain characteristics useful in casework with abusive parents:

1. A person with few, if any, managerial tendencies.
2. Someone who is willing to put himself out for patients, but who does not go around sacrificing himself much to everyone's discomfort.
3. Someone who has a fair number of satisfactions in his life besides his job so that he won't be looking to the patients to provide these satisfactions.
4. Someone with a strong working knowledge of child behavior that can be shared with absuive parents at appropriate times.

In short, the successful caseworker must be someone who is willing to give much of himself to abusive parents, but not to the point where he himself becomes "abused". He must also understand the dynamics of abuse sufficiently to know what is reasonable to expect of abusive parents in terms of change and what they will need in order to change.

Finally, the caseworker who works with abusive parents must do within the context of his agency, where heavy caseloads and frequent turnover of personnel are a fact of life. Generally speaking, caseworkers never have enough time to do the things necessary for best results: establishing rapport with and meeting the needs of abusive parents.

Modes of Psychotherapy

Essentially, there are three basic approaches to psychotherapy, cognitive, behavioral, and affective (Erskine, 1975). The psychoanalytic mode emphasizes the cognitive approach gaining insight and causation. Behavioral modification focuses on what the person is doing that causes a problem, i.e.: his behavior, not his thoughts or feelings. The affective mode emphasizes feelings and emotions, based on the assumption that if these change, then behavior and thoughts will change.

Steele (1975) found that although a few parents have been successfully treated by classical psychoanalysis, the general character structure and lifestyle of most abusive parents make this procedure quite impractical and probably unsuccessful. Steele states that with most abusive parents, the therapist must be more willing to adapt to patient needs and to allow more dependency than is ordinarily considered appropriate. Furthermore, intensive psychotherapy which skillfully utilizes the transference neurosis, can stimulate great growth and deep structural change in these patients despite their severe immaturity and developmental arrest.

Another method of individual psychotherapy in child abuse focuses on a confrontation technique in which the therapist tells the parent not to punish his child under any circumstances (David, 1974). This technique is designed to establish the therapist as a significant helper and to reassure the parent that the control he lacks will be provided by a potent outsider. It is also a way to get at the parents' underlying feelings, which must be worked

through. Although this approach may be useful during the early stages of treatment, the technique has limited application. It also increased the parents' dependence on the therapist and thus encourages continuance of the symbiosis, something that abusive parents do not need (Justice and Justice, 1976).

Highly directive therapy also involves other risks. For instance, parents may take out their hostility on the child because their submission to the therapist reminds them of the unpleasant past. Additionally, overdirection may cause parents to say what they know is "right", simply for the therapists' benefit (Kempe and Hopkins, 1975).

A transactional analysis approach is utilized by Justice and Justice (1976) in working with abusive parents. The researchers state that "TA" uses all three approaches (cognitive, behavioral and affective) and are necessary to produce long lasting change. The cognitive approach is illustrated by the use of structural analysis, getting clients to recognize which part of their personality structure -- Parent, Adult or Child is involved in a particular transaction. The behavioral approach is used in making contacts with parents to carry out certain behavioral "prescriptions" such as make a friend, visit a neighbor, interview for a job. Hypnosis and relaxation training teaches parents how to act differently in tense situations. In the affective mode reliance is on Gestalt techniques and confrontation as well as "permission" and "protection" to bring out underlying feelings of anger or sadness.

Behavior therapy has been employed to deal with an incredible range of behavior problems, both the traditional psychiatric syndromes and the unclassifiable behavior anomalies of everyday life. The behavior change strategies are unlimited with respect to type of problem, qualities of the clients, and nature of the settings appear to be a justifiable claim by looking at Morrow's (1971) bibliography. And yet there is one notable exception: the treatment of child abuse is not indexed either in Morrow's work or in the journal literature subsequent to 1969. There has been one behavioral interpretation of child abuse (Wylie and Wylie, 1970) various papers and articles that have implications for the partial treatment of abusing parents and battered children, but no real systematic application of learning principles and behavioral techniques.

A program designed by Tracy and Clark (1974) at this date appears to be the most extensive application and evaluation on the use of social learning theory and behavior therapy as a basis for treating child abuse. This child abuse project at Presbyterian University of Pennsylvania Medical Center chose social learning theory as the basis for its treatment model. This was done because the project was designed to change behavior through the use of social as opposed to primary reinforcement. The theory involved the identification of the behavioral goals, followed by specific technique of achieving them and by constant evaluation. Also the model seemed well suited to deal with environmental factors that prevent a person from developing competence as a parent and as an

adult. The choice was appropriate for another reason. The project director, realized the negative attitude many social agencies hold toward learning theory and behavior modification and therefore attempted to use less provocative words.

A precise behavioral analysis of the parent's techniques of child management is completed in this program. The staff member makes no attempt to get a description of the specific abuse, but rather asks the parent to discuss general punishment or techniques of controlling the child. Often it becomes clear that punishment is the adult's only way of controlling the child. Subsequent interviews and observation identify the times and places when an adult is likely to be upset and short tempered. Special attention is directed to the child's actions and to the adult's thoughts and feelings immediately before a confrontation with the child. The interview also focuses on the immediate consequences or what happened directly after the abusive action.

If analysis reveals that severe turmoil at bedtime is likely to illicit strong punishment, specific plans can be developed for treatment. For example; it may be that the child has no bed -- only a drawer or a bed he must share. If easing the stress at bedtime is a high priority, the worker can help the parent get a bed or can rearrange the sleeping facilities to lessen the aggravation. Too, it may be that the turmoil at bedtime is increased by constant verbal punishment. In this case, the worker can demonstrate the technique of "catching the child being good", a technique that

involves teaching the parent to reinforce positively the child's good behavior.

A recurring problem discussed by the investigators was accountability -- the social learning model continually confronted the staff with this issue.

A related problem is the stereotype many professionals hold of theories of learning and behavior therapy. In the beginning this stereotype prevented a close examination of the social learning model, but gradually gave way to a more inquiring view.

Another program utilizing a behavioral approach to treating child abuse is discussed by Jeffries (1975). The basic premise in this study is that changes in feelings and attitudes may start by changes in what you do. Direct ways of helping families of abused children were focused in three main areas: interventions to change the negative quality of general interacting between children and care given, interventions to change attitudes, and interventions to change the child's responses. Examples of specific strategies include: teaching parents how to play with their children, practicing things such as smiling, touching, talking, eye contact. These are positive responses that can be learned and practiced. In addition, learning to give positive attention -- parents and caretakers may need to learn how and when to smile, touch, look at and talk to their children.

Jeffreys states that the goal of this program is to help people do what they want to do but feel they cannot, so that they

no longer feel helpless or fatalistic in the face of their child, their family and society.

In a paper by Evans, Dubanoski and Higuchi (1974) several behavioral treatment strategies are suggested in working with abusive parents. No evaluation of these procedures was mentioned, but implications were made that they lent themselves better to evaluation than other approaches. They include the following:

1. A program designed to reduce the frequency and intensity of the punishment; teaching the parents to set up prior criteria for the use of punishment; and using punishment, if they are going to, in systematic ways likely to be effective.

2. Teach parents impulse control: particularly training them in relaxation and encouraging them to use deep muscle relaxation as an alternative response to mounting irritation and tension over the child's behavior.

3. Social agencies and welfare workers would systematically attempt to reduce sources of stress, which might range all the way from improved housing and vocational training to more direct help such as home visits by parent aides and homemakers.

4. Attempts should be made to reduce negative feelings and anger towards the child by systematic desensitization techniques.

5. A parent education course designed to teach basic principles of behavior management with emphasis on non-punishing techniques such as extinction, reinforcement of alternative behavior, timeout, shaping. The course would also have a simple content in child development, typical milestones, and the like.

The authors contend that these procedures have the advantage that methods of measurement can be clearly spelled out, and that the treatment strategies themselves, are based on established psychological principles. They conclude by stating that how much

worse might it be if we persist with current treatment programs that are not subjected to rigorous evaluation.

Group Therapy

Some authors emphasize the need for treatment to be conducted in a group setting. This is because the problem is viewed from both a psychological and social perspective. Membership in a group allows abusing parents to acquire the social skills and the sense of belonging and acceptance they so badly need (Steele, 1975).

One of the first reports of group work with abusive parents was published by McFerran (1958). The goals of this group were to provide parents with the opportunity to meet with others who had similar problems, exchange ideas, and have a social experience. The focus was more educational then therapeutic, and no differentiation was made between abusive and neglectful parents in terms of who was admitted to the group.

Groups have also been used in work with potentially abusive mothers. One group was composed of mothers with infanticidal impulses and one who had actually beaten her child (Feenstein et al., 1964). The group met twice a week for an hour in psychoanalytically oriented group therapy. The reported benefits were that the women found that others shared similar destructive impulses, that there was group support for change, that consensual validation was possible, that there was an exposure to different ways of handling stress, and that there was an opportunity for social interaction that women rarely had.

At UCLA, an interdisciplinary team was designed specifically for abusive parents consisting of a psychologist, psychiatrist, public health and psychiatric nurses, and a psychiatric social worker (Paulson et al., 1974). Therapy groups are conducted by teams composed of a psychiatrist or a psychologist and a nurse once a week for one and one half hours. Eclectic techniques are used. The only evaluation data presented is anecdotal and it states that much of the time spent in these groups consisted of continually questioning whether their goal is insight, problem-solving, cathartic, or purely social. In other words, the groups have been trying to define their position in terms of the cognitive, behavioral, and affective approaches to treatment.

A unique program that includes a group therapy component and a therapeutic day care unit for children is located at the Parents' Center Project for the Study and Prevention of Child Abuse in Brighton, Massachusetts (Justice and Justice, 1976). It has a therapeutic day care unit for children who have been abused and weekly group meetings led by social workers for abusive parents (Galdston, 1975). The day care program provides opportunities for parent-child interaction in a protected setting, with the parents acting as participant-observers. The goal is to avoid removing the child from the home and, while protecting the child, allow the parents to view the child from the viewpoint of other caretakers. The project has reported success in terms of the children's physical and emotional maturation, the pleasure that parents begin to derive

from other children and mates and the smaller number of repeated instances of abuse.

Coordinated Team Approach

One of the biggest problems in the delivery of services to abusive families is fragmentation and lack of co-ordination. A number of community agencies may be concerned with child abuse, and if parents are pulled from one to another, the stress in their lives increases and heightens their potential for abuse.

A system outlined by Helfer (1972) illustrates how a co-ordinated team approach could work:

> Step 1.
> The problem is recognized by a teacher, nurse, physician or relative and a report is made to a community protective services agency.
>
> Step 2.
> The child is taken to the emergency room of a hospital that has a child abuse consultation team. An examination is performed and acute treatment is provided.
>
> Step 3.
> The child is admitted to the hospital for further treatment, which allows the case to be further investigated.
>
> Step 4.
> The hospital-community SCAN (Suspected Child Abuse and Neglect) Consultation Team is notified and checks to ensure that a social worker from the protective service agency will assess the family and the home environment.
>
> Step 5.
> A diagnostic and treatment planning conference is held by the consultation team three or four days after the case is reported and the child has been admitted to the hospital.
>
> Step 6.
> If it is advisalbe to remove the child from the home, the protective service agency petitions the court for the authority to do so.

Step 7.
The treatment plan is put into action. A parent-aide, homemaker, if necessary is assigned to the family. The parents are referred for group therapy or perhaps begin receiving casework counseling.

Step 8.
Everyone involved in the treatment program meets regularly to report the family's progress, including medical and psychological follow-ups on the child.

Step 9.
When the team agrees that the parents have progressed to the point where the home is safe, the child is returned. The court is petitioned at the appropriate time to return legal custody of the child to its parents.

Step 10.
Treatment ends but the parents remain in contact with the team in order to periodically check to determine whether the family is functioning satisfactorily.

This is an ideal kind of co-ordinated approach to secondary prevention. In reality, however, such a co-operative concentration of services and professionals is difficult to find.

Primary Prevention of Child Abuse

Primary prevention consists of heading off a problem before it occurs. Unlike secondary prevention, it reduces not only the prevalence of the problem but also its incidence -- the number of new cases.

All the fields involved with the problem of child abuse have devoted their time and effort to treatment helping to ameliorate a problem after it has occurred -- not with prevention. However, enough is now known about the problem to begin instituting some programs designed for primary prevention.

One reason that primary prevention of child abuse is such a formidable problem is that it touches on the sacrosanct question

of whether parents have the right to raise their children as they see fit. Just about every far-reaching strategy that might be designed runs headlong into the issue of parental rights: the right to bear children (including illegitimate children), the right to have any number of children, the right to be left alone, and the right to be free of investigation as to how the children are doing. But the rights of children to a safe and healthy home and a mother and father with parenting skills must be given equal attention (Justice and Justice, 1976). A child has the right to his own home. He has a right to live, a right to a good emotional environment, and to a good education, food, clothing and shelter (Dallas Morning News, 1975).

A variety of commissions and national and international organizations have issued proclamations on children's rights, but their statements have been largely unheeded. For example, the Joint Commission on Mental Health of Children (1970), stated that children have the right to be wanted, to live in a healthy environment, to have their basic needs satisfied and to continuous loving care. The General Assembly of the United Nations also specified the rights of childhood in its Universal Declaration of Human Rights (Baker, 1971). Yet public sentiment and the law still favors parents' rights.

Kempe contends that although opposition to health visitors is likely -- even if families are not required by law to admit them to their homes -- a comprehensive primary prevention program may well require this extensive measure. The home is the only place

where all the critical areas can be observed. If children are followed up beyond infancy, early warning signs of other problems can also be detected and treated.

Nonspecific Strategies

Health Visitor Program

Kempe (1973) proposed an extensive strategy that represents a form of national health screening. The strategy is extensive in the sense that it involves intervention at all levels. The parents would be involved in that the health visitor would consider not only their child rearing practices but any symbiotic relationships in the family plus other characteristics, such as isolation and unemployment, that might result in abuse. The child would be involved in terms of how irritable, difficult and provocative he is and how he reacts to his parents. The environment would be examined from the standpoint of overcrowding, poor housing, and other social and physical indicators of potential abuse. The culture would be involved in the sense that any national health screening policy would require changes in public attitudes, particularly with regard to the concept of parental rights.

Kempe elaborated on his proposal in 1973, while testifying before the Senate Subcommittee on Children and Youth:

> We suggest that a health visitor call at intervals during the first months of life upon each young family and that she become, as it were, the guardians who would see to it that each infant is receiving his basic health rights. These health visitors need not have nursing training and intelligent, successful mothers and fathers could be readily prepared for this task.

Although the idea of national health screening may seem far fetched, there are programs in existence. The United Kingdom has both a national health screening program and a health visitors program (Craig, 1946). Although the law states that these visits must be made, it does not require parents to admit the health visitor to their home. But because these health visitors have earned a reputation for helpfulness and are trained to deal with effectively with uncooperative families, few newborns escape examination.

Parent Licensing and Training

Margaret Mead has pointed out that although society requires people to get licenses before they marry, no constraints are placed on child bearing, which is an even greater responsibility (Hawkins, 1972). When parents are ill-equipped and uninformed, the consequences affect not only the child but in many cases society at large. Toffler (1970) pointed out the need for proved proficiency in parenting as follows:

> Raising children...required skills that are by no means universal. We don't let "just anyone" perform brain surgery or, for that matter sell stocks and bonds. Even the lowest ranking civil servant is required to pass tests proving competence. Yet we allow virtually anyone, almost without regard for mental or moral qualifications, testing his or her hand at raising young human beings, so long as these human beings are biological offspring. Despite the increasing complexity of the task, parenthood remains the greatest single preserve of the amateur.

A number of behavioral scientists are convinced that enough is now known about the principles and techniques of child rearing

and management to dispel any arguments against the idea of requiring all potential parents to take courses that will teach them these skills.

A compulsory parent-training course could either be linked to mandatory licensing for parenthood or stand separately. By itself it would be more likely to gain acceptance; as a prerequisite to licensing, however it would carry more weight in terms of being taken at least as seriously as driver training (Justice and Justice, 1976). Despite the advantages for both children and society in the future, licensing of parents is unlikely to become a reality very soon. "Perhaps in the 21st or 22nd centuries such legislation and licensing programs may end -- or diminish -- child abuse, battering and neglect. In the meantime...?" (Lord and Weisfeld, 1974, p. 80).

In the meantime, strong intervention strategies such as universal parenting training could be initiated. Kempe (1973) states that schools can provide information and experiences to students related to parenting. The courses that do exist are usually homemaking courses and thus reach few male students. One reason that few, if any, boys enroll in these courses is that the instruction focuses mainly on the mechanical aspects of child care: e.g., how to feed and change babies. According to Kempe (1973) the schools need to teach students "something about mothering" -- about nurturing and what a child needs at different ages and stages and how parents should respond to those needs.

In addition to these classes, students would be required to spend time in a day-care center or nursery school affiliated

with their high school. Just as students who take drivers training courses are required to learn by driving real cars, students in child rearing would be required to deal with real children and confront the tasks that parents face.

Many studies indicate that there is a direct association between child abuse and a lack of the knowledge and skills required for parenting (Lystad, 1975; Spinetta and Rigler, 1972). This researcher's experience in working with abuse and neglect cases has also been that parents overwhelmingly have either little knowledge or misconceptions about child development and effective child management techniques.

While the lack of skills in child development and management is not contended as the sole cause of child abuse, there is ample evidence to suggest that it is a contributing factor in many cases.

High Risk Parents

Because the profile of the abusing parent is fairly well established, steps can be taken ahead of time to assist potential abusers. A predictive questionnaire that focuses on feelings of isolation, reaction to criticism, feelings toward spouse, parental treatment, expectations of children, attitudes toward punishment and feelings of nervousness, distress, and potential loss of control has been described by Schneider, Helfer and Pollock (1972). The idea of the questionnaire would be not to label parents who fall in a high-risk category, but to offer them support and guide

them in helpful services. Spouses who scored high in the various attitude or problem areas on the questionnaire would receive several forms of support, including counseling, the services of a parent aide or homemaker, and courses in parent training.

Although hospitals would be a central source for identifying high-risk parents, physicians in private offices could be equally helpful because they see more cases of child abuse than anyone else. But in most areas of the country they report it less (Children Today, 1975). What can physicians do? They can observe the early interaction between mother and child and pick up cues on the potential for abuse. For instance, the high-risk mother often views her infant as ugly or unattractive, is unconcerned about supporting the baby's head, handles the baby roughly, does not coo or talk to it, believes that the baby does not love her and cannot see any physical or psychological attribute in the infant that she values in herself (Morris, 1966).

Once a physician has identified a high-risk mother he should have community resources to which to refer her, such as courses on child development, the services of a parent aide or homemaker. There is however, much he can do on his own. For example, before the baby is born, he can make sure that the high-risk parent gets classes on the care and behavior or babies. He can do "discipline counseling" with the parents, emphasizing that spanking is inappropriate treatment of babies.

The public health nurse is the ideal person to take a leading role in primary prevention of child abuse. She is the

one member of the public health profession who already works in this field and has the respect of other health professionals and the community. Furthermore, as the least threatening professional she can gain entrance to homes where no one else is accepted... she is also the most available professional and in small communities she may be the only resource (Schmidt and Kempe, 1975).

High Risk Children

Just as strategies can be designed for intervention on the parent level, primary prevention can also be based on intervention with the child at risk. As was mentioned earlier, premature, illegitimate, difficult, congenitally malformed, and mentally retarded children seem especially prone to abuse.

An example of a treatment strategy for dealing with mothers and their premature babies would be to allow the mother inside the nursery to handle and feed the baby as soon as possible. Care-By-Parents Units should be available so that mothers of premature babies can become accustomed to and take complete responsibility for their infants before leaving the hospital (Helfer, 1974). If a high risk mother lives with her baby and cares for it a week or two before taking the infant home, she has the opportunity to develop claiming behavior and learn how to handle the baby.

Another procedure designed for early identification and intervention of possible high risk children is observation of interactions between mother and newborn infants. The nurse on the ward is an invaluable source of information concerning the child's

responsiveness to its parents and how often the parents visit (Joyners, 1973).

Public Education

Public education programs on child abuse are another example of efforts with a potential payoff in terms of primary prevention. So far, most of these programs have focused on early detection and on increasing the reporting of suspected cases.

As the public becomes better acquainted with the problem, television and other communications media should address the question of how a person can avoid becoming a child abuser and how a community can build a network of resources to bail people out in times of stress and crisis.

Rather than blowing up pictures of badly battered babies, the communications media should tell people something about how to meet their own psychological needs, get along better with their mates, manage their children without undue physical discipline, relax in times of stress, and make use of community resources to prevent or soften a crisis (Justice and Justice, 1976).

The media can be a decisive factor in public attitudes toward techniques and so on. The effect this could have on the prevention of child abuse and neglect is self evident.

Summary

Several conclusions can be drawn from the research that is currently available related to child abuse:

1. The demographic characteristics of abused children and their parents are fairly well established. This knowledge includes such factors as age of the child most likely to be abused, characteristics that may make the child be seen as "special", i.e.: premature, a congenital anomalie, etc. With regards to the parents, we know that abuse is more likely to occur where there is unemployment, isolation from friends, unplanned and unwanted pregnancies.
2. There are several causal models of child abuse, each with its strengths and weaknesses. Regardless of which model researchers adhere to it appears that there is general agreement related to an interactional effect of the many variables involved in describing child abuse. While the emphasis is different depending upon the model, individual psychological and biological factors, environmental stress, social psychological factors and cultural patterns are all discussed and deemed a part of the total picture.
3. Many secondary preventive (treatment) programs are described and discussed in the literature. They are usually concerned with a broadly based approach to child abuse, which may include several different interventions. For example, a program described by Steele (1975) states the need for "multidisciplinary and multiperson" treatment because of the complexity of child abuse cases. The program may include casework counseling for the parents, a parent-aide, a parenting class experience. While the inherent value of these experiences seems obvious

due to the multitude of needs that abusing families present, they have largely been unevaluated in terms of rigorous experimental procedures. What data that is given consists of percentages of new abuse referrals, frequency of repeated abuse, visits to the clinic. While these outcome measures may be important seldom can a cause and effect relationship be drawn due to the particular program's inadequate evaluation and methodology.

4. Another problem with the research that has been conducted on treatment is the lack of specific comparison between programs that have different theoretical bases. Comparisons such as does rational-emotive therapy produce better changes in the self concepts of abusive mothers than client-centered therapy have not been done. If large scale programs are going to continue to be developed we need to know which kind of therapeutic approach works better for certain areas, who should be doing the therapy, what kind of training should volunteers be getting and so on. Up until the present time, the focus has been on getting programs started assuming that enough information was now available concerning the characteristics of abused children and their parents. We are now in a state of new programs being initiated every day. Monies to fund these programs are more available than ever before. It is imperative that we begin to apply appropriate experimental procedures to these programs and specific treatment strategies so that the conclusions we draw as to their effectiveness (or lack of it) are well founded.

This research project is an attempt to evaluate the effectiveness of two specific approaches that are almost always a part of child abuse treatment programs.

Importance is usually placed upon the need of child abusing parents to develop a "relationship" with someone be it a caseworker, parent-aide or therapist. It is also universally accepted that abusing parents have a distinct lack of knowledge about child development and effective management techniques (Justice and Justice, 1976).

Traditionally, it has been assumed that if parents feel better about themselves, are able to "trust" someone, develop insight into their situation, this will "transfer" over to improving the parent-child relationship. However, this has never been experimentally validated.

It is this researcher's hypothesis that a more direct approach via social learning and behavior modification techniques, will produce better results in changing the attitudes and behavior of abusive parents toward their children, than will a "client-centered" more indirect approach. Teaching parents how to use positive reinforcement, play with their children, how to "catch their child being good" will not only significantly change the perception they have of their children but will also make them feel more personally competent and adequate as a person.

Chapter II includes a description of the procedures used in implementing and evaluating the two treatment approaches under consideration in this study.

CHAPTER II

METHOD

Subjects

The participants for the study were 20 mothers, who are active cases with Protective Services of the Department of Social Services for Ingham County and the Child Abuse Project in Lansing, Michigan. The reason for their involvement with these agencies was that a determination had been made regarding the likelihood of child abuse having occurred in the family and that therapeutic intervention was necessary.

The criteria for participation in the program was that a diagnostic evaluation had been completed and that the child's injuries could not be "reasonably" explained by any other causative factors than abuse. This diagnostic evaluation was completed by an acute child protection team which included a pediatrician, a social worker, psychologist, protective services worker, and possibly a probate court caseworker. Usually included in this evaluation was pertinent social history information, psychological testing, an assessment of the home conditions, and a complete physical examination of the child.

Additional criteria for program participation included that the abused child be between the ages of one and six years and that he/she is living with the mother. The reason for these criteria

was that one of the dependent measures included a rating of the parent-child interaction, which required some active involvement on the part of both mother and child. Children less than one year old would have been difficult to include due to their psychomotor immaturity.

Only mothers of the abused children were included due to limitations on the scope of this study and their generally being more available for treatment. They were also more likely to be the parent having the most contact with the children in the family.

No other demographic requirements were made except that all families resided within Ingham County.

Table 2.1 provides a summary of the demographic characteristics of the participants in the study. The reader can thus determine the extent to which the present results can be generalized to other populations.

Procedures for Obtaining Participants

The investigator met with the casework staff from both agencies involved in order to obtain subjects for the study. Staff meetings were attended and the nature of the project was explained and questions were answered. Copies of the research proposal were given to the staffs in order that they might specifically understand the nature of the program.

After cooperation has been obtained from the agencies to obtain participants, a procedure was set up to handle referrals. One worker in each agency contacted the principal investigator when she

Table 2.1

Demographic Characteristics of Subjects

Characteristics	Component Breakdown	Behavioral Group	Client-Centered Group
Age	Mean	28.5	27.9%
Race	Caucasian	100%	100%
Marital Status	Married	44.2%	45.7%
	Separated or Divorced	55.8	54.3%
Education	Less than high school diploma	32%	33%
	Finished high school or above	68%	69%
Income	Less than $6,000	84%	82%
	Between $6-10,000	18%	18%
Number of Children	Mean	2.6	2.4
Telephone	Not listed	67%	64%
	No phone	14%	15%
Use of Physical Punishment as a child by own caretakers	Yes	77%	79%
Age of Oldest child	Under age 8	94%	93%
Type of Delivery	Full term babies	76%	78%
	Premature babies	23%	24%
	Caesarian section	30%	29%

or he thought an appropriate client was available. At this point, the investigator would obtain a verbal report on the case situation and decide to accept or reject it. If accepted it was then randomly assigned both to treatment condition and therapist.

Therapists

The investigator used volunteer women as therapists for the study. They were obtained from two sources. These included graduate students in a counseling program from the Department of Counseling, Personnel Services and Educational Psychology at Michigan State University and women who were serving as parent-aides in the Child Abuse Project in Lansing, Michigan.

Interviews with prospective therapists interested in participating in the project were conducted by two women, who had previous experience in selecting volunteers to work with abusive mothers in a capacity very similar to this program.

The criteria used to select the women were:

1. attitudes toward the use of physical punishment in parenting,
2. attitudes toward their own childhood experiences,
3. actual experience in working with children,
4. attitudes toward the problem of child abuse.

The use of these areas in selecting women to serve as therapists for the project were only seen as general interview guidelines and not as experimentally validated methods with proven effectiveness. Other factors considered were openness, interpersonal warmth, friendliness, self confidence and reasons for being interested in the area of child abuse. Again, these criteria were based on the subjective judgement of the interviewers. The final judgement for recommending a person to participate as a therapist in the program was for the most part, subjective.

See Table 2.2 for a composite picture of the demographic characteristics of the women selected to be therapists in the study.

Table 2.2

Demographic Characteristics of Therapists

Characteristics	Component Breakdown
Age	Mean = 30.1
Race	Caucasian (100%)
Marital Status	Married (70%) Single (30%)
Education	B.S. or B.A. (90%) M.S. or M.A. (40%)
Family Income	$15,000-$20,000 (65%) $10,000-$15,000 (35%)
Number of Children	Mean = 1.8

A total of 13 therapistis participated in the study. Six women each had one case and 7 women each had two cases. No more than 2 situations were assigned due to the complexity of each case.

Therapist Training

The women, who served as therapists in this study were trained in 5 three-hour sessions, over a 2 week period. The location of the training sessions was in the home of the investigator. This setting was an informal and relaxed atmosphere and was felt to be more conducive to interpersonal openness and concentration of the materials presented.

The 15 hour training sessions were completed on three separate occasions as new therapists became available for the study.

They were scheduled during a two week period in May of 1976, January of 1977, and April of 1977. One additional reason for running three total training programs was that due to the complexity of the cases, each therapist was only given one or two cases, therefore necessitating the need for a larger number of therapists.

Format and Content of Training

Session I

The first activity during this session was to give each person a chance to get to know one another. This was accomplished by having each person in the group talk for five minutes about themselves. After each person spoke, the rest of the group members were given three minutes to ask questions of the person.

An overview of child abuse was then given to the therapists. It was conducted by a pediatrician, who is active in working with abusive families. A monograph was also distributed to each person containing an historical perspective, diagnostic and treatment procedures and the importance of community involvement in abuse and neglect problems (Scheurer, 1976).

The remainder of the session was concerned with a discussion of this research project and questions were answered. An example of this presentation was explaining the two treatment methods under consideration and the need to find out "which one works better". Particular care was taken to avoid using professional jargon in defining the parameters of the research in order to insure adequate understanding on the part of the therapists.

Session II

A presentation was made on the importance and use of listening skills in a helping relationship. This consisted of both didactic and experiential activities, such as role playing. Particular emphasis was placed on its use in a "client-centered" type relationship as well as the importance of helping people identify feelings so as to be better able to understand them. Examples of training content were:

1. Defining problem ownership.
2. Recognizing acceptable and unacceptable behavior.
3. Reflective listening.
4. An emphasis on the "self" and keeping the sessions focused on dealing with the "here and now" situation of each casemother.

Thomas Gordon's Parent Effectiveness Training program (1970) was a resource for this part of the experience.

Role plays were used to practice the listening skills in situations likely to occur in working with an abusive mother. (See Appendix A for role play situation.)

Session III

Behavioral management techniques were introduced along with a simple theoretical explanation. This included the use of positive reinforcement, extinction, time out procedures, how to monitor good child behavior and environmental modification such as "child proofing" your home. These concepts were also explained and discussed in the context of specific problem behaviors that are

characteristic of the kinds of difficulties that mothers encounter with their children.

Gerald Patterson's book entitled Living with Children (1972) was a resource for this part of the training.

Session IV

A presentation of basic child development information was conducted by the researcher. Arnold Gessell's book The First Five Years of Life which included a listing of certain behaviors of children at various ages was used in this session. A discussion followed with the group determining how this information may be used with their casemothers.

Session V

A values clarification exercise was completed specifically related to a child abuse situation. Factors related to how individual attitudes and belief systems are shaped by certain experiences and society norms were discussed. Appendix B contains the value clarification exercise.

Finally case record keeping materials were distributed to each therapist.

Case Materials

Each therapist kept a separate file on the client assigned to them. Included in this file was:

1. The problem behavior checklist filled out by the mother. (See Appendix C).
2. The Draw a Person Projective Test.
3. The Michigan Screening Profile of Parenting. (See Appendix D).

4. The demographic information sheet. (See Appendix E).
5. The Mother-Child Relationship Rating Scale. (See Appendix F).
6. The anecdotal log sheets kept by each therapist for contacts made with a mother. (See Appendix G).
7. Informed Consent for The Michigan Screening Profile of Parenting. (See Appendix H).

Case Supervision

The researcher met with the therapists as a group once every two weeks to discuss their cases and provide support for their activities. Each therapist usually took fifteen minutes to talk about her client, and ask for suggestions from the group that might be helpful in working with her case. These sessions were held at the home of the researcher.

Experimental Conditions

Treatment I

This treatment was called the Parent Education Program or the "direct method". Emphasis was placed on teaching mothers specific information and methods related to parenting. This included what were appropriate expectations to have of children at various ages, behaviorally oriented child management techniques and homework assignments related to these areas.

An example of a non-punitively oriented child management skill that might be presented to a casemother would be a shaping procedure to use in toilet training (Brazelton, 1962). A homework assignment used was asking a mother to keep a list of certain

behaviors that her child exhibited and then seeing how "appropriate" they were to the age of the child.

Weekly sessions with the therapist focused on discussing the information and procedures and problem solving any difficulties encountered by the mother.

The specific content or methods used with each case were tailored to meet the individual situation. For example, one case may require the mother to make a list of everything a child does that pleases her in a given day, while in another situation it may be providing the child with a reward every time he puts his toys away. However, all activities fall under the general heading of a direct, behaviorally oriented approach to problems in the parent-child relationship.

Treatment II

This treatment was called the client-centered or "indirect" method. The emphasis here was on helping the mother make a more adequate adjustment by focusing on the self. The therapist functioned as an empathic listener and allowed the mother to discuss anything she wanted to such as her marital relationship feelings about her own parents or other personal difficulties. No attempt was made to give advice, direction or particular strategies to deal with problem situations. The sessions may include talking about the children, but the therapist attempted to focus on the feelings associated with the situation and not how the mother could solve the problem. The sessions were as unstructured as possible

on the part of the therapist and let the client decide where to "go" with the content. This treatment condition in essence functioned as a comparison group and is typical of the type of approach used on working with child abuse cases.

Measures

The attitudes of subjects towards child rearing and perceptions of their own childhood concerning the participants in the study was assessed on a post test basis by The Michigan Screening Profile of Parenting (MSPP) (formerly called the "Survey on Bringing Up Children"). It is a research instrument that has been used with abuse/neglect populations. The questionnaire is a 50 item instrument made up of statements which are answered on a 7 point Likert scale from strongly agree to strongly disagree. (See Appendix B for a copy of the MSPP).

The questionnaire has not been fully validated and reliability estimates are still being obtained. The manual for using the MSPP contains what reliability and validity data that is available at the present time (Helfer, Schneider and Hoffmeister and Tardiff, 1977). Preliminary reliability studies indicate the test is useful in detecting group differences.

Scores are obtained in five areas:

1. Relationship with parent (RWP)
2. Emotional needs met (ENM)
3. Dealing with others (DWO)
4. Expectations of children (EOC)
5. Coping (COP).

The instrument is in English and is self administered in 20 minutes or less. Certain questions in various subgroups are reversed so that all answers are not at the same end of the seven point continuum. In scoring, these responses are again reversed so that a high score on any cluster indicates a negative perception in that area.

Mother-Child Interaction Rating Scale

The interaction of a mother with her abused child was assessed by a behavior rating scale specifically designed for this study. Behaviors such as touching, eye contact, statements of encouragement, criticism, etc., were measured. The scales were a 5 point Likert system from never to frequent. (See Appendix I for Rating Guide).

The mother-child interaction was observed and rated in the context of a contrived task, that required them to "work together" in order to achieve some performance criteria. The task was a block building situation that required progressively higher levels for satisfactory performance. (See Appendices J and K for Guidelines and Directions of Block Building Task).

This particular activity was chosen in order to observe how both the mother and child "reacted" to higher levels of frustration, which would possibly produce some conflict which could be measured along certain dimensions. This rating was completed on a pre and post test basis. Each therapist did the pre test rating for her case. The post test was completed by one person who was blind as to which treatment condition casemothers were assigned.

The Draw A Person Projective Test

The researcher has used this instrument in his clinical work with abusive and neglectful parents, both as a part of diagnostic assessment and also as an outcome measure of therapy. It provides another source of information as to how the individual "perceives" himself, his relationship to other people, his view of family, etc. Graphic visual representation of how an individual "sees" and "organizes" his own phenomenology is obtained.

The administration of the instrument was completed on a pre and post test basis. The mother was given 2 sheets of paper and asked to first draw a picture of a whole person (it is emphasized that stick figures are not acceptable as they do not provide much data for assessment), and second, a picture of the opposite sex from whichever sex was drawn on sheet one.

Each mother was told that this measure would be useful to the therapist in helping her with her problems. She was encouraged to do "her best" and given reassurance that her artisitc ability was not being measured.

The drawings were rated by an independent certified consulting psychologist who has had extensive experience in using the technique in performing psychological assessments on the type of participants involved in this study. He was blind as to which treatment condition participants were in and whether the particular drawings being rated were done on a pre or post test basis.

While the Goodenough-Harris Draw-a-Person technique (1963) was originally designed for children it has since been extended to

adults. Its scoring system is straightforward and objective in content. The reader is referred to the test manual for specific information about the test.

It should be noted that the drawings of both a male and female were required of the participants and that each of them were scored separately. However, for analysis in this study these two scores were collapsed to obtain one total score for both drawings. Therefore, there will be one composite score for the pretest drawings and one composite score for the post test drawings for each participant.

Other Data Collected

The MSPP has an extensive demographic sheet that is filled out along with the questionnaire. Many of the questions on the sheet are particularly relevant to an assessment of abuse/neglect situations.

Log sheets were also kept by each therapist. This information included a summary of each session's activities and an opportunity for the therapist to verbalize her feelings and thoughts about certain things that occurred during a meeting with the casemother. The result was a complete written account of each case on a session by session basis. A summary of comments made in the log sheets will be presented in the Results section of this investigation.

Information related to other programs that each mother was involved in outside of this one was also gathered.

General Guidelines for the First Session and Suggested Activities for the Behavioral treatment are in Appendices L and M.

Hypotheses

Hypothesis 1. Mothers of abused children who have had training with the Parent Education Program will have more positive attitudes towards child rearing than mothers, who have received the client-centered treatment.

Hypothesis 2. Mothers of abused children, who have had training with the Parent Education Program will interact more positively with their child, than mothers, who have received the client-centered treatment.

Hypothesis 3. Mothers of abused children, who have had training with the Parent Education Program will have a more positive self concept than mothers who have received the client-centered treatment.

Experimental Design and Analysis Procedures

The basic design of the study is shown in Table 2.3 which used Campbell and Stanley's (1963, pp. 13-24) true experimental design number four, "Pretest-Postest Control Group Design".

Small sample t-tests were used to test the differences in treatments between the two groups. The .05 level of significance was chosen to indicate significance for this study.

Table 2.3

Experimental Design

Treatment Group	Design
Group 1 (Experimental Group)	R O X O
Group 2 (Comparison Group)	R O O

R = random assignment; O = observation or measurement;

X = treatment

CHAPTER III

Results

Chapter III contains the statistical analyses of the results of the study. The analyses relevant to each of the hypotheses will be reported in turn. Following the presentation of the results of the statistical analysis, Chapter III will conclude with a summary of the therapist's case log comments and the group supervision sessions.

Hypothesis I

Hypothesis I states that mothers of abused children who have had training with the Parent Education Program will have more positive attitudes towards child rearing than mothers, who received the client-centered program. These attitudes were measured by the Michigan Screening Profile of Parenting. This hypothesis was tested by obtaining the number of scores in each case which indicated potential parenting problems. A mean for these scores was examined for each group. Table 3.1 which displays the results of the analysis shows that the attitudes towards child rearing did not differ significantly between the two groups ($p < .05$). The differences were however, in the predicted direction.

Table 3.1

Post Counseling Attitudes of Abusive Mothers Toward Child Rearing (N = 20)

Treatment Group	Mean	S.D.	t value*
Parent Education Program	2.30	1.21	
			1.90
Client Centered Program	2.00	1.32	

*.05 level of significance requires a t value of 2.28.

Hypothesis 2

Hypothesis 2 states that mothers of abused children who have had training with the Parent Education Program will interact more positively with their child than mothers who received the client centered program. This variable was measured by a rating scale and tested by examining the mean differences between the two groups on a pre and post test basis. Table 3.2 which displays the results of this analysis indicates that the rated mother-child interaction did not differ significantly on a pre and post test within each treatment condition. However, there was a significant difference between the two groups on the pre-test, giving rise to the possibility that the two groups were different from each other in the interaction with their children before treatment began.

Hypothesis 3

Hypothesis 3 states that mothers of abused children who have had training with the Parent Education Program will have a more

Table 3.2

Pre and Post Treatment Interactional Style
of Abusive Mothers with their Children (N = 20)

	Treatment Group	Mean	S.D.	t value*
Post test differences	Parent Education Program	49.5	18.60	.66
	Client Centered Program	51.5	23.64	
Pre test differences	Parent Education Program	51.5	18.89	2.33*
	Client Centered Program	45.1	24.12	
Pre-Post test differences	Parent Education Program	51.5	18.89	.72
		49.5	18.60	
Pre-Post test differences	Client Centered Program	45.1	24.12	2.24
		51.5	23.64	

*Significant at .05 level.

positive self-concept than mothers who received the client centered program. This self-concept perception was measured by the Draw-A-Person projective drawing technique. The drawings were rated according to the scoring system developed by Goodenough and Harris (1963) for this test. This system is an objective assessment of formal aspects of the drawings such as shape, form, proportion, balance, symmetry and design. The higher the score the more "adequate" the drawing.

Table 3.3 which displays the results of this analysis indicates that the rated drawings did not differ significantly between the groups on a post test basis. Also neither group differed significantly on a pre and post test basis within each treatment condition. The differences were however, in the predicted direction.

Table 3.3

Pre and Post Treatment Self Concepts of Abusive Mothers (N = 20)

	Treatment Group	Mean	S.D.	t value*
Post test differences	Parent Education Program	96.5	25.39	.064
	Client Centered Program	94.5	18.86	
Pre test differences	Parent Education Program	93.3	25.04	.115
	Client Centered Program	89.3	31.93	
Pre-Post test differences	Parent Education Program	93.3	25.04	.069
		96.5	25.34	
Pre-Post test differences	Client Centered Program	89.3	31.93	.201
		94.5	18.86	

*.05 level of significance requires a t value of 2.28.

Summary of Log Sheet Contents

Each therapist kept a session by session written commentary of activities and impressions concerning their case. The following statements are a synopsis of their remarks.

1. The majority of interviews took place in the home of the casemother. However, in every case, the therapist met with her casemother in other settings. These included, going out for coffee, going shopping, on a picnic, walking in a park, etc. Remarks were made stating the "need" of the mother to "get out of the house" for awhile.

2. Many distractions were noted by the therapist that they felt interfered with the sessions. These included things like the television or radio playing, phone calls and most often, interference from the children. The casemothers had difficulty in talking with their therapist because of the constant interruptions from the children, such as fighting, having to change a diaper, a child wanting his mother's undivided attention, etc. There were several notations that the therapist interceded in these activities and helped the casemother get things under control. This was accomplished by making suggestions to the mother about how to discipline a child, or even "taking over" and dealing with the child directly. Comments were made by several therapists that they thought their casemothers "learned more" by observing than by talking and listening.

3. All therapists reported the importance of observing different relationships in the family. This included all possible combinations. These observations were thought to be important

because it was illustrative of how:

a. problems were solved in the family.

b. physical punishment was used.

c. the parenting skills of the casemother were effective or ineffective.

d. the day to day life in the family was lived.

e. Every therapist commented that the day-to-day routine of the family was disorganized, and in many cases, the physical environment was particularly in disarray. This included poor housekeeping standards, dangerous items left within reach of children, and small children in need of a bath or change of clothing.

5. Several therapists reported that their casemothers appeared "surprised" that they were volunteers and not paid for coming to see them. The casemothers had a difficult time understanding why someone would want to help them if it wasn't their "job". In one case, the casemother for several sessions thought the therapist was a "babysitter" to come and take care of her children so she could get out of the house. This perception was true even after the purpose of the sessions had been thoroughly explained to her.

6. In almost every case the therapist found it necessary and helpful to talk to other professional people who were involved with the case. This included protective service workers, probate court workers, pediatricians, public health nurses and so on. The reason given for wanting to talk with these people included wanting more information about the case and trying to locate a particular

resource for the casemother, such as a Day Care center for the children, budget counseling, educational opportunities, etc.

7. All therapists commented on the difficulty of keeping the two treatment conditions separate. At times they thought it was necessary to "listen" to the mother talk about her problems (which may or may not have been related to the children). On other occasions, direct advice or intervention into a particular problem was thought to be helpful. However, when direct advice on suggestions were given the therapists found it difficult to determine if their solutions were carried through, if even attempted.

8. Within the direct treatment approach, several different and unique behaviorally oriented approaches to dealing with the children were attempted.

a. Providing the casemother with a memo slate board to write things down that were important to take care of for the family.

b. Making a daily chart of the number of temper tantrums as manifested by a child.

c. Teaching a casemother a shaping procedure for toilet training her child.

d. Modeling for a mother how to play with a child, such as getting down on the floor and making funny noises with them.

e. Writing down a list of things a casemother "liked" about her child.

f. Demonstrating how to use an egg timer to help structure the bed time routine.

9. The majority of therapists found termination with their case difficult. The main reason given was that it took them several sessions to "establish a relationship" with their casemother and that the situations were so complex that a longer involvement was deemed necessary.

10. It was difficult for the therapists to meet with their casemothers on a regular, consistent basis. Reasons given for this difficulty were casemothers not remembering a visit was scheduled and they would be gone from the home when the therapist came; families would move; crisis situations would come up in the family and casemothers would break the appointment.

11. All casemothers were worried about their financial situation and spent a lot of time talking about it.

12. Many comments were made by the therapists that the formal assessment procedures (dependent measures) were helpful in providing them with information about their casemother and aided in establishing rapport.

13. Most everyone thought their involvement with a casemother was "helpful" but had difficulty defining their reasons for this opinion. What documentation that was given included things like the house was cleaner, the kids didn't fight as much, the casemother was working part time or taking a parenting class, etc.

14. The predominant problems that seemed most important to the casemothers included difficulty with the children and conflict in a relationship with a spouse, ex-spouse, or boyfriend.

Summary of Group Supervision Activities

The researcher met with the groups of therapists every two weeks. The purpose of these sessions was to discuss any problems they were having with their cases. The meetings were held at the researcher's home and lasted about two hours.

Content of these sessions consisted of the therapists talking about their casemothers and asking the group for suggestions. However, it soon became obvious at the beginning of these meetings that the therapists wanted the researcher to "tell them what to do" and be the "expert". They would share information with each other (descriptive) about their casemother but looked directly to the researcher for guidance and answering of specific questions. The researcher made a conscious effort to try and involve the group in coming up with suggestions and being supportive of individual efforts. There was much verbal positive reinforcement given by group members to each other during these sessions. The group appeared to develop a sense of "cohesiveness" as the mutual support and sharing increased with each session. No formal analysis was done of these group supervisory meetings.

Problems encountered by the researcher in conducting these meetings include the following:

1. Having people not showing up at the scheduled time.
2. Trying not to let one person monopolize the meeting.
3. Dealing with difficulties that the therapists were having in implementing the specific treatment condition.

These difficulties will be discussed in detail in Chapter IV.

A Speculation

The fact that the hypotheses were not supported can be viewed a number of ways. The treatment model developed for this study may have been a poor one; the sample may have somehow been unique and resulted in uniquely nonsignificant data; the conditions under which the treatment was given may have been inadequate; or the dependent variables might have been inappropriate. These various alternative explanations of the results will be discussed in detail in Chapter IV.

Summary of Results

There was no evidence to support any of the three tested hypotheses. However, the non-significant results for Hypotheses 1 and 3 were in the predicted direction.

In addition, no evidence was found to support pre-post test differences in either treatment group.

Finally a summation was presented relative to therapists' comments concerning the session to session management of their case and the activities involved in their supervision.

CHAPTER IV

DISCUSSION AND CONCLUSIONS

Overview

The purpose of this study was to determine if a direct, behaviorally oriented treatment program would have a more beneficial effect upon the overall parenting capacity of abusive mothers than an indirect client-centered treatment.

To answer this question a 2 group experimental plan was initiated. Two treatment packages were developed and used with 20 abusive mothers, each condition having ten participants. Treatment 1 consisted of therapists teaching behavioral approaches to mothers in areas where they were having child management problems. An example of a technique employed was teaching a mother how to use positive reinforcement in toilet training a youngster. Treatment 2 provided abusive mothers with an empathic relationship which could focus on whatever area a casemother might find problematic for her. No specific advice or direction was given to the therapy by the therapist, thus giving the treatment a client centered, non-directive emphasis.

Therapists were trained in 3 different groups over a period of 9 months. A total of 13 women served as therapists for the study. They were trained by the chief investigator of this study

over a period of five three-hour sessions. Content of the training consisted of:

a. an overview of child abuse;

b. communication skills;

c. values clarification;

d. child development;

e. behaviorally oriented child management techniques.

Dependent measures included the Michigan Survey Profile of Parenting, the Mother-Child nteraction Scale and the Draw-a-Person projective test. These measures were used to assess three variables related to abusive mothers' approach to child rearing:

a. attitudes

b. behavior towards children

c. self concept.

Three basic directional hypotheses favoring a behaviorally oriented treatment program for abusive mothers were tested. Although none of the hypotheses were supported in the sample t-test analysis, 2 were in the stated direction.

Discussion

Based on the results of this study the behavioral model for helping abusive parents become more effective in their child rearing skills may be inadequate. Quite simply, the importance given to providing mothers with direct advice and skill practice related to improving their parenting capacity may be both over-simplified and overstated.

However, these negative findings can be explained by one or all of a number of nontheoretical considerations related to the validity of the experiment. These include: sampling, instrumentation, history, procedures, and design and analysis. The purpose of this discussion section is to explore the adequacy of these explanations in accounting for the lack of positive findings. In addition, the adequacy of the theoretical basis of the study will be further considered.

Sample

Perhaps the most plausible relevant sample related hypothesis is that 1) the sample was so variable in terms of the "clinical makeup" of the participants; 2) the sample size was so small; and 3) the measures were relatively insensitive. These factors made it difficult to detect small between group differences if they existed.

Another sample-related explanation of this study's negative findings is that many of the participants were involved in other treatment programs at the same time this study was being completed. These programs ranged from formal parenting classes to individual psychotherapy. Thus, the casemothers may have been contaminated by being "overtreated" (involved in several treatments at one time) and also exposed to programs very different in their theoretical orientation. The researcher is aware that random assignment should negate this possibility, but nevertheless feels it may have contributed to the negative findings.

Instrumentation

If the instruments used to measure the treatment effects are (a) poorly conceived or (b) administered unsystematically the resulting error variance may be sufficient to obscure significant differences within groups and post test difference between groups. The first issue is related to the validity of the instruments, while the second concerns reliability.

Three different dependent variables were used in this study: attitudes towards parenting as measured by the MSPP, mother-child interactional behavior as measured by the Mother-Child Interaction Rating Scale and self concept as measured by the Draw-a-Person projective test. Evidence for their validity appears to exist because of the high "clinical value" placed on these areas whenever treatment programs are developed for use with abuse cases. In Chapter II, specific note was also taken of the factors deemed most important when assessing an abuse situation, such as inappropriate expectations of children, low opinion of self and the negative, punitive quality of the relationship between the abused child and the parents. Therefore, validity does not appear to be a significant issue in this study concerning the dependent measures. At the very least, construct and content validity is inherent in the instruments used.

In terms of reliability, the measures are questionable. While every attempt was made to obtain good, clean, scorable and standardized records, the fact remains that each case presented specific problems in this area. The therapist who administered

the instruments to the mothers in their homes encountered difficulites with this arrangement such as interruptions from telephone calls, children wanting attention, a spouse "glaring" at the casemothers while they filled out questionnaires or tried to interact with their children on the block building tasks. In some cases, the casemothers did not complete the measures until the third or fourth session instead of the first, thereby shortening the pre and post test treatment time span. It is quite probable that the difficulty encountered in standardizing the testing conditions from case to case contributed greatly to the possible unrealiability of the measures.

Experimental Manipulations

If the treatment conditions are operationalized inadequately, the validity of an experiment can be questioned. This may introduce unexplained variation into the data which can obscure treatment differences. Consequently, the experiment will not accurately test the question it purports to investigate. This issue will be discussed relative to the treatment modalities chosen for experimental manipulation, possible therapist bias, and length of treatment.

Type of Treatment

The two treatments compared in this study were (a) a behaviorally oriented child management program and (b) a client-centered model. While no group experimental studies were found in the literature review undertaken for this study related to

comparison of the specific treatment modalities, it is evident that in much of the individual case reporting both treatments are used and often within a program developed for a particular case (Jeffrey, 1974; Tracy and Clark, 1974). Therefore, perhaps an attempt to "separate" the two treatments for comparison was to create a distinction that was difficult to maintain during the course of treatment.

It was reported by the therapists that they found it difficult to keep the treatments separate and only apply one method to a particular case. Questions were asked such as "how can you teach a mother how to use positive reinforcement with her 4 year old son, who wets his pants, when what she really wants to talk about is her boyfriend beating her up?" This kind of a situation often presented itself to the therapist who was then faced with the dilemma of either "pushing on" a discussion of the children if the case was in Treatment 1 or stop and take time to "listen" to a case-mother talk about other problems, regardless of the design consideration of the experiment. In addition, it is highly probable that in most cases there was "exposure" to both treatment conditions. What appears to have happened then, is that the behavorial treatment condition was presented to the casemother within the context of a client-centered working relationship. This situation most certainly contributed to the non-significant results obtained in the study.

Therapist Bias

Throughout the course of the training, comments were made by the therapists that indicated that they "favored" one particular method over the other in working with a casemother. This was also evident during the course of supervision. Therapists would come to the session and report how "difficult" it was to get their casemother to focus on the children and how much "smoother" things went when they just "talked" together. Clearly, it appears that the therapists had difficulty maintaining the distinction between the 2 treatment conditions and often reinforced this problem by their own treatment bias and general uncomfortableness in maintaining a specific focus to their involvement.

History

Random assignment was completed in this study relative to the treatment conditions. However, many participants were placed in other treatment programs prior to completing this one. For example, a casemother may have become involved in a group therapy situation or parenting class because the caseworker thought she needed it. The researcher attempted to prevent this kind of situation from occurring, but it still happened. Therefore, the activities between the first and second measurement may have been different between and within the groups in addition to the experimental conditions.

Length of Treatment

This was a relatively short term treatment program compared to most therapies involved in child abuse cases (Helfer and

Kempe, 1976). In addition, it has been the researcher's clinical experience that most abuse cases are in treatment for at least one year and usually longer. Therefore, the time framework for this program may not have been powerful enough to produce significant treatment results in the direction hypothesized. This would apply to both within and between group differences.

Procedures

There were many nuisance variables encountered in conducting this research that most likely contributed to the non-significant findings. These variables will now be discussed.

When a therapist actually began working with a casemother, she often encountered environmental obstacles which made treatment difficult. For example, in several instances spouses would be home and the mother would express uncomfortableness in talking about a problem in front of him. Other situations include television sets and radios playing, phone calls, child interruptions, friends dropping in or already being there and so on. In addition, on some occasions a therapist would go to the casemother's home and find her not there and no message as to where she was or when she might come back. Then there was the other extreme. A casemother was not only always home but called the therapist several times in between visits to talk about a problem. Casemothers would also attempt to get a therapist to provide other services for her such as transportation for running errands. In one case, when the therapist informed the casemother that she would not do this, the woman became belligerent and angry and stated "I thought that's why you were here, to take

me places." Therapists remarked they often felt it necessary to do some of these things in order to establish a good relationship with their casemother.

Another major source of difficulty was encountered with one of the agencies from which case were obtained. It was hard to keep in contact with individual caseworkers to secure information about a casemother or inform them of how the treatment was progressing. Caseworkers also varied extensively from one person to another regarding their own expectations of what the program could provide. Therefore, many cases were not placed in the program because it could not provide what the caseworker wanted for their client, such as long term therapy, working with the child, etc. The worker would then be frustrated and more reluctant to refer people to the program.

It took over a year to obtain the 20 cases in this study. This was due to several reasons. First, caseworkers often wanted a more long range program, second, the complexity of each situation required complicated logistical planning because many professional people were involved. For example, it was not unusual for a casemother to have a protective services worker, a parent-aide, a visiting nurse, a probate court worker, a pediatrician and be a participant in a parenting class or attending parents anonymous meetings. Third, prospective therapists were not always available and it took time to train them. Fourth, clients were not always readily available either due to some legal determination still being resolved or some other need being deemed more important by the person or persons responsible for co-ordinating a treatment program.

The impact of these factors is difficult to assess but it seems reasonable to assume that they might have contributed to the negative outcome.

Design and Analysis

Lack of statistical significance can frequently be attributed to an improperly designed experiment or to inappropriate analysis of the data. The design and analysis in this study appear to have been properly and appropriately employed. The procedures were straightforward and did not require a complicated design or statistical analysis.

It was desired however to examine the interaction between the therapist variable and the treatment conditions. This was not accomplished due to lack of data. Not every therapist had more than one case in each treatment which made a test of interaction impossible. Given some of the non-statistical results of the study, had this analysis been possible, useful information would have been obtained relative to the effectiveness of the treatments.

Theory

Potentially the learning model has considerable power in the formulation of intervention and treatment strategies such as those attempted in this study. The model requires the monitoring of specific behavior, on both the part of both parents and child that ends in abuse. The idea is that if the immediate antecedents of abuse are properly identified, steps can be taken to modify the behavior they represent - and perhaps prevent it from occurring.

In addition, child abuse has been conceptualized within an apparently accurate behavioral framework. In learning terms, child abuse is viewed as a failure on the part of a parent to have learned alternative means of managing a child other then through physical punishment. In addition, these parents themselves learned their child rearing attitudes and behaviors by observing models (their own caretakers) using punitive measures and having inappropriate experiences in their own childhood. Theoretically, this is a straightforward and simplistic formulation.

It may be too simple a theory in which to formulate causal and treatment models of child abuse, however. Its weakness may be in failing to account for several relevant influences such as: (a) psychodynamic determinants i.e. the lack of a "mothering imprint"; (b) the importance of frustration and stress; and (c) family structure. These possible child abuse causal correlates are not all inclusive but only serve to represent other important aspects of the problem, which are not accounted for by the learning model.

A more powerful causal and treatment model may then be one which accounts for all the major influences seen in child abuse situations within an interactional framework. Such a model was described in Chapter 1 and is called the psychosocial systems model.

Conclusions

A Positive Future Perspective

Because this study was closely connected to an existing program which uses volunteers for working with child abuse cases,

it was in part an evaluation of that program. Therefore, many of the recommendations made also pertain to improving the existing program's services. Also, while there were no significant differences found in the study, the researcher believes that the treatments were useful and that much was learned that is valuable to developing future similar child abuse programs involving parent aides. These issues will now be addressed.

Individual Case Improvement

Many of the therapists verbally reported that their casemothers were engaging in more productive behaviors at the end of the project than they were at the beginning. For example, therapists stated that their casemothers were taking adult basic education classes, looking for part time employment, keeping more regular appointments with them, handling the children in less punitive ways, and generally appearing more organized in their daily activities. In every situation the therapist felt that the one-one contact they had with their casemother was extremely useful and productive. Perhaps a more meaningful analysis of treatment effects in this research could have been obtained by doing in depth individual case studies. The researcher contends that many positive and worthwhile effects of the treatments went undetected due to the emphasis placed on group differences and not on individual circumstances. (See Appendix N for a table which presents individual pre and post test scores).

Parent-Aide Reinforcement

On a systems level, again there is reason to state the outcomes of this study in a more positive framework. The supervisor

of the parent-aides who participated in this research, commented that these women demonstrated more "active interest" in the total child abuse program than the other parent-aides. Her opinion was based on the fact that she received more phone calls from these women about how their cases were progressing, they returned written evaluative materials to her quickly; they attended more inservice training sessions, and very rarely missed scheduled supervisory appointments.

The supervisor thought that the reason these parent-aides were more involved in the total program was because of their participation in this research project. They were actually made to feel a part of a new and innovative program and their input into it's effectiveness was crucial. Somehow it appears as though they adopted the program as partially their own and this motivated and reinforced them to put out a lot of extra time and energy.

This seems to give rise to the possibility that the interest and activity level of the volunteers involved in a community based child abuse program can be strengthened by including them in a meaningful way in a research project such as the one presently under consideration. You not only increase the likelihood of obtaining meaningful data, but you can actually have an impact in making an existing program more effective by virtue of the way you conduct the research. However, the researcher recognizes the possibility that any "extra" attention that is received may account for these findings via the Hawthorne Effect.

Supervisor Reinforcement

The parent-aide supervisor also became excited and more "involved" in her role. As time wore on during the project, she began venting a lot of her frustrations about the supervisory role. Areas of conflict were mentioned such as lack of support from the agency administration, difficulty in obtaining monies for special needs, a poor working relationship with other agencies and what kinds of training do parent-aides really need. In all these areas, the supervisor became more aggressive and appeared to get more of what she wanted both for the program and for herself. Since the end of the research, one tangible piece of evidence supporting this position is the development of evaluation instruments and a training program for parent-aides. The possibility of the Hawthorne Effect is again noted.

Working Relationships Between Agencies

There was a certain amount of resistance and resentment among caseworkers in the two agencies connected with the child abuse program involved in this study. The parent-aide supervisor felt that her actions were controlled by the agency that funded the program. For example, this agency required her to submit records documenting case progress. However, they did not consult her on how or what data should be collected. In addition, cases were closed out and removed from the parent-aide program without the supervisor's knowledge. On the otherhand protective service caseworkers felt the parent-aide supervisor was too selective in accepting referrals and took too much time in assigning a case.

This situation seems to be the result of having a program located and implemented within one agency but funded by another. What would seem to be a more useful and productive structure is to provide some sort of joint control, where both agencies have an equal voice in the direction and scope of the program. This issue seems to have been particularly sensitive in this situation because both agencies are on the same level and no clear cut order of accountability exists between them. In most situations where this problem may occur, at least one agency is usually at a higher level than the other and has some built in expectations already established. An example of this would be federal grants to state programs.

Volunteers

Para professionals play a major role in carrying out treatment strategies in child abuse programs such as the one under consideration in this study.

One of the most important non-statistical outcomes of this study is related to the whole concept of volunteers. It is the researcher's contention that it is equally important to determine what kinds of people we could safely and conscientiously turn over the activities such as those in this study as well as the type of training to give them.

Selection

The qualities which the researcher feels are important to look for in people who make good volunteers are: empathy, being able to listen effectively; being very humble about what they can

do and how much they know; and have a wholesome warmth about them. These individuals should also seem to be doing a reasonably good job in handling life themselves. We do not have to make all the mistakes of the people we are trying to help in order to reach them effectively.

In some cases it may be useful to look for people who have had special experiences. While these are not as numerous as the researcher had thought, it is possible that personal experience with a particular problem such as child abuse may make volunteers more helpful to others who have the same problem. It would be useful to scientifically determine for instance whether a "former" child abusing mother, who is making a reasonably good adjustment might be a more effective parent-aide than a non-abusing mother.

The researcher is skeptical of the use of tests of cognitive abilities to screen for counseling competence and is very skeptical of experience in counseling as a prerequisite, particularly in a situation with volunteers. Too many people seem to have had a lot of experience but it has been of the wrong kind and it tends to perpetuate their errors.

An example related to this study concerns two women who were graduate students in counseling. They appeared to have more difficulty relating to their casemothers and tried to make their sessions similar to "formal" counseling procedures. When it was clear this approach wouldn't work, they began to question their counseling effectiveness and had difficulty seeing that this situation really called for a considerable amount of modification

of their expectations of what could be considered as counseling activities. Therefore, preference should probably be given to people who have had little if any formal experience.

It would also be helpful to ask for a detailed evaluation of the volunteer from those who really know this person quite well.

In the last analysis, the best way to know whether we have a good candidate is close observation of her through the training period and a probationary period where his work is scrutinized rather carefully.

Training

Once we have decided on whom we are going to use as volunteers, "How do we do it?" There is a real danger here!

Many potential good volunteers have been ruined by too much didactic training. We must be careful that we do not lose the very essence of their skill by giving them too much formal training which often presents them with many things that make them less effective.

In the training conducted in this study a priority focus was an attempt to provide the therapists with an opportunity to become more effective in their basic human interaction skills rather than spend much time on understanding all the psycho-dynamic aspects of child abuse, the child abuse laws, etc. Teaching people to talk and listen effectively to others is in the researcher's opinion the most important aspect of any helping relationship.

The major thrust of these activities should be in-service training which would involve periodic seminars built around the real problems that are being experienced by the volunteers and not theoretical problems which they never meet. This objective was achieved through the use of role played child abuse situations in this project.

Supervision

Good supervision is the most vital part of the whole training procedure. The major training for good, effective helpers takes place in guided, supervised experience with many opportunities for interaction with those who have had a bit more experience.

It seems helpful that at least part of the training comes from someone who is from the same group being trained. People in a variety of settings have found that trainees often tend to accept training most readily from somebody with whom they can identify or someone who is like themselves in characteristics or background or future. The researcher found it initially difficult to get the therapists to "accept" him as an equal; someone with whom they could really share their thoughts and feelings with. It may have been helpful to have conducted the training with the assistance of a "seasoned" parent-aide.

Finally, training and supervision is most effectively done in groups and not individually. Training groups offer the singular advantage of being a microcosm of people who can react to the volunteer in much the same way that her future target population

will react to her, thus giving the volunteer an in vivo experience in actually using the skills.

Treatment

Communities with child abuse programs usually have a diagnostic and educational component to their activities. However, treatment tends to be the most notably lacking area. Even communities with many therapeutic resources may lack effective alternatives to meet an individual family's needs. Existing resources often have to be modified.

Professionals and agencies that provide therapeutic services have traditionally assumed that if people want help, they'll show up. This assumption, however, does not always apply to abusive or neglecting parents. For them, the request of help usually takes a more subtle form - like bringing a beaten or malnourished child to the hospital emergency room. These parents are typically untrusting and afraid of being labeled as "bad", they miss scheduled appointments, can be hostile and unresponsive to traditional service methods. In short, they require "reaching-out" services as well as individualized care. For example, in this study, one parent-aide took her casemother to the library to show her how to check out childrens' books and toys. The casemother never knew this fine service was available and always felt guilty that she could not purchase these things for her children.

General Problems and Considerations

One basic fear that abusive parents have about entering treatment is that of reliving a new edition of their life-long pattern of being criticized and punished for failing to do well.

In the initial contacts, the therapist should bear in mind how the parent must be perceiving the situation. Suspicion and reluctance should not immediately be interpreted as paranoid or irrational behavior, but rather as the inevitable result of past experience. In addition, the therapist should not expect the parent to appreciate their good intentions. Offers of help are often spurned. This can be very frustrating and unrewarding to the therapist.

An angry, argumentative, and evasive parent can be an almost impossible person to work with. Often, there is little the therapist can do except wait patiently without retaliation, trying to find time to be supportive and appropriately helpful.

This kind of situation can sometimes be lessened or avoided if the therapist is not active in the reporting or investigation of the family. That way, those that are involved in the identification and diagnostic process can then remain the primary target of parental anger, leaving the therapist in a position of really being perceived as a helper.

It may also be useful to involve male as well as female therapists in the treatment process. Men are notoriously reluctant to accept help, but the presence of a male therapist may make them more receptive to therapy.

Treatment Modalities

The researcher feels that the treatment conditions in this study were not good comparisons. Behavior modification is a specific set of techniques usually implemented in narrowly defined problem situations. However, client-centered counseling is a much more pervasive concept that applies to the overall "atmosphere" of the counseling relationship. Therefore, whatever specific treatment strategies that are used probably occur within the context of an empathic atmosphere.

What may be a more useful treatment comparison would be a situation where two techniques that are very specific in terms of their implementation to certain problem situations would both be presented to the participants in a client-centered relationship.

Treatment programs are also usually very comprehensive and include many different "fronts" in dealing with child abuse cases. Perhaps a comparison of these overall approaches to the problem is more useful than looking at specific treatment strategies. It would be a rare situation where one treatment method could possibly meet all the needs of child abusing parents. Treatment programs need to begin focusing on other family members besides the mother, especially the abused child. Treating the children usually consists of providing foster care, a day care nursery and so on. Very seldom is the child included in any treatment such as play therapy, family therapy, etc.

Treatment Recommendations

The following is a summary of recommendations regarding the treatment of abusive families:

1. The actual behavior of physical abuse should be viewed as a serious manifestation of abnormal rearing within a family structure.

2. The family as a whole must be the prime focus of treatment.

3. Therapy should be viewed as a long term project.

4. Therapy will and should most likely include different techniques for different purposes.

5. Therapy will have to be "creative" and involve non-traditional methods.

6. Working with abusive families is a particularly frustrating experience for a therapist.

7. The therapist should not be a part of the diagnostic and investigative effort in a given case.

8. Treatment is best carried out by a team effort that is multidisciplinary in its makeup.

Research Recommendations

The rationale for this study had three bases (a) the growing interest in the area of behavior therapy as applied to more complex clinical problems, (b) the lack of research support for the uses of behavior modification techniques in these more complicated problems and in particular the area of child abuse,

and (c) the lack of experimental studies regarding treatment techniques as applied to child abuse situations.

The fact that the results of the present study are negative should not discourage future research based on the behavior therapy model. The model remains a potentially useful starting point for investigating the most effective way of intervening into the parent-child relationship which is seen as crucial in child abuse situations. Future researchers however, should consider several methodological variations of the present study: (a) define more clearly the treatments under consideration; (b) increase the length of time the treatments are applied; (c) strive to standardize the conditions under which the treatments are administered; (d) build in dependent measures which give the participants a chance to "evaluate" the effectiveness of the treatments; (e) better standardization of the conditions under which the dependent measures are gathered; (f) try to keep the participants involvement in other concurrent treatment programs at a minimum; (g) develop the training component of the therapists involvement so that they can "differentiate" the treatments under consideration more clearly; (h) provide closer and more regular supervision of the therapists during the course of the study; (i) evaluate the therapist component of the study as an independent variable; (j) develop a close working relationship with the community agencies that will provide possible study participants; (k) set a definite time limit between the training of therapists and assigning them cases; (l) have more definite and clearly defined

expectations of the therapists such as time requirements, records to be kept, etc.; (m) define more clearly the criteria used for selecting potential therapists -- and more along the lines of interpersonal strengths than demographic characteristics; (n) include the whole family in the treatment application, especially the child.

APPENDICES

APPENDIX A

LISTENING SKILL ROLE PLAY

Family "R"

This is a family of two inexperienced parents and their first baby. Mrs. R. is 24, and Mr. R. is 29. The baby was 1 month old at the time of hospital admission for acute shock from dehydration due to diarrhea and vomiting.

Gestation and birth were normal, and the baby's first two weeks at home were fine as well. After two weeks, he began eating poorly, did not gain weight, and was "fussy and cried a lot". Diet was changed, and the baby did better on this for two days, after which he developed diarrhea and became even more fussy. During this period, the mother described herself as getting more and more tense. She was most nervous nights when her husband was working, and frequently called her local doctor at night, until he lost patience with her and told her "if she couldn't be a good mother to take the child to St. Lawrence and they'd find someone to take care of him". This made her mad and when the child later got very sick she said, "See, I told you so". The baby continued to have diarrhea with vomiting, was listless, would not take any liquid including water. The mother did not know what to do and let him sleep. Finally, the baby turned blue, and Mrs. R. called her husband, who realized it was serious and rushed the baby to the hospital. While in the hospital, the baby gained weight and the diarrhea and vomiting cleared up.

Mrs. R. has many concerns about the baby. She is afraid of harming him either by hitting him or by dropping him accidentally. She is afraid she would spoil him by picking him up when he is crying, and also feels that he cries too much, especially when she is alone with him. She can't understand why he doesn't cry as much when her husband or relatives are around to pick him up. She has epilepsy, and is afraid of having a seizure while holding the baby. She doesn't know how long a baby should sleep and can't tell when he has had too much or too little to eat.

Mr. R. feels that there is no significant problem with the baby, and this his wife is a little up tight because she has never been around little babies. He feels that she'll be a good mother after she has had some experience, and he likes it that she depends on him for help

with the baby. He feels that the baby makes things less lonely for her, and loves the baby and feels he is pretty healthy. Neither parent seems to comprehend how sick the baby was when brought to the hospital.

Parent's Backgrounds

Mrs. R.'s parents died while she was in her teens, and she lived with her sister thereafter. She sees her parents as good people who spoiled her because they were afraid she might die or have a seizure, and therefore they would not let her do anything at home. Consequently, she does not know how to cook or keep house or take care of babies. She feels insecure and inadequate at this, especially as her husband is a better cook than she. She sees her relatives (including in-laws) as friendly and helpful; however, they all live out of town. A neighbor lady has told her to come over with questions any time, and Mrs. R. has done so once or twice. She seldom leaves the house without her husband, and spends most of her time watching TV and reading mysteries. She has worked as a waitress, and is thinking about going back. She sees her husband as a positive and understanding person, but does not understand why he works nights, even though he explains that he'd have to take a cut in pay to work days. She thinks that the baby is a lot of trouble right now, but that it'll be worth it when he grows up. The baby was a planned and wanted child. When he cries, she rocks him and tries to quiet him, and if that doesn't work she closes the door and turns up the TV. She doesn't like to pick him up very often because she'll spoil him, and does not hit him because if she did she would hit him too hard and hurt him. She is very anxious about all aspects of child rearing, and though she has read several books she is too insecure to handle even minor problems.

Mr. R. is a high school graduate who makes a good income working in a factory. He sees his parents positively, and feels that they are pleased with him. He likes working the night shift, and does not want to change. He has no solutions for his wife's lonliness and nervousness at night. He says he's a quiet man, with few friends though he would like to meet more.

Both parents, then, have few outside interests or geographically close friends and relatives. Both came from loving families, though the mother was somewhat overprotected.

Problem list:

Plan:

APPENDIX B

VALUE CLARIFICATION EXERCISE

Abuse and Neglect: Values Game

I. Goals:

1. To present and support personal perceptions and attitudes openly to other group members.

2. To listen and understand perceptions and attitudes of others.

3. To analyze the dynamics of one's group and how it makes decisions.

4. To better understand other's values by facilitating openness and trust.

5. To learn how to accept the position of others without rejection merely because it may be different than one's own.

II. Story:

Bertha is a 22 year old mother of two children, ages 2 years old and three months. Her son Rocky (age two) was born out of wedlock. Bertha's boyfriend at the time deserted her when her pregnancy was confirmed. Bertha's pregnancy was unwanted. It was medically and emotionally difficult. Bertha did not want to keep Rocky at birth, but succumbed to family pressure. Rocky has been both a neglected and abused child since birth. The last abuse incident occurred one week ago. Rocky had been burned several times on his hands and feet. It was determined that these burns were inflicted by a cigarette and by the mother. Rocky is still in the hospital. He will be placed in foster care until some treatment plans have been arranged. Bertha has verbalized her inability to continue to care for both children and has expressed a desire to release Rocky for adoption.

Several people are involved in the case and were called together to discuss planning for both mother and Rocky. People

present at the staffing were: Grandmother (Bertha's mother), Bertha, Sidney (a Protective Services worker involved with Bertha at the time of Rocky's hospitalization). Ann (a case-worker who has seen Bertha in counseling for one year) and Dr. Davidson (the family physician).

Bertha begins the case-staffing by stating "I want to give up Rocky - I never liked him - he's always been just like his father. I can't seem to care for my baby with Rocky around and I'm scared that I'll hurt both of them unless I can get rid of this kid".

Grandmother, with much feeling, states that she is opposed to Bertha releasing Rocky for adoption. "I took care of my kids when things were tough - it really hurts me to hear Bertha talk that way - she knows I'll take care of the kids for her".

Sidney, the P.S. worker, comments that "there are many supportive services that can help you keep your son. I know that you have tried some of these things in the past, but I would be willing to help. Through day care, a possible parent aide and with continual support from the caseworker, I think things can work out".

Dr. Davidson said, "I have known this family for years and I feel Rocky should be removed permanently from the home."

Ann, the caseworker, states "I've talked with Bertha for over a year. Bertha is pretty clear with us that she doesn't want to be a parent to Rocky and that in fact she has felt this way since Rocky's birth. She has made many efforts to cope with Rocky and I feel it is important that we respect her difficult choice, and get about making plans for Rocky further".

III. Directions:

1. Rank the five characters in the story with one (1) being the highest ranking and five (5) the poorest. All five people must be ranked and each number (1-5) can only be used once. Members should give a one word description of each character and write that next to each character (e.g. indifferent).

2. The total group and members should then decide on a single rating list for the group (time is 30 minutes). Using the descriptor, what value is expressed as most important? Least?

Critique Guidelines:

1. Was everyone open to others' opinion?

2. What behaviors in the group facilitated the group reaching a consensus? Give feedback to individual members.

3. What behavior in the group did not facilitate the group reaching a consensus? Give feedback to individual members. Twenty minutes before the end of the group, critique the experience with the members of your own group.

4. What criteria did the group use to rate people?

APPENDIX C

CHILD BEHAVIOR CHECKLIST

Child's Name _____

Child's Sex _____

Child's DOB _____

All parents experience problems in raising their children. The purpose of this checklist is to determine the areas of concern that you have about your child's behavior. This information will assist us in helping you become a more effective parent.

Please check (X) all the behaviors listed below that are causing you concern about your children. Thank you.

___ eating

___ sleeping

___ crying

___ toilet training

___ temper tantrums

___ messiness

___ lying

___ fighting

___ poor co-ordination

___ breath-holding

___ acts younger than age

___ short attention span

___ seeks attention from adults

___ bossiness

___ low level of energy

___ moody

___ stealing

___ teasing others

___ acts older than age

___ stuttering

___ likes to hit

___ refuses to obey rules

___ always wants to be with mother

___ fakes illness

___ finger sucking

___ nervousness

___ fear of strangers

___ plays alone often

___ always wants to be with father

___ sexual problems

___ always wants things immediately

APPENDIX D

Number_____

Date _____

SURVEY on BRINGING UP CHILDREN*

Instructions

Using the scale shown on the right, please indicate your degree of agreement or disagreement with each of the 60 statements shown below and on the reverse side of this survey form.

Simply circle the number which corresponds with your feelings about the statement.

Rating Scale

Strongly Disagree	(7)
Moderately Disagree	(6)
Slightly Disagree	(5)
Neither Agree nor Disagree	(4)
Slightly Agree	(3)
Moderately Agree	(2)
Strongly Agree	(1)

Statement:								
1.	Families usually understand when a mother tries to do the right things for her children.	1	2	3	4	5	6	7	26
2.	I was not criticized too much by either of my parents.	1	2	3	4	5	6	7	27
3.	I usually felt I did not deserve the punishment I got as a child.	1	2	3	4	5	6	7	28
4.	I sometimes fear that my mate is too easy on the children and is spoiling them.	1	2	3	4	5	6	7	29
5.	In order for them to grow into decent human beings, children must be punished in a firm way.	1	2	3	4	5	6	7	30
6.	I am close to other people.	1	2	3	4	5	6	7	31
7.	I never become angry with my children.	1	2	3	4	5	6	7	32
8.	My mother and I have always gotten along well.	1	2	3	4	5	6	7	33
9.	Children should know, even before the age of 2 years, what parents want them to do.	1	2	3	4	5	6	7	34
10.	No one has ever really listened to me.	1	2	3	4	5	6	7	35
11.	Sometimes it is hard for me not to feel jealous of my mate.	1	2	3	4	5	6	7	36
12.	I am always good to other people.	1	2	3	4	5	6	7	37
13.	When people try to help me with my baby, I feel awful.	1	2	3	4	5	6	7	38
14.	Whenever I have a problem, there is always someone to whom I can turn for help.	1	2	3	4	5	6	7	39
15.	I am afraid of many things.	1	2	3	4	5	6	7	40
16.	I plan to raise my children basically in the way my parents raised me.	1	2	3	4	5	6	7	41
17.	When I am pregnant I become very depressed. (or) When my mate is pregnant she becomes very depressed.	1	2	3	4	5	6	7	42
18.	Children are rarely ready to be toilet trained at one year of age.	1	2	3	4	5	6	7	43
19.	I am always being criticized by other people.	1	2	3	4	5	6	7	44
20.	My child(ren) is (are) always good.	1	2	3	4	5	6	7	45
21.	The main thing that I remember from my childhood is the love and warm feelings my parents showed me.	1	2	3	4	5	6	7	46
22.	At least one of my parents wanted too much from me.	1	2	3	4	5	6	7	47
23.	My marriage couldn't be happier.	1	2	3	4	5	6	7	48
24.	Most children should walk well by 9 or 10 months of age.	1	2	3	4	5	6	7	49
25.	Sometimes my mate doesn't seem to want to talk to me and this really bothers me.	1	2	3	4	5	6	7	50
26.	I have never felt really loved.	1	2	3	4	5	6	7	51
27.	At least one of my children remind me of someone I don't like.	1	2	3	4	5	6	7	52
28.	When I was a child my parents used severe physical punishment on me or at least one of my siblings.	1	2	3	4	5	6	7	53
29.	Most people say parents automatically feel love for their children, but it's not that easy.	1	2	3	4	5	6	7	54
30.	It seems that when I needed her the most, my mother has been least helpful.	1	2	3	4	5	6	7	55

Summary of Rating Scale

1	2	3	4	5	6	7
Strongly agree	Moderately agree	Agree Slightly	Neither agree nor disagree	Disagree Slightly	Moderately disagree	Strongly disagree

Simply circle the number which corresponds with your feelings about the statement.

31.	Although my mother tries (tried) to make helpful hints to me, it ends up sounding more like criticism.	1	2	3	4	5	6	7	56
32.	Children need to be taught, before the age of 2, to respect and obey their parents.	1	2	3	4	5	6	7	57
33.	I am very well liked by everyone.	1	2	3	4	5	6	7	58
34.	At least one of my parents didn't really listen to me or understand my feelings.	1	2	3	4	5	6	7	59
35.	A good mother should be home all of the time with her children.	1	2	3	4	5	6	7	60
36.	I have often felt that my mother would (or would have) take over completely and run my life if I gave her half a chance.	1	2	3	4	5	6	7	61
37.	It is extremely important for me to have my children behave well even when they are babies.	1	2	3	4	5	6	7	62
38.	Children under 3 years of age often play with their food.	1	2	3	4	5	6	7	63
39.	It bothers me alot when my baby grabs the spoon and food gets slopped all over while he is eating.	1	2	3	4	5	6	7	64
40.	My mate understands my problems.	1	2	3	4	5	6	7	65
41.	I am always friendly to others.	1	2	3	4	5	6	7	66
42.	Often when my baby cries, I don't know what to do about it.	1	2	3	4	5	6	7	67
43.	Sometimes I just feel like running away.	1	2	3	4	5	6	7	68
44.	It bothers me alot when anybody criticizes the way I take care of my children.	1	2	3	4	5	6	7	69
45.	I have always been very close to my mother.	1	2	3	4	5	6	7	70
46.	I go through times when I feel helpless and unable to do the things I should do.	1	2	3	4	5	6	7	71
47.	As a child I often felt that no one paid much attention to what I wanted and needed.	1	2	3	4	5	6	7	72
48.	My mate is always more help to me when I am pregnant. (or) I am always more help to my mate when she is pregnant.	1	2	3	4	5	6	7	73
49.	When my baby cries I often get the feeling I just can't stand it.	1	2	3	4	5	6	7	74
50.	I think preschoolers should know when parents are upset and try to be good at these times.	1	2	3	4	5	6	7	75

80=2

APPENDIX E

Number 22078

SURVEY on BRINGING UP CHILDREN*

Fact Sheet

Please write the number which corresponds to your response in the answer box to the right of the question.

			Answer	
1.	Your age in years.	1.		6
2.	Race: 1—oriental 2—caucasion 3—black 4—other	2.		7
3.	Sex: 1—male 2—female	3.		8
4.	How many children do you have?	4.		9
5.	Age of youngest child (put X if no children)	5.		10
6.	Age of oldest child (put X if no children)	6.		11
7.	Marital Status: 1—married 2—divorced 3—separated 4—never married 5—widowed	7.		12
8.	Were you separated from your mother before the age of 11 years? 1—yes 2—no	8.		13
9.	When you were a child did you have a pet? 1—yes 2—no	9.		14
10.	When you "got out of hand" as a child, how were you punished? 1—none 2—physical punishment 3—non-physical punishment	10.		15
11.	Financial situation per year: 1—Under $4,000 2—$4-6,000 3—$6-10,000 4—$10-15,000 5—$15-20,000 6—Over $20,000	11.		16
12.	Have you ever been seriously ill? 1—yes 2—no	12.		17
13.	Education—check highest grade achieved: 1—less than 8th 2—8th 3—10th 4—12th 5—College not completed 6—College completed	13.		18
14.	Have you ever lost a very close relative or friend by death? 1—yes 2—no	14.		19
15.	Is your telephone number listed in the telephone directory? 1—yes 2—no 3—I don't have a phone	15.		20
	For women only			
16.	Have you ever had a premature baby? 1—yes 2—no 3—never had a baby	16.		21
17.	Have you ever had a Caesarian Section? 1—yes 2—no 3—never had a baby	17.		22
18.	Did anyone ever tell you when you were born your mother's pregnancy or delivery was very difficult? 1—yes 2—no	18.		23

80-1

*Developed by Ray E. Helfer, M.D., Michigan State University and Carol Schneider, Ph.D., University of Colorado

APPENDIX F

RATING SCALE

I. Child's Activity Level (physical)

Passive, Inactive 0 1 2 3 4 Very Active

II. Mother's Positive Emotional Involvement with Child

A. Tone of Voice

Angry-Hostile	Distant-Cold	Unemotional Neutral	Lukewarm	Very Kind	Very Warm Loving
-2	-1	0	+1	+2	+3

B. Amount of Expressed Positive Emotion

None 0 1 2 3 4 Very Much

III. Mother's Attitude Toward Child's Behavior

Unaccepting 0 1 2 3 4 Completely Accepting

IV. Amount and Kind of Contact of Child Toward Mother

A. Physical

AMOUNT: Never 0 1 2 3 4 Very Frequent

CLOSENESS: Distant 0 1 2 3 4 Close (includes attitudes, touching, body language, etc.)

VIGOR: Passive 0 1 2 3 4 Vigorous

B. Auditory-Verbal (communicating with mother)

AMOUNT: Never 0 1 2 3 4 Very Frequent

C. Visual; eye-to-eye

AMOUNT: Never 0 1 2 3 4 Very Frequent

D. With Materials

AMOUNT: Never 0 1 2 3 4 Very Frequent

E. Social Stimulation

AMOUNT: Never 0 1 2 3 4 Very Frequent (child involving mother in relationship)

F. Communicative Stimulation (verbal) Trying to Send a Message.

AMOUNT: Never 0 1 2 3 4 Very Frequent

V. Amount and Contact of Mother Towards Child

A. Physical

AMOUNT: Never 0 1 2 3 4 Very Frequent

CLOSENESS: Distant 0 1 2 3 4 Close (includes attitudes, touching, body language, etc.)

VIGOR: Passive 0 1 2 3 4 Vigorous

B. Auditory-Verbal (communicating with child)

AMOUNT: Never 0 1 2 3 4 Very Frequent

C. Visual; eye-to-eye

AMOUNT: Never 0 1 2 3 4 Very Frequent

D. With Materials

AMOUNT: Never 0 1 2 3 4 Very Frequent

E. Social Stimulation

AMOUNT: Never 0 1 2 3 4 Very Frequent

F. Communicative Stimulation (verbal) Trying to Send a Message.

AMOUNT: Never 0 1 2 3 4 Very Frequent

VI. Responsiveness of Mother to Child's Behavior (rating the mother)

A. Frequency

To Distress	Never	0	1	2	3	4	Very Frequent
To Social Expressions	Never	0	1	2	3	4	Very Frequent
To Demands	Never	0	1	2	3	4	Very Frequent
To Physical Needs	Never	0	1	2	3	4	Very Frequent

B. Selectivity of Response (choosing the "right" response)

	Never	0	1	2	3	4	Always

VII. Appropriateness of Mother's Behavior

A. Effectiveness

	Never	0	1	2	3	4	Always

B. For Age and Ability of Child

	Never	0	1	2	3	4	Always

APPENDIX G

CONTACT SHEETS

Name: _____ Length of Session: _____

Date: _____ Session #: _____

SUMMARY OF ACTIVITIES DURING SESSION

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL COMMENTS/IMPRESSIONS

_____

_____

_____

_____

_____

_____

Use space below to record any description of your child's behavior that are not sufficiently covered by the above scales:

APPENDIX H

INFORMED CONSENT FOR SURVEY ON BRINGING UP CHILDREN*

The past few years have seen considerable interest develop in how people are brought up and how they, in turn, bring up their children. This survey was developed to help answer some of the questions that have been raised in considering the variations in bringing up children.

All responses will be confidential and your name and address will not be used except to contact you. Only a number will appear on the answer sheets and not your name.

I understand the above points and agree to voluntarily fill out this survey.

Witness _____ Signed _____

Address _____
Street

_____
Town State Zip

Phone _____

Date _____

*Survey developed and conducted by Ray E. Helfer, M.D., Michigan State University, College of Human Medicine and Carol Schneider, Ph.D., University of Colorado. 1/75

THIS FORM MUST BE FILED IN A LOCKED FILE AVAILABLE ONLY TO THE PROJECT DIRECTOR.

APPENDIX I

RATING GUIDE

1. Make no effort to describe a consistent behavior picture or personality.

2. Base ratings on outward behavior you actually observe. Do not try to interpret what might be going on in the mother or child's mind.

3. Avoid tending to note near the middle of all scales. Make use of the full range offered by the scales. Use extreme ratings whenever warranted.

4. If you are unable to reach a decision, go on to the next item and come back later to those you skipped. Rate each item quickly.

APPENDIX J

GUIDELINES FOR THE BLOCK BUILDING TASK

1. Read the instructions to the mother and answer all questions. Make sure she thoroughly understands what she is supposed to do before beginning.

2. If she has questions as she goes along -- answer them but do not interfere in her completion of the task.

3. If the child completes all the tasks before the time limit is up, have the mother continue interacting with the child using the blocks in any way she wishes.

4. Do your ratings immediately after the task is completed. Follow the guidelines given for the rating scale.

5. Make sure the mother "knows" you are rating the child and not her. If she asks questions about her child's performance, tell her you have to "score" and "analyze" the results before discussing them. However, tell her there is no need for her to worry or have to have undue concern about her child's performance.

APPENDIX K

BLOCK BUILDING TASK

Child's Name: _____

Child's DOB: _____ Treatment: _____

The following task is designed to determine how well your child learns. Please follow the instruction carefully. Thank You.

PROCEDURE:

Place the 12 blocks on the table, floor, etc. and begin building a 3 block tower.

1. SAY TO THE CHILD:

   See these blocks we have to play with? Watch. I am making a big tall tower. Let's see if you can make a tower just like it right here. Give the child 3 blocks to build his own tower. If he does this successfully go on to the next section. If not, say, let's try it again. Continue until the child is successful.

2. SAY TO THE CHILD:

   Now let's see if you can make a tower with 4 blocks. See if you can make one to look just like mine. Give the child 4 blocks to build his own tower. If he does this successfully go on to the next section. If not say, let's try it again. Continue until the child is successful.

3. SAY TO THE CHILD:

   Now let's see if you can make a tower with 6 blocks. See if you can make one look just like mine. Give the child 6 blocks to build his own tower. If he does this successfully, go on to the next section. If not, say, let's try it again. Continue until the child is successful.

4. SAY TO THE CHILD:

Now let's see if you can make what I am going to make. (Mother may choose to build anything she wishes) and try to get the child to build one just like it.

APPENDIX L

GENERAL GUIDELINES FOR FIRST SESSION

1. Introduce yourself to the mother. Just spend some time getting acquainted. Tell her a little bit about the program and assess how appropriate you think it would be. Make sure she understands that you are not connected with any agency and have no control over any determination in her case. Tell her you are part of a program interested in helping mothers with problems they are having with their children.

2. The mothers in the study should be aware that their participation is voluntary and they may drop out at any time.

SPECIFIC GUIDELINES FOR SESSION 1 - T_1

1. Have mother fill out biographical sheet.

2. Fill out problem checklist - use this for discussion of children.

3. Do the observation and ratings. Remember to fill out the rating immediately after the 15 minute observation.

4. Have mother do the HTP - need her name, date on the drawings.

5. Begin discussing specific problems mother is having with the child. If there is more than one child in the family, try to focus in on the one that is causing the mother the most difficulty.

GUIDELINES FOR T_2 - Client-centered

Everything is the same as in T_1, except that the content of the interviews can include any topic. Whatever the mother wishes to discuss is the direction the interview should take.

IMPORTANT!

Remember to reinforce even the smallest gains made by the mother. Use generous amounts of praise and encouragement whenever possible.

APPENDIX M

SUGGESTED ACTIVITIES FOR T_1

1. Teach mother how to record and observe child's behavior for a set time period.
2. Use of positive reinforcement - Choose a behavior and develop a program to strengthen the behavior.
3. "Child Proofing" the home.
4. Modeling how to "play" with child.
5. How to set rules and enforce them.
6. Making a list of "typical" behaviors of the child for his/her age and recording them. (Developmental Checklist).
7. Make a list of child's strengths - "good points".
8. "Guessing Game" infants and pre-verbal children to find out what needs are not being met.
9. Listening for child's feelings.
10. Shaping procedures for toilet training.
11. "Let's make a trade" - substituting for something else, i.e. crayons instead of magic marker, etc., rag instead of mom's nylons.

APPENDIX N

INDIVIDUAL CASE PRE AND POST TEST SCORES

Subjects						
	Pre	Post	Change	Pre	Post	Change
1.	36	62	+ *	1. 97	94	-
2.	73	63	-	2. 88	86	-
3.	38	25	-	3. 92	107	+ *
4.	74	40	-	4. 83	78	-
5.	28	31	+	5. 105	125	+ *
6.	60	76	+ *	6. 115	119	+
7.	58	57	-	7. 89	80	-
8.	62	60	-	8. 102	97	-
9.	45	42	-	9. 78	99	+ *
10.	51	39	-	10. 84	80	-
11.	46	76	+ *	11. 90	87	-
12.	96	79	-	12. 78	118	+ *
13.	25	40	+ *	13. 89	86	-
14.	41	46	+	14. 103	99	-
15.	39	20	-	15. 86	85	-
16.	24	31	+	16. 104	98	-
17.	45	80	+ *	17. 95	94	-
18.	56	61	+	18. 81	120	+ *
19.	48	46	-	19. 82	77	-
20.	31	36	+	20. 85	81	-

* = at least a 15 point positive increase.

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