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The Treatments of Child Abuse

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Child abuse is a major problem in our society today. It is the major killer of children in the United States. (Kalman, 1977) There are many different estimates of the rate of occurrence, and no one knows for sure how prevalent it is. The major problem with making estimates of incidence is that so many cases are never reported. Only 20-50% of the cases are reported. (Kempe, 1978)

There are three types of child abuse. (Roth, 1975) One type is situational. This type is in response to an overwhelming stress. It usually happens one time, and is the easiest to help. The second type is behavior patterned abuse. The parents turn to each other for their needs. If they can not meet each other's needs, they make one of their children a scapegoat. The parent selects one child for punishment because he is not able to handle his own inadequacies. The last type of abuse is chronic. This type is the most serious and damaging. The parent uses the child as an extension of their self, and when the child doesn't do what the parents want, they strike out and punish the child.

A large number of child abusers have some basic characteristics that may influence the fact that they abuse their children. (Claudine Penick, Personal communication, Sept. 1980) These factors may add to
the stress in their lives, and help to cause the abuse. Some child abusers find themselves in an unwanted pregnancy. They never develop a bond with their child during the pregnancy, and don't feel they can become close to the child after the child is born. Some abusers see the child as an extension of themselves. They are either terrified by this idea because they don't like themselves, or get very angry when the child turns out to be different from their idea of themselves. Some abusers have financial and marital problems. They may believe that adults do not have fun. They believe that adults should be grown up, and not do anything fun. A lot of abusers are isolated. They don't develop a feeling of closeness or a basic trust with anyone. They don't share their feelings with anyone, and never develop a real friendship. The major problem with most abusers is they do not know how to parent. They do not have basic parenting skills, and they have unrealistic expectations of their child.

Many models have been developed as to why child abuse occurs. (Claudine Penick, Personal communication, Sept. 1980) Some models are outdated, and are no longer believed to be a reason for the occurrence of child abuse. One example of this is the environmental stress model which states that if there was no more poverty and lack of occupation, there would be no more child abuse. The social psychological model states that the combination
of severe stress, influence of class norms and the passing down of your parents role model leads to the psychopathic state of the parent with the child. The problem with this is that not all child abusers are psychopaths. This same problem exists with the mental illness model because not all child abusers are mentally ill.

One of the more up to date models is the psychodynamic model. According to this it is believed that the parent has the inability to trust others. The parent is probably in a non-supportive marriage, and is unable to nurture the child. Another model is the social learning model. This states that the abusive parent has failed to acquire the basic skills of parenting. The abuser does not gain any joy from parenting. There is also the family structure model. This model states that there are alliances and certain structures in the family. The way the alliances are structured is where the child abuse is coming from. Certain alliances may be formed so that one child may be left out. The personality and character trait model states that a label is attached to the parent. The parent has some personality or character type that makes him a child abuser. There is also the psycho-social model which is set up as follows:
The host, (the parent) lives in an environment of constant change. The host has expectations of the agent (the child). The vector is the culture in which the parents were raised; how the parents learned to parent or what society expects of the parents. The child is basically in the wrong place at the wrong time. There is a constant interaction between the triangle that sets the scene for child abuse.

Since there are so many different models for child abuse, there are many different types of treatment. In a study done in Cleveland, twenty practitioners were sampled who had experience with child abuse. (Cunningham, 1966) There was little consistency in the techniques the practitioners used or those they thought to be most effective. The only major point they agreed on was that parents abuse their children mainly because of their own emotional immaturity. There are many different methods of treating child abuse, many different ideas as to how these methods should be implemented and a lot of different ways in which social agencies combine these methods.
A large number of the treatment methods overlap in ideas, but all basically have a different outlook as to what is the best treatment. One type of approach used in treatment is the psychodynamic approach. This approach contends that a case of child abuse is influenced by the "abuse-prone" personality traits of the parent. (Green, 1976) The parent was not raised in a loving environment, and does not know how to nurture and love their child. In the psychodynamic approach the key elements are role reversal, excessive use of denial and projection as defenses, rapidly shifting identification and displacement of aggression from extraneous services onto the child. The psychodynamic treatment believes that to treat the child abuser it is necessary to modify the personality traits of the parent, the characteristics of the child that enhance his scapegoating and the environmental stresses around the parent. This treatment process emphasizes the need of the parent to get involved in an emotional experience with an adult. This adult can be anyone from a physician or psychiatrist to a social worker or mature volunteer. The basic goals of the psychodynamic treatment are to help the parent develop a trusting relationship with adults. This treatment method emphasizes that the parent should be given as much help as possible such as child-rearing service, home visits and medical services. The parent
should also be given educational and vocational assistance. A role model for child-rearing techniques also should be provided for the parents. This model contends that traditional psychiatric treatment must be modified, and the therapist must be very supportive and flexible. The ultimate goal is to get the parent to enjoy their child, and to be able to successfully nurture.

Another type of treatment approach is the social learning approach. This theory is concerned with society's effect on the individual. This theory emphasizes that efforts must be made to help the parents participate socially, and must focus on the social interaction between the parent and the child. (Tracy, 1977)

This approach makes several observations about abusive parents. These parents have few skills to help them function completely as adults. They are frequently ignorant of child development, and they use punishment to control the child's behavior. The social learning technique identifies the behavioral goals, and attempts to teach the parent more effective and positive means of discipline.

Using the social learning treatment an analysis is done of the parent's means of discipline. During the whole treatment process the parents are encouraged to take part in the plans. The treatment focuses on the
parent's behavior, and attempts to change the adult into the role of a competent parent. The treatment attempts to teach the parent to positively reinforce the child's behavior. It identifies what times are particularly stressful, and attempts to relieve the stress. The family worker reinforces every bit of small progress made. An attempt is made not to get the parent too dependent upon the family worker. Role playing demonstrations are set up for appropriate child discipline.

In two studies done using the social learning treatment model, it was found that in both studies after the parents were trained, positive behavior towards their children increased and aversive behavior decreased. The aversive behaviors were not eliminated, but after training, the levels of aversive behavior were far below the baseline, and were much like those of a normal family. During the seven month follow-up, no abusive incidents occurred. The basic goal of this treatment was to define the specific behavior related to the child abuse, and to change that behavior.

Another treatment that is used is the crisis intervention treatment. This approach argues that the parents are undergoing some major situational stress at the time of the abuse. This treatment focuses on the crisis and its precipitating events.
Lydia Rapoport has developed a model of crisis intervention which is as follows:

1. Keep an explicit focus on the crisis and clarify the precipitating event and its relation to personal distress.
2. Help the parents with their feelings surrounding the situation.
3. Help the parents and the child to deal with separation anxiety if placement is required.
4. Provide information about all the processes that will follow.
5. Create a bridge to community sources that can help stabilize the family situation. (Brown, 1979)

The main point of this treatment is to look at the stages of the crises, and help the parents realize a crisis is going on. Support is given to the family in order to help them deal with the stress. This treatment emphasizes that once the feelings surrounding the crisis are looked at, some of the stress will be alleviated.

Another type of treatment is the Rational-Reality based approach. This approach contends that a strategy is needed that allows parents to understand the positive benefits that come from not abusing the child, and the negative aspects of abusing the child. (Cox, 1979) This treatment method operates in the present, and places little emphasis on the past. This treatment takes Rational Behavior Therapy and Reality Therapy and combines the two. Both therapies emphasize learning to function in the real world as it presently exists and finding ways of fulfilling oneself in such a manner that others are
not deprived of the ability to fulfill themselves.

This treatment begins with the adults attending individual counseling sessions in which they are taught Rational Behavior therapy and Reality Therapy techniques and philosophies. At first the client is taught the goals of learning rational thinking and what accomplishing these goals could mean to an individual once he has changed his thinking or behavior patterns. This is done through individual discussion and lectures. It is emphasized to the adult that he need only understand the goals at this time, and no pressure is used on the person to change his goals. Then the client is taught the basics of the two theories and he is asked to accept these criterion on a cognitive basis. This is done through handouts and is discussed in counseling sessions. The client is then asked to begin evaluating their present behavior in terms of these criterion. The client is asked to to begin making small changes. Even the smallest positive change is given verbal reinforcement.

The next stage is to teach the client the stages of an emotion. There are five steps to this which are as follows:

1. The individual perceives the situation through one or more of the senses.
2. The individual cognitively describes the situation to himself.
3. There is a pushing description of the situation through the person's belief system.
4. The individual chooses an appropriate emotion for his description of the situation.
5. The individual arrives at consequent feelings and behavior based on the emotion he has chosen. (Cox, 1977)

When the individual has gained understanding of emotions, he will better be able to choose the emotion appropriate to the situation.

The next step is to teach each client the understanding and utilization of the Rational self-analysis. This self-analysis has a number of evaluations which the individual writes about. In section A, the client states the objective facts of the event which makes him upset. The individual then makes a camera check of section A, and makes sure all that he has written down is truly fact. This part goes into section Da. In section B, the client writes down his thoughts about the event. This is the self-talk section. The client states any ideas or subjective thoughts that were a source of negative emotions he was exhibiting about the situation. The client then challenges each of the statements, and writes these challenges in section Db. In section C, the client writes down the emotional labels that describe the emotional response to the situation. This assists the client in distinguishing between thoughts and feelings. In section E, the client writes a more appropriate response. The client is then told to concentrate on using the more appropriate
response the next time in that situation. By writing down all of this, the client is better able to understand his problems. He understands how he could have acted more appropriately to the situation.

The next step is to teach the client the use of imagery in rational self-analysis. The client does repeated rational self-analyses covering problem-eliciting behaviors. During these the client is told to go through the self-talk, the challenges and decide the more appropriate behavior. After doing several of these the client is instructed to imagine himself in a situation that led to problem behavior. He is then instructed to imagine that situation again, only this time behaving in the way he would like to. While doing the imagery he is to review repeatedly the challenges he had written down. The client is asked to do this for ten minutes per day.

After the client is totally familiar with this process, he is asked to join a group of people who have gone through the process. The group discusses the process, and then their inappropriate behavior. The clients report their positive or negative behavior to the group in detail, and the group scrutinizes these objectively.

This process was used with 35 adult abusers. (Cox, 1979) All 35 had gone through the complete program, including the group discussion. The study reported that
the program had not existed long enough for extensive research to be completed. The study reported that of the 35, 23 indicated having a closer and more affectionate relationship with their children. They indicated they felt better about themselves, and were able to restrain their irritation at their child. Five people indicated having some greater self understanding and being able to restrain themselves longer, but not totally when the child was disruptive. Seven indicated no feeling of increased self-understanding, and they weren't able to restrain themselves when the child was disruptive. The study indicated that much more research was needed to find out the effects of this treatment.

Another type of treatment used is systematic desensitization. In a study using this treatment, the parent was slowly desensitized to the things about the child that irritated him, and could possibly lead to the abuse. (Sanders, 1978) In the case that was described, the subject said he felt comfortable with the baby if he was playing happily or if he could do something to stop the crying, such as feed him. If the crying persisted, and he couldn't do anything about it the client became anxious, jealous, and had the desire to kill. During the first four months of treatment, techniques other
than desensitization were used such as assertion training, behavioral rehearsal, training in personal effectiveness and the use of imipramine. After this the desensitization occurred. For the first four sessions, the client learned how to relax the muscles of his body. A list was made up of the anxiety producing situations, and they were rated in terms of feelings of anxiety. For the next 12 sessions, the client was instructed to become totally relaxed. While he was in this state each item was presented as many times as needed until he became relaxed for three consecutive presentations. A videotape was made of the son crying, and this was played during the last session. In the follow-up it was found that on one occasion, he became angry at the child for crying, but he was able to express his anger verbally rather than physically. About four months later he became angry and spanked the child, but he was in control, and reported he felt different from the way he used to. He reported he was more relaxed, and able to handle the child's crying. He was seen for an additional nine months and the imipramine was discontinued. It is not known how much the imipramine contributed to his improvement, but five months later there had been no further abuse. This study suggests that desensitization may be a factor in the treatment of child
abuse, although the fact that only one subject was used shows a need for further research.

Another type of treatment is the use of lithium. The decision to use lithium in the case cited was because the abuse occurred while the woman was in a rage, and it has been found that lithium tends to be effective in controlling rage. (Panter, 1977) In the case used, the woman had been treated with other drugs, and had been hospitalized. The last time she was hospitalized, lithium was prescribed. Her rage, assaultiveness and self-destructive behavior diminished greatly. She reported that she had struck her children twice since the lithium treatment, but she admitted that it was different from the other times. She reported she did not hurt the children, and was able to gain control quickly. This study implies that in some cases, lithium may be the appropriate treatment, although again only one subject was used.

Another type of treatment focuses more on the child than the other treatments have. The majority of the treatment methods contend that the adult does not know how to be a proper parent, and once he becomes a good parent the problem will be solved. Harold Martin in his book *The Abused Child*, contends the child has been ignored for too long. He disputes the notion that the best way to help the child is to help the parent. He
says that we have avoided the children far too long. In treatment of the child, he should be seen individually by a worker. The following things should be covered in treating the child:

1. The child's ambivalent feelings about his parents.
2. His fear something is wrong with him.
3. His need for affection and attention
4. His fear of future abuse
5. His need to learn new ways to express his feelings

The parent also needs treatment along with the child since the problem is with the parent, but there is the contention that the child needs help also.

Another method of treatment is Parents Anonymous. This organization is a group in which professionals and abusive families cooperate. (Holmes, 1978) The members undergo treatment in groups of 2 to 10 members. The group is led by a "chairperson", but it is directed by a professional. Parents Anonymous has no rigid structure or rules to follow. What happens in the group usually depends upon the group members. The professional's job is to clarify, give information or facilitate. The chairperson assumes leadership and keeps track of the members.

An important part of P.A. are the crisis telephone calls. When a member is in a crisis, he calls another member for help. The members are expected to call at least one other group member during the week. The members
are expected to become actively involved, and to use other members to help themselves. They accept the responsibility of helping each other out. Members learn how to recognize problem behaviors and to work on them with a group member's help.

The group sets goals, the first one of which is to stop the abusive behavior. The member is given group support, because other members have been through this. If a member fails, the group assures him this does not mean complete failure. A second goal is to learn how to handle and express feelings. All feelings are acceptable to the group if they are handled in constructive ways. A third goal is to change the member's self-image. It is important for the members to see themselves as worthwhile, and for them to realize they do not have to be perfect. Another goal is to create a comfortable relationship between the parent and the child. Members are helped to deal with their children in positive ways, and to play with their children. P.A. is a method that self-admittedly does not help everyone since everyone does not respond well to others in a group.

The last type of treatment in which the most research has been done is the behavioral and behavioral-cognitive method. This model suggests that maladaptive behaviors are acquired and maintained through principles of learning.
Child abuse is seen as an inappropriate response to severe-acting out behavior in children. It is important to determine the behavioral contingencies which exist in the parent child relationships.

One type used is the training of parents in positive reinforcement. In one study, 2 parents were used. The family member was observed for a given time interval followed by observations of the other family members. During the baseline sessions, it was found that there were generally low and inconsistent patterns of effective social reinforcement. During the training there were nine sessions in which the mother was requested to complete assigned readings in "Parents Are Teachers", and to implement some of the suggestions from the text. Role playing was also used in addition to the readings. After the training sessions it was found the rate of approval accelerated rapidly.

The results indicate that a short term training program resulted in an improvement in the child rearing skills of parents. The results did not indicate that this training helped in a long term situation as the study reported that some of the constructive changes were maintained only for as long as five months.

In a second type, the treatment was directed towards chronic conflicts between the parent and the child that
appeared to cause the abuse. (Mastria, 1979) In Stage 1, the intake and orientation, the mother and therapist were shown scenes of her and her son interacting in play sessions. She was then taught alternate ways of handling negative interactions. For the next session, she was told to relay her feelings concerning herself and her child. In session 2 this report was discussed.

In Stage 2, the pretest, the mother and son spent three 40 minute play sessions together with no further instructions given. In Stage 3, the treatment, the parent was seen by the therapist for 10 consecutive 90 minute sessions. Portions of the videotape were shown that maintained conflicts and those portions that contained cooperative behavior. The mother was taught through modeling and feedback to give attention and praise to her son's cooperative behavior, to ignore aggressive behavior and to distract her son from aggressiveness. She was also taught to withdraw from situations in which she felt she was losing control. In Stage 4, the post test, the mother and son again engaged in three 30 minute play session. In Stage 5, the follow-up, occurred 5 months after Stage 4. The mother and child were again videotaped in a 40 minute play session.

During the pre-treatment, the parent had paid attention to the child's negative behaviors and did not pay attention
to his positive behaviors. During the post treatment, these behaviors reversed. The parent said she felt better about herself and her child, and she had not abused her child since the treatment.

During the pre-treatment, the child had shown assaultive behavior, and did not show physically or verbally affectionate behavior. During the post treatment, the assaultiveness disappeared, but affectionate behavior continued to be absent. The child reported he felt better about himself and his mother. He also reported no abusive incidents.

One behavioral-cognitive method used groups to help the abusive parent. (Ambrose, 1980) Each group was conducted by 3 leaders, 2 females and one males. The curriculum consisted of 4 forms: child development, teaching skills, behavior problem management and anger control. Each module was built upon inputs from the preceding modules. A variety of methods were used including didactic questioning, modeling, role playing, videotape presentations, group discussions and problem solving.

For the child development module, the parents were given the Child Development Guide. The parents were taught the developmental tasks appropriate for their child. The parents were given a homework assignment in which they were to note which age appropriate tasks
their child could perform.

In the teaching skills module, the parents were to teach their child an age appropriate self help or play skill. This was done using videotapes and was used to help improve parental teaching skills.

In the behavior problem management, the parents were encouraged to attend to and reward their child's appropriate behaviors instead of punishing bad behaviors. They were told to keep track of the number of times good behavior occurred as well as the number of times they reinforced behavior. They learned the three step plan to reduce a problem behavior.

1. Find an alternative behavior to reward.
2. Change the antecedents to encourage the alternative behavior.
3. Change the consequences so that the problem behavior is not rewarded. (Ambrose, 1980)

The parents were taught the use of time-out, ignoring and privilege loss. The parents then picked a child behavior problem and developed a behavior problem program.

In anger management the parents were taught to replace anger producing cognitions with more constructive coping thoughts. The group leader told everyone that how a person thinks about a situation affects how he feels in that situation. The parents were asked to monitor their thoughts in an anger producing situation, and to generate alternate coping thoughts. This study reported that
this type of program can produce short term changes in parent cognition and behavior, but that more evaluations of the program is needed.

Another type of behavioral-cognitive treatment maintains that there is a cycle between the parent and the child. (Sheff, 1980) The parent gets angry at the child and physically punishes the child. The child then gets angry at the parent, and acts out. It winds itself into a vicious circle, and the circle must be broken. The parent must be the primary one to change.

Anger control advances in four stages: motivating the parents to change, helping them to recognize the anger, teaching them control procedures, and helping them not to get angry initially.

To motivate the parents to change, they must understand that their anger makes the child angrier, and reinforces the child's misbehavior. To recognize the anger the parent must recognize the situations that precipitate angry reactions and the angry feelings themselves. The parent must be able to identify those situations which make them angry, and those bodily cues that identify anger. Some methods of anger control are the time-out and relaxation training. To help parents not become angry initially involves teaching the parent the appropriate expectations of their child and his behavior.
The parent must be taught alternative disciplinary techniques so he knows what to do in discipline situations. These techniques include ignoring the problem behavior, time-out of the child from reinforcement, offering alternative activities to the child, and giving an immediate, appropriate and consistent punishment.

It is also necessary to teach the child appropriate behaviors. It is important to give clear parental instructions, and specify exactly what is wanted. It is also important to give appropriate modeling, because the parent is a powerful model to the child. Reinforcement must be used appropriately. It is necessary to reinforce the good behavior and not the bad. This paper contended that this type of treatment is not for all types of child abuse, but it can be very effective in many cases.

All of these treatment methods can be used in many different ways and through different types of people. One way is the hotline, which is an emergency treatment for crises. (Kempe, 1978) The hotline may be valuable just by being there. It's much easier for a parent to cope with problems if he knows help is available. The hotline may also encourage people to seek help at an earlier time. The helpers involved with the hotline are lay people who have been trained to cope with distraught people. They have an exact knowledge of the facilities in the area, and so are able to refer the parent to other agencies.
Another way of treating the abuser is through the social worker. Social workers alone can not have enough impact on the problem. Most children who die as the result of abuse do so in families already in the care of a social work department. (Kempe, 1978) The main difficulty with the social worker is that the caseload is far too large to enable him to keep up well enough with all the families, and to be aware of crises as they appear.

There are also social services homemakers. These are usually women trained in housekeeping and family care. (Kempe, 1978) The homemaker can help the mother in these skills. She may join the family full time for a few weeks, or come for a number of hours a week. The homemaker needs to avoid taking over too much, and must show respect for the mother's feelings.

A major way of getting to child abusers is through lay therapists. The lay therapists are men and women who volunteer to work for a child protective agency. (Kempe, 1978) They devote their time to being supportive to the family, and act as their friend. This relationship is not a professional one, and can be what the parent wants it to be. The volunteer develops a relationship of acceptance and trust. He helps to overcome the isolation and frustration of the parent.
It is important to be selective in picking the volunteers. They should have benefited from good parenting. They should be mature and understand abusive and neglectful parents. Their own lives must be rewarding, and they can not look to the parents for support and help. Their own families must be understanding.

Generally in the beginning the lay therapist gives practical help to the parents. He can assist the family with such problems as establishing eligibility for public assistance, initiating school conferences, financial planning, transportation and living arrangements. Eventually the parent will probably learn to trust the therapist, and the lay therapist can help the parent with different parenting styles.

Another source of help is the crisis nursery. These are very rare in the United States. In these nurseries the parent can bring their child when they can no longer cope or when they need a place to live during the treatment. (Kempe, 1978) These nurseries are valuable because when the mother needs some time away from the child, she can have immediate protection. Also this type of facility assures the parent that the child is safe.

The abuser can be helped through psychotherapy. (Kempe, 1978) The treatment must be undertaken with limited goals in mind. The goals must take into account
the patient's life situation, his ability to express his feelings, his capacity for change and his ability to use support.

Group treatment is another form of treatment. (Kempe, 1978) This treatment can be successful especially when the group is one of couples. The couples can share their feelings and their ways of coping. Different types of groups exist, some educational, teaching parenting skills, while others can deal with feelings and coping mechanisms.

Residential treatment allows for immediate care of the family. (Kempe, 1978) A number of these types of centers exist. At one type the child can live there, gradually increasing contact with parents. Another type is designed for the mothers. The father stays at home while the mother gets treatment. There is also the type of center where the entire family stays anywhere from one to six months. The advantage of the entire family situation is it allows the therapists to learn in detail about their patients. The disadvantage of this type of arrangement is it is expensive and deprived families tend to regress in residential care. It is difficult for them to resume normal independent lives. A new solution has been developed in this area which is to have the child placed in a foster home with the parents, and have
the foster parents act as lay therapists.

A visiting nurse is another source of help for the parents. (Kempe, 1978) These are public health nurses who call on clients in their homes. She does more sympathetic listening than talking, and she must realize she is not there to supervise. She is there to help the parents gain an understanding of their child, and to enjoy his presence.

The community based approach is a multidisciplinary representation of the professions of medicine, law, education and mental health. All of these groups work together to help the child and the parent. In this way indexing can occur among the different agencies, and effective communication can be opened up.

Different means exist in which the child can get help. One way is through individual play therapy. Not many children get play therapy, but it is felt to be important in helping a child deal with his problems. The first goal is to build trust which usually takes a lot of time and effort. It is also important to maintain reality in the playroom.

Another type of treatment is therapeutic play school. This doesn't have to be elaborate, but it is important because it provides a sanctuary for the child for a number
of hours per week. It may take him time to develop trust in the staff and other children, but when he does things will move much more quickly. This school is also important, because it may be the first time his feelings have been taken seriously, and the first time he's experienced the full attention of an adult.

Foster care may be necessary for the child. (Kempe, 1978) This type of care keeps the child safe from the parent for the time being. Foster care should not continue for too long, and every effort should be made to reunite the parents and the child.

Group treatment is also available for the children although it is limited. (Kempe, 1978) This usually involves pre-adolescent or adolescent children in groups of four to eight, and has been used effectively for all types of problems.

There are many different ways in which the above treatments are combined. Different ways exist in which social services agencies combine these treatments to make up their child abuse program.

A study was done on the different treatment combinations, and it was found that the highest reincidence of abuse during treatment was found in services that relied on less well trained workers to conduct intake and case management. (Cohn, 1979) Clients receiving lay services
were reported to have a lower tendency towards abuse. It was found that there was a 30% reincidence of abuse or neglect during treatment. (Cohn, 1979)

At the Family and Children Services in Richmond, the main treatment method is lay therapists. Every family is first seen by a social worker who assesses why the family was referred, the stresses present, the interrelationships and the expectations of the children by the parents. (Claudine Penick, Personal communication, March 1981) Most of the time the treatment program is geared towards the lay therapists. Family and Children Services feels that the main advantage of the lay therapist is they are not professionals. They go into the home in a less threatening form. The volunteers have more time, and can spend about 3-5 hours a week with the parent whereas the social worker can only spend an hour per week with the parent. The volunteer meets the parents on their turf, and focuses on the parent, not the child. The volunteers are present to be role models and friends. The lay therapists are well trained in and have a very extensive support system backing them up. There is a nurse available for consultation, and a home care specialist available to teach home management skills. They also use therapy, educational groups, and Parent's Anonymous as needed. The criterion for improvement is personal growth and no abuse present.
At the Children's Trauma Center of Children's Hospital Medical Center in Oakland, California, there is individual therapy for the parents and the child. (Dept. of H.E.W., 1977) The center maintains two mother groups, one couples group and has marriage counseling for individual couples. Group treatment is a treatment used by choice, and many people participate in several modalities. In most cases the parents need to be seen individually before they are ready to move onto a group. The CTC is a long term institution, and most families are seen for one to two years.

Child abuse is seen at the CTC as an outcome of a negative interaction between intrapsychic and societal forces. Their treatment program includes reparenting and validation. It is important to get these parents who are so self critical to hear something good about themselves. From the beginning, an effort is made to emphasize the positive in these parents. Dependency is encouraged in the beginning. At first the therapist is doing things with and for the family, and then the family is encouraged to do things on their own.

Individual therapy is not encouraged for those who can participate in group or couple therapy. In group therapy the parents discuss feelings, then validation and reparenting. Child therapy is available for those children who are old enough.
The CTC also has supportive services. Someone is on call 24 hours a day. A parent aide program is provided where the parent aide is seen as a special friend, and the parent is encouraged to relate their experiences. A child enrichment program provides the children with an enriched stimulating environment. An emergency fund provides money for the clients. A trauma clinic exists where the pediatrician follows the progress of the children.

The CTC's criterion for improvement includes the acknowledgement of the abuse, and the ability of the parents to recognize their feelings. It includes the ability to see others as helpful, and to see their children differently. It also includes the ability to recognize one's self as worthwhile, and there should be an improvement in communication.

The Scan Program of Pittsburgh Children's Hospital is the same as the CTC with a few exceptions. (Dept. of H.E.W., 1977) The Scan Program does not provide long term treatment. Instead it uses a short term approach. The group meetings are with the mothers, and the groups give these mothers an introduction to the helping profession without establishing a long term therapeutic relationship. There are many referrals made to mental health facilities. The Scan program attempts to make the same types of improvements as the CTC.
At the Bowen Center in Chicago, Illinois, the services to adults include individual diagnosis, casework for adults, and an ego psychology framework. The primary therapeutic goal is to meet the needs of the parents with the expectation that if re-parenting is successful, and the parents needs are met, then the parents will be more successful in meeting the children's needs. The emphasis of the treatment is addressed to meeting the parents' needs, and helping them to achieve a close dependent relationship with the staff at the center. The staff is supportive with an emphasis on exploring feelings and areas of tension. The treatment is a long term process with contacts once a week.

A group therapy for mothers tries to give them a socialization experience, and to help them gain increased self-esteem through activities such as personal grooming and crafts. Once a month there is a parents night with a dinner and group activity.

For the children a day care and after school program are provided. The children are given breakfast, and they participate in arts and crafts and games. After school activities are provided for the older children. Play therapy is held two to three times a week for more severe problems. All of these programs help the child deal with, express and work through his anxieties and fears. The
main emphasis of this program though is not the children, but meeting the parents' needs. The emphasis of the program is reparenting.

In Billings, Montana, The Billings Child Abuse and Neglect Community-Based Team has been set up. The great majority of the families receive counseling services from the protective services staff within the Department of Welfare. The thrust of the department of welfare is to coordinate whatever other services can be worked through other agencies. A team of workers tries to utilize the county attorney's office, the department of public welfare, the regional hospital, the regional community mental health center and the health department. The department of welfare investigates each case, and reports the findings to the county attorney who makes the decision as to whether or not to bring the case to court. The members of the team act as consultants to each other. This type of system does not provide the needs of many families for long term support.

The Laramie Child Abuse Council and Treatment Team in Laramie, Wyoming is also a team of people which offers more treatment for the parents. It is a reality-oriented type of treatment which provides therapy and education in child development and child management. Very specific and distinct suggestions are made, and discussed in order
to see whether or not they have helped. This therapy is often done in the families' home. The overall treatment philosophy centers around a very positive approach to families both in terms of the therapist's communications about what can be accomplished and in terms of an evaluation of strengths and assets. This type of set up is helpful because it provides long term therapy while coordinating other services that are needed.

Much more research is needed for the evaluation of the treatment methods for child abuse. Much of the research that has been done in the past has used a small number of subjects, and follow-up studies have not been done. Much of the research that has been done is incomplete. Child abuse is a major problem in the United States, and it is important to find the best treatment and service package.


Hunter, Cornelia and Joanne Sterling. "Volunteers Serve as Adjunct to Treatment for Child Abusing Families." Hospital and Community Psychology, 26 (1975), 136-137.


