



1983

A Meta-Analytic Review of Therapeutic Intervention Methods for the Treatment of Child Abusing Parents

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A META-ANALYTIC REVIEW OF THERAPEUTIC INTERVENTION METHODS
FOR THE TREATMENT OF CHILD ABUSING PARENTS

by

Denise Cafaro Noell

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
Master of Arts

January

1983

ACKNOWLEDGMENTS

My sincere appreciation is extended to the members of the advising committee, Professors Gloria J. Lewis and Steven I. Miller, for their direction and guidance in the development of this thesis, to Jean C. Billingham of the St. Vincent de Paul Center for providing me with the opportunity to work with child abusers, and to my husband, John, for his unwavering support.

VITA

The author, Denise Cafaro Noell, was born on October 10, 1953 in New York. She is the daughter of Charles Cafaro and Grace Grasso Cafaro. On July 4, 1981, she was married to John William Noell.

She received her elementary education in the public school system of Central Illinois, and her secondary education at Dunlap High School in Dunlap, Illinois where she graduated in June, 1971.

In May, 1975, she was conferred the degree of Bachelor of Arts from Loyola University of Chicago. The author was inducted into Loyola's chapter of Alpha Sigma Nu, the National Jesuit Honor Society, in April, 1981.

Between September, 1980 and May, 1981, she counseled mothers of abused children, individually and as a group, in the Child Abuse Preventive Service Program of the St. Vincent de Paul Center in Chicago, Illinois, and in January, 1983, she was awarded a Master of Arts in guidance and counseling.

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CHAPTER I

The subject of child abuse has been treated extensively by researchers since 1962 when C. Henry Kempe and his colleagues coined the phrase "battered child syndrome" to draw the attention of pediatricians to the existence of this condition (David, 1974). Since that time, in an effort to gain knowledge about the etiology of the maltreatment of children, many studies focusing on the child abusing parent have been conducted.

As a result of these studies, the profile of the child abuser is clearer now. Child abuse appears to be a psychodynamically determined dysfunction of the parenting process (Kempe, 1969; Helfer & Pollock, 1968) in which there are involved three basic elements. First, there exists a high expectation and demand by the parent for the child's performance (even though the child may be overindulged in other ways). Secondly, there is a corresponding parental disregard of the child's own needs and limited abilities (Steele & Pollock, 1968). The third element is the resulting maltreatment of the child.

From the child abuser's perspective the child exists primarily to satisfy parental needs. The child who does not achieve this deserves to be punished: criticized, belittled, scolded, and physically reprimanded. Steele identifies the problem as one which lies in the parent's unrealistic expectations of what the child is able

to comprehend and do, as well as misperceptions of what the child is like and what his or her intentions are. The child is therefore seen as being more mature than he or she actually is. Failure to comply with the parent's wishes implies stubbornness or deliberate meanness on the part of the child, behavior which the parent sees as his or her moral right and obligation to correct. Hence, punishment carries the approval of traditional family authority. Child abuse is clearly not a rational act. It is not premeditated, and it is often followed by a deep grief and great guilt (Kempe & Kempe, 1978).

As one examines the abusive pattern of child rearing, it is helpful to gain an understanding of its origin and development. Parents who abuse their children are described almost without exception as having themselves been victims of child abuse (Fontana, 1973). Thus, abusive behavior is associated with a pattern deeply embedded in one's character structure (Steele, 1975). Glass (1970) supports this position in his observation that child abusing parents are adults who were unloved as children, and who may have been abused themselves, either physically or emotionally, by their own parents. Other researchers (Steele & Pollock, 1968) found in researching the backgrounds and life histories of the abusive parents of their study, that all had experienced intense parental demands for submissive behavior and immediate compliance, accompanied by constant parental criticism. It becomes evident then that this pattern of child-parent interaction is very frequently intergenerational and culturally bound.

Steele and Pollock (1968, 1970) believe that the prime factor in

the genesis of parental abuse is a lack of "basic mothering"--the lack of the deep feeling of being cared for and about--during one's early years, the effects of which are profound and enduring. Kreindler (1976) describes this same condition as a failure of the parent to develop a capacity for "motherliness," an attribute which includes elements of tenderness, awareness, regard for the needs and wants of the child, and the appropriate emotional interaction with it. The deprivation of "motherliness" or "basic mothering" is more nearly universal in the population of parents who maltreat their children (both fathers and mothers) than any other single factor such as race, creed, sex, income, education, cultural milieu or living condition (Steele & Pollock, 1968; Wasserman, 1967).

Kreindler (1976) posits that without the presence of motherliness, the growth of two areas of personality development is impaired. First, one experiences a lack of development of what Erikson (1950) calls "basic trust," an essential prerequisite for the development of satisfying relationships with others. Secondly, one fails to develop a sense of personal identity (Erikson), that is, a sense of him or her self as a unique and separate person with a continuity of character and the ability to maintain solidarity with social groups.

So, having failed to have received "motherliness" from their parents, child abusers suffer from an intense need for love and acceptance and self-affirmation (Janzen & Harris, 1980). Abusive parents feel insecure and unsure of being loved, and look to their children as sources of reassurance, comfort and loving response. Child abusing

parents possess deficient ego controls which, when threatened or un-
balanced by personal or environmental pressures, become externalized.

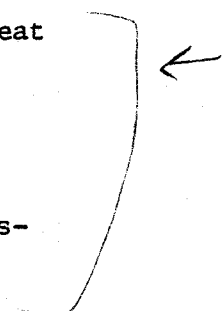
Child abusers project their aggressive hostility upon the child, identifying the child with themselves and themselves with their own abusing or rejecting parents (Blumberg, 1978). This is a condition aptly described by Morris and Gould (1963) as "role reversal."

A closer look reveals that child abusers are alienated, asocial and isolated individuals (Steele & Pollock, 1974) who have a marked inability to establish a genuine relationship with another human being (Wasserman, 1967). As Helen Alexander (1976) points out, abusive parents are suspicious and distrustful. Holmes (1975), too, describes child abusers as individuals who suffer from severe deficiencies in interactional skills. It has been noted that parents who abuse their children have a defective communication system and no social support within their environment (Gilbert, 1976). Abusive parents are often lonely, cut off from others both in fact and in feeling, and have few contacts with the immediate family (Blair & Justice, 1976).

Abusive parents are typically immature and impulsive individuals (Elmer, 1965; Green, 1974; Kempe, 1962; Zalba, 1977) who have difficulty in problem solving, planning and generally coping with adult life. Abusive parents show an unusually high vulnerability to criticism and disinterest or abandonment by important others, or to anything that already lowers their inadequate self-esteem (Pollock & Steele, 1972). Green (1974) characterizes abusive parents as using projection

and externalization to defend self-esteem.

More fundamentally, it has been found that parents who maltreat their children lack parenting skills and good parenting models, as well as basic information regarding the child development process (Spinetta & Rigler, 1962). Further, they usually gain little satisfaction from their roles as parents (Tracy & Clark, 1974).



It is clear that much is known about the psychodynamics of child abuse. An understanding by professionals of the profile of the abuser is a necessary prerequisite to the effective treatment of their parental dysfunction. Having gained such knowledge, professionals then raise the following question: which modes of treatment presently exist for the treatment of child abusing parents, and under which circumstances is each most effectively employed? It is precisely this question to which this thesis will address itself. This study will endeavor to provide a critical review of the literature regarding therapeutic intervention methods for the treatment of child abusing parents by employing the use of an analytic schema.

The purpose of this study will be to provide for professionals a clearer understanding of the various therapeutic intervention methods which presently exist for the treatment of child abusing parents. As one reviews the existing literature in this area, the need for such a study quickly becomes evident. Those who are concerned with the treatment of child abusers find that a comprehensive study of the various intervention techniques presently does not exist. A

critical review of the literature in this area will fulfill two needs for such a study. First, it will serve to elucidate from a broad perspective the appropriate use of particular intervention methods. Secondly, it will provide some groundwork for the development of new intervention techniques.

Before proceeding, it is necessary to define some essential terms. There are several of importance to this study.

It is not an easy task to define the condition which Kempe first described as "the battered child syndrome" and which is now generally regarded as "child abuse." The task is not an easy one since within the child abuse category there can be great variation. One definition of child abuse describes the condition as one of "non-accidental, physical or mental harm resulting from abuse, exploitation or neglect which requires immediate intervention" (Margrain, 1977). Another researcher claims abuse of a child exists when the child's physical or mental health or welfare is harmed--or threatened with harm--by the acts or omissions of his or her parents or other person responsible for the child's welfare (Cox, 1979). Both of these definitions are applicable to the present study. However, since the focus of the present study is on the treatment of the abusing parent, it seems appropriate to define child abuse from his or her perspective. From the parent's viewpoint, abuse may be the result of his or her unrealistic view of the child as the powerful one who fails to meet the parent's needs or who is "out to get" him or her (Holmes, Barnhart, Cantoni, & Reymer, 1975). The distinction of abuse from the perspective

of the parent is significant in that it enables the therapist to deal with his or her negative reactions to abuse by permitting the therapist to see child abusers as the hurting and needy people they are.

It is helpful to clarify the distinction between abuse and neglect, the two major components of the general term of "child abuse." The term neglect has two meanings as it will be used in this paper (Steele, 1975). One meaning is that of material neglect signifying a lack of adequate food, clothing, shelter and the like. A second meaning of neglect is that situation in which the parent provides less of the warm, sensitive interaction than is necessary for the child's optimal growth and development.

Abuse has a four-fold meaning (Herbruck, 1979). First, it can describe physical abuse, that is, any act which occurs when an adult (parent) causes bodily injury to a child. Verbal abuse, a second type of abuse, is the use of words as weapons by the parent resulting in feelings of inadequacy in the child. A third form of abuse is emotional abuse which occurs when the adult employs the use of such things as guilt and fear to influence a child's behavior. In emotional abuse, the interaction between parent and child is loaded with hidden feelings, veiled threats, pleas for love, and references to past wrongdoings. Finally, passive abuse, the fourth form of abuse, occurs when the passive abuser manipulates another into acting out for them their own hostile feelings toward the child.

Though neglect is not, strictly speaking, considered to be

abuse, the separation of abuse from neglect is not always easy, since neglect readily appears to abuse the child (Janzen & Harris, 1980). While one could say that abuse and neglect co-exist, there is a striking difference in these two forms of interaction. Simply, the response of the neglecting parent to distressing situations is to give up and abandon efforts to even mechanically care for the child. The abusing parent takes a more active role and punishes the child for his or her failure (Steele & Pollock, 1968).

In this thesis the term "child abuse" will be applied to both conditions which describe the physical and emotional abuse or neglect of a child by his or her parent, and which indicates that the home is an unfit residence where there exists psychological or physical threats to the child's welfare and existence (Paulson, 1974). The term "maltreatment" will also be employed to describe the same condition.

The word "parent" will be used in a generic sense to describe any caretaker or guardian of the abused child.

The third key term of the study is "therapeutic intervention methods." This descriptor will be used as a reference to the modes used in the treatment of child abusing parents. Therapeutic intervention methods will encompass any of the services administered by professionals and paraprofessionals which alleviate the stresses which result in the symptom of child abuse (Ebeling & Hill, 1975).

Therapeutic treatment types can be considered from short-term

and long-term perspectives (Parke & Collmer, 1975). Short-term care involves some type of crisis intervention which may prevent an imminent case of child abuse from occurring. Long-term care, on the other hand, involves restructuring the social interaction patterns of family members which may be the cause of abuse, or of modifying the parent's values, attitude, personality or behavior which are seen as causing the abuse. Alexander (1980) contends that long-term treatment is essential to any adequate treatment program for child abuse. She says that little, if any, change will occur in the parent without on-going care. If changes in the parent are to be integrated, intervention services must not be withdrawn prematurely.

The schema which will be used in this study to examine the various intervention methods is based on a meta-analytic approach to research (Glass, 1976). That is to say, it will be structured so as to provide an analysis of analyses of treatment types for child abusers. Principally, the schema of this study draws from two meta-analytic designs. The first is one which allows the researcher to systematically combine studies. This will be accomplished by synthesizing the various studies according to the cluster method of Light and Smith (1971). The second aspect of the schema of this study is one which provides a vehicle for systematically classifying the findings of those studies. This is achieved by charting factors such as samples, methods of analysis, controls, outcomes, and the like (Boocock, 1972; Miller, 1978; St. John, 1975).

Further explanation will be provided in Chapter II of the

meta-analysis, and of the specific approach which will be employed in this study. Chapter II will also introduce and delineate the clusters evident in the literature. A chart and a discussion of the studies in each grouping will be furnished for every cluster in the third chapter. At the end of the discussions of the clusters in Chapter III, statements will be made and conclusions will be drawn about each classification. In the final chapter, these analyses will be summarized. Concluding statements will be made about the relationships between clusters, and recommendations will be given regarding the various therapeutic intervention methods based on the information gained by the meta-analysis. Chapter IV will also contain a discussion about the need for future research.

CHAPTER II

In this segment of the study, the reader will be provided with an explanation of the concept of meta-analysis. This will be followed by descriptions of the two existing meta-analytic designs which compose the schema of the present study, and an explanation of how the schema works to analyze the data. Additionally, this chapter will introduce the reader to the nine clusters evident within the literature.

Meta-analysis refers to the statistical analysis of a large collection of results from individual studies for the purpose of integrating the findings (Glass, 1976). It was developed out of the need to summarize studies in an orderly way so that knowledge could be extracted from large bodies of research. It is an interesting and sensible alternative to the conventional review which is typical of past attempts to manage large amounts of research literature.

How is meta-analysis accomplished? Reviewers who perform meta-analysis first locate studies of an issue by clearly specified procedures. They then characterize the outcomes and findings of these studies in quantitative terms by use of multivariate techniques (Cohen, 1981). For example, Smith and Glass (1977) used this technique to examine the outcomes of psychotherapy. They selected four hundred controlled evaluations of psychotherapy which met the criterion

of having at least one therapy treatment group compared to an untreated or a different therapy group. Essentially, these studies were coded and integrated to analyze the magnitude of the effect of therapy (the dependent variable) across sixteen independent variables (examples: the type of therapy, the duration of therapy, and the number of years of experience of the therapist). The authors computed the effect of therapy as the mean difference between the treated and control subjects divided by the standard deviation of the control group. The findings of their study offered convincing evidence for the efficacy of psychotherapy. A number of other researchers have employed the meta-analytic method to synthesize the results of research (Cohen, 1981).

The notion of meta-analysis forms the conceptual framework for the development of the schema used in the present study. Within this framework, the first component of the analytic schema is one which concerns itself with combining studies. It is taken from Light and Smith's (1971) cluster method, a type of meta-analytic approach. The basic strategy behind Light and Smith's concept of combining studies stems from the standard sample taken from a common population. With cluster sampling, the authors take the notion of standard sampling one step beyond general approaches by positing that populations can be subdivided into smaller, identifiable populations known as clusters.

A cluster is a natural aggregation within a population, not merely a random sample from a population. A cluster may be thought

of as a natural focal point of any process under investigation, the smallest natural unit which is available among the data. One cluster does not constitute a complete study; a study contains several clusters or units of analysis.

Two important aspects of Light and Smith's (1971) method are that the establishment of the clusters constitutes mutually exclusive and exhaustive criteria. By being mutually exclusive, it is assumed that clusters differ in ways that are not reflected in variations within any one cluster; conversely, variations within clusters are not necessarily reflected in variation among them. The idea that clusters comprise exhaustive criteria implies that any given study relating to the treatment of child abusers can fit into one and only one cluster.

The clustering concept is useful, particularly when one is dealing with a large amount of research. It will be the procedure used for combining literature under examination in this study.

Light and Smith (1971) also propose a method of analyzing clusters which, like the meta-analysis originally described by Glass (1976) and the one used by Smith and Glass (1977), relies on statistical data. The cluster method of analysis requires the researcher to statistically investigate the various ways that clusters can differ; for example, by the means of the variables, by co-variate relations, and so on. However, the research which will be examined in this study is mostly unmeasured and descriptive in nature. So there arises the need

to employ the use of some meta-analytic design which has the capacity to evaluate descriptive research.

There emerges from this need the second component of the schema of this study. It models itself on previous attempts to use charts as a way of classifying and analyzing studies according to various factors such as methodology, instrumentation, sample, controls, and outcomes (Boocock, 1972; Miller, 1978; St. John, 1975). Such an approach enables the researcher to characterize the results and features of a group of studies in descriptive terms. A classification chart can be considered a meta-analytic method, though not in the strict statistical sense, since it is guided by the general principle of meta-analysis as originally defined by Glass (1976): to summarize studies in a systematic way so that knowledge can be extracted from large bodies of individual research.

Boocock (1972) used classification charts in a study which concerned itself with research findings in the area of the sociology of learning. In a chapter treating the subject of adolescents, for example, the author examined literature which compared the relative strength of peer and parental influence on the learning process. She charted the following information for each study: the sample, the year of data collection, the indicants of parental influence and of peer influence, and the major findings (see Table 1). Preceding the chart, Boocock (1972) provided a narrative discussion which highlighted the design, focus, methodology and major contributions of each study. The author then cited trends, areas of consensus and disagreement, and made

TABLE 1

DESIGN OF STUDIES COMPARING PARENT AND PEER INFLUENCES

	<u>Simpson</u>	<u>Epperson</u>	<u>Kandal and Lesser</u>	<u>Musgrove</u>	<u>Riley and Riley</u>
<u>Sample</u>	917 boys in 2 white Southern city high schools.	619 3-6th graders, 159 10-12th graders.	2327 students in 3 high schools; 1141 of their mothers.	778 students ages 9-15 in 2 areas of English Midlands.	2500 students in 8 New Jersey high schools.
<u>Year of Data Collection</u>	1960	1963	1965	1962	1950's
<u>Indicants of Parental Influence</u>	Father's occupation; whether parents had recommended professional occupation to subject.	% saying "I would be most unhappy" if parents disapproved of decisions.	Highest level of education desired for child.	% naming parent as preferred companion; social distance scales; sentence completion (Mothers can ____, Fathers can __).	Topics and amount of communication; perceived expectations of parents.
<u>Indicants of Peer Influence</u>	Occupation of best friends' fathers; participation in extracurricular activities.	% saying "I would be most unhappy" if best friend disapproved of decisions.	Highest level of expected education of 3 best friends.	% naming friends as preferred companion; social distance scales; sentence completion (Boys, or Girls, can __).	Topics and amount of communication; perceived expectations of peers.
<u>Major Findings</u>	Both groups' influence; Parent influence stronger, especially for working-class boys.	Concern for parental greater than concern for peer disapproval. Difference greater among older students.	Concordance with mother greater than with best friend, but high agreement with both.	Decline of choices to parent over time, but choice related to type of activity. No change in social distance.	Communication with and influence of parents and peers dependent upon topic. Division of labor between parents and peers.

general statements about the outcomes of the studies as a group. Boocock's (1972) efforts resulted in a rich analysis.

Classification charts are a viable alternative to statistical examinations in meta-analysis since they allow the researcher to summarize and analyze descriptive studies. They constitute the second component of the schema of the present study.

In summary, the meta-analytic schema to be used in this study fashions itself in part on a cluster approach, and in part on classification charts. The schema is one which has been specifically designed to:

1. combine studies of a general topic in a systematic way,
and
2. summarize and analyze large bodies of descriptive
literature.

Now that an understanding has been made of the components of the meta-analytic design of the present study, it is necessary to explain how it works to analyze the data. The cluster principle was first applied to the large amount of literature about the subject of the treatment of child abusers. Nine natural aggregations or clusters appeared, and classification charts were designed for each.

Every cluster contains a discussion of all of the studies within that particular aggregation. Charts which classify data within the various clusters are also provided. The information that is charted will vary from cluster to cluster depending upon the various

characteristics of the treatment type. For example, it is true that hotline intervention and group treatment, two separate clusters, differ in fundamental, obvious ways: the former is accomplished by telephone on a one-to-one basis, and the latter is administered in person with other child abusers and a facilitator(s). So, for each cluster special characteristics which best describe that grouping were selected for charting the studies therein, characteristics which lay the groundwork for a clear and insightful analysis.

To reiterate, every cluster will contain a discussion of the studies it contains, followed by a classification chart and an analysis. The analyses will search for trends, patterns, differences and similarities within the various characteristics assigned to each cluster. As an example, one classification characteristic used for many of the clusters will be "Goal of Therapy." If cluster A contains twelve studies, the analysis of A will examine the "Goal of Therapy" of all twelve studies, searching for general areas of consensus, patterns, trends and differences within that characteristic. It will do the same for the other characteristics assigned to cluster A. Each analysis will examine the characteristic of a given cluster both individually and as a group. The discussion, charting and analysis within the nine clusters will occur within Chapter III.

An analysis among clusters will be provided in Chapter IV. This analysis will search for the same sort of information sought in the individual clusters--areas of consensus, patterns, trends, differences --but this time looking among clusters. To carry the previous example

further, the "Goal of Therapy" will be examined across the nine clusters. This part of the present study will, in effect, meta-analyze the meta-analyses.

It is necessary at this point to discuss the clusters which appear in the literature regarding the treatment of child abusing parents. The nine clusters are: psychotherapeutic techniques, group therapy, casework, social-learning techniques, multidisciplinary teams, residential treatment, hotline services, lay therapists, and self-help programs. A general introduction to each will serve to orient the reader to the discussions, charts and analyses which follow in Chapter III.

Psychotherapeutic techniques, the first treatment cluster, seek to understand the unconscious processes within abusive parents and to make changes in their structures. Psychotherapeutic treatment must be taken with specific goals in mind, either short-term or long-range, depending upon the length of treatment and the readiness of the abusing parent (Kempe & Kempe, 1978). Long-term therapy, for example, can help abusive parents to resolve their ambivalence toward their own parents and also help them to see how their own experiences affect their relationship with their child. Some short-term therapeutic techniques, those with more immediate goals, concern themselves with particular issues, such as the development of satisfying relationships, or set out to change one particular pattern of behavior.

Group therapy forms a second treatment cluster. Group therapy

consists of a number of abusive parents who are led by a professionally trained therapist or therapists to discuss some topic related to the maltreatment of their children.

Casework, the third cluster, is an approach to the treatment of child abuse involving one professional, usually a social worker, who traditionally investigates the family situation in which abuse occurs, counsels and supports the family, makes recommendations to the court, and, on occasion, testifies on information which leads to foster placement of the abused child.

Fourthly, there is a cluster consisting of social-learning techniques. This cluster encompasses various modes derived from learning theory which are used in treatment of child abusing parents. Treatment modalities of this sort are based on the cognitive learning of good parental skills as a means of fulfilling some deficit which contributes to the abuse of the child by the parent.

A fifth cluster consists of the multidisciplinary team treatment of child abusing parents. This therapeutic approach stresses the combined services of a group of professionals and paraprofessionals. The concept behind this treatment type is that child abusers are in need of a myriad of services which a team of persons could best initiate, coordinate and implement (Barnes, Chabon & Hertzberg, 1974).

Residential treatment, the treatment of families in a mock-home environment, is a sixth cluster which appears in a review of the literature. The primary feature of residential therapy is that it intensifies

the effects of the various treatments that can be offered to child abusers while keeping parents and children together.

The seventh cluster is composed of hotline services which are emergency telephone lines for potential child abusers.

The eighth cluster is that of lay therapists, also known as parent aides, who are individuals recruited by child protection agencies to devote part of their time to the support, concern and long-term nurturance of parents who maltreat their children, and, in effect, to function as family friends in non-professional capacities.

A final cluster is comprised of self-help programs. Self-help programs are groups organized by child abusing parents for child abusing parents and for parents who fear they might abuse their child (Herbruck, 1979). Self-help programs allow for anonymity and sharing in an environment where there exists non-judgmental and unconditional mutual acceptance. Parents involved in self-help groups work together to discover how not to abuse their children, and how to support each other during crisis situations.

It is evident that there exist a number of treatment modes for child abusing parents. The analyses which follow now in Chapter III, performed by the previously described cluster/classification chart method, will serve to synthesize the research literature in this area.

CHAPTER III

Discussion of Cluster I

For an overview of the cluster pertaining to the use of psychotherapeutic techniques in the treatment of child abusing parents, the reader is referred to Figure 1.

Steele (1975) notes that many modes of psychotherapy have been used in the care of abusive parents. He says that intensive psychotherapy, when accompanied by supportive adjuncts such as lay therapy, group treatment or casework, can stimulate great development and deep structural changes in child abusers. Therapists treating child abusers must adapt to the needs of these parents and allow more dependency than that which is normally considered appropriate.

Steele comments specifically about two forms of psychotherapy, classical psychoanalysis and behavior therapy. According to this researcher, the character structure and lifestyle of most abusive adults make the application of classical psychoanalysis impractical and generally unsuccessful. He believes, however, that psychoanalytically-oriented dynamic psychotherapy, if skillfully applied, can be used with success. Behavior modification techniques have also been used to change the attitudes and actions of child abusers in short periods of time, but Steele wonders about the long-term rehabilitative ability of these techniques. A second reservation Steele has with behavior

	<u>STEELE</u>	<u>BEEZLEY ET AL.</u>	<u>MARTIN & BEEZLEY</u>	<u>BLUMBERG</u>	<u>KEMPE & KEMPE</u>	<u>DAVID</u>	<u>FRIES</u>	<u>POLAKOW & PEABODY</u>	<u>GILBERT</u>	<u>POLANSKY ET AL.</u>	<u>SANDERS</u>	<u>ODX</u>
	<u>75</u>	<u>76</u>	<u>76</u>	<u>77, 79</u>	<u>78</u>	<u>74</u>	<u>75</u>	<u>75</u>	<u>76</u>	<u>72, 74</u>	<u>78</u>	<u>79</u>
THEORETICAL BASES	Psychoanalytically-oriented dynamic psychotherapy	Primarily reality therapy, but can be diversified	Traditional psychotherapy with focus on parent's attitudes & behaviors toward child	Psychoanalysis	*	Reality therapy	Individual psychotherapy coupled with group treatment	Behavior therapy	Behavior therapy	Behavior therapy	Behavior therapy	Reality therapy
GOALS OF THERAPY	Development and structural changes in parent	Explore feelings & behavior to gain intellectual & emotional insight	Resolution of internal conflicts within parent	Abreact early childhood experiences of parent	Specific limited goals, which vary depending upon parent & therapist	Protect child; provide external control over parents' impulses; explore client's thoughts & feelings	Seek differences in pretest/posttest scores of experimental & control groups	Develop in parent more appropriate & adaptive means of control over child	Prevent harm of child; present for parent a good model of how to deal with children	Promote verbal accessibility of parent	Resolution of abusive behavior toward child	Increase reasoning skills & help parents understand personal benefits of not abusing child
TECHNIQUES	Dependency of parent on therapist	*	Nurturing/reparenting, extensive outreach, treatment of parent-child relationship	Collateral approach	Prepsychotherapeutic psychiatric evaluation of entire family; both parents involved in therapy	Confrontation	*	Contingency contracting, assertive training & discrimination training	Play therapy, target treatment	Superficial talk, improvement of parents' self-image, frank talk, teach precise description of attitudes, therapist acts as listener and role model	Systematic desensitization preceded by: assertion training, behavioral rehearsal, training in personal effectiveness, use of anti-depressant	Rational behavior training
ADJUNCTIVE SERVICES	Lay therapy, casework, group treatment	Lay therapy or self-help & other "less traditional" treatments	Lay therapy, group treatment, case-work & others	*	*	*	*	Group therapy toward end of treatment	Self-directed program following treatment	Group therapy	*	Group therapy

* Not indicated

FIGURE 1. OVERVIEW OF CLUSTER OF PSYCHOTHERAPEUTIC TECHNIQUES

therapy is its use of negative feedback, a technique Steele calls "highly questionable" because negative feedback is essentially a repetition of the same process of child rearing which led the parent to his or her present difficulty.

Beezley, Martin and Alexander (1976) address the topic of psychotherapy in the treatment of abusive parents. Rather than citing specific techniques, they simply state that psychotherapy can be diversified in its use with abusive parents depending upon the parent, the experience and style of the therapist, and the vast number of possible approaches. In any case, the aim of psychotherapy with the abusive parent is always the same: to explore his or her feelings and behavior with the goal of intellectual and emotional insight. The counselor performs psychotherapy by appointment in an office setting. These authors recommend the use of psychotherapy in conjunction with less traditional treatments, such as lay therapists or self-help groups, since abusive parents are in need of support and nurturing.

Beezley and her associates note some of the limitations of using psychotherapy to treat child abusers: (1) abusive parents are typically distrustful and erratic in their behavior, and therefore frequently not available for meetings, (2) the focus of psychotherapy is on intra-psychic conflicts and not the immediate concern, parent-child interactions, and (3) changes in parents as a result of psychotherapy may occur too slowly to protect the child's physical and psychological well-being.

Martin and Beezley (1976) wrote a chapter about psychotherapy for abusive parents which appeared in a textbook concerning the maltreated child. They preface their discussion of treatment by stating that there are three ways to view psychotherapy for abusive parents. They say first that such parents have a right to or a need for help, even if the child does not benefit from it. A second consideration of therapy is the advantage to the child of the parent's improved mental health. A third way to consider psychotherapy is to focus primarily on the changes in attitudes and behaviors of the parent toward the child. With these three views or purposes in mind, Martin and Beezley treat three therapeutic issues.

The first issue is: what components constitute an effective treatment program for abusive parents? These authors say that the therapist must make five special considerations. The first is that it is essential to involve more than one person in the treatment process of the abusive parent. They support this by saying that the treatment of the child abuser is a two-part process, the nurturing or reparenting experience, and the traditional attempt to resolve internal conflicts with psychological insight and understanding. The two-part treatment is most successful when multiple therapies are applied, for example, when the use of lay therapy is combined with individual psychotherapy, or when casework and group treatment are used in conjunction with individual psychotherapy. A second consideration is that the treatment process requires much more outreach than that which is normally required in traditional psychotherapy. Because abusive parents are

typically suspicious, distrustful and needy, they may require evidence of concrete giving. The therapist meets this need through home visits, by telephoning the parent to see how he or she is doing, and making suggestions for solving problems. Also, Martin and Beezley note that the role of the therapist's secretary is a critical one--he or she should be welcoming toward the parent, especially during the initial phases of treatment. Thirdly, treatment of abusing parents ought not to be as short or time-limited as with other clients. Though the length of treatment varies from patient to patient, initial intense treatment frequently lasts from eight months to two years with gradual diminution in the frequency and intensity of sessions. The therapist, however, is always available for periodic contact as a sort of parental figure since two important goals of therapy are to enable the parent to develop trusting and important relationships with other people, and to reach out and develop life lines in times of stress. The fourth consideration as cited by Martin and Beezley is that court-ordered therapy has special problems. In such cases, it is incumbent upon the therapist to deal early in the treatment with the feelings of anger and hostility the parent has toward the court, social agency or therapist for having been coerced into therapy. A related problem of court-ordered therapy is that courts usually require written documentation of the parent's progress in therapy. Martin and Beezley suggest that the therapist prepare the document jointly with the parent, an action which results in many benefits. The final consideration is that in working with abusive parents, the reactions and counter-transferences of the therapists are particularly important and common. Here Martin

and Beezley caution the therapist to be especially attentive to his or her own unresolved problems which may cause counter-transference reactions. Also, the therapist ought to be aware of his or her own feeling of anger or revulsion about the maltreatment of the child.

A second therapeutic issue raised by Martin and Beezley (1976) is the relationship of treatment to the attitudes and behaviors of the parent toward the child. These researchers suggest that there needs to be a third part to the traditional two-part process of treating abusive parents; namely, a treatment which deals directly with the distorted parent-child relationship. They cite a variety of ways that the third part phase can be provided: modeling, crisis nurseries, Parents Anonymous, and so on.

Assessing the readiness and ability of parents to provide adequate parenting to the abused child is a third therapeutic issue raised by these authors. They say that the criteria for assessing this rests in two areas, in the psychological improvement of the parent, and in an improved parent-child relationship. Within the first area, that of psychological improvement of the parent, Martin and Beezley list nine guidelines: decreased isolation, increased pleasure in life, increased self-esteem, ability to use life lines, improved management of stress and crisis situations, more realistic self-expectations, alternative ways of dealing with anger, fewer unhealthy interpersonal relationships, and the utilization of therapy and treatment. The reader is cautioned by Martin and Beezley not to use inappropriate measures of parenting ability (getting a job, keeping therapy appointments or obtaining

better housing) since these criteria are not related to the parent's ability to provide adequate parenting for the child, but simply are a measure of the parent's cooperation with the therapist or his or her improvement in areas other than child care. Rather, Martin and Beezley (1976) contend that an improvement in the parent-child relationship can be evidenced in the following ways: if the parent sees the child as an individual, if the parent enjoys the child, if the parent's expectations of the child are age-appropriate, if the parent is able to tolerate the child's negative behavior, if the parent can allow the child to receive emotional gratification from people outside the family, and if the parent is comfortable with expressing love and affection to the child.

Blumberg (1977, 1979) is a proponent of psychoanalytically-oriented treatment for child abusing parents. He believes such a mode can enable the child abuser to abreact the early childhood experiences which are at the root of his or her character disorder. What Blumberg advocates is a collateral psychotherapeutic approach which requires the involvement of the abusive parent and the abused child.

An examination of the use of psychotherapy in the treatment of child abusing parents was done by Kempe and Kempe (1978). These authors contend that the psychotherapeutic treatment of these individuals must be undertaken with specific, but limited goals in mind. These goals must:

- a) be immediate and superficial, e.g., to change one pattern of behavior in the parent, or to help him or her develop

satisfying relationships,

- b) consider the life situation of the parent, the ability of the parent to articulately express his or her own feelings, the parent's capacity for change, and his or her ability to use support, and,
- c) take into account the length of time the therapist is available, and the therapist's skill in using the necessary treatment approach.

While Kempe and Kempe (1978) believe that in some instances abusive parents can profit from years of analytically-oriented psychotherapy, they say that as a general rule the therapist ought not endeavor to uncover long-standing and deeply buried needs in these parents since the therapist can, in fact, do little to meet these needs. Moreover, not all therapists are qualified for such treatment, nor are all parents capable of introspection or able to explore their pasts.

These researchers require that a psychiatric diagnosis of the entire family take place before psychotherapy begins. This diagnosis serves to determine the strengths of each parent as well as existing patterns of interaction. And, they say that if possible, both parents should be involved in therapy since it is both parents who are responsible for the abuse of the child.

Several researchers have reported on studies in which various psychotherapeutic techniques were employed. One such article (David,

1974) focuses on the use of the confrontation technique in therapeutic work with child abusers. The confrontation technique calls for an authoritative statement by the therapist which directs the patient to control certain desires, drives and impulses causing conflict. The statement is preceded by the question, "What do you feel or think about what I say?" David believes that within a therapeutic context an authoritative statement by the therapist can help to explore the client's thoughts and feelings about the need or desire to comply with the statement. An authoritative statement may also create within the client the desire to consider the significance of controls and the meaning they may have in his or her own circumstance.

David (1974) maintains that an evaluation of the client preceding the confrontation is essential in order to obtain important information about the child abuser's leading conflicts, accessibility, elasticity, and the strengths and weaknesses of his or her defense symptoms. The establishment of rapport with the client is also required before the confrontation occurs. The focus of the therapy according to the author is the "integrative task" dealing with the problems the client's ego attempts to solve at each moment. The goals of the therapist and the client are static, though the primary goal of the therapist is to protect the child.

How exactly does the confrontation technique work? David (1974) describes the case history of one child abusing mother and quotes from one interview with her in which he employed use of confrontation:

Therapist: 'I am going to tell you something. . . , and I want you to tell me what you think or feel about what I tell you. . . I WANT YOU TO STOP PUNISHING S. (the abused child) NO MATTER WHAT THE PROVOCATION. What do you think or feel about what I told you?'

Abusing Parent: 'Who are you to tell me how to treat my children? What gives you the right to tell me how to raise them? I try hard. I love my children and nobody seems to understand.'

The confrontation is made in the early part of the interview so that there is sufficient time to work through the expressed feelings. Simply stated, the confrontation technique provides an outside control for the child abusing parent who lacks internal control.

The purpose of another study (Fries, 1975) was to determine whether or not the use of a treatment program consisting of individual psychotherapy and group treatment influenced certain personality factors in child abusing parents. To do this, the researcher used two groups, one control and one experimental. Prior to treatment, all of the subjects were tested with the Sixteen Personality Factor Questionnaire, the Edwards Personal Preference Schedule, and the Acceptance of Self and Others Scale. The parents in the experimental group then received six hours of individual psychotherapy and fourteen two-hour group therapy sessions. Following therapy, all of the subjects were again tested with the same instruments used in the pretest.

The results indicated significant differences in the pretest and posttest scores of the experimental group in three subsets of the Edwards Personal Preference Schedule, two subtests on the Sixteen

Personality Factor Questionnaire, and one subtest on the Acceptance of Self and Others Scale. There were no significant differences in any areas between the pretest and posttest scores of the control group. By comparing the posttest score of the experimental and control groups by using the pretest score as the adjusting variable, Fries made a second finding that there were no significant differences in any of the personality factors studies on any of the three instruments.

Fries (1975) was able to conclude that:

1. The treatment program brought about changes in the experimental group in several personality factors. Following therapy, subjects in the experimental group were more sober, serious, secure, self-assured and adequate. Also, these subjects exhibited greater degrees of acceptance of self and others, had a lesser need for order and structure in their lives, as well as less need for personal autonomy following treatment. And, their need for change was elevated during the course of treatment.
2. The control group experienced no changes in the personality factors studies during the treatment period.
3. No significant differences were found between the groups in the areas of self-acceptance, acceptance of others, emotional maturity, purposive self-directed behavior and feelings of inferiority after adjustments were made for pretest differences in the groups.

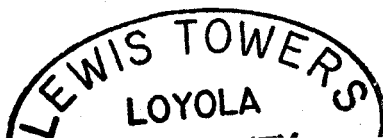
Polakow and Peabody (1975) propose the use of behavior therapy to treat child abusers. They state that child abuse can be seen as an attempt by the parent to control some undesirable behavior of the child after other less violent means have proved ineffective. They believe that abusive parents can develop the ability to employ more appropriate and more adaptive means of control over the child if they are taught the skills necessary for them to deal effectively with their children's inappropriate behaviors. The behavioral model of Polakow and Peabody combines three techniques which have been previously used with success in the treatment of criminal offenders and drug abusers: contingency contracting, assertive training, and discrimination training.

A lengthy case example of the treatment of one child abuser illustrates the use of a five-phase approach which incorporated the three techniques of Polakow and Peabody's model. The first phase dealt with determining the behavioral contingencies which existed in the parent-child relationship, while simultaneously establishing the therapist as a social reinforcer. The second phase concerned itself with the development of a behavioral contract between the therapist and the client which specified the negotiation of a contract between the parent, a mother, and her child, a son. The contract between mother and son stipulated that the mutually agreed upon behavioral changes in the boy would be reinforced by the mother through rewards such as allowance and attention, and that any undesirable or inappropriate behaviors would be ignored. Further, the parent was instructed in the use of "time out" procedure used to deal with undesirable behaviors which she

could not ignore. Positive behavioral changes were achieved in small increments. In the third phase, most of the acting-out behaviors had ceased, the mother was adept in the use of positive reinforcement techniques, and the therapist was able to begin discrimination training with the client. Discrimination training was achieved during a play situation involving the son and one of his peers in which the parent was instructed by the therapist to correctly reinforce, ignore or punish by means of a "time out" procedure, certain behaviors of her son. The parent began to participate in group therapy designed to develop interpersonal and social skills, the fourth phase of her treatment. In the fifth stage, the therapist withdrew from the contract between the mother and her son, thereby giving complete control to the client. The authors report great success in their treatment program in which the parent was seen for one hour each week for sessions extending over a one-year period.

Another behavioral approach to the treatment of a child abusing parent was described by Gilbert (1976). The two aims in Gilbert's treatment program were 1) to prevent physical harm of the child by the parent, an incident feared by the client, and 2) to present for the client a good model of how to deal with the child in a warm, intimate and loving manner, one which the client could learn and copy.

Gilbert's program involved the parent, the therapist and the abused child. In the first part of treatment, the therapist interacted with the child by playing games of increasing intimacy and contact. The parent was encouraged to imitate the behavior of the therapist.



Initially, the parent exhibited resistance to this, but it was pointed out by the therapist that changes in behavior often precede changes in attitude. The author notes that the parent gradually became aware of the fact that she was able to enjoy the company of her child. The second part of Gilbert's treatment program was composed of outlining targets of treatment, that is, forms of behavior the parent desired to show the child but was unable to, for example, talking to the child, smiling at the child, picking the child up. The targets were rank ordered in terms of the anxiety they produced in the parent. The targets were worked through with the therapist as a model, and the parent was encouraged to increase her involvement with the child between sessions. The achievement of targets was monitored throughout the duration of treatment. When the therapy was terminated, the parent was enjoying the child's company.

Following therapy, Gilbert (1976) reports that the child abusing parent was placed on a self-directed and self-maintained therapeutic program. This program consisted of the targets already practiced by parent and therapist; this time, however, the targets were rated according to the enjoyment they produced. The notion behind the self-directed program was that it enabled the client to see her own progress, thereby promoting her self-esteem and self-confidence. Gilbert's charts of the various targets allow the reader to gain a clear understanding of the steady progress achieved by the client in the self-directed program. Follow-up visits by Gilbert indicated that the improvement in the behavior of the parent was maintained.

Yet a third treatment approach based on principles of behavior therapy has been suggested, one which seeks to promote the verbal accessibility of child abusers (Polansky, De Saix, & Shlomo, 1972; Polansky, Borgman, De Saix, & Sharlin, 1974). These researchers define verbal accessibility as the readiness of the parent to talk directly about his or her important feelings and attitudes, and to discuss them with the therapist. They believe that as a general rule parents who are able to discuss their feelings with the therapist are more likely to meet their children's needs. Parents who are verbally inaccessible are generally lonely and isolated.

Polansky and his coauthors believe an increase in verbal accessibility on the part of the child abuser not only prepares him or her for treatment. They say it also has curative value. As the child abuser verbalizes his or her insecurities and hostilities, he or she is taking responsibility for them, an indication of maturity and improvement.

There are several techniques the therapist can employ to promote verbal accessibility in the parent. One way is by encouraging the parent to talk, no matter what the topic. These first topics, however, should be about concrete external and superficial matters. Also, the authors have found that support through improving the parent's self-image is conducive to verbal accessibility. Another technique is to help the parent learn to precisely describe important attitudes and to help him or her say what they want to. The therapist ought not to let pass any opportunities to deepen the level of communication

between him or herself and the parent. The therapist should also be aware of cultural stigmas against discussing family problems, inside or outside the home, as well as guilt which follows outbursts against loved ones. Such cultural inhibitions can often be counteracted in group therapy. Verbal accessibility can exist only in an honest relationship; therefore, the therapeutic atmosphere must be one which allows for frank talk. Finally, the therapist must act both as listener and a role model in helping the parent become more verbally accessible. The therapist should appropriately share his or her own feelings with the client.

Systematic desensitization has been suggested as a psychotherapeutic technique which could be successfully used in the resolution of abusive behavior toward children (Sanders, 1979). Sanders reports the case of a child abusing parent who, following two incidents of abuse to his infant son, was hospitalized, subsequently released, and then referred to Sanders for therapeutic treatment in which systematic desensitization was employed.

During the first four months of the treatment of his client, Sanders made use of the four techniques which preceded his use of desensitization: assertion training, behavioral rehearsal, training in personal effectiveness, and the drug Imipramine, an antidepressant. In the period of desensitization, the client was first instructed in how to relax the muscles of his body, a technique which he practiced at home. The client then drew up a list of anxiety-provoking situations involving the child, and rated these situations in terms of his

subjective feelings of anxiety on a scale of one to one hundred in gradations of ten. For the next twelve sessions, the child abuser was instructed to become completely relaxed. While he was in this state, each situation was presented to him by the therapist as many times as was necessary until the parent was able to maintain his relaxed state for three successive presentations. During the final session, a tape recording was played of his son crying.

Sanders (1978) reports that following desensitization, his client felt more relaxed and in control of situations involving his son which were previously anxiety producing. The parent was seen for an additional nine months for general therapy during which time the use of Imipramine was discontinued. A follow-up five months after the end of therapy indicated that there had been no further incidents of child abuse. Though he does not know to what extent Imipramine may have affected his client's improvement, Sanders suggests that the desensitization process was the major factor in the abatement of his client's abusive behavior.

Cox (1979) combined the philosophies of rational behavior training and reality therapy into a therapeutic strategy known as the Rational-Reality based approach. It was designed to teach child abusers how to increase their reasoning skills, and to help them understand and perceive positively the personal benefit of not maltreating the child (as opposed to the negative aspects of reducing frustration by abusing the child).

The rational behavior training component of Cox's approach functions primarily to train child abusing parents to think rationally, though it has other secondary goals. Rational thinking is comprised of five criteria. It:

- a) is based on objective facts,
- b) is life-preserving,
- c) helps a person achieve his or her self-defined goals,
- d) enables a person to function with a minimum of significant internal conflict, and
- e) enables a person to function with a minimum of significant conflict with his or her environment.

The reality therapy component of Cox's approach deals with the psychological needs of the child abuser, and it is based on three tenets fundamental to the Rational-Reality concept. The first tenet is to help the child abuser fulfill the basic needs to love and to be loved, and to feel that he or she is worthwhile to him or herself and to others. A second tenet is that any individual with a serious emotional problem lacks the proper involvement with another and is, therefore, unable to satisfy the needs of the first tenet. The final tenet concerns itself with the ability to fulfill one's own needs in a way that does not inhibit others in fulfilling their own needs.

Cox's model emerges from incorporating the five criteria of rational thinking with the three tenets of reality therapy. The author posits that his model represents the antithesis of the child abuser, and it is from this perspective that his treatment program was developed.

The treatment commenced with individual counseling sessions in which the philosophies of the two theories of the Rational-Reality

concept were discussed and diagrammed in detail until every adult gained a clear understanding of each therapeutic rationale and how he or she would incorporate them into his or her own behavior. This was achieved through the use of five techniques.

The first technique involved teaching the client the consequent goals of learning the skills involved in rational thinking in terms of what the accomplishment could mean to the client. The material was given to the parent in hand-out form and discussed both in lecture and in individual counseling sessions. The goals were presented as ones he or she could achieve through rational thinking and behavior. At this point in treatment, the parent was told simply to consider the goals as behavior that could be of benefit to him or her at some future date. The second technique was to teach the child abuser the five basic criteria for rational thinking and the three tenets of reality therapy. These criteria were also given to the parent in hand-out form and discussed in individual counseling sessions. The parent was asked to accept the criteria and to begin evaluating his or her present or potential behavior in terms of meeting these rationales. Cox characterizes the third tenet as one in which the parent was taught the five stages of the anatomy of an emotion: the individual perceives a situation through one of the senses, describes the situation to him or herself ("self-talk"), pushes the description of the situation through his or her belief system, chooses an emotion appropriate to the description of the situation, and arrives at the consequent feelings and behavior based on his or her chosen emotion. A fourth technique used

by Cox was to teach the parent the understanding and utilization of Rational Self-Analysis (RSA), the crux of his treatment approach.

RSA was comprised of six sections (A, B, C, Da, Db, E), each based on one of the first three parts of an emotion as previously described.

In section A, the client wrote down the facts of an event that occurred which upset him or her. Section Da required the client to check section A to be certain that A was devoid of any subjectivity or value judgments. If section A was found to be a factual description, the parent passed section Da; if not, the parent had to review A until it was purely factual. The client was asked for an evaluation of his or her thoughts about the event in section B ("self-talk"). This section included subjective value judgments and ideas that were the parent's source of undesired behavior or negative emotions. Next, the client rationally debated each of the statements in section B by writing his or her challenges in section Db. For example, if the parent had said, "If Suzie (4 years old) wouldn't defy me and try to do things her own way, I wouldn't hit her so hard." A challenging statement to this section in Db could be, "Trying to do things their own way is age-appropriate behavior for four year olds." In section C, the parent gave a precise emotional label to his or her response to the event. This section served to help the parent distinguish between feelings and thoughts. Section E contained what the parent felt would have been a more appropriate emotional response than the one he or she gave, a response that could be used if he or she was ever again in a similar situation with the child. The five criteria of rational thinking and three tenets of reality therapy were listed at the bottom of the RAS to

help the parent analyze his or her feelings and to evaluate the appropriateness of his or her response. Finally, a fifth technique concerned itself with teaching the parent the use of imagery in rational self-conditioning. Here, the parent was instructed to picture him or herself in the same situation, but behaving in the way he or she would have liked to behave. While doing this, the client simultaneously reviewed the challenging statements he or she had written in Db. The parent then participated in a group of child abusers, all of whom had been through a similar orientation program. In this group the parents discussed their past behavior while employing the techniques of rational behavior training and reality therapy.

After using these five RAS techniques for some time, Cox (1979) reported that the parents were better able to understand their problems of abuse, gained insights into practical responses, reacted more rationally and responsibly to situations, perceived and thought about situations objectively, controlled their emotions responsibly, and chose appropriate behaviors for which the situations called. Of his thirty-five clients, twenty-three indicated that they were able to restrain their irritation on occasions when the child behaved inappropriately and that they enjoyed a closer and more affectionate relationship with the child. Lesser success was reported with the remaining twelve clients.

Analysis of Cluster I

Figure 1, the classification chart of psychotherapeutic techniques,

reveals similarities, differences and trends among the individual studies. This chart enables one to make several concrete comments about the literature pertaining to the use of psychotherapy in the treatment of child abusing parents.

For one, it appears that on the average, the literature commenting on this method of treatment was written about 1976, the earliest piece being published by Polansky et al. (1972), the most recent pieces by Blumberg (1979) and Cox (1979). The cluster is comprised of fourteen studies in all.

A second revelation is that the majority of the pieces about psychotherapy (Cox, 1979; Gilbert, 1976; Polakow & Peabody, 1975; Polansky et al., 1972, 1974; Sanders, 1978) rest on the theoretical tenets of behavior therapy. Three approach the psychotherapeutic treatment of abusive parents by use of reality therapy (Beezley et al., 1976; Cox, 1979; David, 1974), a treatment type which focuses on present behaviors and confronts reality. Clearly, then, behavior therapy and reality therapy are closely aligned in that the immediate emphasis on both is on behavior. Three more are proponents of psychoanalysis (Blumberg, 1977, 1979), traditional psychotherapy (thought to refer to psychoanalysis) (Martin & Beezley, 1976), and psychoanalytically-oriented psychotherapy (Steele, 1975). And, finally, one advocates what is called individual psychotherapy (Fries, 1976).

Accordingly, it is reasonable to surmise that the principal goal of researchers in using psychotherapeutic techniques has been to resolve

the parent's abusive behavior (Sanders, 1978), with a secondary goal of gaining insight and understanding about past experiences. The researchers within this cluster express this principal goal of behavior change in a variety of ways: by exploring abusive behavior to gain insight (Beezley et al., 1976); by providing external control over the parent's impulses (David, 1974); by helping the parent develop more appropriate and adaptive means of control over the child (Polakow & Peabody, 1975); by presenting for the parent a good model of how to deal with their child (Gilbert, 1976); by promoting the parent's verbal accessibility (Polansky et al., 1972, 1974); by increasing the reasoning skills of the parent (Cox, 1979). The secondary goal of this cluster, to gain insight and understanding about past experiences, has been espoused in various ways: by facilitating deep developmental and structural changes within the parent (Steele, 1975); by resolving internal conflicts (Martin & Beezley, 1976); and by abreacting early childhood conflicts (Blumberg, 1977, 1979). Kempe and Kempe (1978) say only that the goals of psychotherapy are specific, limited and varied. Fries' study (1975) had the goal of determining the effects of behavior therapy on child abusers, a study which yielded positive results.

A fourth statement to be made by analyzing the psychotherapeutic classification chart is that the vast majority of techniques within the cluster, as one might expect, corroborates what has been determined to be the primary thrust of the psychotherapeutic treatment of child abusers, that is, behavioral change. Hence, techniques such as training

in personal effectiveness (Sanders, 1978), behavioral rehearsal (Sanders, 1978), contingency contracting (Polakow & Peabody, 1975; Sanders, 1978), discrimination training (Polakow & Peabody, 1975), target treatment (Gilbert, 1976), rational behavior training (Cox, 1979), systematic desensitization (Sanders, 1978) and play therapy (Gilbert, 1976), plus the many techniques cited by Polansky et al. (1972, 1974) to promote verbal accessibility, are seen widely throughout the literature. There appear to be two other minor patterns when examining psychotherapeutic techniques. The first is a proneness toward re-parenting/nurturing and extensive outreach (Martin & Beezley, 1976). Steele (1975) identifies this technique as one in which the therapist encourages the dependency of the parent. The second minor pattern among the techniques is to involve more than one person in the treatment process. Martin and Beezley (1976) say that the parent-child relationship must be treated as part of the therapeutic program. Blumberg's (1977, 1979) approach is collateral, one which involves the parent and child. Kempe and Kempe (1978) contend both parents must be involved in the therapeutic process. Other noteworthy techniques are the use of an anti-depressant drug in treatment (Sanders, 1978), the use of confrontation (David, 1974), and the use of a pre-psychotherapeutic psychiatric evaluation (Kempe & Kempe, 1978).

The use of group therapy as an adjunctive service to the psychotherapeutic care of child abusers is generally accepted (Cox, 1979; Fries, 1975; Martin & Beezley, 1976; Polansky et al., 1972, 1974; Steele, 1975), but Fries (1975) prescribes its use toward the end of individual

treatment. The services of lay therapists have also been found to be used in conjunction with psychotherapy (Beezley et al., 1976; Martin & Beezley, 1976; Steele, 1975). Two studies advocate casework (Martin & Beezley, 1976; Steele, 1975), and another cites self-help programs (Beezley et al., 1976) and other less traditional treatments, as acceptable adjuncts to individual psychotherapeutic care. Gilbert (1976) employed a self-directed treatment program following psychotherapy.

To conclude, the works pertaining to the psychotherapeutic treatment of child abusers were written, on the average, about 1976. The majority of studies rest on the theoretical tenets of behavior therapy. Other approaches rely on reality therapy, a theory closely aligned with behavior therapy in that the immediate emphasis is on behavior and change, another approach that has been used in psychoanalysis, but to a much lesser degree. It follows that the basic goal of the studies in this cluster has been to change behavior, with a secondary goal of exploring intrapsychic conflicts. Logically, the techniques used within this cluster are traditional ones used in behavior therapy. Two other often used techniques are to reparent/nuture and allow dependency of the parent, and to involve more than one person in the treatment process. Group therapy and lay therapy are the services most frequently used as adjuncts to individual psychotherapeutic care of child abusers. There was indication in the literature of some support of casework as an adjunctive service.

Discussion of Cluster II

Numerous researchers have written about the group approach to the treatment of child abusing parents. The classification chart marked Figure 2 provides an overview of the group therapy cluster.

Wasserman (1975) states that work with groups of child abusing parents has proven effective. He says that the biggest benefit of groups is the fact that they give these isolated parents the chance to socialize in a group of parents who have similar problems, an experience which lowers their resistance to facing and dealing with their troubles.

Zalba (1975, 1977) says that there is some indication that ego-oriented group therapy may be the preferred mode in the treatment of child abusing parents due to the facts that such adults are characteristically isolated, socially unskilled, tend to deny problems, have a general inability to control impulses, and have difficulty with figures of authority.

Caskey and Richardson (1975) concur with Zalba's statements about the use of group methods in the treatment of abusive parents. They believe that group treatment is desirable in working with child abusers since the types of problems from which they suffer are ones which have responded to the appropriate application of group techniques. Examples of this would be the potential of groups to effect a constructive psychological change (such as the reduction of anxiety or an increase in self-confidence), or their potential to effect personal growth

	<u>WASSERMAN</u>	<u>ZALBA</u>	<u>CASKEY & RICHARDSON</u>	<u>STEELE</u>	<u>WALTERS</u>	<u>BEEZLEY ET AL.</u>	<u>KEMPE & KEMPE</u>	<u>HERRENKOHL</u>	<u>MC FERRAN</u>	<u>GALDSTON</u>
YEAR OF STUDY	<u>75</u>	<u>75, 77</u>	<u>75</u>	<u>75</u>	<u>75</u>	<u>76</u>	<u>78</u>	<u>78</u>	<u>58</u>	<u>71</u>
TREATMENT APPROACHES	Social-ization	Ego-oriented	*	*	Discuss stress, child management & development	Psychotherapy	Varies	*	Casework	Psychoanalytic
GOALS OF THERAPY	Help parents face and deal with problems	Improve isolation & social skills, help parent to face problems & control impulses & deal with figures of authority	Effect constructive psychological change or personal growth; others	Help parents express emotions, become desensitized to criticism & channel for socialization	Become effective parents	Varies	*	Personal growth	Instruct parents in principles of child care	Protect child, study child abuse as dysfunction, study forces which precipitate child abuse, train personnel
COMPOSITION OF GROUPS & NUMBER OF PARTICIPANTS	Child abusers/*	Child abusers/*	Child abusers/*	Varies, couples preferred/*	Couples/ 8-12 persons	Varies/open-ended; 7 ideal, 5-10 persons range	Support couples groups/*	*/*	Child abusers/*	Couples/ 1-10 persons
FACILITATORS	*	*	*	Professionally trained M-F cotherapists	*	Cotherapists	Cotherapists	M-F cotherapists	Protective service case-workers	M-F cotherapists
COMMENTS	*	*	*	*	Meetings 90 minutes in length	Most effective with individual therapy	Effectively used with individual therapy	Parallels growth achieved through participation in religious groups	*	Day care facility for children while couples in group

* Not indicated

FIGURE 2. OVERVIEW OF GROUP THERAPY CLUSTER

FIGURE 2. (Continued)

YEAR OF STUDY	<u>SAVINA & SANDERS</u>	<u>PAULSON & CHALEFF</u>	<u>PAULSON ET AL.</u>	<u>FEINSTEIN ET AL.</u>	<u>OUNSTED ET AL.</u>	<u>JUSTICE & JUSTICE</u>	<u>JUSTICE & JUSTICE</u>	<u>TUSZYNSKI & DOWD</u>	<u>MC NEIL & MC BRIDE</u>
	<u>73</u>	<u>73</u>	<u>74</u>	<u>74</u>	<u>74</u>	<u>75</u>	<u>78</u>	<u>78</u>	<u>79</u>
TREATMENT APPROACHES	*	Parent surrogates	Eclectic	*	Casework	Transactional analysis	Eclectic	Network therapy	Marital therapy
GOALS OF THERAPY	Discuss problems which precipitate abuse & instruct in child care	Facilitate personal-social growth & development	Facilitate personal growth through relationship with parent surrogates	Create a support system	Help mothers with their problems & teach more constructive means to deal with children	Break up symbiosis	Focus on individual problems; make specific behavioral changes in parents	Confront destructive patterns of relating and form supportive network of relationships	Support system & train in decision-making
COMPOSITION OF GROUPS & NUMBER OF PARTICIPANTS	Couples/ 0-8 persons	Couples/*	Child abusers/*	Mothers/6	Mothers/ 5-8	Couples/*	Couples/ 5 couples	Child abusers/*	Couples/ 3-5 couples
FACILITATORS	M-F cotherapists	M-F cotherapists	M-F cotherapists	2 psychiatrists	*	M-F cotherapists	M-F cotherapists	M-F cotherapists	M-F cotherapists
COMMENTS	Group meets 1 time weekly for 1 1/2 months	*	*	Group meets 2 times weekly for 1 hour	Group for children met simultaneously	Techniques: confronted discounts; corrected mis-information, remove injunctions	Length of treatment: 5-6 months	Variety of services used: art therapy, couples therapy, parent education, etc.	Length of treatment: 6-18 months

* Not indicated

(greater acceptance of one's self, or an increased awareness of one's own feelings).

Steele (1975) notes that there has been increasing use of group therapy as a mode of treating child abusers. He points out that the composition of groups may vary from mothers to abusive parents to couples, but that couples are preferred since abuse is always a family problem with one parent condoning the abusive behavior of the other, though he or she may not actually be abusing the child. The author goes on to say that groups are led by professionally trained therapists, preferably a male/female team, a particularly important model if the group consists of couples.

Steele cites two major consequences of group process for child abusers. First, groups help such parents to express their emotions more openly and to become desensitized to criticism. Secondly, groups provide channels for contacts into a wider community. Steele states that though group therapy may be the primary mode of treatment of abusive parents, it should be supplemented with other individual forms of treatment. He suggests this as a logical consequence of the fact that the basic difficulties from which the abusive parent suffers are the results of the deficits in the relationship between parent and child in one's early life.

Walters (1975) supports the use of group methods as an economical and effective means of treating abusive parents, and he provides a discussion of the mechanics of creating and executing a group treatment

program.

Walters (1975) proposes that adult abusers and their spouses should be approached about forming a group from the point of view that all parents have problems with their children, and that by discussing topics such as stress, child behavior management and development, they could all become more effective parents. The therapist should provide parents with child care and transportation at the times of group meetings.

A group consists of eight to twelve parents. Following brief self-introductions initiated by the therapist, he or she should explain the three-fold purpose of the group: a) to identify when parents are under stress; b) to identify behavior of children that creates stress for parents; and c) to help each other find effective and appropriate ways to manage their children. At the end of the ninety minute session, the therapist reiterates the purposes of the group. The parents are asked to monitor closely the annoying behavior of their child and their own feelings during the next week.

The author cites four pitfalls to be avoided in the group treatment of child abusing parents. The therapist should 1) avoid criticizing any method of coping suggested by a child abuser; 2) never violate the confidentiality of the group discussions; 3) not change role as facilitator of the group; and 4) not tolerate non-payment of fees by group members.

Beezley, Martin and Alexander (1976) give guidelines for group psychotherapy for abusive parents. They say that the ideal group consists of about seven persons, with an acceptable range of five to ten members. Groups of this sort must necessarily be open-ended, admitting new members when it becomes necessary to remain an acceptable size. They posit that the co-therapy model is important in all groups, regardless of composition, and they state further that the purpose and composition of groups can vary.

Beezley and her associates discuss the advantages and disadvantages of group therapy. The advantages are numerous. First, group therapy is economical; it provides the means to treat more people with fewer professionals. Further, groups decrease isolation, increase socialization, and encourage mutual support systems. Other advantages are that groups increase confrontation of denial of problems, and provide child development and child rearing information. There are also disadvantages to group therapy. First, when in severe crisis situations, abusive parents are usually in need of individual support. Secondly, extremely disturbed parents may disrupt a group, resulting in their rejection by other group members. And, some parents may feel too threatened by the idea of exposing deep feelings to a group to profit from such a treatment mode.

These authors raise other significant issues surrounding group treatment. The time and place of meeting, transportation, child care and pre-group preparation are important considerations to be dealt

with before a group is undertaken. They conclude their discussion by stating that group treatment is most beneficial when the parents are also receiving some type of individual therapy.

Kempe and Kempe (1978) comment on the topic of group therapy in a chapter dealing with the treatment of child abusing parents. They believe that group therapy, alone or together with individual treatment, can be very successful, particularly when the group is composed of couples. Further, they hold that groups can focus on a variety of topics, though if they are primarily educational in nature, members will need other methods of dealing with individual concerns. Groups led by professionals have the added advantage that members often respond to the therapists as parents, a condition which enables them to deal with difficulties they experienced early in their own lives.

Another article dealing with group therapy treatment of child abusing parents was written by Herrenkohl (1978). In this piece, the author parallels the dynamics of personal growth in child abusing parents who participate in group therapy to those who participate in religious groups. The author bases her arguments on an investigation she conducted which focused on the effectiveness of treatment services thought to contribute to recidivism or discontinuation of abuse in two hundred and fifty families who received one or more of a variety of therapeutic services. While interviewing these families, it was discovered that a number of them attested to change due to involvement in group therapy or in religious groups. The results of Herrenkohl's

intensive interviewing suggested parallels between the two treatment modes in the process by which personal growth occurs.

Herrenkohl (1978) cites six such parallels. First, both treatment modes offer the group members the opportunity to discover a network of social support, thereby ameliorating their social isolation. A second parallel between the two groups is that both provide child abusers with the experience of being respected as intelligent and valuable persons, a source of growth of self-esteem. The alleviation of guilt is a third aspect of personal growth in the two modes. In group therapy, the parents' guilt is mitigated by the understanding that they are not alone in being labeled "child abuser", and that much of their behavior was shaped by circumstances beyond their control. Group therapy also helps to correct guilt resulting from the parents' overidentification with the children in the sense that the parents erroneously interpret every misbehavior of the children to be reflections of their own failures, rather than the result of developmental processes. Participation in group therapy and in religious groups also influences hope among group members, a fourth aspect of personal growth. In group therapy, hope is increased as one's personality changes and self-reliance improves. As group members become more in touch with their own feelings and more able to communicate them, they become more able to cultivate meaningful relationships. Fifthly, the group therapy process and participation in religious groups provide surrogate parental acceptance and love through male/female co-therapists who form the parental framework within which personal growth

can occur. Finally, both modes have direct effects on behavioral expressions of anger. In group therapy, articulation of feelings, empathy with the child, and the acquisition of knowledge of the child development process are emphasized so as to help the parents gain more control over motor patterns of expression.

McFerran (1958) wrote the earliest article describing group treatment of abusing parents. It summarizes the outcomes of a parents group organized by caseworkers to supplement and reinforce their efforts with child abusers in protective service. The purpose of the group was to instruct parents in principles of child care. Additionally, the group was found to provide the opportunity for the parents, who varied in race, sex, income and intellectual capacity, to meet others with similar problems, to exchange ideas, and to have social experiences. The group met during evening hours at a community center. Assistance was given to parents with practical matters such as babysitting and transportation.

McFerran (1958) uses case illustrations to highlight her findings about the group. For one, McFerran discovered that the members felt pride in association with the group. A second insight was that sentiments of warmth, friendliness, acceptance and a "group feeling" existed in the meetings. The author also found that many members made efforts to apply at home some of the ideas acquired from group participation. McFerran's fourth discovery was that the meetings supplemented the caseworker's efforts with parents whose children were no longer seriously

neglected or abused. Fifthly, the group functioned in a preventive capacity. The author's final conclusion was that the group participation and individual casework interacted to provide more effective service to the clients in protective care.

The Parents' Center Project for the Study and Prevention of Child Abuse (Galdston, 1971) consisted of an approach which combined group treatment of parents and a day care facility for their children. In Galdston's program, the parents participated in group meetings which afforded them the opportunity to share and compare their experiences about themselves, their marriages and their children while concurrently their children, without removal from their homes, attended a day care facility for eight to ten hours a day, five days a week. The Project had several objectives. The first was the protection of the children from physical abuse. A second objective was to study child abuse as a dysfunction of parenting. The examination and characterization of the forces which precipitate violence in family life was a third goal of the Project. A final goal was to use the program as a way of training personnel to deal with abusive families and to establish criteria for their training.

During intake of parents, emphasis was placed on the Project's purpose to help the parents provide optimal care for their children. Attendance of fathers was at first optional, but it later became a requirement for both parents to participate in the meetings. The group varied in size from one to ten members, and was led by one male

and one female social worker.

Galdston (1971) gives an interesting explanation of the dynamics of the group. Initially, he says, the mothers complained about the inadequacies of their husbands, but after a short while, this theme shifted to their concerns about their children. According to Galdston, their expressed concerns about their children were actually manifest anxieties about their own phobias and desires. More precisely, the children were regarded as embodiments of their parents' phobias and instinctual lives. And, just as abusive mothers have not learned to live with their own phobias and desires, so they have not learned to live with their children (or without them in both cases). Therefore, the goal of their group was to attain some understanding of the issue of responsibility for sexuality as a personal prerogative, and to settle questions raised in the Oedipal complex. Galdston and his colleagues at the Parents' Center Project believe that once these understandings were achieved, the children were no longer at risk for abuse. Since the Project achieved success with the families it treated, Galdston calls for the creation of a number of such centers as a way of treating a larger population of child abuse families.

The article by Savino and Sanders (1973) describes an outpatient therapy group for abusive parents which was led by two therapists, a male child psychiatrist and a female public health nurse, who served as father and mother figures for the participants.

Since it was believed that both parents were involved in the

child abuse phenomenon, both parents were required to attend the weekly hour and a half-long sessions. The number of participants in the group varied to a maximum of eight. When parents did not attend a session, they were telephoned by the facilitators and encouraged to return the following week. The authors note that they experienced resistance by the couples at the onset of the group, but that this anger dissipated after a few sessions.

The Savino and Sanders group moved in two directions. The first direction was toward dealing with the resistance the parents felt in discussing the problems which precipitated their abusive acts, such as isolation, marital conflict and poor peer interaction. The authors report that parents who were able to discuss such issues openly benefited the most from the group therapy. The second direction taken by the Savino and Sanders group was toward instruction in child care since the parents in their group displayed a marked deficiency in their knowledge about normal physical and emotional developmental patterns.

Paulson and Chaleff's paper (1973) directs itself to the idea that because most abusive parents have suffered from chronic, severe emotional deprivation in their childhoods, they are in need of mothering and parenting to facilitate their personal-social growth and development. To meet this need for mothering/parenting, Paulson, a male clinical psychologist, and Chaleff, a female psychiatric nurse, both in their fifties, developed a group psychotherapy program in

which they fulfilled parent surrogate roles as co-leaders.

The group existed over three years, and it treated a total of sixty-one abusive parents whose average age was twenty-six. Both parents were encouraged to attend the meetings which were held weekly for two hours in the evenings. During the first half hour of every evening, the parents were instructed in child care and development by the female therapist.

Paulson and Chaleff (1973) report that in the initial phase of treatment, the parents resisted therapy, were suspicious of the co-therapists, and exhibited feelings of isolation. Gradually, the parents began to express rage, anger, dependence and they manipulated the co-therapists. These behaviors were accepted without judgment, condemnation or fear of rejection by Paulson and Chaleff. As the group members' needs for security were fulfilled, their relationships with the therapists became characterized by trust and sharing. And, as greater feelings of trust developed, the parents were able to acknowledge their needs for help with their marriages, individual and family lives.

In summary, the uniqueness of Paulson and Chaleff's group was in its primary use of co-therapists as parent surrogates. The special characteristics of their treatment design were that the co-therapist constituted a family unit, that it allowed for identification and modeling of the co-therapists by the members, and that intimacy, empathy, trust and mothering were used to develop Paulson and Chaleff's

roles as surrogates.

Paulson, Savino, Chaleff, Sanders, Frisch and Dunn (1974) present a paper which summarizes their findings concerning the applicability, successes and failures of group therapy in the treatment of parents who maltreat their children. Their study was based on two therapy groups led by professionally trained male/female co-therapists which existed over three years. The focus of the group was not precisely stated; Paulson and his associates simply remark that the group "constantly struggled with its purpose" (problem solving, insight seeking, socialization). These researchers characterize the early part of the group process as one in which resistance occurs, and also as a time when the co-therapists were regarded with suspicion by the group members. Following several months of group process, however, the resistance diminished and the therapists were increasingly placed in parent surrogate roles. The position of the co-therapists as parent surrogates provided the opportunity for group members to share an intimacy of understanding with mature adult figures, a critically important aspect of the treatment.

In their article, Paulson and his colleagues (1974) reflect on group therapy, a treatment they characterize as eclectic in approach because of the fact that it based itself on a number of existing theoretical modalities. They also offer several vignettes which illustrate how this mode of treatment contributed to emotional growth and greater maturation in the parenting role, with the resultant effect of ending abuse of the child.

A paper by Feinstein, Paul and Esmiol (1974) addresses itself to the hypothesis that group psychotherapy has special advantages in treating women with the impulse to harm their children. These authors gathered data for their study from case records and the first eighty hours of group therapy of six women who met the criterion of having the impulse to harm their children. The group met twice weekly for one hour and was led by two psychiatrists. As background for their discussion of the group process, the authors' report shared biographical characteristics and symptoms of the mothers of their study.

According to Feinstein and his colleagues, group therapy offered five therapeutic advantages. The first advantage was that the group experience brought the mothers to the realization that their murderous impulses were not unique. A second benefit was that the support of the other group members was instrumental in enabling some mothers to overcome their phobic symptoms. Thirdly, consensual validation by the group participants was helpful in correcting transference distortions. Observations of transference distortions by group members were less likely to be interpreted as criticism than were similar observations by the therapist. A fourth advantage was that the members of the group were able to learn different methods of adaptation from each other, and to use the group as a forum for testing them out. Finally, the authors report that the group provided a matrix for meaningful social interaction for women who were otherwise socially isolated.

A treatment program consisting of a group for abusive mothers

and a group which met simultaneously for their children was described by Ounsted, Oppenheimer and Lindsay (1974). This program treated twenty-four families which were characterized as being isolated, ones in which the mothers had unhappy and emotionally deprived childhoods, and ones having distorted interaction between family members.

Before entering the group, individual therapy was given by a social worker to the parent and child in the home. When the mother was judged ready, she was introduced to a group of five to eight other abusive mothers. At the same time, the child was introduced to a group of toddlers. The groups met simultaneously in adjoining rooms.

The goal of treatment was to help the mothers with their problems and, at the same time, to teach them more constructive ways to deal with their children. The others kept diaries of the situations with their children which precipitated abuse; the diaries were then brought to meetings for discussion with the therapist. It was found that the mothers gave one another support. In times of crisis, they were encouraged to call the social worker. The authors say that of the twenty-four mothers who attended regularly for one or two years, all showed signs of improvement, and in no case did abuse recur.

Justice and Justice (1975) used transactional analysis in a group setting to treat child abusing parents. The problem of abuse as they saw it was one of symbiosis, both in the relationship between the parent and child, and in the parents' relationship.

Justice and Justice (1975) describe the symbiotic dynamic between

parent and child as one which occurs when the parent seeks comfort, nurturing and emotional support from the child, and expects the child to fulfill the role of parent. When the child is unable to meet these expectations, resentment and anger build in the parent. Eventually, he or she explodes into an act of abuse. The authors' notion of symbiosis as a dynamic in abuse is further supported by the fact that many abusive parents were maltreated as children, and it is thought that persons who have suffered such deprivation of dependency or excess dependency in their childhoods seek the child position in a symbiotic relationship. Also, symbiotic is the relationship between parents in which one parent actively abuses the child while the other ignores the abuse or passively stands by.

Therefore, the goal of Justice and Justice's treatment plan was to break up the symbiosis between parents and between parent and child. The authors chose to work with couples in a group setting. A requirement of participation was that both parents attend the meetings. The parents were first asked to contract for changes they wanted to make in themselves while in group therapy. Secondly, the parents were required to complete a script questionnaire which revealed common injunctions (don't feel, don't need, don't ask). With this orientation of the parents in mind, Justice and Justice focused on confronting discounts, correcting misinformation about parenting, and giving the parents permission to feel, need and ask for what they needed.

Changes in the symbiotic relationships of the group members were

measured by Kiresuk's (1973) Goal Attainment Scale (GAS) (see Table 2). The scale measured changes in seven categories the authors believed were representative of the ways parents were not meeting their needs: violence, management of children, discounting, talking and sharing with mate, isolation, residency and employment. Ratings on the scale were made by subjective evaluations by the parents and the therapists.

The results of Justice and Justice's (1975) study were assessed after a twenty-one month period during which time twenty persons (ten couples) went through the group. Of the seven couples who had a child removed from the home by child welfare authorities, all but two had their child returned at the recommendation of the therapists who evaluated readiness for this.

Three years later, Justice and Justice (1978) again evaluated the effectiveness of group therapy for child abusing parents by using the GAS. Their 1978 article reports on thirty married couples, a maximum of five couples at a time, who underwent treatment for an average length of five to six months in a group led by the authors. The subjects of their study varied in income, race and education. When a couple became part of a group, they were introduced to the other members, asked to complete and rank order a checklist of problems, and were then separately interviewed in depth. The authors note that the subjects of their study were initially resentful about receiving therapy and behaved in uncooperative ways. After several weeks, however,

TABLE 2

Goal Attainment Scale

Entry Date:
 Level at Entry:
 Level at Follow-up:
 Follow-up Date:

T Score at Entry:
 T Score at Follow-up: _____
 Goal Attainment Change:

FOR: CLIENT _____

Check whether or not scale has been mutually negotiated for each dimension and expected change level ATTAINMENT LEVELS	DIMENSION READINGS AND WEIGHTS						
	Yes x No	Yes x No	Yes x No	Yes x No	Yes x No	Yes x No	Yes x No
	Dimension 1: VIOLENCE (W ₁ =)	Dimension 2: MANAGEMENT OF CHILDREN (W ₂ =)	Dimension 3: DISCOUNTING (W ₃ =)	Dimension 4: TALKING AND SHARING WITH MATE (W ₄ =)	Dimension 5: ISOLATION (W ₅ =)	Dimension 6: EMPLOYMENT (W ₆ =)	Dimension 7: RESIDENCY (W ₇ =)
a. Most unfavorable expected outcome (-2)							
b. Less than expected success (-1)							
c. Expected level of success (0)							
d. More than expected success (+1)							
e. Best expected success (+2)							

Scale derived from Kiresuk, Thomas, "Goal Attainment Scaling at a County Mental Health Service," Evaluation, 1:2, 1973.

the participants developed an attachment to the group.

The focus of the group was on individual problems, and on making contracts for specific behavioral changes. The therapists employed the use of a number of therapeutic approaches. Some of the approaches used were transactional analysis, rational emotive therapy, behavior therapy, and parent effectiveness training. The group had no scheduled program for working on specific problems. The sessions were a combination of the experiential and the didactic.

The GAS was again employed to determine the outcome of methods used in the group. This time, however, the parents listed their own main areas of concern and set goals to be reached in therapy. The common problems were: isolation, symbiosis, tension/temper, talking and sharing with mate, child development and management, and employment. A GAS Follow-up Guide was made for every group member; on it goals were set in each area of concern in three-month periods. The same guide was used every six months for follow-up. The weights assigned to each scale varied from parent to parent. Weights were used to designate importance of problems and to calculate GAS scores.

For successful termination from the group, couples were required to achieve a minimum expected level of outcome (0) in each problem area. The formula for calculating the T-score uses the numerical value attached to each level of outcome (from -2 to +2) and the values assigned as weights to each scale. It was determined from follow-up that the composite GAS score for each spouse had to be fifty-five

before it could be said that the couple successfully completed the therapeutic program. Justice and Justice treated thirty couples in their group between 1973 and 1977. Of these, twenty-two couples completed group therapy with no recurrence of abuse, four dropped out of therapy and lost custody of their children, and five others at writing were still in the group.

The group treatment program of Tuszynski and Dowd (1978), The Family Life Center, based itself on the belief that one of the principal determinants of abuse is the inability of the parent to form a supportive network of relationships. Their approach stressed the importance of confronting the destructive patterns of relating (confrontation), while at the same time helping the parent to establish a non-isolating and supportive network (alternative). This modification of network therapy was administered through groups. Tuszynski and Dowd describe their program as "comprehensive," that is to say, it was one which combined the treatment of the parent with treatment of the child. They contend that the maintenance of the family unit is critically important in the treatment of abusive families. However, to keep with the focus of the present paper, only the treatment of the parents will be discussed.

Upon first contact with the Family Life Center, parents were given a half-day evaluation (psychiatric interviews, testing and development of social histories) by the Center's treatment team which was comprised of a social worker, a psychiatrist, and an early childhood specialist.

This was done to gain an understanding of individual family member's strengths and weaknesses. Though the program had the capacity to treat parents up to five days a week if necessary, on the average parents spent two days a week at the Center, six hours a day, up to a maximum of two years. The isolation of parents was initially confronted by the program by providing transportation to the Center for the families. The authors say that such examples of concrete giving to the parents by the therapists were necessary to establish trust. Offices of the Center were warmly decorated. There were no waiting rooms, no formal individual treatment offices, and no formal titles for the professional staff.

Treatment sessions consisted of group therapy, couples therapy, art therapy, parent skills classes, basic education and home management classes. Treatment in groups had three underlying goals: to promote a positive social network, to establish guidelines for appropriate social behavior, and to confront intrapsychic conflicts of the members. There were three separate groups within the program to move the abusive parents from intense confrontation, to a resolution of problems, to termination from the program. Tuszynski and Dowd (1978) say that group sessions were led by male-female co-therapists. The emphasis of sessions was to support the client while simultaneously producing a level of anxiety which was necessary if the client was going to change. Therapy focused on confrontation of abusive behavior, not on complete personal changes in group members.

These researchers noted significant changes in the individual

behaviors of the program participants--decreased hostile feelings, increased capacity to cope with hostile feelings and stress, and some improvement in self-image and awareness of problems.

McNeil and McBride's report (1979) on two group treatment programs suggests the efficacy of using a group approach with couples identified as child abusers. The groups varied in size between three and five couples each, and met weekly for an hour and a half. They were led by male/female co-therapists. Couples usually remained in the groups from between six and eighteen months. Initially, parents expressed resistance to joining the groups, but these feelings seemed not to be problematic by the end of the first session.

The primary focus of the group was on marital relationships, with a secondary focus on child abuse. The authors found that as parents improved their marital relationships, the danger of child abuse in the family decreased. In an effort to ameliorate marital relationships, the facilitators encouraged the parents toward two goals. The first was to develop a mutual support system within the groups as a way of improving social isolation. Secondly, the members were encouraged to use the groups to assist them in making significant decisions about such topics as foster placement, adoption and divorce. With the help of the groups, the members learned to separate emotion from logic and were thus trained in effective decision making. McNeil and McBride's article, which is richly illustrated with case examples, treats at some length the role of the therapist. It highlights the importance of

demonstrating acceptance of the parents, building trust, and indicating disapproval of abusive behavior. According to the authors, the female therapist model is an important one because it provides a model of adult relationships, one which can be used to reeducate the parent.

Analysis of Cluster II

The classification chart of the group therapy cluster (Figure 2) elucidates several general areas which are particularly noteworthy when analyzing the research about the group treatment of child abusers.

The size of the group cluster is significant. It is comprised of twenty studies and the average work of the twenty within the cluster was published in mid-1974. It is interesting that the earliest piece written (McFerran, 1958) precedes by thirteen years the second work published about this topic (Galdston, 1971), after which time came a spate of studies. The most recent study about the group treatment of child abusers was done by McNeil and McBride (1979).

One finds when examining the treatments of the various studies of the groups that the greatest area of consensus is toward a psychotherapeutic group orientation. Five researchers specifically espouse such an approach: Beezley et al. (1976) who calls for psychotherapy; Galdston (1971), one of the pioneers in group work with abusers, who adheres to a traditional approach, psychoanalysis; Justice and Justice (1975) who use transactional analysis; Paulson and Chaleff (1973) who call for the use of parent surrogates, a psychotherapeutic group orientation which has essentially a psychotherapeutic purpose; and Zalba (1975, 1977) who contends that groups should be ego-oriented. Two other

studies use casework as their approach (McFerran, 1958; Ounsted et al., 1974). The studies of Tuszynski and Dowd (1978) and Wasserman (1975) emphasize a group approach to enhance the socialization of child abusers. An eclectic group approach is advanced by Justice and Justice (1978) and Paulson et al. (1974). There are sundry other approaches: one emphasizing marital therapy (McNeil & McBride, 1979), one which varies (Kempe & Kempe, 1978), one which centers around a discussion of stress and child management and development (Walters, 1975), and five unspecified approaches (Caskey & Richardson, 1975; Feinstein et al., 1974; Herrenkohl, 1978; Savino & Sanders, 1973; Steele, 1975).

There appear to be five noticeable trends evident within the area of therapeutic goals of the studies about groups. First, a number of researchers specify behavioral changes as the goal of therapy. Justice and Justice (1978) on one occasion state specific behavioral changes as the goal of treatment, and another time (1975) say the goal is to break up symbiotic relationships; Zalba (1975, 1977) says the goal is to help parents control their impulses; one of the goals of the Tuszynski and Dowd (1978) group endeavored to confront destructive patterns of relating; Steele (1975) says groups strive to achieve the goals of helping child abusers express their emotions and become desensitized to criticism; McNeil and McBride (1979) advocate training parents in decision-making as the goal of their group; and, finally, Zalba (1975, 1977) believes groups should, as one of their goals, help child abusers deal with figures of authority. The second major trend

among the goals of this cluster is toward the development of a support system to improve isolation and promote social growth. Several studies mention this goal: Feinstein et al. (1974); McNeil and McBride (1979); Paulson and Chaleff (1973); Steele (1975); and Tuszynski and Dowd (1978). A third major therapeutic goal apparent in a review of the literature about the group treatment of child abusers is to help these individuals face, discuss and deal with their problems (Justice & Justice, 1978; Ounsted et al., 1974; Savino & Sanders, 1973; Wasserman, 1975; Zalba, 1975, 1977). A fourth goal of the literature about group therapy is the instruction of parents in the principles of child care and, in general, to help them become more effective parents (McFerran, 1958; Ounsted et al., 1974; Savino & Sanders, 1973; Walters, 1975). Of equal weight is the goal of facilitating personal growth and development in the parent which is espoused by several (Caskey & Richardson, 1975; Herrenkohl, 1978; Paulson & Chaleff, 1973; Paulson et al., 1974). Two studies did not state the goal of group therapy (Galdston, 1971; Kempe & Kempe, 1978), and one other said it varies (Beezley et al., 1976).

By far the majority of studies (nine) indicate that groups should be composed of couples (Galdston, 1971; Justice & Justice, 1975, 1978; Kempe & Kempe, 1978; McNeil & McBride, 1979; Paulson & Chaleff, 1973; Savino & Sanders, 1973; Steele, 1975; Walters, 1975). Six researchers say that the composition of groups should be child abusers (Caskey & Richardson, 1975; McFerran, 1958; Paulson et al., 1974; Tuszynski & Dowd, 1978; Wasserman, 1975; Zalba, 1975, 1977), two others say that

group composition ought to be of mothers of the abused child (Feinstein et al., 1974; Ounsted et al., 1974), two more contend composition varies (Beezley et al., 1976; Steele, 1975), and one author does not comment about group composition (Herrenkohl, 1978).

The average number of participants in a group is between six and seven, but of the twenty studies about groups, only eight make statements about the ideal number of participants (Beezley et al., 1976; Galdson, 1971; Justice & Justice, 1978; McNeil & McBride, 1979; Ounsted et al., 1974; Savino & Sanders, 1973; Walters, 1975).

The overwhelming majority of researchers call for a model of co-therapists to facilitate group process (Beezley et al., 1976; Feinstein et al., 1974; Justice & Justice, 1975, 1978; Kempe & Kempe, 1978; McNeil & McBride, 1979; Paulson & Chaleff, 1973; Paulson et al., 1974; Savino & Sanders, 1973; Steele, 1975; Tuszynski & Dowd, 1978). Nine of these say the male-female co-therapy model is preferred (Galdson, 1971; Herrenkohl, 1978; Justice & Justice, 1975, 1978; McNeil & McBride, 1979; Paulson & Chaleff, 1973; Paulson et al., 1974; Savino & Sanders, 1973; Steele, 1975; Tuszynski & Dowd, 1978). Steele (1975) adds the additional requirement that the male-female co-therapists must be professionally trained. McFerran (1958), when describing the facilitators of her group refers only to protective service caseworkers. The facilitators of the group of Feinstein et al. (1974) were two psychiatrists.

There are other general statements that can be made about the literature concerning the group treatment of child abusers. There is

no agreement, and little comment, about the length of therapy. The Savino and Sanders (1973) group met once weekly for one and a half hours. Walters (1975) says only that groups should meet for one and a half hours, but does not remark about the frequency of meetings. The group of Feinstein et al. (1974) met twice weekly for one hour. Other researchers who make statements about the length of treatment are Justice and Justice (1978) and McNeil and McBride (1979) who say group treatment extends from between five to six months and six to eighteen months respectively.

Three other insights can be gained from Figure 2. First, both Beezley et al. (1976) and Kempe and Kempe (1978) believe group treatment is effectively used with individual therapy, and Tuszynski and Dowd (1978) use group treatment with a variety of services. And secondly, the design of two studies includes groups or day care facilities while mothers participate in group treatment.

In summary, the group therapy cluster is the largest of the nine clusters. The average piece within this cluster was published between 1974-75, though the earliest work was published in 1958. The most recent work appeared in 1979. With regard to the approach of groups, the greatest area of consensus is toward a psychotherapeutic orientation. Other approaches which have had support worth mentioning are casework, socialization, and the eclectic. There are sundry other approaches cited in the literature. There are five basic goals among the literature about groups: 1) to produce behavioral change; 2) to develop a support system; 3) to help parents face, discuss and deal

with their problems; 4) to instruct parents in child care; 5) to facilitate personal growth and development. The majority of researchers indicate that the ideal size of a group is between six and seven persons, that it is comprised of couples, and that it is led by male-female co-therapists. There is little comment about the length of group meetings or the length of treatment, but there is evidence of a slight tendency to use groups in conjunction with individual therapy and a variety of other services.

Discussion of Cluster III

As evidenced by Figure 3, a cluster overview, many researchers have considered casework as a means of treating child abusing parents.

The therapeutic relationship between the social worker and the child abuser is a topic treated by Alexander (1972) who says that the role of the caseworker is not to "play detective"; rather, he or she strives to find out what stresses exist in the family. The caseworker must make great efforts to let the parents know that he or she is interested in what the parent has been feeling and experiencing, and to develop the parent's trust. Once trust begins to develop, the dependency of the parent on the caseworker can be intensive, but the caseworker must be prepared to respond to this in a nurturing and supportive way. The social worker is available to the parent on a twenty-four hour basis.

In the beginning of the therapeutic relationship, by assuming the mother role and by making frequent home visits, the caseworker gains

	<u>ALEXANDER</u>	<u>POLANSKY ET AL.</u>	<u>MITCHELL</u>	<u>DAVOREN</u>	<u>STEELE</u>	<u>HELLER</u>	<u>WASSERMAN</u>	<u>HOLMES ET AL.</u>	<u>ZALBA</u>	<u>ARVANIAN</u>	<u>ROTH</u>	<u>BEEZLEY ET AL.</u>	<u>BLUMMENG</u>	<u>KEMPE & KEMPE</u>
YEAR OF STUDY	72	72, 74	73	74	75	*	75	75	75, 77	75	75	76	77	78
TREATMENT OBJECTIVES	To find out what stresses exist in the family & to help parent understand & communicate feelings	Bring about change in parent by fostering dependency	Assure safety & well-being of children, preserve family when possible, seek cooperation of parents	*	*	Short-term crisis intervention, child protection & initial family therapy	Provide a long-term, consistent relationship with one person	*	Perform ego-functions & work closely with parent	Reparent	Teach parent appropriately directed aggressive behavior	Highly divergent	Management of legal, social & financial matters	*
GUIDELINES	Also says to examine marital patterns & be sensitive to familial relationships	Prearrange interview, focus on parent, create appropriate tone, expect anger and initial uncooperativeness	Adjunctive services indicated to alleviate problems of parent	Cultivate liking for parent, reduce expectations of parent, act like friend, be flexible & nondirective	*	*	*	Lists clues to abuse, define precipitating factors, recognize need for placement, emphasizes interagency cooperation	*	Look at family unit of functioning; include all members in treatment	2 areas of treatment: behavior control & meeting needs	*	Psychiatrist administers psychotherapy	*
TECHNIQUES	Frequent home visits, mothering, help mother find enjoyable outlets, praise, few demands, dependency, avoid focus on child	Frequent contacts, concrete giving, feeling need to be special, demeanor, tact, discuss feelings, minimal demands, moral insulation	Focus on parent	Be available 24 hours; home visits	Says social workers "have been active in developing innovative techniques" and services	*	*	Help parent understand rage, meet dependency needs of parent, educate parent, expand life satisfactions, modify behavior, break isolation, prepare for setbacks	Provide long-term, relationship-oriented approach	Be emphatic, listen carefully, allow dependency	Teach problem-solving techniques, give concrete input, discuss characteristics of child abusers, develop good parenting practices	*	*	*
COMMENTS	*	Use of authority can have appropriate place in treatment	*	Attributes of social worker: few managerial tendencies, willing to be put out, satisfied person, strong knowledge of child behavior, good listener & observer	Casework has "traditional values and methods"	Insufficiently staffed to do long-term therapy	*	*	*	*	Services must be on-going over long period of time	Built-in conflicts to casework	*	Long-term treatment; adjunctive services indicated

* Not Indicated

FIGURE 3. OVERVIEW OF CASEWORK CLUSTER

insight into family life and problems. Alexander (1972) warns that the child is often presented as the problem by the parent in cases of abuse. The role of the social worker is to help the parent understand his or her feelings, but he or she must be cautious that attempts to clarify are not easily misinterpreted as criticism. The caseworker can also assist the parent in communicating anger and disappointment without fear of punishment or abandonment by the social worker. The caseworker must accept these sentiments of the parent, legitimize them, and work something out with the parent. It is essential that the goals set by the social worker and parent be realistic.

There are several other important ways the social worker can help the abusive parent. One is by helping him or her find meaningful and pleasurable outlets and joy in life. Also, the social worker can give constant recognition and praise to the parent, and thereby fulfill an essential need. A third way the caseworker can help the parent is by avoiding focus on the child. Alexander (1972) states further that the child abusing parent needs reassurances from the caseworker that he or she does not have to meet every demand or expectation. Lastly, the author believes different therapists ought to be available for each spouse in a family.

Alexander (1972) examines familial relationships as a consideration in treating the child abuser. With regard to parental ties, the author says that even if the child abuser can acknowledge how hurt and attacked he or she has been by his or her own parent(s), the longing for parental love is so compelling that the child abuser cannot break

the tie. The social worker must sympathize with the hurt and disappointment the abusive parent feels, a particularly sensitive area in terms of the parent's self-esteem. Marital patterns must also be looked at by the social worker. Alexander's (1972) experience has been that most marriages in child abuse families are virtually non-existent; in these cases, the child is the only link in the parents' ability to communicate, perceive and deal with each other.

One final comment made by Alexander (1972) is that the caseworker ought to be aware that pregnancy is an especially difficult time for child abuse families, a time when needs, especially those of the mother, are heightened.

The caseworker treatment approach is described twice by Polansky, once with his colleagues DeSaix and Shlomo (1972), and a second time with Borgman, DeSaix and Sharlin (1974). Polansky and his associates say that the aim of the social worker is to bring about change in the child abuser through a dependent relationship which he or she fosters in the parent, not simply to provide services to the family.

As a prelude to treatment, Polansky and his collaborators give the social caseworker some guidelines for making initial contact with the child abuser. They say first that the caseworker ought to prearrange the initial appointment, allowing the parent the opportunity to change the time if it is inconvenient. Only in emergencies, or after repeated unsuccessful attempts to make the initial contact, ought the caseworker "barge in" on the family. Secondly, they stress that the caseworker's

concern is for the parent first and the child second. A third guideline is that the caseworker ought to expect withdrawal, denial, feigned friendliness or psychoacquiescence in the parent during initial meetings. As a fourth guideline, these authors recommend that the tone of the first visit be softened with a statement such as "We have been told that there are some problems here, and it is our job to look into such things and help parents in all matters concerning their children." By creating a tone of this sort, the caseworker does not appear to be flaunting authority or to be deliberately intrusive. Lastly, these researchers warn the caseworker that he or she will many times be the recipient of anger for the complaint by the abusive parent. In these instances, the worker ought to hear the parent out with strength and calmness so as to establish a relationship with the parent. These researchers delineate the various options open to the caseworker in making recommendations for the family (to decide the complaint was unjustified, to decide the parent is untreatable and remove the child from the home, to decide the parent is treatable and leave the child in the home, etc.). They say the caseworker has a professional responsibility to decide the ideal solution for the family and come as close to it as possible.

Polansky and his associates (1972, 1974) point out that most public welfare departments have strong values against creating dependent relationships between worker and child abuser, relationships considered to be demeaning and harmful since they undermine self-determination and other signs of personal growth. Contrarily, Polansky and his co-authors

say that by fostering dependency, the caseworker can achieve ends which are beneficial to the child abuser. The social worker strengthens the initial bond between him or herself and the parent. Further, abusive parents are lonely and deprived people, and by meeting their dependency needs, they are given reassurances which contribute to their growth. Another good reason for fostering dependency is to provide the child abuser with a model he or she can emulate in meeting the needs of their own child.

How does the social worker achieve dependency of the parent?

This is done by use of the following eight techniques:

1. frequent contacts - it is usually true that the more frequently the parent is seen by the social worker, the greater the parent's dependency will be on him or her. These authors support the idea that the caseworker make "many shallow contacts" with the parent in order to facilitate a dependent tie.
2. concrete giving - when needed, the social worker ought to attempt to procure items such as transportation, financial assistance, and clothes for the parent.
3. feeding the need to be special - the caseworker ought to focus attention on the parent, not only by watching and listening carefully, but by showing awareness of his or her feelings.

4. demeanor - simply, the caseworker should be warm and thoughtful, but at the same time a strong person.
5. tact - the caseworker ought to display a sensitivity to the parent's feelings, and make an effort not to make him or her feel bad when avoidable.
6. discussing feelings - the caseworker ought to demonstrate interest in the parent's feelings.
7. minimal demandingness - the caseworker should be cautious not to make premature or excessive demands on the parent.
8. moral insulation - the caseworker ought not to appear shocked at the parent's behavior or feelings.

Finally, these researchers make some remarks about the use of authority in the casework treatment of child abusing parents. They say that the social caseworker's position of representing legal authority and the use of force adds "respect" for the worker, and further, it enables the child abuser to find reassurances in the idea that an outside person can impose order in his or her life, something the child abuser has not been able to do for him or herself.

An interesting caseworker's view of working with child abusers is given by Mitchell (1973). Mitchell says that the caseworker has a three-fold job when dealing with parents who maltreat their children: to assure the safety and reasonable well-being of the children in the family, to preserve the family whenever possible, and to seek the

cooperation of the parent in planning for the children if other arrangements must be made for their care.

In Mitchell's view (1973), the caseworker relates primarily to the parent, and she reports that she has been able to establish fairly good rapport with parents in most cases. The caseworker then helps to alleviate the problems of the parent through a variety of services (homemakers, foster placement, lay therapy) so that the parent is free to meet the child's needs. In instances where the abusive parent is unresponsive to the caseworker's efforts, Mitchell suggests that the threat of court action may produce positive and immediate results.

Davoren (1974) considers the role of the social worker in the treatment of child abusers. She says that the social worker is available on a twenty-four hour basis as a source of satisfaction to the parent. By being so available, and through home visits, the caseworker learns what the parent is like--his or her personality, the crisis-producing situations in his or her life, how he or she responds to crises, and so on. Davoren (1974) says that in addition to being aware of the personal characteristics of the individual child abuser, it is also important for the caseworker to understand common traits among all child abusing parents since these traits have an important relationship to treatment, namely, that abusive parents treat their children as they were treated as children, and they therefore believe that children are born to provide for their parents and solve their problems.

Davoren (1974) gives guidelines to the social worker. She says

that the caseworker should cultivate a liking for the parent by looking for some positive aspect of the parent, no matter how small. The caseworker ought also to reduce his or her expectations of the parent's performance since any demand, even a slight one, is usually regarded with animosity. The casework approach requires that the therapist behave like a trusted friend to the parent, not a manager, and that total interest be directed toward the parent, not the child. Davoren (1974) cautions the social worker not to take over for the parent because directive behavior of the social worker can only have negative results. Ideally, two therapists should be available to the parent, a psychiatrist and a social worker. The author also believes the caseworker ought to be flexible and open to changing his or her preconceived notions. Lastly, Davoren (1974) says that if a report has to be filed about the family with some enforcement agency, this should be done with someone other than the therapist.

There are several characteristics in a social worker Davoren (1974) believes are useful for work with abusive parents:

1. an individual with few managerial tendencies,
2. someone willing to put him or herself out for the parent, but who does not go around sacrificing him or herself to everyone else's discomfort,
3. a person with a fair number of satisfactions in life outside of the job so as not to look to the parent as a source of satisfaction,

4. an individual with strong working knowledge of child behavior that can be appropriately share with abusing parents,

5. someone who is a good listener and observer.

Steele (1975) describes individual or social casework as having "traditional values and methods." He also says that social caseworkers have been active in developing innovative techniques of working with abusive parents as well as in developing services for them.

Helper (HEW Publication) says the role of the social worker is to perform short-term crisis intervention, child protection, and initial family therapy. This author says they are not "sufficiently staffed" to perform the long-term therapy child abusers are in need of.

Wasserman (1975) says that long-term help through a consistent relationship with one person can prove effective in the treatment of child abusing parents. He cites the social caseworker as an example of a person trained for this work.

In another article, a group of social service workers highlight some of the important aspects of working with the parent in child abuse cases (Holmes, Barnhart, Cantoni, and Reymer, 1975). They treat twelve topics and give case illustrations for each.

To begin, these authors warn the caseworker that he or she may experience resistance within themselves to treating abusive parents.

If the worker and parent have a warm, on-going relationship, the social worker may deny the abusive acts of the parent, wishing to see only his or her pleasant side. Resistance may also occur if the caseworker minimizes the fears and concerns of the parent, or the extent of abuse.

Holmes and her colleagues (1975) also examine the development of the treatment relationship. They say that the initial contact may be difficult and extensive outreach is often required. A lengthy list of clues to alert the caseworker to possible abuse is provided. Some examples of clues would be if the parent expresses fear of losing control, if the child is blamed for family difficulties, such as marital problems, if the home is excessively sloppy or excessively neat, or if the client reports that a friend or relative is the abusive adult. If the caseworker fails to pick up these clues, the parent may think that his or her behavior is so horrible that it is unmentionable; on the other hand, there is no need to have the parent's identity revolve around being a child abuser. The caseworker ought also to avoid focusing on the child, especially during the early part of treatment and in times of crisis.

These researchers say that in providing intervention the caseworker must attempt to define the precipitating factors of the abuse. The tasks of the caseworker are to determine the behaviors of the child that trigger the violent response in the parent, and the patterns that exist in the relationship between the parent and child.

Another aspect of treatment is helping the parent to understand

his or her rage. Rage is defined here as a well of suppressed anger and fear that has been stored up since childhood so that its causes can no longer be remembered or identified (as opposed to anger which is an emotional reaction to a situation in which a) an individual perceives him or herself as having been hurt or mistreated, b) the "angry" person is able to identify the reason for his or her anger, and c) the reaction is in proportion to the severity of the perceived injury). Holmes and her co-authors (1975) say that the abusive parent must come to an understanding of his or her rage and its source so as to find new ways of coping. In the therapeutic relationship, the child abuser can learn to express anger without fear of loss of the relationship or loss of physical control. They cite Parents Anonymous as a particularly effective way of facilitating this aspect of treatment.

A fifth role of the caseworker is to parent the parent by meeting his or her dependency needs without infantilizing him or her. As the parent's needs are met, he or she becomes better able to fulfill the parenting role. The social worker ought to show acceptance and concern for the parent while focusing in on what hurts him or her. It is also important for the caseworker to set limits with the parent.

One further aspect of treatment is educating the parent. The caseworker endeavors to fill gaps in the parent's knowledge of normal child development and age appropriate behavior of the child.

A seventh significant aspect of treatment is to help the abusive parent expand his or her life satisfactions. This is necessary because

child abusers generally suffer from low self-esteem, feelings of inadequacy, hopelessness and despair about their ability to improve their lives, conditions which damage the parent-child relationship. The parent needs to be told by the caseworker that he or she deserves to have fun, and that by doing so there will exist a healthier home environment for the child. The caseworker can legitimize the parent's desires and reinforce his or her efforts toward achievement.

Caseworkers must also help parents modify their behaviors. Abusive parents often adopt behaviors in their childhoods which helped them to survive but which are inappropriate in their roles as parents (role reversal, for example). The caseworker must help parents establish reasonable standards for themselves, as well as help them improve their self-images.

It is also a function of the social worker to assist abusive parents in breaking the barrier of isolation. The authors posit that child abusers have defective communication systems and weak support systems. The caseworker must work with other important persons in the parents' lives to build stronger support systems within their environments.

The caseworker also functions to help the parent prepare for setbacks. Abusive parents suffer from feelings of defeat as a result of their low self-esteem, coupled with the high demands they place on themselves. The parent must also be helped to understand that progress is erratic and setbacks ought to be expected.

Holmes and her co-authors (1975) also state that the caseworker must recognize the need for placement when it exists. They say that while the emphasis is to prevent separation of the parent and child, under certain circumstances separation is necessary and the most appropriate course of action. There are two factors social workers use to determine if placement is required: the inner resources and the external support system of the parent.

These researchers consider one further aspect of casework treatment for child abusing parents: the relationship between agencies. They say that since many agencies are involved in the treatment of a child abuse family, it is important that each agency and its staff members be clear about their roles and consult frequently. The manipulative parent can play one agency against another in a self-defeating way if community resources do not communicate and cooperate.

A long-term consistent, relationship-oriented approach by a social worker in the treatment of child abusers is advocated by Zalba (1975, 1977). Zalba characterizes parents who maltreat their children as difficult ones to work with because they tend to deny their abusive behaviors and/or personal problems, they characteristically exhibit hostility, rage, demandingness and acting-out behavior toward the caseworker, they fear close relationships and prefer authority-based ones, and because they feel little guilt about their abusive and hostile acts.

With these difficulties in mind, Zalba (1975, 1977) presents the reader with two treatment objectives of the caseworker: to work

closely with the abusive parent, and to perform certain ego functions for him or her. By performing "ego functions," Zalba refers to such things as setting limits on behavior, making realistic judgments for and with the parent, and helping parents develop realistic perceptions. In short, the caseworker gives his or her ego ability to the parent in the hope that the positive relationship he or she established with the parent and the effectiveness of his or her ego behavior will enable the parent to incorporate some of the caseworker's ego strengths. The resultant effect is that the child abuser is able to comprehend his or her own underlying sentiments of hurt and fear instead of using flight and denial to cope with them. The parent is then able to understand the deficits of his or her own childhood, incorporate attitudes of the worker, and evolve a new ego and identity.

The casework approach is analyzed in an article by Arvanian (1975) who uses three case examples to illustrate treatment techniques.

Arvanian believes early involvement of the therapist at the time of the crisis situation facilitates the therapeutic relationship. While it is not essential to find out immediately who committed this abusive act, it is incumbent upon the therapist to align him or herself with the parents and to focus on the life situation of the family unit at the onset of intervention. This author believes that home visits are vitally important to this end.

Since treatment of the abusing parent is based on his or her relationship with the therapist, the caseworker must be empathic, give

emotionally to the parent, and focus on the parent's anger. The caseworker allows the parent to become extremely dependent until the parent is able to internalize his or her feelings. This "reparenting" process improves the self-esteem of the abusive parent because he or she is made to feel worthwhile. It is emphasized by Arvanian (1975) that the therapist must listen carefully to what the parent says, both verbally and non-verbally, and to act accordingly. That is to say, if the parent asks for removal of the child from the home, this should be done. The caseworker also helps the abusive parent in dealing with day-to-day problems, and in introducing the parent to and encouraging him or her to use community resources.

In conclusion, Arvanian states that the caseworker must first look at the family unit of functioning and include all members in the treatment plan. She emphasizes that the therapist express care and acceptance of the abusive parent who is isolated and depressed. In short, the social worker acts as the parent's parent. The goals for change within the family must be realistic, and the situation must be constantly reevaluated by the social worker.

In his article pertaining to the casework treatment of child abusers, Roth (1975) specifies two general areas of treatment, behavior control and helping the parents meet their own needs.

Roth (1975) perceives abuse as one part of a cyclical group of factors: frustration, anger, abuse, guilt, inhibition of aggression. He suggests that intervention can be administered at any point in this

cycle of events with the goal of teaching the parent that aggressive behavior is acceptable if it is appropriately directed. With regard to the needs of the child abusing parent, Roth contends that his or her self-image must be rebuilt or developed. To this end, the role of the caseworker is to provide the theoretical input (teaching problem solving techniques) as well as concrete input (homemakers, helping the parent find a job). As an additional measure taken to rebuild the child abuser's self-image, the caseworker frequently and repeatedly discusses in an indirect manner with the parent typical characteristics of individuals who maltreat their children (fear of rejection, isolation, low self-esteem, low frustration tolerance).

Another part of Roth's (1975) whole treatment scheme is that the caseworker ought to follow four steps in developing good parenting practices in the child abuser. First, the social worker must let it be known to the parent that he or she knows how to discipline a child, and that the parent is in need of the social worker's help in this regard. Secondly, as the parent develops, the caseworker seeks to solicit and support some of the parent's ideas. A third step is that as the parent develops his or her own ideas and implements new ones, he or she must solicit support from the social worker. Lastly, as parents become more adept, they tell the caseworker what they did and why it was effective and appropriate. As evidenced by this process of developing good parenting practices, Roth (1975) supports the idea that the primary concern of the caseworker is to achieve the dependency of the child abusing parent.

Roth (1975) also addresses the question of on-going treatment, a service he believes must be provided over a long period of time, particularly to families in which the parents do not know how to seek help in crises. The author notes that during follow-up visits, all material covered in treatment ought to be summarized.

Other authors (Beezley, Martin & Alexander, 1976) describe casework services as highly divergent depending upon the social worker's level of expertise, the priorities of the child welfare department involved, and the size and nature of the worker's load. They say that some social workers give long-term supportive and/or insight-oriented psychotherapy, while others investigate and give short-term care to families in which child abuse occurs. Characteristically, a caseworker carries a heavy case load, a condition which impairs the quality and quantity of services he or she can administer.

Beezley and her associates (1976) contend that the role of the social worker has built-in conflicts. Why is this? Because in addition to investigating a family situation, making recommendations to the court, and in some cases, testifying on information which may lead to a judicial decision of foster placement of the abused child, the social worker is also expected to develop a trusting relationship with the parent. These researchers also make note of the many advantages of providing abusive parents with casework services. First, individual casework carries the legally mandated authority to organize services so that treatment for family members is procured. Secondly, casework allows the professional to view the family as a unit. A third advantage

is that individual casework permits direct access to the abused child, a feature which assures that the child's point of view is being represented and allows for the first-hand observations of the child's growth and development. Fifthly, since casework services are administered through home visits, the social worker can comment on parent-child interactions as they naturally occur. A final advantage is that if the caseworker and parent are able to establish a relationship, the parent will have the opportunity to learn the important developmental lesson that all individuals possess both good and bad traits.

Within his discussion of psychotherapy for adults, Blumberg (1977) comments that one must not underestimate the role of the well-trained social worker as an integral part of the treatment plan for the child abuser. The social worker functions to assist the abusive parent in managing legal, social and financial matters so that the psychotherapy, administered by a psychiatrist, can achieve some degree of success.

Social caseworkers are viewed by Kempe and Kempe (1978) as "anchor-men" who provide long-term treatment to parents who abuse their children. The authors say, however, that the individual caseworker alone cannot have enough impact on the problems of such families. The primary drawback to casework is that the case load is usually too large for one person. Kempe and Kempe (1978) believe that it is necessary for others to work with the caseworker so as to enable him or her to keep up with families and to be aware of crises.

Analysis of Cluster III

The casework classification chart, Figure 3, enables one to analyze the literature within this cluster along several lines.

The average date of publication of the pieces within this cluster was late 1974. The first works to appear about the casework treatment of child abusers were written by Alexander (1972) and Polansky et al. (1972). The most current publication was by Kempe and Kempe (1978). The cluster is comprised of sixteen studies in all.

The literature suggests that the primary treatment objective in casework is to bring about a change in child abusers by establishing a long-term, consistent relationship with the patient (Wasserman, 1975). This would encompass other objectives like re-parenting (Arvanian, 1975), performing ego functions and working closely with the parent (Zalba, 1975, 1977) and promoting change in the parent through a dependent relationship (Polansky et al., 1972, 1974). There is another school of thought among those researchers who propose more mundane objectives of the caseworker: to manage the parent's legal, social and financial matters (Blumberg, 1977), to seek the cooperation of the parents (Mitchell, 1973), and to find out what stresses exist in the family (Alexander, 1972). It is agreed by Helfer (NI) and Helfer (1973) that the objective of casework is to assure the safety and well-being of the child. Four studies do not state the treatment objective of casework (Davoren, 1974; Holmes et al., 1975; Kempe & Kempe, 1978; Steele, 1975). Other stated treatment objectives of proponents of casework greatly vary (Alexander, 1972; Helfer, NI; Mitchell, 1973; Roth, 1975): to

preserve the family whenever possible, to perform initial family therapy and short-term crisis intervention, to teach parents appropriately directed aggressive behavior, to help parents understand and communicate feelings. Beezley et al. (1976) say the treatment objectives of casework are highly divergent.

There are no similarities among the treatment guidelines within the literature about casework; those espoused by various researchers differ markedly. There are some twenty guidelines cited (cf. Figure 3 - "Guidelines") varying widely from such things as being nondirective (Davoren, 1974) to including all members of the family in treatment (Arvanian, 1975) to prearranging the interview (Polansky et al., 1972, 1974).

The most frequently cited technique among the casework literature is meeting the dependency need of the child abuser (Arvanian, 1975; Holmes et al., 1975) through mothering (Alexander, 1972) and a long-term relationship-oriented approach (Zalba, 1975, 1977). There is equal support for four other techniques: 1) frequent contacts through home visits (Alexander, 1972; Davoren, 1974; Polansky et al., 1972, 1974); 2) making the child abuser feel special by demeanor, tact and concrete giving (Polansky et al., 1972, 1974), praise (Alexander, 1972), empathy and careful listening (Arvanian, 1975); 3) discussion about topics such as feelings (Polansky et al., 1972, 1974), the idea of rage (Holmes et al., 1975) and the characteristics of child abusers (Roth, 1975); 4) education of the parent (Holmes et al., 1975) by helping him or her develop good parenting practices and by teaching him or her problem

solving skills (Roth, 1975). Two authors agree on each of the following techniques in the casework treatment of child abusers: to focus on the parent (Alexander, 1972; Mitchell, 1973); to make few demands on the parent (Alexander, 1972; Polansky et al., 1972, 1974); and to help the parent expand his or her life satisfactions and find enjoyable outlets (Alexander, 1972; Holmes et al., 1975). Five studies did not enumerate techniques (Beezley et al., 1976; Blumberg, 1977; Helfer, NI; Kempe & Kempe, 1978). Two individual techniques worthy of mention are to prepare the parent for setbacks (Holmes et al., 1975) and to be available to the parent on a twenty-four hour basis (David, 1974).

A few final comments must be made about the casework approach.

The first is that two studies propose casework must be on-going over a long period of time (Kempe & Kempe, 1978; Roth, 1975), but one other study (Helfer, NI) contradicts this by stating that casework is insufficiently staffed to do long-term therapy. Beezley et al. (1976) make the observation that casework has built-in conflicts. A second final comment is about the use of authority of the caseworker, a measure Polansky et al. (1972, 1974) say can have an appropriate place in treatment. And, lastly, Steele (1975) characterizes casework as having "traditional values and methods."

To summarize, on the average, the literature about the casework approach appeared in late 1974. The primary treatment objective found in the literature to affect change in the child abuser is by establishing a long-term, consistent relationship with the parent. A second treatment objective of caseworkers encompasses mundane tasks.

Two studies support the objective of assuring the safety and well-being of the child in casework. No similarities were found among the treatment guidelines in the literature. The technique for which there was the greatest agreement was to meet the dependency need of the abusive parent through mothering and a long-term relationship-oriented approach. Four other techniques were found to be generally accepted: frequent home visits, making the parent feel special, discussion, and education of the parent. There was a variety of other techniques mentioned. There is concern by one researcher that casework is not sufficiently staffed to achieve its long-term goals. The casework mode is regarded as traditional in the treatment of child abusing parents.

Discussion of Cluster IV

Figure 4 provides an abbreviated overview of the cluster pertaining to the use of social-learning skills in the treatment of child abusing parents.

The social-learning model of Parke and Collmer (1975) includes instruction of parents in child rearing practices and normal child development since they believe many child abusers share common misperceptions in these two areas. Parents are taught practical aspects of child care (such as toilet training and discipline), methods of behavior modification (extinction, for example), and behavior management techniques (for instance, reinforcement). This is done by the therapist in parent group meetings, in the home, or in a clinical setting.

Techniques derived from learning theory are also discussed by

YEAR OF STUDY	PARKE & COLLNER 75	STEELE 75	BEEZLEY, MARTIN & ALEXANDER 76	MARTIN & BEEZLEY 76	JEFFREY 76	KEMPE & KEMPE 78	JANZEN & HARRIS 80	TRACY & CLARK TRACY, BALLARD & CLARK 74, 75	SCHKUNER 77	SANDLER ET AL. 78	DEHIOLO & SANDLER 80
BASES OF MODELS	Instruction in child rearing & child development	To develop satisfactory parental attitude & behaviors	Parent education and modeling behavior	Modeling	Change negative attitudes, interactions & deflect aggressive responses	Improve parent-child interaction	Teach skills in child care, modeling; teach expectable behaviors	Social reinforcement	Behavioral treatment	Parent Training	Parent training & cognitive behavioral instruction
TECHNIQUES	Behavior modification & behavior management	*	Timing in instruction & development of trust	F.E.T. courses in late part of treatment	Reinforcement, teach parent to play & give attention to child, adopt home, contracts, distraction, "quietly telling without shouting", behavioral check-off list	Videotaping, discussion & instruction in child development	Nurturing by therapist	Family health worker who models & gives instruction in positive techniques of child management	Child development information, teaches age-appropriate behaviors & non-punitive behavior-oriented child management skills	Reading & practice assignments; role playing, contingent reinforcement	Teach reinforcement & child management skills; videotaping, modeling, role playing, parent rehearsal, contingency contracting, muscle relaxation, problem solving skills, self-control, modification of verbalizations
THERAPEUTIC ENVIRONMENTS	Parent's home, in parent group meetings or in clinical setting	*	Small parents' groups for parent education & a variety of settings for modeling	Clinical setting where parent observers trained persons deal with their child	Clinical setting or in the home	Clinical setting	Clinical setting	In parent's home	*	Clinical setting or in home of parent	Clinical setting or in home of parent
COMMENTS	*	Effectively used only with mildly abusing or neglectful parents	Should not be used as primary intervention	One essential component of larger treatment plan	*	Treatment preceded by data gathering about child & parent; used in conjunction with other supportive therapy	*	Functioned within a larger, hospital-based program	Measured effects of behavioral treatment against client-centered treatment	*	*

* Not indicated

FIGURE 4. OVERVIEW OF CLUSTER OF SOCIAL-LEARNING TECHNIQUES

Steele (1975). He points out that these techniques are based on the assumption that the parent abuses the child because he or she has not been given the opportunity or information to develop satisfactory parental attitudes and behaviors. To an extent Steele agrees with this assumption, but argues that the emotional or affective deficit of the child abusing parent is deeper than his or her lack of factual information. His position is supported by the fact that in many cases of abuse, even serious ones, the parent is able to care for the child perfectly well. Therefore, in Steele's opinion, only neglectful or mildly abusing parents are able to profit from the cognitive learning of good parental techniques.

Beezley, Martin and Alexander (1976) discuss the use of two social-learning techniques: providing parent education and modeling behavior. These researchers say that most child abusers are in need of parent education because they have serious deficits in their knowledge and understanding of child care and development. Information of this sort is ideally administered to small parents' groups; however, Beezley and her associates warn the therapist that when providing this information to parents, timing is an important factor. Child abusers must have time to develop trust, and they must have some of their emotional needs met before they are able to turn their attention to their children. Beezley and her collaborators also qualify the use of this social learning technique by stating that it is appropriately used as a supplement to some other treatment mode and should not be expected to produce change when used as the primary intervention.

The second social-learning technique treated by Beezley, Martin and Alexander (1976) is the modeling of appropriate child care methods and parenting skills as a method of changing parent-child interactions. Modeling can be done under a variety of circumstances: by the therapist when the parent visits the child during separation, by letting the parent observe others deal with their own child and other children, and by allowing some qualified person (day care worker, preschool teacher, foster parent) demonstrate ways to deal with children. Under no circumstance should criticism of the parent be implied during experiments in interaction.

Martin and Beezley (1976) believe that treatment of the parent-child relationship should be one component of the therapeutic program for child abusing parents. This component essentially constitutes a social-learning approach. These researchers say that the parent-child relationship is improved when the child abuser is able to observe trained persons deal with the child, and then to model the appropriate parent-child interactions. Martin and Beezley (1976) note that parent effectiveness training courses have been used with some success in treating the parent-child relationship in abusive families. However, they believe that most parents are not ready for such treatment until many months after their abusive behavior has been identified; they add that even though child abusers may intellectually understand how parent-child interactions can be improved, they may be unable to change their abusive behavior.

Jeffrey's (1976) piece describes simple and practical ways to

change parent-child interaction. Two categories of treatment, changing negative interactions, and changing attitudes and deflecting aggressive responses, pertain to the treatment of the abusing parent. There are several techniques therein.

This researcher says that negative interactions can be altered in several ways. One way is to instruct the parent in the use of simple reinforcement techniques which increase positive response to the child. During scheduled treatment, the therapist gives outside incentives or rewards to the parent to help increase his or her positive response to the child. Jeffrey's informal observations were that the increased positive responses learned in therapy were maintained by abusive parents following treatment. Negative interactions can also be ameliorated if the parent learns to communicate by listening, responding, and talking with his or her child. The therapist can facilitate this through a series of "talking sessions" whereby the parent, child and therapist all practice talking together and listening to the child and each other, and expand on what the child said. These sessions are recorded and the tapes are used to give feedback to the parent. A third technique is to help the parent learn to play, an activity which enables many positive responses (e.g., smiling, laughing, touching) to be learned and practiced. Teaching the parent to play can be done in practice sessions where the therapist acts as a model, though Jeffrey warns that modeling must be done with great sensitivity. It is helpful for the parent to practice playing once a day for a specified amount of time. Background and local play groups can also help the parent and child learn to play.

Fourthly, by learning to give positive attention to the child, the parent can decrease negative interactions. In homes where there are too many things not to touch or nowhere for the child to play or make a mess, it is difficult for a child to behave positively. By learning to make their homes adapt to people, the abusive parent can alter negative interactions between him or herself and the child. Negative interactions can also be corrected by contracts or agreements between parents and children. Contracts can be drawn up to avoid particular conflicts and situations which lead to negative interactions. A final technique is to help abusive parents learn new handling techniques. One such technique is "distraction" which occurs, for example, when the parent proposes some enjoyable activity for the child in order to divert the child's attention from some inappropriate behavior. A second handling technique is known as "quietly telling without shouting", a self-explanatory measure. These handling techniques can be practiced by the therapist and the parent through role playing and real situations. As a prelude to her discussion of teaching the parent handling techniques, however, Jeffrey says that the parent must decide in what specific areas commands and instructions are necessary, and that the parent must practice "double thinking" a command or instruction, an act which requires the parent to consider twice whether a particular command is necessary. The author says this is needed because, generally speaking, child abusing parents give too many commands.

Jeffrey (1976) believes that the parents can learn new ways of behaving toward their children by changing attitudes and learning to

deflect their aggressive responses. In cases where a common behavior of a child is perceived by the parent as defiant, bad or abnormal, a list of ordinary behavior can be drawn up from published norms. Each time one of the behaviors occurs, such as a four-year-old breaking a glass at the dinner table, the parent is required to check off the behavior on the list before doing anything else. This technique aims to change the parent's unreal expectation of the child, and to redirect the aggressive response from the child to the list. It is necessary for the therapist and parent to first practice this technique.

Kempe and Kempe (1978) also believe in the merits of working with the child abuser to change the interaction between the parent and child. This learning theory-based treatment is preceded by the therapist taking a complete history of the child's development and gaining an understanding of the child's problems that have concerned the parents and the methods the parents have used to cope with them. It is also useful if the therapist has information about how the parent was treated as a child, since this knowledge enables the therapist to better understand the parent's approach to the child. Once these tasks are accomplished, the actual treatment begins.

The parent, child and therapist gather in a playroom. After the three have become comfortable, the therapist models behavior for the parent. The therapist reenacts specific problematic family scenarios, such as mealtimes. Some of the interactions between child and parent or therapist are videotaped, and the parent and therapist

view and discuss them in the child's absence at a later time. During the discussion, the therapist points out laudable parental behavior to increase the confidence of the parent, and to ask the parent how he or she felt at that time. The goals of the discussion of the videotapes are to help create for the parent distance between his or her behavior and the child's, to aid the parent in recognizing qualities of each for the first time, to help the parent understand how he or she and the child affect one another, to bring to the parent's attention the causes and effects of alternative ways of reacting to the child, and to give the parent knowledge of child development so as to make his or her expectations of the child realistic and demands reasonable. In summary, the therapist combines historical information, interactional observation, modeling, reenactment of family situations and discussion and teaching to achieve the end of establishing satisfactory parent-child interactions. Kempe and Kempe (1978) qualify the use of their social learning treatment model by saying that it can only be used when the child abuser is already receiving successful and supportive therapy.

Janzen and Harris (1980) have written in support of using techniques derived from learning theory. They posit that by teaching the abusive parent new skills in child care and by giving him or her the opportunity to observe how others care for their children, the parent is able to overcome the deficits in his or her own parental role model and substitute aggressive responses to the child with more appropriate ones. These researchers state that change in the abusive parent can

occur only in the context of a relationship with the therapist where the parent feels concern for him or herself as an individual, and not simply an instrument to meet the needs of the child. Hence, learning and change are in the context of being nurtured and given to by the therapist.

The learning techniques of Janzen and Harris (1980) number three: modeling, teaching parenting skills, and providing knowledge about the expectable behaviors of children at given ages. Through these three techniques, the parent develops more realistic and consistent responses to the child. A clearer expression of parental expectations and rules to the child has many benefits. The child is less likely to deviate from the rules and expectations, the parent experiences less pressure for direct supervision, and the child feels more comfortable, positive and responsive to the parent. The result of this is a changed pattern of parent-child interaction.

One project sought to use social-learning theory and techniques of behavior therapy as the basis of treatment for abusive parents (Tracy & Clark, 1974). The program was designed to change behavior through the use of social reinforcement. It involved an assessment of the parent's present behavior, an identification of behavioral goals, followed by specific techniques of achieving them, and constant evaluation. Also, it dealt with environmental factors.

To orient the reader to their treatment approach, Tracy and Clark (1974) make some observations about abusive parents from a

social-learning perspective. First, they say that abusive parents have few skills to help them function as adults. Secondly, abusive parents are often ignorant about child development. A third observation is that abusing parents almost always control their children's behavior through punishment because they lack alternative means of control. Also, abusive parents respond more readily to therapists of similar socio-economic backgrounds who will work with them in their own homes. A final observation is that the therapeutic staff often overestimate the competence of abusive parents.

Tracy and Clark's (1974) project was organized by and operated from a hospital, and coordinated by a registered nurse. Assisting the coordinator were three social service workers of the hospital who investigated suspected cases of abuse, and four family health workers who were between the ages of thirty-five and fifty. The health workers were residents of the community they served and were chosen on the basis of their ability to listen sensitively in an interview and to respond in simple terms; no prior training was required of them. A psychological consultant conducted two ninety-minute training sessions each week, one for the hospital staff and one for the family health workers; the coordinator regularly attended these sessions. The consultant also conducted bi-monthly sessions in which material designed to teach the assessment of behavior through interviews and observation was presented.

The program itself consisted of five steps. It began by

identifying the cause of injury as a child was brought into the emergency room. If abuse was determined by the social service workers and attending physician, the project intervened. Then, assessment interviews were conducted so as to determine general techniques of punishment used by the parent to control the child's behavior, the ways he or she coped with a range of environmental problems, and the antecedents and consequences of their abusive behavior. The third step was to decide if the child was able to be returned to the home if the project continued intervention. (In all cases, the project had sufficient evidence to return the child to the home; however, the authors do not indicate what course of treatment would have been taken if it was not thought to be safe to return the child to the home.) Once this decision was made, the staff drew up plans and goals for treatment. Then, the family was introduced to the staff as the child was being discharged from the hospital. A few days following the child's release, the family health worker began treating the family according to the behavioral analysis and treatment plans/goals previously formulated.

The general aim of the family health worker was to move the abusing mother or father into the role of a competent parent by informally demonstrating positive techniques of child management, such as "catching the child at being good." As he or she worked with the parent in the parent's home, the health worker was encouraged and helped to reformulate the original behavioral analysis and treatment plans. Further, the family health worker functioned as a role model

for the parent, serving as an advocate for the family in housing projects or welfare offices, but avoiding the reinforcement of dependent behavior on the part of the parent. Behavioral change in the parent was monitored by frequency counts which were charted weekly on the basis of the observations made by the family health worker and on the basis of verbal reports made to him or her by the parent.

Tracy and Clark (1974) point out some of the problems with the project. One was the lack of an objective instrument of evaluation. A second problem was the need to establish continuity between the child's hospitalization and the treatment of the parent. There was also the problem of accountability of the staff. The authors believe, too, that the project's staff needed additional consultation time. Lastly, one general problem cited was the stereotype many professionals hold about theories of learning and behavior therapy. Tracy, Ballard and Clark (1975) published a follow-up of this same project. That paper augmented the original article in six ways:

1. It clarified the goals of the project: to identify families with an abused child, to increase the effectiveness of parental behavior, and to decrease abusive behavior.
2. It defined interventions more precisely as "direct," those in which a family member is present and actively involved, and "indirect," those made on behalf of the family in the family's absence.

3. It listed two additional ways of assessing behavioral change in the parent: through clinical reports and verbal reports of others.
4. It gave insight into how the family health worker formulated goals by clustering "concerns" under general categories with the purpose of increasing family functioning. An example of this would be a cluster "developing a regular mealtime schedule" with "going grocery shopping on a regular basis" under "Household Management." These clusters were jointly rated by the family health worker and the project coordinator as worse, same, improved, very improved and unknown; the ratings were justified by frequency counts.
5. It provided the reader with a case study.
6. It made some statements about the efficacy of the project by stating that it could lead to an improved family environment and improved family functioning.

One researcher (Scheurer, 1977) undertook a study to evaluate the effectiveness of a social-learning therapeutic program for abusive mothers and their children. His behaviorally-oriented program taught these parents child development information and age appropriate behaviors of children, as well as nonpunitive behaviorally-oriented child management skills. The notion behind this researcher's efforts

was that mothers who maltreat their children have a distinct lack of knowledge in these areas.

Twenty mothers were involved in Scheurer's study. Ten were assigned to a behaviorally-oriented treatment group, and ten to a client-centered treatment group. The behaviorally-oriented group applied direct intervention on the parent-child relationship. This was done by teaching the mother the use of positive reinforcement instead of physical punishment. In the client-centered group, the mother discussed personal problems in an empathic relationship with the therapist.

The author made three hypotheses about the treatment of the two groups. The hypotheses were that mothers who received behavioral treatment would:

1. have more positive attitudes toward parenting,
2. interact more positively with their child, and
3. have a more positive self-concept,

Scheurer's (1977) first hypothesis was measured by the Michigan Screening Profile of Parenting, the second by the Mother-Child Interaction Rating Scale, and the third was analyzed by the Draw-A-Person test. In each case, the researcher failed to achieve statistical significance, though in the cases of the first and third hypotheses, the results were in the predicted directions.

In another study (Sandler, Van Dercar, & Milhoan, 1978); two child abusers were involved in a parent training program which

consisted of reading assignments, practice assignments, role playing and contingent reinforcement.

The Patterson Coding System, an instrument designed to analyze sequential family interactions, was used in a series of pre-treatment sessions with both families to gain data regarding the nature of their interactions. Based on the observations of these sessions, the training program was developed. Training consisted of nine sessions in which the child abusers were requested to complete reading assignments and review tests in a text entitled Parents Are Teachers (Becker, 1971). Also, the parents were encouraged to implement various suggestions offered in the book by the use of weekly handouts specifically delineating child management practices. If the parents successfully completed the assignments, they were given tangible rewards. Training also included instruction in "approval" and "physical positive" through the use of role playing whereby the therapist served as the role mother and the child abuser played the role of the child; these roles were then reversed.

Sandler and the other experimenters (1978) observed several constructive changes in parent-child interactions and improvement in the child management skills of the two parents as a result of their short-term parent training program. Some of these changes were maintained for as long as five months following training. They concluded that a number of positive family interactions, particularly along pro-social dimensions, may be produced by such intervention efforts.

Sandler was involved in another similar research project (Denicola & Sandler, 1980) which studied the effects of parent training and self-control techniques on two abusive parents. Prior to treatment, the parents listed problems relevant to their own life from a number of commonly encountered child-related problem behaviors listed in the Problem Behavior Workbook. These problems were used to focus treatment in terms of relevant problem situations. Again, the Patterson Coding System was used for eight sessions prior to intervention.

Their 1980 project consisted of two components of intervention, parent training and cognitive-behavioral instruction, which were administered over twelve sixty to ninety minute sessions. The parent training focused on teaching reinforcement skills and in changing inappropriate or punitive child management techniques. Again, parents read parts of Parents Are Teachers (Becker, 1971) and completed exercises from it for each session. This material was reviewed verbally and discussed. Parents also viewed twelve videotaped demonstrations of problem situations which were followed by discussions in which the parent was asked to suggest inappropriate parental responses, and then to propose positive behavioral responses based on the Becker readings. Modeling, role playing and parental rehearsal based on the problem situations cited by the parents from the Problem Behavior Workbook were also part of the parent training component. Contingency contracting was also employed whereby objective agreements were made between the experimenter and the parent, for example, to implement at home a child management technique. Successful completion of the

agreement by the parent resulted in tangible rewards. Parents were given constant feedback through all aspects of training. The cognitive behavioral component focused on helping parents cope with aggressive impulses, feelings of anger and frustration. Techniques used here were deep muscle relaxation, development of problem solving skills, instruction of self-control of arousal and self-modification of verbalizations, and instruction in the emotional and cognitive components of anger. The parents were provided the opportunity to practice their coping skills in a variety of problem situations.

The results of Denicola and Sandler's (1980) study indicated a reduction in aversive behavior and an increase in pro-social behaviors during treatment and follow-up. The parents completed a questionnaire at the end of the last treatment which measured their subjective evaluations of the program. This questionnaire revealed that the parents attributed change to learning more appropriate child rearing techniques and to an improvement in their coping ability.

Analysis of Cluster IV

The classification chart marked Figure 4 is a useful tool for examining the literature within the cluster which embraces social-learning techniques.

This cluster consists of twelve studies. The first work was published by Tracy and Clark (1974), and the most recent were authored by Denicola and Sandler (1980) and Janzen and Harris (1980); on the average, however, publications about the use of social-learning methods

appeared in the second half of 1976.

It is generally agreed upon by the researchers that the basis of a social-learning model should be a) to educate and train the parent in child rearing, care and development (Beezley et al., 1976; Denicola & Sandler, 1980; Janzen & Harris, 1980; Parke & Collmer, 1975; Sandler et al., 1978), and b) to change negative parental attitudes and behaviors (Denicola & Sandler, 1980; Jeffrey, 1976; Kempe & Kempe, 1978; Scheurer, 1977; Steele, 1975). Very closely related to this two-fold basis, but somewhat more specific in method, is the modeling basis of social-learning treatment of which Beezley et al. (1976), Janzen & Harris (1980), and Martin and Beezley (1976) are proponents. Tracy and Clark (1974, 1975) are mavericks in positing a social reinforcement basis to their social-learning program.

For the most part, the techniques used in the social-learning treatment programs focus on instructing the parent in behavior modification and management of the child. Numerous researchers support such techniques (Denicola & Sandler, 1980; Jeffrey, 1976; Parke & Collmer, 1975; Sandler et al., 1978; Scheurer, 1977; Tracy & Clark, 1974, 1975). In their studies, these researchers explain use of such techniques as reinforcement, contracts, distraction, contingent reinforcement, "quietly telling without shouting", and so on. A second pattern one finds in analyzing techniques used in social-learning models is to teach the parent new skills to better manage his or her own abusive behavior. Techniques of this kind would include teaching

the parent how to play, how to use a behavioral check-off list (Jeffrey, 1976), problem solving skills, self-control and modification of verbalizations (Denicola & Sandler, 1980). There is yet a third minor trend in the literature with regard to the use of social-learning techniques, techniques which fall under the rubric of parent education (Martin & Beezley, 1976) and include instruction in child development (Kempe & Kempe, 1978; Scheurer, 1977), parental rehearsal (Scheurer, 1977) and adaptation of the home to the child (Jeffrey, 1976). Miscellaneous other techniques used are: videotaping, one employed by Kempe and Kempe (1978), and Denicola and Sandler (1980), discussion (Kempe & Kempe, 1978), nurturing (Janzen & Harris, 1980), the development of trust and timing in instruction (Beezley et al., 1976).

Seven of the researchers within the cluster indicate a preference for social-learning treatment to be administered in a clinical setting (Denicola & Sandler, 1980; Janzen & Harris, 1980; Jeffrey, 1976; Kempe & Kempe, 1978; Martin & Beezley, 1976; Parke & Collmer, 1975; Sandler et al., 1978); six agree that social-learning treatment can be done in the home of the parent (Denicola & Sandler, 1980; Jeffrey, 1976; Parke & Collmer, 1975; Sandler et al., 1978; Tracy, Ballard, & Clark, 1975; Tracy & Clark, 1974). There is mentionable support for treatment to be given in small parent group meetings (Beezley et al., 1976; Parke & Collmer, 1975). Beezley et al. (1976) limit group treatment to instruction in parent education, but say that modeling, on the other hand, can be done in a variety of settings. Scheurer (1977) and Steele (1975) do not remark about therapeutic

environment.

There are a few additional statements to be made about the literature regarding the social-learning treatment of child abusers. First, there is the noticeable tendency to use social-learning therapy in conjunction with other modes of treatment. Beezley et al. (1976), for example, say social-learning treatment should not be the primary intervention used in treating abusive parents. Martin and Beezley (1976) contend that it should be one part of a larger treatment plan, a place it holds in the program of Tracy and Clark (1974, 1975). Kempe and Kempe (1978) agree that social-learning should be used with other supportive therapy. Secondly, Steele (1975) limits its effective use to treatment of mildly abusing or neglectful parents. Thirdly, Kempe and Kempe (1978) posit that social-learning treatment must be preceded by data gathering about the parent and child.

By way of summary, the average date of publication of the literature of the social-learning cluster was late 1976. The basis of most social-learning models is either a) to train the parent in child rearing, care and development, or b) to change negative parental attitudes and behaviors. A specific treatment basis, modeling, was also discernible in a review of the literature. By and large, the techniques used in this mode focus on instructing the parent in behavior modification management of the child, though two other trends were found with regard to techniques: to teach the parent skills to better manage his or her own behavior, and to give instruction in

parent education. There was a preference among the researchers to administer social-learning treatment in a clinical setting, though some recognition given for treatment in the home, and yet lesser support for treatment in small parent group meetings. There was the noticeable tendency among the studies to use social-learning therapy in conjunction with other modes of treatment.

Discussion of Cluster V

Research studies which promote a multidisciplinary approach to the treatment of child abusing parents are summarized in Figure 5.

An article by Barnes, Chabon and Hertzberg (1974) discusses a multidisciplinary child abuse team designed to aid families in which a child has been abused. The philosophy behind this hospital-affiliated multidisciplinary program was that long-term help and treatment from a variety of disciplines is necessary to prevent future abuse in a family. The goal of the team was to induce positive changes in the family dynamics and situation in order for the parents to perform their parenting responsibilities while providing an adequate environment for the growth and development of their children. The program established close ties with local departments of social service in order to insure inter-agency cooperation and the presence of an effective network of treatment.

The team members consisted of two-full-time community aides, a full-time nurse, a consulting pediatrician, a consulting psychiatrist, a full-time social worker, and a full-time secretary. These team

YEAR OF STUDY	<u>BARNES ET AL.</u>	<u>HELPER</u>	<u>FONTANA & ROBINSON</u>	<u>GREEN</u>	<u>BLUMBERG</u>	<u>OPPENHEIMER</u>	<u>CARROLL</u>
	<u>74</u>	*	<u>76</u>	<u>76</u>	<u>77, 79</u>	<u>78</u>	<u>80</u>
FUNCTIONS OF TEAMS	Induce positive changes in family dynamics and situation so parent is able to provide adequate environment for growth & development of child	Meet regularly to discuss referrals, respond to consultation, gather data, diagnose, support the family, collect data at conferences, recommend treatment plan, follow-up	Provide services to parent to maintain family unit & prevent separation of parent and child; when necessary to separate parent and child, give supportive services to family	To provide the comprehensive services needed to modify components of abuse	To consider social, legal and psycho-therapeutic aspects of care	To help parents experience growth & learn self-worth, to teach parent skills, to fulfill social & emotional needs of parents, to eliminate abuse	To help parents grow psychologically
AVAILABLE SERVICES	Those of: community aides, nurse, pediatrician, psychiatrist, social worker, secretary	Those of: community protective service worker, hospital social worker, pediatrician or family physician, public health nurse, psychologist or psychiatrist, lawyer, law enforcement officer, coordinator	Those of: psychiatrists, psychiatric social worker, pediatric nurse, social work assistants, group mothers	Those of: homemaker, visiting nurse or parent surrogate, hotline counselors, and involvement with one of these: psychiatrist, physician, social worker or nurse	*	Group therapy, casework, marriage counseling, dance/drama therapy, family life education instruction, parenting skills	Individual, marriage, group therapy, crisis nurseries, lay therapists, volunteer programs, education in parenting & concrete emergency assistance
TEAM AFFILIATIONS	Hospital-based with ties to social service agencies	Hospital-based	Hospital-based & works in cooperation with social service agency	Hospital-based	*	Based in family service agency	Based in social service departments
COMMENTS	All families screened to be certain they are able to profit from services	Identifies acute & long-term phases; W.A.R.	Two-part-program: out-patient & in-patient treatment supplemented by hotlines	*	Contends any form of abuse must be managed in a multidisciplinary fashion	Services administered in a weekend day camp format	*

* Not indicated

FIGURE 5. OVERVIEW OF MULTIDISCIPLINARY TEAM TREATMENT CLUSTER

members were carefully selected and screened in terms of knowledge, expertise, emotional stability, and practical skills in working with abusive adults. The social worker, who was the leader of the program, was responsible for coordinating the goals of the team, the smooth functioning of treatment, and the establishment and maintenance of effective relationships with community agencies. The social worker also served as the primary therapist for family members, and gave on-going supervision, guidance and consultation to the community aides and the team nurse. The community aides were paraprofessionals whose major functions were to meet regularly with the families in their own homes and work toward the formation of constructive, trusting relationships with the parents. Community aides acted as empathic listeners available to parents on a twenty-four hour basis, and as role models by demonstrating good mothering techniques. Further, these paraprofessionals also served to help reduce environmental stresses such as housing problems and unemployment. Community aides were conceived as the cornerstones of team activity, and their interventions were perceived as critical factors in overcoming the isolation of child abusers. The pediatrician generally functioned to consolidate family health information from other area physicians and from hospitals previously in contact with the family. He or she was also responsible for preparing medical evaluations and for providing on-going medical care for the family. The nurse complemented the role of the pediatrician by giving crisis intervention for acute medical problems, acting as a liaison in coordinating past medical and social agency data, functioning

as the family's advocate if treatment involved other health systems, and by giving the parent continual assistance and health education. In short, the primary responsibility of the nurse was to see that the health needs of the family were met. The psychiatrist was responsible for interviewing each family and for bringing into focus the relevant psychodynamics of the family system. He or she also evaluated the possibility of organic disorder in the abusive parent. The psychiatrist gave consultation to the social worker and was present at all weekly half hour staff meetings.

All families who participated in the multidisciplinary program of Barnes and his colleagues were carefully screened to be certain that they possessed the capacity to profit from the services. A thorough review, assessment and analysis of each family was done to determine their particular needs, difficulties, and situation. The program served thirty families in a two-year period, all of whom exhibited a markedly reduced potential for abuse. In only three cases did a marginal repetition of abuse occur while the family was in on-going treatment.

Helfer's manual (HEW Publication) advocated a hospital-based multidisciplinary group approach for the successful treatment of child abuse. He says that a multidisciplinary group should be composed of one of each of the following individuals: a protective service worker from the community, a hospital social worker, a pediatrician or family physician, a public health nurse, a psychologist or psychiatrist, a

lawyer, a law enforcement officer, and one salaried coordinator.

These team members are assigned specific, sometimes overlapping, and interdependent roles.

Helfer contends that the functions of multidisciplinary team members are to:

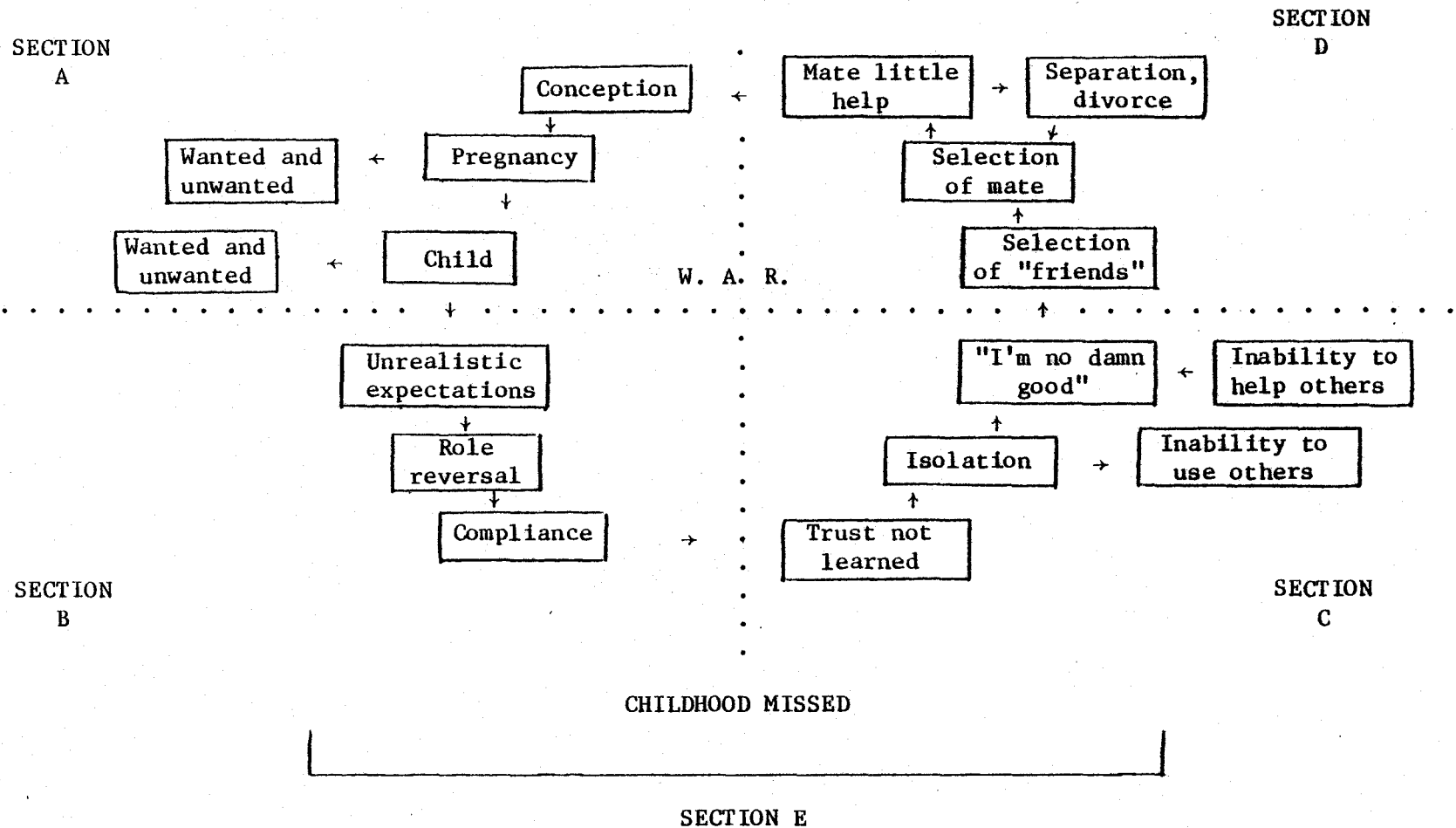
1. meet regularly to discuss referrals
2. respond to consultation from physicians and others
3. gather the data necessary to make diagnosis
4. support the family throughout process
5. collect data at case conference
6. recommend treatment plan
7. follow-up on treatment plan.

Helfer divides treatment into two phases, the acute phase and the long-term phase. The one to three month-long acute phase commences as soon as abuse is suspected. It is coordinated by the hospital social worker who gradually transfers the case to the protective service worker. The long-term phase, which lasts from six months to years, provides the most effective treatment since it is built around a theoretical framework which embodies present understandings of the psychodynamics of abuse. The reader is referred to Table 3, an overview of the theory of the World of Abnormal Rearing (WAR), which is an illustrative accompaniment to Helfer's discussion of treatment approaches.

In section A, the parent needs information about family planning and birth control, even though parents reared in WAR resist receiving it. Helfer says special counseling is necessary along these lines. Section B illustrates the needs abusive parents have to learn about child development, what to expect of their children, how to play with

TABLE 3

World of Abnormal Rearing



Taken from Ray E. Helfer, "Child Abuse and Neglect: The Diagnostic Process and Treatment Programs," U.S. Department of Health, Education and Welfare, Publication # (OHD) 75-67.

their children, and general child rearing and parenting skills. To meet these needs, treatment programs such as parenting courses, group discussion sessions, nursery school and grade school cooperatives, and modeling can be used. The needs of abusive parents to break their isolation, learn trust, improve their self-image, and have access to others (see Section C) can be met through the use of parent-aides, self-help groups, helping the parents get transportation, telephones and babysitters, and through professionally led group therapy. Helfer considers this area of treatment to be the most significant, one which may take months, but can be remedial in most cases. Section D highlights the needs of child abusers to strengthen their relationships with their spouses, to understand and respond to the needs of their spouses, and to learn how to select friends. Treatment techniques used in this phase of WAR are marriage counseling and involving the spouse in all aspects of treatment. Helfer encourages the maintenance of marriages whenever possible during treatment since in crises the parents need one another. Section E, not germane to the present study, involves the treatment of the abused child, though the author does note here that the abusive parent must be helped to understand that it is acceptable for a child to act like a child.

Helfer examines other topics related to treatment. First, he considers how crises in abusive families ought to be handled by the treatment team. He says that personal counseling ought to be available on a twenty-four hour basis. Logistical crises (transportation, food, money, housing) should be handled quickly by someone knowledgeable of

community services. Secondly, he says that if a relative of a child abuser is seen positively, he or she could be incorporated into the treatment plan, but this must be done with great caution. A third related topic is that there exists a group of parents who abuse their children on the grounds of religious, cultural or racial beliefs. Helfer says, however, that most families can be helped. Lastly, the author emphasizes the need of child abusing parents to learn how to physically handle a baby (diapering, feeding, walking, playing). This instruction can be given by a public nurse, or by a hospital training program.

Fontana and Robison (1976) describe a hospital-based project which utilized a multidisciplinary team approach for treating child abusing mothers. The primary goal of their project was to provide services to maltreating mothers in an effort to maintain the family unit and to prevent the separation of mother and child; a secondary goal was to effect a separation where necessary while providing supportive services for the family. The program was based on the concept that abusive parents have been the recipients of inadequate parenting and are in need of role modeling to improve their capacities to mother.

The multidisciplinary team consisted of psychiatrists, psychiatric social workers, a pediatric nurse, social worker assistants and group mothers. The roles of the psychiatrists were to diagnose and screen, provide individual and group therapy, formulate treatment plans and consult with the staff. The social worker assistants, or lay therapists, were each assigned to a parent to serve as her companion, friend,

supporter, advocate, and as a primary link between the mother and the community. Other paraprofessionals, group mothers, assisted the abusive parents in the development of homemaker skills by establishing a daily routine around housekeeping, shopping and working, and by teaching the parent mothering techniques. Finally, the pediatric nurse visited the mother and child weekly following treatment. Two other components existed as part of the multidisciplinary team treatment: a lifeline was established between group mothers and abusive parents, and a twenty-four hour hotline at the project's headquarters was available for anyone who wanted to call on behalf of the parent.

The program described by Fontana and Robison (1976) consisted of two parts, an inpatient facility and outpatient treatment. The inpatient component was a residence which was able to accommodate a capacity of eight mothers and eight to ten children. (The father participated in all treatment services but did not enter the residence.) On admission, mothers received a battery of psychological tests. During the first three weeks in residence, individual treatment plans were formulated through daily observation of the mother and child and through interviews. The mothers received a variety of treatment services. They participated in structured play therapy in a nursery with their children twice weekly which served to encourage the mother to relate more positively to the child, and to pinpoint behavior deviations that trigger negative responses. Further, the parents participated in other educational experiences, such as sessions in self-improvement, child care, family planning, family health, arts and crafts, and so on. Also, a

behavior modification technique was used in the treatment of the mothers whereby two situations, feeding and free play, were videotaped. After each session, the tape was played back to the mother by a psychiatrist who discussed them with her. Videotape feedback was found to be useful in teaching and demonstrating problems in interaction between mothers and children, as well as in evaluating progress and determining assessment criteria. The outpatient component was identical to the inpatient except that the mothers received therapeutic assistance in their own homes.

The average length of residence of mothers was three to four months. Following treatment in the inpatient facility, the mothers received "after care" for up to one year. After care consisted of continued supervision and supportive services: weekly visits by the pediatric nurse, weekly participation in group therapy, and visits twice weekly by the social worker assistant.

Fontana and Robison (1976) report that their project was successful in preventing separation in sixty-five percent of the sixty-two families served over a two-year period.

Green (1976) contends that any sensible plan for the treatment of abusive parents must be designed to modify the major components of child abuse: the personality traits of the parents which contribute to the tendency for abuse, the characteristics of the child that enhance the likelihood of his or her abuse, and the environmental stresses which increase the burden of child care. This author says that a

multidisciplinary approach is required in order to provide the child abuser with comprehensive services he or she is in need of.

Green (1976) enumerates the services needed by the abusive parent: homemaking assistance, home visits by nurses or parent surrogates, a twenty-four hour hotline to help neutralize environmental stress, day care facilities, instruction in child rearing practices and in the physical and psychological development of children. One critical aspect of the multidisciplinary approach is the involvement of the parent in an accepting and gratifying relationship with an un-critical adult. This adult could be a psychiatrist, physician, social worker, nurse, or any other mature volunteer.

This researcher points to problems faced by treatment teams in providing care to child abusers because of certain characteristics these parents possess. First, court-related activities must be separated from the activities of the therapeutic team since their connection could inhibit the establishment of a confidential, supportive and trusting relationship with the therapist. Secondly, the suspicious and distrustful nature of abusive parents toward authority could also interfere with the establishment of a trusting relationship with the treatment staff. A third problem is that child abusers have difficulty in accepting advice and help from a therapeutic team because of their low levels of self-esteem. Maltreating parents feel jealous and competitive with adults who preempt their roles as parents; therefore, Green (1976) says the focus on the child must be approached gradually and cautiously by the treatment team. Lastly, Green (1976) says abusive

parents are masochistic and provocative individuals who have strong unconscious desires to turn the treatment situation into a reenactment of the frustrating interactions they experienced with their own parents. Other treatment obstacles may exist because of the feelings and attitudes the therapist may possess: negative countertransference, overidentification with a "good parent," threatening feelings experienced because of the parent's infantile and demanding qualities.

In concluding his discussion, Green (1976) briefly outlines his own team treatment program. He says the goals and techniques of his intervention program are to help the child abuser establish a trusting, supportive and gratifying relationship with the therapist and other adults. This is achieved by a non-critical and need-satisfying attitude of the therapist. The parent is allowed to regress and enjoy dependency gratifications which he or she was denied as a child. Members of the team give the parent child rearing advice and information about normal child development, are available on an emergency basis, make home visits, secure medical services for the family, establish contacts with schools and social agencies, and provide models for child rearing. The parent is encouraged to develop friendships with peers and to participate in community activities. Group therapy is used.

The team also strives to improve the parent's self-image through educational and vocational assistance. Once trust and rapport is established between parent and therapist, they explore together the parent's painful past and attempt to understand its relationship to the present maltreatment of their child. Parents are encouraged to

vent their anger and rage as part of the therapeutic process. They are at this point amenable to suggestions on the part of the therapist.

Blumberg (1977, 1979) contends that any form of child abuse must be managed in a multidisciplinary fashion which takes into consideration social, legal and psychotherapeutic aspects of care.

Oppenheimer's (1978) article pertains to a project which consisted of an integrated approach to the treatment of child abusers primarily through group therapy and casework services, with the use of adjunctive services.

In Oppenheimer's (1978) project, the parents participated in a weekend day camp over four weekends. The camp provided the framework in which the parents realized the long-term goals of the project: to experience growth and learn self-worth. The project also had short-term goals: to teach parents new and constructive parenting skills, to fulfill the social and emotional needs of parents, and to eliminate child abuse. These short-term goals were achieved through professionally supervised group experiences for the parents, through modeling of normal relationship by the professional staff, and through the use of a crisis facility for the child when the parents needed supportive relief from the care of their children. The treatment model of Oppenheimer's (1978) project was not based exclusively on one technique. It was comprised of a blend of humanistic psychology, education, social casework, and behavior modification.

Group meetings, led by a social worker and a family and marriage

counselor, were held on Saturday mornings. The group had a four-fold emphasis. In the first week self-esteem was discussed as a way to broaden the parents' awareness of self in terms of identity, thoughts and feelings. At the second session, the discussion centered around the topic of self-gratification. Here, parents learned to find self-gratification without depending upon their children as sources of satisfaction for fulfillment of psychological needs. The third week was devoted to the use of mutual sharing as a way of counteracting personal loneliness. At the last group session, the members discussed the concept of empowerment, the belief that each individual has the ability to take responsibility for their own life, and the power to guide and direct their own life in a harmonious and meaningful way.

On Saturday afternoons, parents participated in dance and drama therapy as a way of becoming more aware of their feelings of joy, pleasure, sadness or solitude.

Three hour sessions devoted to family life education and the teaching of parenting skills were held on Saturday mornings. For this, parents used a book entitled Living With Children: New Methods for Parents and Teachers (Patterson, 1976) and an accompanying workbook as texts. The family life education classes were based on the concept that all behavior is learned. The staff instructed the parents in rewarding good behavior of their children, using extinction and "time out" for their inappropriate behaviors, and in employing nonpunitive disciplinary techniques. The parents were given the assignment to have

selected by the second session a behavior of their child that they would like to change, a system of reinforcement that they would use to reward new and good behavior, and a means of disciplining the bad behavior that did not require physical punishment. The third session consisted of a review of all the programs selected by the parents and introduced the concept of "transfer of change," that is, that tangible rewards (gold stars, candy, toys) be exchanged for social rewards (hugs, praise, kisses). The fourth session reviewed the texts, the parents selected a second behavior to deal with, and the parents evaluated the program.

Lastly, the staff attempted to induce spiritual awareness among its members. To this end, a non-denominational service was held on Saturday evenings.

The therapist must convey to the parent the belief that a solution does exist to his or her problems, and express a personal commitment to the parent by emotional support of the parent's problem-solving efforts. Thus, client trust is developed, a necessary prerequisite to exploring the characteristics of the parent's situation, and the emotions associated with the abusive acts. In this way, the parent learns to accept responsibility for his or her actions.

According to Oppenheimer (1978), all families who participated in the camp project reported improvement in their parent-child relationships and displayed new knowledge of children's needs and new skills in child management.

Carroll (1980) argues that a treatment review team should be established in social service departments to provide a variety of services to child abuse families. Among the services which such teams should provide are: individual, marital, family and group therapy and counseling, crisis nursery, placement, lay therapy, volunteer programs (e.g., Big Brother), day care resources, homemakers, education in parenting and concrete emergency assistance (e.g., transportation). Treatment for parents should be focused toward helping them grow psychologically, and it should be preceded by psychiatric evaluations.

Treatment review teams examine treatment plans, evaluate progress or lack of progress of the family, and serve as adjunct to other teams which focus on intake. They are staffed within social service departments by staff social workers, protective service supervisors, and staff psychiatric or psychological consultants, as well as externally by public health nurses, educational program representatives, and the like.

Analysis of Cluster V

Knowledge about the literature written on the use of multidisciplinary team treatment of child abusing parents can be gained by scrutinizing Figure 5, the classification chart for this cluster. The chart reveals several things.

The earliest piece by Barnes et al. (1974) lies on the frontier of the works pertaining to the use of a multidisciplinary model. The most recent piece was published in 1980 (Carroll). On the average, the

eight studies within this cluster were written in early 1977.

There is agreement among three of the seven multidisciplinary researchers as to the function of such teams. Blumberg (1977, 1979), Green (1976), and Helfer (NI) all believe that the primary function of multidisciplinary teams is to provide the comprehensive services --social, legal and psychotherapeutic--needed to modify the components of abuse. Teams provide comprehensive services by meeting regularly, responding to consultation, gathering data, supporting the family, synthesizing data, recommending a therapeutic plan and following up on treatment. Carroll (1980) and Oppenheimer (1978), on the other hand, say the function of multidisciplinary teams is to help the parent grow. Two other studies stand alone in definition of function, Fontana and Robison's (1976) which holds that the function is to maintain the family unit when possible and separate parent and child when necessary, and the study of Barnes et al. (1974) which posits that the function is to induce positive changes in the family situation so as to provide an adequate environment for the child.

The services made available by multidisciplinary teams can be analyzed from two perspectives. The first perspective is in accordance with what has been determined to be the primary function of multidisciplinary teams, i.e., to provide comprehensive services. Therefore, one finds that teams of this type have one or more members from each of the following categories: a social worker, psychiatric social worker, community social worker, hospital social worker or social

worker assistants (Barnes et al., 1975; Fontana & Robison, 1976; Helfer, NI); a nurse, public health nurse, pediatric nurse, a visiting nurse or parent surrogate (Barnes et al., 1974; Fontana & Robison, 1976; Green, 1976; Helfer, NI); a psychiatrist(s) or psychologist (Barnes et al., 1974; Fontana & Robison, 1976; Green, 1976; Helfer, NI); a lay therapist, homemaker, community aide or group mother (Barnes et al., 1974; Fontana & Robison, 1976; Green, 1976); a pediatrician or family physician (Barnes et al., 1974; Helfer, NI); and a coordinator or secretary (Barnes et al., 1974; Helfer, NI). Helfer's (NI) multidisciplinary model, in addition, requires a lawyer and a law enforcement officer, and those of Fontana and Robison (1976) and Green (1976) call for hotline counselors. Therefore, it is reasonable to conclude that multidisciplinary teams whose function is to provide comprehensive services to the family are usually comprised of six members: social worker, nurse, lay therapist, pediatrician, psychiatrist/psychologist and a coordinator. The services of teams analyzed from the second perspective uphold what has been found to be the lesser function of multidisciplinary programs, to help the parents grow. Services which work toward this end are primarily group therapy, marriage counseling and education in parenting (Carroll, 1980; Oppenheimer, 1978), but other services such as dance/drama therapy, casework, family life education (Oppenheimer, 1978), individual counseling, crisis nurseries, lay therapists, volunteer programs and concrete emergency assistance (Carroll, 1980) have been employed.

Multidisciplinary team programs are equally found to be affiliated

with hospitals (Green, 1976; Helfer, NI), social service agencies (Carroll, 1980; Oppenheimer, 1978), or both (Barnes et al., 1974; Fontana & Robison, 1976). Blumberg (1977, 1979) does not indicate the affiliation of multidisciplinary team programs.

The final observations to be made about the multidisciplinary team treatment of child abusers pertain to program designs. Helfer (NI) divides his multidisciplinary approach into acute and long-term phases. Fontana and Robison's (1976) program has a two-part in-patient/outpatient design, and Oppenheimer (1978) administered his multidisciplinary services in a weekend day camp format. Two more interesting points are: 1) Barnes et al. (1974) requires a pretherapeutic screening of families to be certain they have the capacity to profit from treatment, and 2) Blumberg (1977, 1979) contends that any form of abuse must be managed in a multidisciplinary fashion.

To recapitulate, the average study pertaining to multidisciplinary team treatment of child abuse was written in the early part of 1977. The review revealed that one of the primary functions of such teams is to provide the comprehensive services needed by the family to modify the components of abuse. The other studies posit the primary function to be to help the parent grow. The multidisciplinary teams whose function is to provide comprehensive services to the family are usually comprised of six members: social worker, nurse, lay therapist, pediatrician, psychiatrist, psychologist, coordinator. Services frequently found as part of teams whose function is to help the parent grow are group

therapy, marriage counseling, education in parenting, along with others. No common program design was found among the studies within the present cluster.

Discussion of Cluster VI

Figure 6 summarizes the various research which has addressed the use of residential treatment as a viable therapeutic mode for parents who maltreat their children.

Kempe and Kempe (1978) define residential therapy as a treatment mode which promotes immediate care to the family and allows for the intense application of various treatments in a way which keeps parents and children together and encourages bonding. These authors observe that a variety of residential programs presently exist--those designed for single mothers and children, those which treat married mothers and children while the father occasionally visits, and those geared toward the treatment of entire families. Kempe and Kempe (1978) say that average length of residency in centers of this sort varies from one to six months, but that their residential program of the National Center for the Prevention and Treatment of Child Abuse and Neglect in Denver, Colorado consists of a three month residency period composed of intensive treatment and followed by long-term nonresidential care.

Kempe and Kempe (1978) explain what happens in residential care. In addition to receiving individual therapy, the abusive parents spend gradually increasing amounts of time with the child as he or she reassumes responsibility for the child. The parent observes the child

YEAR OF STUDY	<u>KEMPE & KEMPE</u> 78	<u>ALEXANDER ET AL.</u> 76	<u>PANKE & COLLNER</u> 75	<u>LYNCH & OUNSTED</u> 76	<u>OUNSTED ET AL.</u> 74	<u>BLUMBERG</u> 72, 79
GOALS OF TREATMENT	Intense application of treatment	Short-term intensive care, improve parent-child interaction, identify most helpful therapeutic approaches	Help mother develop parenting skills	Treat mothers in residence	To provide service for mothers	Provide a place for mother & child where mother can experience those things she lacked in her own childhood, thereby enabling her to act more appropriately with her own child
COMPONENTS OF TREATMENT	Modeling, formal parent training, social experience, develop recreational skills	3 parts: treatment of parents, the abused child & siblings, and parent-child relationship	*	Medical, social, psychiatric preadmission assessment, daily group therapy, individual & marital therapy, informal psychotherapy, occupational therapy	3 parts: "second day packing," abreaction of emotions, development of open relationship	Nurturing/parenting of parent by trained lay persons
FACILITIES	*	2 complexes: family unit & child care unit. Every parent & child has private bedroom; commonly share dining room, kitchen, laundry, craft areas. Shared housekeeping & meal preparation	Describe National Center Program as a "crisis nursery"	Small house adjacent to a hospital; private bed/sitting rooms, shared main sitting rooms, dining area, kitchen, laundry; meal preparation optional. Shared housekeeping	Domestic dwelling annexed to hospital, set in peaceful garden area, bed/sitting rooms, dining area, kitchen, communal sitting area and laundry	Simply mentions "living-in" arrangements for mother and child
COMMENTS	Length of treatment varies between one and six months	3 phases to treatment: acclimation phase, working phase, discharge phase; length of treatment is one to several months followed by 3 months out-patient	*	Affiliated with a hospital; program headed by a psychiatrist	Affiliated with a hospital; program headed by a physician	Therapeutic measure to be taken before or during individual therapy

* Not indicated

FIGURE 6. OVERVIEW OF RESIDENTIAL TREATMENT CLUSTER

being cared for by the professional staff, thereby being informally taught good child care skills. Additionally, the parent participates in formal parent-child interaction sessions, enjoys social experiences, and learns to develop practical recreational skills such as engaging in a hobby, homemaking and budgeting.

Residential therapy has two major advantages. It provides professionals with the opportunity to observe life on a day to day basis in a potentially abusive situation. And, it enables them to see how crises are precipitated. There are also drawbacks to residential therapy. For one, it is an expensive undertaking. There is the second problem that some families tend to regress while in residential care, making it difficult for them to resume independent lives at the conclusion of treatment.

Kempe and Kempe (1978) also describe an interesting and innovative program, an off-shoot of residential treatment, which requires that the child be placed in a specially prepared foster home where the biological and foster parents develop a cooperative relationship under the supervision and with the therapeutic help of the National Center. Under an arrangement of this sort, the foster parent functions as a surrogate parent, model and lay therapist for the abusive parent. The goal of this program is to return the child to his or her home in three months.

A paper by Alexander, McQuiston and Rodeheffer (1976) describes in depth the residential program of the National Center in Denver. This

treatment program was conceptualized by C. Henry Kempe to a) provide short-term but intensive treatment for parents, the abused child, and siblings; b) improve parent-child interaction; and, c) identify the most helpful therapeutic approaches in order to implement them in an outpatient setting.

Alexander and her colleagues (1976) describe the form and content of the residential program. They state that the services of this program are administered on a twenty-four hour basis to a maximum of four families at a time. The facility is comprised of two separate complexes within one building, the family unit and the child care unit. Families remain in residence from a period of one to several months, followed by three months of outpatient treatment. Initial treatment plans for the parents are developed from pre-admission psychiatric evaluations.

In their paper, these authors outline the three focal points of the residential program: the treatment of parents, the treatment of the abused child and his or her siblings, and the treatment of the parent-child interaction. There are three phases to the treatment program of the parents. The first phase consists of an initial acclimation. During this time, the family is in need of a safe and nurturing home, and so the focus of the therapy for the parents at this point is primarily supportive. It is a time for bonding to occur with the staff, as well as a time to establish trust. In the second phase, the working phase, increased expectations are made of the

parents in terms of care and management of the child, contributions to routines in daily living in the family unit, and in terms of therapy. It is during this working phase that the parents and professionals decide about the ability and desire of a parent to care for and meet the needs of his or her child. In the final phase of residential treatment, the family is prepared for discharge. Parents are given verbal reassurances and gestures of continued caring by the therapeutic staff. An important goal of this third phase of treatment is to assist the parents in obtaining and accepting help from community resources following discharge.

Alexander and her associates (1976) comment on two noteworthy aspects of the residential program: the therapeutic milieu and the formal treatment plan. With regard to the former, the parents live in a home-like facility where emotional support and friendship are extended to them by a professional staff. Every couple has a private bedroom, as does each child. The dining room, kitchen, family room, laundry facilities and craft areas are commonly used by all of the families in residence. The housekeeping responsibilities and the preparation of meals are shared under the guidance of a staff member. A variety of hobbies, crafts and recreational activities are available to the parents. In short, the aim of residential therapy is to allow the daily routines of families to continue as normally as possible. Parents are free to leave the residence, but they are required to participate in therapy, planned activities, scheduled visits with their child, and negotiated child care responsibilities. This therapeutic

milieu underlies the more formal treatment plan for the parent which includes weekly individual psychotherapy and marital therapy, group therapy, and regularly scheduled visits by the social service caseworker and the lay therapist who will continue contact with the parent after his or her departure from the residence.

A second focal point of the National Center's residential program is the treatment of the parent-child relationship. Critical to the treatment process are interventions designed to change the child rearing attitudes and patterns of the parents. The authors note that while in residence the contact between parent and child is carefully planned and timed according to the problems and needs of each. Initially, few expectations are placed on the parents for the care and management of the children. Increasingly greater responsibility for the care of the child is given to the parents throughout the duration of their residential treatment. By the end of their treatment they are expected to have assumed full care of the child. Essentially, parent-child interaction is treated in four ways. The first is by visiting with children so that the child abusing parent can observe child care workers interacting with children other than their own. The parent joins the child in playful activity at times of the day when the child tends to be in a good mood. Slowly, the parent learns and appreciates age-appropriate behaviors in the child. By positively reinforcing parenting behavior, the staff worker helps the parent to internalize a new set of values regarding parent-child interaction. A second method of improving the parent-child relationship is to allow

the parent to observe good models, a process which teaches the child abuser new approaches to parenting. The parent observes early childhood specialists engage in play and care activities of a child. The child care worker "thinks aloud" about the activity he or she is engaged in with the child, verbalizations which focus the parent's attention on the planning involved in providing nurturance, protection, and age-appropriate activities to stimulate the child's growth and development. Thirdly, parent-child interactions are improved by exploring with the parent new ways of interacting with the child. This involves formal therapeutic sessions conducted by a child psychologist who uses videotaping to teach child management techniques and information about normal child development. Parents are shown toys which are appropriate to the child's developmental level, and games for parents and children are demonstrated. A fourth way of ameliorating parent-child interaction is to have the parent practice good child management. This is achieved by slowly increasing the frequency and length of contact between parent and child. Gradually the worker and parent switch roles, the worker becomes the observer, and the parent assumes more responsibility. The authors caution the reader that the parent ought not to fail repeatedly with the child, but should be given tasks at which he or she can succeed, adding more until the parent has full responsibility for the child.

It is interesting that Parke and Collmer (1975) describe Kempe's National Center program in Denver as a "crisis nursery" which includes "admission of the mother and infant 'rooming in' fashion so that the

mother can be helped to develop parenting skills."

Lynch and Ounsted (1976) report on a residential therapy program of a children's hospital in England. This program was designed to treat mothers in residence while their abused children were patients of the hospital; the willing participation of the fathers, who visited on occasion for psychotherapeutic treatment, play therapy sessions and involvement in the care of the child, was required.

The facility consisted of a small house located a few yards from the hospital which was used to treat a maximum of three families who were referred by pediatricians, family doctors, psychiatrists, and social workers. (Lynch and Ounsted provide numerous tables to demonstrate the general characteristics of the families referred and admitted.) There were three private bedrooms / sitting rooms for the mothers. A main sitting room, dining area, kitchen, bathroom, and laundry facilities were shared. The women were either able to prepare their own meals or obtain them from the hospital kitchen. The mothers were free to come and go as they chose, though they were responsible for keeping clean their own rooms and communal areas. Simply put, the facility was designed so as to guarantee privacy while assuring access to the hospital facilities and staff.

Lynch and Ounsted's (1976) residential program was directed by a psychiatrist, though its day-to-day operations were administered by a medical staff with pediatric and psychiatric training (at least one male and one female). Also involved in the operation of the program

were a social worker, an occupational/play therapist, a psychologist, and an experienced nurse. The therapeutic staff had weekly meetings.

The therapeutic process was preceded by medical, psychiatric and social assessments of the mother and her spouse. Upon entry into the program, the care of the child was taken over almost exclusively by the nursing staff. The mothers were placed in an undemanding routine in which they were allowed to regress, and where they were given privacy, peace, warmth and food. The parents received a variety of treatments: daily group therapy, individual and marital therapy, and informal psychotherapy (role modeling, practical help). In addition, the parents saw their family doctor and social worker once a week for a few hours each. The parents were encouraged to attend sessions between the occupational therapist and the child during which the therapist made developmental and behavioral observations of the child and his or her interaction with their parent. The occupational therapist also helped parents learn to play with their child and to understand and better cope with the child's behavior.

Lynch and Ounsted (1976) comment that abusive parents moved through the different phases of therapy at different paces, but observed that during the second week of treatment, many of these parents abreacted the emotions they denied. Before discharge from this residential program, arrangements were made for parents to spend weekends at home. The involvement of family and program continued following discharge, but it varied in extent, depending upon need, from family

to family.

Another residential program (Ounsted, Oppenheimer & Lindsay, 1974) was established to provide service for mothers in a domestic dwelling which was annexed to the hospital where their children were being treated. The mothers' house, which was set in a peaceful garden area, contained three bed/sitting rooms, a dining area, a kitchen, a communal sitting room, and laundry. Preceding the admission of the mother to the unit, a diagnosis was done of the parents, of the family's background, and of family relationships.

During the first few days in the residential unit, the mother and child received complete care: food, warmth, privacy and tranquility in an undemanding routine with the attentive care of mature adults. Shortly after her arrival, Ounsted and his colleagues (1974) observed a phenomenon in the mother which they called the "second day packing." On about the second day or so of her stay, the mother usually panicked and wanted to leave the unit. Once she was calmed by the staff, the mother settled into a routine. These researchers say that it was common for clarifications to occur during the second week in which parents admitted to their abusive acts toward their children. When this crisis occurred, the consultant, a physician who did not interfere in day to day activities, stepped in. The consultant saw the parents together and separately as they abreacted with relief their denied emotions and feelings of alienation. It was essential for the physician at this time to make clear to the parent that all persons, with adequate

provocation, could abuse children. Ounsted and his associates (1974) say, too, that it was helpful to go over each violent act in detail with the parent so that fantasies could be eliminated. By the end of the third week, the in-patient or residential program hoped to have established an "open relationship" with the parent and child. For the parent, this means the program helped her to mature and learn to care for her child. Though Ounsted and his co-authors have no statistical results of their efforts, they say that in most cases there was noticeable improvement in intrafamilial dynamics.

Blumberg (1977, 1979) mentions "living in" arrangements for mother and child as a therapeutic measure to be taken before or during individual psychotherapy. He defines such treatment centers as places where both mothers and children can be nurtured and parented by trained lay persons. Blumberg (1977, 1979) contends that in a residential treatment mode, the mother acquires the experiences she lacked in her own childhood, thereby enabling her to react appropriately to her own child.

Analysis of Cluster VI

The attention of the reader is now directed to the classification chart marked Figure 6, the overview of studies pertaining to the residential treatment of child abusers. It is a useful visual aid in the meta-analysis of the present cluster.

The residential treatment grouping consists of seven studies written, on the average, about mid-1976. Ounsted et al. (1974) wrote

the earliest piece, and Blumberg (1979) has been the most recent researcher to comment about this treatment mode.

One finds two trends when examining the goals of treatment in the literature about residential programs. Two research studies cite the intensive application of treatment as their goal (Alexander et al., 1976; Kempe & Kempe, 1978), though Alexander et al. (1976) qualify this goal by saying that it must be done on a short-term basis. Two other goals, to help the mother develop parenting skills (Parke & Collmer, 1975) and to improve parent-child interaction (Alexander et al., 1976) are related, but less strongly than the two studies advancing the goal of intensive application of treatment since there is greater room for definition between the latter two studies than the former two. Another stated goal is to reparent the mother in residential therapy (Blumberg, 1977, 1979). Alexander et al.'s (1974) goal of residential care is to identify the most helpful therapeutic approaches. Two other goals, to treat mothers in residence (Lynch & Ounsted, 1976) and to provide services for the mother (Ounsted et al., 1974) are un-specific. An interesting pattern found among the goals is that many of the researchers refer to mothers when describing the focus of their treatment goals (Blumberg, 1977, 1979; Lynch & Ounsted, 1976; Ounsted et al., 1974; Parke & Collmer, 1975).

It is not an easy task to identify trends in the components of treatment among the publications pertaining to the residential mode. What can be identified in very loose terms as a trend is the individual

psychotherapeutic care of the child abuser. Reference to this is made by Ounsted et al. (1974) in describing abreaction of emotions by the parent and the development of an open relationship with the therapist; by Lynch and Ounsted (1976) who call for individual therapy and informal psychotherapy; by Alexander et al. (1976) who list treatment of parents in a discussion of their multi-faceted treatment program, and, lastly, by Blumberg (1977, 1979) who calls for reparenting and nurturing of the parent by the therapist. One other apparent trend among the components of treatment in the residential studies is toward social learning. Here, Kempe and Kempe (1978) call for the use of modeling and formal parent training, and Alexander et al. (1976) propose treatment of the parent-child relationship. Finally, two studies regard the development of recreational (Kempe & Kempe, 1978) and occupational (Lynch & Ounsted, 1976) skills to be significant components of residential treatment. Also, Lynch and Ounsted (1976) are proponents of marital therapy and daily group therapy, and Kempe and Kempe (1978) of social experience, for the parent in residential care, but support for these was not found elsewhere in the literature. Parke and Collmer's (1975) discussion of residential programs did not include information about the components of treatment.

One finds similarities when examining the facilities of various residential programs. The residence of Lynch and Ounsted's (1976) program was a small house next to a hospital; this is much like the residence of Ounsted et al.'s (1974) program which was a domestic dwelling, also annexed to a hospital. The residence of Alexander et

al.'s (1976) program is described as two complexes, one for the family and one for the abused child. In three studies there were private bedrooms for the parents, and commonly shared dining areas, kitchen and laundry facilities for all families in residence (Alexander et al., 1976; Lynch & Ounsted, 1976; Ounsted et al., 1974), and in the Lynch and Ounsted (1976) program, the bath was shared. The studies of Lynch and Ounsted (1976) and Ounsted et al. (1974) also had communal sitting areas. A craft area was made available in the Alexander et al. (1976) program. The housekeeping responsibilities were shared by the families in residence in two programs (Alexander et al., 1976; Lynch & Ounsted, 1976). Meal preparation was also shared in the Alexander et al. (1976) program, but this was optional in the Lynch and Ounsted (1976) facility. The study of Parke and Collmer (1975), which describes a residential facility as a crisis nursery, and the study of Blumberg (1977, 1979) which refers simply to living-in arrangements for the mother and child, do not tell one much about the actual set-up of residential treatment. Kempe and Kempe (1978) do not even raise the subject of facilities in their work on residential therapy.

There are other disparate points to be highlighted in an analysis of the residential mode. The first is that two of the residential programs were headed by medical doctors (Lynch & Ounsted, 1976; Ounsted et al., 1974). A second point worthy of mention is that of length of treatment. The two pieces which raise this topic agree that treatment in residence lasts from one to six months (Kempe & Kempe, 1978) or several (Alexander et al., 1976) months. Alexander et al. (1976)

require an additional three months of outpatient treatment following discharge. As a last point about residential treatment, Blumberg (1977, 1979) indicates the use of residential treatment either before or during individual therapy.

To conclude the analysis of the residential cluster, this grouping of studies is the smallest of the nine of the present study. The average date of publication of the seven studies in the cluster was mid-1976. One finds two trends when examining the goals of treatment in the literature about residential treatment: a) to intensively apply treatment and b) to help the child abuser develop parenting skills to improve parent-child interactions. Other goals were generally unspecific. A pattern evident among the goals is that many researchers refer to mothers when describing the focus of their treatment goals. What can loosely be defined as trends in the components of treatment are the individual psychotherapeutic care and social-learning therapy of the child abuser. Facilities of residential programs are found to be annexed to hospitals and have private bedrooms for the parents and commonly shared other living areas. It is agreed that treatment in residence lasts from one to several months.

Discussion of Cluster VII

As illustrated by Figure 7, several authors discuss the topic of hotline services as a mode in the treatment of child abusing parents.

Kempe and Helfer (1972) are among the first advocates of twenty-four hour, seven days a week telephone lifelines in the treatment of

YEAR OF STUDY	<u>KEMPE & HELPER</u> 72	<u>JOHNSTON</u> 73	<u>PIKE</u> 73	<u>TAPP ET AL.</u> 74	<u>PARKE & COLLIER</u> 75	<u>MARTIN & BEEZLEY</u> 76	<u>BLUMBERG</u> 77	<u>WOLKENSTEIN</u> 77	<u>KEMPE & KEMPE</u> 78
GOALS OF TREATMENT	*	Interrupt abuse, help parents to cope, refer to long-term counseling; educate the public	Encourage parents to seek help throughout psychotherapy	Place parent in a network that results in potential long-term solution to other problems	Prevent abuse through support; serve as a referral agency to long-term treatment programs	Psychological improvement in parent	*	*	*
FUNCTIONS	*	Active listener; referral and volunteer service	Provide listening, resource volunteer and referral services	Tune-in, explore, focus and summarize problems; explore resources and develop plan	*	Provide emotional support, assistance and help	"Talk down and cool off" parent	*	Variety of ways cited: referral, send police or counselor, give parent exact instructions
AVAILABILITY OF LIFELINES	24 hour basis/ 7 days a week	24 hour basis/ 7 days a week	24 hour a day basis	24 hour a day basis	24 hour a day basis	*	24 hour a day basis	24 hour a day basis/ 7 days a week	24 hour a day basis/ 7 days a week
COMMENTS	Predicts that in time hotlines will be a part of all social agency treatment	Direct service volunteers go directly to home and assist parents in a variety of ways	Hotline program augmented by volunteers who meet with parents	*	Public made aware of hotlines through a variety of media	*	Preventive measure taken following treatment	To be used as an alternative for parents who do not respond to traditional therapeutic techniques	Staffed by volunteer lay persons with basic training who work under direction of social worker

Not indicated

FIGURE 7. OVERVIEW OF CLUSTER OF HOTLINE SERVICES

parents who maltreat their children. They predict that in time hotlines or lifelines will have to be provided by all social agencies handling the treatment of child abusers.

Another one of the original proponents of the hotline mode (Johnston, 1973) describes a private hotline service known as Parental Stress Service which she founded for potential child abusers. The hotline operates twenty-four hours a day, seven days a week. In addition to functioning as an active listener and as a referral service, the Parental Stress Service also employs the use of direct service volunteers who go to homes of the parents and assist them in a variety of ways.

Johnston cites five aims of the Parental Stress Service hotline. The first is to interrupt the cycle of abuse, that is, to help parents meet their own needs so abuse might not occur. A second goal is to aid parents who can no longer cope and who fear losing control. Thirdly, the service aims to direct potential or actual abusers to existing agencies for long-term professional counseling. To establish a twenty-four hour service, seven day a week program is a fourth goal. Lastly, the hotline strives to educate the public about the problem of child abuse.

Pike's article (1973) provides an account of a hotline project known as Child Abuse Listening Mediation (CALM). Two paid directors of CALM share all of the new telephone calls, and they are available through an answering service on a twenty-four hour a day basis. A

significant part of the listening, referral and resource service CALM provides is to encourage clients to seek help through psychotherapy. A group of volunteers augment the hotline service. Parents are told of the availability of CALM volunteers; if a parent consents to see one, he or she is contacted by a volunteer. The volunteer is expected to help the parent in any way possible while a need for help exists. As the parent's self-image improves, his or her scope of friends, activities and interests broaden, and dependency upon the volunteer decreases. Pike (1973) states that there exists in every human the need to feel a sense of being worthy and cared about in a meaningful way ("mothering").

One other article (Tapp, Ryken, & Kaltwasser, 1974) outlines a program which provides twenty-four hour telephone counseling service to child abusers. This service assures the abusive parent of his or her anonymity, as well as the confidentiality of the call.

Tapp and his associates (1974) list three special problems the telephone counselor may encounter in such a helping process. First, the counselor must face the difficulty of "tuning-in" with the client, that is to say, the therapist must establish an emotional bond with the child abuser by identifying, accepting and reflecting feelings. They cite tuning-in as a potential problem for the counselor because of the negative feelings the counselor may have about someone who has hurt a child, or because of certain attributes and behaviors of the parent, but suggest some possible actions on the part of the counselor to help

him or her with the management of such feelings.

A second problem faced by the telephone counselor is to explore, focus and summarize problems. Tapp and his colleagues (1974) propose the use of a series of questions which indicate the probability of abuse. They also recommend the use of open-ended questions as a way of gaining an understanding of the types of problems the child abuser experiences, and of his or her specific beliefs about child rearing. In short, this problem concerns itself with the task of the counselor to focus on the totality of the child abuser's problems while attempting to identify the problems which have the potential for resolution.

A third problem is to explore resources and to develop a plan. It is important for the counselor at this stage to actively involve the child abuser in the problem solving process. To do this, the counselor must have knowledge of available community resources and other resources which are able to aid the parent in the solution of some of his or her problems. Tapp and his co-authors (1974) contend that it is imperative that a definite plan of action, detailed step by step, be developed with the caller so that he or she knows what exactly to do next and what the counselor will do to facilitate that action. A plan of this sort places the child abuser in a helping network that results in the potential long-term solution to other problems.

The subject of hotline services is one briefly treated by Parke and Collmer (1975) in their interdisciplinary analysis of child abuse who list two aims of hotline services: to prevent abuse before it

occurs through the availability of support, and to serve as a referral agency by encouraging parental involvement in some long-range therapeutic program. These authors note that the types of hotline counselors and their degree of training, as well as the types of referrals made, vary widely among hotline services. Parke and Collmer (1975) state that the public can be made aware of twenty-four hour emergency hotlines through a variety of media: radio, television, billboards, and newspapers.

Martin and Beezley (1976) support the use of hotlines in the treatment of child abusers. They believe that a psychological improvement can take place in the child abusing parent if he or she has an ability to use "life lines" since it is less likely that the abusive parent will seek emotional support from the child if he or she is able to turn to others for sustenance and help.

Blumberg (1977) recognizes the use of twenty-four hour hotlines as a preventive measure to be taken following treatment of child abusers. Hotlines, says Blumberg, are staffed by trained personnel to "talk down and cool off" any telephoning parent who feels the imminent compulsion to abuse his or her child.

Wolkenstein's paper (1977) argues that not all child abusing parents respond to the traditional therapeutic techniques. As an alternative, he proposes the use of a hotline service wherein therapists are available to parents on a twenty-four hour basis, seven days a week, for as long as necessary. The optimal number of families to be

served in this way is five.

Wolkenstein (1977) observed four stages in the therapeutic process with the families he treated. The first stage was an overall feeling of emotional release by the abusive parent. Secondly, Wolkenstein (1977) reported an outburst of rage at other family members who they thought did not allow them to respond to the problem as they felt it. A third stage in the therapeutic process was denial of the initial problem. The final stage occurred when the parent was able to achieve an integration and resolution of reality, that is to say, when the parent was able to accept that the fears of child abuse were non-realistic, but still suggestive of a potential for violence due to a damaged parent-child relationship.

Kempe and Kempe (1978) describe the hotline mode as one which constitutes an effective emergency treatment of abusive parents. They characterize telephone hotlines as services which operate on a twenty-four hour basis, seven days a week. Hotlines may be staffed by paid or volunteer lay people who have had basic training in telephone counseling and who work under the direction of a social worker. These counselors have an exact knowledge of the resources and facilities available to the caller in his or her community.

Kempe and Kempe (1978) say that the telephone counselor may respond in a variety of ways to the telephone call from an abusive parent, for example, by dispatching a police car, by instructing the parent to take the child to a neighbor, by immediately sending the

child to a neighbor, or by immediately sending a counselor to the parent's aid. The counselor notes any information gained from his or her discussion with the parent and gives it to the relevant social service department to be handled the following day. Feedback to the telephone counselor is desirable so as to judge the successfulness of the telephone response.

Analysis of Cluster VII

Much information about trends, patterns, similarities and differences among the published literature about the use of hotline intervention methods can be gleaned from an inspection of the classification chart marked Figure 7.

One can see that Kempe and Helfer (1972) were the first researchers to address the use of hotline services in the treatment of abusive parents. Use of this treatment method was last addressed by Kempe and his associate, Kempe (1978). Literature about child abuse hotlines appeared, on the average, at the beginning of 1975.

Most frequently advanced as the goal of hotline services is to refer the child abuser to long-term counseling (Johnston, 1973; Parke & Collmer, 1975; Pike, 1973; Tapp et al., 1974). Johnston (1973) and Parke and Collmer (1975) also propose that a goal of hotline treatment is to help prevent abuse through support. Two goals stand alone: to educate the public about the problem of abuse (Johnston, 1973) and to produce a psychological improvement in the parent (Martin & Beezley, 1976). Blumberg (1977), Kempe and Helfer (1972), Kempe and Kempe

(1978) and Wolkenstein (1977) do not indicate what they believe to be the goal of hotline treatment.

There is agreement that the primary function of hotlines is to act as a referral and resource service (Johnston, 1973; Kempe & Kempe, 1978; Pike, 1973; Tapp et al., 1974), and that the secondary function is to actively listen to the child abuser (Johnston, 1973; Pike, 1973; Tapp et al., 1974). The lesser functions are to utilize volunteers who go to the direct aid of the parent (Johnston, 1973; Kempe & Kempe, 1978; Pike, 1973), and to help the parent develop an exact plan of action (Kempe & Kempe, 1978; Tapp et al., 1974). The function of hotline services as stated by Martin and Beezley (1976), to provide emotional support, sustenance and help, could be interpreted to be a generalization of any of the four previously stated functions. It is not known to what precise function Blumberg (1977) refers when he says hotline services "talk down and cool off" the parent. Wolkenstein (1977) does not set forth a function of hotline services.

All but one of the nine studies (Martin & Beezley [1976] do not make comment about this) require that hotline services be available on a twenty-four hour a day basis (Blumberg, 1977; Johnston, 1973; Kempe & Helfer, 1972; Kempe & Kempe, 1978; Parke & Collmer, 1975; Pike, 1973; Tapp et al., 1974; Wolkenstein, 1977). Of these, four add that the twenty-four hour availability be on a seven day a week basis (Johnston, 1973; Kempe & Helfer, 1972; Kempe & Kempe, 1978; Wolkenstein, 1977), but it is reasonable to presume that the others consider this to be a fact understood by the reader.

A few final observations are to be made before concluding the analysis of the hotline mode. The first observation is that two of the studies within this cluster make comment about the appropriate use of hotline services. Blumberg (1977) says that it is a treatment alternative for those who do not respond to traditional therapeutic techniques. It is believed by Kempe and Helfer (1972) that in time hotlines will be part of all social agency treatment programs. And, lastly, Parke and Collmer (1975) say that the public can be made aware of hotlines through a variety of media.

To summarize the analysis of the literature about hotlines, the works of this cluster appeared at about the beginning of 1975. The most frequently advanced goals of this treatment mode are to refer the child abuser to long-term counseling and to help prevent abuse through support. There is agreement that the primary function of hotlines is to act as a referral and resource service, with a secondary function being to actively listen to the abusing parent. All but one of the studies require that hotlines be available on a twenty-four hour basis.

Discussion of Cluster VIII

The studies pertaining to the subject of lay therapists as a treatment modality for child abusers are highlighted in Figure 8.

One article (Foresman, 1965) describes a homemaker agency which aimed to help abusive parents understand their problems, and to strengthen, support and supplement the efforts of parents to improve

YEAR OF STUDY	<u>FORESMAN</u>	<u>KEMPE & HELFER</u>	<u>SAVINO & SANDERS</u>	<u>LIPNER</u>	<u>PARKE & COLLMER</u>	<u>BERZLEY ET AL.</u>	<u>KEMPE & KEMPE</u>	<u>JANZEN & HARRIS</u>
	65	72	73	75	75	76	78	80
CATEGORIES	Homemaker	Foster grand-parents, visiting nurses, homemakers	Visiting nurses	1) Parent aide, 2) homemaker, and 3) visiting nurse	Parent aide, homemaker	*	*	*
PRIMARY FUNCTIONS	Help parent understand his/her problems and improve his/her conditions	To become meaningfully involved in a major way in the life of the parent	Establish positive relationship with parent & teach child development, information & child management techniques	1) friend, 2) help with home management, 3) sympathetic listener, & 4) teach mothering skills	To act as friend; provide advice and support to parent; help with management of children and household tasks	Home visits, transportation and social experience	To provide friendship, practical help, small amount of entertainment.	Companionship; general support and help with care of children
QUALIFICATIONS	Friendly, enthusiastic, preferably married & raised own children, interested, eager to learn, patient, and tolerant	Patient, loving, flexible, compassionate, good listener, noncritical and nondirective	*	Compassionate, empathic, gentle, patient, a desire to help	Same race, education, socio-economic class as parent	Successful parent, highly satisfactory family relationships, adequate support system, had good parenting	Same background as parent, mature, a successful parent, understands dynamics of abuse, desire to help, empathic, a rewarding personal life, profited from good parenting	*
FREQUENCY & LENGTH OF TREATMENT	1 or 2 visits weekly to home of parent	1 or 2 visits weekly for 8-12 months	*	*	8-12 months	Long-term (18 months to 2 years)	On-going; fluctuates with needs of the parent	*
SUPPORTIVE SERVICES/ SUPERVISION	Functions as part of a casework team/ supervised by social worker	Part of a larger treatment team	Used with group therapy	Used with casework	*	Part of a team treatment/ supervised by social worker through weekly consultations	Has access to professionals	Used as an adjunct to casework

* Not indicated

FIGURE 8. OVERVIEW OF CLUSTER OF LAY THERAPISTS

conditions for themselves and their children. The author promotes homemakers as a supplementary service to casework.

According to Foresman (1965), homemakers achieve their goals by making brief visits to the family once or twice a week. She says the service of homemakers is imaginative and comes from an ability to improvise and cope with what one finds in the home of an abusive parent (no food, inadequate housing, parental immaturity). The homemaker acts as a substitute parent, helps to organize the household, and can appraise the family situation for the caseworker.

Who qualifies to be a homemaker? Foresman (1965) says friendly, enthusiastic women, preferably married, who have raised their own children. There is no educational requirement of the homemaker. She must simply be interested, eager to learn, patient and tolerant of others.

In Foresman's agency, training of the homemakers consists first of general orientation to the agency. Potential homemakers are then introduced to the functions of the child welfare staff since they act as part of the casework team. Further orientation is given in such matters as nutrition, household budgeting, child development, and the relationship of the homemaker to the parent. The homemaker also receives on-going training consisting of participation in child guidance clinic case conferences when children known to the homemaker are under discussion. Occasionally, homemakers attend community workshops on child development and behavior as part of on-going training.

Since homemakers need continuing support and guidance to relate well to families without becoming overinvolved, the homemaker supervisor, a social worker, gives close supervision and interpretation to the homemakers. The supervisor also acts as a liaison between the evaluation and plans of the caseworker and the homemaker's activities and observations.

Lay therapists are considered by Kempe and Helfer (1972) in their article on innovative therapeutic approaches. They report excellent results with lay workers, persons who they generally describe to be meaningfully involved in a major way in the lives of child abusing parents. According to Kempe and Helfer, the lay therapist or parent aide visits the parent in his or her home once or twice weekly over an eight to twelve month period. The modus operandi of the lay therapist is to listen to the parent, to show him or her approval and special attention, and to present to the parent a noncritical viewpoint. The parent is encouraged to be dependent upon the parent aide in the early part of the relationship. The lay therapist, or a substitute, is always available by phone to the parent.

Kempe and Helfer (1972) list six limited goals of the parent aide. They are 1) that the child eventually be returned to his or her home; 2) that the child not be reinjured; 3) that the child is perceived to be an individual who is enjoyed; 4) that the family become well enough to recognize impending crises; 5) that the parents make use of community resources; and, 6) that parents mature and eventually relinquish their dependency on the primary therapist.

Their discussion of lay therapists becomes more specific as Kempe and Helfer (1972) focus on three categories therein: foster grandparents, visiting nurses and homemakers.

Foster grandparents are persons between 24-60 years of age who have had the experience of having been raised by loving mothers and fathers, and who themselves are parents. These individuals possess qualities of patience, lovingness, flexibility, compassion, as well as an ability to listen, be noncritical and nondirective. Foster grandparents are matched by socio-economic class and race to child abusing parents in a maximum of two or three families and, for a small hourly wage, essentially "mother" them. Little attention is paid to the children. The foster grandparent sees the mother alone, and both parents together. Kempe and Helfer's model of foster grandparent requires that he or she meet every two weeks with the pediatrician, psychiatrist, and social worker who are also involved in the treatment of the family, and further, that the foster grandparent receive on-going support from the social worker. Finally, the training of foster grandparents is simply described as "not difficult"; specific measures are not delineated.

A secondary category treated by Kempe and Helfer (1972) is that of the visiting nurse. The visiting nurse is a natural choice to be lay therapist since he or she is usually readily admitted to the home by the abusing parent, and since he or she is a resource for advice in health care. In the beginning of the relationship, the visiting nurse goes to the home of the abusive parent two times each week. This

reduces to one weekly visit for about one year, but not for less than eight or nine months. The relationship is never discontinued. Simply, the authors list "do's and don'ts" for the visiting nurse. Visiting nurses do not give advice, do not behave in judgmental or critical ways, do not supervise or inspect, and do not seem to instruct. Rather, they do more sympathetic listening than talking, they exercise patience, help the parent to obtain a reasonable understanding of his or her child, and to learn to enjoy the child's presence, and through mothering, to facilitate the development of trust in the parent and improvement of his or her self-image.

The final category of lay therapist which is considered by Kempe and Helfer (1972) is that of the homemaker. This type of lay therapist works in a non-overbearing way to assist the parent with the household tasks (cooking, cleaning, budgeting, groceries), and with the management of the children. The homemaker is one part of a larger team and ought not to be considered the primary therapist. Among their brief comments the authors note that homemakers should not be sent to homes where their services are obviously not needed.

An article by Savino and Sanders (1973) proposes that home visits by nurses, in conjunction with group therapy, can be an effective model in dealing with abusive parents.

Savino and Sanders (1973) recommend several guidelines to govern the role of the lay therapist. First, visits should be made only when the group member requests it. Secondly, the lay therapist must establish

a positive relationship with the parent before any teaching can be done. A third guideline offered by Savino and Sanders (1973) is that the lay therapist must exercise care in not communicating rejection of the parent. Fourth, the lay therapist must focus minimum attention on the child. Fifth, the lay therapist ought to make use of observation as an assessment tool during the first few meetings when he or she simply sits, watches and listens. A final guideline is that some home visits should be made when both parents are present. This allows the lay therapist to take the opportunity to foster better communication between the couple.

These authors say there are four instructive ways for a lay therapist to function: 1) to point out to the parent normal child behavior; 2) to serve as a model for the parent in an unintrusive manner; 3) to interpret the child's behavior for the parent; and 4) to teach the parent behavior modification techniques such as reinforcement and extinction which modify maladaptive behaviors in the child. They indicate that behavior modification techniques could also be taught to the parent in Child Management Classes instructed by nurses.

The use of lay therapists in the treatment of child abusers is also discussed by Lipner (1975). She examines three types: the parent aide, the homemaker, and the visiting nurse.

Lipner (1975) says that a parent aide, a paraprofessional volunteer, can provide an essential element for change in an abusive parent: the consistent and supportive involvement of a good friend. In addition

to the qualities of compassion, empathy, gentleness and patience, the parent aide must also possess a desire to help and the capacity to mother, as well as the ability to focus on the needs of the parent, not the abused child. The parent aide works in collaboration with the caseworker by helping the abusive parent learn to make use of community resources, and with things such as shopping and appointments.

The homemaker, according to Lipner (1975), can be an essential part of the treatment process for abusive parents, but the successful use of the homemaker depends on careful planning and an awareness of the qualities necessary for effective service. A homemaker is neither a therapist nor a "spy"; rather, he or she is sensitive to the parent's real problems, gives experience in mothering, and provides help and relief in home management. It is important for the homemaker to be alert to problems, to recognize them, and to refer them properly and speedily.

A third category of lay therapist treated by Lipner is the visiting nurse. The role of the visiting nurse is to act as a sympathetic listener for the parent while teaching him or her mothering skills in an unobvious way. The visiting nurse does not check parents, supervise them, or give them much advice. It is essential that the visiting nurse have an understanding of the dynamics of child abuse.

According to Parke and Collmer (1975), the lay therapist, or parent aide, functions as a family friend for an abusing parent in one or two families. The principal function of the lay therapist is to

provide advice and support to the family, usually in the parent's home, on a regular basis for eight to twelve months. One important aspect of the role of the lay therapist is that he or she always be available by phone to the child abusing parent. Parke and Collmer (1975) believe that the counselor ought to make attempts to match lay therapists and families by race, education, and social and economic class since such similarities would facilitate the parent's acceptance of intervention. Parke and Collmer (1975) see the focus of the aide's work as the parent and his or her problem; the child is viewed as secondary in importance.

Finally, Parke and Collmer (1975) briefly describe another category of the lay therapist, namely, the homemaker, an individual who serves the function of relieving the mother and/or sharing with the mother the responsibilities of managing the children and the household tasks.

Beezley, Martin and Alexander (1976) indicate the use of lay therapists in treating child abusing parents. They consider lay therapists to be paraprofessionals who devote a maximum of twenty hours per week, with or without remuneration, to the long-term nurturance and support of child abusing parents in three or four families. This is achieved by making home visits, by providing transportation, and by offering some social experience to parents. The intensive involvement of lay therapist and parents extends over an eighteen month to two-year period. This is followed by a gradual lessening of involvement, though the relationship is perceived as a never-ending one.

Beezley and her colleagues (1976) list certain requirements one must meet in order to become a lay therapist. The lay therapist must be:

- a.) a parent who feels successful in that role;
- b.) an individual who enjoys highly satisfactory family relationships;
- c.) someone who has an adequate support system in his or her own life; and
- d.) a person who has experienced good parenting in his or her own childhood.

An individual who meets these qualifications is then involved in a three-month training program. During the training period, the individual is interviewed by a professional who explains the program and the commitment required by the lay therapist. The potential lay therapist is then involved in group meetings and discussions concerning child abuse and expectations of a lay therapist. Additionally, the individual is given reading materials and audiovisual tapes to assist him or her in preparation for the role of lay therapist. It is important that the individual feel he or she has become integrated into the treatment team and has the necessary support and background before the termination of the training period.

The question of support is one which Beezley and her colleagues (1976) address. The lay therapist should be supported primarily by a social worker through weekly consultation. The social worker is also available to the lay therapist by telephone to help with some of the

limitations the lay therapist may experience (overidentification of the parent, difficulty in recognizing medical or psychological problems in the children, keeping parents from becoming too dependent), and to provide backup for the lay therapist. A psychiatrist provides secondary support. The support given to the lay therapist by the professional staff ought to free the lay therapist from feelings of responsibility for the safety of the child.

These authors cite advantages in using lay therapists: it is an inexpensive treatment mode, it provides a much needed supportive relationship, and it is less threatening than traditional professional treatment. However, they also note that the use of lay therapists is contraindicated in cases where the parent is psychotic, sociopathic, violent, an addict, or disturbed in some other extreme way.

Kempe and Kempe (1978) believe that lay therapists ought to be from the same socio-economic background as the abusive parent. These similarities allow the therapist to provide a good model for the child abuser, and to understand his or her social problems. What qualities must the lay therapist possess? Kempe and Kempe (1978) prescribe several. First, he or she must be a mature individual who has profited from good parenting. Further, the lay therapist must have an understanding of the dynamics of child abuse, as well as an authentic desire to help the abusive parent. Additional qualities of the lay therapist are that he or she must have a rewarding life and not seek love and gratitude from their clients. The lay therapist must also have the empathy to understand the problems of the parent without sharing them.

These authors also treat the topic of the nature of the relationship between client and abusive parent. The relationship essentially involves the lay therapist providing three things to the child abuser: friendship, some practical help and a small amount of entertainment. However, Kempe and Kempe (1978) warn that the lay therapist faces problems in establishing this relationship--he or she usually does not receive an automatic welcome from the child abuser and for a time must persist with firm determination in his or her efforts. Another problem is the question of confidentiality. Once engaged, the relationship does not "end" at a specified time; the relationship is on-going and fluctuates according to the needs of the parent.

One final aspect of the function of the lay therapist as outlined by Kempe and Kempe (1978) is the support system within which he or she works. The lay therapist must have access to professionals to whom he or she can turn. Kempe and Kempe (1978) say that the lay therapist should not feel responsible for the safety of the child or the quality of care the child receives. The support system ought also to include other agency personnel who can intervene when necessary, an arrangement which protects the lay therapist's position as friend.

Brief comment is made by Janzen and Harris (1980) regarding the role of lay therapists in the treatment of parents who maltreat their children. They say that parent aides provide assistance to abusive parents in their homes by working with them, providing them with companionship and general support, and by helping them in the care of their children.

Analysis of Cluster VIII

Figure 8, the classification chart of the cluster of lay therapists, discloses information useful for a meta-analysis of this treatment type.

One of the first observations one can make about this cluster of studies is that the earliest piece (Foresman, 1965) was published seven years in advance of the second work that appeared about the subject (Kempe & Helfer, 1972). The latest piece was written by Janzen and Harris (1980). The average date of publication of the eight studies within the cluster was in the early part of 1974.

Various categories of lay therapists are described throughout the literature. The most often noted category is the homemaker (Foresman, 1965; Kempe & Helfer, 1972; Lipner, 1975; Parke & Collmer, 1975), followed by the visiting nurse (Kempe & Helfer, 1972; Lipner, 1975; Savino & Sanders, 1973), the parent aide (Lipner, 1975; Parke & Collmer, 1975), and foster grandparents (Kempe & Helfer, 1972). Three researchers do not describe specific categories (Beezley et al., 1976; Janzen & Harris, 1980; Kempe & Kempe, 1978).

It is clear that the primary functions of the lay therapist number two. The first is to act as a friend of the child abuser (Janzen & Harris, 1980; Kempe & Kempe, 1978; Lipner, 1975; Parke & Collmer, 1975) by becoming meaningfully involved with the parent (Kempe & Helfer, 1972) through the establishment of a positive relationship (Savino & Sanders, 1973). The function of a friend implies that the lay therapist

act as a sympathetic listener (Lipner, 1975), provide advice (Parke & Collmer, 1975) and give general support (Janzen & Harris, 1980; Parke & Collmer, 1975) to the parent. The second primary function of the lay therapist is to help the parent in practical ways (Kempe & Kempe, 1978), a function which would encompass activities such as aiding the parent in the care and management of children (Janzen & Harris, 1980), giving assistance with household tasks (Lipner, 1975; Parke & Collmer, 1975), providing transportation (Beezley et al., 1976) and, in general terms, helping the parent improve his or her condition (Foresman, 1965). Beezley et al. (1976) say one function of the lay therapist is to make home visits, but this is thought to be for the purpose of the previously stated functions. Noteworthy other functions of the lay therapist are to teach the abusive parent child development information, child management techniques (Savino & Sanders, 1973) and mothering skills (Lipner, 1975), and to help the parent have some social experience (Beezley et al., 1976; Kempe & Kempe, 1978). One definition of function (Foresman, 1965), to help the parent understand his or her problems, stands alone in the literature.

According to the literature, the most important qualifications of a lay therapist are that he or she has raised children (Foresman, 1965) successfully (Beezley et al., 1976; Kempe & Kempe, 1978), is a patient individual (Foresman, 1965), possesses a desire to help (Kempe & Kempe, 1978; Lipner, 1975), and is interested and eager to learn (Foresman, 1965). Moreover, there is common support for the qualifications that the lay therapist be compassionate (Kempe & Helfer, 1972; Lipner, 1975),

empathetic (Kempe & Kempe, 1978; Lipner, 1975), and have been the recipient of good parenting (Beezley et al., 1976; Kempe & Kempe, 1978), have a highly satisfactory personal life (Beezley et al., 1976; Kempe & Kempe, 1978), and be from the same background as the parent (Kempe & Kempe, 1978; Parke & Collmer, 1975). There are a variety of other qualifications which have isolated acceptance, such as that the lay therapist be mature (Kempe & Kempe, 1978), gentle (Lipner, 1975), friendly and enthusiastic (Foresman, 1965), loving and flexible (Kempe & Helfer, 1972), a good listener (Kempe & Helfer, 1972), nondirective and noncritical (Kempe & Helfer, 1972), married (Foresman, 1965), and one who understands the dynamics of abuse (Kempe & Kempe, 1978). The qualifications of the lay therapist are not discussed by Janzen and Harris (1980) or Savino and Sanders (1973).

It is agreed by Foresman (1965) and Kempe and Helfer (1972) that visits be made by the lay therapist once or twice weekly to the home of the child abuser. The other six studies do not remark about the frequency of treatment (Beezley et al., 1976; Janzen & Harris, 1980; Kempe & Kempe, 1978; Lipner, 1975; Parke & Collmer, 1976; Savino & Sanders, 1973). Kempe and Helfer (1972) believe that visits by the lay therapist extend over an eight to twelve month period, a contention agreed to by Parke and Collmer (1975). Beezley et al. (1976) indicate a long-term treatment program of eighteen months to two years, a period of time more closely aligned with Kempe and Kempe (1978) who say treatment by lay therapists is on-going, a descriptor thought to refer to a long-term basis. The length of the therapeutic relationship is a subject not

raised by Janzen and Harris (1980), Lipner (1975) or Savino and Sanders (1973).

Lay therapy is most predominantly used as an adjunctive service to casework (Foresman, 1965; Janzen & Harris, 1980; Lipner, 1975), and in one instance (Janzen & Harris, 1980), the work of the lay therapist is noted to be supervised by a social worker. There is some recognition of its use as part of team treatment (Beezley et al., 1976; Kempe & Helfer, 1972), but even if used in team treatment, the role of the lay therapist is supervised by a social worker (Beezley et al., 1976). One study (Kempe & Kempe, 1978) states that lay therapists have access to professionals. Savino and Sanders (1973) are alone in prescribing the use of lay therapy in conjunction with group treatment. Parke and Collmer (1975) do not address the use of supportive services in lay treatment of child abusers.

In conclusion, the average work pertaining to lay treatment of child abusers was published in the early part of 1974. The most frequently noted category of lay therapist are the homemaker and the visiting nurse. There are two primary functions of lay therapy: to act as a friend of the abusive parent, and to help the child abuser in practical ways, but other functions are noteworthy. Many qualifications of the lay therapist appear in the review, but the most commonly accepted are that he or she has raised children successfully, is patient, compassionate and empathetic, has a highly satisfactory personal life, possesses a desire to help, has been the recipient of good parenting, and be from the same background as the parent. Most of the studies do

not remark about the frequency of treatment, but those who do say visits are made to the home of the child abuser once or twice weekly on a long-term basis. Lay therapy is predominately used as an adjunct service to casework, and there is some recognition for its use as part of team treatment.

Discussion of Cluster IX

Several researchers have considered the use of self-help programs as a treatment mode for child abusers (see Figure 9).

An outline of a self-help group known as Mother's Anonymous (M.A.) is presented by Kempe and Helfer (1972) in their examination of innovative therapeutic approaches. This organization, which was founded in 1970 by a former child abuser, operates under the following basic tenets: that the objective is to help severely damaging relationships between mothers and children; that long and short term "do it now" therapy has the goal of establishing, strengthening and maintaining healthy physical and emotional relationships between mother and child; that destructive behaviors and attitudes should be rechanneled into constructive ones; that the parent-child relationship is the most important one a child forms; that M.A. is an accessible way to deal with the problems of parent-child interaction before severe crises occur; that M.A. asks no fee of its members.

M.A. functions within certain guidelines. There must be mutual recognition and admission by members of the problem of child abuse, and the members must want and accept help, as well as follow constructive

YEAR OF STUDY	<u>KEMPE & HELPER</u> 72	<u>STEELE</u> 75	<u>WALTERS</u> 75	<u>STAROKEATHER & TURNER</u> 75	<u>KREED</u> 75	<u>PANKE & COLLIER</u> 75	<u>MARTIN & BEZZLEY</u> 76	<u>ROBERTSON</u> 76	<u>BEZZLEY ET AL.</u> 76	<u>BLUMBERG</u> 77, 79	<u>KEMPE & KEMPE</u> 78	<u>COLLINS</u> 78
GOALS	Promote healthy parent-child interaction	*	*	Prevent damaging relationships between parent & child	*	Meet others with similar problems, discuss themselves, marriages and children, and provide social experience	Alter attitudes and behaviors toward children	*	Help parent face problems in nonjudgmental, accepting environment	*	Facilitate trust so as to come to grips with and share feelings	Raise parent's awareness and promote development through social experience
COMPONENTS OF CHANGE	Mutual recognition and acceptance of problem, members must want help, follow constructive guidance	Minimize fear & anxiety in accepting treatment	Degree of involvement of parent	Weekly group meetings, and through personal and telephone contact	Support contact	Presenting behavior alternatives and by mutual support	Confrontation and support from group members	*	Mutual support	Mutual confessions, exchange of emotions & attitudes, criticism	Confrontation, mutual support & shared solutions to problems	Development of "moral career"
PROFESSIONAL AFFILIATIONS	Professionally led and affiliated with a hospital or child abuse consultation team	Sponsored by a professional	*	Led by abusive parent who is group organizer and advisor	Sponsor or chairperson who is a parent	Functions with or without professionally trained leaders, but if leaders, parent surrogates indicated	*	*	Every group has a sponsor; some are affiliated with protective service departments	*	Not led by a professional, but group has access to such an individual	Led by a professional sponsor
COMMENTS	*	Used as a lead-in to more extensive treatment programs	Viable alternative to agency or professional treatment	*	6-10 members per group who participate for one or more years	Groups meet weekly for two hours	*	Only benefits parents who actively seek help and those who will use help if referred	Facilitates acceptance of professional help	Used as an adjunct to or in preparation for individual psychotherapy	*	*

* Not indicated

FIGURE 9. OVERVIEW OF CLUSTER OF SELF-HELP PROGRAMS

guidance, so that their children can grow up in healthy and loving homes. The organization recognizes that the problem of child abuse is not one that can be cured immediately; rather, they say it is one which requires constant constructive guidance and a "one step, one day at a time" approach by members. The members admit that their children are defenseless against abusive acts and should not be blamed or maltreated regardless of cause; the problem of abuse is within the parents. Members of M.A. acknowledge that their abusive behavior alienates them from their children, and that by using self-help to the fullest extent and by learning self-control, they will reunite their families into harmonious units and earn love and respect.

Kempe and Helfer (1972) speak to the issue of how a self-help group can maintain autonomy while profiting from the guidance of professionals. They make five statements. First, they believe that the weekly group meetings are important, and that they need leaders who understand the dynamics of small groups and have the skills to lead them. A second comment they make is that self-help groups do well to loosely but specifically identify with hospitals or community child abuse consultation teams. Affiliations of this sort help the members who occasionally need individual care and treatment. Thirdly, Kempe and Helfer (1972) say that abusive parents need counseling in child rearing practices and normal developmental patterns of children. A professional could inform the members since parents in self-help groups usually do not have experience in these areas. A professional could actively follow-up for "no shows" and "drop outs", a mandatory function

of self-help groups. A final statement made by these authors is that self-help groups have the limited goal of decreasing or eliminating abuse, and that a mothering model is needed to deal with the problem of love of the parent for the child. A professional could also serve the group in this respect.

Steele (1975) is of the opinion that self-help groups constitute an extremely important movement in the therapeutic care of parents who maltreat their children. Self-help groups, organized on a voluntary basis by abusive parents and sponsored by a professional worker, help child abusers who out of fear and anxiety cannot relate to any other treatment modality. He adds that after participation in self-help groups, some parents may be able to enter more extensive programs.

Walters (1975) considers self-help groups to be a viable alternative to agency or professional treatment of the child abusing parent. He regards the self-help model to be an effective treatment mode to the extent that the parent involves him or herself in the group. Walters encourages acceptance of this treatment type by professionals.

Reflections on the development of a Boston chapter of Parents Anonymous (PA) were given by Starkweather and Turner (1975) in a publication dealing with intervention and treatment of child abuse. In addition to describing some of the problems encountered in establishing a new chapter (publicity, leadership, attendance), their article also explains how their self-help group endeavored to treat parents who maltreat their children.

The primary objective of PA is to prevent damaging relationships between parents and children by means of two methods: through weekly group meetings where parents can share their experiences and feelings and learn to support and challenge each other, and through personal and telephone contact among members during crisis. PA takes a "do it now" approach in dealing with problems, and it promotes openness and honesty among its members. One very great benefit of this self-help program is that members can help one another recognize certain situations that lead to abusive episodes.

Reed (1975) conducted an interesting interview with the founder of Parents Anonymous (PA). That interview elucidated many guidelines for treating abusive parents according to this self-help approach.

Since over eighty percent of all participants in PA hear of the organization's existence through television, radio, newspaper and other published material, announcements of a chapter should be done through these media forms. New chapters can be organized by an abusive parent, a paraprofessional, or a service agency, and they can meet in any non-threatening environment (e.g., community center, church, school). All chapters have a sponsor or chairperson, a parent who understands group dynamics and has belief in the self-help concept. If the sponsor is already affiliated with an agency that has an authoritative position regarding child abusing parents, he or she must work autonomously with PA. Other volunteers who provide transportation and babysitting services, circulate literature and raise funds, also work with chapters.

An average group consists of six to ten members who participate for one or more years. At the first meeting of a new group, members exchange telephone numbers and addresses and begin to form support contact. They call one another at times of extreme stress and crisis to release angry feelings by telephone, to request temporary care for their children, or to ask for temporary care for themselves (companionship). Meetings commence and develop in a variety of ways: by one member responding to another's nonverbal communication, by picking up on a problem discussed at a previous meeting, or by asking for follow-up on a telephone crisis call.

If a member has committed an abusive act, the group reacts by applying peer pressure, by making a group commitment to work especially hard with that parent, or in extreme cases, by asking other persons to intervene and provide services which guarantee the safety of the child. PA cannot offer the comprehensive services that acutely mentally ill parents need. There is no formal follow-up for former members in this self-help program.

Parke and Collmer (1975) cite three opportunities afforded to child abusing parents who participate in self-help groups: the chance to meet others who have feelings and problems similar to their own, a forum to discuss personal experiences related to themselves, their children and their marriages, and the opportunity to gain meaningful social experiences in their otherwise isolated lives. Self-help groups meet weekly for two hours, and function either with or without a professionally trained leader; however, if the group is led by a

professional, Parke and Collmer (1975) recommend the use of surrogate parent leaders, a model which facilitates the identification and modeling of surrogate parent roles.

To illustrate, these authors highlight some of the features of one self-help group, Parents Anonymous (PA). PA operates independently of a professional leader. The participants of the group attempt to assist one another by presenting positive behavioral alternatives to a child abuser, and they strive to achieve cohesiveness by using each other for support and guidance without judgment. Group members exchange telephone numbers, and are encouraged to contact each other to relieve stress and to report positive experiences.

Two other proponents of the self-help model are Martin and Beezley (1976) who say that self-help groups can assist abusive parents in altering their attitudes and behavior toward their children. The important components of change of this form of therapy are the support and confrontation the abusive parent receives from the other child abusers in the group.

Robertson (1976) is yet another advocate of self-help groups. She divides child abusers into three categories: those who actively seek out and use help, those who will use help if their problem is discovered and if they are referred by professionals, and those who will not accept any type of help, even though it may be obvious that their child is maltreated. This researcher believes all of the parents in the first category can benefit from self-help group involvement, and she says that

many of the parents in the second group can profit by participating in self-help group therapy. Child abusers within the third category, however, require more intensive intervention than the self-help model can provide.

The benefits of self-help groups have been delineated by other researchers (Beezley, Martin, & Alexander, 1976). Self-help groups such as Parents Anonymous assist the abusive parent in facing his or her problems in an environment of nonjudgmental and unconditional mutual acceptance. In groups of this type, participants exchange telephone numbers and contact one another for support and guidance during crisis situations. They say every self-help group has a sponsor (social worker, psychologist, nurse or psychiatrist), but he or she is not the identified leader; rather, the sponsor of the self-help group serves to individually contact persons who may be distressed following group meetings. Beezley and her colleagues (1976) point out that some protective service departments have formed affiliations with chapters of Parents Anonymous and refer child abusers as an additional treatment modality. Conversely, participation in self-help encourages members to accept professional help.

The topic of self-help groups is also treated by Blumberg (1977, 1979) who calls for use of this treatment type as an adjunct to or in preparation for individual psychotherapy. Blumberg (1977, 1979) believes that self-help groups are an acceptable alternative for any abusive parent who is threatened by figures of authority or who feels hostile to anyone in the parent role. Catharsis is achieved by self-help group

participants by means of "mutual confessions," through an exchange of expression of emotions and attitudes, and by criticism of self and others. Blumberg (1977, 1979) adds that self-help groups have preventive as well as therapeutic value.

Under the general rubric of "Treatment in Groups," Kempe and Kempe (1978) devote part of their discussion to the topic of self-help. They also point to Parents Anonymous as an especially effective organization. According to Kempe and Kempe (1978), the greatest advantage of this treatment type is that it facilitates trust because it is composed exclusively of child abusers. Individuals who participate in Parents Anonymous are more easily able than persons in other groups to come to grips with and share their feelings about their abused children, sentiments they once felt were uniquely theirs. These researchers also state that in Parents Anonymous, child abusers can confront one another without hesitation, and can share potential solutions to family problems with the authority of having tested them out. Parents Anonymous is not led by a professionally trained counselor; however, the group has access to such an individual who can assist the group with parents who suffer from extreme disorders, as well as provide follow-up for members who are particularly upset at the conclusion of a group discussion.

Collins (1978) studied child abusers who participated voluntarily and involuntarily in self-help group therapy. Her book, based on her 1976 dissertation, consisted of an analysis of Parents Anonymous (PA), a group for which she served as sponsor. Her book outlines the goals and emphasis of PA, the composition of group membership, provisions for

entering and leaving the group, divisions of labor, group mores and group preservation.

Collins (1978) also examined the impacts of self-help therapy on abusive parents and found that self-help groups 1) served to socialize the parents, 2) created roles for these individuals as lay professionals in the field of child abuse, 3) constructed "life careers" from their affiliation with the self-help group based on their acceptance of the label of "child abuser," and 4) helped them to deal with the transformation of the label of "child abuser" into something positive.

Points listed as numbers 3 and 4 comprise six stages in the "moral career" of the child abuser, that is, Collins saw the natural evolution of the parents toward self-image, skill development and social functioning occurring in several steps. The first stage was being different and feeling guilty. The second step was moral identification with the problem of child abuse. Thirdly, the parents experienced an apprenticeship period and a time of moral frustration. Next, the parents acknowledged themselves as child abusers. In the last step, the parent experienced moral self-acceptance and became a recruiter.

Collins (1978) argues that the self-help group served as a catalyst for naturally raising the child abuser's awareness and promoting his or her development through a series of social experiences. The result was that the parents formed "careers" of affiliation with the group. Collins' study (1978) makes extensive use of direct quotes from PA group members. Additional insight into the workings of PA is given

by Herbruck (1979) whose book is comprised of transcripts from meetings of a Cleveland, Ohio chapter and accounts of other relationships with members of that group.

Analysis of Cluster IX

One can discern distinct trends, patterns, as well as areas of disagreement and consensus, by examining the classification chart of the literature about self-help programs (Figure 9).

Studies about self-help therapy appeared, on the average, at the end of 1975. In all, thirteen studies were written which discussed the use of the self-help mode in treating child abusers. Kempe and Helfer's (1972) publication was the first about this topic; Blumberg's (1979) work is the most contemporary.

The most commonly espoused goal of self-help programs is to raise parents' awareness about their problems. Those who advance this same goal in various ways are: Kempe and Kempe (1978) who say the goal is to facilitate trust so as to enable child abusers to come to grips with shared feelings, Parke and Collmer (1975) who posit the goal is to enable parents to meet others with similar problems and discuss themselves, their marriages and their children, Beezley et al. (1976) who contend the goal of self-help groups is to help parents face their problems in a nonjudgmental, accepting environment, and Collins (1978) who believes the goal is to raise parents' awareness. A second commonly held belief about the goal of self-help therapy is that it seeks to promote healthy parent-child interaction by altering the parents' attitudes and behavior

toward their children (Kempe & Helfer, 1972; Martin & Beezley, 1976; Starkweather & Turner, 1975). A third minor trend with regard to the goal of self-help programs is to promote the development of the parent through social experience (Collins, 1978; Parke & Collmer, 1975). The majority of research studies do not set forth the goal of self-help therapy (Blumberg, 1977, 1979; Reed, 1975; Robertson, 1976; Steele, 1975; Walters, 1975).

Two components of change stand in the foreground of the literature of the self-help treatment mode. The component of change for which there is the greatest subscription is the mutual support provided by self-help participants (Beezley et al., 1976; Kempe & Kempe, 1978; Martin & Beezley, 1976; Parke & Collmer, 1975; Reed, 1975) through weekly group meetings and personal and telephone contact (Starkweather & Turner, 1975). There is also agreement among the studies that the ability of the abusive parent to share solutions to problems effects change (Kempe & Helfer, 1972; Kempe & Kempe, 1978; Parke & Collmer, 1975). There is evidence of minor accord for the exchange of attitudes and emotions (Blumberg, 1977, 1979; Kempe & Helfer, 1972), the willing involvement of the abusive parent (Kempe & Helfer, 1972; Walters, 1975), and the use of confrontation (Kempe & Kempe, 1978; Martin & Beezley, 1976) as components of change in self-help therapy. It is interesting that three other unrelated components have individual support: the facts that self-help participation minimizes fear and anxiety in accepting treatment (Steele, 1975), that child abusers make moral careers out of their affiliation (Collins, 1978), and that

criticism by other group members (Blumberg, 1977, 1979) are said to produce change. Components of change through self-help participation is a topic Robertson (1976) does not treat.

Trends in the literature with regard to the professional affiliation of self-help programs are not particularly lucid. The majority of studies do not speak to the issue (Blumberg, 1977, 1979; Martin & Beezley, 1976; Robertson, 1976; Starkweather & Turner, 1975; Walters, 1975). The studies that do speak to the issue fall into one of two categories, those who specifically require a professional leader (Collins, 1978; Kempe & Helfer, 1972), and those who call for professional affiliation, such as Kempe and Kempe (1978) who say self-help groups have access to professionals but are not led by them, and Beezley et al. (1976) and Kempe and Helfer (1972) who say self-help programs are affiliated with hospitals, protective service department, or child abuse consultation teams. Steele's (1975) position here is not clear. He says groups are sponsored by professionals, but does not clarify whether or not those professionals lead the groups. Beezley et al. (1976) are also unclear in stating that every group has a sponsor. Reed (1975) agrees with Beezley et al. (1976) but says that the sponsor be a parent. Parke and Collmer (1975) say groups can function with or without professionally trained leaders.

One other significant similarity found in the literature of this cluster pertains to the appropriate use of self-help therapy. A few studies point out that self-help involvement facilitates the acceptance of professional help (Beezley et al., 1976; Blumberg, 1977, 1979;

Steele, 1975), though one of these studies (Blumberg, 1977, 1979) says self-help treatment also has value when used as an adjunct to individual psychotherapy. While Walters (1975) regards it as a viable alternative to professional treatment, Robertson (1976) contends that it benefits only those who seek help and those who will use help if referred.

Lastly, one finds in the literature few references to length of treatment, size of self-help groups and frequency of meetings. The only guidelines about this are given by Parke and Collmer (1975) who posit that these groups meet weekly for two years and Reed (1975) who says self-help groups consist of six to ten members who participate for one or more years.

To conclude the analysis of the self-help cluster, work in this area appeared, on the average, at the end of 1975. The most commonly espoused goals of self-help programs number three: to raise parents' awareness about their problems, to promote healthy parent-child interaction by altering the parents' attitudes and behavior toward their children, and to promote the development of the parent through social experience. Two components of change stand in the foreground of the literature of the self-help treatment mode. The first is the mutual support provided by self-help participants. The second is the ability of the abusive parents to share solutions to problems. Trends in the literature with regard to professional affiliation are not lucid. The majority of studies do not speak to the issue, but those that do fall into one of two categories for which there is equal support, those who

require a leader and those who call for professional affiliation. Self-help groups are thought to consist of six to ten members and meet weekly for about two years.

This now concludes Chapter III and the individual analyses of the nine clusters evident within the literature of treatment types for child abusers. By use of a cluster/classification chart schema, the literature has been synthesized and analyzed. This has yielded certain general statements and conclusions about each category of treatment.

CHAPTER IV

In the preceding chapter, nine clusters apparent within the literature pertaining to the treatment of child abusers were individually examined according to the meta-analytic schema. The present chapter attempts to meta-analyze the nine meta-analyses; that is, it will perform an analysis among clusters, looking for areas of consensus, patterns, trends and differences which enable one to make summarizing and concluding statements about the relationship between clusters. This chapter will also contain recommendations regarding the treatment approaches based on the information gained by the meta-analysis, as well as discuss areas in which there is the need for future research.

To orient the reader to the analysis among clusters, Figure 10 is provided. This classification chart gives prominence to areas which are common to the nine clusters. For the final analysis, general terms common to all nine clusters were used. One gains several insights from this overview of the clusters.

The first insight is that the literature about treatment modes for child abusers was written, on the average, in the second half of 1975. As a group, the lay therapy cluster had the earliest average date of publication (early 1974), and the multidisciplinary cluster the latest (early 1977). If one peruses the various classification charts, one finds few studies published after 1978. The earliest study published

	<u>PSYCHO-THERAPEUTIC</u>	<u>GROUP THERAPY</u>	<u>CASEWORK</u>	<u>SOCIAL-LEARNING</u>	<u>MULTI-DISCIPLINARY</u>	<u>RESIDENTIAL</u>	<u>HOTLINE SERVICES</u>	<u>LAY THERAPY</u>	<u>SELF-HELP PROGRAMS</u>
AV. YEAR OF STUDIES	Beginning of 1976	Mid-1974	Late 1974	Second Half of 1976	Early 1977	Mid-1976	Beginning of 1975	Early 1974	End of 1975
NO. OF STUDIES	14	20	16	12	8	7	9	8	13
TREATMENT BASES	Behavior Therapy, Reality Therapy, and Psychoanalysis	Psychotherapy, Casework, Socialization, Eclectic	Social work	Learning theory	Eclectic	Eclectic	*	*	*
OBJECTIVES	Change abusive behavior; explore intra-psychic conflicts	Behavioral changes; develop support system; help parent face and deal with problems; instruct in child care; facilitate personal growth	Long-term consistent relationship with parent; mundane tasks; assure safety and well-being of child	Train parent in child rearing care & development; to change negative parental attitudes and behaviors; to model	Provide comprehensive services needed to modify components of abuse; to help parents grow	Intensively apply treatment; to help parent develop parenting skills to improve parent-child interactions	To refer child abuser to long-term counseling and to help prevent abuse through support	To act as friend & help parent in practical ways	To raise parents' awareness about their problems; to promote healthy parent-child interactions by changing parental attitudes & behaviors, to promote the development of the parent through social experience
METHODS	Traditional techniques used in behavior therapy; reparenting/nurturing; more than one person in treatment process	Couples, led by M-F cotherapists; little comment about length of treatment or meetings	Meet the dependency needs of parent; frequent home visits; make parent feel special; education; discussion	Those which focus on instructing the parent in behavior modification, management of child, teaching parent the skills to manage his/her own abusive behavior; Parent education	Teams comprised of various specialists who administer a variety of services	Individual psycho-therapeutic care; social-learning therapy for child abuser	To act as a referral and resource service; to actively listen	Various types: homemaker, visiting nurse, parent aide, foster grandparent	Mutual support; shared solutions to problems
COMMENTS	Group Therapy, Lay Therapy and Casework often found as adjuncts to Psychotherapy	Tendency to use with individual treatment and other services; 6-7 members ideal size of group	Regarded as traditional treatment; no agreement about guidelines; concern about insufficient staffing to achieve long-term goals	Tendency to use social-learning with other modes of treatment; preference to administer in clinical setting	Teams affiliated with hospitals and/or social service agencies; no consistency in program design	Treatment lasts for several months; facilities found to be annexed to hospitals	General agreement of 24-hour availability	Qualifications specified; one or two visits weekly on a long-term basis; frequently used as adjunct to casework or part of team treatment	Professional affiliation not clear; 4 to 10 members per group; group meets weekly for two years

* Not indicated

FIGURE 10. OVERVIEW OF TREATMENT MODES FOR CHILD ABUSERS

about treating child abusers was the one by McFerran (1958) in the group cluster, followed by Foresman's (1965) article about lay therapists. It was not until the early 1970's that articles began appearing regularly (Alexander, 1972; Green, 1971; Johnston, 1973; Kempe & Helfer, 1972; Mitchell, 1973; Paulson & Chaleff, 1973; Pike, 1973; Polansky et al., 1972; Savino & Sanders, 1973; etc.). A few studies were published as late as 1980 (Carroll, 1980; Denicola & Sandler, 1980; Janzen & Harris, 1980). And, there is research in progress (Clearinghouse on Child Abuse and Neglect Information, 1982).

A second insight produced by Figure 10 is that the group cluster is the largest of the nine (twenty studies). On the other hand, the smallest cluster is the one pertaining to the residential treatment of child abusers (seven studies), closely followed by the multidisciplinary and lay therapy clusters (eight studies each).

There are a few similarities to be observed when examining the treatment bases of the various clusters. The most obvious is that the group, multidisciplinary and residential clusters are based on an eclectic approach. A second comparison to be made is between the use of a social work basis by both the group and casework clusters. There is yet a third parallel between the psychotherapeutic and group therapy clusters in that their respective bases are in psychoanalysis and psychotherapy. The social-learning cluster stands alone in its use of learning theory as its basis of treatment, as does the psychotherapeutic cluster in its basis of behavior theory/reality therapy, and the group therapy cluster in espousing a basis of socialization. Three clusters

do not specify their bases of treatment (hotline services, lay therapy, and self-help programs).

More concrete statements can be made with regard to the objectives of the nine modes of treatment. The first is that three trends predominate in an investigation of the objectives of treatment types. One was the goal of changing the abusive behavior of the parent. This same theme was found to be expressed in four of the clusters (psychotherapeutic: change abusive behavior; group: behavioral changes; social-learning: change negative parental attitudes and behaviors; self-help: changing parental attitudes and behaviors). The second predominant trend was the goal of providing support to the child abuser (group: develop support system; casework: long-term, consistent relationship with the parent; hotline: prevent abuse through support; lay therapy: to act as a friend). The final predominant therapeutic objective found in a review of the literature was training the parent (group: instruct in child care; social-learning: train the parent in child rearing, care and development, and model; residential: help the parent develop the parenting skills to improve parent-child interaction). Other minor trends were found among the clusters: to help child abusers achieve personal growth (group: facilitate personal growth; multidisciplinary: to help parents grow; self-help: to promote the development of parents), to help them deal with their problems (group: help parents face and deal with their problems; self-help: raise parents' awareness about their problems), to help child abusers with the problems of day-to-day living (casework: mundane tasks; lay therapy: in practical

ways) and, lastly, to provide abusive parents with the many services they are in need of (multidisciplinary: comprehensive services; residential: intensively apply treatment). One objective stands alone in the overview of treatment objectives, namely, the goal of assuring the safety and well-being of the child (casework).

What does one find in analyzing the methods of treatment set forth by the nine clusters? One finds wide support for those methods which serve to provide support to child abusers (psychotherapeutic: reparenting/nurturing; casework: meet the dependency needs of the parents, frequent home visits, make the parent feel special, discussion; hotline: resource service, actively listen; lay therapy: the many supportive services performed by homemakers, parent aides, visiting nurses, and so on; self-help: mutual support). Minor trends are also found in an analysis of methods. One of these is to educate the parent (casework: education; social-learning: parent education); another is to employ techniques commonly used in behavior therapy (psychotherapeutic: traditional techniques used in behavior therapy; social-learning: teaching the parent the skills to manage his or her own behavior); a third minor trend is the use of groups (group: see Figure 10 for specifications; self-help: shared solutions to problems); a fourth is the use of long-term counseling (residential: individual psychotherapeutic care; hotline: to act as a referral); and, finally, instruction in child behavior modification management (social-learning: instructing the parent in behavior modification management of the child; residential: social-learning therapy for the child abuser). Two

methods have isolated support, one which advocates combined services (multidisciplinary: teams comprised of various specialists who administer a variety of services) and another which suggests that the therapeutic process involves more persons than the child (psychotherapeutic: more than one person in the treatment process).

Other remarks must be made about the relationship among the clusters. One such important remark pertains to consistency within the individual treatment plans. For some clusters, there is no consensus about significant aspects of treatment (casework: no agreement about guidelines; multidisciplinary: no consistency in program design; self-help: professional affiliation not clear). Conversely, a few clusters are precise about particular requirements of their therapeutic programs (group: six to seven members ideal size of group; hotline: general agreement of twenty-four hour availability; lay therapy: qualifications specified; self-help program: six to ten members to a group). Another meaningful comment one can make about the nine clusters is that the various modes often use other services as adjuncts to treatment (psychotherapeutic: group therapy, lay therapy and casework often found as adjuncts to psychotherapy; group therapy: tendency to use with individual treatment and other services; social-learning: tendency to use with other modes of treatment; lay therapy: frequently used as adjunct to casework or as part of team treatment). A third general observation about the clusters as a group is that there appears to be the inclination to have treatment continue on a long-term basis (casework: long-term goals; residential: treatment lasts for several

months; lay therapy: one or two visits weekly on a long-term basis; self-help program: group meets weekly for two years). Three clusters indicate a preference toward a clinical setting (social-learning: preference to administer in a clinical setting; multidisciplinary: teams affiliated with hospitals and/or social service agencies; residential: facilities found to be annexed to hospitals), a fourth general observation worthy of note. Finally, it is interesting to reiterate that one treatment type is considered to be traditional, i.e., casework.

This now brings the reader to the conclusion of the meta-analysis. This thesis set out with the purpose of providing a critical review of the literature regarding therapeutic intervention methods for the treatment of child abusing parents. By using an analytic schema, the goal was to show the various trends which can be observed throughout the existing literature and to draw comparisons and contrasts among the studies done on this topic. The study also had the intention of assisting the reader to reach a better understanding of the various therapeutic intervention methods which presently exist. In doing this, the study attempted to fulfill yet two other goals of the study: to provide the reader with the knowledge necessary for the appropriate use of particular intervention methods, and to lay the groundwork for the development of new intervention techniques.

How successful has the schema been in analyzing the literature? For the most part, it has accomplished its many goals. That is not to say, however, that there were not problems with the analytic design.

The greatest problem with the schema had to do with the overlap that existed between some clusters, thereby violating the "mutually exclusive" criterion of the clusters. This was true, but inevitable in some instances. For example, the group of Tuszynski and Dowd (1978) was administered by a team of counselors, and the multidisciplinary team treatment described by Carroll (1980) was actually casework service. There was also overlap between behavior theory-based treatment within the psychotherapeutic and social-learning clusters. Another example of overlap was the Fries (1975) study which could have easily fit into the group cluster as it sits in the cluster of psychotherapeutic techniques. The problem of overlap was managed by placing the study in the cluster in which it was thought to be principally based. These instances of overlap were, in the overall, few in number.

Other problems of the study had to do with semantics. One such problem was that it was not always possible to discuss treatment of child abusers, the focus of this thesis, without discussing the treatment of the abused child, or the treatment of all or part of the family. Examples of this would be any of the residential programs which require participation of the entire family, or Blumberg's (1977, 1979) collateral therapeutic program, or programs which also include marriage counseling (Oppenheimer, 1978, for example). A similar problem, one worthy of a much lengthier discussion than the one provided here, is the distinction between the terms "prevention" and "treatment." One recalls that the definition of "treatment intervention methods" used for the purposes of this study encompassed the notion of prevention in that it included

". . . any of the services. . . which alleviate the stresses which result in the symptom of child abuse." But, after analysis, one is left with the feeling that as ideas prevention and treatment cannot be combined. Certainly, both treatment and prevention imply correction of a problem, treatment with more or less permanent effects, prevention with more temporary ones. The notion of prevention, though, almost contains some quality of avoidance, as opposed to resolution, of the problem. Future research studies could profit by refining the distinction, a task not yet undertaken by researchers studying the treatment of child abusers.

Some recommendations must also be made before the meta-analysis can be considered truly complete. The first is a basic one. There is the need for renewed interest in the treatment of child abusers. The fact that few studies have been published since 1978 seems to be an indication that interest in the subject has waned. Given the general lack of specificity in treatment procedures among the clusters, it is true that more research is sorely needed. Counselors who treat child abusers presently lack clear direction in choosing and applying services.

Along these same lines comes a second recommendation. Research in treatment modes for child abusing parents is especially needed in the residential, multidisciplinary and lay therapy approaches. Too few studies about these topics have been conducted to give one a clear understanding of their appropriateness, applicability and effectiveness in the treatment of child abusers. Because studies about group treatment were found in abundance, continued research in this area does not seem

as pressing unless new approaches therein are tested.

One of the most important recommendations to be made as a result of the present study is that there is a serious need for the development of new approaches more firmly rooted in generally accepted theories of counseling. One does not find, for example, approaches based in gestalt therapy, or in the existential-humanistic approach. Only one study each was found to be based on transactional analysis (Justice & Justice, 1975), the client-centered approach (Scheurer, 1977) and rational-emotive therapy (Cox, 1979). From this, one can conclude that the scope of counseling theories on which present treatment approaches base themselves is narrow, and that the potential for the development of new approaches is great.

This meta-analytic review has also brought to light the dearth of quantitatively-oriented studies one finds among the research about the treatment of child abusers. Only five studies (Denicola & Sandler, 1980; Fries, 1975; Justice & Justice, 1975, 1978; Sandler et al., 1978) use quantitative data to evaluate the effectiveness of treatment types, therefore making it impossible to summarize by way of percentages, frequency distribution, or any other scientific method, common criteria that seem to be important in a discussion of treatment types. Major contributions to the field could be made by those researchers who would quantify the effectiveness of treatment approaches.

It is important to the conclusion of this study to make one last recommendation and appeal for future research. It seems logical that by

combining what were found by the meta-analysis to be the most widely accepted treatment approaches, one would have a model of treatment which could effectively manage the problem of abuse.

What features would this model have? Briefly, it would have a multidisciplinary team format so as to provide on a long-term basis the many services found to be needed by child abusers and their families. This team would be coordinated and led by the traditional counselor of child abusers, the social service caseworker. The team members, specialists within their fields, would work together to achieve the most frequently found objectives of treatment--to change the abusive behavior of the parent, to train the parent, to help the child abuser achieve personal growth, to help the abusive parent with day-to-day living, and to help child abusers face and deal with problems--by employing the most often found methods--support, education, behavior therapy, group treatment, and child behavior modification management. The roles of the team members and the treatment guidelines would be clear and precise. In short, this ideal model would embrace the results of the present analysis. The development of this model would provide an interesting subject for some future research study.

Treatment programs for child abusing parents are, for the most part, in underdeveloped stages. While much research is yet needed in order to provide a solid basis for reasonable and planned future treatment models, there is much to be gained by examining what has been accomplished to date.

REFERENCE NOTES

Additional reference sources for this study in the treatment of child abusing parents include: Mr. Fred Parris, Clearing House on Child Abuse and Neglect Information, Ms. Joan Solkeim, Educational Coordinator, National Center for Prevention and Treatment of Child Abuse and Neglect, Ms. Ann H. Cohn, Director, National Committee of Child Abuse, and Ms. Debra Daro, Berkeley Planning Associates.

REFERENCES

- Alexander, H. Long-term treatment. In C. Henry Kempe & Ray E. Helfer (Eds.), The battered child, 3rd ed. Chicago: University of Chicago Press, 1980.
- Alexander, H. The social worker and the family. In C. Henry Kempe & Ray E. Helfer (Eds.), Helping the battered child and his family. Philadelphia: J. B. Lippincott Company, 1972.
- Alexander, H., McQuiston, M., & Rodeheffer, M. Residential family therapy. In Harold P. Martin (Ed.), The abused child: A multi-disciplinary approach to developmental issues and treatment. Cambridge: Ballinger Publishing Company, 1976.
- Arvanian, A. L. Treatment of abusive parents. In Nancy Ebeling & Deborah Hill (Eds.), Child abuse: Intervention and treatment. Acton, MA: Publishing Sciences Group, Inc., 1975.
- Barnes, G., Chabon, R., & Hertzberg, L. Team treatment for abusive families. Social Casework, 1974, 55(10), 600-611.
- Beezley, P., Martin, H., & Alexander, H. Comprehensive family oriented therapy. In Ray E. Helfer & C. Henry Kempe (Eds.), Child abuse and neglect: The family and community. Cambridge: Ballinger Publishing Company, 1976.
- Blumberg, M. L. Collateral therapy for the abused child and the problem parent. American Journal of Psychotherapy, 1979, 33(3), 339-353.
- Blumberg, M. L. Treatment of the abused child and the child abuser. American Journal of Psychotherapy, 1977, 31(2), 204-215.
- Boocock, S. S. An introduction to the sociology of learning. Boston: Houghton Mifflin Company, 1972.
- Carroll, C. A. The function of protective services in child abuse and neglect. In C. Henry Kempe & Ray E. Helfer (Eds.), The battered child, 3rd ed. Chicago: University of Chicago Press, 1980.
- Caskey, O. L., & Richardson, I. Understanding and helping child abusing parents. Elementary School Guidance and Counseling, 1975, 9(3), 196-208.
- Clearing House on Child Abuse and Neglect Information (Bibliography), 1982, February, 54.
- Cohen, P. A. Student ratings of instruction and student achievement: A meta-analysis of multisection validity studies. Review of Educational Research, 1981, 51(3), 281-309.

- Collins, M. C. Child abuser: A study of child abusers in self-help group therapy. Littleton, MA: PSG Publishing Company, 1978.
- Collins, M. Occupation: Child abuser: A study of people finding careers in self-help group therapy. Dissertation Abstracts International, 1977, 37(7-A), 4646.
- Corey, G. Theory and practice of counseling and psychotherapy. Monterey: Brooks/Cole Publishing Company, 1977.
- Cox, S. G. The rational-reality based approach to treating the criminal child abuser. Journal of Employment Counseling, 1979, 16(1), 45-52.
- David, C. A. The use of confrontation technique in the battered child syndrome. American Journal of Psychotherapy, 1974, 28(4), 543-552.
- Davoren, E. The role of the social worker. In Ray E. Helfer & C. Henry Kempe (Eds.), The battered child, 2nd ed. Chicago: University of Chicago Press, 1974.
- Denicola, J., & Sandler, J. Training abusive parents in child management and self-control skills. Behavior Therapy, 1980, 11(2), 263-270.
- Feinstein, H. M., Norman, P., & Esmiol, P. Group therapy for mothers with infanticidal impulses. In Jerome E. Leavitt (Ed.), The battered child: Selected readings. General Learning Corporation, 1974.
- Fonatan, V., & Robison, E. A multidisciplinary approach to the treatment of child abuse. Pediatrics, 1976, 57, 760-764.
- Foresman, L. Homemaker service in neglect and abuse: Strengthening family life. Children, 1965, 12, 23-26.
- Fries, C. Changes in personality factors of child abusers following psychotherapy. Dissertation Abstracts International, 1975, 36(3B), 1430.
- Galston, R. Violence begins at home: The parents' center project for the study and prevention of child abuse. Journal of the American Academy of Child Psychiatry, 1971, 10(2), 336-350.
- Gilbert, M. T. Behavioral approach to the treatment of child abuse. Nursing Times, 1976, 72, 140-143.
- Glass, G. V. Primary, secondary and meta-analysis of research. Educational Researcher, 1976, 5(10), 3-8.

- Green, A. H. A psychodynamic approach to the study and the treatment of child-abusing parents. Journal of the American Academy of Child Psychiatry, 1976, 15(3), 414-429.
- Helfer, R. E. Child abuse and neglect: The diagnostic process and treatment programs. U. S. Department of Health, Education and Welfare: DHEW Publication No. (OHD) 75-69.
- Helfer, R., & Kempe, C. (Eds.). Child abuse and neglect: The family and the community. Cambridge: Ballinger Publishing Company, 1976.
- Herbruck, C. C. Breaking the cycle of child abuse. Minneapolis, MN: Winston Press, 1979.
- Herrenkohl, E. C. Parallels in the process of achieving personal growth by abusing parents through participation in group therapy programs or in religious groups. Family Coordinator, 1978, 27(3), 279-282.
- Holmes, S., Barnhart, C., Cantoni, L., & Reymers, E. Working with the parent on child abuse cases. Social Casework, 1975, 56(1), 3-12.
- Janzen, C., & Harris, O. Family treatment in social work practice. Itasca, IL: F. E. Peacock Publishers, Inc., 1980.
- Jeffery, M. Practical ways to change parent-child interaction in families of children at risk. In Ray E. Helfer & C. Henry Kempe (Eds.), Child abuse and neglect: The family and community. Cambridge: Ballinger Publishing Company, 1976.
- Johnston, C. Parental stress service--How it all began. Journal of Clinical Child Psychiatry, 1973, 2, 45.
- Justice, B., & Justice, R. Evaluating outcome of group therapy for abusing parents. Corrective and Social Psychiatry and Journal of Behavior Technology, Methods and Therapy, 1978, 24(1), 45-49.
- Justice, R., & Justice, B. TA work with child abuse. TA Journal, 1975, 5(1), 38-41.
- Kalisch, B. J. Child abuse and neglect: An annotated bibliography. Westport, CT: Greenwood Press, 1978.
- Kempe, C. H. A practical approach to the protection of the abused child and rehabilitation of the parent. Pediatrics, 1973, 51(4), Part II.

- Kempe, C. H., & Helfer, R. E. Innovative therapeutic approaches. In C. Henry Kempe & Ray E. Helfer (Eds.), Helping the battered child and his family. Philadelphia: J. B. Lippincott Publishing Company, 1972.
- Kempe, R. S., & Kempe, C. H. Child abuse: The developing child. Cambridge: Harvard University Press, 1978.
- Kreindler, S. Psychiatric treatment for the abusing parent and the abused child: Some problems and possible solutions. Canadian Psychiatric Association Journal, 1976, 21(5), 275-280.
- Landman, J. T., & Dawes, R. M. Psychotherapy outcome: Smith and Glass' conclusions stand up under scrutiny. American Psychologist, 1982, 37(5), 504-516.
- Light, R. J., & Smith, P. V. Accumulating evidence: Procedures for resolving contradictions among different research studies. Harvard Educational Review, 1971, 41(4), 429-471.
- Lipner, J. D. The use of community resources in work with abusive families. In N. Ebeling & D. Hill (Eds.), Child abuse: Intervention and treatment. Acton, MA: Publishing Sciences Group, Inc., 1975.
- Lynch, M., & Ounsted, C. Residential therapy--A place of safety. In R. E. Helfer & C. Henry Kempe (Eds.), Child abuse and neglect: The family and community. Cambridge: Ballinger Publishing Company, 1976.
- Margrain, S. Review: Battered children, their parents, treatment and prevention. Child Care, Health and Development, 1977, 3(1), 49-63.
- Martin, P., & Beezley, P. Therapy for abusive parents: Its effects on the child. In H. P. Martin (Ed.), The abused child: A multidisciplinary approach to developmental issues and treatment. Cambridge: Ballinger Publishing Company, 1976.
- McFerran, J. Parents group in protective service. Children, 1958, 5(6), 223-228.
- McNeil, J. S., & McBride, M. L. Group therapy with abusive parents. Social Casework, 1979, 60(1) 36-42.
- Miller, S. I. A social psychological evaluation of school desegregation studies dealing with racial attitudes: A preliminary analysis. The International Journal of Critical Sociology, 1978, 2, 54-68.

- Mitchell, B. Working with abusive parents: A caseworker's view. American Journal of Nursing, 1973, 73, 480-483.
- Morris, M. G., & Gould, R. W. Role reversal: A necessary concept in dealing with the battered child syndrome. American Journal of Orthopsychiatry, 1963, 33, 298-299.
- Morris, M. G. Toward prevention of child abuse. In R. Kalmar (Ed.), Child abuse: Perspectives on diagnosis, treatment and prevention. Dubuque: Kendall/Hunt Publishing Company, 1977.
- Oppenheimer, A. Triumph over trauma in the treatment of child abuse. Social Casework, 1978, 59, 352-358.
- Ounsted, C., Oppenheimer, R., & Lindsay, J. Aspects of bonding failure: The psychopathology and psychotherapeutic treatment of families of battered children. Developmental Medicine and Child Neurology, 1974, 16(4) 447-456.
- Parke, R. D., & Collmer, C. W. Child abuse: An interdisciplinary analysis. In E. M. Hetherington (Ed.), Review of child development research. Chicago: University of Chicago Press, 1975.
- Paulson, M. J., Savino, A. B., Chaleff, A. B., Sanders, R. W., Frisch, F., & Dunn, R. Parents of the battered child: A multidisciplinary group therapy approach to life-threatening behavior. Life-Threatening Behavior, 1974, 4(1) 18-31.
- Paulson, M. J., & Chaleff, A. Parent surrogate roles: A dynamic concept in understanding and treating abusive parents. Journal of Clinical Child Psychology, 1973, 2(3), 38-40.
- Pike, E. L. C.A.L.M.--A timely experiment in the prevention of child abuse. Journal of Clinical Child Psychiatry, 1973, 2, 43-45.
- Polakow, R. L., & Peabody, D. L. Behavioral treatment of child abuse. International Journal of Offender Therapy and Comparative Criminology, 1975, 19, 100-103.
- Polansky, N. DeSaix, C., & Shlomo, S. Child neglect: Understanding and reaching the parent. New York: Child Welfare League of America, Inc., 1972.
- Polansky, N. A., Borgman, R. B., DeSaix, C., & Shlomo, S. Verbal accessibility in the treatment of child neglect. In J. E. Leavitt (Ed.), The battered child: Selected readings. General Learning Corporation, 1974.

- Rathbone-McCuan, E., & Pierce, R. Intergenerational treatment approach: An alternative model of working with abusive/neglectful and delinquent prone families. Family Therapy, 1978, 5(2), 121-141.
- Reed, J. Working with abusive parents: A parent's view. Children Today, 1975, 4, 6-9.
- Rieder, K. A. Parents: The unrecognized victims of child abuse. Military Medicine, 1978, 143(11), 758-762.
- Robertson, J. M. The abusive parent: A different perspective. Canada's Mental Health, 1976, 24(4), 18-19.
- Roth, F. A practice regimen for diagnosis and treatment of child abuse. Child Welfare, 1975, 54(4), 268-273.
- Sanders, R. W. Systematic desensitization in the treatment of child abuse. American Journal of Psychiatry, 1978, 134(4), 438-484.
- Sandler, J., Van dercar, C. & Milhoan, M. Training child abusers in the use of positive reinforcement techniques. Behavior Research and Therapy, 1978, 16, 169-175.
- Savino, A. B., & Sanders, R. W. Working with abusive parents: Group therapy and home visits. American Journal of Nursing, 1973, 73, 482-484.
- Scheurer, W. E. An evaluation of two treatment methods related to improving the parenting skills of abusive mothers. Dissertation Abstracts International, 1978, 39(1-A), 135.
- Smith, M. L., & Glass, G. V. Meta-analysis of psychotherapy outcome studies. American Psychologist, 1977, 32, 752-760.
- Starkweather, C. L. & Turner, S. M. Parents anonymous: Reflections on the development of a self-help group. In N. Ebeling & D. Hill (Eds.), Child abuse: Intervention and treatment. Acton, MA: Publishing Sciences Group, Inc., 1975.
- Steele, B. F. Working with parents from a psychiatric point of view. U. S. Department of Health, Education and Welfare: DHEW Publication No. (OHD) 77-30070.
- St. John, N. School desegregation outcomes for children. New York: A Wiley-Interscience Publication, John Wiley and Sons, 1975.
- Tapp, J. T., Ryken, V., & Kaltwasser, C. Counseling the abusing parent by telephone. Crisis Intervention, 1974, 5(3), 27-37.

- Tracy, J. J., Ballard, C. M., & Clark, E. H. Child abuse project: A follow-up. Social Work, 1975, 20, 398-399.
- Tracy, J. J., & Clark, E. Treatment for child abusers. Social Work, 1974, 19, 338-342.
- Tuszynski, A., & Dowd, J. An alternative approach to the treatment of protective service families. Social Casework, 1978, 59, 175-179.
- Walters, D. R. Physical and sexual abuse of children: Causes and treatment. Bloomington, IN: Indiana University Press, 1975.
- Wasserman, S. The abused parent of the abused child. In S. Steinmetz & M. Straus (Eds.), Violence in the family. New York: Dodd, Mead and Company, 1975.
- Wells, D. P. Child abuse: An annotated bibliography. Metuchen, N.J.: The Scarecrow Press, Inc., 1980.
- Winder, A. E., Greif, A. C., & Kelso, E. P. Family therapy: The single parent family and the battered child. Family Therapy, 1976, 3(2), 97-107.
- Wolkenstein, A. S. The fear of committing child abuse: A discussion of eight families. Child Welfare, 1977, 56(4) 249-257.
- Zalba, S. R. The abused child. In R. Kalmar (Ed.), Child abuse: Perspectives on diagnosis, treatment and prevention. Dubuque: Kendall/Hunt Publishing Company, 1977.
- Zalba, S. R. Treatment of child abuse. In S. Steinmetz & M. Straus (Eds.), Violence in the family. New York: Dodd, Mead and Company, 1975.

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

9-22-82
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