

THE EFFECTS OF FRAMING AND LEVEL OF EXPERIENCE ON CONSULTANTS'
CONCEPTUALIZATIONS AND RECOMMENDATIONS FOR TREATMENT
IN CASES OF CHILD ABUSE

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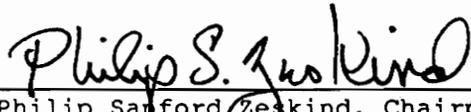
Elisabeth A. Shingler

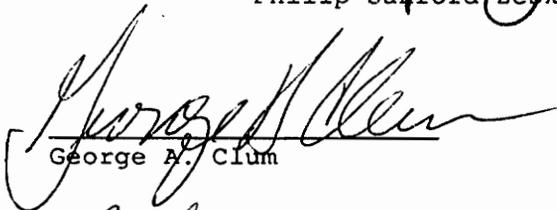
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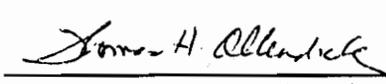
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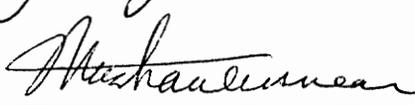
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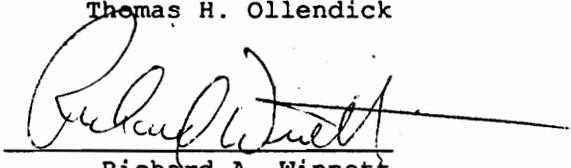
APPROVED:


Philip Sanford Zeskind, Chairperson


George A. Cium


Thomas H. Ollendick


Marshall D. Tessnear


Richard A. Winnett

April, 1992

Blacksburg, Virginia

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Committee Chairperson: Philip Sanford Zeskind

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(ABSTRACT)

Professionals charged with planning treatment for abusive families often seek consultation during the process of making decisions about treatment. This study examined whether the level of experience of the consultant and the frame in which the case is presented affect conceptualizations and recommendations for treatment for cases of child abuse. To provide theoretical background for the study, a developmental ecological systems perspective on child abuse is presented. Research indicating that the most effective treatment for multiproblem abusive families addresses multiple ecological levels is reviewed.

Consultants were forty members of Multidisciplinary Teams on Child Abuse and Neglect with treatment planning experience, 40 team members with related experience but no treatment planning experience, and 40 undergraduate psychology students with no experience in child protection (novices). Each consultant reviewed written copies of two case presentations of child abuse. One was presented in a frame emphasizing factors related to the individual abuser in the development of the abuse, the other in a frame presenting factors from multiple ecological levels in the development of the abuse. Consultants provided written

recommendations and conceptualizations for each case, rated the effectiveness of interventions from four ecological levels in treatment of the abuse, and rated the importance of factors from the four ecological levels in development of the abuse.

Results showed that the number of levels of recommendations provided increased as consultants' experience increased. Treatment planners and consultants with related experience also rated multiple levels of intervention as more effective and as more important to the development of abuse than novices did. In ratings provided for these variables, treatment planners and consultants with related experience did not differ from each other. Individual framing of cases led to a higher percentage of individual level conceptualizations for all consultants. However, nonsignificant trends in the responses suggest that the treatment planners may be the least affected by framing of cases. The author reviews the implications these results have for clinical practice.

DEDICATION

This dissertation is dedicated to my husband, Peter Kenneth Martel, who helped me get into, survive, and get out of graduate school.

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Multidisciplinary Teams on Child Abuse and Neglect whose members participated in the study were Amherst County, Appomattox County, Buckingham County, Floyd County, Giles County, Halifax, Lynchburg, Martinsville-Henry County, Mecklenburg County, Patrick County, Russel County, Smyth County, and Wise County. Their cooperation was critical to gathering subjects with experience addressing child abuse and

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In the field of child protection there is no area more charged with responsibility and controversy than that of identifying the problems within abusive families and deciding what treatment course to recommend in order to prevent future abuse. Mistakes can be made in conceptualization, the process of identifying the factors precipitating and maintaining abuse, as well as in the recommendations for treatment. The costs of these mistakes can range from reinjury or death of a child (Smith & Hocking, 1981) to failure to give a salvageable family situation the chance to be salvaged. Unnecessary removal of children from their homes to enter the tangled web of out-of-home placement exposes both children and families to the risk of being further damaged by the placement ("Foster Care," 1984; National Association of Former Foster Children, Inc., 1986).

In an effort to share the responsibility for such important decisions and to maximize the perspectives and resources brought to bear in planning treatment, many child protection agencies and services use consultation with a supervisor or multidisciplinary team as part of the process in planning treatment for abusive families (Code of Virginia Chapter 12.1; Grosz & Beezley, 1979). This study was designed to examine whether the level of experience of the consultant and the frame in which the case is presented affect the conceptualizations and recommendations for treatment given for cases of child abuse which are presented to consultants.

Definition and Model of Physical Child Abuse

Though physical abuse of children, the type of maltreatment examined in this study, is the first identified (Kempe et al, 1962) and most researched form of child maltreatment, a plethora of definitions of abuse and a confusing array of models has often limited the integration of studies done by different investigators (Parke & Collmer, 1975). In order to prevent confusion and to provide a model which encompasses many currents of research, the first topics to be addressed are provision of a definition and a model of physical child abuse.

Child maltreatment includes the subcategories of abuse and neglect, with the modifiers of emotional, physical, and sexual often applied before these labels. This paper is concerned with physical abuse, using Parke and Collmer's definition of "nonaccidental physical injury (or injuries) as a result of acts (or omissions) on the part of ... parents or guardians that violate the community standards concerning the treatment of children" (Parke & Collmer, 1975, p. 513). Physical abuse is not the most common form of maltreatment, composing only 25% of verified reports in a national sampling of the United States between 1976 and 1982 (Russell & Trainor, 1984), but it is the most thoroughly researched and conceptualized. This is not surprising given the impact severe cases of physical abuse have on the public's concern about maltreatment, and the comparatively long history of identification of physical abuse as opposed to other forms of maltreatment (Kempe et al., 1962; Russell & Trainor, 1984).

In examining consultants' responses to cases of physical child abuse, the current study made use of an integrated model of the etiology

and maintenance of abuse based largely on Belsky's (1980) ecological model of child maltreatment. The developmental ecological systems model presented below adopts Belsky's integrative approach, recognizing that maltreatment is multiply determined and thus combining elements from earlier models that have been seen as competing explanations of abuse.

A developmental model of abuse must outline the processes involved in the etiology and maintenance of abuse, not merely note factors coinciding with abuse and attribute linear causality to those factors (Parke & Collmer, 1975, Zeskind, 1985). Within the developmental ecological model, abusive parents are actors whose behavior has been shaped through the impact of social situations in their own childhood and adult life, in interactions with their children whom they abuse (Parke & Collmer, 1975), and the overarching cultural belief systems and practices (Belsky, 1980; Korbin, 1980). There is a mutual influence over time amongst parent, child, and social situation (including cultural factors).

The contribution of an ecological perspective to the analysis of the development of abuse is to define the ecological contexts within which abuse is developed and maintained. Within this framework the ecology of development is defined as "the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives" (Bronfenbrenner, 1977, p. 514). Development is influenced by relations within and between environmental settings, as well as the larger social settings which contain the smaller settings - the model is thus a "nested" one. An environmental setting is a place with specific

physical features, participants, activities, roles, and time limits (Bronfenbrenner, 1977). The abusive parent and abused child are developing human organisms, caught at a particular cross section of time at the moment of abuse.

Belsky (1980) defines four levels of ecological analysis and their embodiment in a model of child abuse: the ontogenic or individual level, the development and resulting characteristics of the abuser; the microsystem, the family environment with all its interactions; the exosystem, the community in which the family system is embedded; and the macrosystem, cultural values and beliefs. Because these levels are nested, interaction can occur between and amongst all levels, in any combination or direction.

Thus, Belsky neatly accommodates earlier, less comprehensive models, as labeled and described by Parke and Collmer (1975), within the levels of his model. The psychiatric model identified individual characteristics of the abuser, such as psychosis, poor impulse control, lack of empathy, rigid, domineering personality as causal factors. These factors are included in the ecological level of the individual. The sociological model identified social stressors, community housing and living conditions, unemployment, and social isolation as causal factors. These factors fit into the exosystem. Cultural attitudes toward violence and children, another part of the sociological model, are included in the macrosystem. The social-situational model focused on interaction between parents and children, identifying children's contribution to their own abuse. This interaction occurs in the microsystem. The larger social context in which Parke and Collmer

(1975) place such interaction is comprised of components in the exosystem and macrosystem as described above.

The ecological aspect of the model is useful for the organization it provides for those attempting to integrate different levels of analysis in research or treatment. Just as Rappaport (1977) outlined levels of analysis useful to community psychologists in identifying different locales and methods of intervention, so the ecological division suggests questions and solutions which cut across many traditional boundaries (Belsky, 1980). The nested nature of the model, along with a systems orientation, emphasizes the necessity of examining relationships among variables associated with abuse. To the practitioner observing influences of the exosystem on the behavior of a parent in the microsystem of the family three possible targets of intervention are suggested. Addressing one may result in cascading influences in the others. For example, a mother with low self-esteem, a factor in the individual, may have little tolerance for stressful factors in the microsystem. The misbehavior of her children may prompt abuse because she perceives this misbehavior as an indictment of her parenting ability. The mother's unemployment, a factor influenced by the exosystem, may both exacerbate and result from low self-esteem. Thus, an intervention in the exosystem, helping her find employment, may impact the microsystem's parent-child interaction through altering mother's individual development, decreasing the likelihood of abuse.

Advocates of systems theory complained that early developmental ecological models placed inadequate emphasis on the properties of systems (Minuchin, 1985). Developmental psychologists were accused of

simply outlining systems as environments for the individual developing organism, their true focus of study. Recently, developmental psychologists have become more sophisticated in their appropriation of the systems perspective (Fogel & Thelen, 1987; Zeskind & Marshall, 1991). The challenge of demonstrating adequate integration of a systems perspective must be met by any model purporting to be a systemic model. In order to address this concern in the current ecological examination of child abuse, six characteristics of systems proposed by Minuchin (1985) and examples of their applicability within the developmental ecological systems model of abuse are presented below.

1. "Any system is an organized whole, and elements within the system are necessarily interdependent... consideration of elements out of context produces fragmented and invalid data" (Minuchin, 1985, pp. 289, 290) Thus, the particular child-rearing behavior of a parent must be understood within its macrosystem context. An East African woman who cuts the faces of her sons and rubs charcoal into the cuts is insuring that her children will be allowed to participate as adults in their culture. The American parent who pays for her children's teeth to be painfully realigned is also attempting to increase their cosmetic appeal to members of their culture (Korbin, 1980). In context, neither woman would be labeled abusive. A failure to consider the context of cultural values would not yield full understanding of either case and cause both to be seen as physically abusive.

2. "Patterns in a system are circular rather than linear" (Minuchin, 1985, p. 290). The microsystem interaction of parent and child is a spiral of feedback loops in which each influences the

behavior of the other who in turn influences the behavior of the first and so on (Parke & Collmer, 1975). The dynamic, bidirectional analysis of development inherent in systemic analysis has also been labeled a transactional perspective (Sameroff & Chandler, 1975)

3. "Systems have homeostatic features that maintain the stability of their patterns" (Minuchin, 1985, p. 290). On the level of the exosystem, a community may act systematically to deny support to maltreating families, whose members are viewed with suspicion. These families continue in their maladaptive behavior with no social life lines to pull them out of the cycle because the community reacts with suspicion to maltreating family members, and the vicious circle of suspicion and isolation continues to maintain itself (Polansky, Gaudin, Ammons, & Davis, 1985).

4). "Evolution and change are inherent in open systems" (Minuchin, 1985, p. 290). When Third World countries change from agricultural to industrial societies, structures at the level of the exosystem change in many ways. Some of these changes intrude into the open microsystem of the family, prompting evolution there as well (Korbin, 1980). This change is not necessarily positive. Polynesian families' attempt to adopt Western child-rearing practices in their newly "nucleated" families has resulted in progression from a virtually abuse-free communal culture to exceptionally high rates of reported abuse and neglect in Polynesian nuclear families of industrialized New Zealand (Korbin, 1981).

5. "Complex systems are composed of subsystems" (Minuchin, 1985, p. 291). In the microsystem of the family there is a parental

subsystem, sibling subsystem(s), and parent-child subsystem(s). Each family member may be a member of several subsystems, which each have their own dynamics within themselves and in interaction with other subsystems. For example, problems in the marital subsystem can lead to or exacerbate difficulties in the parent-child subsystem, resulting in abuse (Lynch & Roberts, 1982).

6. "The subsystems within a larger system are separated by boundaries, and interactions across boundaries are governed by implicit rules and patterns" (Minuchin, 1985, p. 291). At the boundaries of microsystems within the superordinate exosystem, a maltreating family may be denied support from other neighborhood families because of its failure to provide support to neighborhood members and values, an implicit rule for access to support (Polansky et al, 1985).

Thus, a developmental ecological systems perspective on abuse emphasizes the complexity of the etiology and maintenance of abuse. The model is transactional across and within levels of analysis, which function as embedded systems. An ecological model that includes emphasis on its developmental and systems nature may allow previously divergent explanations of abuse to be combined in more detailed theory allowing for multiple pathways to the development and maintenance of abuse. As described below, researchers have begun to investigate abuse from this complex viewpoint, and practitioners have recognized the necessity of multilevel conceptualizations and interventions to treat and prevent abuse. The examples provided in the following sections are provided to clarify the developmental ecological systems perspective through application to both research and practice.

Research: Examining Multiple Ecological Levels
in Relation to Maltreatment

Researchers are aware of the multifaceted nature of abuse and have begun to examine multiple variables in interaction with each other, using a variety of theoretical guides. The studies presented below are reviewed from a developmental ecological systems perspective.

Social support, personality, and mother-child attachment tap three ecological levels in relation to maltreatment. An examination of mothers' social support networks, quality of interaction with helping professionals, quality of caregiving, and children's development (measured by quality of attachment) revealed interesting patterns of interconnection (Crittenden, 1985). Mothers' maltreatment status, either a) abusive-and-neglectful, b) neglectful only, or c) adequate, was highly associated with the quality of mothers' social network patterns, a measurement at the level of the exosystem. The measure of mother-child attachment, at the microsystem level, was related to both maltreatment status and mothers' quality of interaction with helping professionals. The latter was interpreted as tapping into mothers' working models of relationships, a factor at the individual level of analysis. Rather than arguing that any of these variables alone determines the others, the author takes a systems oriented perspective remarking, "it appears that there may be an interaction among the mothers' working models of relationships, their influence on their children's development, the type of networks they attract, and the type of influence the networks will have (directly or indirectly) on their children's development" (Crittenden, 1985, p. 1311).

A successful prediction of child maltreatment from structured interviews with pregnant women drew information from multiple ecological levels and descriptions of interactions within and between those levels (Murphy, Orkow, & Nicola, 1985). From an individual level, parents' history of abuse or neglect as a child, experience as a caregiver, criminal record or mental illness, temper outbursts, and low self-esteem were queried. At the level of the microsystem, parents were asked about their relationship with children already in the family, including expectations, punishment, provocativeness of children, previous accusations of abuse, and the reaction to the present pregnancy. Questions about the exosystem centered on stresses and supports connected to finances, housing, employment, and social systems.

Parents were placed in risk categories according to the rank of their total score in the distribution. Variables which were significantly different between the high risk parents and all other levels of risk were: at the level of the exosystem, crisis and isolation; at the level of the microsystem, stress in parental relationship and ambivalence about wanting the child; and at the individual level, depression. In a sampling of children who had been rated high risk and matched controls who had been labeled no risk, maltreatment in the first 1-2 years of life was correctly predicted in 80% of the actual cases of maltreatment, adequate parenting was correctly predicted in 89% of the actual cases in which no maltreatment occurred. Out of those predicted to be abused or neglected, 52.5% had been maltreated during the first 1-2 years of life, while out of those predicted not to be abused or neglected, 96.8% had not been abused or

neglected in the first 1-2 years.

In a functional analysis of child abusive behavior, Wolfe and his colleagues (Wolfe, Fairbank, Kelly, & Bradlyn, 1983) examined interaction in the microsystem influenced by individual characteristics of the parent. Abusive mothers and matched controls watched videotapes of stressful and nonstressful child behavior while their physiological arousal was monitored. Abusive mothers showed more arousal to both stressful and nonstressful scenes. This replicated similar findings by Frodi and Lamb (1980) who found abusive mothers more aroused by videotapes of a crying and smiling infant. Crowe and Zeskind (1992) found that nonparent adults classified as having high child abuse potential by their scores on the Child Abuse Potential Inventory were marginally more aroused by listening to infant cries than were matched nonparent adults with low child abuse potential scores. These investigations indicate that arousability, a factor at the individual level, may impact the quality of the microsystem's parent-child interaction.

Practice: Multilevel Interventions in the Assessment and Treatment of
Child Abuse

Child protection practitioners have also begun to look at child abuse from a multilevel perspective and to advocate intervention at several ecological levels to help prevent recurrence of abuse in identified abusive families. Ideally, such intervention will be preceded by a multilevel assessment of the microsystem of the family, individuals in the family, as well as factors from the exosystem and

macrosystem. Hansen and MacMillan (1990) described recently developed assessment tools to evaluate multiple ecological levels in order to identify needs prior to intervention and to measure progress after intervention with maltreating families. Abuse and neglect screening instruments reviewed provide for structured inventories of parent factors on the level of the individual as well as child characteristics and family interactions at the level of the microsystem, with support present in the exosystem also measured. They also reviewed measures of factors at the individual level including measurement of parenting skills through analogue parenting tasks and identification of child-management skills, measurement of anger arousal and control in child-management situations, and measurements of parenting attitudes, beliefs, and problem solving skills. Assessment tools for the microsystem which were reviewed included observational measures of stimulation by mothers and observational measures of affectionate behaviors between parents and infants during their interaction. Tools for assessing the exosystem were examined. These measures focus on the availability, the function, and the nature of contacts and the type of support provided in families' social support systems. According to this review, there are psychometrically promising means available to assess abusive families from a developmental ecological systems perspective (Hansen & MacMillan, 1990).

The goal of child welfare policy in the United States since the 1980s has been to prevent the removal of children from their own homes whenever possible. If children must be removed from their homes for their safety, the next priority is to return them from substitute care

as soon as is safely possible (Stein & Rzepnicki, 1984). Permanency planning (Howe, 1983) is the catchword for a general response adopted by child welfare services to decrease the amount of time children spend in temporary foster care. This approach includes requiring early consideration of long-term plans as well as examination of alternatives and development of time-limited casework plans to achieve appropriate placement in a timely manner, using legal avenues when necessary and reviewing progress on the plan regularly. Howe (1983) emphasized that whether permanency planning for abused children in foster care is to result in returning a child to the family of origin or finalizing placement outside the family of origin, multiple levels of systems should be evaluated and the interactionist nature of systems taken into account. He argued that ignoring these factors will lead to the development of inaccurate plans and placements. For example, using time-limited service agreements with parents may not increase parental motivation if the caseworkers fail to include parents in the development of these plans, thereby creating a power struggle between the microsystem of the family and the the service provider in the exosystem. Likewise, neglect to accurately take into account pressures from the exosystem, such as employment demands on parents, could negatively impact parents' motivation. They may simply give up when faced with deadlines that are unrealistic because the caseworker did not acknowledge the limitations imposed by such factors. Howe notes, "service interventions must be assessed within the interactional context of the case; client motivation must be viewed in interactionist terms, with a client's hopelessness and depression seen as defined by 'person

in treatment' rather than simple personality issues" (Howe, 1983, p.296). An accurate interactionist perspective does include individual level personality variables as a part of the full picture.

Intervention programs have been designed to meet the goals of preventing placement outside of families and reuniting families. Examples of such programs are presented below. Each takes action on multiple ecological levels and takes advantage of the systems property of mutual influence of factors at different levels, recognizing the possibility that development can be redirected in a positive direction for abuser, victim, and the abusive family as a whole.

Multilevel Program Descriptions

The creators of the Child Abuse Project of Sinai Hospital in Maryland were early advocates of intervention on multiple ecological levels (Barnes, Chabon, & Hertzberg, 1974). Their team treatment approach recognized abuse as a symptom, with abusive families often having lives like those of other seriously dysfunctional multiproblem families. In order to address these multiple problems, assistance for abusive families in this program begins with identifying the particular problems facing each family and designing interventions to ameliorate these problems. A possible target of intervention is "environmental stress" at the the level of the exosystem, addressed by providing assistance for such things as financial, housing, and child care needs. Psychological and organic factors at the level of the individual are also targeted for intervention, with provision of therapy, education, and medical treatment for abusive parents when appropriate. Interventions in subsystems of the microsystem of the family include

therapy for the abused child and marital therapy for the parents.

A member of a hospital-based child abuse and neglect team provided guidelines for similar teams charged with developing treatment plans for families whose maltreatment has led to the hospitalization of the injured child (Heap, 1982). She advocated a psychosocial inquiry to identify and then address problem areas at the following levels: (a) individual, factors in parents' backgrounds predisposing to abuse or difficult relationships with children; (b) microsystem, destructive interaction between marital and parent-child relationships or family interaction; (c) exosystem, the present crisis (e.g., unemployment) and its influence on the family's situation.

Wodarski (1981) designed a comprehensive treatment program to cover a wider area of dysfunction than traditional treatments. The author noted that the program is designed to provide treatment that takes into account psychopathological, sociological, social-situational, family systems, and social learning models of abuse. The first eight weeks of the program address training in child management, alleviating parental deficits at the level of the individual in order to improve functioning of the microsystem. The second eight weeks target enrichment of the parents' marriage, one subsystem of the microsystem. The final eight weeks provide enrichment of vocational and interpersonal skills. The goal of this segment is to improve interaction with the exosystem, thus providing the family with social support. This goal is met by addressing individual level deficits of the parents. This program is a good example of multilevel interventions implemented with the expectation that improvements at one ecological level will interact with

other levels to promote improvements in those systems as well.

Project 12-Ways, sponsored by the Rehabilitation Institute at Southern Illinois University at Carbondale, offers a variety of services to abusive families to prevent recurrence of abuse (Project 12-Ways, 1981). Services provided at the level of the individual abusive parents include training in reduction of stress, training in self-control and assertiveness, and counseling to address alcohol abuse. Services for the microsystem of the family include counseling for marital problems, training in basic skills for children, developing leisure skills for the family, counseling on health maintenance and nutrition for the family, and assisting in making the home physically safe. Services provided to improve functioning in the exosystem are training for job placement, building social support, and providing behavior management consultation for the community institutions where abused children may need extra help (e.g. foster homes, day care centers, mental health services).

Holliday and Cronin (1990) described a time-limited, intensive, home-based program called Families First. This family preservation program provides in-home services to families for up to 20 hours a week over a four- to six-week period. Using a crisis intervention and family education model the treatment focuses on building family strengths at the microsystem level by addressing individual level issues and deficits of parents through providing counseling and education, training alternative parenting techniques, and teaching household management skills. Money is available to provide for needs such as food, utilities, clothing, and medical care. Program providers' advocacy with

community resources targets growth in exosystem support.

The programs described above are just some of many expressly designed to address abuse from multiple ecological levels. In The Child Protection Team Handbook (Schmitt, 1978), the members of the University of Colorado Medical Center child protection team laid out guidelines for assessment and treatment planning based on over 20 years of practice dealing with child abuse and neglect. Their suggested "master problem list" to be used in examination of each case lists the following factors identified here by the ecological level represented (Grosz & Beezley, 1978). Problems to address on the individual level are emotional problems of the mother and emotional problems of the father. Problems in the microsystem to be examined are marital problems, emotional and developmental problems of the child, emotional and developmental problems of the siblings and parent-child interaction. Problems in the exosystem are listed under the category of environmental problems. Finally, in recognition of the property of systems in which the whole is greater than the sum of the parts, an integrative category asks for assessment of the safety of the home. The team must combine the information listed above to decide whether the abused child can be safely maintained in the home at this point in time.

Thus, the idea of using intervention on multiple levels to treat abusive families is accepted by many practitioners. Evaluations of programs suggest that intervention on multiple levels is necessary for successful treatment of multiproblem abusive families.

Evaluations of Multilevel Treatments for Child Abuse

The Parents and Children Together (PACT) program of Wayne State

University in Detroit was expressly designed to prevent recurrence of abuse. A major goal of the project is to allow abusive families to maintain or regain custody of their children, decreasing foster placement of abused children (Van Meter, 1986). Citing Belsky's (1980) ecological perspective on abuse, the designers of PACT address problems in the exosystem, such as finding housing, increasing cooperation with the child's school, or getting emergency utility consideration; in the microsystem, by addressing family interaction; and at the level of the individual, by teaching parents new child management skills. This intense treatment program averages eight to nine months of service to each family. Effectiveness of the program has been measured by "calculating the cost of foster care avoided or the early return of children from foster care and subtracting the cost of the program expenditures" (Van Meter, 1986, p. 82). In fiscal year 1984-85 the savings to the county served amounted to approximately one million dollars. Although specific data were not given, the author indicated that 3- and 6-month follow-up of families showed that gains in parenting skills and attitudes are maintained over this length of time, allowing parents to maintain custody of their children.

A study by Wolfe and colleagues (Wolfe, Sandler, & Kaufman, 1981) demonstrated that the combination of a competency-based parent training program and provision of community services and/or monitoring of child safety was more effective at improving child behavior problems, parent-child interaction, and caseworkers' ratings of family treatment needs than provision of community services and/or monitoring of child safety alone. Their eight-week program included group and in-home training in

problem solving, child-management techniques, and self-control. Each of these interventions were delivered at the level of the individual to remedy deficits of abusive parents. The outcome measures showed improvement in functioning of the microsystem, made possible by parents' gains in individual functioning. Thus, the addition of a service at the level of the individual to services provided at the level of the exosystem improved the targeted variables in the microsystem.

In a controlled study of a similar program of behavior therapy with abusive families, investigators from Oregon found that some families were more responsive to treatment than others (Szykula & Fleischman, 1983). Specifically, the more stable, less problematic families in which abuse seemed the outgrowth of "failure to manage the child in an authoritative and supportive but nonabusive manner" (p.12) benefitted from the treatment which included training in parenting and training in cognitive self-control. As in the study by Wolfe and colleagues (1981) cited above, the intervention targeted deficits at the level of the individual in order to promote change in the microsystem. Children in the control condition received the usual mix of services arranged by caseworkers ranging from limited supervision to individual and family therapy in the community. In the "Less Difficult" group following treatment one of thirteen (8%) social learning training group and five of thirteen (38%) control children had to be removed from their homes to protect them from repeated maltreatment, a significantly better outcome for the treatment group. The "More Difficult" group included multiproblem families with such issues in the exosystem as serious problems with unemployment, problems in relationships with extended

family and community members, problems at the level of the individual of depression or extreme anger, and difficulties in the microsystem such as marital problems, in addition to the problems in parent-child interaction. In the More Difficult group seven of eleven (64%) of the social learning training group and five of eleven (45%) of the control children were removed from their homes to ensure their safety, not a significant difference between the two groups. The authors suggest that the numerically higher rate of removal from social learning training homes resulted from the closer supervision provided by the program. The results of the study make clear that for multiproblem families, intervention focused on problems at only one level may not be sufficient to prevent the recurrence of abuse.

Brunk, Henggeler, and Whelan (1987) made a direct comparison of parent training directed at individual deficits and multisystemic therapy directed at whatever combination of ecological levels therapists deemed deficient for identified families. Each treatment was provided to both abusive families and neglectful families in eight weekly sessions of one and a half hours each. Parent training was provided in groups averaging 7 parents from 5 families, while multisystemic therapy was delivered with each family separately at home or in the clinic. Thirty-three of the initial forty-four families involved completed pre and post measures as well as the full treatment program, with no significant difference in dropout rates between the two treatment modalities. Families receiving each treatment modality improved on measures of psychiatric symptomatology, stress, and individual and family problems. However, standardized observational measures of

parent-child interaction and multisystemic therapists' reports of microsystem interaction demonstrated greater improvements for the multisystemic treatment families. Parents receiving the multisystemic treatment increased their effectiveness in controlling children's behavior, and children showed less passive noncompliance. Parent training proved superior to multisystemic treatment only in decreasing report of social problems, most likely because the group setting of the parent training provided a social support group for these parents. The authors suggested that multisystemic therapy may have proved more successful because of its more flexible, multilevel, ecological and systemic approach. They also cautioned that the differences in treatment delivery may have been the cause of differential success rate.

For practitioners, these outcome studies suggest that the most appropriate approach to treatment for abusive families with problems on multiple ecological levels is to provide services designed to address the issues identified at each problematic level. This may be done by intervening directly at each level where there are difficulties or by strategically intervening at levels which can impact other problematic levels.

Consultation in Child Protection Decision-Making

Planners and providers of services for abusive families often seek consultation during the tasks of conceptualizing the causal and maintenance factors in a case of abuse and providing recommendations for treatment of the abusive family (Stein & Rzepnicki, 1984). Such consultation may take the form of formal case staffings, multidisciplinary team meetings, discussions with supervisors, and

conversations with colleagues (Child Welfare League of America, 1975; Schmitt, 1978a). Although one purpose of consultation may be to share the responsibility of errors, the consultee generally seeks an informed and objective response from the consultant which may support or raise relevant questions about possible courses of action (Schmitt, 1978b). In Virginia and many other states, one approved role for multidisciplinary teams based in hospitals and communities is to provide consultation on cases of child abuse to the Department of Social Services (Code of Virginia Chapter 12.1, 63.1-248.6). Though some such teams may assume case management responsibilities that exceed simple consultation (Bourne & Newberger, 1980), this study was designed to examine only the consultation stage. Also, though group dynamics and team structure may effect the communication received in team consultation settings (Bourne & Newberger, 1980; Smith & Hocking, 1981), the current study addressed only individual consultant's independent conceptualizations and recommendations for treatment. There are many possible obstacles which may interfere with a consultant's ability to provide the informed and objective response sought by the consultee. This study will examine two possible obstacles: the consultant's level of experience in the field of child protection and the consultee's framing of the case brought for consultation.

Consultant Experience as a Relevant Factor

Experience Makes No Difference?

Given the increased effectiveness of multilevel interventions with multiproblem families (Szykula & Fleischman, 1983) one might expect that consultants who have had more experience making recommendations for

treatment and receiving feedback about the effectiveness of such interventions would be increasingly likely to conceptualize multiproblem cases as such and to recommend multilevel interventions. However, some have argued that clinical judgment studies indicate that experience is not helpful in learning to make accurate judgments of diagnosis/case conceptualization and treatment (Goldberg, 1968, Brehmer, 1980).

Goldberg (1968) argues that clinical settings usually provide no realistic opportunities for clinicians to improve the accuracy of their predictions, and cites studies to back up his claim that experience doesn't lead to greater accuracy. He quotes B.F. Skinner (1968) who described the similar difficulty teachers have in learning from experience because, "They almost never learn about their long-term successes or failures, and their short-term effects are not easily traced to the practices from which they presumably arose." (pp.112-113, cited article p. 492) Goldberg asserts that conditions more conducive to learning would include some form of immediate feedback on links between cues used for decision-making and the outcome of treatment, the ability to control the order of cases so hypotheses can be tested immediately, and the tallying of results in an orderly manner. In short, the procedures associated with research rather than with practice promote effective learning (Goldberg, 1968).

Brehmer (1980) takes the argument further by noting that people are ill-equipped to learn from the disordered experience present in probabilistic situations where outcomes are multiply determined and outcomes may be affected by actions taken based on the judgments made. In learning from experience one must also define what, if anything,

there is to be learned. People tend to make decisions based on underlying assumptions of deterministic causality rather than of probability. Brehmer suggests that ignoring probability in making decisions may stem from lack of a cognitive schema for probabilistic prediction, as well as from the difficulty of observing all possible outcomes in everyday life.

Lowery (1985) noted that in some clinical judgment tasks, agreement in the field may be so pervasive that the level of clinicians' experience has no impact on the task. In her study of child custody evaluation criteria she found that clinicians with extensive experience in child custody evaluations and clinicians with no such experience showed no differences in their ratings of the importance of various criteria to determine child custody in a divorcing family. Studies of clinical judgment in analogue situations also suggest that experience may make little to no difference in the decisions made or the process of making those decisions.

Analogue studies of clinical judgment. Berven and Scofield (1980) used a computerized case management simulation task to examine the decision-making of rehabilitation counseling graduate students and experienced rehabilitation counselors. They found no differences between the groups on actions taken and order in which choices were made.

Oskamp (1965) found no difference in the ability of advanced undergraduate students, psychology graduate students, and practicing clinical psychologists in their ability to predict customary behavior patterns, attitudes, reactions, and interests of an individual from

written case study information. There was some overlap in experience level between the clinical psychologist and graduate students group, and group memberships were small and unequal (8, 18, and 6).

In another study with few subjects, Corcoran (1986) failed to find significant differences in the quality of nursing care plans made by 6 expert and 5 novice nurses for hypothetical cases of varying complexity. However, the decision strategies used by experts were different from those used by novices, and the author noted that had memory aids been used by the experts their decisions would have been better as several errors noted were incomplete plans which resulted from forgetting problems identified earlier in the decision process. Perhaps the picture is not as dismal as suggested.

Experience and clinical judgment in child abuse. Starr (1987) compared 23 health and mental health professionals, (mean of 14 years of experience working with abusive families), to 45 undergraduates from an introductory psychology class in their ability to identify abusive vs. nonabusive parent-child pairs in videotaped free play sessions. Neither the professionals or the undergraduates were able to correctly identify abuse status at greater than chance levels. Observations recorded by the professionals were not systematic. Most focused on the behavior of either parent or child, not on the interaction between them. There was thus little evidence of appreciation for a systemic perspective on child abuse or for learning from experience.

Stein and Rzepnicki (1984) reviewed several studies on protective service workers' decisions regarding whether or not to remove children from their homes when child abuse is discovered. They concluded that

most caseworkers base their decisions on ill-defined, idiosyncratic criteria. Experience does not appear to teach workers how to make reasonable, consistent decisions. These authors devised and successfully implemented a model for decision-making, showing that their training program made a difference in the way workers handled decisions about removing children from their homes following identification of abuse.

Experience Does Make a Difference

Studies of clinical and knowledge-based judgment. Not all investigators have failed to find benefits from experience in clinical judgment. As noted above, Corcoran (1986) found that more experienced nurses used decision strategies which differed from those used by novice nurses. The experienced nurses were able to interrelate data about sources of pain, treatments, and side effects of treatments, while novice nurses seemed to treat each pain-related problem as a separate, smaller chunk of information. Experienced nurses varied their overall approaches to cases based on the complexity of the cases, while novices did not, perhaps because the experts' chunking ability allowed them greater sensitivity to the demands of the task. It is also possible that the routine cases were simply more familiar to them, therefore less complex, while all cases were equally complex for the novices.

Murphy and Wright (1984) examined the structural differences among the concepts of psychological disturbances held by four groups of respondents with different levels of clinical experience. They compared supervisors, experienced counselors and beginning counselors at a treatment program for emotionally disturbed children, and undergraduates

with no clinical experience. Groups with more experience also had more related training. The number of attributes listed per each of three pre-established categories of psychological disturbance and the level of inter-rater agreement on category attributes increased with experience. Murphy and Wright noted that these experts and novices not only had different content in their categories but the categories of experts were less distinctive than those of novices. For example, experts listed "feels sad" and "feels angry" as characteristics for the depressive, aggressive, and disorganized categories while novices listed "feels sad" only for the depressive category and "feels angry" only for the aggressive category. The authors attributed this difference to the experts' ability to view seemingly disparate surface features as linked together by deeper structures of theories of origins of psychological disturbances. In comparison, novices appeared to be categorizing disturbance only by the surface features.

Dawson, Zeitz, and Wright (1989) compared clinical experts' and clinical novices' personality descriptions, recall of behaviors, and predictions of responses for three target children described in 30 scenarios for each child. The scenarios were based on observations of children in a treatment program for emotionally disturbed children. The first target child (aggressive child) description was composed to be a realistic portrayal of an aggressive child in the setting. The second target child (inverse child) was composed to have the same type of responses as the aggressive child, with responses given to inverse antecedents, i.e. being aggressive when the aggressive child would be most compliant and compliant when the aggressive child would be most

aggressive. The third target child (random child) was composed to have the same types of responses randomly assigned to antecedents. Results indicated that experts' personality descriptions of the aggressive child were more accurate than novices'; experts' recall of behaviors was organized around antecedents, while novices did not show any particular pattern of organization of behaviors recalled; and experts' predictions about children's type of behaviors in response to particular types of antecedents were more accurate than novices' for the aggressive and inverse children but not for the random child. Further analyses suggested that experts' superior performances were based on experts' abstract categorization of information on the children, not on their recall of specific data. There were no differences between experts and novices in the amount of specific data recalled. Thus, experts appeared to have information-processing strategies that facilitated their performance. The authors argued that underlying theories about psychopathology allowed experts to encode information at a more abstract level than novices, accounting for the differences in performance. They noted that the ability to recognize patterns of antecedent-behavior links is crucial to clinicians in the process of conceptualizing cases and making appropriate treatment plans.

Hardiman, Dufresne, and Mestre (1989) demonstrated that novices and experts in solving physics mechanics problems differed in their categorization of problems. Experts relied more on deep structures, considering the underlying principles involved in the situation, while novices relied more on surface features of the problems. Those novices who attempted to use principles more often made categorizations more

similar to experts' and were more successful at problem solving than their peers who relied more on surface features. Thus, results in this structured problem-solving domain were similar to those in the social/clinical domain investigated in the studies cited above.

Lurigio and Carroll (1985) examined the organization of information about offenders in experienced probation officers (3 or more years of experience) and inexperienced (less than 3 years of experience) probation officers (POs). They found that experienced POs had fewer and more developed schemata of criminal types than inexperienced POs. A second study demonstrated that other POs' construction of criminal types from elements provided were significantly more consistent with the schemata than were descriptions constructed by clerical staff from the probation office. POs had better developed schemata for those criminal types they had directly experienced in their case loads. Given the task of making predictions for cases presented, experienced POs responded more quickly, confidently, and consistently to schematic cases than to either mixed schemata cases or real cases. Clerical staff showed none of these differences. The authors noted the advantage of schemata in allowing a higher level of efficiency and accuracy for more experienced POs, although inaccurate or incorrectly applied schemata may lead to erroneous decisions. They also noted that the experienced POs knew more about criminal types than the inexperienced POs, and eliminated their use of some useless stereotypes held by inexperienced POs. Again in this social knowledge domain, experience makes a positive difference in decision-making ability by promoting the formation of deeper structures.

Fiedler (1950) compared the early therapeutic relationships with

patients formed by therapists from three different theoretical backgrounds. Subjects were five expert therapists (defined by their national or local reputation as experts) and five nonexpert therapists, with each theoretical background represented in both the expert and nonexpert groups. Although length of experience was not used as the criterion for expertise, the mean number of years of experience for experts was 12.4 (range 5-25) while for nonexperts the mean was 2.4 years (range 1-3). Judges' ratings of one audiotaped session between the sixth and seventeenth treatment hour for each therapist were used as basis of comparisons. Experts' relationships with patients were more similar to the Therapeutic Ideal than were nonexperts'. In their relationships with patients, experts from different theoretical schools resembled each other more than they resembled nonexperts from the same schools. Expert therapists rated higher in their ability to communicate with, understand, and maintain rapport with their patients than nonexperts. Differing theoretical schools did make a difference in the status which therapists assumed toward patients. It appears that experience was a greater influence than training for these clinicians.

Lambert and Wertheimer (1988) found both relevant training and experience improved subjects' accuracy in diagnosing psychopathology from fictional case histories. They used subjects ranging in human service experience from no to 30,000 hours, and in education from undergraduate students with no more than an introductory class in psychology to graduate students in clinical psychology and paraprofessionals in clinical care at a mental health facility. The authors found that academic training led to improvements in accuracy

between no, low, and moderate levels of training. Experience led to improved performance only when it reached the moderate level (250-300,000 hours of experience). The authors suggested that their inclusion of lower levels of education and experience revealed influences obscured in earlier studies with a more restricted range of these variables.

Clavelle and Turner (1980) investigated the clinical decision-making process among trained paraprofessionals, social workers, and clinical psychologists by having subjects conduct simulated initial interviews using cards with patient information which could be chosen from labeled categories as the subjects wished. Periodically throughout the simulation, subjects were asked to make decisions on patients' need for medication, suicidality, and need for hospitalization. All subjects had experience with these types of decisions, with similar levels of experience across the different training groups. There was no greater consensus on decisions among professionals than among paraprofessionals. However, professionals, especially psychologists, were more confident of their decisions, though only when confidence was appropriate. Psychologists were also most systematic in their process of gathering information, and quickest to come to firm decisions. Thus, training may have been responsible for some differences in process of decision-making, though outcomes were comparable across training groups.

Baxter, Chodorkoff, and Underhill (1968) found advanced psychiatric residents less likely to admit emergency psychiatric patients to the hospital than first year residents, although once admitted the patients admitted by most residents were deemed appropriate for admission when

evaluated by ward residents. Haas, Malouf, and Mayerson (1988) found that on three of ten vignettes of ethical dilemmas, therapists with more years of experience dealt with the issues less actively. It was impossible to tell whether the difference was connected to differences in general professional ethics at the time more experienced clinicians were in training, or to lessons in cynicism they had learned through experience. Brown (1970) found that more experienced counselors had less favorable initial impressions of clients and were less satisfied with counseling outcomes than were less experienced counselors. These studies suggest that the lessons of clinical experience may not always be positive ones.

Experience and clinical decision making in child abuse. In examinations of mandated reporters' decision about whether or not to report a possible case of abuse or neglect, there is evidence that experience and training make a difference. Nightingale and Walker (1986) compared Head Start volunteers and employees with different levels of experience working in preschools, with and without experience being a parent, and with and without training in identifying and reporting maltreatment. Subjects rated the likelihood that they would identify and report cases which were described in written vignettes. They also indicated whether they had made such reports in the past. Trained reporters gave higher ratings of identification and likelihood of reporting abuse and neglect than reporters lacking specific training in identification and reporting of maltreatment. Trained reporters had identified and reported more cases of maltreatment in the past year. Also, reporters with more preschool work experience were more likely to

report the vignette cases and had identified more incidents of maltreatment during the past year. Education interacted with training such that untrained reporters with higher educational levels were less likely than untrained reporters with lower educational levels to identify or report abuse in the vignettes and less likely to have identified abuse during the past year. For more highly educated reporters who had received training, there was no difference in their response to the vignettes and the responses of less educated trained reporters. More highly educated trained reporters had made more reports in the past year than less educated trained reporters. Parenting experience made reporters with more preschool experience and reporters with training more likely to identify maltreatment than reporters with no parenting experience. Parents without prior training or preschool experience were less likely to say they would report the vignette incidents.

Deitrich-MacLean and Walden (1988) investigated the effect of experience on observers' ability to identify two abusive and two nonabusive mother-child dyads in videotaped teaching interactions. One abusive and one nonabusive dyad were obvious in status to a pilot group of graduate students, while one nonabusive and one abusive dyad were subtle, more difficult for the pilot group to identify. Fifty-two caseworkers with experience in protective services were divided into low (less than 36 months) and high (36 months or more) protective service experience groups. There were no significant differences in the ability of these groups to identify the abuse status of dyads. The child protection workers were accurate 76% of the time in distinguishing

abusive from non-abusive dyads. The investigators noted that a pilot study group of 10 clinical and developmental psychology graduate students was significantly less accurate than caseworkers in identifying abuse status of the two more subtle dyads. The investigators suggest that the teaching interaction they used may have provided more relevant interaction information than the free play interaction used by Starr (1987) cited above, which failed to lead to identification above chance levels for undergraduates or professionals.

In follow-up analyses, Walden, Grisaffe, and Deitrich-MacLean (1990) divided the child protection workers into groups with high (all judgments correct), moderate (3 of 4 judgments correct), and low (2 or less correct) accuracy. Accuracy was not related to education or total experience in child protection work. The experts observed more communication patterns, task-oriented behavior, and other-directed behavior than less accurate judges. The more accurate judges used more interactional as opposed to individual categories of observation. More accurate judges made more observations of abuse and used more categories of observations for abuse when the dyads were abusive, while identifying more favorable observations and categories of favorable observations for nonabuse when the dyads were nonabusive.

Thus, the evidence for influence of experience on clinical judgment is mixed. Even the few studies done in the specific realm of judgment concerning child abuse have mixed results. When decisions about treatment of abusive families are made with the help of a consultant, the experience level of the consultant is not the only factor which may influence decisions. The case presentation of the consultee may also

influence the conceptualization of and treatment recommendations provided for cases of child abuse.

Case Presentation as Framing

A consultant receives the basic facts of a case presented for consultation embedded within the consultee's case conceptualization. The presentation provides additional information about the basic case information. Explicitly or implicitly, the consultee indicates which types of information about the case are most important to the etiology of the abuse and most important to consider in making a treatment plan. This additional information about information has been labeled "framing" (Kahneman & Tversky, 1984). Asked to make a decision about a case, a consultant is using information presented within a particular frame. A possible outcome of framing is the biasing of the consultant in the direction of the perspective provided by the case presentation.

Smith and Hocking (1981) identified the danger inherent in mistakes made in case conceptualization for cases of abuse. They noted that when the formulation is derived from insufficient consideration of all relevant circumstances, new information may be disregarded or improperly weighted, with the bias becoming more pronounced through time. They cite, "one example of this was a case where the initial formulation attached high importance to the psychiatric condition of the mother with little weight being attached to the child's total needs and safety. When the mother's mental condition subsequently improved, insufficient attention was paid to reassessing the situation in respect of the child's needs and the child later died as a result of nonaccidental injury" (Smith & Hocking, 1981, p. 276). Simply requiring decision

makers to obtain all the relevant information, as listed in Grosz and Beezley's (1978) master problem checklist with a multilevel perspective as reviewed above, does not insure full use of information. Accurate decision-making depends on an accurate evaluation of information, regardless of the conceptual bias surrounding its presentation. Examining the effects of framing on conceptualization and recommendations is thus an important focus of the current study.

The Influence of Framing on Judgment

Basic studies of "risky choices", decisions which are made without advance knowledge of their outcomes, have demonstrated that different framing of identical information can lead decision-makers to make vastly different decisions (Kahneman & Tversky, 1984). By varying the descriptions surrounding choices about which approach to use in treating a hypothetical potentially fatal virus, Kahneman and Tversky demonstrated that people used the same mathematical information about effectiveness of the approaches to draw different conclusions about the best choice for treatment. Although the actuarial information was the same in both presentations, differences in framing the outcomes seemed to produce different psychological evaluations of the information, and thus different decisions. By phrasing the choices in terms of either lives lost or lives saved, the descriptions encouraged subjects to evaluate the same data from different perspectives. Several different means of providing such potentially biasing frames to recipients of information have been investigated and are briefly reviewed below.

Labeling

A very obvious frame is the explicit provision of a particular viewpoint by attaching a label to information provided. Fiske, Kinder, and Larter (1982) successfully biased students' evaluation of political systems by providing the label of "democratic" or "communist" government in the opening sentence of an article containing ambiguous information about the governing practices of an unfamiliar country. In two classic studies of labeling effects on clinical judgment, subjects were influenced in diagnoses given for an audiotaped interview with a man who was actually an actor reading lines scripted to reveal normal psychological functioning (Temerlin, 1968; Temerlin and Trousdale, 1969). Subjects listening to the tape included clinical psychologists, psychiatrists, law students, and graduate and undergraduate students in psychology. Before experimental subjects heard the tape, the comment was made by a prestigious confederate (whose professional identity was varied to be relevant for the subjects being addressed) that although the man on the tape appeared neurotic he was actually psychotic. Subjects exposed to the psychotic label were significantly more likely to diagnose mental illness (either psychosis, neurosis, or character disorder) than were control subjects who were either given no suggestion of mental illness or were given a suggestion of mental health.

Shushinsky and Wener (1975) played audiotapes of normal females to mental health workers and undergraduate students following a protocol similar to Temerlin's (1968). Experimental subjects were given the suggestion of mental illness. The authors found that both mental health workers and students were biased in their ratings when given the label,

but students were biased only when a relevant prestige figure, a college professor, was the source of the label. When the label was provided to students by an unidentified "Dr. R." they were not affected by labeling bias. Shushinsky and Werner argued that the mental health workers found Dr. R. a relevant prestige figure in their hospital setting, while students did not.

DiNardo (1975) also found that the identity of the prestige figure determined whether or not labels provided by the prestige figure influenced experimental subjects' ratings of audiotapes scripted for normal psychological functioning. Graduate students in clinical psychology gave higher pathology ratings than controls who received no labels when the prestige figures were psychiatrists, but not when they were psychologists. DiNardo also varied the social status of the tape recorded interviewees, the effects of this manipulation will be discussed in the section below reviewing demographic framing.

Langer and Abelson (1974) found that traditional therapists described a videotaped interviewee as significantly more disturbed when he was labeled "patient" than when he was labeled "job applicant". By varying only one adjective in a list of descriptors given to undergraduates interviewing other students for 10, 20, or 30 minutes, Huguenard, Sager, and Ferguson (1970) significantly affected interviewers' after-interview ratings of interviewees in simulated employment interviews. The randomly assigned student interviewers were given standard computerized printouts said to be the results of personality assessment of the interviewees. Those interviewers with the adjective "warm" in their 7 adjective list rated interviewees

significantly higher on warm-related words and lower on neutral words than students given the adjective "cold" in place of "warm". Gordon (1976) examined clinical psychology graduate students' diagnoses of abbreviated constructed Rorschach protocols in a small group setting. He compared responses which were reported orally after hearing the evaluations of low and high status confederates and responses which were reported orally before hearing the confederates' responses. The subjects' evaluations were influenced in the direction of confederates' diagnoses despite the fact that 24 of the 30 subjects were at least partially aware that examining compliance with others' ratings was the purpose of the study.

Order

The order in which information is presented is another means of biasing recipients' judgments about identical information. This "anchoring" effect has been demonstrated in clinical judgment, where clinicians exposed to symptoms in different orders in therapeutic analogues arrived at different estimates of psychopathology (Friedlander & Stockman, 1983).

Overshadowing

Framing is information about information. Some types of information may change the evaluation of other information through a phenomenon labeled overshadowing. For example, Reiss, Levitan, and Szyszko (1982) noted that the highly salient feature of intellectual subnormality may distort evaluators' perception of emotional disturbances in those who are mentally retarded. They demonstrated the existence of diagnostic overshadowing for both alcoholism and mental

retardation. In their study, psychologists gave diagnoses and ratings of problems for case descriptions suggesting phobia. One group of raters was given the suggestion that the phobic individual was mentally retarded, another group was given the suggestion that the individual was alcoholic, and a control group was given the suggestion that the phobic individual was of average intelligence. For both the alcoholic and mentally retarded cases psychologists were less likely to diagnose phobia than for the average intelligence case. Mentally retarded cases were rated as significantly less neurotic and psychotic than either the control or alcoholic cases. A follow-up study indicated that case descriptions of schizophrenia and avoidant personality disorder presented with suggestions of mental retardation were rated by practicing clinical and school psychologists as significantly less likely to be examples of schizophrenia, psychosis, an emotional disturbance, a personality disorder, a thought disorder or to need long-term psychotherapy than when the same cases were presented with a suggestion of average intelligence (Reiss, Levatan, & Szyszko, 1982). Reiss and Szyszko (1983) replicated these results using the schizophrenic case description with psychologists varying in experience with mentally retarded people. The overshadowing phenomenon clearly produces errors in diagnostic judgment, as the presence of one problem does not preclude the existence of another. Somewhat more controversial is the effect that information about demographic factors have on judgment.

Demographic Framing

Information about social class, race, and income has been

investigated for the influence it has on decision-makers. As reviewed below, at times such information appears to influence actual and analogue decisions, and at times it does not. Beyond the scope of this review is the question of whether the influence of demographic information is a source of error or an accurate reflection of actual differences in groups varying on these factors.

Analogue studies. In DiNardo's (1975) investigation of labeling effects described above, he provided two different audiotapes for graduate students in clinical psychology to rate. Both tapes portrayed interviews with an actor scripted to portray a psychologically healthy man. However, the actor varied his articulation, intonation, and language to portray a middle-class man in one tape and a lower-class man in the other. Prior to listening to the tape, subjects read a written history of the man which portrayed a history matching the social class of the tape they heard. Subjects who received the lower-class presentation gave significantly higher ratings for pathology of the interviewee than subjects who received the middle-class presentation.

Abramowitz and Dokecki (1977) reviewed clinical analogue studies which varied demographic factors and tested for effects on clinicians' judgments. They concluded that variations of patient race, sex, and values generally produced null or minimal influence of these manipulations on decision-making. However, socioeconomic status (SES) information more consistently produced effects on clinicians' psychological appraisals in analogue situations. The authors point out that the influence of SES may reflect effective environmental-cue utilization by clinicians who are aware of real differences in levels of

pathology present in different social classes.

Analogue studies concerning child abuse. In Nightingale and Walker's (1986) analogue study of Head Start personnel's identification and reporting of abuse, the family SES did not influence subjects' judgments of whether abuse had occurred or whether to report it. However, Head Start workers rated success with high SES families as more likely if the family had prior involvement with Child Protective Services (CPS) than if the high SES family had no prior CPS involvement. There was no such effect for prior CPS involvement in low SES families.

McPherson and Garcia (1983) examined the effects of patient socioeconomic status and familiarity with the patient on pediatricians' responses to a hypothetical emergency room report on a two year old boy brought to the emergency room with injuries suggestive of abuse. Pediatricians' judgments of abuse vs. accident-prone were not affected by SES. Pediatricians were less likely to report abuse and more likely to diagnose a child as accident-prone when the patient was described as having been seen since birth in the pediatrician's private practice rather than seen for the first time in the emergency room. The authors noted that SES and familiarity tend to be confounded in natural settings. They also found that physicians rated the problem (either abuse or accident-proneness) as more likely to be chronic for low SES patients than for high SES patients.

Natural setting studies. In an examination of determinants for decision to admit psychiatric emergency patients to the hospital or not, Baxter, Chodorkoff, and Underhill (1968) found that patient demographic variables of sex, age, race, and economic status had no effect. In

contrast, Kuhlman, Telintelo, and Winget (1982) found that the decision of whether to use physical restraints by a staff of predominantly white therapists with psychiatric emergency room patients was influenced by the race of the patient. The authors found a greater tendency to restrain black patients only in evolved restraint situations, where immediate restraint was not required. They observed that these were the more difficult restraint decisions where the patient was moderately disturbed, rather than mildly disturbed and clearly not in need of restraint nor severely disturbed and clearly in need of immediate restraint.

Natural setting studies concerning child abuse. Investigations into the determinants of decisions in child protection have yielded mixed results for the effect of demographic factors. Hampton and Newberger (1985) examined the reporting practices of hospital personnel responsible for reporting cases of child abuse and neglect of all types. For a year, a confidential monitoring of identification of abuse through use of an anonymous data form or WATS line enabled researchers to tally hospital staff's identification of abuse separately from hospital and agency reports to child protective services (CPS), which were used as comparisons. 805 children were identified as maltreated by this process. Hospital staff members' rates of identification of abuse and rates of reporting of abuse were compared. Safeguards were included to insure that the same children were not counted twice. Significant differences in patterns of reporting for different demographic groups were identified. 91% of identified Latino families were reported, 74% of identified black families were reported, and 61% of identified white

families were reported. Families in the two lowest income categories had the highest rates of reporting, 78% and 80%, while families with incomes over \$25,000 a year were reported in only 37% of cases. Degree of severity of injury was a statistically significant determinant of reporting only when income was excluded from the discriminant function analysis. Physical abuse was the second most likely form of maltreatment to be reported once identified, following sexual abuse. Still, 24% of identified physical abuse cases went unreported.

The influence of demographic factors in placement decisions for children removed from their homes due to maltreatment has been identified in two studies. Katz, Hampton, Newberger, Bowles, and Snyder (1986) reviewed hospital records of 185 suspected abused and neglected children. Children with physical injuries were more likely to be placed in out of home care if they were from poor (Medicaid-eligible) families, while children with non-physical injuries (produced by neglect) were more likely to be removed from their homes if their families were more affluent. The authors suggest "that physical injuries may more frequently be diagnosed as 'abuse' in poor families and more frequently characterized as 'accidents' in more affluent families. The fact that more affluent families are more likely to lose their children in cases of non-physical injury suggests that a negative evaluation is made of families who appear to neglect children despite adequate financial resources" (p.261).

Segal and Schwartz (1985) examined case files of 424 children in an emergency treatment center for abused and neglected children to determine which variables predicted discharge to their natural family

environment. Children coming into care from their natural family, spending shorter time in treatment, of younger age, and of black race were more likely to be discharged to their natural family. The authors suggest that the smaller number of substitute care placements for black children may have increased their probability of returning home.

Paluszny, Cullen, Funk, Liu, and Goodhand (1989) reviewed recommendations of hospital child protection team, the county Childrens' Services Board, and the court for 81 cases of children admitted to a pediatric ward for maltreatment. Although identifying that each agency focused on different criteria in making intervention recommendations, none of the agencies' final decisions were affected by race, sex, or economic status.

Thus, in analogue and natural setting studies of clinical judgment, including decisions about child abuse, demographic information provides a frame which is often, but not always, shown to have an effect on decisions.

A professional seeking consultation on a case of child abuse may frame the basic case information in several potentially biasing manners. The basic information may be presented in different orders which reflect its relative importance within the presenter's perspective, different suggested viewpoints or labels may be applied, different content may be viewed as salient and thus included, and different phrasing of information may reflect the perspective taken. With each of these factors demonstrating effects independently, we can expect that in combination they may have a biasing effect on the consultants receiving the framed information. The dimension of level of analysis within the

ecological model is relevant for the conceptualization of cases of child abuse (Belsky, 1980). That is, a consultee viewing child abuse only or predominantly from the individual level of analysis might present information regarding the case with the bias that the history and characteristics of the abusive parent are the most important factors. Another consultee adopting a more multilevel approach might present information concerning the same case from the viewpoint that individual, family, community, and cultural variables all need to be considered. It is these two frames which were evaluated in this study, investigating whether information framed in an individual level perspective leads to different conceptualization and recommendations than the same basic information presented from a multilevel perspective.

Interaction of Experience and Framing

The influence of framing on a consultant's decisions may depend on both the frame provided by the consultee and characteristics of the consultant. One important consultant variable is the level of relevant experience of the person receiving the potentially biasing information. Although persons more experienced with making judgments in the relevant subject area might be expected to be less influenced by biasing attempts based on their greater familiarity and assumed competency at the task, research results are mixed. In their comparison of political novices' and experts' recall for characteristics of the government of an unfamiliar country, Fiske and her colleagues found that novices were more strongly influenced by labeling than experts were. The experts actually showed a tendency to adopt a bias toward the opposite label from the one they had received (Fiske, Kinder, & Larter, 1982). The

researchers hypothesized that experts were able to process data both consistent with the label and data inconsistent with the label, while novices' evaluations were more limited, based only on data consistent with the label.

The opposite effect has also been demonstrated with diagnostic judgment, as some studies show experienced clinicians more affected by the framing than undergraduates without diagnostic experience. The order of presentation of pertinent information in written synopses of five treatment sessions had more influence on clinicians than undergraduates, with clinicians more likely to resist changing their earlier impressions in response to later information (Friedlander & Phillips, 1984).

Although initial results suggested that the effects of labeling might be more pronounced with clinicians of greater experience, manipulation of the relevance of the prestigious person providing the label to the subject group indicates that all experience levels are equally susceptible to the effects of labeling when the person providing the suggested viewpoint is equally salient (Sushinsky & Werner, 1975). Manipulation of the content variable of mental retardation has been demonstrated to be equally biasing to professionals with different levels of experience with mentally retarded populations (Reiss & Szyszko, 1983).

Doctors and nurses, who had group differences in type of training and personal backgrounds as well as type of experience, were affected by different factors in their decisions of whether or not to report abuse in an analogue study by O'Toole, Turbett, and Nalepka (1983).

Physicians were influenced by patient race and socioeconomic status as well as by severity of injury and family factors. Nurses from low SES backgrounds were affected by race of the parent, but nurses of high SES background were not. Younger nurses were influenced by SES of family but older nurses were not. Finally, nurses with no children were affected by parents' SES while nurses with children were not. Thus, there seems to be no simple rule for determining the interaction of framing and experience, despite the intuitive appeal of the supposition that those with more experience in the relevant field should be more able to remain objective in the face of biasing frames. This study examined the interaction of experience level and framing in conceptualization of and treatment recommendations for cases of child abuse.

Incoming Bias

A final factor to be acknowledged when investigating the process of decision-making is the possibility of individual decision-makers' incoming biases. Perhaps experience will not lead all to the same conclusions, because not all will evaluate the experience similarly due to biases they bring to the task or material at hand.

There is ample evidence that clinicians and others are affected by their biases which predate the decision situation. Lord, Ross, and Lepper (1979) offer evidence that incoming biases may overrule basic information. When presented statements and procedures that confirmed and disconfirmed their strongly held beliefs regarding capital punishment, advocates and opponents of capital punishment rated the studies agreeing with their beliefs as more convincing and shifted their

positions further in the direction already favored before presentation of articles. Borresen (1965) found that different counselors' diagnoses of their clients under both standard and random assignment of clients in a university counseling center showed different preferences for diagnostic categories. Bishop and Richards (1984) found that university counselors who described their theoretical orientation as humanistic judged their clients as more severely troubled educationally than did counselors who identified their orientation as cognitive. However, this difference in intake judgments did not effect predictions for length of treatment. Grosz and Grossman (1968) noted that five psychiatric residents showed idiosyncratic patterns of responding to a wide variety of clinical questions on standard forms for patients. These response sets included a high positive responder and a low responder. The low responder never recorded a higher incidence of positive findings than the high responder. Sandifer (1972) gave six psychiatrists the analogue task of determining treatment for six patients viewed in filmed diagnostic interviews. The psychiatrists' gave estimates of the percentage of all psychiatric patients they would refer to different courses of of treatment before they viewed the six patients in the study. Differences in their recommendations of psychotherapy for the study patients were best explained by their previously measured preference for psychotherapy for patients in general. Batson and Marz (1979) compared the impressions of trained therapist psychology graduate students and untrained undergraduates after the subjects conducted mock intake interviews with two confederate clients. The clients presented one relatively situational problem and one relatively dispositional

problem, based on attribution theory. Therapists were more dispositional in their diagnoses of clients' problems than were nontherapists, however both groups made more situational diagnoses for situational problems than for dispositional problems.

Batson, Jones, and Cochran (1979) found that undergraduates placed in the role of diagnosticians at a referral agency perceived subjects' problems as more person-oriented when they had person-oriented resources to share, and as more situation-oriented when they had situation-oriented resources in their referral bank. The investigators demonstrated that these differences were mediated by differences in subjects' perception of their helping role. They note that professionals may take the same biased view of their helping role and diagnose in line with the preponderance of person-oriented resources available in the community.

When information is presented within a frame, incoming bias of the decision-maker may interact with the frame in influencing decisions. Houts (1984) had psychodynamic, behavioral, and cognitive clinicians evaluate the prognosis for a client in a videotaped intake interview. Three different versions of the interview portrayed a female client who explained her presenting problems of fear of going on elevators from a behavioral, cognitive, or psychodynamic perspective. Psychodynamic clinicians were more pessimistic in prognoses across all three patient explanations than behavioral and cognitive clinicians who did not differ. Those psychodynamic clinicians who viewed the client giving a psychodynamic frame to basic information were less pessimistic than psychodynamic clinicians viewing the cognitive or behavioral frames.

Duehn and Mayadas (1976) found that behavioral therapists' descriptions of clients were not influenced by information on clients' socioeconomic status, but the descriptions of psychodynamically trained therapists were more negative for clients of lower SES (more dissimilar in status from the therapists). Langer and Abelson (1974) found similar results in their investigation of labeling described above. Behavior therapists did not vary their ratings of adjustment for a videotaped interview labeled job applicant vs. patient. Therapists from more traditional perspective rated adjustment lower when the interviewee was labeled a patient.

The preponderance of evidence indicates that decision-makers' incoming bias has a significant influence on their decisions. Thus, in any study of decision-making a measure incoming bias on relevant issues is necessary to allow for full interpretation of results. Such a measure was included in the current study.

Purpose of Current Study

In summary, previous research suggests that a multilevel approach is the most accurate and effective approach consultants can take to conceptualizing and treating multiproblem abusive families. Two important factors which may exert influence on consultants' conceptualization of cases of abuse and their treatment recommendations are the consultants' level of experience and the frame surrounding the case presented for consultation. This study examined the simple and interactive effects of the factors of level of consultant experience and case framing. To simplify interpretation of results, demographic information was held constant across case presentations. Consultants'

incoming bias was also measured to aid in interpretation of results.

Hypotheses

Main Effect for Level of Experience

As consultants' experience with child abuse cases increases, both conceptualizations and recommendations for the cases presented will reflect increased emphasis on levels above the individual level, as well as representing more levels. Ratings of importance of levels above the individual level to the development of abuse and of effectiveness of interventions above the individual level in helping the child to remain safely in his family will also increase with consultants' level of experience.

Main Effect for Framing

A main effect for framing will be demonstrated such that when cases are presented in an individual frame they will elicit a higher percentage of individual level responses, fewer levels of responses, as well as higher ratings of importance and effectiveness of individual level factors and interventions. When cases are presented in a multilevel frame they will elicit lower percentage of individual level responses, more levels of responses, as well as higher ratings of importance and effectiveness for microsystem, exosystem, and macrosystem level factors and interventions.

Interaction Between Level of Experience and Framing

The interaction between level of experience and framing will also be examined. To the extent that increased experience provides increased objectivity, the effects of framing will decrease as amount of experience increases.

METHOD

Subjects

Subjects were 40 professionals and volunteers in the area of child protection who reported experience making treatment plans for abusive families, 40 child protection professionals and volunteers who reported no experience with making treatment plans for abusive families, and 40 undergraduates who reported no direct experience with serving abusive families. The 80 child protection professionals and volunteers were recruited through their membership and presence at Multidisciplinary Teams on Child Abuse and Neglect (M.D. Teams) in southwest and central Virginia. They participated voluntarily, with the understanding that a report of the results of the study would be shared at an annual statewide MD Team meeting and in written reports to participating teams. The 40 undergraduate consultants were recruited from introductory psychology course and participated voluntarily, receiving extra course credit for their participation in the study. Demographic characteristics of consultants are listed in Table 1, with means, standard deviations, and ranges for each variable. Analyses of variance were conducted, followed by Newman-Keuls post hoc tests ($p < .05$) to locate differences amongst the groups on demographic measures. This statistical analysis indicated that there was no significant difference in age between the treatment planner group and the related experience group, while both groups were significantly older than the novice group $F(2,116) = 64.3, p < .001$. Likewise, there was no significant difference in number of children for consultants in the treatment planner and related experience group, while both these groups had significantly more

Table 1

Demographic Characteristics of Subjects

Variable	n ^a	M	SD	Minimum	Maximum
Age					
Treatment Planner	39	37.6	10.2	24	67
Related Experience	40	38.7	10.9	22	72
Novice	40	19.2	1.0	17	21
Number of Children					
Treatment Planner	40	1.3	1.3	0	4
Related Experience	40	1.7	1.6	0	9
Novice	40	0	0	0	0
Education (in Hollingshead level scores^b)					
Treatment Planner	40	6.4	0.6	5	7
Related Experience	40	5.8	0.8	4	7
Novice	40	5	0	0	0
Length of Involvement in Child Abuse and Neglect Concerns (in years)					
Treatment Planner	40	9.3	5.4	1	21
Related Experience	39	5.5	5.2	0	20
Novice	40	0	0	0	0
Child Abuse and Neglect Training (number of specific training experiences)					
Treatment Planner	40	7.1	2.2	2	11
Related Experience	40	4.4	2.2	0	9
Novice	40	.9	1.1	0	4

^aNumber of subjects out of 40 providing information on each variable.

^b4 = high school graduate, 5 = some college, 6 = 4 year college graduate, 7 = graduate degree completed (Hollingshead, 1975)

children than consultants in the novice group, $F(2,117) = 22.6, p < .001$. A t-test on Hollingshead occupational scores of treatment planners and related experience consultants found no significant difference between the two groups, see Table 2. Level of education, grouped into Hollingshead levels (Hollingshead, 1975), was significantly higher for the treatment planner group than for the related experience and novice group, while treatment planners and related experience consultants had significantly higher educational level than novices, $F(2,117) = 31.9, p < .001$. The length of time which consultants had been involved in child abuse and neglect concerns followed a similar pattern, with treatment planners having significantly more years of involvement than related experience consultants and novices, while related experience consultants had significantly longer involvement than novices, $F(2,116) = 45.8, p < .001$. Likewise, the amount of training in issues concerning child abuse and neglect was greatest for treatment planners, followed by related experience consultants, with novices having significantly less training than consultants in either of the experienced groups, $F(2,117) = 104.5, p < .001$.

A measure of incoming bias, consisting of four 7-point Likert-type scale items, assessed consultants' ratings of importance of individual, microsystem, exosystem, and macrosystem factors in causing physical abuse.

Table 2

Occupations and Hollingshead Occupational Scores for Treatment Planner and Related Experience Consultants

Occupation	Hollingshead Score	Treatment Planner	Related Experience
social worker	7	16	5
public administrator	8	8	11
counselor/therapist	6	3	1
registered nurse	8	2	4
probation officer	7	2	0
unemployed	use spouse's score	1	0
housewife	use spouse's score	1	4
extension agent/ home management advisor	6	1	2
physician	9	1	0
member of the clergy	8	1	4
secretary	6	1	2
bus driver	3	1	0
police officer	6	1	0
psychologist	9	0	1
volunteer	use spouse's score	0	1
teacher, secondary school	8	0	1
voc/ed counselor	7	0	1
sales, retail	6	0	1
no response	use spouse's score	0	1
	Mean Hollingshead Score	7.1	7.5

Analyses of variance of responses to these items demonstrated some reliable group differences, as seen in Table 3. Novices rated individual factors less important than did treatment planner and related experience consultants, who did not differ from each other, $F(2, 117) = 5.5, p < .01$. Likewise, novices rated exosystem factors less important than did treatment planner and related experience consultants, who did not differ from each other, $F(2, 117) = 9.6, p < .001$. Ratings of microsystem factors showed the same trend, but did not reach significance. A ratio measure of individual ratings to the sum of microsystem, exosystem, and macrosystem ratings showed a significant effect for experience, $F(2, 117) = 3.3, p < .05$, but post-hoc Newman Keuls tests failed to locate differences amongst means. Examination of the number of levels rated 5 or higher, indicating the rater felt that the level had a contribution to the development of abuse, showed no significant difference between groups, $F(2, 117) = 2.2, p > .10$.

A total of 153 subjects participated in the experimental task. Of these, 5 were not included in the analysis because they did not complete the entire task, 1 subject was an undergraduate intern attending MD Team meetings as part of her internship and was excluded because she did not fit clearly into any of the 3 categories, and 2 undergraduates were excluded from analysis because they reported experience serving abusive families. From the remaining subjects, 25 treatment planners were selected to be excluded from the analysis in order to maintain equal cell sizes as proposed in the initial experiment design. These subjects were selected randomly within each of the four different groups which varied in order of presentation of vignettes, maintaining a balance of

Table 3

**Consultants' Ratings of Importance of Factors at Each Ecological Level
Prior to Reading Vignettes**

Ecological Level Ratings	Experience Level					
	Treatment Planner		Related Experience		Novice	
	M	SD	M	SD	M	SD
Individual	6.1	0.99	6.1	0.88	5.4	1.64
Microsystem	6.0	1.01	6.0	1.01	5.5	1.18
Exosystem	6.0	0.97	6.0	0.89	5.1	1.18
Macrosystem	5.3	1.29	5.0	1.43	5.1	1.27
Number of Levels Rated ≥ 5	3.5	0.78	3.5	0.85	3.2	1.01
Ratio Measure Individual / Microsystem + Exosystem + Macrosystem	.36	.06	.37	.07	.34	.11

Note: n = 40 for each experience group

10 subjects from each group in the final sample. The decision to maintain equal cell sizes was based on concern to avoid the statistical complications of unbalanced analyses. The disadvantage of increased stringency of between-group comparisons when harmonic means are used in unbalanced analyses and post-hoc comparisons was judged to outweigh the advantage of increased power of within-group comparisons for the treatment planner group produced by larger group size. (Keppel, 1982).

Vignettes

Four vignettes describing hypothetical cases of physical abuse were constructed for use in the study. Two cases were each presented from two perspectives, one conceptualized at the individual level and a second conceptualized as multilevel. In order to maximize the verisimilitude of the vignettes while controlling for important content (maximizing external and internal validity as much as possible in this analogue design) vignettes were composed in the following manner. Case characteristics were chosen to allow multilevel conceptualization of both cases, with influences from all levels available within the content. The precipitating behavior of the children was chosen from Kadushin and Martin's (1981) tally of child behaviors leading to abuse, with both rated as occurring in approximately the same number of cases. Demographic characteristics of the families represent typical families of school-aged abused children, as described in a national sample of reported abuse (Russell & Trainor, 1984). Particular characteristics, such as living in a trailer park and having a husband in the Navy, were chosen as familiar to those working to treat and prevent child abuse in Virginia.

In order to maximize the similarity between the hypothetical vignettes and actual case summaries presented in the course of case staffings or consultation with coworkers, two Child Protective Services (CPS) workers who had discussed different biases in views of the importance of different factors to physical child abuse were recruited to write the vignettes in narrative form. The CPS workers were given the basic information for the two cases and instructed to write a narrative reflecting the bias, one more multilevel and one more individual, that they had expressed in self-report. The narratives were then edited to make them of similar length and comparable format, and to add an explicit statement of viewpoint to the individual frame vignettes reflecting ideas the CPS worker had expressed in interviews with the author. The case information, instructions, case summaries as written by the CPS workers, and the final, edited versions of the vignettes are presented in Appendix 1. Two graduate students in clinical psychology who were naive to the purposes of the study each reviewed both individual and multilevel presentations of a case. When asked to describe any differences noted in the presentations they correctly identified the individual and multilevel conceptualizations.

Procedure

The experiment was completed during meetings of Multidisciplinary Teams by 40 treatment planners and 37 consultants with related experience. A total of 11 M.D. teams from southwestern and central Virginia participated in the study, with group sizes ranging from 3 to 26 consultants, with a median size of 10. An additional 3 consultants with related experience were recruited from a twelfth M.D. team to

complete the cell, they each completed the questionnaire individually. Novice consultants completed the experiment in groups of about 10 to 15 consultants.

After signing letters of informed consent, MD Team members were given pieces of paper with the written question "Have you been responsible for determining what type(s) of treatment or services would be provided for a child abusing family? This could have been your individual responsibility or part of your task as a member of a team making treatment decisions." The positive or negative response to this question was used to assign each consultant to the treatment planner or related experience group, respectively. Undergraduates who indicated experience serving abusive families on an experience checklist were excluded from the study. Each consultant received a booklet containing: general instructions; a measure of incoming bias; two vignettes, one in each frame, counterbalanced for order and content within each subject group; open- and closed-ended measures following each vignette; forms for demographic information; and checklists for training, recommendations, and experience information. A sample booklet is presented in Appendix 2.

General instructions were presented in written form and read to all participants. The instructions asked consultants to complete the tasks in order, respond with their own opinions, and to refrain from consulting with others during the task, though noting that the examiner would answer any questions during the task. The first measure administered was an incoming bias scale which consisted of four 7-point Likert-type scale items on which consultants rated the importance of

individual, microsystem, exosystem, and macrosystem factors in causing physical abuse. Higher scores indicated greater importance.

Consultants were instructed to read the case summaries and answer the questions following them in order. Each vignette was immediately followed by open-ended questions asking what recommendations the subject would give to help meet the CPS goal of maintaining the child in the vignette safely in his family, and what factor(s) contributed to the development of abuse in the family. In order insure that varying availability of services in different locales would not unduly bias the results, consultants were instructed to give recommendations for services that were not available in their own community, but which they would recommend if available. Responses to the open-ended questions were coded for the ecological level(s) they tapped, following the scoring system presented in Appendix 3.

Two coders trained to over 90% reliability on coding of open-ended responses. Percentage of reliability was defined as number of agreements divided by number of agreements plus number of disagreements. Reliability checks were made on one fourth of the consultants' open-ended responses. Acceptability of agreement levels was evaluated by checking the mean agreement rating in each successive group of three consultants. In the eleventh reliability group, agreement between coders fell to an average of 57%, below the 75% agreement level set as criterion for continuation of coding without retraining. The coders retrained, rescored these three consultants, and continued coding with no further difficulty maintaining an acceptable level of agreement. The overall agreement of the coders was 92.8% for the reliability sample of

38, one fourth of the total respondents. Two outcome scores, number of levels represented and percentage of responses that were from the individual level, were calculated for recommendations and conceptualizations given in open-ended responses.

After responding to the open-ended questions, consultants rated 20 interventions on 7 point Likert-type scale items to indicate how helpful they felt each intervention would be in maintaining the child described in the vignette safely in his family. Higher scores indicated higher levels of estimated effectiveness. Consultants were also asked to indicate when they were unfamiliar with an intervention. Each intervention listed represented action in one or more ecological level(s). Summary effectiveness scores for each level were calculated by summing and averaging the effectiveness ratings given for each intervention tapping that level. Ratings for interventions which a subject indicated were unfamiliar were not included in the summary scores for that subject. A list of levels scored for each intervention is found in Appendix 4.

Following the effectiveness ratings, consultants were asked to rate the importance of eight factors to the development of the case of abuse presented in the vignette. Eight 7 point Likert-type scale items were used, with higher ratings indicating greater importance of the factor in the development of abuse. Each factor rated represented a conceptualization based on one ecological level, with each level represented by two factors. Summary importance scores for each level were calculated by summing and averaging the importance ratings given for the two factors representing that level.

Finally, participants were asked to provide demographic information and to complete checklists indicating the type and extent of training they had in the area of child abuse and neglect and identifying the types of recommendations and services they had provided for abusive families.

RESULTS

Open-Ended Responses

Two 3 between (Experience) x 2 within (Framing) analyses of variance were conducted in order to test the effects of child protection experience and type of framing on number of levels of recommendations and percentage of individual level recommendations given in the open-ended response format. Means and standard deviations of results are presented in Tables 4, 5, and 6. In these and subsequent analyses, analyses were followed by Newman-Keuls post-hoc tests ($p < .05$) where indicated to locate the differences in cell means.

Recommendations

A main effect for experience in child protection was observed for the number of levels of recommendations given in open-ended responses, $F(2,116) = 29.87, p < .001$. The number of levels of recommendations given by consultants increased with increasing amount of child protection experience. Thus, experienced treatment planners gave the highest number of levels of recommendations, followed by the related experience group, while novices, undergraduates with no child protection experience, gave the lowest number of levels of recommendations.

Conceptualizations

A main effect for framing was found in percentage of individual level responses provided in open-ended conceptualizations, $F(1,116) = 4.71, p < .05$. When cases were presented in an individual frame, conceptualizations had a higher percentage of individual level responses than when cases were presented in a multilevel frame.

Table 4

Means and Standard Deviations of Open-ended Responses Given by Consultants to Framed Cases of Child Abuse

Variable	Experience Level					
	Treatment Planner		Related Experience		Novice	
	M	SD	M	SD	M	SD
Conceptualizations ^a						
Number of Ecological Levels						
Individual Frame	2.7	0.57	2.5	0.68	2.2	0.88
Multilevel Frame	2.7	0.62	2.4	0.79	2.6	0.78
Percent Individual						
Individual Frame	42.1	18.80	44.7	20.66	47.2	30.29
Multilevel Frame	35.0	18.80	42.3	23.49	37.0	25.21
Recommendations ^b						
Number of Ecological Levels						
Individual Frame	2.9	0.53	2.3	0.77	2.0	0.69
Multilevel Frame	2.9	0.52	2.6	0.59	1.9	0.72
Percent Individual						
Individual Frame	28.8	18.02	36.9	28.27	26.2	28.44
Multilevel Frame	30.5	15.77	35.1	17.07	34.3	31.00

^an = 40 for treatment planner and novice groups, n = 39 for related experience group

^bn = 40 for treatment planner and related experience groups, n = 39 for novice group

Table 5

The Effect of Level of Child Protection Experience on Consultants' Open-Ended Responses

Variable	Experience Level			F(2,116)	p
	Treatment Planner	Related Experience	Novice		
Conceptualizations ^a					
Number of Ecological Levels					
M	2.7	2.4	2.4		
SD	0.59	0.73	0.85	2.53	<.09
Percent Individual					
M	38.5	43.5	42.1		
SD	19.00	22.00	28.15	0.96	>.38
Recommendations ^b					
Number of Ecological Levels					
M	2.9	2.4	2.0		
SD	0.52	0.71	0.70	29.87	<.001
Percent Individual					
M	29.6	36.0	30.3		
SD	16.84	23.22	29.83	1.52	>.22

^an = 40 for treatment planner and novice groups, n = 39 for related experience group

^bn = 40 for treatment planner and related experience groups, n = 39 for novice group

Table 6

The Effect of Case Framing on Consultants' Open-Ended Responses

Variable	Frame		F(1,116)	p
	Individual	Multilevel		
Conceptualizations				
Number of Ecological Levels				
M	2.4	2.6		
SD	0.74	0.73	1.81	>.18
Percent Individual				
M	44.7	38.1		
SD	23.40	22.66	4.71	<.04
Recommendations				
Number of Ecological Levels				
M	2.4	2.5		
SD	0.76	0.72	2.23	>.13
Percent Individual				
M	30.7	33.3		
SD	25.55	22.18	0.85	>.35

Note: N = 119, with each subject receiving both individual and multilevel frames

Closed-Ended Responses

A 3 between (experience) x 2 within (framing) multivariate analysis of variance (MANOVA) was conducted on the ratings of importance of the four levels of conceptualization. Another 3 between (experience) x 2 within (framing) MANOVA was conducted on the ratings of effectiveness of the four levels of intervention recommendations. The MANOVA on conceptualizations indicated a main effect for experience, $F(2, 117) = 16.52, p < .001$. The MANOVA on recommendations also indicated a main effect for experience, $F(2, 117) = 8.92, p < .001$. The significant univariate tests for each main effect in the MANOVAs are described below. Newman-Keuls post-hoc comparisons were used when indicated to locate differences among cell means ($p < .05$).

Recommendations

Main effects were found for consultants' level of experience in child protection for effectiveness ratings for three of the four ecological levels of recommended interventions which were rated for effectiveness. Results are presented in Tables 7, 8, and 9 and outlined below.

Individual Interventions

A main effect was found for experience, $F(2, 117) = 6.77, p < .005$. However, Newman-Keuls post-hoc tests failed to locate significant differences between cell means. Visual inspection suggests a trend similar to patterns described below such that novice consultants rated individual interventions less effective than did consultants with treatment recommendation experience and consultants with related child protection experience, who did not differ from each other.

Table 7

Means and Standard Deviations of Consultants' Ratings of Effectiveness of Interventions at Each Ecological Level for Framed Cases

Ecological Level	Experience Level					
	Treatment Planner		Related Experience		Novice	
	M	SD	M	SD	M	SD
Individual						
Individual Frame	5.3	0.90	5.5	0.87	4.9	0.95
Multilevel Frame	5.2	0.96	5.4	0.85	4.7	0.95
Microsystem						
Individual Frame	5.3	0.81	5.1	1.13	4.7	0.93
Multilevel Frame	5.1	1.01	5.2	0.75	4.6	0.75
Exosystem						
Individual Frame	5.7	0.78	5.7	1.02	4.8	1.04
Multilevel Frame	5.7	0.87	5.7	0.85	4.7	1.12
Macrosystem						
Individual Frame	4.5	1.45	4.7	1.34	4.4	1.15
Multilevel Frame	4.8	1.50	4.9	1.31	4.1	1.39

Note: n = 40 for each experience group

Table 8

The Effect of Level of Child Protection Experience on Consultants' Ratings of Effectiveness of Interventions at Each Ecological Level

Ecological Level	Experience Level			F(2,117)	p
	Treatment Planner	Related Experience	Novice		
Individual					
M	5.3	5.4	4.8		
SD	0.92	0.86	0.95	6.77	<.002
Microsystem					
M	5.2	5.2	4.6		
SD	0.92	0.95	0.84	6.71	<.002
Exosystem					
M	5.7	5.7	4.8		
SD	0.82	0.94	1.08	13.39	<.001
Macrosystem					
M	4.7	4.8	4.3		
SD	1.48	1.32	1.28	2.04	>.13

Note: n = 40 for each experience group

Table 9

The Effect of Framing on Consultants' Ratings of Effectiveness of Interventions at Each Ecological Level

Ecological Level	Frame		F (1,117)	p
	Individual	Multilevel		
Individual				
M	5.2	5.1		
SD	0.93	0.97	2.38	>.12
Microsystem				
M	5.0	5.0		
SD	1.00	0.89	0.88	>.34
Exosystem				
M	5.4	5.4		
SD	1.02	1.06	0.08	>.77
Macrosystem				
M	4.6	4.6		
SD	1.32	1.44	0.19	>.66

Note: N = 120, with each subject receiving both individual and multilevel frames

Microsystem Interventions

A main effect was found for experience, $F(2, 117) = 6.71, p < .005$, such that novice consultants rated microsystem interventions less effective than did consultants with treatment planning experience and consultants with related child protection experience, who did not differ from each other.

Exosystem Interventions

A main effect was found for experience, $F(2, 117) = 13.39, p < .001$, such that novice consultants rated exosystem interventions less effective than did treatment planners and consultants with related experience who did not differ from each other.

Conceptualizations

Main effects for consultants' level of child protection experience were found for all four ecological levels when they were rated for importance of factors contributing to the development of abuse. Results are presented in Tables 10, 11, 12 and outlined below.

Individual Factors

A main effect was found for experience $F(2, 117) = 4.10, p < .05$, for ratings of importance of individual level factors in development of abuse. However, Newman-Keuls post-hoc tests failed to locate significant differences among cell means. Visual inspection suggests a trend similar to those described below for the remaining levels, in which novice consultants rated the factors as less important in the development of abuse than either treatment planners or consultants with related experience, who did not differ from each other.

Table 10

Means and Standard Deviations of Consultants' Ratings of Importance of Factors at Each Ecological Level to the Development of Abuse in Framed Cases

Ecological Level	Experience Level					
	Treatment Planner		Related Experience		Novice	
	M	SD	M	SD	M	SD
Individual						
Individual Frame	5.9	1.10	6.3	0.97	5.6	1.35
Multilevel Frame	6.2	0.79	6.2	1.12	5.6	1.21
Microsystem						
Individual Frame	5.5	1.16	5.5	1.02	4.6	1.04
Multilevel Frame	5.6	1.16	5.3	1.13	4.6	0.99
Exosystem						
Individual Frame	5.8	1.01	5.7	0.88	5.3	1.14
Multilevel Frame	5.9	0.74	5.7	0.96	4.9	1.08
Macrosystem						
Individual Frame	4.3	1.32	4.4	1.47	3.2	1.29
Multilevel Frame	4.4	1.19	4.4	1.54	3.2	1.18

Note: n = 40 for each experience group

Table 11

The Effect of Experience on Consultants' Ratings of Importance of Factors at Each Ecological Level to the Development of Abuse

Ecological Level	Experience Level			F (2,117)	p
	Treatment Planner	Related Experience	Novice		
Individual					
M	6.0	6.2	5.6		
SD	0.96	1.04	1.27	4.10	<.02
Microsystem					
M	5.5	5.4	4.6		
SD	1.15	1.07	1.01	12.18	<.001
Exosystem					
M	5.8	5.7	5.1		
SD	0.87	0.91	1.12	7.63	<.001
Macrosystem					
M	4.3	4.4	3.2		
SD	1.25	1.5	1.23	12.09	<.001

Note: n = 40 for each experience group

Table 12

The Effect of Framing on Consultants' Ratings of Importance of Factors at Each Ecological Level to the Development of Abuse

Ecological Level	Frame		F(1,117)	p
	Individual	Multilevel		
Individual				
M	5.9	6.0		
SD	1.18	1.08	0.21	>.64
Microsystem				
M	5.2	5.2		
SD	1.15	1.17	0.01	>.38
Exosystem				
M	5.6	5.5		
SD	1.03	1.01	0.94	>.33
Macrosystem				
M	4.0	4.0		
SD	1.16	1.43	0.03	>.86

Note: N = 120, with each subject receiving both individual and multilevel frames

Microsystem Factors

A main effect was found for experience $F(2, 117) = 12.18, p < .001$, such that novice consultants rated microsystem factors less important in the development of abuse than did treatment planners and consultants with related experience, who did not differ from each other.

Exosystem Factors

A main effect was found for experience, $F(2, 117) = 7.63, p < .001$, such that novice consultants rated exosystem factors as less important in the development of abuse than did treatment planners and consultants with related experience, who did not differ from each other.

Macrosystem Factors

A main effect was found for experience, $F(2, 117) = 12.09, p < .001$, such that novice consultants rated macrosystem factors as less important in the development of abuse than did treatment planners and consultants with related experience, who did not differ from each other.

DISCUSSION

Abusive parents frequently develop their abusive behavior through the influence and interaction of factors from multiple ecological levels (Belsky, 1980). The most effective interventions for such abusive families involve intervention at multiple levels (Brunk, Henggeler, & Whelan, 1987; Szykula & Fleischman, 1983; Van Meter, 1986; Wolfe, Sandler, & Kaufman, 1981). Many factors may influence the responses of consultants asked to provide input into the understanding of and treatment recommendations for abusive families. Two important influences may be the child protection experience of the consultant and the frame within which the consultee presents the case. This study examined the influence of consultant experience and case framing on conceptualizations and recommendations for treatment given for hypothetical abusive families. It provides one of the first examinations of factors in consultations which may affect treatment planning for abusive families.

Experience

The amount of experience consultants had in addressing child abuse and neglect significantly affected their case conceptualizations and recommendations for treatment of abusive families. In open-ended responses, increased experience in the area of child protection led to greater number of levels represented in treatment recommendations, as hypothesized. When consultants generated treatment recommendations without assistance, consultants with treatment planning experience generated recommendations representing the greatest number of ecological levels, followed by consultants with related child protection

experience, while novice undergraduate consultants with no child protection experience generated recommendations representing the fewest number of ecological levels.

In contrast, when consultants used rating scales in the closed-ended response section of the study, there was no difference between the responses of the treatment planners and related experience consultants in recommendations or conceptualizations. Recommendations for microsystem and exosystem level interventions were rated more effective by consultants with child protection experience than by novices. While individual level intervention recommendations showed a main effect for experience, significant differences in cell means could not be located in post-hoc analyses. Visual inspection indicated a pattern of both experienced groups rating interventions higher than novices. In their ratings of conceptualizations, both groups of respondents with child protection experience rated microsystem, exosystem, and macrosystem factors higher in level of importance than did novices. Results were similar for individual level conceptualizations, but significant differences in cell means could not be identified through post-hoc analysis. A significant effect for experience was noted and visual inspection showed a similar pattern of experienced subjects giving higher ratings than novices.

Differences in Experience

In finding congruence of responses to closed-ended responses for both groups with experience addressing child abuse and neglect, it appears that multidisciplinary team exposure, for whatever length of time, has a significant impact. In this respect, the results of the

current study resemble those in a study by Deitrich-MacLean and Walden (1988). They failed to find group differences between professionals with wide differences in amount of time spent in child protective services, while finding significant differences between the CPS groups and graduate students. It may be that a little exposure to working on child abuse and neglect concerns goes a long way. A similar change in attitude with minimal experience was noted by Moffic et. al. (1983). They found that over the course of a year of training and experience in a multidisciplinary setting, social work students and psychiatric residents each moved closer to the norm of attitudes of their respective faculty members.

One reason this study found differences for level of experience within a group of people with child protection exposure while Deitrich-MacLean and Walden (1987, 1988) did not may be the differences in composition of experience levels in the groups studied. Deitrich-MacLean and Walden's entire child protective services worker sample, both high and low experience groups, would fall into the treatment planner group in this study. The related experience group is intermediate to their experienced and graduate student groups. An additional factor may be the nature of the task being examined. Supervision and consultation, relevant to the tasks of this study, continue in supervisory positions more likely to be held by treatment planners of long experience. However, direct client contact, more crucial to Deitrich-MacLean and Walden's variable of interest, does not continue in the supervisory and administrative positions held by some of their more experienced group. Thus, treatment planners' skills at consultation may continue to evolve,

while CPS workers of long tenure who move to administrative positions may get rusty in client observation skills.

Differences in Level of Task Structure

Another important area to examine is the difference in the effects of experience on the open-ended versus the closed-ended responses of consultants. The relatively unstructured open-ended task more closely resembles the actual process of case consultation observed by this researcher across a variety of treatment settings. As others have suggested (Dawson, Zeitz, & Wright, 1989), experience is most likely to show an effect in judgment situations closely resembling the usual tasks performed by those with more experience. The open-ended task required subjects to generate recommendations themselves, rather than to simply judge the effectiveness of recommended interventions. Although this study does not provide a means for testing schema content and structure, we can speculate that the open-ended task tapped into differences in schemata of treatment possibilities. Such differences may have resulted from differences in experience and training across the groups.

Schema research suggests that treatment planners would be expected to have easiest access to the greatest amount of stored information, followed by related experience subjects who would be expected to have less information and less ease of access, with novices likely to have the least amount of information as well as the greatest difficulty accessing it (Fiske, Kinder, & Larter, 1983; Murphy & Wright, 1984). Thus, on the open-ended task, related experience consultants may have had difficulty generating treatment recommendations, although they would agree with treatment planners that the same types of treatments would be

effective. Given the supportive structure of the lists of interventions to be rated, related experience consultants demonstrated their agreement with treatment planners by giving the same level of ratings of effectiveness. Novice consultants' lower ratings of effectiveness of interventions may indicate a difference in theoretical beliefs concerning the treatment of child abuse. The novices' lower ratings of importance of factors at different ecological levels to the development of abuse could reflect this same difference in theoretical beliefs.

Differences in Theoretical Beliefs

Importantly, the measure of incoming bias taken at the beginning of the task provides some support for such a difference in beliefs. Both treatment planner and related experience consultants rated individual and exosystem factors as significantly more important to the development of abuse than novices did, and microsystem factors as marginally more important than novices did. Macrosystem ratings were the only ecological level which failed to show a difference in incoming bias amongst groups.

Differences in Training

This study adds its weight to others suggesting that differences in training contribute to differences in performance of subjects with different levels of expertise (Lambert & Wertheimer, 1988; Murphy & Wright, 1984; and Stein & Rzepnicki, 1984). As noted above, the number of specific training experiences related to child abuse and neglect increased significantly with each level of experience. Beyond simple quantitative differences, treatment planners were more likely to have received protective service training, which includes specific

instruction in treatment planning, though the theoretical bias of this training was not examined in this study. The finding that consultants differing in training as well as in experience provide different responses evokes the results of an analogue study of professionals' diagnosis of child abuse (O'Toole, Turbett, & Nalepka, 1983). O'Toole and colleagues found that nurses and physicians received different training in causes and diagnosis of child abuse, and their diagnostic practice echoed these differences. Physicians, from a narrower training background, used fewer types of information in making diagnoses and sought less additional information than nurses, from a broader-based training background. However, as O'Toole, Turbett, and Nalepka noted, there were significant demographic differences as well as training and professional differences between the two groups they studied. In the current study, differences amongst all three groups of treatment planner, related experience, and novice consultants included amount of training in issues related to child abuse and neglect, length of involvement in child abuse and neglect concerns, and level of education. There were no significant demographic differences unrelated to profession between the two experienced groups. They did not differ in age, number of children, occupational level, or sex. The comparability of experienced groups gives additional support to the notion that training differences may have contributed to the differences in responses found between the treatment planners and consultants with related experiences.

Framing

Framing of cases of child abuse from individual and multilevel perspectives showed a significant effect on consultants' open-ended conceptualizations. Conceptualizations provided for cases presented in individual frames had a significantly larger percentage of individual responses than those presented in multilevel frame. The framing effect was found across all levels of consultant experience. As in a study by Sushinsky and Wener (1975), there was no difference in framing's influence for respondents with different levels of training and experience. Importantly, no effect for framing was found in consultants' closed-ended responses. Again, the structure of the closed-ended format may have served as a decision aid to consultants, causing them to consider options they may not have generated on their own in the open-ended task, and to rely less on their memories. Interestingly, Arkes (1981) recommended actively considering alternatives and minimizing the role of memory in clinical judgment in order to improve the accuracy of such judgment. Lord, Lepper, and Preston (1984) cited the advantage of considering the opposite as a corrective strategy for social judgment in general. The listing of items in the closed-ended response task, whether of potential contributors to development of abuse or of possible interventions for abuse, promotes these strategies.

Strohmer, Shivy, and Chiodo (1990) found that clinicians displayed selective memory for information presented to them about clients. Clinicians recalled more information which confirmed rather than disconfirmed a hypothesis they were asked to evaluate a week after

reading a report on a hypothetical client. The implicit hypotheses provided by the consultees' framing of cases might influence consultants' judgments in the same manner, causing them to recall information confirming the frames. This effect could be expected to be weakened by providing the a structured list of alternatives to consider.

If the frames in the current study had been provided by an especially salient prestige figure (DiNardo, 1975; Sushinsky & Wener, 1975), or if responses were made public (Gordon, 1976), there may have been stronger pressure to comply with the frames. In such circumstances, even the structured closed-ended responses may have been effected by framing. One of the limitations of this analogue study is that it does not include two factors, prestige and social pressure, which are inherent in any consultant situation. These factors are particularly likely to be intense in consultations with a team.

Another possible reason why more open-ended responses did not show main effects for framing is discussed below, the nonsignificant trend for interaction between frame and experience.

Interaction Between Framing and Experience

Although there were no significant interaction-effects, two interactions demonstrated a marginally significant trend, with a probability level falling between $p < .05$ and $p < .10$. For the number of ecological levels given in open-ended conceptualizations, when cases were presented in an individual frame, the number of levels represented in consultants' responses increased with increased experience in child protection. However, when cases were presented in a multilevel frame, treatment planners continued to give the highest number of ecological

levels in responses, but novices gave more than related experience consultants. This was due to the fact that novices increased the number of levels of responses they gave to cases in a multilevel frame, compared to cases in an individual frame. Thus, it appears that only novices were affected by framing in the number of levels represented in open-ended conceptualizations. For number of levels represented in open-ended recommendations, the number of levels increased with level of experience for both frames, but consultants with related experience showed an increase in number of levels given in multilevel frame, while novices and treatment planners did not. It appears that only consultants with related experience were affected by framing in the number of ecological levels provided in open-ended recommendations. Taken together, these results suggest that treatment planners are impacted slightly less by framing than are consultants with less experience. This would follow the results of Fiske, Kinder, and Larter (1982), who found that those with more experience were less likely to accept the frame provided. They suggest that more fully developed schemata allow experts to process information discrepant with the label as well as information consistent with it. In the current study, it is also likely that treatment planners have more experience evaluating framed material. They may have developed strategies or biases which protect them somewhat from the influence of framing. However, as indicated by the main effect for framing found on percent of individual level responses in open-ended conceptualizations, the treatment planner group was not immune to framing.

Limitations

Because this study is an analogue design, the extension of its findings to actual treatment planning consultations must be conducted with caution. As noted above, the dynamics of personality interaction, professional status and role competition, and peer group pressure for consensus may be active in actual consultations, but are not present in this study. Researchers have warned that the multidisciplinary group process provides perils for decision-making (Bourne & Newberger, 1980), and that groups develop their own idiosyncratic decision criteria (Paluszny, Cullen, Funk, Liu, & Goodhand, 1989). In contrast, Pfeiffer (1982) found in an analogue study that multidisciplinary team meetings actually reduced the number of errors in placement decisions for hypothetical special education students. Whether interpersonal interaction provides problems or corrective measures to the decision-making process, the current study cannot address the interpersonal aspects of consultation.

The novice group in this study was composed of undergraduate students who differed significantly from the experienced consultants in age and number of children. These demographic differences may have impacted the responses of the novices. The group did allow comparisons with other studies using undergraduates as an extreme experience group (eg. Dawson, Zeitz, & Wright, 1989), and was readily available at the time the study was conducted. Nonetheless, generalizing results from these novices to novices of the same age and life status as the experienced consultants is a bit risky. The novice group also had a different sex ratio than did the experienced groups, a limitation not

recognized until after data was collected and analyzed. In studies of decision-making in the area of child abuse and neglect where differences between responses of males and females have been found, sex was confounded with other variables such as occupation and education. The sex ratio was similar for the two experienced groups in this study. However, the difference in the sex distribution of the novice group is another limitation of the study.

Although this study grew out of a developmental ecological systems perspective of child abuse, the measures used do not allow the conclusion that in providing more multilevel ratings and rating the importance of several ecological levels higher than novices did, the experienced consultants in the study were endorsing the developmental ecological systems perspective. A simple conjunctive view of multiple factors contributing to abuse, without acknowledgment of developmental or systems characteristics, could underlie the same pattern of results.

Finally, the administration of the measure of incoming bias at the beginning of the study may have biased responses by sensitizing subjects to the variables being examined in the study (Solomon, 1949). If so, it is at least comforting to know that all consultants received the measure at the same point and had the same potential of becoming biased. The alternative of providing a control group with no incoming bias measure was not feasible due to logistical constraints.

Summary

This groundbreaking study of influences on conceptualizations and recommendations for treatment in cases of child abuse found extensive influence of level of consultant experience and some impact of framing

of case presentation. Consultants with experience in addressing concerns around child abuse and neglect gave more importance to factors above the ecological level of the individual in understanding abuse and treating it than did novices. Increasing experience led consultants to include more ecological levels in their recommendations for treatment. Framing influenced the conceptualizations of consultants at all levels of experience, and trends in interaction between framing and experience suggested that consultants with experience making treatment plans were less vulnerable to the effects of framing.

Implications for Practice

Open-ended tasks left consultants more vulnerable to the effects of framing, and created differences in recommendations given by the two groups of experienced consultants. An important implication of this finding is that providing structured guidelines or decision aids might improve the performance of consultants and others making treatment decisions.

This author adds her voice to those encouraging the use of decision aids for making decisions about the conceptualization and treatment of child abuse. Smith and Hocking (1981) suggested an index of concern to help teams evaluate level of danger for abused and neglected children. Grosz and Beezley (1978) provided guidelines for multidisciplinary teams in Colorado. Corcoran (1986) suggested that memory aids could eliminate decision errors made by experienced nurses. Adherence to guidelines would also address the class and race bias some have found in decisions concerning abuse and neglect (Hampton and Newberger, 1985).

Cosier and Dalton (1988) noted that the type of decision to be

made determines the most effective method of presenting information to the decision maker through decision aids. The first step is to decide whether conceptualizing the causes of abuse and planning treatment for abusive families is a high uncertainty, high information situation or a high uncertainty, low information situation - this probably varies with case. Cosier and Dalton suggest an expert system as an appropriate aid along with a devil's advocate (consider the opposite or alternatives) component for high uncertainty and high information situations. For high uncertainty and low information situations a dialectical inquiry, arguing opposing sides to uncover assumptions and make decisions, is suggested. They also propose the possibility of integrating computers into treatment decisions. Schwab, Bruce and Wilson (1990) developed a decision support system which provides a rank-ordered list of prospective out-of-home placements for a child by comparing an individual child to groups of children previously admitted to the facilities, and by providing workers with a list of characteristics of children at each facility. Such a decision support system does not give guidelines or make decisions, but provides easier and more reliable access to information than human memories do.

An expert system on a computer, as described by Mutschler (1990), uses a knowledge base and decision rules to make decisions. The first challenge in developing such a system for treatment planning is determining what are acceptable knowledge, practice, and policy in addressing child abuse. A caveat for anyone inspired to develop decision aids is the finding that if aids are not user friendly, or users do not feel they are useful, decision aids will be ignored by the

decision-makers (Sommerfeld & Hughes, 1987).

The results of this study suggest that, at least in Virginia, training and experience combine in improving child abuse decision-making performance. The need for training to develop skills for child abuse decision-making was identified by Levin (1983) as she found teachers failed to detect and report child abuse because they lacked the knowledge base to identify its occurrence. Nightingale and Walker (1986) found that training helped to overcome many impediments to adequate identification and reporting. Having general problem-solving skills is not enough, domain specific knowledge is necessary for effective problem solving (Bransford, Sherwood, Vye, & Rieser, 1986).

Implications for Theory

Results of the current study provide evidence for the applicability of a developmental ecological systems perspective in the examination of the systems involved in helping abusive families. The current study suggests that whether or not treatment planners and related experience consultants would describe their approach as a developmental ecological systems perspective, the responses given by more experienced, more highly trained consultants are more consistent with this perspective. One explanation for this is that treatment planners, and to a lesser extent, consultants with related experience, are part of the exosystem which interacts with the microsystems of abusive families. The changeable nature of open systems, combined with the circular interaction pattern between ecological levels and individuals within systems, may have combined to influence the experienced consultants to adopt a multilevel perspective and approach to treatment. Child

protective services training may have created or intensified this effect by impacting the development of individual treatment planners.

Likewise, the finding that consultees' framing of cases can impact the responses of consultants is an example of subsystems of the helping system affecting each other, as predicted by the developmental ecological systems perspective. The nested nature of the model is embodied in the trends suggesting that consultants with treatment planning experience, a factor at the ecological level of the individual in the helping microsystem subset of the exosystem, respond differently than consultants without such experience. Thus, outcome is determined by an interaction of individual ecological level factors and transactions with other subsystems. One of the limitations of the current study is the absence of actual microsystem level transactions such as those which would be present in a Multidisciplinary Team on Child Abuse and Neglect.

Thus, a developmental ecological systems perspective is useful not only for charting the development and maintenance of abuse, but for examining the systems designed to combat abuse. The current study also suggests that the Multidisciplinary Teams on Child Abuse and Neglect and the Child Protective Services of central and southwestern Virginia endorse the multilevel approach necessary to disrupt abusive families' homeostatic maintenance of abuse.

Further Questions

This study has identified group differences in decision-making performance of consultants varying in level of experience. It allows the general remark that increased training and experience tends to

improve performance on this decision task, however it does not allow location of individual differences or consideration of the influence of multiple factors which may be the basis of increased expertise. Results of other investigators suggest the need for future studies to address the relative contributions of specific training experiences (Moffic et al, 1983, O'Toole, Turbett, & Nalepka, 1983), profession (O'Toole, Turbett, & Nalepka, 1983), parental status (Corcoran, 1986, Nightingale & Walker 1986), caseload differences (Lurigio & Carroll, 1985), consultants' personal history of abuse (Trepper & Barrett, 1989), incoming bias (Houts, 1984), and personality (Pihl & Spiers, 1977). As Shanteau (1988) has said, identifying true experts should be done by the quality of their performance, not by the passing of some number of years of practice or completion of specific training. By examining the expertise of those within the experienced group (Walden, Grissafe, & Detrich-MacLean, 1990), we might better understand the processes leading to improved outcome. We would then be better prepared to train novices to become experts, as well as to rule out those who may not be trainable (Hardiman, Dufresne, & Mestre, 1989; Shanteau, 1988).

Resistance to framing is another individual difference to be examined further, especially given that although treatment planners were perhaps less susceptible to the effects of framing, they were not immune. Examining the same features listed above might prove profitable in understanding why some decision-makers are more resistant to the effects of framing than others.

The study of decision-making in the treatment of child abuse is still in its infancy. In choosing areas for investigation in the

future, it will be helpful to give high priority to areas that offer hope for improving these decisions. Equally important is the need to continue to define what constitutes good decisions in the area of child protection.

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APPENDIX 1

Instructions

Write case summaries in narrative form, including the information presented for each case. The case summaries should be written from the viewpoint of a caseworker who holds the view that the most important factors in these cases are the personal history and characteristics of the abusive parent (from the viewpoint of a caseworker who holds the view that family interactions, stress from the community, cultural/societal values, and the personal history and characteristics of the abuser are all important factors in these cases). Remarks in parentheses may be included or not, at your discretion, but all other information should appear somewhere in the summary, in your own words. The summary may contain comments about the information presented, but do not add any other information about the case.

CASE #1

Josh J., 7 year old male

INITIAL REPORT INFORMATION

*Reported by second grade teacher of child.

*When she questioned origin of bruises and cuts on face, child said his mother had hit him because he wet the bed.

*No previous record of abuse.

INVESTIGATION FINDINGS

*description of injuries: serious bruises and cuts on Josh's face, no other injuries

*identified abuser: Mother admits hitting Josh

*Precipitating event: Josh wetting the bed, a chronic problem, mother

angered at the time ("I've tried everything I can think of to get this kid to know that I'm serious about not wetting the bed.")

FAMILY MEMBERS

*Mrs. J., 26 years old, white, employed parttime at local fast food restaurant. Reports being abused as a child ("My mother used to hit me and I vowed I was not going to treat my kids that way.") Remorseful about abuse incident, indicates did not mean to hit Josh so hard.

*Mr. J., 28 years old, white, unemployed (laid off from local factory after family moved here when he got a job there 6 months ago). Not involved in abuse incident. Indicates wife takes responsibility for the children except when she is at work.

*Josh, 7 years old (described by teacher as a quiet, well-behaved child).

*Michael, 3 years old. (No evidence of abuse-related injuries)

ENVIRONMENTAL DESCRIPTORS

*moved to area 6 months ago, when father found employment at local factory

*no extended family or other social connections in the area

*live in trailer park (Mrs. J. complains the neighborhood is full of neighbors of the type she "wouldn't want my kids hanging around")

*(trailer is neat and well cared for)

PRESENT DISPOSITION OF CASE

*founded physical abuse

*no immediate danger to child

*goal of consultation - recommendations for services to support continued placement in home without further abuse

CASE #2

Mark M. , 8 year old white male

INITIAL REPORT INFORMATION

*Reported by third grade teacher of child

*When she asked for explanation of bruises and marks on arms and back he said his mother beat him for not staying with her in the grocery store.

*No previous record of abuse.

INVESTIGATION FINDINGS

*description of injuries: serious bruises and belt buckle marks on Michael's back and arms, no other injuries.

*identified abuser: Mother admits hitting Michael with a belt

*precipitating event: Michael walked away from Mother several times in grocery store after she had told him to stay beside her ("He kept leaving after I told him over and over to stay right beside me, I was really put out by the time we got done and got home.")

FAMILY MEMBERS

*Mrs. M., 25 years old, white, not currently employed. Day care too expensive to allow her to work. Reports being abused as a child ("My dad used to beat us"). Remorseful about incident, says did not realize the belt would hurt Michael so badly.

*Mr. M., 25 years old, white, Navy seaman. Currently at sea, due to return shortly from 6 months sea duty.

*Mark, 8 years old. (described by teacher as lively, average intelligence child)

*Stephen, 3 years old. (No evidence of abuse-related injuries)

ENVIRONMENTAL DESCRIPTORS

*have been in area about a year, since father assigned to local naval base

*live in small apartment near the base, base housing was not available (Mrs. M. complains, "They don't pay enough to live decent off-base, but there aren't enough spaces on base either.")

*no extended family or close friends in area

*(apartment neat and well-cared for)

PRESENT DISPOSITION OF CASE

*founded physical abuse

*no immediate danger to child

*goal of consultation - recommendations for services to support continued placement in home without further abuse

CHILD PROTECTION WORKERS' RESPONSES

Individual Frame - Josh J.

This case involves the founded abuse of 7 year old Josh J. at the hands of his mother Mrs. Jean J., age 26. The initial complaint was made by Josh's teacher. He was struck in the face resulting in cuts and bruises following his wetting the bed. Mrs. J. admitted the incident, explaining she was angry and frustrated because of the bed-wetting, a chronic problem for which other attempted solutions had failed. There is no information of other abusive incidents. Mrs. J. appeared remorseful and there is no indication of further risk to the child at this time.

Other family members are Josh's father, Mr. John J., age 28, and a 3 year old brother, Michael. We are not aware of their involvement in

any problematic behavior.

Mrs. J. reports being abused as a child by her mother, and identifies this as behavior she wishes to avoid.

The family is socially isolated having moved here only 6 months ago and without relatives or friends in the area. They live in a trailer park where Josh and Michael are restricted in their contacts with neighbors, most of whom Mrs. J. does not approve. Mr. J. is presently unemployed and Mrs. J. works at a fast food restaurant. The majority of child care responsibility falls to her, however he fills this role when she is at work.

Our staffing today is to develop a service plan aimed at preventing further abuse while maintaining this family's integrity.

Individual Frame - Mark M.

This case involves the founded abuse of 8 year old Mark M. at the hands of his mother Mrs. Mary M., age 25. He was struck on the arms and back with a belt, resulting in bruises and buckle marks. Mark's teacher made the initial report. Mrs. M. admitted the incident explaining she became angry with her son during a grocery shopping trip when he kept walking away from her in the store, despite her instructions not to. Mrs. M., who reports being abused as a child by her father, appeared remorseful over her behavior. There is no information of other abusive incidents, and Mark does not seem to be at further risk at this time.

Other family members are Mark's father, Mr. James M., a 25 year old seaman due to return soon from several months at sea, and his brother Stephen, age 3. We know of no problematic incidents involving either.

Though they have lived in this area about one year, this family has

developed no close friends, and there are no relatives here. They maintain a small apartment near the naval base, which Mrs. M. keeps neat and clean. She is unemployed and identifies insufficient income as a problem negatively impacting the quality of her family's life.

Our staffing today is to develop a service plan aimed at preventing further abuse while maintaining this family's integrity.

Multilevel Frame - Josh J.

Received report of possible physical abuse on Josh J., 7 year old white male from x school. The teacher questioned and he reported to her mom had hit him because of bed-wetting. The injuries include bruises and cuts to the face. The teacher (2nd grade) states no other indications of abuse have occurred/appeared in her class. Josh is further described as quiet and well behaved in class.

Mom admits in interview she struck Josh for the bed-wetting incident, apparently not the first. She seems very frustrated in knowing how to deal with the problem and seemed to be at the "end of her rope". Mrs. J. seems to be sorry for the incident saying she didn't mean to hit Josh so hard. A review of physical abuse definition was done during interview with Mrs. J.

Further interview with Mrs. J. reveals her being abused as a child, or at least being struck by her mother. She works part time at Big Fatty Corn Burgers and seems to have most of the child caring responsibilities on her as her husband Mr. J. doesn't seem to assist her with the children except when she is at work. Mrs. J. says she has no friends or acquaintances in the trailer park seeming to be very isolated. There are no relatives in the area.

Michael J. is 3 years old and displays no evidence of being abused. Mr. J. is 28 year old white male who is currently laid off from his factory job that he secured six months ago. This job dictated the family moving to the area. There appears to be organization in the home as the J. trailer is orderly.

Summary A very socially isolated, frustrated mother who seems to have heavy continuous child care responsibilities. This mother was quite probably abused herself and is continuing the abuse cycle by abusing her child. Loss of income is undoubtedly an additional stress on the family.

Multilevel Frame - Mark M.

Report from school received concerning possible abuse (physical) of Mark M., 8 year old white male. Mark's teacher (third grade) interviewed him briefly and was told by Mark that his mother beat him for straying away from her at the grocery store. Bruises and belt buckle marks on Mark's arms and back were observed by teacher and worker. No other apparent injuries and the teacher reports no other observations of or indicators of abuse previously. His teacher describes him as lively, of average intelligence.

Interview with mom reveals her admitting causing the marks on Mark, and she states Mark had walked away from Mrs. M. several times in the store. She had instructed him several times to not continue this and became quite angry by the time the shopping was completed.

Mrs. M. is sorry the abusive incident occurred and seemed surprised the belt would leave such marks. Mrs. M. stated her father "beat" her. She is unemployed and feels she cannot afford day care. Mrs. M. has

been in the area a short amount of time and appears isolated - no family or close friends in the area. Her husband Mr. M., 25 year old white Navy man is "at sea" and has been there 6 months. This would seem to further complicate Mrs. M.'s isolation, though he is due home shortly.

The family moved to the area as a result of Mr. M.'s assignment. Housing may be an additional stress as it is cramped and "off-base". The home reflects organization as it is neat and orderly. Stephen M., Mark's brother, is 3 years old. There seems to be no evidence of abuse of him.

Summary - a very isolated mother who acts as single parent much of the time because of her husband's service assignment. She was quite probably abused herself and is continuing the abuse cycle. Inadequate housing is a probable stress.

VIGNETTES IN FINAL FORM

Individual Frame - Josh J.

This case involves the physical abuse of 7 year old Josh J. at the hands of his mother Mrs. Jean J., age 26. The initial complaint was made by Josh's teacher. Josh was struck in the face resulting in cuts and bruises following his wetting the bed. Mrs. J. admitted the incident, explaining she was angry and frustrated because of the bed-wetting, a chronic problem for which other attempted solutions had failed. Part of Mrs. J.'s anger seems to be based on her perception of Josh's continued bed-wetting as a deliberate challenge to her authority. There is no information of other abusive incidents. Mrs. J. appeared remorseful and there is no indication of further risk to the child at this time.

Other family members are Josh's father, Mr. John J., age 28, and a 3 year old brother, Michael. We are not aware of their involvement in any problematic behavior.

Mrs. J. reports being abused as a child by her mother, and identifies this as behavior she wishes to avoid. The family is socially isolated having moved here only 6 months ago and without relatives or friends in the area. They live in a trailer park where Mrs. J. restricts her children's contact with most of the neighbors because she does not "approve of " them. Mr. J. is presently unemployed and Mrs. J. works at a fast food restaurant. The majority of child care responsibility falls to her, however he fills this role when she is at work.

In summary, in this case a mother abused in her own childhood has physically abused her child in an exaggerated attempt to control him at a time in her life when she has little control in other areas of her life. Our goal today is to develop a service plan aimed at preventing further abuse while maintaining this child in his family.

Individual Frame - Mark M.

This case involves the physical abuse of 8 year old Mark M. at the hands of his mother Mrs. Mary M., age 25. He was struck on the arms and back with a belt, resulting in bruises and buckle marks. Mark's teacher made the initial report. Mrs. M. admitted the incident explaining she became angry with her son during a grocery shopping trip when he kept walking away from her in the store, despite her instructions not to. Mrs. M., who reports being abused as a child by her father, appeared remorseful over her behavior. Her outburst seems to reflect an

overreaction to what she perceives as Mark's challenge to her authority. There is no information of other abusive incidents, and Mark does not seem to be at further risk at this time.

Other family members are Mark's father Mr. James M., a 25 year old seaman due to return soon from several months at sea, and Mark's brother Stephen, age 3. We know of no problematic incidents involving either.

Though they have lived in this area about one year, this family has developed no close friends, and there are no relatives here. They maintain a small apartment near the naval base, which Mrs. M. keeps neat and clean. She is unemployed and reports insufficient income prevents her from obtaining day care which would allow her to work.

In summary, this is a case where a mother abused in her own childhood has physically abused her son in an exaggerated attempt to control him at a time when she has little control in other areas of her life. Our goal today is to develop a service plan aimed at preventing further abuse while maintaining this child in his family.

Multilevel Frame - Josh J

The physical abuse of Josh J., 7 years old, was reported by his teacher. Josh reported to her that his mom had hit him because of bed-wetting. The injuries include bruises and cuts to the face. The teacher states no other indications of abuse have appeared in her class. Josh is further described as quiet and well behaved in class.

Josh's mom, Mrs. Jean J., admitted she struck Josh for the bed-wetting incident. She seemed very frustrated about not knowing how to deal with this recurrent problem and appeared to be at the "end of her rope". Mrs. J. seems to be sorry for the incident, saying she didn't

mean to hit Josh so hard.

Mrs. J. revealed she was abused as a child, or at least was struck by her mother. Mrs. J. works part time at a fast-food restaurant and seems to have most of the child caring responsibilities on her. Her husband Mr. J. doesn't assist her with the children except when she is at work. Mrs. J. is very isolated, with no friends or acquaintances in the trailer park where the J.'s have lived for the past 6 months. There are no relatives in the area.

The other child in the family, Michael J., is 3 years old and displays no evidence of being abused. Mr. J. is a 28 year old factory worker who is currently laid off from the job that dictated the family moving to this area. There appears to be organization in the home as the J. trailer is orderly.

In summary, this case of physical abuse involves a very socially isolated, frustrated mother who seems to have heavy continuous child care responsibilities. This mother was quite probably abused herself and is continuing the abuse cycle by abusing her child. Loss of income is undoubtedly an additional stress on the family. The case has been brought for consultation concerning measures to be taken to prevent further abuse while leaving this child in his home.

Multilevel Frame - Mark M.

The physical abuse of 8 year old Mark M. was reported by his teacher. She interviewed him briefly and he told her that his mother beat him for straying away from her at the grocery store. Mark had bruises and belt buckle marks on his arms and back. There were no other apparent injuries and the teacher reports no other observations of

or indicators of abuse previously. His teacher describes Mark as lively, of average intelligence.

Mark's mom, Mrs. Mary M. age 25, admitted causing the marks on her son. She stated that Mark had walked away from her several times in the store. She had instructed him several times not to continue this and became quite angry by the time the shopping was completed.

Mrs. M. is sorry the abusive incident occurred and seemed surprised the belt would leave such marks. Mrs. M. stated her father "beat" her. She is unemployed and feels she cannot afford day care. The M. family has only been in there area a year and appears isolated - no family or close friends in the area. Mark's father Mr. James M., a 25 year old Navy man is "at sea" and has been there 6 months. This would seem to further complicate Mrs. M.'s isolation, though he is due home shortly.

The family moved to the area as a result of Mr. M.'s assignment. Housing may be an additional stress as it is cramped and not on the naval base. The home reflects organization as it is neat and orderly. Stephen M., Mark's brother, is 3 years old. There is no evidence of abuse of him.

In summary, this case of physical abuse involves a very isolated mother who acts as a single parent much of the time because of her husband's service assignment. She was quite probably abused herself and is continuing the abuse cycle. Inadequate housing is a probable stress. The case has been brought for consultation concerning measures to be taken to prevent further abuse while leaving this child in his home.

APPENDIX 2

Have you been responsible for determining what type(s) of treatment or services would be provided for a child abusing family? This could have been your individual responsibility or part of your task as a member of a team making treatment decisions.

Circle the answer which describes your experience.

YES I have made treatment plans for at least one abusive family.

NO I have not made treatment plans for an abusive family.

GENERAL INSTRUCTIONS

Answer the following questions in order, do not look ahead to upcoming sections or go back to revise your answers to sections you have already completed.

Please answer with your own opinion, not what you think others would label as correct. We are interested in your individual thoughts, there are no right or wrong answers.

Please do not consult with others during the task, we want to know what you think as an individual.

If you have any questions during the task, feel free to ask the person administering the task.

YOUR VIEWPOINT ON THE FACTORS INVOLVED IN
PHYSICAL CHILD ABUSE

Indicate how important each of the factors listed below is to the development of physical child abuse by marking the point on the scale which matches your evaluation of importance.

1) Cultural values endorsing physical discipline of children and violence in general.

1	2	3	④	5	6	7
not important						very important

2) Stresses from community factors, such as isolation and unemployment.

1	2	3	4	5	⑥	7
not important						very important

3) Problems within the family, such as difficult children and maladaptive interactions among family members.

1	2	3	4	5	⑥	7
not important						very important

4) Personal history and characteristics of the abusive parent.

1	2	3	4	5	⑥	7
not important						very important

CASE SUMMARY INSTRUCTIONS

Please read the case summaries carefully, and answer the questions following each case before you proceed to the next.

Mark M.

The physical abuse of 8 year old Mark M. was reported by his teacher. She interviewed him briefly and he told her that his mother beat him for straying away from her at the grocery store. Mark had bruises and belt buckle marks on his arms and back. There were no other apparent injuries and the teacher reports no other observations of or indicators of abuse previously. His teacher describes Mark as lively, of average intelligence.

Mark's mom, Mrs. Mary M. age 25, admitted causing the marks on her son. She stated that Mark had walked away from her several times in the store. She had instructed him several times not to continue this and became quite angry by the time the shopping was completed.

Mrs. M. is sorry the abusive incident occurred and seemed surprised the belt would leave such marks. Mrs. M. stated her father "beat" her. She is unemployed and feels she cannot afford day care. The M. family has only been in the area a year and appears isolated - no family or close friends in the area. Mark's father Mr. James M., a 25 year old Navy man is "at sea" and has been there 6 months. This would seem to further complicate Mrs. M.'s isolation, though he is due home shortly.

The family moved to the area as a result of Mr. M.'s assignment. Housing may be an additional stress as it is cramped and not on the naval base. The home reflects organization as it is neat and orderly. Stephen M., Mark's brother, is 3 years old. There is no evidence of abuse of him.

In summary, this case of physical abuse involves a very isolated mother who acts as single parent much of the time because of her husband's service assignment. She was quite probably abused herself and is continuing the abuse cycle. Inadequate housing is a probable stress. The case has been brought for consultation concerning measures to be taken to prevent further abuse while leaving this child in his home.

What recommendation(s) would you make to help meet the Child Protective Services goal of maintaining this child safely in his own family?

Have mother go to counseling either group or individual.
 Parenting classes
 Help her get involved in community activities so she will not
 be so isolated
 Refer for day care services

If there are any recommendations you would like to make that are not available in your community, list them below.

~~At~~ No group parenting classes
 Not everyone is eligible for day care services

What factor(s) contributed to the development of abuse in this family?

possible abuse as a child
 heavy continuous child care responsibilities
 almost one-parent family with no support system

Indicate how helpful each of the interventions listed below would be in maintaining this child safely in his family by marking the point on the scale which matches your evaluation of effectiveness.

* If you are not familiar with a particular intervention please check the spot labeled "I don't know what this is."

1) Advocate to help family find housing, health care, financial support.

	1	2	3	4	5	6	(7)	
not helpful								very helpful
	I don't know what this is _____ .							

2) Anger control training for abusive parent.

	1	2	3	4	5	6	(7)	
not helpful								very helpful
	I don't know what this is _____ .							

3) Church groups willing to "adopt" a family.

	1	2	3	4	5	6	(7)	
not helpful								very helpful
	I don't know what this is _____ .							

4) Crisis day care.

	1	2	3	4	5	6	(7)	
not helpful								very helpful
	I don't know what this is _____ .							

5) Encouragement to reexamine the acceptability of physical punishment of the child.

	1	2	3	4	5	(6)	7	
not helpful								very helpful
	I don't know what this is _____ .							

6) Family therapy.

	1	2	3	4	5	(6)	7	
not helpful								very helpful
	I don't know what this is _____ .							

15) Parent support group.

	1	2	3	4	5	6	⑦
not helpful							very helpful
	I don't know what this is _____ .						

16) Parenting classes or training.

	1	2	3	4	5	6	⑦
not helpful							very helpful
	I don't know what this is _____ .						

17) Parent-child interaction training.

	1	2	3	4	5	⑥	7
not helpful							very helpful
	I don't know what this is _____ .						

18) Social skills training to help parents form social networks.

	1	2	3	4	5	⑥	7
not helpful							very helpful
	I don't know what this is _____ .						

19) Subsidized child care.

	1	2	3	4	5	⑥	7
not helpful							very helpful
	I don't know what this is _____ .						

20) Vocational counseling for parents.

	1	2	3	4	5	⑥	7
not helpful							very helpful
	I don't know what this is _____ .						

Indicate how important each of the factors listed below is to the development of this case of abuse by marking the point on the scale which matches your evaluation of importance.

1) Societal attitudes endorsing corporal punishment of children.

1	2	3	4	5	6	7
not important				(5)		very important

2) Lack of support from the community.

1	2	3	4	5	6	7
not important					(6)	very important

3) Interactions among family members.

1	2	3	4	5	6	7
not important					(6)	very important

4) Characteristics of the abusive parent.

1	2	3	4	5	6	7
not important					(6)	very important

5) The violent nature of American society.

1	2	3	4	5	6	7
not important				(5)		very important

6) Financial stress on the family.

1	2	3	4	5	6	7
not important					(6)	very important

7) Characteristics of the abused child.

1	2	3	4	5	6	7
not important				(5)		very important

8) Parent's history of abuse as a child.

1	2	3	4	5	6	7
not important				(5)		very important

Josh J.

This case involves the physical abuse of 7 year old Josh J. at the hands of his mother Mrs. Jean J., age 26. The initial complaint was made by Josh's teacher. Josh was struck in the face resulting in cuts and bruises following his wetting the bed. Mrs. J. admitted the incident, explaining she was angry and frustrated because of the bedwetting, a chronic problem for which other attempted solutions had failed. Part of Mrs. J's anger seems to be based on her perception of Josh's continued bedwetting as a deliberate challenge to her authority. There is no information of other abusive incidents. Mrs. J. appeared remorseful and there is no indication of further risk to the child at this time.

Other family members are Josh's father, Mr. John J., age 28, and a 3 year old brother, Michael. We are not aware of their involvement in any problematic behavior.

Mrs. J. reports being abused as a child by her mother, and identifies this as behavior she wishes to avoid.

The family is socially isolated having moved here only 6 months ago and without relatives or friends in the area. They live in a trailer park where Mrs. J. restricts her children's contact with most of the neighbors because she does not "approve of" them. Mr. J. is presently unemployed and Mrs. J. works at a fast food restaurant. The majority of child care responsibility falls to her, however he fills this role when she is at work.

In summary, in this case a mother abused in her own childhood has physically abused her child in an exaggerated attempt to control him at a time when she has little control in other areas of her life. Our goal today is to develop a service plan aimed at preventing further abuse while maintaining this child in his family.

What recommendation(s) would you make to help meet the Child Protective Services goal of maintaining this child safely in his own family?

Parenting Classes

Day Care

Mental Health Counseling

Support Groups

Employment services for the father

If there are any recommendations you would like to make that are not available in your community, list them below.

~~Parenting Class~~ all above except for Mental Health

What factor(s) contributed to the development of abuse in this family?

mother abused as a child

unemployed father

financial problems

15) Parent support group.

	1	2	3	4	5	(6)	7
not helpful							very helpful
	I don't know what this is _____ .						

16) Parenting classes or training.

	1	2	3	4	5	(6)	7
not helpful							very helpful
	I don't know what this is _____ .						

17) Parent-child interaction training.

	1	2	3	4	(5)	6	7
not helpful							very helpful
	I don't know what this is _____ .						

18) Social skills training to help parents form social networks.

	1	2	3	4	(5)	6	7
not helpful							very helpful
	I don't know what this is _____ .						

19) Subsidized child care.

	1	2	3	4	5	(6)	7
not helpful							very helpful
	I don't know what this is _____ .						

20) Vocational counseling for parents.

	1	2	3	4	5	6	(7)
not helpful							very helpful
	I don't know what this is _____ .						

Indicate how important each of the factors listed below is to the development of this case of abuse by marking the point on the scale which matches your evaluation of importance.

1) Societal attitudes endorsing corporal punishment of children.

1	2	3	4	5	6	7
not important						very important

2) Lack of support from the community.

1	2	3	4	5	6	7
not important						very important

3) Interactions among family members.

1	2	3	4	5	6	7
not important						very important

4) Characteristics of the abusive parent.

1	2	3	4	5	6	7
not important						very important

5) The violent nature of American society.

1	2	3	4	5	6	7
not important						very important

6) Financial stress on the family.

1	2	3	4	5	6	7
not important						very important

7) Characteristics of the abused child.

1	2	3	4	5	6	7
not important						very important

8) Parent's history of abuse as a child.

1	2	3	4	5	6	7
not important						very important

Demographic Information

Age 32Sex FOccupation SOCIAL WORKEREducation B.S.Marital Status SINGLE

Spouse's occupation _____ Spouse's education _____

How many children do you have? _____

Please check all of the items below which describe your own childhood.

- I was well taken care of as a child.
- _____ I was sexually abused as a child.
- _____ I was physically abused as a child.
- _____ I was emotionally abused as a child.
- _____ I was physically neglected as a child.
- _____ I was emotionally neglected as a child.

How long have you been involved in activities related to child abuse and neglect? 5 years

Please check the sources of training you have received in the area of child abuse and neglect.

- undergraduate coursework
- _____ graduate coursework
- new Child Protective Service worker training
- advanced CPS worker training
- CPS risk assessment training
- inservice training
- workshop(s)
- Multidiscipline Team programs
- media exposure (movies, newspaper reports, etc. available to the general public)
- books
- professional journals
- _____ other (please explain below)

SERVICES PROVIDED AND RECOMMENDED

Please check the appropriate column(s) below to indicate which of these services you have provided (directly or through supervision of a provider) and/or recommended for members of abusive families.

(Note: Only check recommendations which you have actually given in the "real world")

<u>Provide</u>	<u>Recommend</u>	<u>Service</u>
✓		individual therapy for abused child
✓		individual therapy for abuser
✓		parenting skills training for abuser
	✓	marital therapy
✓		family therapy
	✓	parent support group
	✓	Parents Anonymous
✓		day care
✓		temporary foster care
✓		permanent foster care/adoption
		homemaker services
✓		medical services for abused child
✓		legal requirements for abuser to meet in order to regain or retain custody of child
✓		periodic home visits to monitor safety
	✓	housing assistance
✓		financial assistance
✓		employment services
✓		lay visitor/parent advocate
✓		services to nonabused siblings

APPENDIX 3

Directions for Coding Open-Ended Responses

Rules for Dividing Responses Into Units

1. The respondent's divisions need not be adhered to.
2. Each distinct recommendation or idea should be recorded as a separate unit.
3. When a recommendation or idea is repeated, it is not scored again.
4. When a respondent gives an example which goes beyond, or is different from, the recommendation or idea it is intended to explain, the example should be recorded as a separate unit.

Coding Levels of Recommendation / Conceptualization

General Rules:

1. The abusive parent is the base unit in all analyses.
2. Make no inferences about the target or number of levels involved in an intervention or statement which cannot be established as the usual practice for that intervention (or the usual content of that statement).
3. An intervention or statement may include more than one level. When this is the case, all levels involved are to be recorded.

Sufficient Conditions for Levels

1. Individual involves one or more of the following:

personal history of the base unit

personal skills deficit of the base unit

intervention focused on deficits or conflicts of base unit as an individual

knowledge deficit of the base unit

emotions/conflicts of the base unit

2. Microsystem involves one or more of the following
- family member(s) other than the base unit
 - intervention focused on non-base unit family member(s) or subset
 - family interaction
3. Exosystem involves one or more of the following
- building resources and ties to non-professional people beyond family as a primary goal
 - intervention target is outside/beyond the family
4. Macrosystem involves one or more of the following
- values addressed
 - cultural issues addressed
 - intervention at cultural level
 - general historical events noted (not just personal history)
 - court action

Individual

Factor	Cross-coding
anger control training for abusive parent	
group therapy for abusive parent	
homemaker services	microsystem
individual therapy/counseling for abusive parent	
legal requirement for abusive parent to seek treatment in order to regain or retain custody	macrosystem
medical services for abusive parent	
Parents Anonymous	microsystem, exosystem
Parental Stress Line	exosystem

parenting classes or training	
social skills training to help abusive parents form	
social networks	exosystem
vocational training for abusive parent	exosystem
volunteer in-home visitor for abusive parent	
abusive parent abused as child	
abusive parent has hot temper	
abusive parent depressed	
self-isolating parent	exosystem
abusive adult ignores child's need	microsystem
parent has unrealistically high expectations	

Note: "stress" alone is uncodable, "stresses on mother" is coded as individual, "x stresses" is coded for x

Microsystem

Factor	Cross-coding
crisis day care	
educational assessment for children	
family therapy	
group therapy for children	
homemaker services	individual
individual therapy for child	
marital therapy for parents	
medical services for child	
Parents Anonymous	individual, exosystem

parent-child interaction training	
permanent foster placement or adoption	exosystem, macrosystem
special education for child	
subsidized day care	
temporary foster care for child	exosystem
therapeutic day care	
Youth Helping Youth program	exosystem
Big Brother	
vocational training for spouse	exosystem
parents with marital problems	
enuretic child	
arguments between parent and child	
abusive adult ignores child's need	individual
family has strict male/female role divisions	macrosystem
mother has both caregiver and breadwinner responsibilities	exosystem

Exosystem

Factor	Cross-coding
advocate to help family find housing, health care, financial support	
church groups willing to adopt a family	
Parents Anonymous	microsystem, individual
Parental Stress Line	individual
parent support group	
permanent foster placement or adoption	microsystem, macrosystem
social skills training to help abusive parent form social networks	individual
temporary foster care for child	microsystem

vocational training for abusive parent	individual
Youth Helping Youth	microsystem
vocational training for spouse	microsystem
unemployed spouse, unemployed abusive parent	
self-isolating parent	individual
family isolated from community	
family with poor housing situation	
lack of funds	
financial stresses	
rough neighborhood	
run-down neighborhood	
mother has both caregiver and breadwinner responsibilities	microsystem

Macrosystem

Factor	Cross-coding
legal requirement for abusive parent to seek treatment	
in order to retain or regain custody	individual
permanent foster placement or adoption	microsystem, exosystem
family has strict male/female role divisions	microsystem
(macrosystem when expressly labeled in this manner)	

Vita

ELISABETH ASTON SHINGLER

Personal Information

Home Address: P.O. Box 17, Bennington, N.H. 03442

Phone: (603) 588-3479

Date of Birth: October 8, 1957

Citizenship: U.S.

Education

1986-Present Doctoral candidate in Psychology, Virginia Polytechnic Institute and State University, Blacksburg, Virginia.

1987-1988 Pre-doctoral Intern, Child Clinical Track, Brown University Clinical Psychology Internship Consortium, Providence, R.I.

1983-1986 Virginia Polytechnic Institute and State University, Master of Science in Psychology, June, 1986.

1975-1979 Davidson College, Davidson, N.C. Bachelor of Arts in Psychology, May, 1979.

Academic Honor

Psi Chi National Honor Society in Psychology

Research Experience

Doctoral Dissertation - Virginia Polytechnic Institute and State University, title: "The Effects of Framing and Level of Experience on Consultants' Conceptualization and Recommendations for Treatment in Cases of Child Abuse". Research design, administration, analysis and reporting.

Chairperson: Philip Sanford Zeskind, Ph.D.

Research Assistant - Encopresis Project, Rhode Island Hospital Department of Pediatric Psychiatry (1988). Children's treatment group leader, conducted structured group instruction in experimental behavior change program.

Supervisor: Lori Stark, Ph.D.

Master's thesis - Virginia Polytechnic Institute and State University, (1983-1986) title: "The Influence of Attributions and Cry Characteristics on Perceptual Responses of Maltreating and Comparison Parents." Research design, administration, analysis, and

reporting.

Chairperson: Philip Sanford Zeskind, Ph.D.

Graduate Research Assistant - Social Behavior Project, Virginia Polytechnic Institute and State University (1983-1986). Did pre- and post-assessment of children identified as behavior problems and comparison students, scored and coded data, implemented social skills and cognitive/social skills training program, assisted in training of new graduate assistants, supervised undergraduate assistants. Supervisor: Thomas H. Ollendick, Ph.D.

Graduate Research Assistant - Childhood Headache Project, Virginia Polytechnic Institute and State University (1984-1985). Did pre- post and follow-up-assessment of children and adolescents with migraine headaches, implemented experimental treatment program, scored and coded data. Supervisor: Elise Labbe, Ph.D.

Research Publication and Presentations

Zeskind, P.S. and Shingler, E.A. (1991), Child abusers' perceptual responses to newborn infant cries varying in pitch. Infant Behavior and Development, 14, 335-347.

Shingler, E.A. and Zeskind, P.S. (1986, October). The Influence of Attributions and Cry Characteristics on Responses of Maltreating and Comparison Parents, Paper presented at the Virginia Developmental Forum, Charlottesville, Virginia.

Shingler, E.A. and Zeskind, P.S. (1986, April). Maltreaters' Responses to Infant Cries, Poster presented at the Conference on Human Development, Nashville, Tennessee.

Shingler, E.A. (1986, March). A Critical Appraisal of Behavioral Treatments for Childhood Migraine Headaches and Implications for Future Directions, Symposium paper presented at the Southeastern Psychological Association, Orlando, Florida.

Community Organization

1985-1987 Montgomery County Multidiscipline Team on Child Abuse and Neglect, Blacksburg, Virginia - Member, secretary, and participant on Child Abuse Prevention Month Committee. Presented educational programs to community groups, evaluated effectiveness of sexual abuse prevention programs for teachers and students in the Montgomery County public schools, presented sexual abuse prevention material to elementary school students, designed programs and materials on child abuse and neglect prevention for distribution to community organizations, began team effort to organize Parents' Anonymous chapter in the region.

Clinical and Consultation Experience

Clinician, Contoocook Valley Counseling Center, Henniker, New Hampshire, (January 1990-present) Provide outpatient therapy for individual adults, adolescents, and children; family therapy; group therapy for children; consultations to schools and daycare providers. Case load includes multiproblem families referred for treatment following findings of abuse and neglect; families facing the crisis of divorce and remarriage; battered women; parents seeking assistance in improving parenting skills, many with noncompliant, hyperactive, or anxious children; depressed and anxious adolescents and adults. Provide community education through presentations to Headstart, high school peer counseling groups, and other community groups.
Supervisor: Andrew Gersten, Ph.D.

Assessor, Child and Adolescent Unit, Lakeshore Hospital, Manchester, New Hampshire (July-November, 1989). Performed psychological evaluations, assessing cognitive and personality functioning, for children and adolescents admitted to private psychiatric hospital. Administered, scored, and interpreted Weschler Intelligence Scale for Children - Revised, Bender-Gestalt Test, Peabody Individual Achievement Tests, Millon Adolescent Personality Inventory, Minnesota Multiphasic Personality Inventory, Childhood Depression Inventory, Rorschach, Tasks of Emotional Development, Thematic Apperception Test, projective drawings, clinical interviews. Wrote reports and consulted with treatment team.
Supervisor: Richard Fellows, Ph.D.

Senior Clinician, Wediko Children's Services, Hillsboro, N.H. Fall, 1988. Provided infrastructure and program planning as member of an administrative team for proposed short-term, intensive residential evaluation and treatment program for emotionally disturbed early adolescent boys.
Supervisor: Harry W. Parad, Ph.D.

Pre-Doctoral Internship, Brown University Clinical Psychology Internship Consortium, Providence, R.I., July 1987 - June 1988. Three four month rotations and a twelve month one day per week community consultation assignment as described below.*

***Therapist and Assessor, Adolescent Inpatient Unit**, Emma Pendleton Bradley Hospital, Providence, R.I. Patient diagnoses included depression, eating disorders, schizophrenia, personality disorder, conduct disorder, attention deficit disorder, learning disability, mild mental retardation, and situational crisis. Conducted initial assessment of 20 adolescents admitted for evaluation and treatment, assessment instruments used in addition to clinical interviews included: Rorschach, Thematic Apperception Test, Incomplete Sentences, Childhood Depression Inventory, Wechsler Intelligence Scales for Children-Revised, Wechsler Intelligence Scales for Adults-Revised, neuropsychological screening, Child Behavior Checklist, Minnesota Multiphasic Personality

Inventory. Provided inpatient individual therapy for four adolescents. Also provided in-depth family assessment for two adolescents and their families and provided family therapy for one of these families, including coordinating discharge planning and placement. Conducted two social skills training groups, including pre- and post-assessment. Participated in ongoing team case conferences designed to coordinate aspects of patient care, including providing direction for milieu therapy on an individual and group level.
Supervisor: Robert M. Hayden, Ph.D.

***Therapist and Assessor, Charles Bradley Preschool Program, Providence, Rhode Island.** Provided 12 months of individual therapy and parent consultation for a developmentally delayed, conduct disordered student enrolled in the day hospital/preschool program, including assisting in making discharge plans and placement. Provided psychological assessment for multidisciplinary outpatient evaluations of 2 children: an autistic 4 year old and a developmentally delayed toddler. A third outpatient evaluation of a conduct disordered, attention-deficit disordered 6 year old became an inpatient evaluation as he required hospitalization. Also did initial intake interviews for several preschoolers and their mothers. Assessment tools used in addition to parent interviews, child and parent-child observations included Bayley Scales of physical and mental Development, Merrill-Palmer Scales, Child Behavior Checklist, Children's Apperception Test, and Rorschach. Provided 6 months of assessment and parent-child treatment for a 3 year old and her mother with attachment disorder and behavior management issues. Participated in mother-toddler group for 8 months, providing modeling, parent training and information, and guidance in activities designed to improve relationship and language skills for mothers and toddlers with relationship and language development difficulties. Served as participant observer and team member for a class of autistic preschoolers.
Supervisors: Morton Silverman, Ph.D., Marianne Barton, Ph.D.

***Neuropsychological Assessor and Consultant, Rehabilitation Unit, Rhode Island Hospital, Providence, Rhode Island.** Provided neuropsychological screening and assessment for primarily geriatric population of patients on the Rehab Unit, including stroke patients, head injured patients, and chronic pain patient. Consultation to treatment team focused on appropriate neuropsychological functioning considerations to be made in rehabilitation efforts by occupational therapists, physical therapists, and nursing staff, with occasional recommendations to physicians for additional assessment or medication control. Also provided supportive counseling for several patients and families and taught self-hypnotic techniques to chronic pain patient. Instruments used in addition to neuropsychological mental status exam included portions of the Wechsler Adult Intelligence Scales - Revised, Boston Diagnostic Aphasia Exam, Benton test of facial recognition, Luria's frontal lobe tasks, spatial orientation, Wechsler Memory Scale, and the Wide Range Achievement Tests.
Supervisor: Frank Sparadeo, Ph.D.

***Consultant, Northern Rhode Island Community Mental Health Center,** Woonsocket, Rhode Island. Provided client-centered consultation to other mental health professionals and treatment teams at community mental health center. Performed contracted parent and child evaluations for two cases in which social services agency was making placement and custody decisions for abused children. Presented workshops for agency therapists on cognitive-behavioral evaluation and treatment of depression. Provided systems-level consultation for new self-contained public school program for emotionally disturbed children and adolescents, focusing on referral and discharge planning issues. Supervisor: M. Ahmed, Ph.D.

Therapist and Supervisor, Psychological Services Center, Virginia Polytechnic Institute and State University, Practicum placement 1986-1987 academic year. Supervised second-year clinical students' therapy with children and families, assessed and treated child and family involved in the decision of whether to disrupt adoption. Problem areas addressed: childhood headache, oppositional behavior, deficits in affective identification and differentiation, parent training. Tests administered included Beck Depression Inventory, childhood Depression Index, Quay-Peterson Revised Behavior Problem Checklist, Connor's Rating Scale for Teachers, Rorschach, Thematic Apperception Test. Supervisors: Thomas H. Ollendick, Ph.D., Caryn Carlson, Ph.D.

Clinical Supervisor, Wediko Childrens' Services, Hillsboro, N.H., Intensive treatment center for emotionally disturbed children and adolescents, summers 1984, 1985, 1986. Provided group and individual supervision for two treatment teams each summer, 10 staff members per summer. Developed and supervised implementation of group and individual treatment plans for emotionally disturbed children and adolescents, including groups of 9-11 year old boys, 12-15 year old boys, and 14-17 year old girls, approximately 16 children and adolescents each summer. Coordinated meetings with families, provided short-term (three session) family interventions, and facilitated long-term placement planning. General staff training and programmatic responsibilities. Supervisors: Larry A. Tucker, Ph.D., Harry W. Parad, Ph.D.

Therapist, University Counseling Services, Virginia Polytechnic Institute and State University. Practicum placement 1985-1986 academic year. Provided psychotherapy and career counseling for graduate and undergraduate students. Interpreted Strong-Campbell Vocational Interest Inventory, Myers-Briggs Type Indicator. Administered and interpreted Weschler Adult Intelligence Scales - Revised and Bender- Gestalt. Conducted short and medium term individual therapy and group therapy using supportive therapy, cognitive-behavioral interventions, self-hypnosis instruction. Clients' problems included severe depression, deficits in social skills, alcoholism, chronic pain and progressive loss of physical functioning due to degenerative disease, relationship problems, family issues. Supervisor: Marshall Tessnear, Ph.D.

Consultant and Therapist, Social Behavior Project, Virginia Polytechnic Institute and State University, 1983-1986. Gave consultation to principals and teachers concerning disciplinary and emotional problems of elementary school students. Provided individual assessment and treatment of children and consultations with parents. Tests administered include: Childhood Depression Index, Thematic Apperception Test, Bender-Gestalt, Weschler Intelligence Scale for Children-Revised. Supervisor: Thomas H. Ollendick, Ph.D.

Therapist, Psychological Services Center, Virginia Polytechnic Institute and State University, Practicum placement academic years 1984-85, 1983-84. Assessed and treated individuals, couples, and families. Clients' problems included marital discord, depression and suicidal ideation, parenting difficulties. Treatment included supportive therapy, cognitive restructuring, parent training, behavioral marital therapy, assertiveness training. Co-lead relationship enhancement group for couples desiring to improve mildly problematic relationships. Tests administered included Beck Depression Inventory, Child Fear Survey, Minnesota Multiphasic Personality Inventory, Marital Satisfaction Scale. Supervisors: Cynthia Baum, Ph.D., George Clum, Ph.D., Richard Eisler, Ph.D., Elise Labbe, Ph.D.

Adolescent Program Coordinator, Wediko Childrens' Services, Hillsboro, N.H., summers 1983, 1982. Designed and implemented program components for intensive residential treatment facility serving approximately 50 adolescents per summer. Coordinated 35 staff members' execution of program components including wilderness trips, construction projects, and activities. Concurrent responsibility as treatment team member with early adolescent boys (1983) and girls (1982). Supervisors: Harry W. Parad, Ph.D., Robert Mintz, M.S., Carmel Gurruchari, Ph.D.

Assistant Teacher, McIntire Day Program, Charlottesville, VA, 1982-83 school year. Treatment team member in self-contained middle and high school program for severely emotionally disturbed adolescents. Participated in designing this new program, developing and implementing treatment strategies, academic instruction. Head Teacher: Barry Chlebnikow, M.A.

Child Care Worker, Harbor Schools, Haverhill, MA, adolescent girls' unit, 1981-1982 school year. Direct service provider in residential treatment center for emotionally disturbed girls age 14-18. Provided behavior management, one-to-one counseling, served as treatment team member. Supervisors: Debra Combs, M.S., Linda Schwartz, M.A.

Teacher's Aide, Shore Collaborative, Medford, MA, self-contained elementary school class for second through fifth grade emotionally disturbed boys, 1980-81 school year. Contributed to design of individual educational plan for each student, behavior management, academic instruction. Head teacher: Joy O'Leary

Volunteer Telephone Counselor, Parental Stress Line, Boston, MA, service for potentially and currently abusive parents, 1981. Stress and crisis counseling, parent education provided to both one-time and repeat callers.

Supervisor: Sarah Belcher

Counselor for emotionally disturbed children and adolescents , Wediko Childrens' Services, Hillsboro, N.H., summers 1979, 1980, 1981.

Treatment team member involved in behavior management, program implementation, discussion of treatment plans for individual children. Age groups served included girls age 10-12, boys age 12-15.

Supervisors: Sue Turiff Leichtman, M.S., Harry W. Parad, Ph.D., Larry Tucker, Ph.D., Jean Sullivan-Hanson, M.S.

Assistant Houseparent, Perkins School for the Blind, Special Programs, Watertown, MA, 1979-80 school year. Provided direct service to multiply impaired male and female adolescents in a residential setting. Focused on instructing daily living skills, personal counseling, behavior management, group activity coordination.

Supervisor: Cynthia Essex, M.A.

Tutor, North Carolina School for the Deaf, Morganton, N.C., practicum placement spring quarter 1979. Tutored and provided behavior management for a hearing-impaired elementary school student.

Supervisor: Scott Cutting, Ph.D.

Externe, Hopital des Colombes, Montpellier, FRANCE, practicum placement spring 1978. Observed and participated in patient activities on a short-term assessment and treatment ward with a special subsection in alcohol and substance abuse treatment.

Supervisor: Amelia Dockery, Ph.D.

Practicum Student, Broughton State Hospital, Morganton, N.C., summer 1977, Rotated through mentally-retarded/behavior modification ward, assessment-treatment ward, High control (violent patients) ward. Observed and participated in activities with patients.

Supervisor: Scott Cutting, Ph.D.

Volunteer Aide, Center for Human Resources, Charlotte, N.C., spring 1977. Assisted in after-school perceptual-motor skills and social skills training group for primary school students with learning disabilities.

Supervisor: John Kelton, Ph.D.

Elizabeth A. Stimpf