CHILD ABUSE

REFERRAL PROCESSES AND TREATMENT METHODS

by

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INTRODUCTION

Many children in this world are suffering fear and pain, ironically at the hands of those people who are supposed to defend and protect them and meet their needs. These children are the victims of child abuse and neglect. Dr. V. J. Fontana of the New York City Mayor's Task Force on Child Abuse and Neglect estimated that in 1973, 50,000 children could be expected to die and 300,000 be permanently injured by maltreatment. Child battering is probably the most common cause of death in children today, outnumbering deaths caused by any infectious diseases, leukemia, and auto accidents ("The Abused Child," 1974).

Abused children are usually the victims of their caretaker: mother, father, foster parent, mother's boyfriend, step-parent, older brother or sister, or baby-sitter ("The Abused Child," 1974). Abusive parents are not a homogeneous group but a cross section of the general population. They come from all socio-economic strata: from laborers to professionals. Abusive parents live in metropolitan areas, small towns, and in rural communities. Their educational achievement ranges from partial grade school to advanced degrees. Intellectual ability among them ranges from mentally retarded to superior intelligence (Costin, 1972). Although these parents are not all chronologically young, the cluster of ages is in the twenties (Blumberg, 1974). Both the employed

and unemployed have been counted as child abusers (Ten Broeck, 1974). All religious affiliations, races, and ethnic groups are proportionally represented (Costin, 1972). Child abuse is found in families with one child and families with many children. It is found in families with only one parent and families with both parents. Either parent may be the abuser; usually the non-abusing parent supports the spouse and does not protect the child (Ten Broeck, 1974).

Abuse and neglect of children takes many forms; it results from acts, or failure to act on the part of the caretakers. The neglecting parents are either (1) doing things which directly bring about neglect of their children, or (2) they are not doing things which they should be doing to avoid neglect ("The Abused Child," 1974). In the first category of abusers, the following actions are found: desertion, abandonment, leaving young children for substantial periods of time without proper supervision, refusing to support, excessive drinking, immorality, acts of cruelty such as beatings and other forms of physical punishment. The second category includes such things as: failure to provide needed medical attention, housing, clothing or food, failure to give proper schooling, spiritual training and sound constructive discipline. Equally as damaging is failure to give a child the love and affection, the sense of belonging and the security which is so important to a proper personality development and self-concept.

Psychiatric studies show that 9 out of 10 parents who abuse their children are normal, in a technical sense of that word (Smith, 1973). Many of these parents are emotionally immature; chronologically they may be adults, but when it comes to their emotional makeup they

remain at an arrested adolescent stage. Child abusers have been described as immature, impulsive, dependent, angry, rejecting and demanding individuals (Costin, 1972; Blumberg, 1974). They have a low frustration tolerance level so that when problems arise that they can not seem to handle, they strike out. Frequently when they strike out, they do so against their children because children are easy targets to give vent to parental frustrations (Ten Broeck, 1974; Smith, 1973; Blumberg, 1974).

An abusing parent might be one who seeks to gratify his own emotional needs rather than satisfy the needs of his child, or one with borderline intelligence who has a difficult time functioning and doing routine tasks (Smith, 1973). Sometimes when there is a serious marital conflict or financial problem, the parents tend to use the children in their battles against one another. Still another type of abusive parent is the emotionally disturbed parent who is mentally ill, or suffers from alcoholism and/or use of narcotic drugs (Blumberg, 1974).

Many abusive parents have inaccurate perceptions and expectations of children. They expect children to always be neat, clean, quiet, lovable, etc. They demand performance from their children that is clearly beyond their ability and ignore the childrens' own needs, limited abilities and helplessness ("The Abused Child," 1974; Costin, 1972). Abusive parents feel a "sense of righteousness" in punishing the children who do not live up to such principles.

Several common dynamics usually set abusive parents apart from others. They experienced a definite lack of positive mothering during childhood; and most abusive parents were themselves mistreated and abused as children (Ten Broeck, 1974; Costin, 1972). They were taught

to believe that physical violence against children is an appropriate disciplinary action.

This cycle of abuse is passed from one generation to another. "The traditional solution to battering (putting the parents in jail and taking away their children) has perpetuated this cycle" (MacLeod, 1074). There have been attempts by people working with abusive parents to improve the treatment and referral services available so that this cycle of abuse will not be passed from one generation to another.

In recent years, in an attempt to improve the treatment services available, many groups across the nation have started experimenting with new and innovative ways of working with parents. Instead of automatically removing abused children from their parents on a permanent basis, they have worked intensively with the mothers and fathers in an attempt to teach them how to become more adequate parents. The growth of treatment programs has come with the realization that the parental problems that are responsible for the child's injuries may be amenable to treatment (Savino, 1973).

Purpose

The purpose of this study is to compile comprehensive descriptive data concerning the referral processes and treatment methods which are developing across the nation to be used in the treatment of parents referred for child abuse or neglect. Since this study is designed to meet the methodological requirements of exploratory research, it is not appropriate to include hypotheses which are explicit norms of evaluative research.

Since professionals and para-professionals from many different fields (law enforcement, medicine, social services, education) are working in the area of child abuse and neglect, coordination of their efforts to help abusive parents has been difficult. This study should lead to information that can enable those professionals to become familiar with the processes and methods which others find helpful. This type of comprehensive data does not exist presently, even though it is needed. As a result of this study, agencies will be able to learn of methods and techniques which are proving useful for others in working with abusive parents.

Definition of Terms

1. Referral processes. A differentiation will be made between those services which an agency provides directly to its families and those considered referrals. A referral will be the act of directing the parents to another source for information or assistance, e.g., Alcoholics Anonymous, Legal Aide, mental health clinics, etc.

2. Therapy treatment methods. Therapy methods will be defined as those approaches which are used for treating a disorder. Those approaches may be accomplished either individually or as group treatment. Therapy might also encompass purchasing the services of competent individuals as consultants to provide specialized therapy methods.

3. Parents referred for child abuse or neglect. This category will include parents, guardians or caretakers of a child who have been referred to an agency because of neglect or abuse of children.

4. Re-parenting. A treatment process wherein the caseworker or aide actually serves as a parent to the client, to develop the kind of relationship with that client that he did not have with his own parent. This consists of being a parent-surrogate i.e., someone dependable, supportive, loving, accepting, and available to them at a time of need.

5. Transactional analysis. The name of an approach to interactional psychotherapy developed by Eric Berne in the years between 1950--1970. It consists of a theory of personality organization based on structural analysis, which maintains the supposition that every person possesses various ego states, referred to as the Child, Adult and Parent ego states. The theory first analyzes simple transactions, then series of stereotyped transactions and finally, long complex operations involving several people and based on sometimes elaborate fantasies. The theory tends to stress those basic human needs which are most directly related to everyday observable behavior.

6. Behavior therapy. This is a treatment method developed primarily by Wolpe (1958) which rests upon the theory that neurosis is accounted for by the learning of unadaptive behavior through normal learning processes. Behavior is seen as responses to stimulation, both external and internal, therefore the goal of therapy is to modify unadaptive stimulus-response connections.

7. Reality therapy. This is a series of theoretical principles developed in the 1950's by Dr. William Glasser. The theory concentrates on personal responsibility for one's own behavior, while the therapist

guides the individual to enable him to see himself accurately, to face reality, to fulfill his own needs, without harming himself and others.

8. Group counseling/therapy. This is a group process whereby persons with similar surface problems learn to face, express and cope with their most disturbing feelings and thoughts. They also develop the courage and self-confidence to apply what they have learned in changing their behavior. Group members are encouraged to focus their attention on the here and now, using role playing as one method of helping members learn to cope with specific situations and persons. This process helps break the pattern of social isolation and decreases the stigma of being the only person with a problem. When conducted with a family unit this is referred to as family therapy/counseling.

9. Individual therapy/counseling. A process whereby a person is treated by a therapist/counselor to gain insight into the personality traits which motivate his behavior, and encourage him to take new courses of action. Many different approaches to therapy and counseling have been developed for use with individuals; their basic goal is to help the person better understand himself and teach him alternative modes of behavior so that changes in undesirable behavior are possible.

10. Therapeutic day care. This is defined as a treatment oriented process for pre-school children who have suffered a crisis. These children attend day care centers where the staff members are trained to provide sensory stimulation and learning experiences which would not be available to these children in their own homes.

11. Family residential treatment. This is a process where parents and children reside at a treatment center while therapy is being provided to them. The family may be separated within the center during the initial stages of treatment, but daily contact is encouraged. Parent-child contact usually increases in frequency and duration as treatment of both parent and child progresses.

12. Family life education. This is the education process providing future and present parents exposure to the complex and simple problems of being a parent. It involves teaching growth and development patterns of children, discipline, physical care of children, interpersonal family relations etc.

13. Positive parenting. This is a process attempting to establish a nurturing role between a therapist/counselor and the parent being treated. The therapist/counselor is to be a loving friend, who by showing genuine concern and interest, hopes to increase the self-confidence of the parent and thus his ability to better cope with life. This is very similar to "re-parenting".

Chapter II

REVIEW OF LITERATURE

The overall field of child abuse and neglect encompasses many different facets. The major area of concern for this study will be those families who have been referred to an agency because of suspected or proven abuse or neglect of children.

In the study "The Child-Battering Parent: Sick but Slick" (Horn, 1974), Logan Wright warns that abusive parents have a trait which misleads people who deal with them, i.e., the ability to appear normal and non-abusive. He tested two groups of parents, 13 convicted of battering and 13 non-batterers, using personality and intelligence tests. He found that although the two matched groups differed on only six items out of twenty-five, those differences revealed critical patterns concerning aggressive feelings, bad thoughts, temptations, and lack of control. The tendency for battering parents to present themselves favorably breaks down in their responses to these scales because the socially desirable answers are not that obvious. This investigation has shown that even though these parents appear normal in many ways, they still have certain psychopathic tendencies to be dealt with in working with them.

Henry Kempe and Ray Helfer (1970) have designed "A Plan for Protection: The Child Abuse Center," which speaks to the degree of involvement which is necessary and realistic in dealing with parents.

They say that on a degree-of-involvement continuum, the most realistic point is the one where the home is made safe and the child is returned to live there with his parents. The Four Step Plan that they suggest to accomplish this includes: (1) hospitalizing the child for diagnosis; (2) separating the child from the parents temporarily for protection; (3) beginning to make the home safe for the child's return; and (4) gradual return of the child to the home. Step three would include establishing a relationship with the parents first, providing substitute mothers and friends who help attack the wall of isolation around most battering parents, and supplying emotional needs by helping the parents learn how to ask for and accept the help of others.

In a book entitled Helping the Battered Child and His Family (1972), Kempe and Helfer have expanded their original design. Part I of this book sets out therapeutic approaches that were mentioned in other literature which was surveyed. They suggest that one helpful approach is that of including parent-aides as an integral part of the therapy process. The authors pointed out that Foster Grandparents are being used as parent-aides by The Colorado General Hospital. R. C. Smith, (1973), in an article entitled "New Ways to Help Battering Parents" reports that an extensive lay-therapist, or parent-aide program exists at the University of Colorado Medical Center where women are sent to visit battering parents in their homes and help in any way they can. A project is also under way in Los Angeles, California, which hopes to develop a treatment model, workable in large urban areas, which will draw on local social services and volunteer citizen groups used as aides (Intellect, 1974).

In an article by Norman Epstein and Anne Shainline (1974), a one year experimental program which was used in New Jersey is described. Although it did not speak directly to those families with problems of child abuse and neglect it did include chronic, multi-problem families. Paraprofessional parent-aides were used with these families to help solve their problems. Parents reported a marked difference in their living situation as a result of this type of parent-aide help.

Kempe and Helfer (1972) also mention in their book that visiting nurses could provide valuable assistance and direction to battering parents. It has already been suggested that abusive parents often have unrealistic ideas about the normal physical and emotional development of children. Anne B. Savino and Wyman R. Sanders (1973) have reported on a program developed at UCLA's Neuropsychiatric Institute which includes public health nurse home visits as a part of their approach. They conduct out-patient therapy groups which include, as one aspect, a focus on child care; normal physical and emotional development patterns. Nurses are also assigned to visit the home whenever a group member requests it. The nurses perceive their primary function as that of establishing a "mothering type" relationship with the abusive parent. They also attempt to model appropriate behavior and help the parent interpret their children's actions.

Another therapeutic approach mentioned by Kempe and Helfer (1972) concerns setting up crisis nurseries to relieve the burden of 24 hour-per-day care on abusive parents. Paul D'Agostino (1972) reports that those working in the Department of Welfare in Boston saw a need for something other than the child remaining constantly in the home or being placed in

foster care. They approached the Junior League of Boston and received assistance from them in setting up a therapeutic child care facility to give relief to their battering parents. A similar type of facility called The Extended Family Center has been developed for the City of San Francisco. In an article written for Children Today (1974) by the director of the center, Elsa Ten Broeck, the daily operations of the center are explained. Its purpose is to provide day care services and act as an extended family for isolated parents who are acting out through violence against their children. The center has also found it helpful to use formerly abusive parents as full-time staff members in helping in the treatment process as parent consultants.

The final suggestion in Part I of the Kempe and Helfer (1972) book is that parent self-help groups such as Mothers or Parents Anonymous be formed. A group such as this called Families Anonymous has been set up at the University of Colorado Medical Center. The program is similar to the Alcoholics Anonymous program where battering parents meet voluntarily in group therapy (supervised by a public health worker and a psychiatric social worker) to help themselves and each other. Besides supervising the sessions, the workers serve as advisors, counselors and friends of the people in the groups.

Another such set-up was reported in an article entitled, "Parents Anonymous and Child Abuse" (Intellect, 1974). Three Parents Anonymous Groups meet in Indianapolis for weekly role-playing, rap sessions, and encouragement. Members can also telephone other members when they feel they're losing control of themselves. Also, in Berkeley, California an off-shoot of Parents Anonymous called Parental Stress Service has been

developed. It includes crisis lines and a referral set-up using mostly volunteers.

In an article in Exceptional Children (1974), Jean Nazzaro reports on several other types of services that are appearing across the nation. Florida set up a hot-line for emergency calls and referrals and has reported receiving over 30,000 calls in one and one-half years (Nazzaro, 1974). In California, along with the treatment services that are available for battering parents, there is a tie-in to a parental stress hot-line (Nazzaro, 1974). In Oregon, a volunteer group of citizens who call themselves the Child Abuse Study Committee Inc. are working in the area of public education (Nazzaro, 1974). They have developed a film and lecture series to be presented to various community groups.

Metroville Nashville, and Davidson County in Tennessee found that they were not providing the needed care to families referred for child abuse and neglect. On the basis of recommendations in a study done for them by Urban Institute in 1970, "A New System for Improving the Care of Neglected and Abused Children", a new comprehensive emergency service for neglected and dependent children was established. These emergency services involve 24 hour intake, caretaker service (someone to go into the child's home), homemaker service and foster homes. The objective was to avoid the institutionalization of children over a three year period.

A considerable amount of the literature available seems to be pointing toward a multi-service type of approach to be used in the treatment of families referred for child abuse or neglect (Burt, 1974; D'Agostino, 1972; Epstein, 1974; Kempe, 1972; MacLeod, 1974; Savino, 1973; Smith, 1973; Ten Broeck, 1974). In a letter written to the

American Academy of Pediatrics (1970), Jacob Brem, M.D. recommended that the team approach be used when dealing with battering parents. He proposed a team composed of the child's physician, and consultants from the social, nursing, psychiatric and health services. He thought the team approach would suggest the possibility of creating child abuse control centers, similar to the poison control centers which existed for some years.

Celeste MacLeod (1974) in "Legacy of Battering" reports that the University of Colorado started one of the first intensive multi-service treatment centers for parents who abused their children. They found that nearly 80% of abused children who came to their hospital could be returned home within six months if the parents received intensive help during that period.

The Children's Trauma Center in Oakland, California follows the Denver approach (MacLeod, 1974) at the University of Colorado. Their program emphasizes group "reparenting" sessions where couples meet weekly with a social worker. A client emergency fund for small loans and gifts is maintained. When abuse is suspected they call a conference of doctors, social workers, nurses, police, probation officers, protective service workers, teachers, etc. They have a working multi-service approach.

The Illinois Department of Children and Family Services received a grant to demonstrate the effectiveness of an integrated approach to provide varied service to families in which children were neglected and abused. The services provided included casework, group work, day care,

educational therapy, homemaker services, tutoring, temporary foster care, emergency sheltering and pediatric care.

The City of Boston, Massachusetts has been progressive in developing multi-service treatment centers for abusive parents in their area. One such center is set up in the Children's Hospital Medical Center. Social service personnel from the Department of Public Welfare and two voluntary agencies are integrated into a consultation group called Trauma X. Besides formulating plans for each treatment group, they are responsible for educating the hospital staff and the Boston community to increase their competance in dealing with child abuse and neglect (Eli Newberger, 1973).

Also located in Boston is "The Parents Center Project: A Multiservice Approach to the Prevention of Child Abuse." Shirley Bean (1971) reported that their primary approach was to be group treatment with couples meeting weekly. Individual counseling in emergencies is handled outside the group. Supervised day-time care of the abused youngster is also available. In the first 22 months of their existence, 23 families were actually treated; none of the 42 children from those families has been physically abused again since the parents entered the project.

A child abuse project exists at the University of Pennsylvania Medical Center which chose social learning theory as the basis for its treatment model (Tracy, 1974). The project consists of a coordinator, social workers, and family health workers (aides) who attempt to identify behavioral goals and follow specific techniques of achieving them. This

outreach staff must find out where the problems are and teach the parent how to handle them.

Summary

As is evidenced in this chapter, those working in the field of child abuse and neglect are using many new and innovative techniques in working with the families referred to them. Many of these new techniques are being written about in periodicals to inform others about what is being done.

The next chapter will explain the methodological approach used as a part of this study to gain additional information concerning the treatment methods and referral services available to those families suspected of child abuse and neglect.

Chapter III

PROCEDURES

Sample

A national survey was undertaken of all agencies that are providing referral or treatment for families referred to them for child abuse or neglect. Various sources were used in an attempt to locate those agencies. Those sources included research and periodical articles which mentioned such project, The National Clearinghouse for Child Abuse and Neglect, research firms with a knowledge in the area, The U.S. Office of Child Development, The National Center for Child Abuse and Neglect, and the U.S. Childrens Bureau. Further attempts were made through the National Office of the Department of Health, and the National Center for Child Advocacy to locate more agencies to be included in the sample.

The list compiled for the survey included the name and addresses of 66 agencies or centers that are either using innovative treatment methods or are under contract with the Federal Government to develop multi-disciplinary team approaches in the treatment of child abuse and neglect. The list included public social service agencies, hospitals, parent self-help groups, emergency treatment centers, day care agencies and community research centers.

Survey Instrument

The instrument that was used in this survey is included in the appendix. It was designed by the researcher specifically to collect

the descriptive data needed to complete this study.

Questions 1--4 asked for information concerning how many staff members are employed by an agency, what their jobs are, what workers' education is, and if they went to college, what discipline they studied.

Questions 5 and 6 asked if volunteers or consultants are used and to what extent.

Questions 7 and 8 were included to determine what arrangements are being made for the children while the parents are in treatment, and to what extent they are being included in the therapy.

Question 9 asked what other agencies or professional individuals are used for referral and what kinds of services they provide.

Question 10 covered the gamut of direct services that are available within the agency, while Question 11 requested what other types of services might be purchased by the agency for the client.

Questions 12 and 13 covered information on the actual range of time involved for treatment and the estimated average treatment time for families.

In Question 14 respondents were asked to mention whether there is one particular type of treatment or therapy that seems to be more successful in changing attitudes and behaviors than others.

This questionnaire provided the researcher with a substantial amount of information about child abuse and neglect; specifically what types of jobs exist in the field, how much education is necessary for staff, what is happening to the children involved, and what kinds of services and treatments exist for the families in question.

The instrument was reviewed and critiqued in the development process by a professional working in the field of child abuse and neglect. The comments offered were taken into account and several changes were made in the survey instrument.

Data Collection

The survey instrument form was sent to 10 groups from the available list as a type of pilot study. The purpose was to determine whether the form was understood by those completing it and if the information received was of the nature expected. After corrections were made, the survey form was sent to the other agencies to be sampled.

A cover letter was developed to send with the survey form. It included information about the purpose of the study, and a request that names and addresses of other known groups be added to the information requested on the form.

The survey forms and cover letter were sent by mail to all identified agencies at the same time. A self-addressed stamped envelope was included to expedite return. If the form had not been returned after one month, a follow-up phone call was made to the group to determine whether they had actually received it and intended on completing it.

Analysis of Data

The information gathered from the survey forms was compiled into sections, so that descriptive statements could be made about the state-of-the-art concerning the referral processes and treatment methods being

developed and used by agencies in dealing with families referred for child abuse and neglect.

The agencies in the sample were divided into two separate groups for the purpose of reporting the results from the survey form: 1. hospital settings; and 2. "other" groups, representing social service agencies, parent self-help groups, advocacy groups and day care centers.

Chapter IV

RESULTS AND ANALYSIS OF DATA

Sample

The original sample for this study included 66 agencies and groups nationwide that have responsibility for providing some services to families suspected of child abuse or neglect. Responses were received from 53 of those 66 who were mailed the questionnaire, but only 45 completed all aspects of the instrument.

Fourteen questionnaires were returned from the West Coast, seven from the Mid-West, two from the South-West, three from the South, twelve from the East, three from the North and four from New England. A large portion, (seven of the nine) West Coast groups classified as "other" for this study were located in the state of California. An attempt was made to analyze the data to locate geographic differences in the context of child abuse and neglect, but no differences were noted.

Various sources were used in an attempt to locate the agencies and groups to be included in the sample. Those sources included research and periodical articles mentioning such agencies, research firms with a knowledge in child abuse and neglect, The National Clearinghouse for Child Abuse and Neglect, The United States Office of Child Development, The National Center for Child Abuse and Neglect, The United States Childrens Bureau, The Center for Child Abuse Education, The Philadelphia Urban

League's Child Advocacy Project, and the National Association of Children's Hospitals and Related Institutions.

From all of the available sources, a list of agencies was compiled. The list included the names, addresses and phone numbers of those agencies or groups identified that have the responsibility for providing some sort of services to families suspected of child abuse or neglect. That list is included in the Appendix.

Collection of Data

The questionnaire designed by the researcher for this study was sent to 10 of the agencies or groups on the list as a pre-test. Eight of the original forms were returned, completed within three weeks. The forms were reviewed to check the content and ascertain if the questions were yielding the information necessary to conduct the study. As the information seemed to be reportable, the determination was made to send the remaining questionnaires out with only one modification. The questionnaire was printed on both sides, and it was necessary to make note that there were additional questions on the back. Two of the groups participating in the pre-test did not turn the page over and complete the form on the back side. Those groups were contacted by telephone and asked to respond to those additional questions.

The procedure for getting responses was as follows. If a group had not returned the survey form within one month, an attempt was made to contact that group by telephone to determine if they had actually received the form or to question why they had not responded. Seven of those 17 so contacted stated that they either did not have a program

established to deal with child abuse and neglect, or their program was so new, they did not feel they had enough information to complete the survey form. Several of the survey forms were returned by the post office because groups had moved and left no forwarding address. It was necessary to send a second survey form to nine of the groups who, when contacted by phone, had no recollection of receiving the first survey form sent. All questions were not filled out by all groups and therefore the number of responses reported in the review of data is different for each question. The exact number of responses being used will be reported for each question.

Many of the respondent groups also included brochures and printed material giving additional information about their programs. The relevant information from those sources was included where appropriate.

Results of Data

As has been mentioned, child abuse and neglect is a very complex problem that is being dealt with in a multitude of different ways across the United States. The intent of this study was to ask questions of those groups working in the field of child abuse and neglect to determine exactly how the problem is being handled and by whom. This section represents the results as well as an analysis of the data collected.

Staff size. Those persons responding to the questionnaire were asked to identify the exact number of persons working either for their organization or specific unit. It was assumed that because many of the groups being questioned had just developed within the past couple of years, the staff sizes would be small. Responses were received from 43 groups on this question.

Usually if an organization is really committed to offering certain services, they will establish a unit within their organization to handle that problem and staff it with enough persons to carry out the services. Even though the predominant staff size was found to be quite small, there still appeared to be a commitment to provide services by augmenting the regular staff in many ways. This is discussed in another section.

Table I shows the variation in staff size among the various groups. There were no consistent patterns to be found which related to staff size. Even those groups having no official staff members assigned were providing services to the parents and children referred to them for child abuse and neglect. Two of the hospital groups that have no official staff members assigned made use of social workers, doctors, and nurses from within the hospital in dealing with cases of neglect and abuse. One of the parent self-help groups had no official staff members, but used a community advisory board to run affairs.

The group having the largest staff size (43 persons) was the National Center of Child Abuse and Neglect, located at the University of Colorado Medical Center. It had received several government grants enabling it to increase staff size and the services offered. The majority of those responding had a staff size of 15 persons or under.

There also appeared to be no significant differences in relation to staff size between the hospital groups and those in "other" settings. Those groups having large staffs were evenly split between the settings, leading one to believe that size possibly relates more to the amount of money available and the level of commitment than to anything else.

TABLE I

RANGE IN STAFF SIZE

Staff size	Primary breakdown		Total
	Hospitals	Other	
0-5	5	5	10
6-10	9	5	14
11-15	8	2	10
16-20	1	1	2
21-25	2	1	3
26-30	0	1	1
31-35	0	1	1
36-40	0	1	1
41-45	1	0	1
Total	26	17	43

Job types. The groups surveyed were asked what types of jobs were being filled by their staff members. The percentages for the following table were figured using the 44 groups that responded to this question. The "other" job title category found in Table II included: psychologists 20%, coordinators 11%, homemakers and para-professionals 9% each, teachers and trainers 7% each, researchers, occupational therapists, child development specialist, lawyers, information officers, each at 4.5%, and physical, speech, and family therapists, treatment directors and advocates with 2% each.

In reviewing the data on the questionnaires it became apparent that those groups having a small staff started with an administrator and clerical staff. Many of those staffs were then supplemented with volunteers and staff designated as coordinators of volunteers. As the staff size increased, social workers were added in many cases to assist with intake, counseling and investigative work. In the hospital settings, the small staffs were generally made up of doctors and nurses. As they enlarged they added social workers and aides to their team.

Most of the social service agencies responding had staffs made up of a large number of social workers as might be expected. A frequently mentioned addition to those agencies was a homemaker.

There was a wide variety in the types of jobs which were being filled by the groups surveyed. Only five of the groups responding did not have a variety of staff positions available. This, coupled with the fact that the "other" category under types of jobs showed great

TABLE II

JOB TYPES

Job titles	Primary breakdown		Total	Percentage of respondents
	Hospitals	Other		
Intake	5	6	11	25
Counselors	3	6	9	20
Investigators	3	3	6	14
Social workers	20	14	34	77
Doctors	18	3	21	48
Nurses	14	19	18	41
Clerical	14	19	33	75
Administrators	10	18	28	64
Aides	4	6	10	23
Other	11	11	22	50

variety and diversion, indicated that those organizations currently established to deal with the aspect of treatment and referral for child abuse and neglect, were indeed turning towards the team approach.

Staff education background. A question was asked of the respondents concerning the educational background of those staff persons working directly with parents. The intention of this was to determine if those involved with the therapy and treatment were required to have an extensive education or if more para-professionals were being used. Percentages were figured using the exact number of staff members mentioned by respondents in each of the categories.

Of those groups working in a hospital setting: no staff persons were being used who had less than a high school education; 21% of total staff were high school graduates; 18% were college graduates with a bachelors degree; 36% were college graduates with a masters degree; 4% were college graduates with a doctoral degree; and 21% had a medical degree. This sample was largely skewed because there were so many medical doctors being used as staff members.

Of the "other" groups surveyed: 3% were using staff persons who had less than a high school education; 29% of total staff were high school graduates; 30% were college graduates with a bachelors degree; 32% were college graduates with a masters degree; 4% were college graduates with a doctoral degree; and 2% had a medical or law degree.

It would appear from the above data that those groups sampled were relying heavily upon those individuals who had at least a bachelors degree in college or above.

This showed that a certain amount of knowledge and expertise, gained through education, was expected of the personnel in the field. It was suspected that there was an overloading in the Ph.D. and "other" category because of the use of medical doctors, especially in the hospital settings. The percentage of those at the Ph.D. level would be very small if the medical doctors were removed from those categories.

Disciplines studies. Respondents were also asked what disciplines had been studied in school by members of their staff. Here again, the percentages were figured using the exact number of disciplines mentioned in each of the categories.

It was reported that in hospital settings 43% of the staff had studied social work, 24% medicine, 9% psychology, 7% child development and 17% had been in other miscellaneous disciplines. This included nursing, special education, sociology and law.

Of the other groups surveyed 44% had studied social work, 15% counseling, 17% medicine, 5% child development, 12% psychology and 7% had been in other disciplines. Those included sociology, education and law. From these data, it would appear that all of the groups were relying on staff persons who had been trained in the field of social work.

Additions to staff. Several alternatives were available and were being utilized by the groups surveyed in an attempt to fill voids in staff size or types of experience of staff members. These included the purchase of outside consultants, the extensive use of volunteers, the purchase of additional services for the families being treated, and the referral of families to other agencies or individuals that could provide the necessary treatments. Each of these alternatives will be discussed in turn.

It was found that those groups functioning in hospital settings were purchasing the services of consultants on a very limited basis as only 25% of them reported they were doing this. Twenty-four hospitals responded to this question. One group mentioned that they had psychiatric services and family workers provided to them free through joint agreements. Those 25% using consultants were turning towards psychiatrists, social workers, group specialists and management specialists to help fill voids in their programs.

This limited use of specialists by hospitals could be due to a lack of money available for use in this way, a conviction that any services needed could be provided by already existing staff, or a certain lack of commitment by hospital administrators to become any more involved in the service area.

The parent self-help, advocacy and social service groups were making more extensive use of consultants. Thirteen of the 19 groups responding, 68%, reported purchasing the services of consultants. These groups were using many different types of consultants; the most frequently mentioned were psychologists, psychiatrists, and pediatricians.

Two of the groups used consultants for training, while two others used them to help with management type decisions.

The services of these experts seemed to be needed only on a limited basis, but were necessary for certain parents and children. Because having these professionals as full-time staff members would be very expensive, the purchase of their services on an as needed basis helped stretch already limited budgets.

One area where there seemed to be a difference between hospital settings and the "other" groups was in the use of volunteers. A very important part of the treatment offered by the groups classified as "other" appeared to be the extension of services through the assistance of volunteers. Only 14%, three of twenty-one, of those groups stated that they were not using volunteers, and two of those three had volunteers built into their long-range plans. In the hospital based programs, volunteers were being used in 42% of the groups. Twenty-four hospitals responded to that question. Of interest is the fact that some of the hospital groups with small staffs were not utilizing volunteers in their programs, as of yet.

Volunteers were used by the various groups in many different ways and seemed to be the key in many instances to the variety of services that could be offered. Twenty-one percent of all groups who used volunteers, had programs which centered completely around the volunteers. In these cases they manned the 24-hour crisis or hot line, worked with both the parent and the child, provided emergency respite care, led parent groups, participated in speakers bureaus, and provided transportation.

Volunteers serving as parent-aides or lay therapists seemed to be the most popular use. In these cases, aides were called upon to visit those parents in treatment to establish a positive, friendly relationship with them in an attempt to alleviate the loneliness and isolation which is often present in abusive or neglectful families. A major purpose of this relationship was parent education and "re-parenting". This is a process whereby the aide becomes a parent-surrogate; someone accepting of the person being worked with; available to them at any time of day or night depending on need.

Providing the parents a chance to be away from the child periodically during the day was also an important aspect of the therapy being offered by many of the respondents. To encourage this, eight of those sampled mentioned that volunteers were also working with the abused children in child-care facilities. In three cases, groups mentioned that they were using graduate students in various kinds of volunteer roles. The most common seemed to be that of case-aide or leader of parent groups.

Another popular use of volunteers dealt with education within the community. Speakers bureaus were formed offering presentations to any interested community group or educational institution. Volunteers also served as advisory council board members, intake workers, statisticians, clerical help, in data gathering and in providing transportation to families in need.

Considerable additional information was received from the respondents concerning the recruitment, training and use of volunteers. A synopsis of that material follows here.

The Child Abuse Listening Mediation, Inc., (CALM) in Santa Barbara, California, was established to determine the feasibility of an outreach appeal to parents with problems. Three groups of volunteers contributed thousands of hours of time to CALM each year: 1) a 21-member Advisory Board of Trustees; 2) a fund-raising Auxiliary consisting of 40 active members and 30 associates; and 3) 20 case work lay therapists who went into homes of clients, to help distressed parents. CALM required that lay therapists must have had two warm parents who had a solid emotional childhood and must have been successful parents themselves. They required no course work or professional training. They responded as a friendly next-door neighbor answering phone calls at any time, and were available in moments of crisis. Their specific duties were to provide "mothering," that is, to be a friendly and supportive listener and a sympathetic friend who encouraged parents to develop their own ideas and build up their own self-esteem. No volunteer was allowed to have more than two clients at a time. (Pike, Note 1).

Another group called Parental Stress Service used their volunteers in much the same way. They visited the client's home both on an emergency basis and on a regular basis to establish a helping friend and advocate relationship with the parent. The PSS volunteers also answered the 24-hour telephone hotline and provided active listening and sympathetic counseling, giving callers an opportunity to reduce their anger and frustration and gain control over their emotions. They also had volunteers who led parent groups, provided emergency respite care and formed a speakers bureau.

Their volunteers were recruited through public announcements, requests to church and service groups, community contacts, and word of mouth. The director used an extensive questionnaire and interview to screen each volunteer. After a 30-hour pre-service training course, each volunteer was expected to make a one-year commitment for a minimum of four hours per week of service, and attend the twice monthly inservice training sessions. The classroom training, entailing lectures by the staff and outside professionals and role playing, covered the dynamics of child abuse, telephone crisis counseling, identification of high risk cases, treatment of the parent, child development, legal aspects, and resources in the community (Parental Stress Service, Note 2).

The Children's Trauma Center (CTC) used the Junior League of Oakland as volunteers in their project. They were trained by CTC to provide assistance in three areas: 1) a parent-aide program where volunteers were involved in the "re-parenting" process; 2) a child-enrichment program which provided child care, creative activities, and language development to abused children whose families were in treatment with the Center; and 3) a media-speakers group that used slides and narration when addressing community groups and high school social living classes regarding child abuse and the issue of parenting.

To become qualified to volunteer in one of those three areas, the League members underwent an extensive seven-week training program. The course included an overview of child abuse, medical and legal aspects of child abuse, the abused child in a day care treatment program, cultural differences in families, abusive parents told it like it was, and an exploration of each volunteers violent feelings and a discussion of

how we use anger to cover feelings of fear and helplessness (Childrens Trauma Center, Note 3).

Parents Anonymous is a national crisis intervention program whose primary objective was to help and prevent damaging relationships between parents and their children. Through the organization, parents served as a type of volunteer in aiding themselves and other parents. Members met together in a chapter meeting with parents who have similar difficulties as often as once a week.

The chapter members selected a member to provide the active leadership. This member was then the chapter chairperson, who was backed up by a sponsor, a professional person in one of the mental health fields. Together, the group members supported and encouraged each other in searching out positive alternatives to the abusive behavior in their lives. Members also shared phone numbers and, occasionally addresses, so that during the week, should a crisis arise, they could call or visit one another for direct help. They also called other group members and shared their successes in preventing a crisis or abusive incident (Parents Anonymous, Note 4).

The speakers bureau concept seemed to be a very important one, as many persons in the field believe that if abuse is to be deterred, education for parenting must begin early in life. By speaking to teenagers in junior high schools about the kind of training they need to become good parents, it is hoped the cycle of abuse can be broken in some families.

These were just a few examples of the ways volunteers could be recruited, trained and utilized. They were indeed, providing many

valuable services to the parents they were working with. Without volunteers, it is doubtful that the list of direct services provided by these groups would have been as extensive.

Some groups found that another way to better meet the needs of their families was to purchase actual services for them when necessary. Only 18%, seven of forty-one, of all respondents were involved in doing this. It could have possibly been due to limited funds available to these groups. Those services being purchased were day care, counseling, homemaker and art therapy for the children.

Referral of families. One action that was being consistently taken by all the groups surveyed concerned the referral of families to other agencies or professional individuals. Only one group in the survey mentioned that they were not offering any referral services. However, this hospital was offering a wide variety of services itself to the families with whom they were dealing.

Many different types of agencies and individuals were mentioned by the respondents. The one referral mentioned most frequently was the Department of Family Services (social service welfare agency) which usually housed a Protective Services unit for investigating all suspected cases of child abuse and neglect.

Other frequently mentioned agencies included: mental health, family and child counseling, day care facilities, public health groups, child guidance clinics, psychiatric agencies and private practitioners, visiting nurses, and juvenile court and probation offices. Others being used for referral included Planned Parenthood, employment counselors,

legal aide associations, crisis hot/lines, homemakers, Parents Anonymous, lay therapists, physicians, special education centers, police departments, Big Brothers and Big Sisters, the Salvation Army, and residential treatment centers.

Although many services were being offered directly by the groups sampled it can be seen that a variety of other services were being made available by referral of the parents to other organizations or individuals who had additional expertise. The use of these various types of referral services was an important part of the treatment of parents. It was understandable that these groups surveyed could not possibly offer all the services that the parents were in need of; thus referring them to others depending on the need, was critical.

Services offered. Those responding to the questionnaire were asked to categorize the kinds of services that they directly provided for their families. A total of 43 groups responded to this question. The frequencies of the various services offered are shown in Table III. The most frequently offered service by all groups was individual counseling, followed by group counseling and family therapy. "Other" included lay therapists (2), parent aides (2), child development, referral services, speakers bureau, crisis nursery, speech and hearing tests, foster care, parent education (3), homemaker, extended family involvement, and parent groups (3).

One service which was not being provided by any of the groups was that of alcohol/drug treatment. As this is one of the reasons mentioned which could trigger child abuse in some families, it seemed strange

TABLE III

SERVICES OFFERED

Services	Primary Breakdown		Total
	Hospitals	Other	
Psychological evaluation	12	3	17
Alcohol/drug treatment	0	0	0
Housekeeping	2	4	6
Hot line/emergency	7	13	20
Individual counseling	20	13	33
Psychiatric treatment	9	1	10
Group counseling	14	12	26
Financial counseling	5	4	9
Transportation	9	10	19
Family therapy	18	8	26
Legal aide	4	1	5
Medical help	15	4	19
Day care	6	9	15
Other	4	12	16

that none of the groups included that type of treatment in their programs. (This service was not included even in referral services listed by any of the respondent groups.)

The main services being offered; individual counseling, group counseling and family therapy were aimed toward helping persons better understand themselves and working out conflicts in their personality. It is interesting to note that even hospitals recognized the importance of counseling as a service and listed it as number one over medical help.

Another frequently offered service which seemed to be gaining popularity was that of a hot line/emergency telephone service. Groups were finding that having someone to talk with who is non-threatening and non-judgemental could be an effective deterrant for parents experiencing child-rearing problems. CALM's self-referral rate, which used a 24-hour Listening Referral Resource Center, rose from 25% in 1970 to 61% in 1974, which led them to believe that they were making some progress in the prevention of child abuse and neglect in their area (Pike, Note 1).

Another important aspect of services was that of providing transportation to parents in therapy. This eliminated an excuse that the parent might try to use for non-attendance at treatment sessions or group therapy. It also provided an excellent opportunity for the person providing the transportation to establish a warm, trusting relationship with the client outside of the therapeutic setting.

As many of the referrals for abuse and neglect come from multi-problem families, it seemed logical that a multi-service approach would be most advantageous to all involved.

Arrangements for the children. This study was also geared toward discovering what arrangements were being made for the abused or neglected child while the parents were in treatment. Respondents were asked to list appropriate categories and pin-point the one arrangement being used

TABLE IV

ARRANGEMENTS FOR THE CHILDREN

Arrangements	Primary breakdown		Total
	Hospitals	Other	
Own home	18	18	36
Receiving home	7	7	14
Detention	3	5	8
Foster care	15	10	25
Hospitalized	18	6	24
Day care/play school	1	5	6
Relatives	1	1	2
Special child care homes	0	1	1

most frequently. Thirty-eight of those answering this question did list the alternatives being pursued for the children, but only 23 of those groups pinpointed the one arrangement being used most frequently. Table IV reports the frequencies of all of the options for the children listed on the questionnaire.

The data indicated that these groups had a commitment towards keeping the family together during therapy, whenever the child was not in great danger. Of those 23 groups pin-pointing the one arrangement being used most frequently, 14 left the children in their own homes. Seven groups, all in the hospital setting, listed hospitalization as their first option for the children. Foster care and relatives were listed as first options with one group each.

"The parent who abused a child usually does it because of misplaced love, not hatred. The parent needs help, not punishment, and taking the child away from the parent is often the worst thing to do" (Edelson, 1974).

In the past the most prevalent methods for handling the problem of abuse was with punishment of the parents and removing the child from the home. It was encouraging to note that the practice of separating the family, which created great trauma in the children, was being carefully considered, and other alternatives were being sought. The trend appeared to be toward leaving the child in the home where the family could be worked with as a unit, wherever possible.

The Child Protection Center in Baton Rouge, Louisiana listed these objectives: 1) to prevent separation of parents and child whenever possible; 2) to prevent the placement of children in institutions; 3) to encourage the attainment of self-care status on the part of the parents; 4) to stimulate the attainment of self-sufficiency for the family unit; and 5) to prevent further abuse or neglect by removing children from families who showed an unwillingness or inability to profit from treatment programs (Child Protection Center, Note 5). This was just one

example of the careful consideration that was being given the dilema of what to do with the children.

Other alternatives besides the child's own home were still necessary in certain cases. Hospitalization was often still required as the problem might be discovered when the child was brought into the hospital for treatment of abuse. Many children must be kept in the hospital for treatment of bruises, broken bones or injuries before considering other alternatives.

In other cases where the home situation was threatening or dangerous to the child, foster care and receiving homes were made available for the protection of the child. This solution was necessary in 10% of all cases (Edelson, 1974). It was important that all alternatives be considered and carefully scrutinized before a decision was made on what to do with the child.

Children were included in the treatment of the family in many different ways. The most popular practice was to involve all household members in family counseling or therapy. Thirty-eight respondents also noted that children were involved in individual counseling or, in the case of older children, in group sessions where possible. Many of the children were participating in play therapy, crisis nurseries, day care, therapeutic play school or in child guidance clinics where special schooling was given.

The Valley Children's Hospital and Guidance Clinic was established to offer diagnostic and therapeutic help to both the child and the parents. The children were observed through behavior, play, and testing after which a plan was worked out to find a method with which

the family could eliminate or at least cope with the problems. Behavior therapy, psychotherapy and medication therapy were applied to the child to improve competence. Parents observed how their child was being taught socially acceptable behavior and basic academic skills, so that they could put these techniques into practice at home (Valley Children's Hospital and Guidance Clinic, Note 6).

Many of the groups were offering some type of day care or respite care to the families they were dealing with. These alternatives were important in that they gave the parents a chance to get away from the child for a period of time. This helped alleviate some of the pressures involved with parenting a child 24 hours a day.

Range and average treatment time. Those responding to the survey were asked to indicate what the range of time was from their initial contact with families until they had their last contact or terminated their services. A majority of those answering said that treatment for the families lasted between 1--4 years. One hospital group showing the shortest treatment time said that their involvement with the families only lasted from 2--3 days as they did not actually complete the treatment. Many of the groups that were just getting their programs started were unable to respond to this question.

The groups surveyed were also asked to estimate the average treatment time for their families. Many programs were also unable to respond to this question, and because the question was open-ended, many different ranges of responses were received. Therefore, it was impossible to present the frequencies of the responses in table form.

The most frequent response from both groups was an average treatment time in the vicinity of 3--6 months. The next most frequent category was that of around one year of treatment time. There was very little difference reported by the hospitals and those of "other" groups.

It was difficult to make many conclusions concerning the range and average treatment times reported by the respondents. The apparent thing was that there were no patterns in the data that had been reported. Some of the groups mentioned that involvement could last for "years," indicating that treatment for child abuse and neglect could be a long, involved process with some families. It was encouraging that almost 25% of the total respondents felt that 3--6 months might be the average treatment time for most families. Perhaps it was possible with intensive efforts being made when the families were first referred, to move them through therapy and enable them to function as a parent more effectively in a relatively short period of time.

Most successful treatment methods. Those groups that have been in operation for a period of time were beginning to identify those methods of treatment or therapy that were most successful in changing attitudes and behavior in those families where child abuse and neglect existed. There was a wide range of methods mentioned that were proving most successful with individual groups.

The most frequently mentioned was group therapy or group counseling. Five of those sampled reported this to be the most successful. In some cases this was preceded by individual therapy. One of the programs using groups had found transactional analysis helpful in the group setting.

Three of those in the sample had found some sort of positive parenting or mothering by a therapist or parent aides to be most successful. One of these groups noted that home visits made by the parent aides were significant in helping parents accept and be consistent in attending parent education and group therapy classes also. Several groups mentioned that different things were successful depending upon the family needs, motivations and abilities.

Therapies mentioned as proving successful were behavior therapy and reality therapy. Other methods found to be working were family residential treatment, teaching the non-abusing parent to recognize the need to protect the child, direct contact through community workshops, parent participation in the program, therapeutic day care for the children, supportive assistance given with a positive attitude and concrete services including an emergency fund.

Other approaches mentioned were family life education and self-help consumer operated and oriented programs such as Parents Anonymous. One of the respondents remarked that results had been very discouraging in working with families with a poor psycho-social history. Perhaps this is why some of the groups turned toward treatment based on each individual's need and motivation. What was successful for one person was not necessarily successful for another.

Patricia Beezeley, Assistant Director at the National Center for the Prevention and Treatment of Child Abuse and Neglect made these comments about therapy.

> Therapy for the parent includes helping him build up his sense of self-esteem; helping him develop better basic trust and confidence; helping him to learn how to make contacts with other people in the family, neighborhood and community; helping him to develop the ability to enjoy life and have rewarding, pleasureful experiences with adults and with his own children (Beezley, Note 7).

She went on to mention that groups could be very successful in doing all those things by decreasing isolation and facilitating mutual support systems. Groups provided socialization and helped parents feel that they could possibly be helpful to others. The Children's Trauma Center preferred group therapy because it broke the pattern of social isolation and decreased the stigma of being the only child abuser (Children's Trauma Center, Note 8).

Much of the group counseling and group therapy done included treatment of the family as a whole unit. As the behavior of all family members makes an impact on the atmosphere of the home, it was wise that the children be included in the treatment. The Circle House, the newest treatment facility at the National Center for the Prevention and Treatment of Child Abuse and Neglect was a residential treatment center for the entire family. Daily contact between parent and child was possible and this increased in frequency and duration as the treatment progressed (The Circle House, Note 9). Other examples of how the children were included in an effort to treat the family as a group have previously been mentioned.

Another successful method being used was called "re-parenting." As reported by Edelson (1974), Dr. Henry Kempe discovered through research that a battered child grew up to be a battering parent. Rejected by their own parent, and convinced of their own inadequacy, they had

difficulties in establishing normal relationships with other people and expected a great deal of their children. Dr. Kempe felt the cure for child abuse was to give parents enough self-respect and dignity to achieve the deep friendships they lacked. Through being "re-parented" and building friendships these parents were able to break out of their bonds of loneliness to risk building relationships with others, including their own children. Battering parents need a sustained relationship with a helping person and many of the groups sampled were using parent aides or lay therapists as that helping person. Reports by Dr. Kempe were that the success had been well worth any time necessary for the training of those persons.

Many of these groups were actually sending aides and therapists into the abusive parent's homes to work with them. This seemed to make the situation less threatening and less pressured. The aides were successful in getting the parents to follow through on other treatment and referral that had been arranged for them also.

Several of the groups were including Parent Education or Family Life Education as a part of the treatment process. As many abusive parents had poor knowledge of child development or unrealistic expectations of children, this was also proving successful.

Those groups making use of speakers bureaus were hoping that through Parent Education of the general public also, many misconceptions about child abuse could be cleared up.

After review of the data, it appeared that many different kinds of treatment and therapy might be successful depending on the individual needs of the parents. It was also suspected that groups would generally

stick to those methods which they had success with, rather than experimenting with new approaches. Surely the theoretical framework of staff members dealing with the families also made a difference in what methods were used. It is hoped that all those groups working with parents referred for child abuse and neglect will continue to experiment and try those methods and approaches that have proved successful for other groups.

Chapter V

SUMMARY AND IMPLICATIONS

Summary

In light of the fact that there has been increased legislation to establish and maintain organizations and agencies to deal with parents referred for child abuse and neglect, there are many more of these groups today than there were just five years ago. This exploratory study was undertaken to compile comprehensive descriptive data, describing the referral processes and therapy treatment methods that are being used by these groups across the nation, to change the behavior and attitudes of parents referred for child abuse and neglect.

A questionnaire was sent to 66 groups and agencies that were providing some services to families suspected of child abuse or neglect. The questionnaire asked many questions about the operations of the groups. The intent was to gather information about the staff members employed in the field of child abuse and neglect, what their jobs were, what worker's education was, and if they went to college, what discipline they studied. Questions were asked concerning what direct services were provided, what other agencies or professionals were used for referral, what other types of services and consultants might be purchased by that agency for the client, and the extent of the use of volunteers to provide services and supplement staff. The agencies were also asked to estimate the range and average treatment time for families as well as respond to what one

particular treatment or therapy seemed to be more successful in changing attitudes and behaviors. Questions were also asked to determine what arrangements were being made for the children while the parents were in treatment and to what extent they were being included in the therapy.

Of those questionnaires mailed out, 45 were completed and returned. For reporting purposes, the groups or agencies were broken down into two groups: 1) hospital groups; and 2) "other" groups, representing social service agencies, parent self-help groups, advocacy groups and day care centers.

The researcher determined through this study that it was possible to gather a great deal of information about child abuse and neglect through the use of a mailed questionnaire. In addition to giving specific answers to the questions, many groups sent brochures and printed materials giving supplementary information about their programs.

It was apparent from the data collected, that most of the groups surveyed were basing their program on the team approach method. This was being done in several different ways: 1) by having a variety of staff members performing different kinds of jobs; 2) by purchasing the services of consultants or other agencies; and 3) by a wide use of volunteers to supplement the staff.

As noted in Chapter I, abusive parents have many different types of problems, any one of which may have triggered their response to the child. By turning towards the team approach thereby broadening the variety of services available, it would appear that these organizations were in a better position to meet the particular needs of each parent referred to them.

Limitations

There were several limitations in the collection of data using the mailed questionnaire which should be noted here. Exhaustive attempts were made to locate agencies or organizations from all regions of the United States using many different sources. The National Center for Child Abuse and Neglect, located within the Department of Health, Education, and Welfare should have been an excellent source, but it was impossible to get through their secretary to obtain anything, besides a list of projects that they have funded. The National Clearinghouse for Child Abuse and Neglect, operated by the American Humane Society also proved to be a disappointment in providing assistance. Even after agencies had been identified that might be included in the sample, it was difficult to obtain a current and correct mailing address. Because of this, there were probably many agencies and groups providing services for child abuse and neglect that were not included in this sample.

It would appear that when a person in an organization received a questionnaire requesting information, they either filled it out immediately and returned it, or set it aside and forgot about it. Most of those questionnaires that were returned without a second contact by the researcher, were returned within a week of when they had been originally sent to the group.

It was discovered that, evidentally, some of the persons filling out the questionnaire did not take it seriously. Some survey forms were returned only partially completed with no explanations for those items left blank. After reviewing those incomplete forms and checking the list of those questionnaires that had not been returned at all, it was

decided to contact those agencies or groups by telephone to insure a greater return of data. Another problem emerged here, as it was very difficult and time consuming to locate the correct phone numbers of the groups in question.

When placing a telephone call, the researcher was often transferred three to four times within an agency in an attempt to locate the person that might have received the questionnaire. Upon finally locating that person or the person in charge, it was discovered that many had no recollection of ever receiving the questionnaire. When this was the case, it was necessary to send a second questionnaire which was addressed attention of that person in charge. Even after having talked with those persons on the phone, several of the forms which were re-sent to the groups were never completed and returned.

Through these phone contacts, it was also discovered that several of the groups receiving questionnaires did not have a unit within their organization to deal with child abuse and therefore were unable to answer the form. These groups had to be deleted from the sample as data collected from them would have been irrelevant.

Research Implications

The actual treatment of families for child abuse or neglect, as well as a network of referral services for these same families, is a relatively new notion in the social service field. Because of this, it was quite difficult to actually locate those groups and organizations that are providing those kinds of services. The Department of Health, Education and Welfare should take upon itself the task of locating all

these groups to compile a list of those actually working with families, as well as a listing of the various types of services provided. This study is just a start in that direction, but much more needs to be done.

Additional research should be conducted to determine what methods and treatment techniques are actually proving most successful in changing the behavior and attitudes of those parents referred for child abuse or neglect. This study briefly touched upon that, but as groups have been in operation for longer periods of time, it should be possible to do more extensive research on this subject.

It would also be helpful to obtain additional information on the use of volunteers in the treatment of child abuse and neglect. With limited funding available at the current time, they can possibly become a viable alternative to the hiring of additional staff members.

Theoretical Implications

One noticeable thread seems to run throughout the data that was collected for this study. That is the importance of "education." This "education" must include the entire community: those working with children in schools, hospital personnel, law enforcement officers, private physicians, day care attendants, etc.; the public in general; and last but not least, parents themselves. As people become more aware of the causes of child abuse and neglect and have the understanding that all parents have the potential for being abusive or neglectful given the right set of circumstances, the stigma of seeking help for the problem should be eliminated.

Along with increased public awareness must come a commitment for including parent education in the curriculum of the school systems. Parenting is one of the most important jobs a person can undertake. Therefore, Parent Education seems to be imperative to the general health of the nation and to the prevention and cure of child abuse.

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4. Parents Anonymous. Child abuse: Who are the victims? What is being done? Brochure, Redondo Beach, California, 1975

5. Child Protection Center. EBR Community Coordinated Child Care. Brochure, Baton Rouge, Louisiana, 1974

6. Valley Children's Hospital and Guidance Clinic. What's happening to us? Brochure, Fresno, California, c 1970

7. Beezley, Patricia. Group treatment of abusive parents. University of Colorado School of Medicine, Humphreys Postgraduate Center, Photocopy of typed material, Denver, Colorado, c 1970

8. Children's Trauma Center. Photocopy of typed material, Alemeda County, California, April, 1975

9. The Circle House. The National Center for the Prevention and Treatment of child abuse and neglect, Photocopy of typed material, Denver, Colorado, June, 1975

Appendix A

SAMPLE LIST

Hospital Groups

1. Childrens Hospital Medical Center
   300 Longwood Avenue
   Boston, Massachusetts 02115
   617-734-6000 ext. 2861

2. New England Medical Center
   171 Harrison Avenue
   Boston, Massachusetts 02111
   617-482-2800

3. Joseph P. Kennedy, Jr. Memorial Hospital
   Brighton, Massachusetts 02135
   617-254-3800

4. Childrens Memorial Hospital
   2300 Childrens Plaza
   Chicago, Illinois 60614

5. Childrens Hospital Medical Center
   Elland and Bethesda
   Cincinnati, Ohio 45229
   513-559-4228

6. Childrens Hospital
   561 South 17th Street
   Columbus, Ohio 43205
   614-253-8841

7. Childrens Medical Center of Dallas
   1935 Amelia Street
   Dallas, Texas 75235
   214-637-3820

8. The Childrens Hospital
   1056 East 19th Avenue
   Denver, Colorado 80218
   303-861-8888

9. Fairfax Hospital
   3300 Gallows Road
   Falls Church, Virginia 22042
   703-698-3201

10. Valley Childrens Hospital
    3151 North Millbrook
    Fresno, California 93703
    209-227-2961

11. Hawaii Child Abuse Demonstration Center
    Kauikiolani Childrens Hospital
    226 North Kaukini Street
    Honolulu, Hawaii 98817

12. Texas Childrens Hospital
    6621 Fannin Street
    P.O. Box 20269
    Houston, Texas 77025
    713-521-2070

13. The Childrens Mercy Hospital
    24th at Gillham Road
    Kansas City, Missouri 64108
    816-471-0626

14. Milwaukee Childrens Hospital
    1700 West Wisconsin Avenue
    Milwaukee, Wisconsin 53233
    414-344-7100

15. Childrens Health Center
    2525 Chicago Avenue South
    Minneapolis. Minnesota 55404
    612-871-1134

16. The Family Development Program
Martland Hospital Unit
Department of Social Services
65 Bergen Street
Newark, New Jersey 07107

17. Yale-New Haven Hospital
789 Howard Avenue
New Haven, Connecticut 06504

18. Childrens Trauma Center
Childrens Hospital
Oakland, California

19. Childrens Hospital of Philadelphia
One Childrens Center
34th Street and Civic Center Boulevard
Philadelphia, Pennsylvania 19104
215-EV7-6000

20. Demonstration Center for Child Abuse and Neglect
2600 North Lawrence Street
Philadelphia, Pennsylvania 19133

21. University Presbyterian Hospital
51 North 39th Street
Philadelphia, Pennsylvania 19104
215-662-8000

22. Family Resource Center
St. Louis Childrens Hospital
4386 Lindell Boulevard
St. Louis, Missouri 63108

23. The Childrens Hospital
311 Pleasant Avenue
St. Paul, Minnesota 55102

24. Mary Bridge Childrens Health Center
311 South L Street
Tacoma, Washington 98405
206-BR2-1281

25. Child Abuse and Neglect Model Center
Research Foundation of Childrens Hospital
2125 13th Street, N.W.
Washington, D.C. 20009

"Other" Groups

1. Pro-Child
Department of Human Resources
P.O. Box 7258
Arlington, Virginia 22207

2. Child Protection Center
Division of Family Services
P.O. Box 44065
Baton Rouge, Louisiana 70804

3. Parental Stress Service
P.O. Box 9266
Berkeley, California 94709
415-845-6243

4. Bedford-Stuyvesant Family Services Program
The Wiltwyck School
1239-41 Fulton Street
Brooklyn, New York 11216

5. The Family Learning Center Project
Adams County Department of Social Services
4200 East 72nd Avenue
Commerce City, Colorado 80022

6. Protection Service System
State Division of Youth and Family Services
1155 Magnolia Avenue
Elizabeth, New Jersey 07207

7. Family and Child Advocates
Evanston Mental Health Services
1601 Sherman Avenue
Evanston, Illinois 60201

8. Parents Anonymous
2930 West Imperial Highway
Suite 332
Los Angeles, California 90303

9. Child Abuse Prevention Services
P.O. Box 815
Napa, California 94558
707-252-1116

10. National Center for Comprehensive Emergency Services to Children
320 Metro Howard Office Building
25 Middleton Street
Nashville, Tennessee 37210

11. Parents Anonymous
250 West 57th Street
New York, New York 10019
212-765-2336

12. Child Abuse Prevention Effort
P.O. Box 12662
Philadelphia, Pennsylvania 19129
215-471-4488

13. Philadelphia Child Advocacy Project
Philadelphia Urban League
4089 Lancaster Avenue
Philadelphia, Pennsylvania 19104
215-387-2801

14. Parents Anonymous
2810 Artesia Boulevard - Suite F
Redondo Beach, California 90278
213-371-3501

15. Child Abuse Listening Meditation
P.O. Box 718
Santa Barbara, California 93102
805-963-1115

16. Family Stress Center
YMCA Human Development Department
1115 Eighth Avenue
San Diego, California

17. Family Resource Center
New Mexico Social Services
P.O. Box 2348
Santa Fe, New Mexico

18. The Extended Family Center
Mission Child Care Consortium
2756 24th Street
San Francisco, California 94110
415-282-3922

19. Parent and Child Effective Relations Project
Juvenile Welfare Board
3455 First Avenue South
St. Petersburg, Florida 33711

20. The Panel for Family Living
1115 South 4th Street
Tacoma, Washington 98405

Appendix B

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Reston, Virginia 22090

Susan Smith
11624 Newbridge Court
Reston, Virginia 22091

Dear Sirs,

The enclosed survey form is part of a research study being done for a master's thesis in Management, Housing and Family Development at Virginia Polytechnic Institute and State University.

Comprehensive descriptive data is being compiled on the various types of referral and therapy treatment processes that are being developed across the nation to work with families who have been referred for child abuse or neglect. Information on the final results of the study will be available upon request.

Would you please fill out the survey form as it applies to your agency and return it as soon as possible. It would also be appreciated if you would enclose any available printed material about your specific program.

Because of the national scope of the study, it is important to receive feed-back from as many sources as possible. If you know of other groups that could provide information about their programs, will you please include the name and address of the organization so they can be contacted.

Thank you for your cooperation in this study. A prompt reply would be greatly appreciated.

Susan Smith
Susan Smith

Ben Silliman
Dr. Ben Silliman
Assistant Professor
Counseling & Research
VPI & SU

Name of Organization

1. How many staff members do you have working for your organization or specific unit?

2. What types of jobs do they hold and how many work in each area?

_____ intake	_____ Doctors	_____ aides
_____ counselors	_____ nurses	_____ other (specify)
_____ investigators	_____ clerical	
_____ social workers	_____ administrators	

3. What is the educational background of the people working directly with parents? (Indicate how many in each area.)

_____ less than high school	_____ college graduates (MA or MS)
_____ high school graduates	_____ college graduates (Phd or EdD)
_____ college graduates (BA or BS)	_____ other (specify)

4. What disciplines are included in the education of those with college degrees specified above? (Indicate how many in each area.)

_____ social work	_____ child development
_____ counseling	_____ psychology
_____ medicine	_____ other (specify)

5. Do you use volunteers in your program? If so, in what way and to what extent.

6. Do you purchase the services of consultants for your agency? If so, of what type.

7. What arrangements are being made for the children while you are working with the parents? Check those used and circle the one which is used most frequently.

_____ remain in the home	_____ placed in foster care
_____ placed in receiving home	_____ hospitalized
_____ put in detention	_____ other (specify)

8. If some form of counseling or therapy is included in your procedures, are the children included? If yes, in what way or to what extent?

9. Do you refer your families to other agencies or professional individuals? If so, specify which agencies, professional specialties, and what kind of services they provide. (If more space is required, please add an extra sheet.)

10. What kinds of services do you directly provide for your families? (Check the applicable ones.)

_____ psycological evaluation	_____ psychiatric treatment	_____ legal-aide
_____ alcohol/drug treatment	_____ group counseling	_____ medical help
_____ housekeeping services	_____ financial counseling	_____ day care
_____ hot-line/emergency	_____ transportation	_____ other (specify)
_____ individual counseling	_____ family therapy	

11. Do you purchase services for your families? (If so, from whom and to what extent.)

12. What is the range of time involved from your initial contact with families until you have your last contact or terminate your services?

13. What would you estimate as the average treatment time for families?

14. Is there one type of treatment or therapy that you are finding is more successful in changing attitudes and behaviors than others? If so, what.

VITA

PERSONAL DATA

Birthdate: August 10, 1943

Address: 11624 Newbridge Court
Reston, Virginia 22091

Telephone: Home - (703) 860-4394
Work - (202) 254-7983

EDUCATION

University of Utah
B. of Music, 1965

Virginia Polytechnic Institute and State University
M.S., Child Development, to be awarded June 1976

EMPLOYMENT

March 1975 to present

Evaluation Specialist, ACTION (Government Volunteer Agency), Washington, D.C.
Project Manager for Project Evaluations of Older American Volunteer Programs (Foster Grandparents and Retired Senior Volunteer Programs). Responsible for assessing needs, developing evaluation criteria, design and implementation of questionnaires for data collection, training and supervising other employees in use of the questionnaires, performing data collection through on-site field visits throughout the United States, completing and analyzing results of data collection, handling all correspondence related to evaluations, writing reports and construction of a final report and national profile.

August 1974 to March 1975

Research Analyst, Olympus Research Corporation, Washington, D.C.
Analyzed local self-evaluation methods being used nation-wide, developed a linear reprogramming model for optimizing program alternatives, designed and revised training simulations to assist CETA Prime Sponsors and manpower planners in improving evaluation techniques. Developed a government proposal for training professionals working in the field of child abuse and neglect.

May 1974 to August 1974

Part-time Executive Director, Childcare Assistance Program for Special Children,
Springfield, Virginia.
Duties included recruitment of registry members (Sitters for handicapped children) through advertisement in various media, coordinating of training sessions of registry members with the Northern Virginia Training Center for the Mentally Retarded, supervision of the Registrar (a part-time employee), public relations work in the community, fund-raising from local community agencies, submission of budgetary requests to services boards in Northern Virginia.

October 1973 to August 1974

Child Care Teacher, Common Ground Child Care, Reston, Virginia.
Duties included team teaching in a classroom with 20, 2, 3 and 4 year olds, planning early learning projects, arts and crafts, field trips, music program, language and social development, etc., supervision of 3 other teachers, and scheduling of work hours and duties.

September 1970 to July 1973

Day Care Licensing Specialist, Division of Family Services, Salt Lake City, Utah.
Responsible for recruiting, licensing, training, evaluating and supervising Family Day Care Homes for placement of children on welfare. Set up training for new applicants, renewed Day Care licenses, edited State Day Care Newsletter, initiated a licensing

outline used statewide, helped develop a system of re-evaluation of day care homes for state-wide use, assisted in setting up a Federal Monitoring System for Day Care, assisted in starting a mandatory training and orientation program for all applicants, started a library of educational books for use by day care providers and helped initiate additional training through homemade toys taken on supervisory visits.

November 1965 to October 1966

Child Welfare Worker, Division of Family Services, Salt Lake City, Utah.
Responsible for supervising children placed in Foster Homes, reporting a Juvenile Court on progress of children each 3 months, evaluating progress of natural parents and children, supervision of foster parents, supervision of AFDC case of natural parents whose child had been placed in foster care because of child neglect or abuse.

ACTIVITIES

Member of Mu Phi Epsilon, National Music Honorary
Member of Spurs & Cwean, National Honorary Service
Member of Delta Gamma, National Social Sorority
Member of Alpha Lamba Delta and Phi Kappa Phi- National Scholastic Honoraries
Volunteer for Suicide Prevention 1971-1972
Member of Governors Committee to establish an Office of Child Development in Utah
Member of Phoenix Institute - a Professional Management Consulting Organization
Leader of Children the Challenge Parent study groups, 1974-1975
Member of NAEYC
Drafted a Manual for Training to be used by Family Day Care Providers to improve their skills and the type of care they give children placed in their homes.

Susan Smith

CHILD ABUSE

REFERRAL PROCESSES AND TREATMENT METHODS

by

Susan A. Smith

(ABSTRACT)

The purpose of this study was to compile comprehensive descriptive data concerning the referral processes and treatment methods developing across the nation for treatment of parents referred for child abuse or neglect.

A sample list was compiled which consisted of 66 agencies that are providing services to those parents. Data was collected through a mailed questionnaire. The results were compiled using 45 completed questionnaires.

Concerning staff working in the field, data revealed there were no consistent patterns which related to staff size. The majority had a staff of 15 or under: the range was zero (no one officially assigned) to 43. Groups augment staff by purchasing outisde consultants or services, referral to other agencies or individuals, and an extensive use of volunteers. Volunteers are used in different ways: on hot-lines; providing respite and day care; leading parent groups; in speakers bureaus; providing transportation; and as parent-aides.

The percentage of staff members having at least a bachelors degree in college was quite high. The discipline studies most frequently by staff was social work. In staffing, groups start with an administrator and clerical staff. As they grow larger, they most

frequently added social workers. There was much diversity in jobs, showing they are turning towards the team approach.

When the child is not in danger, groups prefer to leave the child in his own home. Children are often included in treatment; through therapeutic day care, individual or group counseling, and family therapy.

Many different types of services were offered. The most frequently mentioned was individual counseling, then group counseling and family therapy. Group therapy and counseling was mentioned as the most successful treatment method.

The average treatment time seems to be in the vicinity of three to six months, but groups indicated therapy could last for years.